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# EVIDENCE BASED MIDWIFERY

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# Accessing data from safe havens and warehouses: pinnacles and pitfalls

*Key words:* Data access, safe haven, data warehouse, evidence-based midwifery

The next research assessment exercise is on the horizon and it is time for midwives to consider how to map and plan a path to achieving reliable and valuable public health research data on the childbearing population. 'Big data' population data, linked data and anonymised data are now available for the clinical and research community to explore, combine and test, providing midwives with new information sharing opportunities.

This means that midwives and women, with researchers, have new opportunities to engage in finding answers to key questions that impact on maternal and child health and wellbeing at the macro, meso and micro levels.

Opportunities for multidisciplinary research that starts in pregnancy and ends in Primary 7 or beyond is now theoretically possible. For example, how many of us have wondered about the milestone achievement of babies growing into childhood with complex instrumental births compared to babies with ideal physiological births?

What about the babies whose mothers had to take anti-depressants or anti-epileptic drugs, or insulin therapies and what about longer-term educational outcomes for the preterm babies?

Now we can do much more than wonder – we can actually search a large combined data set to obtain a sufficient sample of linked data from registries of birth, child health and educational attainment to answer questions with more robust evidence.

The intermediary role of the Honest Broker Service (HBS) (Health and Social Care, 2015) is a new development in UK politics and one that is likely to have a huge impact on the distribution of taxpayer's money in years to come. Imagine if you could predict the most effective targeting of resources across the UK, based on robust data from a range of relevant resources? Tempting, indeed. The potential for future planning to optimise health and social welfare is becoming a reality as we move rapidly towards full digitisation.

Why am I so excited about this? The answer is simple. For years we have tried to access reliable maternity, child health and medication data and obstacles presented to securing these have included limited access due to handheld records in archives, data spread across multiple sites, missing data entries, missing data from files, difficulty in securing access, time restrictions, governance issues and politics.

Today, whether you are a practitioner, an educator, a manager, an organisational body – such as the RCM – or a researcher, we all have access to valuable intelligence data gathered through the intermediary role of the HBS and brought into the safe haven of a data warehouse for us to explore: electronic data that has been imported, verified and cleaned (Health and Social Care, 2015).

Data access and security agreements have been put in place, appropriate training in using the data has been provided and ethical and research governance procedures are in place. Looks very straightforward, you may think. However, the process of securing access and bringing data from various sources is not simply 'a couple of clicks away'. Accessing data from safe havens and warehouses has both pinnacles and pitfalls.

My experience of recent encounters has demonstrated teething problems in the new system. I can assure you these problems are not insurmountable and they are similar to those encountered in developing any new system. They are more to do with understanding the administrative processes, including research governance and ethics, but most of all getting your head around the length of time it takes to draw in the data and the financial costs incurred.

I was first introduced to the HBS about a year ago and the pinnacle before me was the great potential for a data crunching climb that made my jaws grind with excitement. However, having engaged with the services, I now know the pitfalls and would advise taking time to chew over some of the following challenges and consider the money required to obtain the data and the time factor involved, including acquiring full ethical approval and research governance.

My research team was quoted an estimated cost of £450 per day for the services required and at least four days of work for our specific projects that required data from all of Northern Ireland and access to three different datasets (maternity, child health and prescription). The pitfall for us was not expecting to have to pay for the service as the cost was not included in the sales pitch in December 2014.

My closing comments for this year are that the potential for rich and valuable research outcomes of immense public health benefit surpass any discomfort that is associated with bedding down a new service and living with the teething troubles.

In conclusion, everything has a cost. Hopefully in the future we may agree licensing for institutions to access certain datasets and thereby minimise costs to this excellent data rich resource, because if we search this haystack of information, we will surely find the needles that prick our consciences and jettison us into reasoned action and the delivery of worthwhile public health outcomes.

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**Professor Marlene Sinclair, editor**

PhD, MEd, PGDip, BSc, RNT, RM, RN.

Professor of midwifery research at Ulster University, Northern Ireland

# Generativity: transforming and transmitting midwifery practice

***Valerie Larkin** Phd, BA, RM, RN.*

Senior lecturer in midwifery, University of Northumbria, Room H210, Coach Lane Campus East, Coach Lane, Benton, Newcastle upon Tyne NE7 7XA England. Email: val.larkin@northumbria.ac.uk

Abstract

*Objective*. To explore midwives' perceptions of developing their practice knowledge and skills, concerning maternal postnatal genital tract assessment (GTA); and to highlight how midwives pass on their practice knowledge and skills to student midwives.
*Design*. A constructionist grounded theory methodology was employed to guide the design and processes. Ethical approval was gained from the regional research ethics committee and the research and development committee at the data collection site. Sampling was purposeful and data were collected using narrative style in-depth interviews involving 14 midwives.
*Setting*. A small maternity unit providing midwifery care to childbearing women in both the hospital and community setting in the north east of England.
*Findings*. The findings of this study suggest midwives engage in two processes: transforming practice and transmitting practice. Transforming practice involved the midwives progressively changing their practice over time. The principal factor that affected the midwives transforming their practice was engaging in diverse practice experiences, which facilitated competence and confidence with a range of assessment methods. Transmitting practice involved the midwives creating learning opportunities for student midwives and articulating their clinical reasoning. However, the midwives voiced concerns that changes to maternity services provision limited the contact midwives and student midwives had with women postnatally. They believed this impacted upon the ability to develop and pass on their practice knowledge and skills concerning maternal postnatal GTA. The findings suggest midwives engage in generativity, a process in which adults attempt to develop a future legacy by initiating change in the thoughts and actions of themselves and others.
*Conclusions*. This study provides a rich understanding, from the midwives' perspectives, of how and why their midwifery practice knowledge and skills concerning maternal postnatal GTA has changed. The significance of opportunities to engage in diverse experiences and opportunities for discourse and reflection to transform experience into learning is highlighted.

*Key words*: Postnatal care, genital tract, assessment, education, student midwives, evidence-based midwifery

## Introduction

The demands upon UK healthcare provision are increasing, reflecting changing public expectations, complex health needs, advances in care and restraints upon financial and human resources (NHS England, 2014). This, together with an increased complexity in their caseload, creates challenges for healthcare practitioners and requires healthcare staff to be responsive and adaptive with changing skill sets, reflecting a commitment to lifelong learning (Department of Health and NHS Commissioning Board, 2012). This paper presents findings from a research study exploring midwives' experiences and practice in relation to their assessment of maternal genital tract health. It will present data from the study concerning how the midwives perceived they had developed their practice knowledge and skills post-registration, and how they attempted to pass on this midwifery expertise to students.

## Background

Midwives have a professional responsibility to provide midwifery care to women and their families throughout the childbirth continuum (WHO, 2014; NMC, 2012). Following childbirth, women experience a range of physical and emotional health needs, which are complex and interrelated and, if unfulfilled, may impact upon their health and wellbeing, including social roles such as childcare and employment (Woolhouse et al, 2014).

Maternal physical health needs include those associated with the genital tract, particularly perineal morbidity and uterine bleeding and infection (East et al, 2011). Therefore, the assessment and prompt identification and treatment of postnatal genital tract health is a maternal health priority (Knight et al, 2014). As assessment underpins care decisions, the ability to provide safe, effective and sensitive care rests upon the ability of the practitioner to make appropriate assessments utilising effective clinical reasoning abilities (NMC, 2015). Professional guidance suggests a holistic and individualised approach to maternal postnatal genital tract health. Therefore, midwives must decide if and what form of genital tract assessment (GTA) method they will employ (NMC, 2012).

Within the literature, there are a range of terms utilised to define the thinking processes that inform practice actions. These include clinical reasoning, critical thinking, theoretical reasoning, reflective reasoning, diagnostic reasoning and decision-making (Jefford et al, 2011; Simmons, 2010).

Clinical reasoning involves thinking about issues, decision-making processes and produces knowledge in and for practice, which influences practice actions (Simmons, 2010; Mattingly and Fleming, 1994). It results from the integration of knowledge and insights concerning practice, the client, practitioner and context to inform the most appropriate selection of practice decisions and actions for that particular client on that particular day (Jefford et al, 2011; Simmons, 2010). This is sometimes referred to as praxis, an integrative, ethical and action-orientated response to client needs, initially proposed by Aristotle (Kilpatrick, 2008; Connor, 2004).

There is an established body of work examining how healthcare practitioners develop and refine their reasoning

abilities, suggesting engagement with an increasing repertoire of practice experiences, professional knowledge and skills are significant factors (Bonis, 2009; Higgs et al, 2008; Hunter, 2008; Eraut, 1994). This occurs pre-registration, with practice mentors and educators providing appropriate learning opportunities for students, but also post-registration, as practitioners engage in the diversity of practice experiences and respond to a range of evolving healthcare demands and practices (Skirten et al, 2012; NMC, 2008; Eraut et al, 2005). However, work to date has not explored how midwives evolve and develop their practice knowledge and skills in relation to postnatal GTA.

The present demands and challenges upon the UK healthcare system make this exploration timely. Within maternity care, postnatal care and service provision is frequently perceived to be marginalised and potentially at risk during times of service change and limited resourcing (Wray and Bick, 2012). There has been concern expressed in the professional literature about the content and provision of contemporary postnatal care (RCM, 2014a; Care Quality Commission (CQC), 2013). Issues raised include a potential 'decline in the standard of care received': a reduction of inpatient stay and a reduction in the number of postnatal contacts between midwives and postnatal women (Wray and Bick, 2012: 495). A national survey of midwives conducted by the RCM identified the most significant factor influencing the decision about the number of postnatal visits a woman receives is organisational pressures rather than maternal need (RCM, 2014b).

## Design and method

A constructionist grounded theory methodology was employed to guide the research design and processes, including analysis of the data, the use of theoretical sampling to evolve the emerging research categories and the construction of a grounded theory (Charmaz, 2006).

Ethical approval was gained from the regional and local ethics committees. The data collection site was a local maternity unit. Recruitment to the study involved the researcher attending team meetings, distributing information posters and leaflets and one-to-one information-giving with potential midwife participants. Participants were sought among midwives who provided postnatal care in either community or hospital setting. As the research process developed, theoretical sampling was also employed to allow the data to determine the direction of the inquiry, in keeping with principles of grounded theory methodology (Silverman and Marvasti, 2008). Confirmation and elaboration of the evolving theory was made possible and disconfirming cases enabled exceptions to be highlighted and inform the theory construction.

Narrative-style, in-depth interviews were undertaken at a location identified by each midwife participant – usually a meeting room at the hospital site – and lasted up to one hour. The interviews were recorded and transcribed verbatim and the midwives were provided with a copy of the transcript for comment and 'respondent validation' (Silverman, 2006: 291). Recruitment to the study continued until data saturation was achieved (Charmaz, 2006).

The data were reduced by sorting, shortening and summarising into descriptive and abundant codes. This was followed by several cycles of coding to develop focused codes and categories representative of the data (Saldana, 2009). The simultaneous refinement of codes with further data collection helped to maintain the analysis close to the data, which is the grounded aspect, ensuring the evolving insights are contextually situated, which facilitates greater theoretical complexity (Charmaz, 2006).

It also helped to safeguard the quality of the subsequent theory development through testing and ensuring it was trustworthy. Saldana (2009) highlights that all researchers bring with them and may apply their philosophical and theoretical assumptions, which act as a coding filter when analysing data and constructing codes and categories. However, engaging in constant comparative analysis and discussing thoughts with the supervision team, helped minimise potential bias (Silverman and Marvasti, 2008).

## Findings

The data for this study originates from interviews involving 14 midwives, qualified between one and 29 years, employed in a small maternity unit in the north east of England. The findings have been grouped into two data categories: 'transforming practice' and 'transmitting practice'. As each data category is presented, the focused codes that construct the categories will be explored and supported with quotes from the interviews. The relationship between the categories is conceptualised in the theoretical code of generativity and this will be presented at the end of the findings section and supported by a visual representation of the research findings (see Diagram 1).

### *Transforming practice*

Transformation is a process that involves change (Oxford Dictionaries, 2014). The notion of change and transformation has become topical in healthcare literature, with changing service user needs and expectations necessitating associated practice and health service transformation (Ham et al, 2012):

*"Over the years, you adapt your practice because of the experience that you've had in the past. So you change the way that you work"* (Midwife E).

### *Practice experience*

Practice experience was the factor most frequently cited by the midwives as transforming their practice:

*"I think the main reason why I do what I do and the way in which I do it has been built upon the experiences that I've had in the past"* (Midwife A).

Several of the midwives recalled when they had been newly qualified, with limited experience; they frequently used clinical observations to confirm maternal genital tract condition, due to limited confidence in their assessment skills:

*"I think when you first qualify… you're frightened that you're going to miss anything... because of your lack of confidence because you've just qualified, you feel as though you have to physically do it to know that you've assessed that right"* (Midwife F).

However, as time and their experience progressed, so did

their confidence to utilise a range of assessment methods:

*"But I guess what the experience has done [is it] has given me the confidence in my own beliefs, my own knowledge and my own… yeah, I know what I'm doing and this woman's absolutely fine"* (Midwife I).

The midwives highlighted how encountering a wide range of women with differing genital tract issues had developed their repertoire of clinical experiences to support when and how to undertake maternal GTA:

*"The experience of looking at so many perineums and, you know, discussing so many bladder care things over the years, it's given me a sort of knowledge where I can look at a perineum now... 'Oh okay, I've seen worse than that', or 'I've seen better than that', or 'I've never seen as bad as that. This needs to be acted on.' And there is a personal element of my knowledge"* (Midwife C).

The midwives in this study identified how they assimilated practice experiences and insights to transform their practice. This involved developing a repertoire of experiences, skills and responses that they could draw upon, developing their own personal theory of GTA. Personal theory is theory in use, which directs the actions of the individual midwife (Argyris and Schön, 1974). Theory in use provides a working premise of options and actions appropriate for that individual on that day.

The majority of the midwives suggested as their repertoire of diverse practice experiences grew, so did their confidence and ability to use a broader range of GTA methods. This included utilising effective communication skills with women to provide more personalised assessment reflecting individual maternal needs and preferences:

*"I think I've developed more confidence in myself... like listening to what people are saying. And more confidence... with communication skills... what works and looking at people, like how they react to you to try and adapt things and change things... so I think that has changed a lot"* (Midwife B).

Effective communication and assessment skills include active listening and effective questioning. Midwife N suggested effective listening and questioning skills help to identify incongruence in assessment information and differentiate which women may benefit from additional assessment methods.

*"I think the big thing is experience, the more confident you are as a practitioner, picking up on what women say... Questioning women, when they say, 'I'm all right,' 'Well, are you really all right or are you just saying that?' I think experience is the big thing"* (Midwife N).

Half of the midwives suggested learning from and with others in practice helped to develop their understanding and skills. This involved discussing GTA experiences with colleagues. The midwives suggested that by sharing their experience, and listening to the experiences of other midwives, their repertoire of experiences was enhanced:

*"'Have you tried this, have you tried that?' You know, and someone will say, 'I did this and that seemed to help.' So I think we do sort of confer between us. You pick up things from other people"* (Midwife H).

*Formal theory*

Less explicit reference was made by the midwife participants in this study to formal theory contributing to changes in their practice. However, the majority of the midwives implicitly discussed formal theory. This was most evident when they discussed signs of the genital tract condition and related these signs to postnatal physiology and principles of wound healing:

*"The healing process, the time that it takes, thinking is it pink, is it granulating?"* (Midwife N).

A couple of the midwives made general comments regarding reading midwifery literature to keep abreast of new ideas:

*"Looking at research, reading articles will sometimes help to influence, sort of, how often you check the perineum"* (Midwife A).

Several of the midwives acknowledged their practice had been influenced by changing expectations reflected in professional literature, such as the NICE postnatal care guidance (NICE, 2006):

*"I suppose the major change for here is the changes in guidelines"* (Midwife C).

The midwives suggested there had been more focus and expectations upon routine use of clinical and physical assessments of women in previous years. The midwives suggested, as there was now less emphasis upon routine tasks, they did not feel compelled to undertake routine activities. This had helped to develop their clinical reasoning abilities as they made practice decisions regarding the most appropriate method of maternal GTA for a particular woman on a particular occasion:

*"I think years ago, because things were done routinely, we weren't actually thinking, 'right, what are we looking for?' and giving the woman some choice in that, to actually tell us if she had a problem. It was just that this is what we had to do, and then right, that task's done"* (Midwife H).

The findings suggest the midwives developed their practice knowledge and skills concerning maternal postnatal genital assessment via engagement in diverse practice experiences and to a lesser extent formal theory. These practice experiences and formal theory had the potential to transform and change the midwives' practice over time. The research data also provided examples of the midwives transmitting their practice knowledge and skills.

*Transmitting practice*

The midwives discussed how they attempted to pass on their practice knowledge concerning maternal GTA to the next generation of midwives. This guidance of practice novices was not an explicit aspect of the interview guide, but arose from the data analysis. The midwives discussed two principal approaches they used with student midwives, creating learning experiences and articulating clinical reasoning.

*Creating learning experiences*

Half of the midwives suggested student midwives needed experience of clinical observations of the maternal genital tract postnatally to enable them to develop a repertoire of experiences to draw upon:

*"You've got to be going through the full check... they've got*

*no experience, they've got nothing to pull on"* (Midwife K).

The midwives considered clinical observations enabled the student to comprehend the physiological processes of the puerperium in action. These included the tone and position of the uterus and its involution, the differing amounts, appearance and smell of lochia and the appearance of the genitalia postnatally:

*"I'll always get them to palpate the uterus because then they're feeling the normal or they're hopefully picking up the abnormal... But to understand the abnormal, you sometimes need to know what normal is, because otherwise, how would you know?"* (Midwife C).

Midwife I believed that by engaging in a range of practice experiences, the student midwives also developed confidence in their developing insights and skills:

*"If you know what a perineum looks like, or should be looking like when it's healing, then you'll know when it's not healing correctly. So I think students still need to do that because until they've done that x amount of times, then they won't get to the point of feeling confident"* (Midwife I).

Several midwives suggested that if they were using clinical observation to assess the woman's perineum, then they would ask the woman's consent for the student to also be involved in the assessment:

*"I would always ask permission from the woman for the student to be (involved). I would always say to the woman, 'Do you mind,' if we're looking at something, 'Do you mind if I just explain this to them, to the student"* (Midwife C).

Midwife H identified creating learning experiences for student midwives in relation to assessing lochia. This may involve requesting to see a woman's sanitary pad or asking her to leave a used pad in the sluice:

*"I would make sure they knew what a normal amount (of lochia) was, so I think it would just depend on the student's experience. Probably if they were a new student and I thought the woman was a good candidate, I probably would say, 'Do you mind if I have a look at your pad?' just for the student's experience, so she knows how much lochia there should be on day one"* (Midwife H).

In the above quote, midwife H identifies *"a good candidate"*. Several midwives suggested they would involve women selectively in such learning situations, limiting the inclusion to those women they felt would be amenable and comfortable to such involvement:

*"The women where they've known the student and they've had them in their antenatal care and they've seen them for a while"* (Midwife C).

However, several of the midwives believed contemporary student midwives gained less experience than previous students, of the normal physiological parameters of the postnatal period:

*"I don't think they (student midwives) get as much as we got (exposure to postnatal clinical skills), definitely not... Because they're working in the culture now of… reduced visits"* (Midwife G).

The rationale for this was suggested to be twofold. Firstly, there was less postnatal contact with women, due to a reduction in the number of postnatal visits, and secondly, there was less routine physical assessments, including clinical observations used by qualified midwives. A tension was created for these midwives between the need to provide individualised care for postnatal women, avoiding unnecessary visits or clinical observations and the need to create learning experiences for student midwives to ensure the future generation of midwives have the skills and abilities to employ a full range of GTA methods. To provide learning experiences for student midwives several of the midwives stated they would adapt their postnatal practice to create learning experiences. For several midwives, including Midwife G, this involved making sure she employed *"a full check"* of maternal physical health so that students would become aware and competent at all potential aspects of postnatal assessment.

The most frequently cited adaptation of practice, by five midwives, involved palpating the uterus of women whom the midwife may not otherwise have felt the need to palpate, to enable the student to appreciate normal uterine involution:

*"I think when you've got a student, you probably have to do it more because they're learning, so they've got to be able to know what a postnatal fundus feels like... so they can tell if involution has taken place"* (Midwife E).

However, not all the midwives in this study adapted their practice to facilitate additional learning opportunities for student midwives:

*"No, I don't think I would change because I don't do anything different if I've got a student"* (Midwife L).

*Articulating clinical reasoning*

Several of the midwives in this study suggested that they attempted to provide students with exposure to their clinical reasoning processes. This included relating practice experience regarding maternal genital tract health and assessment to physiological processes of the puerperium:

*"When you have students out, you talk a lot about the anatomy and physiology and the physiology of postnatal recovery"* (Midwife E).

The midwives stated that they would articulate and explain what they were doing and why and what factors had influenced the assessment approach they adopted:

*"I involve them... I will show them... I'll always explain... we'll discuss... I'll get back in the car and I'll always say to them, 'So what did you think of it? What did you think of the perineum?'"* (Midwife C).

Some of the midwives suggested where this discussion took place would depend upon the content of the discussion and maternal considerations:

*"Sometimes it might be appropriate to explain something in front of the woman and other times, it might not be and it might be more appropriate to explain it once you've left that environment, and that just depends on lots of things, on your relationship with the woman, on how sensitive the issue is"* (Midwife F).

Other midwives suggested discussion was very important and helped to compensate for limited practice experience:

*"I wouldn't do anything differently with a student, but I would talk through everything I was doing and letting her know why I have made the decision not to feel her*

*[the woman's] fundus or not to look at her perineum"* (Midwife I).

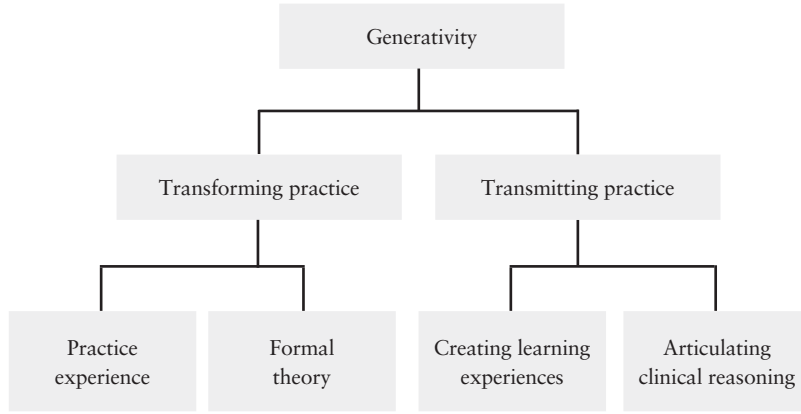
Expectations of the student midwives' skills and abilities changed as the students progressed through the midwifery programme. They acknowledged the students initially had a limited repertoire of responses, usually copied from their midwifery practice mentor:

*"And it's funny, I've heard her [the student midwife] saying the same words that I do and I think that's for now, because that's fine, you'll do that and then you'll get your own"* (Midwife K).

However, as the students progressed through the programme, the midwives' expectations increased, with students now expected to articulate their reasoning process and leading care interactions. In addition, the midwives anticipated the students would develop a range of postnatal GTA methods, with the assessments becoming more individualised and holistic utilising a more discursive and women-focused approach to assessment:

*"I'll sit back and say nothing and let the student midwife do the talking. Obviously if I feel I need to interject, then I will"* (Midwife N).

**Diagram 1. Generativity: transforming and transmitting midwifery practice**




*Generativity*

The midwives in this study provided accounts of changes to their practice knowledge and actions, which had evolved over time and that they considered had transformed their approach to maternal GTA. In addition, they provided examples of how they attempted to transmit their practice knowledge and skills to the next generation of midwives:

*"I think [that your practice] changes every week, every year, in fact every day it's always on the go, it's generating forward"* (Midwife C).

The relationship between these dual processes of transforming and transmitting practice identified in the research findings have been conceptualised in the overarching theoretical code of generativity (see Diagram 1). Erikson and Erikson (1998) developed an eight-stage theory of development and change occurring during the human life cycle. The seventh stage involves generativity, the process in which adults attempt to develop a future legacy by initiating change in the thoughts and action of themselves and others (Slater, 2003).

## Discussion

The midwives in this study suggested practice knowledge and formal theory had the potential to transform their practice. However, the findings of this study imply formal theory has limited impact upon midwives' practice. This resonates with established work suggesting that practitioners do not consider continuing professional development necessarily benefits their clinical practice, or impacts upon practice changes and patient care (Poell and van der Krogt, 2014).

The midwives in this study suggested the principal factor to transform their practice was experience. This included developing a repertoire of direct practice experiences concerning maternal genital health, assessment and care which enhanced their practice knowledge, skills and confidence. Experience is an established component of professional learning (Poell and van der Krogt, 2014). Experiential learning can be implicit, with each practice experience becoming part of the catalogue of encounters, or deliberate, involving reviewing experiences, eliciting feedback, planning specific learning opportunities and developing confidence and commitment (Eraut, 2004). Within the learning theories developed by Kolb and Boud, learning is considered to be personal, interactive and spiral, involving an integration of subjective experience and critical reflection (Segers and van der Haar, 2011). Bonis (2009: 1328) considered 'knowing' is a personal type of knowledge, which comprises of 'objective knowledge interfaced with the individual's subjective perspective on personal experience,' as such knowledge needs experience to become 'knowing'. A key ingredient of this personalised knowing involves engaging and appreciating the unique perspectives of the recipients of care. The midwives in this study suggested their practice learning was 'personal' and evolved from engagement in a range of rich and diverse practice experiences.

Bonis (2009) stated a consequence of knowing is transformation, in which practitioners change and improve their practice. Transformative learning theory was developed by Mezirow and involves the three core elements of individual experience, critical reflection and dialogue (Mezirow and Taylor, 2009). It focuses upon 'how adults learn to reason for themselves, advance and assess reasons for making a judgement' – this involves a revision or transformation of the individual's thinking, beliefs and actions, a perspective transformation (Mezirow and Taylor, 2009: 23). Experience alone is insufficient to ensure transformative learning, as experience constructs an understanding of reality, which may then be reaffirmed through actions, which perpetuate particular experiences, therefore perpetuating a particular understanding of reality (Berger and Luckmann, 1966). Cioffi and Markham (1997) suggested that the experiences of individual midwives might contain bias and, therefore, potentially limit their subsequent reasoning processes, recommending the need for reflection to try and minimise

such factors. The midwives in this study discussed learning from and with others, which enabled them, to some extent, to broaden their practice experiences, and debate issues concerning practice decisions, a learning strategy also identified by others (Gray et al, 2014).

Phillips et al (2002) suggest professional conversations are an important social component in creating and sustaining practice knowledge. Active participation is required to develop knowing through collectively sharing and shaping a community of practice (Wenger, 1998). Situated learning theory explains how practitioners develop new skills and knowledge through social interactions, sharing similar practice experiences and challenges, within their community of practice, stimulating a body of local knowledge of potential solutions (Hargreaves and Gijbels, 2011). This highlights the importance of ensuring opportunities for midwives to interact with colleagues and women.

The midwives in this study suggested that as they developed a repertoire of practice experience and learning, so their confidence in their postnatal GTA skills grew. This confidence enabled the midwives to further develop their repertoire of skills by utilising more women-centred assessment methods, including listening, questioning and discussion. Interactive reasoning involves the face-to-face interactions between midwife and client that help the midwife to better understand the woman's individual needs (Higgs and Jones, 2008). Effective communication and relationship development may enable a more individual and accurate assessment of the woman's individual postnatal health needs and the most pertinent assessment approach within her social context (Frei and Mander, 2011). In addition, women value effective and sensitive communication skills, feeling more able to express their healthcare needs and have a more positive experience of postnatal care (MacArthur et al, 2002).

The research data also provided examples of the midwives transmitting their practice knowledge and skills to student midwives by creating learning experiences and articulating clinical reasoning. Practice experience is recognised as having a central role in professional learning, as it enables students to develop skills in messy, unpredictable and unique practice situations providing rich data for critical reflection, moving experience to learning (Stuart, 2007). The research by Finnerty and Collington (2013) highlighted the importance of midwifery mentors in supporting students' practice learning through scaffolding and fading techniques. This consisted of three components: providing individual support that is gradually removed; being an appropriate role model and offering debriefing opportunities, such as those discussed by the midwives in this study.

The midwives suggested practice experiences enhanced the development of students' skills and confidence. Research involving final-year student midwives in Australia also highlighted the interplay between confidence levels, exposure to experiences and development of professional abilities including independence and decision-making (Carolan-Olah and Kruger, 2014). Engagement in care interactions enables students to develop an appreciation of the subtle nuances involved in developing a trusting relationship with women to facilitate the identification of individual needs (Schmied et al, 2008). As highlighted in the study by Botti and Reeve (2003), as case complexity increases, the experience of students becomes an important factor in determining their reasoning abilities. Research involving medical students also identified engagement in practice experience was a critical component to develop clinical reasoning abilities, but voiced concerns that limited practice opportunities would negatively impact upon building appropriate practice knowledge (Durning et al, 2013). Studies focusing upon pre-registration midwifery and nursing curricula highlight students value opportunities to practise and integrate skills into their practice. However, the research suggests there are less occasions for students to rehearse skills and to reflect in and on practice and, therefore, to transform their practice experience to learning due to workload pressures (Newton et al, 2015; Baldwin et al, 2014).

The Department of Health's (2014) mandate to Health Education England states students need to have appropriate support and this includes practice experience with sufficient opportunities and time to gain appropriate experiences. However, the midwives in this study expressed concern that exposing students to appropriate and sufficient learning experiences in relation to postnatal GTA was increasingly challenging due to changes in the content and organisation of postnatal care and the wider challenges affecting midwives and the maternity services. Such concerns have also been expressed in national surveys and forums (RCM, 2014b; 2010).

The relationship between the processes of transforming and transmitting practice have been conceptualised in this research as 'generativity'. The midwife participants engaged in generativity, as they had transformed their practice over time and were keen to transmit their practice knowledge and skills to student midwives. Slater (2003) suggested during midlife, adults engaged in generativity, work hard to develop areas they believe are important and worthwhile. The midwives in this study were motivated to transform their GTA practice to enable them to provide care, sensitive to the individual needs of the women they encountered. A study in Australia exploring midwives' views upon developing their practice, highlighted similar issues, suggesting the need to provide effective care is motivated by the relationship midwives and women develop, driving the midwife to become 'the best midwife they could' (Gray et al, 2014: 862). Such a sense of caring is an important component for sensitive practice and ensuring a productive and healthy organisation (NMC, 2015; Francis, 2013).

However, the opposing psychological stage to generativity is stagnation, in which the individual becomes unproductive and a sense of inertia prevails (Erikson and Erikson, 1998). Although none of the midwives in this study suggested their practice had the characteristics associated with stagnation, midwife I suggested, despite experience, not all midwives utilised the potential breadth of midwifery skills, providing a routine and standard form of postnatal assessment and subsequent care:

*"I do know midwives who will do postnatal care and go and stick a blood pressure cuff on and feel her [the woman's]*

*fundus and fill in the tick boxes and say, 'that's it. Postnatal care is done.' But postnatal care is not about that; it's about the whole thing, isn't it? It's about discussion and sort of exchange of information"* (Midwife I).

The findings from this study do not provide any insight as to why the postnatal practice of some midwives may become stagnant. However, it is widely reported and acknowledged, including by the midwives in this study, that postnatal care is undervalued and resourced. This impacts upon the midwives' ability to spend time with women assessing their needs and may erode some midwives' enthusiasm and motivation (Schmied and Bick, 2014).

Douglas et al (2014: 2691), when exploring the factors which influence nurses assessment practices, suggested that assumptions that healthcare staff use assessment methods most relevant is 'overly simplistic' and that greater attention needs to be focused upon the barriers, such as lack of time, and lack of confidence, which may limit the use of a wider repertoire of assessments.

## Conclusion

The findings of this study suggest midwives transform their practice in relation to maternal postnatal GTA through a repertoire of practice experience, developing enhanced communication skills and learning from others. Less influential was formal learning processes and theory. In addition, the midwives in this study felt it was important to transmit their practice knowledge to student midwives, by facilitating appropriate learning opportunities and engaging the students in clinical reasoning processes through reflection and discussion. However, all of the midwives acknowledged workplace pressures and changes had diminished practice learning opportunities for student midwives and not all of the midwives compensated for this deficit by creating learning opportunities for students to develop their midwifery skills and insights. While acknowledging healthcare resources are precious and thinly stretched, the implications of limited engagement in postnatal assessment and care may have long-term implications for the practice knowledge and skill development of future midwives, with potential consequences for the care received by women.

Further research exploring student midwives' perceptions of the learning opportunities available within the pre-registration midwifery programme regarding postnatal GTA would be a useful adjunct to this study. In addition, it would be useful to identify student midwives' confidence at undertaking postnatal GTA in the final year of the programme to enable recommendations for curricula enhancement.

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# Domestic abuse in pregnancy: "I'm more used to unhealthy relationships so don't have a clue about healthy relationships"

***Susan Leneghan*** *[1] PGDip SPCHN, BSc, RGN.* ***Marlene Sinclair*** *[2] PhD, MEd, RN, RM, RNT.* ***Patricia Gillen*** *[3] PhD, MSc, RM, RN.*

1. Health visitor, South Eastern Health and Social Care Trust, Upper Newtownards Road, Dundonald BT16 1RH Northern Ireland. Email: susanleneghan@yahoo.com
2. Professor of midwifery research, Maternal Fetal and Infant Research Centre, Ulster University, Newtownabbey BT35 0QB Northern Ireland. Email: m.sinclair1@ulster.ac.uk
3. Head of research for nurses, midwives and AHPs, Southern Health and Social Care Trust, Gilford BT63 5JX Northern Ireland. Email: patricia.gillen@southerntrust.hscni.net

Abstract

*Background.* Legislation, policy and practices have been developed to tackle the problem of domestic abuse (DA) across the world. Perpetrator programmes have been introduced in Northern Ireland (NI) and serious intervention research is underway. Regardless of these policies and interventions, DA is still reported as being statistically significant during pregnancy.

*Aim.* The aim of this research was to understand the perceptions of pregnant women who experienced DA during pregnancy and of their abusive partners and to explore the network of care provided.

*Methods.* The design was exploratory and descriptive incorporating two phases. Data were collected over a 20-month period using semi-structured interviews and a short survey. The sample was obtained through Women's Aid and Focus on Family, who acted as gatekeepers in confirming the eligibility of the participants. Phase One was semi-structured interviews with a purposeful sample of nine women who experienced DA in pregnancy and three male abusers who abused their pregnant partners. Dyads of abused and their abusive partner were interviewed separately. In addition, 18 multiprofessionals providing services to abused women and perpetrators were interviewed. Phase Two was a short survey sent to all heads of midwifery in NI exploring current antenatal education for prevention of DA. Ethical approval was granted by the Office of Research Ethics for Northern Ireland (ORECNI), University of Ulster and research governance was obtained from the five health and social care trusts (HSCT).

*Findings.* Women's perceptions of DA were focused on their experience of physical violence and verbal abuse; however, sexual abuse was not evident in their stories to constitute DA, and this is new knowledge. The three male abusive partners in this study recognised their own abusive behaviour and the need to engage in perpetrator programmes. The pregnant women and their abusive partners requested additional relationship education for all prospective parents and felt that the antenatal period was an opportune time. Midwives requested further education and training to prepare them for their role in preventing DA in pregnancy.

*Conclusion.* The antenatal period has been identified as a time when a discussion regarding healthy relationships is acceptable. The teachable moment for impacting on the lives of mothers, fathers and children is the antenatal period and this time should be used to raise awareness, educate and support both parents in their preparation for parenthood. In NI, current antenatal education does not address DA in pregnancy.

*Key words*: Domestic abuse, pregnancy, antenatal education, evidence-based midwifery

## Introduction

Domestic abuse (DA) is a global issue that pervades all socio-economic, gender and cultural groups with consequences for women, families and society (WHO and London School of Hygiene and Tropical Medicine (LSHTM), 2010). According to the WHO (2013), one in three women will experience abuse by an intimate partner at some point in her life.

The WHO reports that 35% of women across the world have experienced either intimate or non-intimate partner DA in their lifetime (WHO, 2013). In the UK in 2011-12, there were two million victims of DA and 536,000 victims of sexual assault (Flatley, 2013). In Northern Ireland (NI), 27,190 DA incidents were reported to the police in 2012-13 (Police Service of Northern Ireland (PSNI), 2013).

It has been reported that DA is known to either start or escalate during the antenatal period for women (Lewis, 2007) and that almost 30% of women who experience DA do so during pregnancy (Edin et al, 2009). There is a key window of opportunity for more targeted interventions in the antenatal period. The *Experience of domestic violence in Northern Ireland report 2007-08,* from the NI crime survey template, stated almost one-quarter (23%) of female victims of DA reported being subjected to threats or force while they were pregnant. For half of this group (17 out of the 34), DA started during pregnancy (Northern Ireland Office, 2008).

The aim of this study was to understand DA in pregnancy from the perspective of the pregnant woman, their abusive partner and support providers. The objectives were to:

- Explore experience of women abused in pregnancy
- Interview males who abused their partners during pregnancy
- Identify the network of care provided by support services
- Map current antenatal education provision to identify any formal input about DA during pregnancy.

## Method

A qualitative approach was taken, as understanding DA is dependent on the subjective meaning for the women involved (Testa et al, 2011). The design was exploratory and descriptive incorporating two phases. Data were collected using semi-structured interviews and a short survey.

### *Ethical issues*

Ethical approval was sought and obtained by the University of Ulster's research ethics committee, the five health and social care trusts (HSCTs) and the Office of Research Ethics for Northern Ireland. The main issues facing the research team were gaining trust and rapport with very vulnerable women who were pregnant or had been abused during their

  

last pregnancy, or within the previous two years. The principle investigator (PI) worked closely with the team in Women's Aid (WA) and Focus on Family (FoF) to gain the trust of all concerned. The key workers in both organisations acted as gatekeepers and when the participants were deemed to be in a safe place and ready to talk about their experience, they were invited and consented to take part. Informed consent for all participants was obtained in writing and their identities were protected. The WHO (2001) *Ethical and safety recommendations for domestic violence research* were applied in this study to ensure the women, partners and staff interviewed were protected from undue distress and the researcher interviewing had training in sensitive research. Interviews were conducted in a professional setting with privacy and safety for participants and researcher (WA refuges, PSNI premises, university, hospital settings and the offices of FoF). Support from trained counsellors in WA and FoF were on standby.

**Table 1. Inclusion and exclusion criteria**

| | Inclusion | Exclusion |
|---|---|---|
| Mothers | • Disclosed or experienced DA (as per definition) during pregnancy<br>• Received any form of information or support following disclosure<br>• Not awaiting legal proceedings<br>• No more than 24 months after the birth of their baby<br>• >18 years of age<br>• English as a first language<br>• Able to give informed consent and willing to talk about their experiences | • Not disclosed DA<br>• Awaiting legal proceedings<br>• Children are above the age of 24 months<br>• <18 years of age<br>• Difficulty in understanding written or verbal information in English<br>• Unable/unwilling to talk about their experiences |
| Fathers | • Acknowledged they have been abusive<br>• Partner has been pregnant<br>• No legal action is pending<br>• >18 years of age<br>• English as a first language<br>• Give informed consent and willing to talk about their experiences | • Still abusive<br>• Not abused<br>• Partners have not disclosed DA<br>• Not abused during the period of pregnancy<br>• Legal action pending<br>• <18 years of age<br>• Difficulty in understanding written or verbal information in English<br>• Unable/unwilling to talk about their experiences |
| Support providers | • Worked with clients (women/men) where abuse has been disclosed during pregnancy<br>• Offered services and support to clients who have disclosed DA during pregnancy<br>• English as a first language<br>• Able to give informed consent and willing to talk about their experiences | • Not experienced disclosure of DA during pregnancy<br>• Not offered services or support to women or partners following disclosure of DA<br>• Difficulty in understanding written or verbal information in English<br>• Unable/unwilling to talk about their experiences |

*Sample*

The sample was purposefully chosen and the inclusion criteria clearly determined, as detailed in Table 1. Identification of participant dyads for interviews (mothers and fathers who had been in abusive relationships during pregnancy) was facilitated by the gatekeepers at FoF, who were trained psychologists/counsellors and social workers. They approached the mothers who attended the survivors' course and fathers/male abusers who attended the Facilitating Perpetrator Programme, a non-court-mandated perpetrator course, and provided them with information about the study. None of the male abusive partners interviewed were asked to complete a perpetrator programme through the courts, but accessed the FoF programme through their own initiative. Those who agreed to participate in the study were interviewed separately.

*Phase one*

The aim of phase one was to explore the experiences of women who experienced DA during pregnancy, male partners responsible for the abuse and support providers who provided a network of care. A total of 27 of the interviews were digitally recorded and transcribed verbatim, with the remaining three handwritten at the request of the participant.

*Phase two*

The aim of phase two was to map antenatal education in NI to identify if women and their partners were receiving formal input about DA during pregnancy. A survey was distributed to the head of midwifery service in each of the five HSCTs.

*Data saturation and analysis*

Pattern identification of the same themes coming from the data occurred with the women who were interviewed and the data collection was stopped after nine interviews. Due to difficulty in recruiting male abusive partners, data saturation was not reached. Data were collected over a 20-month period between 2012 and 2013. Newell and Burnard's (2011) six-step process was used.

*Verification of data*

Transcripts for the women and male abusive partners were not returned to them, but before the researcher left the field, she discussed the main themes emerging from the data with the participant and cross-checked these with one of her supervisors who was sitting out of sight taking notes (with consent to be a non-participant observer). Due to the sensitivity of the study, it was agreed by the research team to not return the transcripts for fear of distressing the participants and to ensure complete anonymity as the PI did not need to know their contact details. Staff transcripts were returned for verification. Verification of the themes was completed by asking an independent experienced researcher to read a sample of the transcripts and to identify themes. Data were triangulated by listing the findings from each component side by side and identifying convergence, complementarity and seeking consensus on divergent issues.

## Findings

Phase one of the study involved 30 interviews, a purposeful sample of seven women who experienced DA in pregnancy (were not with the abusive partner at the time of interview), two abused pregnant women and their abuser/abusive partner, one male abuser (his partner did not consent to being interviewed) and 18 professionals. The professional group consisted of two social workers, two doctors, three midwives, two health visitors, two police officers, two family workers at WA, one counsellor at FoF and two counsellors at Relate. For the purpose of this paper, one sub-theme and one key theme will be discussed: "*I didn't really know what domestic abuse was*" and "*building healthy relationships*". Other themes will be presented in a paper in *EBM* in 2016.

*"I didn't really know what domestic abuse was"*

The women interviewed experienced two or more types of DA during their most recent pregnancy, with four stating the abuse had started or escalated during pregnancy. This varied in intensity and included many different types of abuse, ranging from, name calling (*"a stupid bastard"* (Betty, WA)) to severe physical violence (*"boiling water threw over me… two bottles and smash me over the head and then stab me in the eye"* (Jill, WA)), including threats to kill.

The male abusive partners/fathers corroborated their partners' information as they had used verbal threatening (*"fuck sake, can you not hang yourself?"* (Scott, FoF) and physical abuse in their relationships ranging from physical scuffles to paramilitary involvement. Other DA, such as sexual abuse, was not highlighted as an issue by any of the mothers or partners in their interviews.

When asked about their understanding of DA, it was evident that both the women and abusers did not see 'abuse' as being anything but physical:

*"I just know physical like you know the partner does like, eh fighting with you and being with knife (laughing) something like that"* (Wendy, WA).

*"When I started going out with him he basically told me he doesn't want me to go out and he doesn't want me to like have me own life. Basically, he doesn't want me to see my own friends... so I thought that was normal"* (Tina, WA).

They requested that clear details about different types of abuse need to be explained:

*"…Just kinda explain the difference of, you know, all the different ones that they can have"*(Ashley, FoF).

This was endorsed by a number of professionals:

*"They do think it is physical… cause I know emotional abuse, I know really a lot of people... take that for granted maybe they're used to that relationship"* (MW02).

With a GP clearly stating: *"…If only people were more aware of what actually abuse was…"* (GP01).

With the help of courses and support for both the abused and the abusers, they recognised what DA was. It was evident from the male transcripts that they had attended a FoF perpetrator programme, a non-court-mandated course, with a very positive outcome, as it changed their lives for the better; they had developed more self-awareness and one father had gained increasing access to his children:

*"He's the one that came to me and started saying sorry for what he was doing and all the rest of it, cause he started to realise what he was doing to me"* (Beth, FoF).

*"During the course we were on, I realised I had more demons I thought I had buried… it was the best move I ever done"* (Bruce, FoF).

*"The judge, it was a phase at that time he wasn't giving me any contact whatever... so I went back to court… I started to get to see them at the house, and then it started to snowball from there, it started to work out"* (Scott, FoF).

However, the abusive partners recognised that non-court-mandated perpetrator courses are not easy to source and are not well advertised, which appears to be a major problem that urgently needs to be addressed:

*"You need more of the courses, you need to make it more widely known"* (Scott, FoF).

They highlighted the need for further education for men regarding pregnancy, the role of the new father and management of potential times of stress; the abusers clearly believed:

*"There's always plenty there for the women, right, the man knows nothing there… men need information on postnatal depression and see how to spot it or get help, stuff like that… there just needs to be a wee bit of an education what we can do and what we can't do"* (Bruce, FoF).

*"Building healthy relationships"*

Participants in phase one of the study were asked how they felt about the introduction of 'healthy relationships' as a topic in antenatal education classes. The majority of participants (27 out of 30 abused, abusers and professionals) agreed that the antenatal period was a window of opportunity to talk to mothers and fathers about healthy relationships. Potential benefits identified by abused/abusive partners included:

*"I'm more used to unhealthy relationships so don't have a clue about healthy relationships"* (Tina, WA).

*"…it would get him to realise what he's doing is bad, maybe he would seek help"* (Tammy, WA).

*"If you explained it as something other than domestic violence... maybe I could go and maybe learn how to be a better man and and how to, how to work my relationship better"* (Eric, FoF).

The majority of the professionals concurred with this. All three midwives commented that the antenatal period would be an opportune time to have a discussion about healthy relationships with both mothers and their partners: *"Don't see why you couldn't speak to them at that stage"* (MW02). However, whether midwives had enough training to carry this out by themselves, and the timing of the discussion, were issues raised: *"Too late in parentcraft"* (MW01). Other endorsements for this included:

*"Yeah, I think dads need to be included in it, yeah I think they do"* (PSNI02).

*"And put the responsibility on the two new parents that they need to, whatever is unresolved needs to be sorted because the most important thing now is this child and this child's needs"* (FamW03, L803-806).

*"I think they should be mandatory classes as early as possible... around the same time, 12 weeks... you could headline it "how to support your mum-to-be"* (FoF).

*"If we are serious as a society about dealing with domestic violence... something more has to be done"* (FamW02).

*Phase two – mapping of antenatal education classes*

Actual antenatal education classes for parents are delivered in each of the five NI HSCTs either during the afternoon (four HSCTs) or evening (all HSCTs) and vary from two hours to 2.25 hours. The classes vary in content and length of delivery with each HSCT delivering a common core class on labour, pain and birth, with some variation in antenatal wellbeing, postnatal care and infant feeding (see Table 2).

None of the HSCTs discussed or included any information pertaining to DA in their antenatal education classes, but it may be discussed during individual antenatal appointments.

  

Two HSCTs provided leaflets about DA and these were left in the department for women to access as needed. One HSCT displayed posters and three provided small purse-sized cards.

Overall there were some mixed feelings by the leaders of midwifery about DA inclusion in routine antenatal care:

"*It is totally inappropriate to discuss this issue within this context... we facilitate opportunities in other venues, such as review appointments... We would not wish to impose on any classes for labour or preparation for parenting any time for discussing domestic violence this is not the purpose of these classes*" (head of maternity services, HSCT).

The survey responses showed a trend towards acceptance about the inclusion of healthy relationship education to be part of routine antenatal care.

## Discussion

DA is regarded as a major health issue for women across the world and at least one in every three women has been beaten, coerced into sex, or abused in some other way (United Nations, 2010). A survey carried out in 48 different countries, reported between 10% and 69% of women having been subjected to physical assault by an intimate male partner at some time in their life (Krug et al, 2002). Statistics for the UK estimated that in 2011-12, 31% of women had experienced DA since they were 16, with the most common perpetrator for women who were seriously sexually assaulted being their partner (54%), (Flatley, 2013), while in NI in 2012-13, there were 27,190 DA incidents of which 11,160 were recorded crimes, representing an average of one domestic crime every 51 minutes (PSNI, 2013). Evidence has shown that pregnancy offers a unique window of opportunity to identify women who are experiencing DA (O'Reilly et al, 2010) and offer them support. Currently all women are given an opportunity to disclose DA through routine enquiry. Even though there is extensive research on the use of routine enquiry, Keeling and Fisher (2015) report 'low rates of identification of domestic violence in healthcare settings as the choice to disclose domestic violence is complex'. In the UK, two separate studies report low prevalence rates of disclosure at booking-in visits – Bacchus et al (2004) found a prevalence of 1.8% and, more recently, Keeling and Fisher (2015) found 7.5% (five out of 205).

### *Perceptions*

People's perceptions of situations vary based on their own understanding and beliefs. In their review, Taillieu and Brownridge (2010) recommended a better understanding of DA for pregnant women, and that research must differentiate between the various forms of abuse experienced by pregnant women. From the women's perspective, the important aspects of the abuse are the experiences itself and its physical and psychological consequences (Gordon, 2000). Two studies, one from a feminist perspective (Johnson and Ferraro, 2000) and one from a criminology perspective (Gordon, 2000), addressed the need to accurately define and specify types of DA. Apart from specifying the types of abuse such as 'common couple violence', it is the severity of the abuse that is an imperative in explaining the nature and occurrence of DA (Gordon, 2000).

As captured in the researcher's field diary while working in the refuge, one woman commented:

"*'Domestic violence' two really big words, and we use them like everybody understands this*" (Field diary, 17 August 2012).

Using simple language, exploring people's experiences, or asking them what they feel DA is, may go a long way to helping mothers and fathers to understand the concept.

### *Current antenatal education programmes in NI*

Current policy and guidelines have driven the HSCT in the UK to operate a policy of routine enquiry that is activated at the antenatal phase and continued throughout the postnatal phase. However, due to previous research identifying mixed results regarding routine enquiry's effectiveness, we would strongly argue there is an urgent need for further interventions to improve education and training of new parents and service providers during the antenatal period to prevent the start or escalation of DA.

Pregnancy is a time of emotional and physical changes when women and their partners may be more open to making lifestyle changes to improve their health and the health of their unborn child. This time may be considered a key teachable moment (Phelan, 2007) or, as previously stated by Herzig et al, (2006: 230): 'It's not just a teachable moment, for some women it is THE teachable moment.' WHO and LSHTM (2010) recommended using primary prevention to reduce the number of new instances of DA by addressing factors that make the first-time perpetration of such violence more likely to occur. Sadly, the findings from the survey demonstrate that current antenatal education classes in NI focus on labour and postnatal care, but do not discuss DA or healthy relationships as a preventative measure.

The need for antenatal education on healthy relationships was supported by the majority of participants in this study. The timing was deemed to be crucial and for some professional participants – the earlier the introduction, the better. Participants suggested using experts from WA, FoF and other multi-agencies would make the programme fit for purpose. How this would be carried out, funding and

**Table 2. Antenatal education class content in the five HSCTs in Northern Ireland**

| Week of antenatal education classes | Belfast HSCT | South Eastern HSCT | Western HSCT | Northern HSCT | Southern HSCT |
|---|---|---|---|---|---|
| 1 | Spontaneous labour and delivery and session with physiotherapist | Labour – preparing for and managing | Introduction, agenda setting, labour, prep for labour | Labour and birth, pain relief | Introduction, labour and pain relief |
| 2 | Tour of delivery suite and reason for alternative delivery and session with physiotherapist | Postnatal care mum and baby | Complications in labour, pain relief | Antenatal care and wellbeing | Infant feeding |
| 3 | Coping with labour and breastfeeding | | Feeding, early days with baby, going home | Parenting care of baby | Postnatal |
| 4 | Postnatal issues | | | | |

content would need to be addressed if this was implemented. Steen et al (2011) found that parent participants attending a managing abusive behaviour programme reported that introducing education on healthy relationships and managing emotions antenatally was important. This has now been piloted in Liverpool Women's Foundation NHS Trust (Steen, 2014).

Providing support and guidance to expectant fathers is essential to help them develop realistic expectations of fatherhood and to improve their confidence as new fathers. In the US, relationship enhancement programmes developed for pre-marital education have been adapted for use in the antenatal period (Glade et al, 2005). A Cochrane review suggested that relatively few prenatal education programmes specifically address expectant fathers' needs (Gagnon and Sandall, 2007) and, in this study, the three abuser voices focused on the lack of support and preparation for parenthood available to them. The male abusive partners stated that the parenthood education in the antenatal period ought to provide an opportunity for them to discuss their fears and expectations about fatherhood. They wanted information and reassurance about labour, signs and symptoms of postnatal depression and what fatherhood means. They believed joint decision-making would yield the greatest net impact on family health, as identified by Mullany et al (2007). The self-image men have of themselves as fathers is a key focus for fatherhood education and trigger for motivating men towards seeking to become 'the best father possible'. Stanley et al (2012) identified this juxtaposition of images of caring versus abusive fathers as being key in behaviour change. The RCM highlighted the need for father involvement in the antenatal period as: 'Positive participation of fathers in antenatal consultations and parent education classes will help to alleviate some of the anxiety and stress many experience and to prepare them for childbirth and fatherhood' (RCM, 2011: 4).

The guide also endorsed the need for midwives to receive further guidance and training to be able to manage and engage fathers more during their partner's pregnancy.

The Fatherhood Institute (UK) offers the Family Foundations – transition to parenthood, a series of seven ante- and postnatal participatory classes for expectant mothers and fathers that is aimed at enhancing parent and child wellbeing. However, this does not appear to be available across the whole of UK, including NI.

Support service providers were also in agreement as they see the lack of perpetrator programmes as a problem when trying to help abusers. Working to improve DA needs to include a focus on addressing the violent and abusive behaviour of those who perpetrate it (Devaney, 2013). There are currently very few avenues of practical support, especially for perpetrators who recognise they have a problem and would like to change their behaviour (Stanley et al, 2011). In general, most abusers of DA never or infrequently come into contact with the police. This leads to few abusers having the opportunity to attend a perpetrator programme. Currently, the majority of programmes are only available for perpetrators who have been convicted of a DA offence (Buzawa et al, 2012; Crown Prosecution Service, 2012). A systematic review by Smedslund et al (2007) found that group-based programmes work for some male perpetrators, in some circumstances, some of the time, but for who exactly, how the programmes work and when that occurs, is still unclear. Gondolf (2012), an advocate of group-based programmes, argues that programmes do work, but that a better understanding of what components are likely to work for particular people, and for certain groups of offenders is needed. He subscribes to the view that perpetrators of DA are heterogeneous in nature, and as such individuals are likely to be different in their response to the programme due to their differing behaviours (Emery, 2011).

The three fathers in this study were able to attend a perpetrator programme with FoF that is not court mandated. This programme is not widely known and the fathers would like to see such services publicised. One father said it would be difficult to find men to attend interventions. However, interventions that aim to change abusive behaviour, need to identify 'pull' factors, such as a non-judgmental response to the disclosure of abusive behaviour and the availability of support and relevant services (Stanley et al, 2012).

The linking of abuse prevention approaches, such as FoF perpetrator programme, to the community (Sabol et al, 2004), or developing awareness campaigns that operate concurrently at both the societal and individual levels will create a supportive context for abuse prevention (Donovan and Vlais, 2005). Leaflets, posters and billboards are all available and being used. Where they are being provided may need to be reviewed to ensure they are placed for the widest possible audience engagement in all areas that women and men attend in everyday life. As suggested within this study, youth clubs, and more discreet places in maternity services, would be appropriate. Using social media, such as a free phone app that can be downloaded or accessed at any time with all the local services and support, may be of benefit. However, this must be non-traceable to ensure safety if it is to be successful. As NICE (2014) has already stated, there remains room for more work to be done to clarify the continuum of services needed. However, it is axiomatic that this should also be targeted to all abusers whether they are male, female, young or old.

### *Limitations*

A limitation of this study was the small number of partners. This study was a Department of Learning and Development funded PhD and had to be completed within three years. Recruitment for the study could not start until full ethical approval was sought.

## Conclusion

The antenatal period has been identified as a time when a discussion regarding healthy relationships is acceptable. The teachable moment for impacting on the lives of mothers, fathers and children is the antenatal period and this time should be used to raise awareness, educate and support both parents in their preparation for parenthood. In NI, current antenatal education does not address DA in pregnancy.


 

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# Metaphors used by women with eating disorders to describe their experience of being pregnant

***Terri Burton*** [1] *MHSC, MEd, BAS, CHN, RM, RN.* ***Beth Hands*** [2] *PhD, MEd, BSocWk, BEd.* ***Caroline Bulsara*** [3] *PhD, MEd Studies BA.*

1. Course coordinator, School of Nursing, The University of Notre Dame Australia, 19 Mouat Street, PO Box 1225, Fremantle, WA 6959 Australia. Email: terri.burton1@nd.edu.au
2. Senior research scholar, Institute for Health Research, The University of Notre Dame Australia, 32 Mouat Street, Fremantle, WA 6959 Australia. Email: beth.hands@nd.edu.au
3. Research coordinator, School of Nursing, The University of Notre Dame Australia, 19 Mouat Street, PO Box 1225, Fremantle, WA 6959 Australia. Email: caroline.bulsara@nd.edu.au

Abstract

*Background*. Eating disorders are prevalent in the general population and are known to have substantial effects on the health of those afflicted. This is furthermore compounded when the person with the eating disorder is pregnant.

*Method*. To address a gap in current literature of how pregnant women with eating disorders make meaning of their experience, a phenomenological study of a cohort of 20 women with diagnosed eating disorders who had birthed within the previous 12 months was conducted in Perth, Western Australia as research for a doctoral qualification. Full university ethical approval was obtained from the human research ethics committee at the University of Notre Dame Australia. The metaphors used by the women to describe their lived experience were analysed to extract meaning and ascribe themes to them. Data were collected using semi-structured interviews and transcribed verbatim and analysed using Colaizzi's (1978) method.

*Results*. The results encapsulated the profusion and vibrancy of metaphorical expressions embedded in participants' accounts and provided a rich picture of the participants' experiences. Four themes emerged in the metaphors used by the participants and these all had negative connotations. The themes articulated were the precarious nature of their lived experience, the existence of a battle or fight, the unending nature of their dilemma and the unwelcomeness of the resurgence of their eating disorder. This enabled greater understanding of the women's lived experiences and this understanding could broaden the cognitive landscape of the midwife to assist with the provision of sensitive care for pregnant women with eating disorders.

*Conclusion*. This paper highlights the strength of metaphors as mechanisms for communicating and sharing experience.

*Key words*: Eating disorders, metaphors, pregnant, women, narrative, phenomenological, evidence-based midwifery

## Introduction

Eating disorders are both a local and global epidemic, with almost a million people in Australia living with an eating disorder in 2012, thus comprising around 9% of the population. Of these, 3% had anorexia nervosa, 12% had bulimia nervosa, 47% had binge eating disorder and 38% had other eating disorders, with females encompassing around 64% of the total (Urbancic and Groh, 2009). Most of these women were within the childbearing years. Furthermore, it is predicted that 15% of women will experience an eating disorder in their lifetime (Butterfly Foundation, 2012) and that 20% of women have an undiagnosed eating disorder (Gonzalez et al, 2007).

This situation is not dissimilar to the recent findings of a nationwide study, which estimated that there are 725,000 people in the UK suffering from eating disorders and a 7% per annum increase in hospital admissions for eating disorders since 2009 (BEAT, 2015). The analysis revealed the high prevalence of eating disorders in females with only 10% of those diagnosed being male and symptomology starting prior to 16 years of age in 62% of cases (BEAT, 2015). Furthermore, the study supported previous evidence that eating disorders can be lifelong conditions with recovery rates for anorexia nervosa and bulimia nervosa both below 50% (Steinhausen, 2002).

A basic literature review of eating disorders in pregnancy utilising PubMed and CINAHL was performed and revealed that eating disorders result in significant morbidity and increased mortality in women of childbearing age (Linna et al, 2013; Urbancic and Groh, 2009; Micali et al, 2007). Additionally, it is acknowledged that eating disorders have a significant negative impact on pregnancy outcomes, including the development of the fetus and parenthood adjustment post-birth (Bulik et al, 2009; Micali, et al, 2007; Keel et al, 2003). While diverse studies have reported significant adverse effects of eating disorders on pregnant women and their unborn children, there has been nominal research that has explored the experience from the women's perspectives.

A phenomenological study conducted by Broussard (2005) involving 13 pregnant women with bulimia nervosa revealed that the women were isolating themselves, living in fear, at war with their minds and using diverse strategies to mollify their brain. A further phenomenological study of 10 pregnant women with anorexia and bulimia undertaken by Shaffer et al (2008) demonstrated that these women experienced a persistent mental struggle while hiding their lived experiences, and during their postpartum periods they felt filled with panic and fear. These findings were similar to those of Furber et al (2011) whose research on eight women with anorexia nervosa and bulimia nervosa revealed that the women had pregnancies permeated with torment; they desired to be the perfect mother as anticipated by society and were secretive about their eating disordered behaviours.

Although these studies have provided beneficial insight into the lived experiences of pregnant women with eating disorders, they have only included some of the four sub-types, rather than explore the entire spectrum of eating disorders. The study findings are important as they enable healthcare providers to more closely align support mechanisms for these women in the future. Therefore, to provide a comprehensive picture of the experience of this phenomenon across all four eating disorder sub-types, a study was conducted in Perth,

  

Western Australia of 20 women comprising the four eating disorder sub-types. An unexpected finding from the study was the women's use of metaphors to describe their lived experience, with most women using at least one metaphor and several of them using as many as three metaphors to portray their life. Metaphors have been identified as being an appreciated means utilised to describe personal experiences (Schuster et al, 2011) and have been employed in treatment for women with eating disorders (Goren-Watts, 2011).

A qualitative meta-synthesis of eating disorder metaphors by Goren-Watts (2011) applied hermeneutics, which depicted and explained the metaphors that women used in discourse regarding their eating problems. Study findings disclosed that the women's relationship with their eating disorders altered throughout the recovery process. This shift was exhibited in the metaphors as the women progressed from a positive metaphor while they were struggling, to a negative association during the initial stages of recovery, to a more complicated and distinct manifestation throughout recovery, and ultimately to gratitude metaphors when considered recovered.

*Metaphor use in everyday language*

Metaphors are figures of speech involving comparison between components to infer a likeness. They suffuse our lives every day in ordinary language, thought and action. They allow us to express concepts by enabling us to link the abstract to the known. They are a beneficial means to portray personal experiences and enable articulation of what may not be able to be clearly depicted, so are, in fact, the embodiment of experience (McGlone, 2007). Metaphors are not merely decorative, they are cognitively significant. Metaphors assist in elucidation of concepts and increase comprehension by those involved in the discourse of others.

The application of metaphor has been utilised throughout history and is renowned in ancient Greek literature in accounts such as Homer's *Odyssey*, whereby the metaphor of travel is employed to explain the acquisition of knowledge (Bonner and Greenwood, 2005). Aristotle's traditional theory in which metaphor was originally categorised under figurative language has a belief of similarity and resemblance inferring that they are used by people in similar manners as they resemble what is commonly known to them both. This transference of meaning was such that the truth conditions revealed in the metaphor were taken literally with the meaning being understood because of the shared language. Metaphors were primarily used to comprehend the transference of meaning from one entity to another (Kok et al, 2011).

Until a century ago, metaphors were seen purely as figures of speech and rhetorical devices, however, they are now regarded as constitutive of reality (Miller, 2003) with a proliferation of studies enunciating 'the various ways illness and health are metaphorically embodied, accounted for and communicated' (Schuster et al, 2011: 583). The function of metaphor in expressing and communicating experience within the context of health psychology and medicine has been well conveyed (Radley and Chamberlain, 2001) and the significance of metaphor in illustrating meaningful depictions of experiences is exemplified in qualitative studies exploring metaphoric expressions in psychotherapy (Lyddon et al, 2001; Levitt et al, 2000). As stipulated by Lyddon et al (2001: 269), 'using metaphors may enable clients to indirectly express feelings that might be too painful to address directly'. The employment of metaphors in qualitative research is pervasive and when used circumspectly and intentionally, can be effective devices both in data analysis and as an external validating focus lending truth value to the findings because they add an extra layer to the research (Richardson, 1994). This is particularly evident when there are repeated metaphors utilised by the participants, as occurred in this present study with the metaphors validating the further discourse by the women. This richness of expression provided by their metaphors gave further depth to the meaning of their lived experiences and the similar metaphors used by the women demonstrated a shared meaning for many of the women.

## Method

The use of a qualitative methodology for this study enabled the researcher to discover and extract metaphors from the participants as they explored their pregnancy journey through the eyes of a person with an eating disorder. This was achieved through a phenomenological approach that aims to explore how people make sense of their personal and social world. The research aimed to describe and interpret the lived experience of pregnancy for women who have a diagnosed eating disorder as described by the women themselves.

*Recruitment*

Women with a known eating disorder diagnosis and who had birthed within the past 12 months were sought for interview to provide insight into their recent pregnancy experiences. Participants were recruited via social media and community websites (Facebook, Gumtree), Eating Disorder websites (Butterfly Foundation, Eating Disorders Victoria, Families Empowered And Supporting Treatment of eating disorders [FEAST]), and a specialist parenting service provider, Ngala Family Services website, as well as referrals from health professionals and other participants in the study. The women were provided with a detailed description of the purpose and procedures to be involved in the study prior to them providing written and verbal consent, as per ethical guidelines from the University of Notre Dame Australia.

*Participants*

Participants consisted of a convenience purposive sample of 20 women with a diagnosis of an eating disorder categorised from the four eating disorder sub-types and who had birthed in the previous 12 months. Of the 20 women recruited, 10 were from Western Australia, three from South Australia, two from Victoria, one from New South Wales, one from the Australian Capital Territory, two from the US and one from the UK. Of the four eating disorder subtypes represented, there were eight with anorexia nervosa and four within the other three eating disorder sub-types, namely bulimia, binge eating disorder and eating disorder not otherwise specified. Self-selected pseudonyms were chosen by the women for themselves and their babies to preserve anonymity.

 

*Data collection*

Multiple data sources were used to assist with the establishment of construct validity and reliability of the study by allowing the development of converging lines of inquiry with the provision of multiple measures of the same phenomenon. Demographic data were collected at the start of semi-structured in-depth interviews using a brief survey. The demographic data included questions concerning age, ethnicity, occupation, education level, marital status, postcode of residence, eating disorder sub-type, age at eating disorder diagnosis, number of pregnancies, number of births, gestation of this birth, birth type, and age, gender and baby birth weight. The interviews lasted between 45 minutes and four hours. Interview questions encompassed: a description of what it was like for the women to be pregnant; feelings and concerns about their body image and weight; behaviours and feelings around compensatory mechanisms, such as restricting, binging, purging, laxative use and excessive exercise; mood during pregnancy; and interactions with healthcare professionals. The women were offered the opportunity to add any information that was of significance to them and had not been included in the interview discussion.

These recorded interviews occurred in one of three ways and as chosen by each participant: either face to face, via Skype or via the telephone. They were transcribed verbatim and then returned to the women to confirm their accuracy and to enable feedback via further interviews to occur. This validated the researcher's interpretations and enabled joint construction of consensual meanings. No difference was perceived by the researcher in terms of the quality and depth of data collected by these different modes of communication.

Additional to this clarification of the truthfulness of the data by further discussion with the women, the researcher kept a journal of structured descriptive and objective observations made during the interviews to assist with accurate reconstruction of the experience. Furthermore, the researcher bracketed preconceived ideas and knowledge about pregnancy and eating disorders in this journal to enable the phenomenon to be described as accurately as possible while remaining true to the facts, thus strengthening its credibility.

*Data analysis*

Data were analysed utilising Colaizzi's (1978) six-step procedure, seeking themes and patterns: reading the transcript for feel and global themes; extracting statements and phrases; formulating meanings; arranging meanings into clustered themes; writing themes into exhaustive descriptions and validating the descriptions with the study participants. Data were stored and managed using NVivo10 software, so they could easily be retrieved and organised. During the process of reading the transcripts and extracting phrases and meanings, metaphors the women used were extracted and analysed further to formulate meanings and ascribe themes to them.

The research was conducted as a doctoral study and data collection occurred over three years from 2012 to 2014. Full university ethical approval was obtained from the human research ethics committee at the University of Notre Dame Australia, with the researcher being mindful that the sensitive nature of the research being performed within this vulnerable group of women had the potential to cause psychological distress to them. The researcher sourced appropriate referral pathways to counsellors should they have been required. It was acknowledged that the wellbeing and care of the women always took precedence over research considerations.

## Results and discussion

Within this current phenomenological study on eating disorders in pregnancy, the demographic data revealed that the women were aged between 21 and 40; had been diagnosed with their eating disorders between eight and 26 years of age; nine of them had been pregnant only once; 11 had between one and six miscarriages; had birthed between 30 and 41 weeks' gestation; nine had spontaneous vaginal births; seven had CS; four had vacuum extractions and their babies weighed between 1000g and 4200g. The discursive analysis in this study revealed a wealth of naturally occurring metaphors that facilitated the process of understanding their lifeworlds. These metaphors provided a safe container to allow the conveyance of deeper meaning and provided valuable insights and a rich picture into the difficulties of negotiating a pregnancy whilst having an eating disorder. All metaphors used by the women were analysed within the context of their use.

*'The battle'*

The metaphors of a battlefield and fighting the demons were evoked in numerous women's portrayals of their pregnancies. The depiction of the mind as a field of struggle or a battle is a tradition stretching back to Greek philosophy (Heide, 2010). This metaphor of contending with self has arcane roots in many cultures. Pursuers are inspired to subjugate, confront or overcome themselves in ancient spiritual texts such, as *The Bible, The Koran, Bhagavad Gita, Tao Te Ching*, and *Confucian Analects* (Slingerland, 2003; Nakamura, 1992). Padulo and Rees (2006: 66) state: 'In the life of the woman with disordered eating, there is a battle of opposites with the body as the killing field.'

It has been postulated that metaphors which individuals generate to portray commonplace features of their lives are significantly related to their personality traits (McConnell et al, 1993) with men being more drawn towards military battle metaphors. However, when women use these metaphors they are in connection with perseverance and sufferance rather than power (Anastasia, 2009):

*"Being pregnant for me was like a war battle… There was a battle going on most of the time… it was hard to enjoy being pregnant… Every moment was a struggle"* (Amanda).

*"Those ever present annoying voices in my head that were telling me I was fat were a constant battle for me… It was a constant struggle after that to try to have some control over my body and over my weight… All the while there are two opposing forces at work in your body, the baby and the anorexia...The battle is exhausting"* (Heather).

This description is similar to that of Kathryn who also demonstrated the endurance required to live with the ongoing battle within her body:

*"There was a constant battle going on in my head. The*

  

*thoughts are always present. It is a constant struggle. You can manage the symptoms but the thoughts still exist. It is always a concern. You have to be honest with yourself and admit that it is a struggle"* (Kathryn).

*"Being pregnant for me was like a war battle. I knew my body would change and I would have to cope with that, but when it began to do so, I was not prepared for the struggle that I would go through in having to battle with the day-to-day changes which I did not like. I got fatter and fatter and I had to battle with the voices telling me that I had lost control and that I would be fat forever. There was no end to this war"* (Julia).

Similarly, Maloni and Kutil (2000) reviewed the conversations of small groups of women in antepartum hospital support groups for women who were hospitalised for treatment of either pre-term labour, incompetent cervix, placenta praevia, premature rupture of membranes, or multiple gestation. The 27 women in these groups also voiced about the war within, which referred to the inner conflicts and emotions they were facing on a daily basis during their personal search for the meaning of their experience. Moreover, the women told of fighting each battle that they faced during their hospitalisation, which agrees with Anastasia's (2009) comments about women's use of this metaphor as being indicative of perseverance.

This corresponds with a phenomenological study conducted by Rubarth et al (2012) investigating the lived experience of 11 patients on restricted bed rest in three high-risk antenatal units in the midwestern US. The women, who were placed on bedrest as they were at risk for pre-term birth, depicted the battles they fought every day for the lives of their unborn babies, speaking about the war within, fighting each battle and bringing in reinforcements.

In the current study, the fight for Alice was with the monster in her head:

*"I battled with the monster in my head and a cycle began with binging, hating myself and purging… I just could not win the battle"* (Alice).

Monsters are unpleasant, frightening and with somewhat unknown capabilities so for Alice, her pregnancy was ambiguous and unpleasant. While other participants had to fight with demons:

"*No one would choose to have this constant fight with demons. It would be good if you could wave a magical wand and it all disappeared but it does not work like that. You need help and it takes hard work to face the demons.*

*"The reality is that I will likely be fighting my demons for the rest of my life"* (Sasha).

For Alice, Amanda, Kathryn, Julia and Sasha, pregnancy involved ongoing battles which were not only constant requiring tremendous perseverance, but were exhausting.

*'Going around on the treadmill'*

There was an enduring quality of having to deal with the eating disorder while having to negotiate the experience of pregnancy for some of the women:

*"I did not seem to be able to get off the treadmill. I went round and round just like a mouse on the treadmill. It did not seem to stop"* (Nardia).

*"It seemed so persistent that I felt as if I was on a treadmill just going around and around. It was so exhausting"* (Julia).

This treadmill metaphor was utilised by women participants in a study of the ideology and reality of delayed mothering conducted by Shelton and Johnson (2006: 321), where it was noted that the life previous to parenting had been structured and predictable but was now aimless like 'being on a treadmill doing the same things over and over and not getting anywhere'. Similarly, Fullagar and O'Brien (2012), in discussing women's accounts of the immobilising effects of depression on their sense of self and direction, mention the women being 'stuck on treadmills'. What is evident in these accounts and those of Nardia and Julia in the current study is women were immobilised, directionless and frustrated.

*'Recreational show ride'*

Another metaphor utilised by numerous women in this study was that of recreational rides at shows or fairgrounds, with three women actually naming the ride as a rollercoaster. Although a rollercoaster ride is a type of leisure activity, it is likewise a journey about which Harrington (2012: 409) states 'the journey metaphor allows each patient's narrative to travel along its own path, adjusting and responding to new directions'.

Rollercoaster rides can be exciting and scary experiences that travel with accelerating and decelerating speeds. Nonetheless, the key is that the person who is taking the 'ride' has very little or no control over the experience:

*"The whole pregnancy was a tumultuous time. It was like being on a rollercoaster. There were highs and lows… To be on a rollercoaster ride with no idea of the eventual outcome was not nice"* (Mary).

*"The pregnancy was like a rollercoaster ride. It caught my breath at times and made me feel really scared. Frightened of where and when it might end. Was it going to conclude safely or would my baby be damaged with the fallout from the ride?"* (Tessa).

Both these women had concerns regarding the journeys' culminations but Mary's depiction of the vacillations involved paralleled those articulated by Alison:

*"It was a rollercoaster ride as there was a lot of anxiety and stress but there was also a joy. Yes, definitely, a rollercoaster with lots of joy but lots of anxiety and lots of oh God"* (Alison).

Whereas, to Alice, it was the feeling of loss of control that concerned her more:

*"It was like being on one of those rides at the Royal Show where you just seem to keep going and going and can't get off even if you want to because it's too scary. You are not the one in control. It just keeps going and going. It's out of your hands"* (Alice).

This rollercoaster terminology was used by the women in the antepartum hospital support group study of Maloni and Kutil (2000) in their quests to make meaning of their pregnancy experiences. It was also used by the antenatal women on restricted bed rest in the research by Rubarth et al (2012: 401) with one woman describing her experience as a 'rollercoaster of sadness and hope'.

*'Walking the tightrope'*

In the current study, another recreational type metaphor was used by likening pregnancy to walking a tightrope:

*"I began to walk the tightrope like in a circus… holding on and taking careful steps to keep in control of it and stop myself from falling. To walk a tightrope requires intense concentration and skill to sustain balance and remain on the rope as one could slip and fall to danger"* (Beth).

This was also how academic women with young children felt in a study by Hirakata and Daniluk (2009), equating their experience when in the precarious position of being torn between work and children with walking a tightrope. Likewise, Karlsson et al (2012: 158) used this tightrope metaphor when describing the experiences of patients who remained awake during regional anaesthesia for hip or knee replacement surgery. Their experiences were portrayed as walking the tightrope between 'doubts about voluntarily giving oneself up while at the same time having a desire to control one's situation'.

Additionally, a qualitative study conducted by Tierney et al (2011: 1232) involving eight women with an eating disorder history and who were or who had recently been pregnant, demonstrated that most of the women in the study 'walked a tightrope between responding to the eating disorder and putting their child first'. This overriding concept, which was identified in the study, related to the divided loyalties that the participants experienced between prioritising their child and disregarding their eating disorder, thus placing them in a difficult and tentative position.

*'Teetering on the edge'*

In the present study, pregnancy is also compared to cliffs:

*"Like being on a cliff and being aware that at any time I could fall into shark-infested waters and be eaten up. It was a constant struggle… of teetering on the edge… aware that I could fall and get too caught up to stop myself. It was an awful feeling. I hated it"* (Beth).

Sharks are viewed as 'scary predators' so for Beth to be standing on a cliff edge being aware that she could fall at any time into shark-infested waters and be consumed depicts the unpredictability and frightening nature of this experience.

Similarly, Molly depicted her pregnancy encounter as one of uncertainty:

*"I felt like I was teetering on the edge of unknowing"*(Molly).

This teetering on the edge metaphor was highlighted by Beck (1993) in the development of a substantive theory of postnatal depression via the illustration of women's experiences of postnatal depression with them facing emotional lability, uncertainty and loss of control as they walked the fine line between sanity and insanity.

*'Uninvited visitor from the past'*

This sense of uncertainty was also portrayed in the present research by Yvonne, with her likening her eating disorder in pregnancy to an uninvited visitor from her past:

*"It surprised me as it seemed like a visitor from my past arrived without any invitation and now I would have to deal with this unwelcome visitor I had not seen for ages"* (Yvonne).

To have an unwanted visitor from the past implies this visitor is known to the person, that the arrival is without invitation and their presence is not desired.

The unwanted guest metaphor was used by Coles (2011) in his exploration of trauma across the generations, with the guest being depicted with negative connotations and unpleasant memories concerning the visit. Karakus (2012), while describing the experiences of earthquake victims, used this metaphor of an uninvited guest with there being a complex relationship with the guest who was seen as an intrusion and superfluous, causing the person to feel apprehensive. These descriptions correspond with those portrayed by Yvonne when discussing her unwelcome visitor from her past.

*The value of methaphors*

Metaphors are carriers of meaning and, as such, are at the root of how meaning is made of the world. Thus, the women's use of metaphors in this study enabled them to describe how they saw themselves within their world and their lived experience of negotiating their pregnancies with an eating disorder. These metaphors vividly highlight the complexity of the phenomenon of having an eating disorder while pregnant. They portrayed existential uncertainty and pregnancies as tumultuous experiences which at times were scary with loss of control being paramount in many of the metaphors used by the women. As stipulated by Aristotle (1926), 'midway between the unintelligible and the commonplace, it is a metaphor which most produces knowledge'. The knowledge produced by the metaphors used in this study have enabled an understanding of the lived world of the women with eating disorders while they were pregnant. This understanding can broaden the cognitive landscape of the midwife and enhance communication between midwives and women with eating disorders while they are pregnant. This occurs by the facilitation of a stronger therapeutic alliance due to shared meanings of the women's language used to describe their pregnancy experiences and the capacity of metaphors to spur useful discourses between them by illumination of that which may be difficult to articulate due to the intensity or intimacy of its nature. Furthermore, the provision of a shared language can be used to educate other healthcare professionals, families and friends about the eating disorder experience rather than just seeing it as a constellation of symptoms. Thus, this shared meaning enhances both communication and understanding between people, as it produces common ground upon which to further build conversation and relationship. This will then lead to the provision of sensitive and empathetic care for this often forgotten group of women.

## Conclusion

Language is a powerful tool in health care, with imagery and metaphors being used throughout health communication. By exploring the use of such metaphors, healthcare providers and researchers alike are able to discover what otherwise may be tacit or even misunderstood about the consumers of such health care, thus rendering their experiences and life more accessible. Therefore, greater exploration of the use of metaphors in health care would be beneficial.

  

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# Exploring the influence that midwives have on women's position in childbirth: a review of the literature

***Tamsyn JN Green** BSc, BA.*

Registered midwife, St George's Hospital, Blackshaw Road, Tooting, London SW17 0QT England. Email: green.tamsyn@stgeorges.nhs.uk

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Abstract

*Background*. Despite evidence of the benefits of upright birth positions, most women give birth in recumbent positions.
*Aim*. This review aimed to summarise current evidence regarding how midwives' knowledge, values and attitudes underpin their practice in relation to women's birth position. The objectives were to identify how midwives promote or limit women's use of upright birth positions; analyse the nature of the midwife-client relationship to better understand the role this plays in women's choice of birth position; consider how this information can inform midwifery policy and educators.
*Method*. Electronic searches on Embase; EBM Reviews (The Cochrane Central Register of Controlled Trials); Global Health; Journals from Ovid; Maternity and Infant Care; Ovid Nursing Full Text Plus; Social Policy and Practice; AMED (Allied Health and Complementary Medicine); Academic Search Complete; CINAHL Plus; E-journals; Medline; PsycINFO; Psychology and Behavioural Sciences; PsycArticles; and SocIndex, together with backward chaining, identified seven articles for inclusion in this review. All articles were peer reviewed and published in English between 2004 and 2015 to identify current research.
*Findings*. Upright birth positions are promoted by providing information and practical support through antenatal education and in labour. Midwives support women in upright birth positions by communication styles that encourage them to trust their bodies. Midwives who prioritise women's preferences over their own also facilitate upright birth positions. Recumbent positions are associated with midwives' lack of training or experience, and prioritisation of their own comfort. External factors influencing midwives' practice include clinical conditions such as length of labour and the nature of the midwife-client relationship.
*Implications*. Midwives could narrow the research-practice gap by imparting what they know about birth position to women. Midwifery educators could help affect change through language and training that normalises upright birth positions. Further research is needed to investigate birth position in high-risk care.

*Key words*: Upright birth, birth position, decision-making, choice, midwife-client relationship, evidence-based midwifery

## Introduction

Since the late 1970s, when research revealed the danger of supine hypotension to the woman and fetus (Caldeyro-Barcia, 1979), further studies have shown multiple benefits of upright birth positions. These include: reduced pain; shortened length of labour; reduced incidence of assisted delivery; improved fetal oxygenation; and greater maternal birth satisfaction (Lawrence et al, 2013; Gupta et al, 2012; de Jonge et al, 2004). Although subject to interpretation, the majority of evidence suggests that upright birth positions are advantageous. However, most women in the UK give birth on a bed in recumbent positions (Healthcare Commission, 2008) and national guidelines recommend that women adopt whatever position they find comfortable (NICE, 2014). This indicates a current research implementation gap that this review aims to explore.

Women's birth positions have changed dramatically since the inception of obstetrics in the 17th century, predominantly practised in high-income countries. Prior to this, women most commonly adopted upright positions in birth (Jowitt, 2014; Walsh, 2012; Coppen, 2005; Dundes, 1987). Medicalisation of childbirth, including the use of instruments such as forceps to resolve birth complications, saw recumbent positions on the bed become the norm in Europe and the US (Dundes, 1987). Walsh (2012) remarked on the conceptual shift from women as agents of birth to recipients of care, highlighting that birth positions evolved to suit birth attendants rather than women.

Midwives are bound by professional regulation to provide woman-centred care by working in partnership with their clients to facilitate choice (NMC, 2012). However, Coppen's (2005) seminal research on birthing positions found that midwives were as likely to hinder as promote upright birth. In the UK, midwives are the primary care providers for women accessing maternity services. Unlike other high-income countries, even women cared for by obstetricians will also be supported by a midwife. Therefore, understanding midwives' influence on women's birth position could have a profound effect on practice. Furthermore, the *Birthplace* study (Birthplace in England Collaborative Group, 2011) reformed maternity care guidelines, so they now recommend that women deemed low risk give birth at home, or in a birth centre (NICE, 2014). This points to an expected increase in women giving birth outside of obstetric units, which are currently the predominant choice of birthplace (Office for National Statistics, 2014). Consequently, this paves the way for an increase in midwife-led care, which highlights the significance of this review for the midwifery profession. The aim of this paper is to summarise evidence on how midwives' knowledge, values and attitudes underpin their practice in relation to women's birth position.

## Method

Platform hosts, Ovid Online and Ebscohost, were used to search electronically across the following databases: Embase; EBM Reviews (The Cochrane Central Register of Controlled Trials); Global Health; Journals from Ovid; Maternity and Infant Care; Ovid Nursing Full Text Plus; Social Policy and

Practice; AMED (Allied Health and Complementary Medicine); Academic Search Complete; CINAHL Plus; E-journals; Medline; PsycINFO; Psychology and Behavioural Sciences; PsycArticles; and SocIndex. Key search words and Boolean phrases included ('midwife' OR 'health professional' OR 'birth attendant') AND ('influence' OR 'impact' OR 'effect') AND ('maternal' OR 'women') AND ('birth' OR 'labour') AND ('position'). These were searched for in the abstract, title and key-words fields. Limiters were then applied to include only peer-reviewed literature published between 2004 and 2015.

A total of 90 articles were found, of which 54 were screened once duplicates were removed. Once clearly inappropriate results, such as an irrelevant topic, were removed, 17 articles were assessed. Papers from low-income countries were excluded, as factors hindering mobility in labour were due to limited resources, such as the ratio of women to labour rooms, and beds that were permanently fixed in a supine position (Mwanzia, 2012). There are also complex ethical considerations in analysing these data that require an in-depth understanding of the exportation and replication of obstetric models of care dominant in high-income countries (Crisp, 2010). This process identified four relevant articles. Electronic searches complemented by alternative search methods provide the basis for a more comprehensive review (Greenhalgh and Peacock, 2005). Therefore, backward chaining identified three further studies, which were found on electronic databases, Science Direct and Scopus. In total, seven papers met the search criteria (summarised in Figure 1) and were included for review. See Table 1, overleaf, for a summary.

## Findings

Two critical appraisal tools were used to evaluate separately the qualitative and quantitative research (Rees, 2012; Walsh and Downe, 2006). While qualitative research in health care is less common, its value in midwifery is acknowledged (Rees, 2012), and it is suited to exploratory research. Our understanding of the qualitative data is enhanced by the authors' conceptual frameworks that highlight differences in midwives' attitudes toward birth position. Nieuwenhuijze et al's (2014) literature-informed framework of communication patterns identifies women's decision-making as a dynamic rather than linear process; Priddis et al's (2011) inverse correlation between instinct and fear highlights how midwives' philosophy of care can be compromised due to pressure to comply with maternity service systems; and Thachuk's (2007) models of informed consent and informed choice used by de Jonge et al (2008), distinguish a woman's right to opt out from a woman who chooses to opt for procedures and is genuinely supported to be the primary decision-maker. The latter model forms the basis of the conceptual framework (see Figure 2).

### *Informed choice vs informed consent*

Midwives influence women's birth position by providing informed choice. De Jonge et al's (2008) qualitative study exploring midwives' views on birth position found that an increased use of upright positions was associated with a model of informed choice. This consisted of midwives giving women information about the advantages and disadvantages of different positions in order for them to make their own choice. An ethnographic study by Priddis et al (2011) found that midwives working in a continuity of care model shared their knowledge with women from the first appointment. These midwives perceived that encouraging women's use of upright birth positions would help avoid unnecessary interventions. Several studies also highlight the importance of knowledge from the perspective of women. One participant said that she 'would have hated to have not had the knowledge that on your back is not the best' (Priddis et al, 2011: 234). Both studies were led by research midwives, which is necessary to gain in-depth qualitative data. However, de Jonge et al (2008) note that researchers were known to some participants, which may have influenced data validity.

Two studies found that attending antenatal classes contributed to women feeling informed (Nieuwenhuijze et al, 2012a; de Jonge and Lagro-Janssen, 2004). In addition, Nieuwenhuijze et al (2012b) found that antenatal education was associated with women's preference for upright positions and an increased sense of control during birth. However, the majority of women perceived recumbent positions as the norm, and specifically expressed that they would use positions perceived to be more unusual – such as all fours – if a discussion with the midwife had familiarised them with its benefits (de Jonge and Lagro-Janssen, 2004). Nieuwenhuijze et al (2014) collected data from 100 participants, of which 50 audiotapes were selected at random for transcription. This qualitative study investigated how maternity care providers communicate with women about birth position. Audio recordings in labour revealed that midwives who demonstrated supportive communication styles tended to provide the rationale behind advising certain positions, again enabling informed choice. Recumbent positions were associated with maternity care providers who used a directive style of communication with minimal or no reference to birth position.

**Figure 1. Inclusion and exclusion criteria**

## Table 1. Summary of articles

| Article reference | Country | Research design | Sample | Key findings | Recommendations | Relevance |
|---|---|---|---|---|---|---|
| de Jonge et al. (2008) Women's positions during the second stage of labour: views of primary care midwives. *Journal of Advanced Nursing* **63(4)**: 347-56. | The Netherlands | • Qualitative<br>• Focus groups<br>• Thachuk's model of informed consent vs informed choice | Purposive sample of 31 midwives from independent midwifery practices (paid to participate) | • Midwives practising informed consent corresponded to supporting birth in supine positions vs midwives practising informed choice corresponded to supporting non-supine birth positions<br>• Majority of experience supporting non-supine birth was using birth stool – common in the Netherlands<br>• Midwives' discomfort limits their support for women in non-supine positions<br>• Midwives more likely to support women in alternative position if woman expressed strong desire for non-supine childbirth<br>• Need for midwives to take control if obstetrically indicated, or woman not proactive in decision-making | • Improve midwifery education on evidence-based practice and information giving on birth positions<br>• Research correlation between midwives' work environment and support for birth positions<br>• Improve birth equipment that facilitates upright birth and comfort for midwife<br>• Provide back care for midwives | • Exploration of midwives' attitudes<br>• Strong profile of midwifery in Netherlands, akin to the UK<br>• Specific to midwife-client relationship |
| de Jonge and Lagro-Janssen. (2004) Birthing positions: a qualitative study into the views of women about various birthing positions. *Journal of Psychosomatic Obstetrics & Gynecology* **25(1)**: 47-55. | The Netherlands | • Qualitative<br>• In-depth semi-structured interviews undertaken 7 to 19 weeks postpartum following pilot cohort study | Purposive sampling of 20 women (3 ethnic minority background) birth settings included home and hospital | • Midwife's advice in labour predominant influence on birth position<br>• Women most familiar with supine position regardless of ethnicity<br>• Antenatal preparation valued by women<br>• Supine position used if quick second stage to enable more controlled birth | • Midwives should be aware of their influence and provide practical advice in pregnancy and labour<br>• Improve information-giving through practical workshops, video, leaflets<br>• Research factors facilitating and inhibiting midwives to support non-supine positions | • Women's perceptions of midwives' influence<br>• Specific to midwife-client relationship |
| Nieuwenhuijze et al. (2014) The role of maternity care providers in promoting shared decision-making regarding birthing positions during the second stage of labour. *Journal of Midwifery and Women's Health* **59(3)**: 277-85. | US | • Qualitative<br>• Deductive content analysis of communication patterns via transcribed audio recordings | 41 nulliparous low-risk women and maternity care providers recorded during second stage labour from 2000-06 | • Directional communication style associated with semi-recumbent position<br>• Most maternity providers use range of communication styles from open and supportive to directional<br>• Limited number of women proactive in specifying preference for position<br>• Decision-making is a dynamic not linear process | • Midwives should be aware of behavioural and communication patterns that support women's preferences<br>• Use of literature-informed framework developed in this study can be used for further qualitative research | • Themes identified styles of communication used by maternity care providers and impact on women's choice of birth position<br>• Specific to midwife-client relationship |
| Nieuwenhuijze et al. (2012a) Factors influencing the fulfillment of women's preferences for birthing positions during second stage of labor. *Journal of Psychosomatic Obstetrics & Gynecology* **33(1)** 25-31. | The Netherlands | • Quantitative<br>• Cross-sectional questionnaire | 1154 low-risk women from total of 54 midwifery practices | • Women with preference for supine position more likely to fulfil this, compared with women who preferred non-supine positions<br>• 80% of antenatal class attendees informed of birthing positions / 22% of all women reported sufficient information by midwives<br>• A second stage longer than 60 minutes corresponded to increased chance of using preferred birth position | • Further research needed on causes of variance between preference and actual use of birth position<br>• Midwives are central to supporting women's choice of birth position through information-giving in pregnancy and birth | • Information given by midwives through antenatal classes and at birth |
| Niewenhuijze et al (2012b) Influence on birthing positions affects women's sense of control in second stage of labour. *Midwifery* **29(11)**:107-14. | The Netherlands | • Quantitative<br>• Cross-sectional questionnaire | 1030 low-risk women from total of 54 midwifery practices | • When women had a preference for upright birth positions, an increased sense of control was experienced at home<br>• Women experienced an increased sense of control when decision on birth position shared with others<br>• Midwives enhance women's experience of childbirth through supporting their decisions on birth position | • Improve midwives' awareness of the positive impact they can have on women by discussing and supporting women's choices<br>• Observatory studies should explore dynamic between care providers and women in practice | • Women's perceptions of midwives' influence<br>• Specific to midwife-client relationship |
| Priddis et al. (2011) Juggling instinct and fear: an ethnographic study of facilitators and inhibitors of birth positioning in two different birth settings. *International Journal of Childbirth* **1(4)**: 227-41. | Australia | • Qualitative<br>• Observation in second stage of labour<br>• In-depth interviews with women<br>• Focus groups with midwives | 10 low-risk women<br>5 labour ward midwives<br>5 birth centre midwives | • Birth centre associated with increase in upright positions<br>• Women and midwives report upright and forward leaning positions are instinctive<br>• Midwives who are flexible and creative with equipment and examinations support birth position choice<br>• Fear more dominant in delivery ward vs instinct more dominant in birth centre equates to midwives' expectation to 'do' or to 'be' in order to protect women | • Research women's perceptions of the bed in different birth settings<br>• Educate students on birth in multiple positions<br>• Expose students to continuity of care models to develop observational assessment skills | • Perceptions of women and midwives<br>• Influence of environment on women and midwives |
| Thies-Lagergen et al. (2013) Who decides the position for birth? A follow-up study of a randomised controlled trial. *Women and Birth* **26(4)**: 99-104. | Sweden | • Quantitative<br>• Cross-sectional follow-up questionnaire comparing instrumental birth rates between birth on birth stools and other positions | 289 low-risk nulliparous women from experimental group (177 adhered to using birth seat / 112 did not) | • Adherence group reported autonomy in decision-making and opportunity to birth in preferred position<br>• Adherence group reported midwife as safe and secure in supporting birth position<br>• Adherence group more commonly reported feeling powerful and strong and self-confident<br>• 14% of both groups reported receiving information of pros and cons of birth positions | • Educate midwives to enable competent support for women in non-supine positions<br>• Further research to investigate nature of antenatal information on birth position, and midwives' understanding of autonomy | • Considers the effect of birth position on perceptions of decision-making |

*Woman-centred care vs midwife-driven care*

The literature indicates that upright birth positions are more likely to be used when midwives have a flexible approach to working with women. Priddis et al (2011) found that midwives providing women with lots of options was associated with an increased use of upright positions and an increased number of birth positions used. Nieuwenhuijze et al (2014) found that providing options with practical guidance on how to use birth equipment also promoted upright birth positions. An understanding that all women have different needs was inherent in their communication: 'There's not one way or one position that works for everybody. That's why you change around' (Nieuwenhuijze et al, 2014: 281).

De Jonge et al (2008) found that midwives encouraged upright birth positions by urging women to trust their own bodies. Similarly, Priddis et al (2011) observed that women who are encouraged to 'listen to their body' tend to specifically choose upright and forward-leaning positions. Nieuwenhuijze et al's (2014) study showed that women never requested recumbent positions. This study also found that some midwives demonstrated their trust in women's experiential knowledge by referring to their previous births. Support for women's birth position was expressed by responding to women's verbal and non-verbal cues.

These findings suggest that midwives who are flexible to meet women's needs promote upright birth positions. However, Thies-Lagergren et al's (2013) study found that even when randomly allocated to upright birth on a stool, the adherence group felt they had been given the opportunity to take their preferred position and associated positive emotions with birth on a birth stool. In comparison, the non-adherence group did not feel as involved in decision-making and associated less positive emotions to their birth position.

There is some evidence to suggest that midwives prefer women to use recumbent birth positions. This has been associated with midwives prioritising their own comfort, due to back problems or pregnancy (de Jonge et al, 2008). Another factor associated with midwives limiting women's use of upright birth positions relates to education and experience. De Jonge et al (2008) found that midwives' inadequate training resulted in reluctance, or even refusal, to offer certain positions. This study also illustrated that midwives were affected by previous bad experiences. For example, one midwife had never supported a woman on all fours, following an incident of shoulder dystocia in this position. In addition, midwives' experience of primiparous women's long labours resulted in a perception that birth position is a more important factor for first-time labourers. Despite the fact that all participants in this study claimed they favoured upright birth positions, a quarter reported that the last 10 births they had assisted were in recumbent positions (de Jonge et al, 2008).

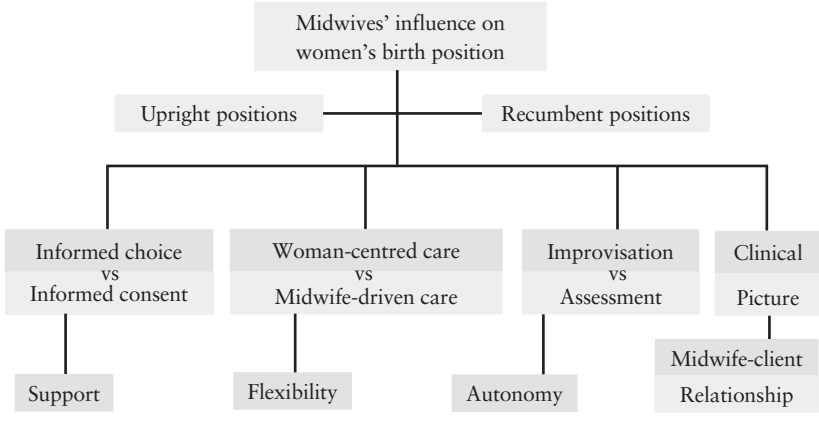
However, there are some important caveats. Observational studies risk influencing midwives' and women's behaviour. Nieuwenhuijze et al (2014) used audio recordings, in comparison to Priddis et al's (2011) direct observation, which is more likely to influence findings. However, the methodological triangulation (observation, interviews and focus groups) used by Priddis et al (2011) could counteract this potential for bias. While Thies-Lagergren et al's (2013) results are inconsistent with qualitative findings, the study lacked information with regards to the specific reasons for non-adherence to allocation. For example, obstetric complications resulting in non-adherence to allocation on the birth stool are likely to impact heavily on women's feelings toward birth.

*Improvisation vs assessment*

Midwives facilitate optimal birth positions by improvising with equipment and being creative in the birth environment. Priddis et al (2011) cite one midwife who carried out vaginal examinations when women were in the bath, and another who described supporting a woman in a standing position despite continuous fetal monitoring. Similarly, midwives used equipment to support their own position, in turn enabling them to support women's positions (de Jonge et al, 2008). Midwives also used tricks, such as implying a full bladder would prevent the baby from descending to encourage women not only to empty their bladder, but to walk around and get off the bed (Priddis et al, 2011). De Jonge et al (2008) found that midwives admitted overruling women's reluctance to be mobile or upright through persuasion. In contrast, several studies showed that supporting upright birth positions was limited by clinical procedures and assessment. Priddis et al (2011) found that midwives asked women to adopt recumbent positions to monitor fetal wellbeing through cardiotopography on admission, even where intermittent fetal monitoring was more appropriate.

De Jonge et al (2008) found that even where midwives supported upright birth positions, many preferred recumbent positions to carry out procedures, such as vaginal examinations, or to view the perineum. This was linked to practising informed consent, rather than informed choice. Priddis et al (2011) found that midwives used procedures to provide women with the rationale for recumbent positions. Two studies suggest that midwives prefer women to give birth in recumbent positions, asking women to lie down for vaginal examinations when they suspect birth is imminent (de Jonge et al, 2008; de Jonge and Lagro-Janssen, 2004).

**Figure 2. Conceptual framework for synthesis of findings**



*The clinical picture*

The midwife's role is to protect normality and identify any deviation from the normal progress of labour. De Jonge et al (2008) found that recumbent positions were more common when midwives anticipated problems, such as fetal distress or blood loss. A further study found that both midwives and women reported use of recumbent positions to control an unusually quick second stage of labour (de Jonge and Lagro-Janssen, 2004). In two studies, obstetric complications were associated with midwives deviating from women's birth position preferences (de Jonge et al, 2008) and using a directive communication style associated with recumbent positions (Niuewenhuijze et al, 2014). Nieuwenhuijze et al (2012a) found that women preferring upright positions were more likely to use them if they experienced a long second stage of labour. Two further studies also found that upright positions were more commonly adopted when women experienced slow progress (Nieuwenhuijze et al, 2014; de Jonge et al, 2004). These data suggest midwives' use of upright positions as an intervention to encourage labour progress.

*The midwife-client relationship*

There is evidence that women perceive midwives' influence as the most important factor when considering birth position (Priddis et al, 2011; de Jonge and Lagro-Janssen, 2008; de Jonge et al, 2004). Indeed, Priddis et al (2011) referenced one woman who specifically attributed feeling comfortable in an upright position to the fact that she felt equal to her midwife. Nieuwenhuijze et al (2014) also found that maternity care providers were more proactive in their care when women had specific ideas about using certain positions. Similarly, de Jonge et al (2008) found midwives more likely to move towards a model of informed choice if women expressed particular wishes in relation to birth position. Women's strength of preference for upright birth positions was significantly associated with its subsequent use in labour (Nieuwenhuijze et al, 2012a). Of significance is Nieuwenhuijze et al's (2012b) finding that women measured their sense of control during birth as higher when they perceived that birth position decisions had been made with others, rather than independently.

Additional findings will be published in a paper in *EBM* in 2016.

## Discussion

The inclusion of qualitative and quantitative research may have limited the literature review due to the extent of knowledge necessary to understand fully the merits of different research approaches. While the studies are comparable due to including only data from high-income countries, there is still considerable variation between models of maternity care. A limitation of this review is the failure to identify research carried out in the UK.

De Jonge and Lagro-Janssen's (2004) finding that the majority of women perceive recumbent positions as the norm highlights the role the midwife has in providing information about upright positions. Despite evidence that antenatal education improves women's experiences of care in labour and their ability to participate in decision-making (Cornally et al, 2014), not all women access this. There is a strong school of support for continuity of care models that enhance the midwife-client relationship, providing more time for discussions on subjects such as birth position (Homer et al, 2002). This is particularly important if women are not able, through lack of time or volition, to benefit from antenatal education. The tradition of giving birth in a recumbent position is reinforced through film and television (Odent, 2013). Given that women's views on birth position are significantly influenced by other women and the media (Mwanzia, 2012), midwives' responsibility in sharing their knowledge about the benefits of upright positions could be deemed increasingly important.

The findings indicate that midwives and women perceive the other as a major influence on birth position (de Jonge et al, 2008). It could be argued, therefore, that the use of upright birth positions relies on a supportive, flexible and autonomous midwife and/or a well-informed woman able to communicate effectively. Importantly, de Jonge et al (2009) found that recumbent birth positions were more prevalent among women from disadvantaged socio-economic backgrounds. This suggests that information-giving is not equal and reinforces midwives' duty of care in providing adequate information to all women.

Birth at midwifery-led units or at home is associated with women's increased use of upright positions (Macfarlane et al, 2014; Coppen, 2005). Midwives' flexibility and autonomy is affected by their work environment (Mander and Fleming, 2002), which this review suggests will, in turn, affect midwives' tendency to support upright positions.

Consistent across three studies was the finding that midwives use upright birth positions as an intervention when labour progress is slow. However, in direct opposition to this idea is de Jonge et al's (2004) consideration that recumbent positions themselves may be seen as interventions, due to the absence of evidence for their use. Jowitt (2014) suggests that midwives supporting upright positions from the beginning of labour could reduce the likelihood of intervention.

## Implications

Midwives could narrow the research-practice gap by imparting what they know about birth position to women. Midwifery educators could help affect change through language and training that normalises upright birth positions.

## Conclusion

External factors influencing midwives' practice in relation to birth position include clinical conditions, such as length of labour or obstetric complications, the client herself and the approach to mobility that is fostered as part of the workplace culture. Communication styles and decision-making between midwives and clients differed in response to these factors. Women experienced a higher sense of control when decisions about birth position were made together with others, rather than independently. Further research is needed to investigate birth position in high-risk care.

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# Episiotomy knowledge, attitudes and practice: a cross-sectional survey of four public Israeli hospitals and review of the literature

***Lena Sagi-Dain*[1] *MD. Shlomi Sagi*[2] *MD.***

1. Senior obstetrician, Department of Obstetrics and Gynaecology, Carmel Medical Center, 7 Michal Street, Haifa, Israel 34361. Email: lena2303@gmail.com
2. Head of department, Department of Obstetrics and Gynaecology, Bnai Zion Medical Center, Haifa, Israel 31048. Email: mdsagi.s@gmail.com

Abstract

*Background*. National episiotomy guidelines state that restricted use is preferable, but the indications for this selective performance are not firmly defined, and the benefits are not clearly determined.
*Objective*. To examine the attitudes of Israeli midwives and doctors towards episiotomy use and to review these in light of the relevant professional literature.
*Methods*. Using anonymous questionnaires, a survey was conducted among midwives and obstetricians in four northern Israel hospitals over a one-year period. In addition to providing demographic and professional data, the accoucheurs were asked to score their agreement with 11 proposed statements regarding episiotomy practice.
*Results*. Overall, 32 midwives and 84 obstetricians completed the questionnaires. Significantly more obstetricians considered episiotomy beneficial in prevention of obstetric anal sphincter injuries and pelvic floor damage (29.1% versus 9.4%, p=0.028, and 19% versus 3.1%, p=0.036, respectively), while more midwives compared to obstetricians believed that national guidelines provide precise definitions regarding episiotomy use (46.9% versus 15%, p=0.001). All of the less experienced accoucheurs (less than 15 years experience) believed there was a need to change the policy regarding episiotomy performance, compared to only 15.6% of their more experienced colleagues (p=0.002). Ethical approval was not required, as the study was conducted with health personnel.
*Implications*. This study demonstrates the accoucheurs lacked awareness of the existing evidence and national guidelines regarding episiotomy use. Moreover, the literature review highlighted the suboptimal quality of the available evidence. Therefore, uniform protocols, educational programmes and further high-quality research are essential to guide episiotomy practice.

*Key words*: Benefits and risks, episiotomy, guideline adherence, health attitude, knowledge, evidence-based midwifery

## Introduction

Episiotomy is a common surgical procedure in the delivery room. Although national guidelines uniformly agree that restricted use of episiotomy is preferable, the indications for this selective performance are not firmly defined, and the benefits of this procedure are not clearly determined. The literature suggests that the lack of defined and uniform guidance regarding episiotomy use, and the influence of subjective considerations, have resulted in widely varying frequency of this procedure. Episiotomy rates differ widely between countries (from about 14% in the US and Canada, to 75% in Yemen), medical centres (private versus public hospitals) and obstetrical personnel (between doctors and midwives) (Chalmers et al, 2012; Johantgen et al, 2012; Lyndon et al, 2012; Frass and Al-Harazi, 2010).

Accoucheurs' characteristics can also affect episiotomy rates; for instance, it has been shown that less experienced obstetricians, male physicians and doctors with night-float call schedule versus traditional call schedule tend to perform less episiotomies (Barber et al, 2011; Goode et al, 2006; Arroll et al, 1990). These differences could also result from varying personal opinions regarding the benefits of episiotomy and an inconsistency in their acquaintance with the professional literature. The objective of the authors' study was to examine the attitude of Israeli obstetric personnel towards episiotomy practice, to examine the parameters influencing these findings and to review the relevant professional literature.

## Method

This cross-sectional survey of midwives and obstetricians attending birth was conducted using an anonymous questionnaire, administered in the obstetrics and gynaecology departments of four public northern Israeli medical centres, from October 2013 to September 2014.

The semi-structured questionnaires were designed with the guidance of an experienced epidemiologist. They were distributed during conventional departmental meetings and completed by all the medical personnel present, which constituted 65% of the total obstetric personnel. The survey included questions on the following: age, gender and profession of the caregiver (midwife or obstetrician), the duration (in years) of delivery room experience, main source of information regarding episiotomy practice (midwife/medicine studies, senior colleagues, professional literature, personal experience) and rating the degree of the agreement with 11 statements regarding episiotomy (fully agree, strongly agree, moderately agree, slightly agree, disagree). The included statements are presented in Table 1 opposite. Selection of these statements was based on professional literature and national guidelines, and their validity was evaluated by a feedback of six senior midwives and two senior obstetricians. As the study was a cross-sectional survey of health practitioners, Institutional Review Board approval was not needed.

Data were analysed using SPSS software (SPSS Inc, Chicago). Continuous variables were presented as mean ± standard deviations (SD) and compared by t-test for independent

  

**Table 1. Statements included in the questionnaire**

| | |
|---|---|
| 1 | Episiotomy is effective in prevention of advanced perineal tears |
| 2 | Episiotomy reduces intrapartum and postpartum bleeding |
| 3 | Episiotomy reduces postpartum perineal pain |
| 4 | Episiotomy decreases pelvic muscle damage, including symptoms of urinary/fecal incontinence |
| 5 | Episiotomy suturing is generally easier than that of spontaneous perineal tear |
| 6 | Overall benefits of episiotomy outweigh its disadvantages |
| 7 | There is compelling national guidelines recommendation that restrictive use of episiotomy is preferable to its routine use |
| 8 | National guidelines provide precise definitions regarding episiotomy technique and indications for its implementation |
| 9 | According to randomised controlled trials comparing different episiotomy types, mediolateral incision is preferable to median |
| 10 | In case of reliable studies pointing to episiotomy ineffectiveness, I would be able to completely cease performing episiotomy |
| 11 | Episiotomy is a long-known simple procedure with minor complications, thus there is no need to change the policy regarding its performance |

samples. Proportions were calculated for the categorical variables, as appropriate, and compared using Fisher's exact test. To simplify the data interpretation and presentation, the main source of information regarding indications for episiotomy use was presented as subjective versus objective sources ('subjective' included personal experience and knowledge attained from senior colleagues, while 'objective' was defined as midwife/medicine studies and professional literature). Subgroup analysis was performed for obstetricians versus midwives, male versus female obstetricians, professional experience (≤15 years versus >15 years) and subjective versus objective main source of information regarding episiotomy indications. $p<0.05$ was considered statistically significant for all comparisons.

## Results

The four participating hospitals undertake approximately 14,000 deliveries annually (Carmel Medical Center – about 3000 deliveries per year, Rambam Health Care Campus – 5000 deliveries, Bnai Zion Medical Center – 3000 deliveries, and the Baruch Padeh Medical Center, Poriya – 3000 deliveries). Average (± standard deviation) episiotomy rates in these medical centres are 13.8±5.4%, with 7.7±3.0% operative vaginal delivery rates, 19.8±3.3% CS delivery rates, and 0.6±0.3% rates of obstetric anal sphincter injuries (OASIS). In Israel, the majority of normal vaginal deliveries are managed by midwives only, while obstetricians usually intervene in cases of complicated labour, such as fetal distress or operative vaginal deliveries. There are no formal guidelines for episiotomy performance, and the procedure is used according to the clinical judgment of the accoucheur attending the delivery.

A total of 117 questionnaires from the four hospitals were analysed (72.4% obstetricians and 27.6% midwives). Characteristics of the respondents are presented in Tables 2a (profession and experience duration) and 2b (gender and information source). Of note, the main source of information regarding episiotomy technique was subjective, encompassing 26 (22.6%) respondents basing their attitude on senior colleagues' experience and 51 (44.3%) on their personal experience. Only 14 (12.2%) of the respondents relied on professional literature, and 24 (20.9%) based their knowledge on midwifery/medical studies. Compared to midwives, the obstetrician group yielded a significantly higher proportion of male participants (60.5% versus 0%, respectively, $p<0.0001$) and utilised a subjective, rather than objective, source of education towards the indications for episiotomy (73.1% versus 53.1%, respectively, $p=0.047$). Less experienced accoucheurs (≤15 years of professional experience) were younger ($p<0.0001$) and demonstrated both a higher proportion of female obstetricians (64.6% versus 43.5%, respectively, $p=0.034$) and the use of an objective educational source (41.5% versus 27.3%, respectively, $p=0.027$).

Table 3, overleaf, represents the proportion of agreement with the proposed statements regarding episiotomy performance (fully/strongly agree). According to these results, significantly more obstetricians compared to midwives

**Table 2a and 2b. Characteristics of the respondents**

| Table 2a | Total | Profession | | Experience duration | |
|---|---|---|---|---|---|
| | | Obstetricians | Midwives | <15 years | >15 years |
| | n=17 | n=84 | n=32 | n=66 | n=48 |
| Age | 44.4±13 | 43.9±14.3 | 46.1±7.9 | 37.1±8.4* | 55.6±11.0* |
| Gender (female/male) | 64/49 | 32/49* | 32/0* | 42/23* | 20/26* |
| Experience duration | 14.5±12 | 14±12.8 | 16.1±9.3 | 5.9±6.3* | 26.2±6.8* |
| Obstetricians/ midwives | 84/32 | - | - | 48/17 | 35/13 |
| Informative source (subjective/objective) | 77/38 | 60/22* | 17/15* | 38/27* | 37/10* |

| Table 2b | Total | Profession | | Experience duration | |
|---|---|---|---|---|---|
| | | Men | Women | Subjective | Objective |
| | n=17 | n=49 | n=32 | n=77 | n=38 |
| Age | 44.4±13 | 48.8±13.7* | 36.4±12.0* | 46.9±13.3* | 39.1±11.0* |
| Gender (female/male) | 64/49 | - | - | 40/37* | 24/14* |
| Experience duration | 14.5±12 | 17.4±13.3* | 8.5±10.1* | 16.3±12.6* | 11.0±9.9* |
| Obstetricians/ midwives | 84/32 | - | - | 60/17 | 23/15 |
| Informative source (subjective/objective) | 77/38 | 35/13 | 23/8 | - | - |

** stands for statistical significance ($p<0.05$).*

**Table 3. Rates of agreement (%) with the proposed statements regarding episiotomy practice**

| The statement | Total | Profession | | Experience duration | | Gender (obstetricians) | | Information source | |
|---|---|---|---|---|---|---|---|---|---|
| | | Obstetricians | Midwives | ≤ 15 years | > 15 years | Men | Women | Subjective | Objective |
| 1. Prevention of OASIS | 23.2 | 29.1a | 9.4a | 18.8 | 28.9 | 24.4 | 35.5 | 24.7 | 18.4 |
| 2. Decreased bleeding | 4.4 | 6.3 | 0.0 | 4.7 | 4.3 | 8.7 | 3.2 | 4.1 | 5.3 |
| 3. Decreased pain | 0.9 | 0.0 | 3.1 | 0.0 | 2.2 | 0.0 | 0.0 | 1.4 | 0.0 |
| 4. Decreased pelvic floor damage | 14.3 | 19.0a | 3.1a | 12.5 | 17.8 | 17.4 | 23.3 | 17.8 | 7.9 |
| 5. Easier suturing | 53.6 | 55.7 | 46.7 | 47.6 | 61.4 | 56.5 | 53.3 | 58.3 | 43.2 |
| 6. Benefits overweight | 18.6 | 22.5 | 9.4 | 17.2 | 21.7 | 19.6 | 22.6 | 27.0b | 2.6b |
| 7. Restrictive use | 83.2 | 81.3 | 87.5 | 84.4 | 85.7 | 76.1 | 90.3 | 82.4 | 84.2 |
| 8. Precise definitions | 23.9 | 15.0b | 46.9b | 20.4 | 34.8 | 13.0 | 16.1 | 22.8 | 23.7 |
| 9. Episiotomy type | 74.5 | 75.3 | 71.9 | 75.8 | 73.3 | 75.0 | 74.2 | 74.0 | 75.0 |
| 10. Able to completely stop | 38.4 | 39.2 | 37.5 | 39.1 | 40.0 | 42.2 | 35.5 | 38.4 | 39.5 |
| 11. No need to change the policy | 6.3 | 6.3 | 6.3 | 0.0a | 15.6a | 6.7 | 3.2 | 8.2 | 2.6 |

*a – stands for statistical significance p<0.05 b – stands for statistical significance p<0.01*

considered episiotomy beneficial in the prevention of OASIS and pelvic floor damage (29.1% versus 9.4%, p=0.028, and 19% versus 3.1%, p=0.036, respectively). In contrast, significantly more midwives compared to obstetricians believed the national guidelines provide precise definitions regarding the use of episiotomy (46.9% versus 15%, p=0.001). A total of 15.6% of the accoucheurs with more than 15 years' experience said there is no need to change the policy regarding episiotomy use, compared to none of their less experienced colleagues (p=0.002). Finally, more obstetricians in the subjective information source group believed that the overall benefits of episiotomy outweigh its disadvantages, compared to accoucheurs using objective sources of knowledge (27% versus 2.6%, respectively, p=0.002). None of the examined parameters (gender, profession, duration of professional experience, or type of experience acquisition) exhibited a significant influence on the degree of agreement with other proposed statements.

## Discussion

In this study, the authors sought to describe the prevailing opinions regarding episiotomy use in four Israeli hospitals. It is worth noting that, according to the results, less than one-third of the obstetricians relied on objective sources of information, such as professional literature, in their decision to perform episiotomy. This finding by itself highlights the need for continuing education on the subject.

*Episiotomy and advanced perineal tears*

The ability of episiotomy to prevent OASIS has been evaluated by numerous studies; however, the results are controversial. A recent meta-analysis of 22 observational studies, encompassing 651,934 deliveries, found episiotomy was related to higher rates of OASIS (odds ratio (OR) 3.82 [95% confidence interval (CI) 1.96–7.42]) (Pergialiotis et al, 2014). However, an inevitable limitation of any non-randomised trial is the lack of control for any unpredictable and not-measurable confounding factors; for example, tight perineal tissue could possibly increase both the risk of perineal tears and the tendency of the accoucheur to perform an episiotomy. The Cochrane Collaboration meta-analysis of randomised controlled trials (RCTs), published in 2009, has demonstrated that restrictive rather than routine use of episiotomy was related to a lower risk of severe perineal trauma (relative risk (RR) 0.67, 95% CI 0.49-0.91), posterior perineal trauma (RR 0.88, 95% 0.84-0.92), the need for suturing perineal trauma (RR 0.71, 95% CI 0.61-0.81), and healing complications at seven days (RR 0.69, 95% CI 0.56-0.85) (Carroli and Mignini, 2009). Despite these data, about a quarter of the respondents (and up to one-third of the doctors participating in the survey) believed that episiotomy is effective in the prevention of OASIS.

*Episiotomy and postpartum bleeding and pain*

The overwhelming majority of the respondents did not support the statement that episiotomy reduces postpartum bleeding and pain. Indeed, many prospective observational trials reported an increased risk of bleeding or pain with episiotomy use (Biguzzi et al, 2012; Driessen et al, 2011; Sosa et al, 2009), while the two RCTs examining the association between episiotomy and the risk of postpartum bleeding did not note any statistical significance (Murphy et al, 2008; Dannecker et al, 2004). Similarly, although few RCTs did not find an association between episiotomy and postpartum pain (Murphy et al, 2008; Harrison et al, 1984), the largest of RCTs, examining the outcomes of routine versus restrictive episiotomy use in 2606 women, yielded significantly lower pain rates during discharge in the latter group (Argentine Episiotomy Trial Collaborative Group, 1993). These results were supported by several other smaller RCTs (Moini et al, 2009; Dannecker et al, 2004; Sleep et al, 1984). In summary, the available evidence fails to demonstrate episiotomy benefits in decreasing postpartum pain or bleeding; on the contrary, this procedure may even be associated with increased postpartum perineal pain.

*Episiotomy and pelvic muscle damage*

A total of 14.6% of the participants, including 19% of the doctors, incorrectly believed that episiotomy is able to

  

decrease pelvic floor muscle damage, including symptoms of urinary/fecal incontinence. Numerous observational articles have examined this subject, yielding inconsistent results. Three RCTs did not observe a significant difference in urinary or anal incontinence between routine and restrictive episiotomy use (Islam et al, 2013; Moini et al, 2009; Murphy et al, 2008), and one additional RCT found higher rates of urinary incontinence three months after delivery in the routine episiotomy group of multiparous women (Klein et al, 1992). The American College of Obstetricians and Gynecologists' (ACOG) summary of recommendations concludes that 'routine episiotomy does not prevent pelvic floor damage leading to incontinence' (ACOG, 2006: 960).

*Episiotomy suturing*

Approximately half of the respondents agreed with the statement that episiotomy suturing is easier than that of spontaneous perineal tear. This opinion supposedly makes sense, since an episiotomy incision is a fairly predictable straight line. However, scarce data exists in the professional literature regarding this issue. Two RCTs, both published 30 years ago, have examined suturing time in routine versus restrictive episiotomy use. A study by Harrison et al, which encompasses a total of 181 women, did not find a significant difference between these two groups (Harrison et al, 1984). Sleep et al assessed 1000 participants and found that women allocated to the liberal policy required significantly more suture material and more hours of time to repair the perineal trauma (Sleep et al, 1984). This can be explained by the lower need for suturing in the restrictive policy group, exhibited by this study and supported by the above mentioned meta-analysis of Cochrane Collaboration (Carroli and Mignini, 2009).

*Episiotomy benefits versus disadvantages*

More than a quarter of the accoucheurs relying on subjective information sources of episiotomy use agreed that the overall benefits of episiotomy outweigh its disadvantages. This percentage was significantly lower in the group basing their opinion on professional literature, which indeed fails to support this statement. This again highlights the need for continuing education of the health practitioners, rather than encouraging them not to rely on their personal experience or on the knowledge of their senior colleagues.

*Routine versus restrictive episiotomy, optimal technique and indications*

There are compelling national guideline recommendations, shared by the ACOG (2006), NICE (2015), Cochrane Collaboration, and the accepted textbooks (Cunningham, 2010; Carroli and Mignini, 2009) that restrictive use of episiotomy is preferable to its routine use. Thus, it is surprising that about one-fifth of the respondents did not fully agree with this statement. In addition, almost a quarter of the accoucheurs, and up to half of the midwives group, incorrectly believed that national guidelines provide precise definitions regarding episiotomy technique and indications for its implementation. According to ACOG: 'There is a place for episiotomy for maternal or fetal indications, such as avoiding severe maternal lacerations or facilitating or expediting difficult deliveries' (ACOG, 2006: 960). However, this guideline provides no detailed definition of such 'difficult deliveries', while 'avoiding severe lacerations' is an important and legitimate goal in any vaginal delivery. Moreover, the ACOG notes that 'there are insufficient objective evidence-based criteria to recommend episiotomy, and clinical judgment remains the best guide for use of this procedure' (ACOG, 2006: 958). NICE states that an episiotomy should be performed 'if there is a clinical need, such as instrumental birth or suspected fetal compromise', leaving much room for subjective clinician's judgment in any other cases in which this 'clinical need' arises (NICE, 2015: 4). Cochrane Collaboration meta-analysis concludes by asking: 'What are the indications for the restrictive use of episiotomy at an assisted delivery (forceps or vacuum), preterm delivery, breech delivery, predicted macrosomia and presumed imminent tears?'. No solid statements are provided (Carroli and Mignini, 2009: 6).

*Median versus mediolateral incision*

An additional incorrect assumption of three-quarters of the accoucheurs is that 'according to randomised controlled trials comparing episiotomy types, mediolateral incision is preferable to median'. While it is a well-known fact that median episiotomy is associated with higher rates of injury to the anal sphincter and rectum than mediolateral episiotomy (ACOG, 2006), no high-quality RCTs were published comparing these. A Cochrane Collaboration meta-analysis detected only three published trials comparing midline and mediolateral episiotomy, however, all of these were excluded from the review due to poor methodological quality, making their results uninterpretable. The authors concluded that this question, therefore, remains unanswered.

*Need to change the guidelines and the ability to stop using episiotomy*

Few respondents agreed with the statement: 'Episiotomy is a simple procedure with minor complications, known for many years, and therefore there is no need to change the policy regarding its performance.' Interestingly, a significant difference was found in the response relating to the duration of professional experience, as significantly higher rates of senior obstetricians agreed with this statement compared to their less experienced colleagues (15.6% versus 0%, p=0.002). Finally, more than half of the obstetricians were not sure whether they could completely stop performing episiotomy in the case of reliable studies pointing to its ineffectiveness. The difficulty in changing well-established obstetricians' habits regarding episiotomy practice has already been described by Klein et al (1995). These investigators undertook an RCT comparing policies of restricted versus routine episiotomy use, and noted that a third of the physicians did not change their use of episiotomy as required by the study protocol; instead, they used episiotomy approximately 90% of the time for patients in both trial arms. When the authors re-analysed the original data according to the attending physicians' beliefs about

episiotomy, assessed by a specifically designed questionnaire, they found that physicians who viewed episiotomy very unfavourably were more likely to allow labour to progress without interference, and women under their care had longer first stages of labour and received fewer oxytocin augmentations of labour and CS.

Conversely, physicians who viewed episiotomy more favourably were more likely to see apparently normal labour as abnormal. They more often failed to open study envelopes in order to randomly assign women participating in the trial, more often diagnosed fetal distress in apparently normal labours and more often thought the perineum was unable to distend or was about to tear severely. The results suggest that accoucheurs' attitudes are substantially influenced by subjective beliefs, and these opinions can be very hard to change.

## Conclusion

The value of this study lies in a greater understanding of the attitudes and knowledge of the obstetricians regarding the use of episiotomy in several Israeli hospitals (a country with one of the lowest reported rate of OASIS worldwide), and considering this in the light of the relevant literature evidence.

The limitations of this paper include the small number of participants, especially in the midwife sector, and the inability to ensure the representativeness of the participants for the general obstetric personnel in Israel. Nevertheless, the main value of the authors' manuscript is the description of the obstetricians' approach, rather than the actual percentages.

The study results demonstrate the insufficient familiarity of the accoucheurs with the existing evidence and national guidelines regarding episiotomy use. Moreover, the current literature evidence defining proper episiotomy use is suboptimal. These findings can explain the differences in attitudes between the obstetricians, which may not be easy to change. Therefore, uniform protocols, educational programmes and further high-quality research are essential to guide episiotomy practice.

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# Information for authors

*Evidence Based Midwifery* is published quarterly and aims to promote the dissemination, implementation and evaluation of midwifery evidence at local, national and international levels. Papers on qualitative research, quantitative research, philosophical research, action research, systematic reviews and meta-analyses of qualitative or quantitative data are welcome. Papers of no longer than 5000 words in length, including references, should be sent to: rob@midwives.co.uk in MS Word, and receipt will be acknowledged. Suitable papers are subject to double-blinded peer review of academic rigour, quality and relevance. Subject area and/or methodology experts provide structured critical reviews that are forwarded to authors with editorial comments. Expert opinion on matters such as statistical accuracy, professional relevance or legal ramifications may also be sought. Major changes are agreed with authors, but editors reserve the right to make modifications in accordance with house style and demands for space and layout. Authors should refer to further guidance (RCM, 2007; Sinclair and Ratnaike, 2007). Authorship must be attributed fully and fairly, along with funding sources, commercial affiliations and due acknowledgements. Papers that are not original or that have been submitted elsewhere cannot be considered. Authors transfer copyright of their paper to the RCM, effective on acceptance for publication and covering exclusive and unlimited rights to reproduce and distribute it in any form. Papers should be preceded by a structured abstract and key words. Figures and tables must be cited in the text, and authors must obtain approval for and credit reproduction or modification of others' material. Artwork on paper is submitted at the owner's risk and the publisher accepts no liability for loss or damage while in possession of the material. All work referred to in the manuscript should be fully cited using the Harvard system of referencing. All sources must be published or publicly accessible.

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# News and resources

**Applications invited for fellowship programme**

The National Institute for Health Research (NIHR) has announced the launch of Round 9 of the NIHR Fellowships Programme 2016. Applications are invited from individuals working in any sector or scientific discipline who propose to undertake people- or patient-based clinical and applied health research at an institution based in England or Wales. The deadline for applications is 1pm on 20 January 2016. Shortlisting will take place in April and interviews will be held in Leeds between 21 and 23 June. For more information and to apply for the fellowship programme, visit **nihr.ac.uk/funding/fellowship-programme.htm**

**RCM awards announced**

Top evidence-based projects and innovative research are to be celebrated at the RCM Annual Midwifery Awards on 8 March. The awards are designed to be a reflection of excellence in midwifery and promote best practice and world-class midwifery standards, showcase practice innovations and ground-breaking initiatives and recognise individual and team excellence. The shortlisted entries have been announced and can be viewed online. Winners will be announced by the guest compère Kate Silverton and the awards will be presented by the RCM chief executive Cathy Warwick. For more information, visit **rcmawards.com**

**Iolanthe awards applications open**

Applications for the 2016 Iolanthe Midwifery Trust (IMT) Awards are open until 5 February. The awards offer a maximum of £1500 for midwives who have projects for further study, or enhancement of their practice, while the student awards are up to £1000. The Jean Davies Award, which is held in partnership with the RCM, includes funding of up to £5000 for midwives working to address the impact of social inequalities on the wellbeing of pregnant women, new mothers and their babies. The Iolanthe Midwifery Research Fellowship is an award of up to £25,000 to assist a midwife in the final stages of a doctorate. For more information, visit **iolanthe.org**

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