Understanding Anxiety, Worry and Fear in Childbearing

A Resource for Midwives and Clinicians

Kathryn Gutteridge
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Foreword

Fear is corrosive, relentless and contagious. It limits our potential and prevents us from doing our best as mothers, midwives and obstetricians. Fear can cast a dark shadow over pregnancy and birth and inhibit optimal hormonal function. At a time when birth has never been safer, it is sadly ironic that we are only just becoming aware of the tragic impact of fear upon mothers and all those involved in birth. Fear around birth is increasing, and this book makes an important contribution to our knowledge in this neglected area. It contains some outstanding chapters.

Birth takes place within a culture, and our culture is focussed on economic growth that requires ever developing technologies, products and markets and promotes growth by advertising which is often fear inducing. Birth is about relationships and trusting relationships can resolve fear, but the organisation of maternity services on an industrial model does not allow relationships to flourish. In some cases, institutional safety procedures play a considerable part in creating and sustaining fear.

Different chapters bring out the long-term impact on women of not being believed, whether as abused children or women in early labour, and the bodily memories which can be reawakened by "care" during pregnancy and birth. So much fear has its roots in women's past experiences of loss of control and the abuse of power when they were at their most vulnerable. Sadly, for many this abuse was by professionals in their previous experiences of maternity services.

Positive birth can be healing, and an argument for continuity of midwifery care runs through this book. Where a trusted midwife can hold safe space for a mother, it is possible for her to feel sufficient confidence in her carers and her body to let go and give birth and then hold safe space for her baby. This is an empowering experience, which is not achieved where women feel they are being processed on a conveyor belt and midwives are micro-managed. Chapter authors from very different backgrounds make strong arguments for listening to women and trusting them and show how this can transform women's birthing experience. This is vitally important, but difficult for midwives who feel that their own voices are not heard and they are not trusted by management.

The authors explore the complexity of the causes and experiences of fear. There are no easy answers, no edict, medicalised answer or product, which will solve the problems created by the abuse of power, medicalisation and the market economy.

There are helpful tips and suggestions for carers to help them protect the woman's agency, communicate well and be kind. The importance of listening and trust is a powerful theme.

This timely book addresses worry and anxiety around birth as well as differing levels of fear. It brings together recent research, innovations in service provision and compassionate insights from different fields of work around birth. In a number of chapters, the issues raised are illustrated with relevant and illuminating stories, a traditional and memorable way of teaching about birth. So much is conveyed where the words of suffering women are quoted. There is much here of relevance to mothers, partners, midwives, obstetricians, managers and those who plan and fund maternity services. This is a book well worth reading.

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Preface

This book has been on my mind for many years. The women I have encountered throughout my clinical career both as a midwife and then as a psychotherapist remind me of the vast amount of work to do in recognising the phenomenon of fearfulness in our childbearing populations. How does a clinician differentiate between a worried or anxious woman compared to one who is secretly terrified of a pregnancy before it has even begun? This book does not claim to answer all the questions but it does start the narrative and brings the subject matter from within the hidden corners of women's lives.

When you begin to read this book, you will note that the authors are in the main midwives, but there are contributions from an obstetrician, psychiatrist and also a doula. Whatever the difference in roles, the central experiences of these authors are that they have encountered, witnessed, and understood the issues they have written so carefully about. This collaboration is important because women present in many ways and to various people in their quest to be understood. The style of writing is largely academic but has a sense of being rooted in the experiences of women. In every chapter there are references to women's experiences and in others there are vignettes or case studies that will elucidate the many ways that women suffer with their anxieties and fears. Some of the chapters are written with very personal observations and in the first person that reaches out to those of us who wish to hear the story.

In deciding how to use the book it may be that student midwives will wish to understand the nature of the problems and dip in and out of chapters. For women who are searching for answers to their anxieties this may suit some of those readers, particularly when looking for answers to approaching future pregnancies and birth.

For maternity clinicians and doulas, this book will provide a comprehensive analysis of anxiety, fear and in some rare cases tokophobia or morbid fear. The authors have approached their chapters with an enlightened approach giving insight into the problems and scenarios that women find themselves facing during their pregnancies and births. There may be some cross over from chapter to chapter but I make no apologies for this as it is important in terms of education and encouraging a deeper understanding.

The chapters themselves give a cultural overview that appreciates the universality of birth today in our diverse and multicultural societies. Although many of the authors are working in the United Kingdom, there is a determination to represent

birth from other healthcare systems such as Ireland and Australia. Of course, this is a small comparison but what the authors show is that this phenomenon is not culture exclusive and may be found in a wide cultural variance.

Fear as an extreme human experience is a rare event in general adult life. However, where it is associated with a normal human experience such as childbearing then it takes on a more secretive or shameful persona. This is likely to become a taboo subject and one which is hidden in everyday life. Add into this another deeply buried secret such as sexual abuse—then the woman is less likely to disclose her fears. It was important in this book to cover this subject matter as these women were found to be highly represented in a seminal paper investigating tokophobia. Maternity clinicians are unlikely to make this association and if they do, they are often unaware of how to offer care in a sensitive way that reduces retraumatisation.

Education for psychological well-being, trauma presentations and acute panic/fear within maternity settings are not mandated. Clinicians will often choose to attend training or education events such as these because they are interested rather than their service or professional organisation requires it. A book that covers this subject matter and is available to a wide clinical and non-professional audience will serve to educate and inform.

The intention in writing this book is not to give every answer to all of the problems or to provide a best clinical pathway to offer care to childbearing women. It is a start to the dialogue; it gives the subject matter importance and thus allows women to apply a name to their emotions and feelings that may be worrying them. In producing a book that begins to give credibility to previously hidden or dismissed anxieties is a leap of faith that cannot be underestimated.

I hope that this narrative is work that will gain strength and inform those providing care for childbearing women. I also hope that it serves to do justice to the many women who have suffered their fears in silence and isolation. This is a book that I wished I could have read many years ago before embarking on the unknown.

In memory of my daughter Rebecca Marie Mistry; she taught me so much watching her as a mother to both of her sons and I am indebted to her for her intelligent and mature observations of our healthcare systems. She was the mother I wished I could have been.

Birmingham, UK Kathryn Gutteridge

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History of Fear and Childbearing

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Maeve O'Connell and Rhona O'Connell

> The greatest battle that ever was fought—Shall I tell you where and when?On the maps of the world you will find it not:It was fought by the Mothers of Men. (Joaquin Miller [1837–1913])

Childbirth has undergone considerable change over the past few centuries. Outcomes have improved due largely to improvements in the health and well-being of women and babies, but also to the increase in knowledge about pregnancy and childbirth. Unfortunately, standards of maternity care are variable; there are concerns about levels of intervention in childbirth in many parts of the world, while there is a lack of resources to ensure safe childbirth in many low resource countries (Miller et al. 2016). Sadly, mainly in low to middle income countries, there is widespread neglect and abuse of childbearing women by health care professionals (Bowser and Hill 2010). Women report a positive childbirth experience when they are treated with respect and feel safe. Unfortunately, many women also experience fear of childbirth and this is not always recognised (O'Connell et al. 2019). In this chapter, firstly we will explore birth and how it is documented through the ages, with relevance to the historical culture of birth and birth workers. Secondly, we will discuss what has influenced changes in maternity care provision and shaped women's thinking about birth and its consequences for today's women.

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1.1 Early Modern Period

Since the first recorded births, midwives have accompanied and assisted women through pregnancy and childbirth. It is likely that married women came to fulfil this role as required, and, once they assumed it, they gained experience and became known as the 'midwife' or 'handywoman'. It has been suggested that in the early modern period there was considerable variation in the practices, skills and competence of midwives, with some practicing occasionally as the need arose, while others made their living from this role (Marland 1993). Apart from myths and folklore, childbirth itself was largely undocumented but it is likely that knowledge and practices of midwives was passed by word of mouth with skills acquired by observation and experience. Unfortunately, the oral traditions of midwives are largely unrecorded.

Childbirth came under scrutiny by the Catholic Church following the Council of Trent in 1545. The concept of original sin became central to Christian faith and thus the Church became interested in the practices of midwives. To ensure salvation, it was considered vital that any infant thought likely to die should be baptised as soon as possible, and thus it became a midwife's duty to baptise the child if required, even if this necessitated the removal of the infant by caesarean section in the event of the woman's death (Donnison 1988). Licences were granted to midwives who could present evidence of their skills and religious orthodoxy. To obtain her licence, the midwife was required to swear not to use 'any sorcery, divination or magick, incantations, witchcraft or any superstitious, hellish or horrid methods' (Devane and Murphy Lawless 2005). By the sixteenth century in Europe, some physicians had taken an interest in childbirth and began to organise and regulate midwives' practice. The municipal authorities took over the licensing of midwives from the church; these fortunately paid more attention to the technical competence of the midwives rather than their moral character. Childbirth was women's business and women relied on other women for information and support. For the most part, midwives were probably skilled in straightforward births, and would have had to deal with difficulties in childbirth themselves, as physicians were concerned neither with theory nor the practice of midwifery until the seventeenth and eighteenth centuries. Not surprisingly, these midwives generally lacked knowledge, given that few women had access to education of any kind. While the midwife was a respected member of the community, both maternal and perinatal mortality rates were high.

Although there was no safe treatment for obstructed labour, puerperal fever, haemorrhage or eclampsia, maternal death rates declined over time probably due to improvements in general health and living conditions (Peller 1943). From the seventeenth century on, midwifery practices were mainly recorded by the male dominated medical profession. Early midwifery textbooks were written by doctors based on the practices learnt from midwives. The midwife was a respected member of the community and though, later she was often castigated by medical doctors, there is no evidence that midwifery practices throughout the ages were harmful, in fact, early lying-in hospitals had high levels of maternal deaths as sepsis was more likely. Through the eighteenth and nineteenth century, more hospital beds were provided for childbearing but women were reluctant to attend a hospital for birth and would prefer to call a midwife of her choice to assist with a home birth.

Over time, medical men become the dominant voice for safety in childbirth and it was easy for them to single out poor midwifery practice. Despite this, although the destitute poor were cared for by uneducated midwives, it was reported that their maternal death rate was considerably less than women who gave birth in lying-in hospitals attended by men (Donnison 1988). For midwives, while their knowledge may have increased over time, access to education was limited; women had little economic or legal protection and were limited in their work opportunities (Wiesner 1994). However, in many areas women would have a choice of which midwife to call for their birth and the reputation of the midwife was important for her to remain in employment.

A danger for childbearing women was infection or child-bed fever. In hospitals, the risk of puerperal sepsis was particularly high. In Vienna, Ignaz Semmelweis observed that women delivered by doctors and medical students were more likely to die from puerperal fever than women delivered by midwives (Citrome 2018). He noted that doctors were performing autopsies prior to attending the births, whereas midwives did not. He introduced the practice of hand decontamination with chloride of lime and the mortality rate of women dropped to that of the level concomitant with midwives (Murphy Lawless 1998). Despite publishing his findings, this practice did not become accepted until many years after his death. Over time, the number of maternal deaths reduced due to an increased understanding of 'germs' as a mechanism of childbirth fever.

An important development in the seventeenth century was the obstetric forceps of the Chamberlain family, prior to this, a crochet hook was commonly used to extract a dead fetus (Gorey 2012). Over time, various instruments were invented but the baby rarely survived. The forceps developed by Chamberlain family was successful in extracting live babies, but they kept this intervention secret for the next 150 years (O'Dowd and Philipp 2000). By the mid-eighteenth century midwives realised the need for skilled help from men in certain cases. An understanding developed between some female midwives and doctors with their instruments so that if difficulties arose the midwife would call the doctor for assistance. Many however, both doctors and midwives opposed the growth of the indiscriminate use of forceps (Aveling 1967).

Caesarean sections were rare and usually performed in an effort to save a baby if the woman had died. By the nineteenth century, surgical techniques improved and with developments in anaesthesia and asepsis, over time, caesarean sections became safer. The term 'once a caesarean, always a caesarean' first appeared in 1916 (Todman 2007). For women to remain in bed for several days after the birth was encouraged; during this lying-in period the physician might visit (Morris Slemons 1912) but the midwife would attend to provide practical support and assist with household tasks.

Fear of childbirth during pregnancy has been documented as far back as the seventeenth century, when Osiander, a physician in Germany wrote about women who committed suicide rather than endure childbirth (O'Connell et al. 2015). In France, Marce similarly documented cases of pregnant women who jumped in the river or gassed themselves. In 1858; He described where pregnant women '…are privately convinced that they are going to die from the ordeal that awaits them. The idea becomes fixed in their heads and triggers a melancholy which takes over all her

thoughts' (O'Connell et al. 2015). Marce compiled a monograph of 79 perinatal psychiatric cases but his work was paid little attention in his lifetime (Trede et al. 2009). The subspecialty of perinatal psychiatry has only recently emerged and Marce's work a 'Treatise on Insanity in Pregnant, Postpartum, and Lactating Women, and Related Medicolegal Considerations' is now recognised as making a significant contribution to the body of knowledge. In his work, Marce observed that fear of childbirth and depression were associated and that the perinatal period was a time in which women were more likely to develop depression, psychosis and acute mood disorders (Trede et al. 2009). This is now recognised as tokophobia.

Throughout this period, puerperal psychosis was seen as part of the dangers associated with childbirth such as fever, haemorrhage and the other disorders midwives encountered. Women with mental health problems were often admitted to asylums. Marland (2003) reviewed asylum records and reported that apart from the various treatments offered, there seemed to be a greater understanding for poor women that their insanity, which was described as mania or melancholia, was associated with a variety of social and environmental factors. This included the fear and anxiety associated with illegitimacy, but also exhaustion, malnourishment and the hardships associated with repeated child-rearing. Recovery was usually achieved, and women returned to their families.

1.2 Twentieth Century and a New Era

By the twentieth century, there was a gradual and then more rapid move to hospital birth for all. Where women gave birth at home, they had support from family and friends and were likely to have assistance from a known midwife or general practitioner. When hospital birth became the norm, this led to more women giving birth among strangers (Walzer Leavitt 1986). The early development of maternity hospitals was to provide care for the deserving poor, and destitute women were encouraged to attend charity hospitals, later as national health services developed and with advances in options for pain relief for labour, women were encouraged to attend nursing homes or local hospitals to give birth. This might also give women a welcome break from their duties at home. As physicians were advancing their knowledge around birth which became increasingly medicalised and pathologised, the woman's birth experience was not important once the woman and baby were healthy on hospital discharge. The myth that hospital birth was safer became the accepted dogma (Tew 1995). Practices such as twilight sleep were introduced, where women experienced the pains of childbirth but by the administration of scopolamine and morphine at the time of birth, forgot the experience and woke to see their baby in a fog of anaesthesia (Michaels 2018). Restrictive practices ensured that women could not make decisions about their care. Symphysiotomies were performed in order to avoid a caesarean section, later and still today in many countries, episiotomies are widely performed. In the future, will we think it strange that women experiencing normal birth were giving birth in lithotomy or supine positions ergo?

Towards the latter half of the twentieth century, various reports condemned home birth and most women moved towards obstetric-led services with increasing reliance on technology and intervention for birth. Initially, the risk of death from puerperal fever or haemorrhage was a driver for the movement to hospital birth, however it was later that Tew (1995) identified that improvements in childbirth were not due to the increased hospitalisation and the provision of medical care; rather, they were due to improvements in health and social conditions of women and their families.

1.3 Biomedical Model of Care

Throughout the twentieth century, developments in maternity care led to increasing dominance in obstetric models of care. Green and Baston (2007) noted this change when they explored women's expectations and experiences of childbirth in 1987 and again in 2000. They found that women in the later survey were far more willing to accept obstetric interventions than the women surveyed in 1987.

One of the myths about childbirth is that it is in the best interest of woman and baby that birth takes place in hospital. This global trend for birth to occur in larger maternity units is problematic for women who are at low risk of complications, as large units have a greater propensity for intervention in labour, and lower rates of spontaneous births (O'Connell et al. 2003).

Davis-Floyd (1994) introduced the term technocratic birth to the debate on childbirth when she observed that the changes in maternity care occurred in parallel with an increasing reliance on technology throughout society. In this interpretation both doctors and midwives accept high levels of intervention and readily adopt prevailing technology in the belief that it leads to best outcomes for women and their babies (Davis-Floyd 1994). The term technocratic birth takes the emphasis from the medical profession as being solely responsible for the levels of surveillance and intervention in childbirth, acknowledging that doctors, midwives and women are also caught in this technocratic age.

The term medicalisation of childbirth implies that the power in this model of care lies with the medical profession; however, in many countries, midwives undertake much of the care of women throughout labour and birth. It appears that midwives have adopted many of the advances in technology without much debate. Sinclair and Gardner (2001) reported that midwives reject the possibility of being over dependent on technology and Kennedy (2002) found that even midwives who support normal birth may adopt technology in order to optimise birth outcomes and possibly reduce the need for further interventions.

Current debates in maternity care include the increasing use of technology and intervention in childbirth. Concerns have been raised in many disciplines, from medicine and midwifery, to sociology, anthropology and others about the impact that this has on women's experience of birth. Different issues prevail in community settings, but, in the developed world most births occur in hospital where technology and intervention have become normalised.

1.4 The Choice for Caesarean Birth

The increase in caesarean births has been recognised as a challenge for contemporary maternity care, with rates varying hugely across countries (WHO 2018a). Circa 2000, the catchphrase 'Too posh to push' became popular after the UK National Sentinel Audit (Feinmann 2002) reported that 5% of caesarean sections were performed at maternal request. This sparked media interest and celebrities were labelled as 'Too posh to push' when they opted for caesarean births. In England and Wales guidelines were introduced in relation to caesarean section at maternal request (NICE 2013) and tokophobia was attributed to rising rates (D'Souza and Arulkumaran 2013). This led to debate about the safety of caesarean sections, rather than exploring why women might be fearful of having a vaginal birth. Caesarean sections have become normalised and seen as 'taking the easy option'. Weaver and Magill-Cuerden (2013) performed an analysis of newspaper articles which used the *phrase* 'Too posh to push'. They found that the phrase was sparked if a celebrity had a caesarean birth, but there was conflation of the issue by the media who took the angle that every planned caesarean birth was due to convenience and status.

That fear of childbirth was not reported until 2009 around the time that NICE Guidelines were being updated was noted (Weaver and Magill-Cuerden 2013). A survey of obstetricians reported that 17% of caesarean sections were performed for maternal request and just 20% of stated that they would not perform a caesarean section for maternal request (Robson et al. 2009). In the Lancet, it was reported that the motion 'It is every woman's right to choose a caesarean' was debated at two well-attended conferences and the majority voted against the motion (midwives and obstetricians) (Feinmann 2002). An audit by the Thomas and Paranjothy (2001) found that half of UK obstetricians perceived a caesarean birth to be a safer option than vaginal birth with more than three quarters of obstetricians recommending a caesarean to reduce risk of urinary or faecal incontinence. This followed on from a study by Al-Mufti et al. (1996) which found that nearly 40% of female obstetricians would choose a caesarean for their own births. It is rather ironic that in many high resource countries, it is acceptable for women to choose to have a caesarean section with its known risk factors, including the long term impact on the woman and her baby, yet many women struggle to get support to have a home birth (Sarda 2011) and few health care professionals spend time to explore with women their reasons for selecting a caesarean birth.

1.5 Respect and Human Rights in Childbirth

Alongside these challenges for high resource countries, in many parts of the world, the lack of respect for childbearing women and the concept of obstetric violence has emerged as an ongoing problem and has now been researched in many countries, principally in Latin America, but also India and African countries (Bowser and Hill 2010; D'Gregorio 2010; Sadler et al. 2016). In other countries, while this term may not generally be acknowledged, there are concerns about human rights in childbirth

(Schiller 2017). Issues such as lack of choice in relation to the care women can expect to receive, women's rights being violated in relation to decisions about care and interventions performed, such as amniotomy, with the assumption that women consent. Midwives and maternity services are challenged by women who make unconventional choices or just say 'no' (Feeley and Thomson 2016). And while the World Health Organisation (WHO) has given a commitment to ensure no mistreatment of women in childbirth (WHO 2014) and that women should have a positive experience of pregnancy and childbirth (WHO 2018b), it is difficult to see how so many accepted practices and interventions are going to change.

1.6 Tokophobia

Throughout history, when maternal death rates were high, women must have been terrified of birth. In the eighteenth century, it was seen as a potential cause of suicide, throughout the last century, traumatic birth was increasingly recognised and seen as a contributor to mental health problems and more recently linked to post-traumatic stress disorder (Andersen et al. 2012; Ayers 2014). Tokophobia was first named in the literature by Hofberg and Brockington (2000) who published 26 case studies in the British Journal of Psychiatry and interest in the issue has grown exponentially since then (O'Connell et al. 2017). There have been calls for an increased awareness of tokophobia and birth trauma in health care professionals, particularly in midwives, since not only is there an association with women's emotional well-being, but also fear and trauma impact the decisions women make in pregnancy (Ayers 2014; Greer et al. 2014; Mayor 2018).

A meta-analysis of the prevalence of tokophobia estimated a global prevalence of 14% and suggested that this number appears to be increasing (O'Connell et al. 2017). However, it is not that tokophobia is just a recent phenomena but rather that research into fear of childbirth only began in 1983 (Areskog et al. 1983a, b). Academic interest in perinatal mental health and tokophobia has been increasing over recent years. Nevertheless, how fear of childbirth was measured and how tokophobia was defined varied in different countries (Nilsson et al. 2018; O'Connell et al. 2017; Sheen and Slade 2018).

Fear of childbirth varies in severity, on a spectrum, from low to phobic fear (O'Connell et al. 2017, 2019). The Wijma Delivery Expectancy/Experience Questionnaire Part A and B (W-DEQ A and B) is the most commonly used tool to measure fear of childbirth, but it is quite lengthy (Garthus-Niegel et al. 2011; Nilsson et al. 2018; O'Connell et al. 2017; Wijma and Wijma 1998). Therefore, various researchers have suggested shortened or adapted versions of the scale to identify the nature of the fear, recognising that reasons for fear may be complex, rather than focus only on the severity of the fear (Garthus-Niegel et al. 2011; O'Connell et al. 2018, 2019; Pallant et al. 2016). Among other different tools, the Fear of Birth Scale (FOBS) has been suggested as a simple screening question for clinicians to start the discussion about fear of childbirth and is now used in antenatal clinics in some countries (Haines et al. 2011; Rouhe et al. 2008). Beginning a

conversation about fear of childbirth can facilitate referral to appropriate expert psychological and emotional support for women (Striebich et al. 2018).

Tokophobia is rare, but fear of childbirth is commonplace (Lewis 2018). Since the majority of women report at least some fears of childbirth (Melender 2002), it is considered normal to have some level of anxiety or fear during pregnancy. The nature of the fear and its severity differ for women and may be triggered by various factors which may lead to be worsened or reduced as the pregnancy progresses (O'Connell et al. 2019). So, while it may be difficult during busy antenatal clinics, interactions with midwives and health care professionals provide critical opportunities to discuss fear and offer emotional support to women. Continuity of care models provides greater opportunities for midwives to develop relationships of trust with women and thus provide more possibilities for women to express their fears. There is a need for high quality and consistent information for women during pregnancy which will not trigger fear, particularly in first time women (O'Connell et al. 2019; WHO 2018a). Moreover, midwives need to be responsive to fear of childbirth and take fear seriously when women share their feelings (Ayers 2016; Dahlen 2010; Larsson et al. 2019; Wulcan and Nilsson 2019).

While experiencing worries and fears during pregnancy are normal, perceptions of pregnancy as a time of joy and happiness, compounded by the societal pressure to be 'a good woman' mean that women commonly experience guilt, shame and stigma about experiencing tokophobia (Sheen and Slade 2018). Women may find it difficult to divulge their feelings with health care professionals and even their partner (Sheen and Slade 2018). The unpredictability of birth is the main fear reported by women (Sheen and Slade 2018) and the key components of fear of childbirth are that women fear pain in childbirth (Geissbuehler and Eberhard 2002; Melender 2002), they lack confidence in their ability to give birth vaginally (Eriksson et al. 2006; Maier 2010; Rilby et al. 2012), some fear losing control or lack of adequate support from caregivers (Sheen and Slade 2018), and for others it is the fear of injury to themselves and their baby (Faisal et al. 2014; Fenwick et al. 2015). It has also been noted that women with fear of childbirth tend to rely on medicalisation of birth and interventions for perceived safety (Greer et al. 2014).

In some countries, particularly in Scandinavia, recognising and addressing fear of childbirth is routine in maternity care (Striebich et al. 2018; Wulcan and Nilsson 2019). Continuity of midwifery care helps (Hildingsson et al. 2018a, b), and specialised support for fear of childbirth from midwives may also help, but midwives find it hard to articulate exactly what it is they do to alleviate fear (Wulcan and Nilsson 2019). Women have reported that continuity of midwife carer provides a sense of safety and improved their confidence for birth which in turn affected their birth experience positively (Larsson et al. 2019). Unfortunately, there appears to be a discrepancy in the experience of women attending specialised care for childbirth fear. Some women, despite attending specialised services, have subsequently been met with a lack of sensitivity by the obstetricians they encounter (Larsson et al. 2019; Lyberg and Severinsson 2010). A survey in the Netherlands identified that obstetricians lacked knowledge and insight into how women with fear of childbirth perceived their communication and attitudes (van Dinter-Douma et al. 2018). There

are calls for greater awareness of fear of childbirth as this is less well recognised than other perinatal mental health issues (van Dinter-Douma et al. 2018). With the need to reduce unnecessary caesarean sections, WHO (2018a) now recommends that antenatal education should include sessions about childbirth fear, the advantages and disadvantages of caesarean sections and that psychoeducation should be available for women with fear of childbirth. Given the growing concern of the morbidities associated with caesarean sections and the considerable evidence of long term mental and emotional impact of fear of childbirth left untreated, there is a need to focus on the emotional well-being of women rather than simply on the mode of birth (O'Connell 2019).

What is also interesting with this discourse around childbirth is that the impact of health care provider's fear and trauma on women's childbirth experiences is only recently recognised (Dahlen and Caplice 2014; D'Souza 2013; Toohill et al. 2015). There is a call for health care professionals to be aware of and examine their own biases and beliefs in relation to childbirth. If midwives and doctors cannot trust that women can give birth without the need for intervention, such as the over use of CTGs in labour, health care professionals need to consider whether they are capable of facilitating birth for women and support women's choices for normal birth (Dahlen 2010). When midwives were asked about their top fears (Dahlen and Caplice 2014), their answers were fairly consistent. The top fear for midwives was the unexpected death of a baby, followed closely by a midwife missing something that could cause harm; this was followed by obstetric emergencies and even maternal death. Can clinicians present the risks and benefits to women in a balanced, objective and neutral way, if they themselves have had a traumatic birth experience, or if they have trauma from witnessing a difficult birth or poor birth outcome? Grief or bereavement counselling and high quality training in obstetric emergencies may facilitate increased confidence in midwives (Dahlen and Caplice 2014).

1.7 Drivers for Change

In considering what has changed in childbirth over the latter half of the twentieth century, a number of factors have shaped contemporary maternity care. The feminist movement gave women increased access to education and employment; in most countries, women obtained reproductive rights to control their bodies. Women gave voice to the type of maternity care they wanted, in the UK, this started with Changing Childbirth (Department of Health 1993) and the more recent Better Births initiative (NHS National Maternity Review 2018). In the 1980s, Archie Cochrane challenged obstetricians to question practices such as hospital birth, routine episiotomies and fetal monitoring, all of which had been introduced without rigorous evaluation (Enkin et al. 2006). This led to the setting up the Oxford Database of Systematic Reviews and the publication of Effective Care in Pregnancy and Childbirth (Chalmers et al. 1989). This was the first attempt to provide evidence for what had become routine maternity care practices. Fairly quickly the use of shaving and enemas were largely eliminated, episiotomies became no longer routine practice; more

recently, we have seen the widespread introduction of skin-to-skin care for newborns and delayed cord clamping. From a global perspective, the Lancet Midwifery series (ten Hoope-Bender et al. 2014) was key in providing the evidence for optimal care for childbearing women in all settings. More recently, WHO (2018b) Guidelines for a positive childbirth experience recognises the importance of psychological, emotional and cultural safety as a key component on maternity care.

That women should have choice in childbirth is increasingly acknowledged, this may relate to choice of place of birth, choice in relation to health care provider, even choice in relation to midwifery led or obstetric care where this is available. While somewhat more contentious, this has also led to an understanding that women may choose a caesarean section or even to reject standard models of maternity care and choose to freebirth (Plested and Kirkham 2016). Women can choose to reject the perceived advice from health care providers with their authoritative knowledge and purported evidence based advice. In some countries, this may be contested in the court system and in other countries women's agency is acknowledged in relation to the right to make decisions in relation to their own care.

1.8 Fear of Childbirth and the Risk Discourse

Modern society is described as a risk focussed society by Beck (2009); each individual is preoccupied with the possibility of danger and potential harm, and obsessed with potential risks and catastrophe. From the very first contact with maternity services, the notion of risk is introduced to women when they are stratified into low and high risk care. While this stratification of women into risk categories has improved outcomes for particular circumstances, there may be unintentional adverse consequences related to iatrogenic factors when applied to all pregnant women (Coxon et al. 2012; Healy et al. 2016; Skinner 2016). Furthermore, there are concerns for midwives being educated through obstetric-led services. Midwives are required to be the guardians of normal childbirth but may have little experience of supporting women through the pain of labour without an epidural anaesthetic. Midwives may lack skills and confidence in supporting normal physiological birth, but may excel in care of women with receiving an epidural. Those midwives, who work in this technocratic model of care, may have developed skewed perceptions of risk. There have been calls for midwives to engage in creating a culture of normality and woman-centred, care using relationship-based models rather than technocratic models of care (Cooper 2015). Yet many midwives have little control in the labour ward environment where they work (O'Connell and Downe 2009).

The paradox of timid prosperity has been described by Taylor-Gooby (2000), where although levels of safety are higher than ever before, there is an increase in the perceived dangers and risk associated with a more affluent society. Of course there are certain risks associated with labour and birth, and it is therefore normal for women to experience fear rather than an irrational fear (Jones 2018; Melender 2002). However, in the case of tokophobia, this fear is not manageable and disturbs women, affecting their well-being and their day-to-day life. A meta-synthesis proposed that women

with fear of childbirth have a personal characteristic, also noted by psychologists who have studied anxiety known as the 'intolerance of uncertainty' (Buhr and Dugas 2002; Carleton et al. 2007), which make some women less tolerant of the uncertain outcomes associated with childbirth (Sheen and Slade 2018). For some women, there is a longing for control, a predictability of the outcome, which is underpinned by an assurance of safety. Various studies have proposed that women with fear of childbirth catastrophise the prospect of labour pain as well the outcomes of birth (Rondung et al. 2016; Thompson 2018). Intolerance of uncertainty leads to women feeling that they are more likely than other women to experience complications, despite the low statistical risk of the particular morbidity. These women tend towards pessimism and consider that each complication will happen to them. Thus, how women are spoken to and the language that is used with them is very important.

Ethical dilemmas may occur when women request care that is contrary to medical advice, for example, in the case of a woman requesting a caesarean section 'without medical indication'. A clinician may believe that the request is not safe and is not the best plan of care for the woman. In other cases, a woman may decline a treatment that the clinician may believe is the best option, for example, induction of labour due to post maturity. Increasingly pregnancies are being dated using ultrasound despite women knowing the date of conception, leading to frustration when given a due date which is sooner than the original date. This may lead to conflict which may stress the woman during the pregnancy and ultimately lead to non-engagement with the health care service.

Larsson (2018) provides feminist insights into the discourse of risk. The media imply that pregnancy is a time of joy but in reality it may be a time of stress or anxiety for women. Women may experience antenatal care as focusing entirely on the baby's needs when discussing risk. As birth is a natural process and expected to be welcomed by couples, there is an expectation for women to be strong and not to complain. There is little focus on childbirth risk to the woman's body or mind, only the health of the baby. It has been argued that with terms such as fetal surveillance and the change in discourse related to the agency of the fetus, this leads to the pregnant body being portrayed as a risk to the fetus (Larsson 2018). When considering the concept of risk in pregnancy, what is the risk, is it the risk of negative outcomes for the woman or her, baby, or for clinicians, is it the risk of litigation where things go wrong in the unpredictable world of childbirth? In pregnancy, women self-police and are policed for their behaviours by 'experts'. Women are expected to weigh up information and 'minimise the risks'. However, pregnant women tend to magnify or overestimate risks and may rely on medicalisation for perceived safety.

There are four principles to ethics in health care: autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress 2001). These principles comprise a framework for which moral decisions may be made in health care. Traditionally, codes for health care practitioners have placed an emphasis on protecting patients from disease and system failure. Until recently, there has been less awareness of the principles of autonomy and justice. That interventions cannot be performed without informed consent is accepted practice, the information women receive in relation to the decisions they can make are variable.

Women often do not realise they may have a choice to try for a vaginal birth after a previous caesarean section (VBAC) or to plan for a spontaneous breech birth, as this will depend on the health care professionals she encounters. Midwives and doctors make recommendations and are often willing to present women with evidence from guidelines to help in decision making; however, many may not realise that many RCOG guidelines lack robust evidence to support recommendations for practice (Prusova et al. 2014). Kotaska (2017) puts forward the argument that the health care professionals perception of acceptable risk may differ from that of the woman's and it must be recognised that women have the right to refuse treatment.

WHO (2018a) recommends that women are given information in a clear and consistent way that does not trigger fear. When presenting choices for women in relation to their care, in particular about various interventions, they are more likely to opt for a health intervention when the relative risk is presented rather than the absolute terms (Akl et al. 2001). Thus, health care professionals should aim to present risks in their absolute terms when discussing options with women, for example, women may have a 70% chance of achieving a successful vaginal birth after a previous CS (RCOG 2015), yet the risk of uterine rupture is less than 1% (Fitzpatrick et al. 2012). This is not always explained to women who have had a previous caesarean section and may do much to assuage their fears. Neither are those women fully informed of the reasons why they underwent a caesarean birth first time around so their decisions are based on poor information.

The achievement of 'a good birth' is framed differently in different cultures (Lane 2015). Of concern, in high income countries, a risk culture is now normal and there is a growing perception of the right to health care being equated with the right to health, resulting in the intolerance of unsatisfactory outcomes (Dahlen 2010; Healy et al. 2016; Lane 2015). Increasingly, the culture of birth is moving to obstetric care in large centralised units, and the closure of smaller local units, despite the prioritisation of choice of model of care for women from various reports (Chief Nursing Officers (CNO) of England, Northern Ireland, Scotland and Wales 2010; Department of Health 1993, 2007). This has been identified as an issue globally, with a trend towards regionalisation of health care resulting in the closure of rural services. There is growing evidence that the loss of rural maternity and birth services has been at detriment to women, resulting in stress, distress and isolation and worse maternal and infant outcomes (Barclay and Kornelsen 2016). NICE Guidelines recommend the promotion of homebirth as the safest place of birth for low-risk women and that women should know what to expect from the various models of care that are offered. For example, in obstetric-led models of care, the woman may never meet the named lead obstetrician. Care in the obstetric, technocratic model tends to focus on surveillance, with fragmented care rather than relationship-based care. It has been suggested that this fragmented care deprives women of emotional support which allows them to explore their fears related to childbirth (Dahlen and Gutteridge 2015). Women are still choosing obstetric-led care which may be attributed to a lack of availability of midwifery-led services and the prevailing perception that birth is safer in a high tech environment.

It has been proposed that the pervading culture of risk in maternity care has impacted the autonomy of midwives. While midwives are the 'guardians of normal birth' and are the experts when working in midwife-led units, when working in obstetric units, midwives have experienced pressure from obstetricians to perform interventions in labour on low-risk women which may be unnecessary or avoidable (Everly 2012). In a paper describing perspective of risk in obstetrics, Bisits (2016) highlights the role of the obstetrician in presenting information on risks to childbearing women. Quality of data in terms of screening tests and prediction is improving rapidly; we now have fairly accurate prediction of outcomes such as trisomy and other genetic disorders. We know that data needs to be presented in absolute terms rather than relative risk. Even highly educated people struggle with interpreting the data presented in terms of how great is the risk. We cannot assume that all women and their partners are able to process this information.

Rapid development of data (information explosion), access to lots of robust and accurate data such as Cochrane has benefitted maternity systems. The majority of risk in maternity care are low prevalence occurrence. Therefore, obstetricians may unintentionally characterise women in terms of their risk of adverse outcome. While experts have specialist knowledge and are thus a source to facilitate managing uncertainty and risk, the evidence suggests that there is resistance to the suggestions of experts (Alaszewski and Coxon 2008). The response of individuals tends to be grounded in their personal and cultural experience and beliefs which may not be rational, but there is little evidence to suggest that experts are better than lay people at predicting the future. There is the argument put forward by Alaszewski and Coxon (2008) that perceptions of risk and a sense of insecurity are subjective and ultimately, people do make decisions which may be non-rational and act on this decision.

1.9 Conclusion

Birth culture has seen vast change, particularly over the last hundred years. Historically, birth was a situation viewed as private, mysterious, 'women's business', in which many women and infants died. In modern society, maternity care is safer than ever before which may be attributed to advanced developments in health care and the Millennium and Sustainable Development Goals (United Nations Millennium Project 2005). However, a 'risk discourse' is prevalent with pregnancy portrayed as a dangerous condition in maternity services. In contrast, the media portrays pregnancy as a time of joy, when in reality it is experienced as stressful by many and fear is increasingly common. Women may need to navigate systems to achieve a positive birth experience. As experts and guardians of normal birth, midwives need to fulfil their leadership role and encourage a woman-centred and relationship-based culture of care. If a culture of normality is maintained, fear of childbirth may be reduced both in the general public and in maternity services. As long as the focus of maternity care is on risk discourse, the emphasis is on clinical governance and risk management rather than on safety of women and babies.

While some women and babies may benefit from stratification into risk categories, it is important to realise that low-risk women may be harmed as a result of unwarranted intervention. Midwives need more opportunities to experience birth in a culture of normality to ensure the profession maintains their skills to facilitate normal birth and reduce the culture of fear that currently pervades birth.

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Global Perspectives of Childbirth Fear Including the Relevant Evidence

2

Helen Haines

The hand that rocks the cradle rocks the world—William Ross Morris (1865)

Irrespective of her country of care, giving birth is a biopsychosocial cultural experience for women. The degree to which either the biology or the psychology or the sociocultural elements is given dominance over one or the other can however be attributed to multiple influences including where a woman gains her birthing knowledge, where she gives birth, who attends her and what her social and cultural status is (Liamputtong et al. 2005; Behruzi et al. 2013). In a truly holistic plan for birth care the observance of all these factors is considered respectfully by those attending the woman. Fear however plays a role in the dominance of one aspect over another and can emanate from within the culture, society, from the system of healthcare (Behruzi et al. 2013) and from fears specific to an individual woman (Dencker et al. 2018).

Expectations or anticipated ways of 'being' or behaving during pregnancy and birth are closely linked to social identity and cultural norms. Cultural differences exist in women's attitudes and beliefs about birth even in countries which seem 'similar' in terms of their health systems and socio-demographics (Haines et al. 2012a). In Sweden and Australia, for example, there may be some attitudinal differences in seeing birth as a natural event or a medical event (Haines et al. 2012b). Compliance or resistance to these expectations for a birthing woman can impose a sense of safety or conversely a fear of failure (Davis-Floyd 2003, 2004).

As mortality in childbirth in highly resourced or emerging economies has decreased, some midwives, doctors, policy makers and commentators have paid more attention to what women are saying about their birthing experiences and

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satisfaction with care. Fear of childbirth as a subject of scientific enquiry is being measured and defined (Nilsson et al. 2018) and investigated in diverse cultural contexts including the Nordic and European countries (Lukasse et al. 2014; Calderani et al. 2019), Australia (Haines et al. 2011; Fenwick et al. 2015), India (Jha et al. 2018); China (Yuhui et al. 2016), Turkey (Korukcu et al. 2019; Sercekus and Okumus 2009), Iran (Katayoun et al. 2017), Israel (Preis et al. 2018; Hamama-Raz et al. 2017), Japan (Takegata et al. 2014), USA (Roosevelt and Low 2016), Canada (Stoll et al. 2016) to name but a few.

When it comes to women's descriptions of the components of their fear of childbirth there is considerable cultural universality: fear of pain, fear of death or damage of oneself or one's baby, fear of humiliation and loss of control and overarching uncertainty (Geissbuehler and Eberhard 2002; Gert et al. 2016; Sheen and Slade 2018). The relative likelihood of fulfilment of the object of the fear is often of no relief to the person who holds that fear (Rondung et al. 2016).

Notwithstanding, the chances of specific fears being fully realised are more likely in some contexts than others. For women in low income countries with poorly resourced health systems, food insecurity, and concomitant high rates of iron deficiency, unclean water, inadequate transportation, childhood marriage and scarce emergency medical services, the possibility of death or permanent disability for them or their baby is stark (Kassebaum et al. 2014). In these contexts the health system response is prioritised to finding solutions to abate maternal and infant mortality and morbidity. Formal psychological support including counselling is unlikely. In contrast for women in highly resourced contexts there are well-known problems with iatrogenic effects of too much medical intervention—this phenomenon is known as 'too little too late' and 'too much too soon' (Miller et al. 2016). Both scenarios can lead to women being fearful of giving birth.

Fears beyond the purely existential for women in resource poor contexts have been described in the literature. For example, women who are encouraged to give birth outside of their traditional birthing places are sometimes fearful of cruel treatment (Bohren et al. 2015) and a lack of surveillance from overburdened birth attendants who are poorly paid or inadequately trained (Shah 2016). Women in both high and low income settings value both a clinically and psychologically safe environment with continuity of practical and emotional support and kind, technically competent clinical staff (Downe et al. 2018). The World Health Organisation (WHO) recently recognised the crucial importance of a positive, kind birth experience and the focus of the global agenda has gradually expanded beyond the survival of women and their babies, to also ensuring that the healthcare pregnant women receive enables them to achieve their full potential for health (WHO 2018).

In her landmark book 'Birth in four cultures' Jordan describes considerable diversity in the practices surrounding the 'management' or care of women during birth (Jordan 1993). Jordan depicts beliefs and practices of birth as reflections of largely uncontested cultural patterns (Van Hollen 1994). In a critique of this, argues though 'that culture is constantly constructed through social practice within the context of power relations, and that culture consists of a multiplicity of contesting viewpoints but that some perspectives can become hegemonic' (p 502). Further, within

individual countries, there are multiple cultures and ethnicities, religions and multiple socio-demographic groups both within and between different regions/neighbourhoods. The dominant political structure can impose significant constraints on how healthcare is delivered. In the developing nation of Kazakhstan, for example, with its history of Soviet-style education, childbirth readiness classes have been introduced; however, it is questionable as to how much this is assisting women in preparing for birth and exercising any decision-making as authoritative sources of information are dominant and individual thoughts and personal preference is not encouraged (Craig and Kabylbekova 2015).

The healthcare system itself has its own culture with particular values and knowledge base—a custom which can be very different from the cultures where it resides (Moore 2016). This is important to consider when thinking about how fear is manifested in women giving birth, and in the people providing supportive and professional care during pregnancy and birth particularly in light of globalisation and the dominant Western medical culture (Moore 2016). Where does the power lie and how much agency do women have in navigating a pregnancy and birth so that their fears may be recognised and allayed? How well does the management of their care enable them to feel safe, strong as well as respected in their personhood?

Taking an example from Ghana, where an interview study of women who had recently given birth illustrated that women want the physical safety that modern obstetrics can offer but they also expect humane, professional and courteous treatment from health professionals and a reasonable standard of physical environment. They are fearful to return to a health service if they are treated poorly. Women from that study indicated that they will act on their experiences of care and consciously change their place of delivery and recommendations to others if they are fearful of degrading and unacceptable behaviour from caregivers (d'Ambruoso et al. 2005). Other studies in low income settings show similar findings where the provision of 'modern' care is connected with fears associated with a loss of female cultural ownership of birth and a loss of the care and support of intimate family members (Theuring et al. 2018).

In Australia, a country with a universal free public health system, rich in economic resources, vast in geography and populated largely on its eastern seaboard, population level maternal infant and maternal morbidity and mortality is very low (AIHW 2018). There are wide disparities however in maternal infant health outcomes for the First Nations Aboriginal and Torres Strait Islander Australians and women in remote and rural areas of Australia. One policy response to this has been the transfer of First Nations women from their remote homelands to the larger urban centres in the third trimester of pregnancy (Kildea et al. 2010; Kildea and Wardaguga 2009). This has brought very specific fears and grief to these women who are then isolated from their kin and unable to fulfil sacred cultural practices essential to their spiritual health and vital to their continuation of culture (Kildea et al. 2016; Kildea 2006). There are some notable midwifery responses addressing these fears with 'Birthing on country' programs providing culturally sensitive maternity care (Kildea and Wardaguga 2009; Wilson 2014). For First Nations Australian women the fear of racism is a simmering threat as they encounter the dominant technocratic Australian health system (Wilson 2014). Health professionals are not universally culturally

sensitive. Many First Nation women have a recent history of their own relatives being part of the 'Stolen Generation' (Human Rights/gov/au January 2019 2017) where government authorities removed babies and children and placed them in institutional care (Mein Smith 2002). If midwives and doctors neglect to place a cultural lens over the lived experience of First Nations Australian women during pregnancy they may not appreciate the profound fear of judgement and real distrust of white authority that these women feel as they prepare to give birth (Wilson 2014; Kruske et al. 2006).

In multicultural societies cultural variations of childbirth fear are seen within the same system of care. In Sweden a cross-sectional study of women attending a large university hospital antenatal clinic described higher rates of childbirth fear in foreign born women compared with women born in Sweden (Ternström et al. 2015). One study examining the experiences from pregnancy and childbirth related to female genital mutilation of Eritrean women who had migrated to Sweden described the strong fear and anxiety felt by these women (Lundberg and Gerezgiher 2008). These women spoke of fears relating to stories of women who died together with their babies when giving birth because of bleeding and infection. They were afraid of their capacity to push out their baby, of further perineal damage and caesarean and they were afraid that the Swedish healthcare attendants would have no knowledge of FGM.

Fear of birth has been studied in Israel with findings indicating that there are differences in fears and experiences of birth particular to the cultures of the Jewish and Arab women living in that country and accessing the same system of care (Halperin et al. 2014). Arab women described fears related to being subjected to higher levels of medical intervention relative to Jewish women who expressed higher levels of overall satisfaction with those same medical interventions (Reiger and Dempsey 2006). A recent study compared the content of fear of birth and preference for mode of birth between Norwegian and Israeli women. The Israeli women were described by the authors as revering womanhood and valuing large families. These women expressed strong fears about pain and the possibility of an imperfect child. They articulated quite different preferences for caesarean section and epidural anaesthesia than the Norwegian women who were more concerned about feelings of loneliness and control, and had stronger fears related to the physical and emotional expectations of birth (Preis et al. 2018).

It is evident then that the society in which the pregnant woman resides has a strong bearing on her view of herself in the performance of becoming a woman. Reiger and Dempsey (2006) suggest that 'cultural norms of anxiety and fear of birth can be materialised in the body through social processes that instil or diminish women's confidence of "doing" childbirth, thus limiting women's capacity to experience the agency of their lived bodies in the performance of birthing' (p 364). This performance of birth as Reiger puts it includes some significant actors which can be socialised by women and her community and responded to by carers in different ways.

Most notable is the role of pain. Indeed if there was one universal leitmotif of childbirth in general and fear of childbirth in particular it would be pain. Graphic depictions of pain during childbirth are commonly seen in the media (Moore 2018). Davis-Floyd famously describes the 'technocratic birth' as the cultural expression of

western values, highlighting a fearful, risk-oriented culture constructed by modern medicine and frequently exaggerated through the media (Davis-Floyd 2003, 2004). Pain is portrayed to pregnant women as the villain to be conquered or conquered by. In fact for young women who have never given birth, their fears in relation to future births are highly influenced by such portrayals of painful birth (Stoll et al. 2015). Pain catastrophising and intolerance of uncertainty were the most evident predictors of fear of birth in a recent study of women with childbirth fear in Sweden. Although preliminary, the study findings suggested that interventions targeting catastrophic cognitions and intolerance of uncertainty might be relevant to psychological treatment for fear, worry, or anxiety relating to giving birth (Rondung et al. 2018).

In Western style technocratic environments the rational explanation for pain in childbirth is understood biologically in physiological and mechanical terms. Its antidote is through modern obstetric practices such as epidural analgesia and caesarean. In the western style medicalised birth setting the endurance of pain may be considered unnecessary with women's empowerment and emancipation via pharmacological rescue entirely possible and a legitimate choice (Phipps 2014). In some cultures however the passage to 'good' womanhood is through a childbirth pain endured with quiet courage—Korean women have been described as culturally reluctant to express pain during labour and delivery (Sukhee 2009). For some Korean women the fear of not managing this pain may be a very real one as they construct their sense of the maternal self.

Agency for some women may be exercised through an embrace of values aligned with modernity most particularly perceptions of risk mitigation (Lupton 2013). In Australia, for example, 30% of women choose to give birth in the private health system despite the availability of a state run universal public system and the now clear evidence that there are higher rates of medical intervention and poorer outcomes in the private system (Dahlen et al. 2014). For some women high fees for the attendance at birth of private obstetricians and paediatric teams is the exchange they are willing to pay for the attendance of technical experts whose transaction with her is to take care of risk and abate the fear and anxiety regarding the uncertainty of birth (Donaldson et al. 1998). Evidence from multiple studies in various cultural contexts points to fear as a key motivator to a preference or direct request for a caesarean birth without medical indication (Yuhui et al. 2016; Mahboubeh et al. 2014; Karlstrom et al. 2010). Considerable scholarship from Sweden has focused on this issue and concluded that providing a caesarean to a fearful woman does not however 'cure' her fear (Hildingsson et al. 2017; Stoll et al. 2017; Waldenstrom et al. 2006).

Lupton (2013, 2012) argues that Western medical hegemony places women in an unequal position with caregivers during pregnancy and birth and reduces her power and agency over her body and her foetus. The power of the caregiver is heightened by their capacity to subdue or extinguish the pain of birth and to provide surveillance over the vulnerable foetus. There is a real tension here as women negotiate a desire to manage the pain of birth and yet maintain autonomy. Nilsson's (2014) hermeneutic study of women with a fear of childbirth and their experience of a Swedish modern birthing environment described constraining power structures, which led to feelings that their birthing bodies were construed as machines which were under

constant surveillance and monitoring. These women felt that control belonged to the birth technocracy not to them. This loss of control or agency is a common component in women's descriptions of the content of childbirth fear (Hildingsson et al. 2011).

For some women in the highly technocratic medicalised birth setting it is not just the fear of pain itself but long held anxieties or phobias around the methods of abating it via needles and surgical means that are of themselves significantly fear inducing (Rondung 2018). There are women in industrialised Western countries with sophisticated health systems who feel so afraid of the technocratic birth that they choose to 'free birth'—that is, to have no professional birth supervision at all from any qualified attendants (Feeley and Thomson 2016; Hollander et al. 2017). Studies from both the Netherlands (Hollander et al. 2017) and Australia (Rigg et al. 2017) show that previous birth trauma is a key driver for some women abandoning the formal healthcare system and choosing to give birth with unregistered assistants who they believe will not constrain their choices.

Highly medicalised maternity settings are filled with midwives and doctors. While empirical evidence linking the fears of these individual maternity care health providers to women's fear is not clear, it seems inevitable that fear is a contagious phenomenon that can be transmitted from a caregiver to a woman in their care by their behaviour and by their words (Michael 2005). Several authors have examined the fears of midwives and found that as birth becomes more technocratic constructs of risk become a more dominant internal concern. They become fearful of harm to the woman and baby and the systematic imperatives of technological interventions such as foetal monitoring and induction while feeling torn in regard to their capacity to deliver holistic supportive care (Salomonsson 2012; Dahlen and Caplice 2014). This inherent component of midwifery practice to provide support is paramount to the care of any pregnant woman and most particularly to those with extreme levels of fear. Reiger and Dempsey (2006) reflection on psychoanalyst Donald Winnicott's description almost 50 years ago of the 'holding circle' (Winnicot 1971) as doing more than offering words of encouragement but actually 'embodying, literally, containment of fear and vulnerability' suggests that emotional support is the embodied capacity of others to 'hold' and contain the woman's fear (Reiger and Dempsey 2006). Midwives have traditionally been such 'holders'.

There is now considerable evidence demonstrating the importance of continuity of care during pregnancy and labour from a known midwife on positive outcomes for a woman's sense of satisfaction with her birthing experience and indeed her likelihood of an uncomplicated birth (Sandall 2016). More recently Swedish research is focusing on evidence to ascertain if the presence of a known midwife may also be an effective means of assisting a woman identified as having a strong fear of birth. Evidence is emerging that a known and trusted midwife, combined with a positive birth experience is a more effective 'treatment' for fear of childbirth than specialised counselling (Hildingsson et al. 2018). Much more research is needed to examine the psychosocial impact of continuity of midwifery beyond the many studies that have focused on satisfaction (Forster et al. 2016).

There have been multiple approaches to treating fear of birth (Striebich et al. 2018) with most research coming from the Nordic countries, UK and Australia. The focus has

been on specialised therapies targeting specific fears including face to face counselling from specially trained midwives or obstetricians (Larsson et al. 2018; Saisto et al. 2001), mindfulness group counselling (Byrne et al. 2014), telephone counselling (Fenwick et al. 2018), art therapy (Ünsalver and Sezen 2017) and internet delivered cognitive behavioural therapy (Ternström et al. 2017). However there is such heterogeneity in the causes, components and contexts of women's fears that the idea of a singular 'clinical' approach that can work for all is most unlikely (Striebich et al. 2018).

This leaves the clinician with a dilemma. How best to help a woman who is deeply afraid of giving birth? Firstly it is important that the clinician recognises that fear of giving birth is a universal emotion that crosses borders between and within countries and cultures. The level to which this fear impedes a woman's quality of life and birthing outcomes varies according to her psychosocial circumstances, her expectations, attitudes, beliefs, life and previous birth experiences and presence of key support networks irrespective of what health system she is exposed to. However the health system itself remains a key component in the realisation of many fears. The capacity of midwives and doctors to sensitively ask every woman a question wherever she may be about fear is a crucial first step in finding the most appropriate way of addressing her concern.

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3 Understanding Fear, Physiology and Finding an Explanation of How the Mind Influences Us During Childbearing

Kathryn Gutteridge

> You may not control all the events that happen to you, but you can decide not to be reduced by them (Maya Angelou [1928–2014]).

It is strange that the association of pregnancy and womanhood should be associated with fear but there it is. The separation and sophistication of we as human beings to other creatures is that we as humans experience and respond to fear. We operate and function in the world for the majority of situations without any anxiety and worry—yet fear is ever present in so many ways. Why as adults do we respond to threats and how does our body know how to respond with complex neurobiochemical stimuli?

At the onset of pregnancy the woman will experience an extraordinary hormonal change which is evident almost within days of conception. The commonest of these hormones oestrogen and progesterone are abundant and rapidly support proliferation of the uterus to sustain the embryo. The visual and very personal effect of these two hormones is the impact they have on mood and affect, often causing swings in mood and tearfulness. The general consensus is that these changes will be accommodated as the pregnancy progresses and mood improves by the second trimester. What is important is that women understand the changes that are expected and not considered to be morbidly deranged.

However where a woman experiences more than mild mood changes and has become fixated upon her rapidly fluctuating body, then this suggests a deeper psychological reaction to her pregnancy. For some women the thought of being pregnant is fear inducing and they may go to extreme lengths to avoid this even to the point of undergoing preventative surgery such as sterilisation or even in some cases hysterectomy. This behaviour is indicative of a woman who is psychologically driven to prevent pregnancy and may be described as tokophobia (Gert et al. 2016). The question is what defines anxiety, worry and in some cases morbid fear.

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3.1 Defining Anxiety and Worry

It is cited that up to 80% of women will admit to some measure of fear and or anxiety during pregnancy, which infers that this behaviour is more normal than not (Melender 2002). However there is a lack of consensus on the symptom range and prevalence presumably due to the difficulty in measuring affect and agreement upon definition. Therefore understanding the issue is framed with challenge and discord; however, anxiety and concepts of fear sit in the psychopathological area of emotional disorders (Rondung et al. 2016).

Anxiety may be described as a 'state of worry, nervousness or unease when there is an uncertain outcome' (Oxford English Dictionary accessed online 2018). In this definition both anxiety and worry are categorised in the same frame; however, when worry is examined separately, this is defined as 'to think about constantly, to ruminate, to experience mental distress' (Oxford English Dictionary accessed online 2018). Combining anxiety and worry is coterminous; there is a relational essence here particularly where women who are already anxious in a non-pregnant state. It is widely accepted that the physiological aspects of fear and anxiety include responses such as palpitations, hyperventilation, dizziness and nausea (APA 2013: DSM-5TM (fifth ed.)), this symptom group is explained as an anxiety response.

The manifestation of anxiety, worry and panic in pregnancy is by and large unique to every woman; however, it is important to understand the neurobiochemical processes that manifest to be recognised as anxiety.

3.2 The Brain

The brain as a human organ is held up as a mysterious repository with little knowledge of how it stores the essence of who we are and memories of life as it were for each and every one of us. The brain is complex and still cannot be completely unravelled making understanding complex as the individual idiosyncrasies present challenges to medical science as the biochemical meets with the pathophysiological world.

The brain is made up of three parts—the brain stem, cerebellum and the cerebrum which is the largest part of the brain; it is composed of two hemispheres, the left and right. The outer layer of the brain is covered by a layer of grey matter called the cerebral cortex which covers the white matter. On closer inspection the brain itself has four distinct components known as lobes; these are the frontal, parietal, temporal and occipital lobes. As a structure the brain has some fundamental functions that maintain life; the cerebellum which is attached to the brain stem and that controls automatic functions such as breathing, heart rate, digestion and blood pressure. The cerebellum which is located at the back of the head controls balance and coordination; it also interprets information from the eyes, ears and other sensory areas. Brain activity is possible because of the cells that are known as neurons transmitting signals in response to nerve impulses. This intricate and complex network of systems is known as neurotransmission. Although

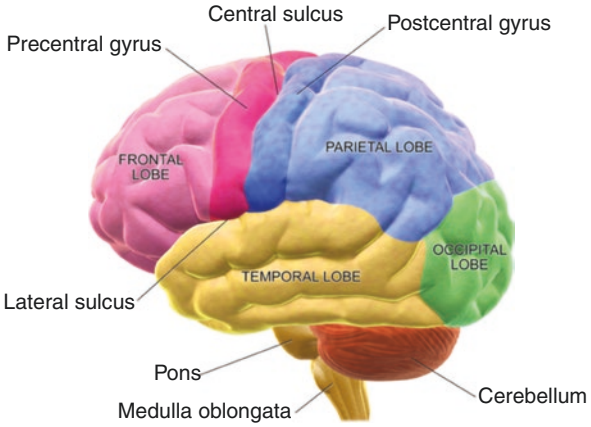

Fig. 3.1 Lateral view of the brain. Blausen 0101 brain lateral view. png. With permission from Wikimedia Commons, the free media repository

this anatomical structure explains what can be seen and understood the concept of who we are as individuals is less clearly articulated from the gross organisation of the brain (Fig. 3.1).

Much research around anxiety has focused upon norepinephrine, particularly in the locus coeruleus (Counts and Mufson 2012). This region is a metencephalic nucleus which has developed from the embryonic status to form the midbrain. This area particularly is associated with excitation, stimulation and arousal. Further to this the visual and auditory nerve pathways are embedded within the locus coeruleus. In addition to the locus coeruleus is the limbic system.

The limbic system situated on both sides of the system has also been called the 'cold brain' or primordial brain as it is the oldest part of human brain development and is described as primitive in its function. Within the limbic system are the structures known as the hippocampus, hypothalamus and the amygdale; these are the areas responsible for making sense of the world around us and emotional responses to events. Where deregulation has occurred such as long standing depression; studies have shown that the hippocampus is smaller and shrunken (Herman 1992). Where this happens it is more difficult to recall events or memories which are why it is important to ask about these functions when diagnosing depression.

Hippocampus Hippocampus found deep in the temporal lobe, and is shaped like a seahorse. It consists of two horns curving back from the amygdala. The role of the hippocampus may be unclear but it plays an essential role in the formation of new memories about past experiences.

Hypothalamus Both the thalamus and hypothalamus are associated with changes in emotional reactivity. The thalamus, which is a sensory 'way-station' for the rest of the brain, is primarily important due to its connections with other limbic-system structures. The hypothalamus is a small part of the brain located just below the thalamus on both sides of the third ventricle. Lesions of the hypothalamus interfere with several unconscious functions (such as respiration and metabolism) and some so-called motivated

behaviours like sexuality, combativeness and hunger. The lateral parts of the hypothalamus seem to be involved with pleasure and rage, while the medial part is linked to aversion, displeasure, and a tendency for uncontrollable and loud laughter.

Amygdala It is a small almond-shaped structure; there is one located in each of the left and right temporal lobes. Known as the emotional centre of the brain, the amygdala is involved in evaluating the emotional valence of situations (e.g., happy, sad, scary). It helps the brain recognise potential threats and helps prepare the body for fight-or-flight reactions by increasing heart and breathing rate. The amygdala is also responsible for learning on the basis of reward or punishment. The amygdala is also responsible for memory retention and modulation.

Activation of the locus coeruleus and the peripheral autonomic nervous system are major components of a normal stress response. Stress increases the turnover of norepinephrine in the brain, and this can be influenced by a variety of mechanisms such as visual and auditory imagery. The locus coeruleus receives a wide range of inputs and, thus, can integrate information from a variety of sources. There are particularly strong connections between the locus coeruleus and the amygdala, which is part of the limbic system (Figs. 3.2 and 3.3).

The signs of anxiety and stress reactions are associated with rapid and rising pulse rate, hyperventilating, rises in the systolic blood pressure, pallor, nausea and

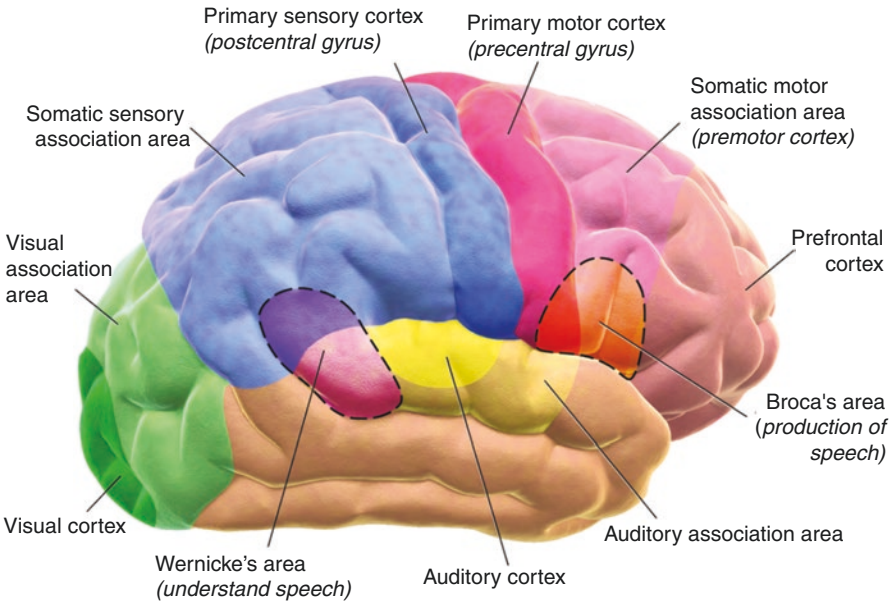

Fig. 3.2 Regions of the brain and functions. Blausen.com staff (2014). Own work, CC BY 3.0, https://commons.wikimedia.org/w/index.php?curid=60100749

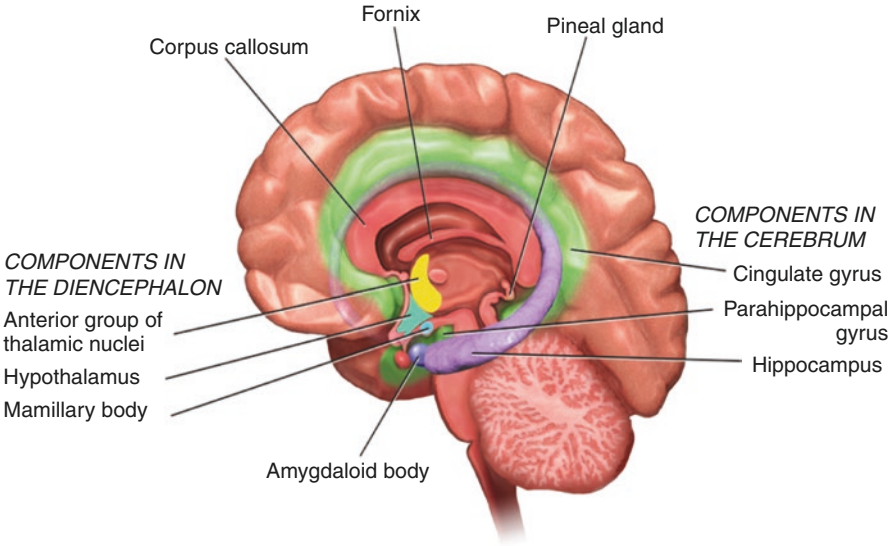

Fig. 3.3 The limbic system. By BruceBlaus. Blausen.com staff (2014). Own work, CC BY 3.0, https://commons.wikimedia.org/w/index.php?curid=31118604

sweating. Noradrenergic mechanisms have been shown to be associated with both panic attacks and post-traumatic stress disorder (Southwick et al. 1993).

Rothschild (2000, p. 8) documents that the limbic system 'has an intimate relationship with the autonomic nervous system' (ANS) which regulates the smooth muscles such as the heart, kidneys, lungs, bladder, bowel and pupils in the eyes. There are two parts to the ANS: the sympathetic branch (SNS) and the parasympathetic branch (PNS), these work in balance with each other, for instance, when one is activated, the other will be suppressed. When a threat is realised the limbic system is alerted and releases hormones that will prepare us for action. The amygdala alerts the hypothalamus and turns on the two systems; thus, the activation of the SNS and release of corticotrophin-releasing hormone (CRH) is effective (Fig. 3.4).

Where this protective response fails a situation occurs; whereby the individual is unable to respond by running away or avoiding the situation; this is called freezing (van der Kolk 1987). If it feels that death is a possibility, or that the threat of harm is enduring (for instance, in cases of childhood sexual abuse), then this is recognised as tonic immobility or 'playing dead' (Herman 1992; van der Kolk and van der Hart 1989). This state of passivity is an innate behaviour that has recognised that there is no time to run or that there is no point in fighting the threat, so the body freezes and the mind switches off; a state of altered reality is entered. This response is often recounted by trauma victims as 'everything slowing down, the body and mind separate and sometimes even a sense of 'watching from above' (Rothschild 2000; van der Kolk and van der Hart 1991). This is an instinctive reaction and is complex in its nature; what the brain is doing is coping with the immediate harm and protecting the

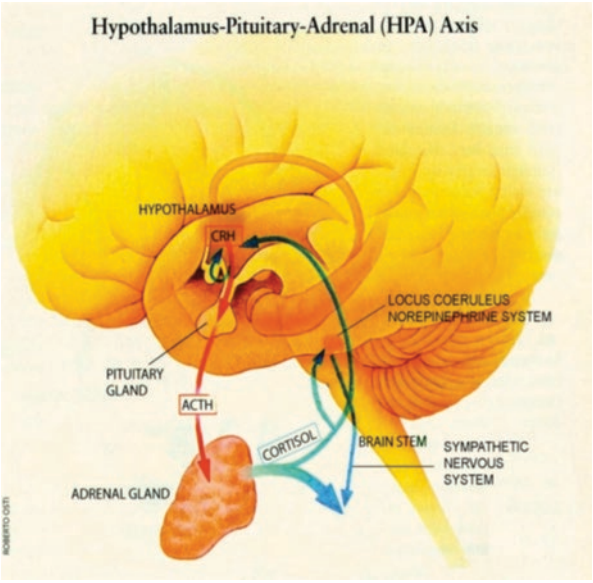

Fig. 3.4 Brain and stress reaction. Published in: Sherin and Nemeroff (2011) CC BY-NC-ND 3.0, https://openi.nlm.nih.gov/detailedresult?img=PMC3182008_DialoguesClinNeurosci-13-263-g001&req=4

individual in the only way it knows. It may be said that whilst the mind effectively 'forgets' the event momentarily, the body is a somatic reminder of the trauma and can be reminded by multiple effects and stimuli.

Vignette 1: Ashwini
Ashwini was labouring with her third child; she had her pregnancy induced because her baby's growth had slowed down. After a few hours her waters broke and there was a lot of fresh blood at the same time. Ashwini remembers the look on the midwife's face (shock and panic), it was then that Ashwini started to have buzzing in her ears and that she felt very warm. Many people came into the room and they were all doing different things; she is unsure who was doing what. She said; 'I kept looking at my husband's face, he looked terrified and I thought I was going to die'. By the time Ashwini arrived in theatre she had started to lose consciousness although she could hear the midwife who had been looking after her say that the baby's heartbeat was dropping. Ashwini then said that she could see herself on the theatre table where she was lying.

This example of acute and immediate shock is an everyday event in most labour wards; however, it is experienced as a life threatening situation by the woman and one that she reacted to with a trauma response.

3.3 Memory

The memory of a trauma is once again linked into the amygdala and the hippocampus; they act like a repository which films and processes our experiences. The amygdala particularly is involved with storing emotional responses, particularly

trauma events and can be highly activated when remembering those experiences. The hippocampus however gives time and context to the memory of events, putting memories in order. Babette Rothschild (2000) and Bessel van der Kolk (1991) have researched widely in this arena and show that survivors of trauma are plagued by feeling that the trauma will never end as they continue to re-experience this event (van der Kolk and Saporta 1991). This response suggests that the hippocampus is suppressed during traumatic incidents and is why the trauma is relived or re-experienced time and again; the term 'flashback' describes this response.

Dissociation is a much debated state of freezing or splitting. It might be very simply explained as similar to walking up stairs to wonder why you have gone up there, obviously that can happen to all of us; however, dissociation as a disorder is much more complex. Explanations of dissociation (Table 3.1) can range from small lapses in memory to something much more permanent (Kolb 1987).

The difficulty with all of the above is that they may respond to 'triggers' but the problem with triggers is that they may have multiple meanings and are difficult to identify.

When memory is examined and deconstructed it is generally split into implicit and explicit; this goes back to psychology explanations and research. Schacter and Tulving (1994) described further that implicit as 'nondeclarative memory' and explicit as 'declarative memory'. Implicit memory is perhaps described best as remembering something like riding a bike or driving a car, whereas explicit is where we remember an event such as a birthday party we enjoyed, these are different processes and are dealt with differently. Going a little bit further into the concept of memory is that of 'conditioned memory'; this is where we have learned how to respond to a particular event.

Ivan Pavlov (1897–1902) was renowned for his psychological observations and experiments demonstrating 'classical conditioning'. He showed that a hungry dog would modify its behaviour when hearing a bell signifying food; the dog would salivate and become ready to eat. The association of the bell and food was repeated for some time and then Pavlov removed the food and just stimulated the dog with the bell only; the same responses were seen—salivation and hunger drooling. This is classical conditioning. Goldman (2012) asserts that we can understand this more fully in the way that drug or alcohol dependency is experienced. The fact that

Table 3.1 Explanation of diagnostic states when in a stress situation

Behaviour	Diagnostic name or state
Having gaps in memory where you can't remember things about yourself	Dissociative amnesia
Feeling as if the world around you is unreal, feeling as if objects or people change shape	Derealisation
Feeling that you are watching yourself in the world, feeling disconnected from parts of your body and emotions	Depersonalisation
Feeling as if your identity changes, that your voice is different and that you speak in a childlike voice	Identity alteration

continued drug or alcohol use is likely to harm us or even cause death does not stop the cycle of need, addiction and use.

This same process can become associated with trauma and PTSD responses, stimuli such as an ambulance with a blue light can trigger a response and flashbacks or physiological responses that were present during that frantic hospital journey when in labour. This is why it is important to understand the nature of the story from every woman in her journey through trauma.

3.4 How Do We Know Who Will Be at Risk of a Traumatic Events

In notable psychoanalytical theory, Bowlby (1969) stated that human infants are conditioned to be naturally instinctive and will be activated by any conditions that seem to threaten safety, attachment, and become aware of fear. Ainsworth (1991) and Bowlby (1969) both observed that anxiety and fear was demonstrated in small children when separated from their women; this led to understanding and development of 'attachment theory'. Therefore many psychoanalysts have long supported the fact that some of us are predicted to experience anxiety and panic disorders through life and its origins are determined in the first few months following birth.

The primary caregiver (woman) ensures that the infant's basic human needs are met, by food, warmth and keeping the child safe. However there is much more to this relationship to ensure that the woman quickly responds to her infant's sensory stimuli. Although they are both learning how to behave with each other there is a symbiotic connection that is present from birth. All midwives are now familiar with the process of 'skin to skin' which is well researched in the benefits of infant attunement and maternal attachment processes (Duhn 2010). When the baby cries the woman has quickly developed her auditory response to know whether her baby is hungry, uncomfortable or even in pain. There is a symbiotic growth of interactions between woman and infant where face-to-face contact enables the infant to respond and react and so learns to regulate it emotions.

There is collective evidence that the right side of the infantile brain cortex develops much quicker in the first year of life (Giedd et al. 1996). However when the infant reaches a year old the total dependency that was present throughout the first year makes way for exploration, crawling and walking. This is the time when the left side of the cerebral cortex begins to develop much more giving way to language skills that start to develop and reach maturity (Bristow et al. 2009).

There is no doubt in any research that a child who has experienced a loving and stable family relationship will begin life with the capacity to self-regulate and be resilient. However where there have been deficits in these formative years there may be insufficient ability to withstand stressful stimuli or events. For instance, if the child witnessed its woman being abused by her partner verbally and physically, then the impact may be felt later in the child's life in terms of stressful events that trigger anxiety or body sensations (Holt et al. 2008).

Attachment is not limited to infancy—it shapes the choices made in adulthood about life risks and aversion to some relationships. Clinical midwives will identify some women who present for the first appointment in a state of anxiety rather than excitement which typifies underlying worries that may have been present pre-pregnancy. The parenting we ourselves experience is often felt to be the childrearing we will deliver to our own offspring (Raphael-Leff 2001); as unpleasant as this may be from a psychoanalytical perspective a therapist will often visit childhood experiences to explain current states of mental wellbeing.

It is fair to say that anxiety, panic and stress disorders have multiple explanations and derivatives and cannot be satisfactorily explained by one theory alone. This is the same for childbearing women. There can be no single reason why a woman should be anxious at the start of her pregnancy; however, she brings with her a complex set of life experiences that shape her and her progress.

3.5 Pregnancy: An Emotional State

How a woman comes to know herself during childbearing is interesting. If the woman has never experienced a pregnancy she will draw on multiple references to compare her own emotional responses to. This may be discussion with other women; usually family or friends, literature, media sources and finally healthcare professionals. It has been demonstrated in other areas of research that pregnant women are much more likely to believe information that is shared by family and friends rather than a health professional (Verma et al. 2016). In our world today accessing information is immediate and limitless; however, the authenticity of that information helping the woman to make decisions will be predetermined by her formative ego state.

Raphael-Leff (2001, p. 60) cites pregnancy as ‘a process’; she describes the woman going through a progression of growth and development just like her fetus. Furthermore Raphael-Leff (2001) states that pregnancy may be divided into three separate maturational phases, which correspond to trimesters. The woman experiences her bodily changes and regulates this with her feelings and emotions that change as her pregnancy grows. This biophysical and psychological mutation is a leap into the unknown for every woman and is influenced by the changes and interactions around her. This might be demonstrated when the first fetal movements are experienced; only felt by the woman but this knowledge can have a positive impact on the woman’s pregnant psyche that all is well. Pregnancy interferes early on with all functioning from bodily norms such as sleep and appetite to the changes in memory and concentration. Some women may find this disturbing and relate loss of control and a feeling of ‘something else’ overtaking her body and mind.

Kitzinger (1992) is clear that women’s bodies are likely to be traumatised and harmed by violation of their rights. This may be a controversial element of discussion; however, she asserts that when relationships are formed with women’s caregivers this is an unlikely consequence. Separating the woman from her body is dangerous and is a fundamental criticism of patriarchal medicine, one that Michel

Foucault philosopher (1989) so eloquently observed in the power of professionals or caregivers over the individual.

Another element of change that is not expected is the unwarranted attention of others in terms of advising and offering information. Well-meaning advice to a newly pregnant woman can frequently suggest that she no longer knows best about her body and that she must trust others rather than herself (Gutteridge 2002, unpublished dissertation). From the first meeting with the midwife and the vast amount of information that is passed on to her, it may be reinforced that 'they know best' and permission has to be sought thereon. A sense of being 'shared' by the world is what may be perceived and this can reactivate old anxieties and childhood character deficits. Memories of childhood can be frequent in the early phase of pregnancy; particularly where there was inadequate mothering and nurturing experiences, history of abuse and where dysfunctional relationships with her own woman are relived (Raphael-Leff 2002). Being told as a child that you were unwanted/unplanned or that your own birth was 'horrendous' and nearly killed your mother can re-emerge in later life and interfere with cognitive processes and ego development. These are the seeds of anxiety and fear that are unknown until a confirmed pregnancy but will undoubtedly emerge as the fetus grows.

Early pregnancy is hard fought and will throw up a range of emotional responses that may be completely unexpected for the woman. Normal daily functioning offers stability and confidence in one's own body, when that changes it is no surprise that the mind struggles with the effects. Worry about miscarriage, changing body image, ability to cope with work and sometimes physical retching with pregnancy sickness are reason enough to doubt the body's ability to cope. However as the early pregnancy transition closes the second trimester is a time of regaining some control as she comes to terms with her changing future and role in society. It is now that the woman consolidates a relationship with her fetus as it starts to move and grow and can be felt deep within her. Stroking her fundus is an unconscious sign that she is in touch already with her fetus and she is soothing her infant or sharing a precious movement (Raphael-leff 2001). It is at this transition that the woman subconsciously communicates with her unborn and this secret relationship deepens. This positive phase of pregnancy makes way then for the final few months where body shape becomes less comfortable, tiredness overwhelming and energy low.

Concerns during the final trimester are differentiated with thoughts of her baby coming into the world and for both the woman and her baby surviving the journey. She will dare to dream that she is to be a woman in society and that she has the final journey of birth within her sights. Fears that were once buried will now emerge particularly where those memories were negative such as previous loss of a baby, traumatic life events, bullying and childhood abuse (Raphael-Leff 2002). There may be a realisation at this stage that the birth is imminent and a sense of overwhelming powerlessness is perceived. Whereas before, the woman may have sought reassurance from family and friends she now seeks guidance and help from midwives and other maternity clinicians. For women who have struggled to hide their worries and fears about birth it is now that the inevitability is felt and that panic ensues.

3.6 Dreams and Fantasies

This element of childbearing and womanly experience is a hidden and little spoken of phenomenon. However it can be disturbing, intrusive and in some women causes heightened fear and worry (Gerhardt 2014; Raphael-Leff 2001). There is very little theory and confident analogy about why we as humans dream. We know that it is associated with the stage of sleep called REM (rapid eye movement), which is in the stage where brain activity is high and physiologically we are still resting. If we are wakened during the REM stage of a dream, then we usually will remember the dream; however, it is normal for most of us to have up to five dreams on average during every sleep.

Sigmund Freud (1900) was the first documenter of dream theories and structured many of his later work about the interpretation and origin of dreams in humankind. He related dreams largely to repressed sexual desire and an unconscious window into the human sleep state (Freud 1953). He saw dreams as an opportunity to understand the unique psychological characteristics' of individuals and stated that dreams were unfulfilled desires and unmet needs (Freud 1953).

The majority of later theorists in psycholanalytical work contested this view as it failed to answer some fundamental questions about humanity. Carl Jung (1974, p. 61) theorised in his work 'that dreams were more messages particularly when they were recurring', it was likened to the mind reminding the individual that something was not right or needed attention. There are many modern studies that have argued elements of the sleeping mind; however, it is important to understand some of the neurophysiology of the brain that affects us.

3.7 During Sleep

The rapid eye movement (REM) phase of sleep is like entering the lift of a high story building, we are travelling sometimes quickly to the place where deep sleep will begin. During REM some of our normal biochemistry is suppressed; the release of neurotransmitters norepinephrine, serotonin and histamine is completely dormant (Aston-Jones et al. 2007). Whilst at the start of pregnancy dreams will usually focus upon the acceptance of being pregnant, changing physicality and her changing status in the world. In the last trimester the dreams will be more centralised around the forthcoming birth with multiple connections to excessive pain, loss of internal organs and bodily damage (Raphael-Leff 2002, p. 51). Nielsen and Paquette (2007) agree that during the third trimester a woman's dreams take on a much more vivid and grotesque nature, women were much more likely to report nightmares that caused them stress and anxiety. These dreams were more often reported as life threatening events to woman or baby and grotesque fetal abnormalities. Women who had a fear of childbirth were more likely to dream and describe nightmares than other women, indeed between 6% and 10% reported severe nightmares compared to women who were not afraid of birth (Saisto and Halmesmäki 2003).

The changes in hormone levels particularly melatonin and prolactin are cited as the precursor for changes in sleep patterns and dream frequency; however, there is much more at stake than just hormone levels. The psychology of dreams is scattered with our life experiences and this combined with hormone levels that are in extremis will create a unique pattern of unconscious fantasies.

3.8 Neurochemistry of the Brain and Hormones

The prefrontal cortex of the brain in an adult has undergone a system of social and neurochemical changes to be responsible for behaviour, logical decision making and emotional intelligence. This happens over years and really only reaches it potential from the age of 25 years. Where stress and anxiety are experienced even for a short space of time the prefrontal cortex changes so that decisions are harder to make and depression may follow stress episodes. Where there are long periods of stress exposure it is possible to see changes in the landscape of the brain and note ongoing impaired memory recall and decision-making (image of 'normal brain' and a stress affected brain) (Rothschild 2000).

The role of cortisol in the brain is increasingly demonstrating the importance in our understanding of regulation and dysfunction. The prefrontal cortex is highly susceptible to this chemical and will show behaviour changes when cortisol is consistently bathing those structures in its harmful effects. Many researchers are looking at both animal and human responses to cortisol overload showing that serious psychiatric illnesses are more likely to occur and brain imagery shows changes to the pathophysiology (Lovallo et al., 2010). Not only is the effect of longstanding stress likely to be shown in brain changes Pert (1997), who first discovered the opiate receptors in the brain goes further in her studies to show that there are dense concentrations of neuropeptides found in the spine and gastric system. Pert's (1997) discoveries relate that not only is dopamine critical to feeling good and emotional happiness the destroyer of this function is cortisol and its effects in suppression of dopamine.

In the words of Kerstin Moberg (2003, p. 3) 'oxytocin plays a much larger physiological role than previously recognised' and it is this hormone that is manifested during childbearing and those who wish to understand the hormonal interplay. The first researcher to identify the effect of oxytocin on childbearing women was Sir Henry Dale (1906) who noted how oxytocin increased the intensity of muscular expulsion of both uterine tissue and later expulsion of breast milk.

Oxytocin has much greater potential than just that of contributing to childbearing and nursing it has been shown to have critical benefits to maternal and infant attachment but also intimate relationships between couples. Moberg (2003) has shown that the presence of oxytocin in the bloodstream can generate a whole range of benefits and behaviours. Oxytocin is constructed of nine amino acids which show similar structure to that of vasopressin and are also known as peptides. Peptides act differently to the steroid group of hormones, the hormone does not enter the cell wall but rather it activates receptors on the outer surface of the cell membrane

almost like delivering a message. Oxytocin and vasopressin are generated from the hypothalamus, nerve fibres take the hormone to the pituitary gland and then it is released into the blood stream. Both of these substances oxytocin and vasopressin have been present in the evolutionary development of mammals (humans included) for millennia, Moberg (2003) proposes that the substances oxytocin and vasopressin are vital for mammalian survival.

It has also been suggested that oxytocin is largely a female hormone due to the longstanding connections in childbirth; however, it is shown to be present in males but in different levels of concentration. The effect of oxytocin on human functioning is profound, lowering blood pressure, reducing stress and anxiety sensations and modulates many systems as it passes through the blood stream (Fuchs et al. 1992). Moberg (2003) states that oxytocin can be released in quantity by touch that is consistent and pleasurable, further demonstrated in studies of animals in various states of arousal. If skin cells are stimulated, then those powerful impulses become coordinated and oxytocin is produced in huge amounts. However oxytocin production can be influenced by various areas in the cerebral cortex or the brain stem either increasing or reducing secretion.

Oxytocin works by the mechanism of a complex mechanical receptor system where it plugs itself in to perform. This is how oxytocin latches onto the uterine muscle and creates contractile responses known as contractions. Dopamine which controls concentration, coordination and movement is known to be a neurotransmitter which is critical in reward and motivation behaviours. The more the production of dopamine, then the higher the stimulation for the release of oxytocin. Most hormones operate on a supply and demand principle, however oxytocin does not, Moberg (2003) suggests it does the opposite. Oxytocin stimulates receptors on oxytocin-producing cells, thus increasing production and influencing physiological responses. There is evidence that oxytocin is produced in the ovaries and testes but it is also found in heart muscle which demonstrates the complexity of this unique hormone and its benefits.

During the early phase of labour when oxytocin is increasing, contractions are varied and sporadic in strength and length. It is during this phase that a woman may be influenced by her surroundings and degree of support. Where she is in a place of feeling safe and secure the incremental rise of oxytocin will intensify her contractions and progress labour (Gutteridge 2014). Alternatively if she has little support, lack of privacy and is labouring in a non-familiar setting and is alone, then the opposite effect may transpire, making labour dysfunctional and more distressing an experience (Walsh and Gutteridge 2011).

What is important in that maternity clinicians understand the complexity of hormones, neurotransmitters and biochemistry of the human physiological state is that any stressors can and will change the function and pathophysiology of childbearing. The examination of normal brain functioning is in the early stages of understanding and explanation; however, it is imperative to deepen our knowledge of how some women in childbearing and pregnancy will respond during their unique experiences.

3.9 The Nature of Fear

There are three key theories about the acquisition of fear: conditioning, vicarious exposure and by indirect transmission (Rachman 1977). Conditioning as a concept was first suggested by Bandura who popularised the 'Social Theory Concept' (Bandura 1977). He postulated that humans observe others and by the nature of observation mimic and behave similarly; this is particularly applicable to children who watch their parents. 'Conditioning' as a concept in respect of fear of childbearing may be demonstrated by the association of hospital and labour pain; this may illustrate that hospitals equate to 'bad experiences' (Rondung et al. 2016).

Conditioning in fear of childbirth is explained by an individual experience that relates to a previous birth or obstetric episode that caused some degree of perceived trauma (Handelzalts et al. 2015). Whilst previous birth related experiences are important in the aetiology of childbearing fear there are other important factors that are accepted as indicative of the development of this phenomenon. Where the woman has been exposed to abuse in her formative years she will have a higher prevalence of developing a childbearing anxiety disorder compared to women who have not (Lukasse et al. 2010).

Vicarious experience of childbirth is another concept that is commonly assumed to increase the woman's susceptibility to developing fear around birth. Observing women during labour or the birth can be evocative and anxiety provoking particularly if the woman is a family member and the 'observer' is emotionally connected. However if the observation of birth is managed with care and educational parameters, then it is unlikely to invoke a fear response. In fact Stoll and Hall (2013) examined this concept with young women who had never given birth and found that they were no more at risk of developing a fear disorder of childbirth. Where a story about birth is regurgitated particularly by a maternal figure to a female child consistently throughout their formative life then the prevalence of childbearing fear is increased (Gutteridge 2016, unpublished thesis).

Transmission through information is an important area of fear acquisition. The media portrayal of pregnancy and birth has been an interesting developing phenomenon. In newspaper publications there are regular reports of negative childbearing stories; this has increased the media appetite for catastrophising birth events. When women are exposed to narratives such as these, there is a positive correlation with perceived adverse perception of childbearing (Melender 2002; Tsui et al. 2007). Further support of negative transmission relates to family and friends of the woman where pregnancy and birth stories are catastrophised. Where a story about birth is regurgitated particularly by a maternal figure to a female child consistently throughout their formative life, then the prevalence of childbearing fear is increased (Gutteridge 2016, unpublished thesis).

3.10 How Do We Deal with This?

It is evident that the acquisition of fear and its derivatives is complex and difficult to analyse. Formulation of assessment tools is also unequivocal making

diagnosis and treatment challenging and often trial and error. It is notable that during the last decade women have presented more willingly during pregnancy to discuss their emotional wellbeing, this is a behaviour change that is welcome and brings opportunity. One of the consequences of this is that midwives are becoming more aware of women's mental health backgrounds and the nature of their anxieties.

Whilst the changing nature of women's readiness to declare their anxieties and fear has moved forward, however midwifery and obstetric expertise and training has not moved at the same pace. This places the woman at a disadvantage, knowledge and opportunity to discuss the implications for herself and the likely outcome for her birth are uncertain. This alone will be a precipitate factor in developing a higher degree of anxiety—fear is a hungry beast and feeds on uncertainty.

3.11 Phobia and Avoidance Behaviour

One of the more common reactions to dealing with anxiety and fear is that of avoidance. Where a situation provokes fear, then we adopt a normal human response to reduce the perceived harm. In a logical stance that is perfectly reasonably especially if the harm is great as in our forebears situation facing a hairy mammoth. However where the harm is generated by fear such as repeatedly handwashing to rid oneself of contamination, then this can be described as a maladaptive behaviour. This kind of response is a compensatory way of dealing with the perceived stressor and yet it does not solve or deal with the anxiety.

The development of a worry, anxiety or fear can be described as a phobia, 'an extreme or irrational fear of something' (Oxford Dictionary). It seems bizarre to describe childbirth and phobia in the same sentence; however, this is what tokophobia is defined as. When Hofberg and Brockington (2000) described this phenomenon using a very small case study it generated hardly a ripple in the maternity entity, yet in the current world it has more relevance than ever. Fear and avoidance are bedfellows; they are symbiotic and feed from each other.

In childbearing fear there are some clear avoidance behaviours that are identifiable. One may be to avoid pregnancy at all costs; this can be to the point of having operative procedures to ensure pregnancy is impossible (Hofberg and Brockington 2000). This extreme act of protection removes the prospect of normal childbearing but does not necessarily remove the phobia. Modern traits of women who are in their reproductive years are to use contraceptive agents to control when they wish to start their families. Contemporary contraception allows women to delay reproduction until the time is right for them and also how many children they wish to have. However there is a darker side to this where women who have delayed their childbearing have an underlying fear of birth and may panic as they perceive their time is running out. This sense of panic is likely to impact very early in the pregnancy; it would not be unusual for this group of women to be in a state of high anxiety as soon as pregnancy is confirmed.

Vignette 2: Lise

Lise was a 39-year-old woman who was in a longstanding relationship, her longest to date. She is a professional women working in the legal profession and had established herself as an expert in her field of work. She knew from an early age in her adult life that she was disgusted by birth, her woman had told her this many times as a child and therefore she vowed never to get pregnant.

At university Lise found herself pregnant after a drunken celebration with some friends, she immediately found herself in a state of panic and had a full blown panic attack. She was seen by the university medical student support team and she denied being pregnant at that time. Lise did everything she could to cause a miscarriage, not eating, drinking alcohol and strenuous exercise. Still she remained pregnant so at approximately 12 weeks pregnant she attended a Marie Stoppes Service in another city so she could maintain her confidentiality.

As a consequence of this pregnancy she opted for a medical termination of pregnancy and she tells this part of her story as if it were someone else. She started to have pain almost within the hour, by this time she was on a train going back to university. By the time she arrived at the station she was gripped by acute contractions and she went to the station bathroom. In this place she describes aborting her fetus into the toilet; she put toilet paper into her mouth to bite on so she wouldn't cry out in pain. After a period of about 1 h she wiped herself down after taking off her underwear and discarding them she made her way back to her room. She stayed there for 2 days and asked her friends to let her tutor know she had a sickness bug.

From this experience she made sure that she was covered by contraceptives, she had an intrauterine coil in situ but also took the combined oral contraceptive pill to give her absolute protection. She successfully made the transition from university into her professional life and although had several relationships was always reluctant to have intimacy with her partners without the use of condoms.

When Lise reached the age of 38 she and her partner of 8 years discussed the 'dreaded' subject of children and although Lise knew she would like a child she would have anxiety symptoms each time she allowed herself to think about it. She decided to discuss her fears with her partner and they looked for psychological support to prepare them for the way ahead. Initially approaching her GP Lise was referred to myself for a discussion about her fears but also about what she could do to overcome her fear of pregnancy.

We identified two elements to this case: firstly, her longstanding memories that her woman had influenced in her thinking about birth but secondly her traumatic and lonely termination of pregnancy whilst at university. After a period of 6 months Lise found herself to be pregnant and although happy was in a state of panic. Early meeting with myself as her clinical lead followed and we were able to break the pregnancy down into manageable parts. This psychological terror was evident at confirmation of pregnancy but also as each phase was encountered. She successfully gave birth to her baby son at term with huge relief to her partner, she was supported by a doula and had a vaginal birth despite her initial thought that she could not manage to go through labour.

3.12 Unremitting Fear

When a woman is gripped by fear at the start of her pregnancy she may be focussed only on where that fear is headed—the birth. She may appear hypervigilant and even irrational, thinking only how her baby is going to escape her body. Visiting the hospital for appointments makes her tearful and stressed, as she struggles to keep appointments because she knows she should. There is a silence associated with this side of pregnancy, women often describe feeling guilty and ashamed of these deep feelings that they hide. Nilsson and Lundgren (2009) described four constituents in their phenomenological study of women with fear of childbirth: 'feeling of danger that threatens and appeals; feeling trapped; feeling like an inferior woman-to-be and finally being left on your own. The essential structure was described as 'to lose oneself as a woman into loneliness'.

The case of Lise is an illustration of what fear can do over a long period of time. Many women cite their realisation of fear as early as when they are a small child, they recall being part of a discussion where birth was discussed or they witnessed a loved family member in labour or bleeding so the association of terror is confirmed. This is not the only manifestation of fear but the brain remembers how she felt at that point and makes its associations; therefore, a trauma memory is formed.

3.13 The Formation of Terror

When a traumatic incident is experienced the normal functioning of daily life is disrupted by those intrusive memories reaching disproportionate levels of intrusion. These can be invasive from a visual and auditory perspective; however, the individual relives the trauma again and again, re-experiencing the profound fear and reacting as if it were happening all over again. There may be somatic responses where the individual feels as if she is actually feeling those hands on her body, for example; this is called soma. Not everyone who is exposed to a traumatic event will progress to a diagnosis post-traumatic stress disorder (PTSD) in fact only about 20% of individuals do (Breslau et al. 1991). There are many theories why some people will develop PTSD and others not but the breadth of understanding to this area of psychology is growing and therefore understanding will change.

One of the key proponents of PTSD and that which differentiates it from a stress response is that of somatic dysfunction. Individuals who are diagnosed with PTSD will give a history of somatic responses where they will experience repeated body symptoms; these will be rapid heart rate, sweaty but cold, hyperventilating, hypervigilance and accelerated startle reflex. All of the symptoms are listed as a part of the DSM-IV and are must be present to give a diagnosis of PTSD (APA 2013; DSM-IV). When the symptoms are present for many days, weeks or even months, then a chronic state of PTSD is experienced and this will have consequences for life functioning, making PTSD a vicious circle.

Vignette 3: Audra

Audra had her second baby at a local hospital where she had given birth before. Her pregnancy was uneventful and she knew that she would like to have a water birth this time as she knew that if she had got into the pool with her first birth she would have coped better with her labour.

When her pregnancy reached 40 + 2 days she had some low back pain and had lost some mucous discharge over the 2 preceding days. She felt her abdomen tightening but did not feel as if she was contracting regularly but to make sure the midwives knew her progress she called in. She was asked the normal questions over the telephone and the midwife advised her to stay at home until her contractions were stronger and more regular.

Audra contacted the hospital again 4 h later and said that she had progressed and wanted to come in so that she could be checked and have access to a pool for her labour. The midwife said that she thought that she was calm during the conversation and that from the information she was hearing that she still had a lot of time before she needed to be in hospital. The midwife also said that they were very busy at that moment and if she came in she would have to wait around.

After 30 min Audra knew that something was happening and she asked her husband to get the car for them to go to the hospital. They arrived within 15 min; Audra was showing signs of second stage of labour, contracting every 2 min and was making sounds of wishing to push. Her husband found a chair and quickly pushed Audra into the Triage department. By now Audra was visibly pushing and was in the main waiting area where other women and visitors were waiting. She was quickly taken through to a cubicle and as she stood up her baby's head was visible, the midwife pulled the emergency bell and she was surrounded by lots of people.

Her baby was born within 1 min and she was pushed into delivery suite on the chair to deliver her placenta. All of the people disappeared with one saying 'she should have go to herself here earlier'. Audra was very quiet and withdrawn and felt that she could not trust these people around her.

When Audra was home with her baby she constantly remembered her experience and although her husband had witnessed the birth he was not aware of her emotions. She had difficulty sleeping and had nightmares of her baby's head hanging out and she was shouting to everyone around her to help; no one responded to her cries.

After a period of about 4 months Audra was on a top deck of a bus going into the town for an appointment, the bus made a detour due to road works which took her past the hospital. As the hospital road came into view Audra started to breathe quickly as if she couldn't get her breath and she began to lose her vision. She was seen huddling down on the floor and was crying incoherently. Someone pulled the emergency buzzer and the bus stopped, Audra was helped by a passenger to get onto her seat and an ambulance was called. After a few weeks of being seen by her GP and being referred to a psychologist Audra was diagnosed with Acute PTSD following childbirth.

The key message to this case was that Audra was felt she was not believed when calling to say she needed to come into hospital during labour, not being believed as an adult changes our perception of trust and sense of belief in the world.

3.14 The Concept of Body Awareness

Most of us do not spend a lot of time thinking about our mind and body; however, there is a continuing relationship that we experience throughout life where one is in tune with the other. We are all able to differentiate between what we hear, taste and smell, these are external cues that happen outside of the body but will stimulate our senses. However the responses to stimuli that are internal receptors (inside of us) such as breathing, sweating, shivering, *butterfly's* sensation may be stimulated externally. This is when we begin to connect our thoughts and memories to a body response. The next case example demonstrates this.

Vignette 4: Jenna
Jenna (25 years old) is pregnant with her first baby; she is in a supportive relationship with her partner. When Jenna meets the midwife for the first time she is anxious however she is unsure why. She almost ran out of the building when it was her turn to go into the room and have her booking appointment. When she gets into the room she notes there is no window and she feels herself becoming increasingly anxious and feeling lightheaded. She is aware that the midwife is smiling and seems to be nice; however, Jenna is pre-occupied with her thoughts. When the appointment ends Jenna is dry mouthed and exhausted but pleased it is all over.

For the next appointment, her ultrasound scan Jenna feels unnerved. She believes it is because she may see that something is wrong with her baby but she is not completely sure. She is called into the scan room and a sonographer greets her. The room is dark and there is only the light of the monitor showing. Jenna's partner is excited and she is chatting with the sonographer. When Jenna is lying on the couch she is breathing very shallowly and starts to feel lightheaded. The next event takes Jenna by complete surprise—she feels some wet liquid on her abdomen and Jenna immediately screams 'no' jumping up and crouching in the corner of the room. This takes everyone else by surprise and they immediately try to calm Jenna down. Jenna is trembling and crying and cannot speak coherently.

Later Jenna tells her partner it triggered memories of when she was a child, captive in a room without windows and subjected to sexual abuse. Her body had recognised the triggers of this in the ultrasound scan room and she had responded with fear of her memories and feeling helpless.

Body memories are powerful and dormant for most of us and where we have had control over our bodies, then we should come to no harm. However as can be seen in Jenna's experience these body memories are authoritative and can emerge when we are least expecting them. Bessel van der Kolk (2014) a leading therapist and academic in trauma work has stated that trauma is deeply held within the physical body and can be awoken by the most innocuous cues. van der Kolk (2015) also believes that the brain, the mind and body are so closely aligned that it is impossible for one not to affect the other.

In Jenna's case there was a deeply rooted fear of rooms without windows and her response to the ultrasound gel on her abdomen was reminiscent of her abuse as a

young girl. No one had expected this reaction least of all Jenna. However memories and trauma can be buried until the right stimuli awakens them, as was demonstrated here.

3.15 Final Thoughts

The development of anxiety and fear is rooted most often in our past. The brain is exposed to this anxiety and fear and processes it differently particularly where the trauma is unexpected and may cause us harm or threaten death. How this relates to childbearing is again complex and not determined in a straightforward way. However what is clear is that many of the processes we have in place to minimise the harm in adult life do not work well during childbearing, the memory may even be stimulated by the hormones of pregnancy.

As maternity clinicians we have a duty to provide care that will do no harm to the women in our caseload. However, we are often less skilled in the variations of psychological wellbeing than we are with anatomical changes that occur at this time. There is perhaps a need to relook at our knowledge base and improve the understanding of how women may be more at risk of trauma and re-traumatisation during childbearing. This chapter has opened up the window into this debate.

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Fear of Birth and Modern Maternity Systems of Care

4

Geraldine Butcher and Clare Willocks

Motherhood: All love begins and ends there. (Robert Browning [1889])

4.1 Introduction

There seems to be a strange dichotomy in society's attitude to birth. It expects women to welcome pregnancy despite around 50% of pregnancies being unplanned. The pregnant woman is seen as radiant, beautiful, and serene looking forward to meeting her baby. This vision cannot be allowed to be blemished by the fact that a growing number of women are expressing that they are fearful of their pregnancy and birth journey. This is where the dichotomy begins: the reason for that fear is often how society portrays birth both in the media and in social conversations (Luce et al. 2016; Stoll and Hall 2014).

Negative stories have more drama and are remembered, whilst positive stories are often left unsaid as women feel it is inappropriate to tell their wonderful story whilst another is clearly unhappy with theirs. So fear increases with many women feeling they are unable to speak to even their closest family and friends (Sheen et al. 2016). Some may raise the topic to be greeted with a well-meaning but exasperating, 'you'll be fine'. This can often come across as dismissive not encouraging and is rarely documented. Sadly, this is also often the response of health professionals too. Fear of birth can also be far wider than fear of pain or something going wrong, it can include fear of the maternity care system and health professionals too.

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It is known that women who have significant fear of birth are more likely to have the self-fulfilling prophecy of a cascade of intervention and a more difficult birth (Adams et al. 2012; Ryding et al. 2015). Dr. Gutteridge has earlier explained how this can arise, and how important it is to assist the woman find hormonal harmony that will facilitate a more positive birth experience with better outcomes. This chapter will explore opportunities and challenges to achieving this within contemporary maternity services. It will consider fear of birth from two viewpoints: fear of birth itself, and how the maternity care system reduces or increases this.

4.2 Fear of Birth

Women who have a significant fear of birth do not always disclose this early in pregnancy. They may think they will get used to the idea and the fear will fade, but as the weeks advance their fear increases as and the baby's birth is getting closer. They realise this fear won't go away and in fact is worsening daily. They may have difficulty bonding with their baby as although the baby may be wanted it is also the reason for them having to face their fear (Bakshi et al. 2007). For a small number their fear may be related to fear of being a parent (Saisto et al. 1999).

Where the fear came from is sometimes hard for women to say and for us to relate to. If you speak to a woman who has a long, complicated labour and assisted birth it is perhaps easier to understand why she is fearful next time around. What do you say to someone who is traumatised after a 2 hour labour and natural birth?, or to the woman in her first pregnancy who has been terrified of birth, and sometimes pregnancy, for as long as she can remember? Whilst the fear can impact on pregnancy and birth, a negative birth experience can also increase the risk of perinatal mental health problems, delayed bonding with baby, and delay infant development (Poggi et al. 2018) so it is crucial that maternity services are responsive and provide discussion and support.

In 2008 I occasionally saw women for discussion around birth choices, including request for caesarean section. The numbers grew exponentially until in January 2013 I started a dedicated Fear of Birth clinic, which later became known as the Birth Reflections clinic. Referrals have increased from 52 per year in 2013 to 130 in 2018. In the beginning I anticipated that most women attending would have had complicated labours and births and attending for support and reassurance; how wrong I was. Almost 50% of women attending the clinic were in their first pregnancy and the issues which resulted in fear ranged from horrific videos of birth shown at school in an effort to discourage teen pregnancy, to having experienced sexual abuse. Some women are truly phobic and for most the phobia originated in childhood or early adolescence. Where the woman had given birth previously there were more who had forceps births, and some who had caesarean sections, but many had normal births with labours of average or quicker length. It is important therefore that the woman's perception is acknowledged and accepted even when it may be harder for us to understand. Although there are overlapping themes I will now look at fear of birth in the context of primary fear and secondary fear separately.

4.3 Primary Fear

Women in their first pregnancies probably all have a degree of anxiety surrounding birth; what if I don't know I am in labour? What if labour is too long? What if it's too painful? What if I can't cope? What if something goes wrong? What if I can't do it? This seems natural and normal, for labour and birth will be a new experience which cannot be controlled or quantified in advance. However, never before has there been such a bombardment of negative images of birth in the media and this can alter the perspective and instil fear by itself (Luce et al. 2016). A study of young Canadian women by Stoll et al. (2014) found that negative media images and positive attitudes towards technology increased the potential for caesarean section requests.

Figure 4.1 shows the commonest reasons for women attending the birth reflections clinic in their first pregnancy.

It can be seen that apprehension is one of the least common reasons for attendance as the majority of this will be alleviated by discussion with the woman's own midwife. There are many women who attend who have general anxiety for whom being pregnant and giving birth just opens up a whole other world of things to worry about (in an unpublished thesis study by Butcher and Rankin (2017) one in five women had moderate anxiety levels at 28 weeks gestation with the majority being undiagnosed). Fear that something may go wrong with them or their babies is the biggest concern. Much of this comes from how birth is portrayed in mass media such as soaps, news, papers, and social media, but also from women's stories particularly where there have been complications in pregnancies of family and friends. It seems there may be a lack in positive information being passed down the maternal line potentially leading to many girls/women being 'disconnected' from their body's wisdom, that they were designed to give birth normally.

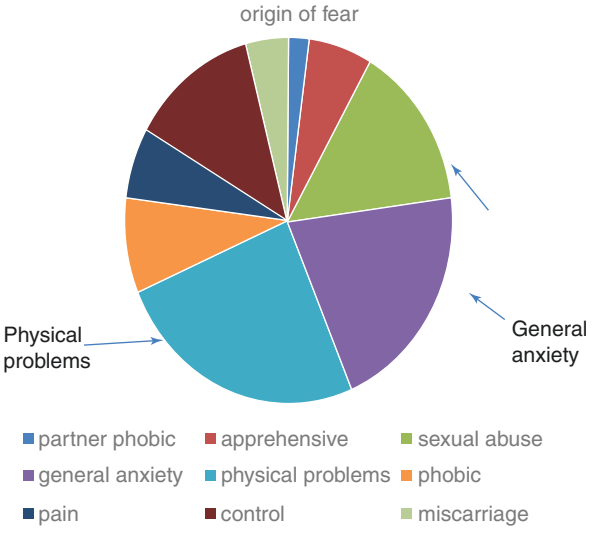

Fig. 4.1 Reasons to attend the birth reflections clinic

Some worries can be reduced by the provision of good quality information, some by discussion and support from their midwife. Maternity services usually provide antenatal education classes and there is a wealth of resources online which can help too. Understanding the physiology of birth and where and when to access care and support may resolve the fear from some women as the information empowers them, and nothing further is needed. However, a Cochrane review by Gagnon and Sandall (2007) suggested more higher quality research is needed as the quality of classes can vary considerably.

However, not all maternity units provide antenatal classes and what if the woman declines antenatal education classes because she is afraid the information given will worry her more than it reduces her fear? A survey by the Royal College of Midwives and Netmums in 2018 found that 29% didn't attend, which included three out of four lower income women. There are other ways to get information and in the NHS this is largely via information leaflets, but what if the woman is avoiding reading the multitude of leaflets given at antenatal clinics? How will this woman be able to make informed choices and feel she is involved in her maternity care?

It is ironic that the root cause of women's fear is often lack of control, and yet the one thing which can potentially give them that control is lost to them. Birth apps and webinars may be the future but we must ensure they provide good quality information, and hand held notes should be intuitive and women centred. Individualised intrapartum care plans which encompass choice in a broader sense are essential.

You will have noticed that fear of pain was the main reason for attendance for only a small number of clinic attenders. This was definitely not what I thought would be the case when the clinic started but shows that we should not work on assumptions.

Women in their first pregnancy may find one to one discussion of their individual fears helps them to look forward to the birth of their baby. This can be done by an experienced midwife and whilst it takes time and time is hard to find it can make the world of difference to how that woman faces the rest of her pregnancy and the birth of her baby. It should be remembered that health professionals are people too and the midwife should have self-reflected and addressed her own fears so that her own issues are not projected onto women.

However, it is hard to discuss issues if the woman herself isn't sure what exactly she is afraid of. This takes significant time and patience, working through things at the woman's own speed. Again, control features highly as today's young women seem to live their lives at a faster pace perhaps than previous generations. They develop ways of coping which involve a lot of forward planning. Each aspect of their lives has its own well ordered 'box', and this is how they get by. Pregnancy and birth cannot be controlled in that sense; when will it happen, how long will it last, how will my baby be born?

Women may try and mask their fear by requesting a caesarean section for what health professionals may class as a minor reason. It is essential therefore that time is given to discuss the woman's feelings in detail and ensure she is making an informed choice, as outlined in NICE Caesarean Section guidelines for England and

Wales (2012). It is ironic that in seeking to have control over birth by having surgery, they ultimately hand over all control to the health professionals.

One in nine women are truly phobic about pregnancy, labour, or birth and have a long-standing fear which they may find difficult to express (Storksen et al. 2012). I have met women who have delayed pregnancy until to wait any longer may mean they will never have a baby. I have met women who wanted a baby, became pregnant, and then had an abortion when the reality of growing their baby and then giving birth became too much to cope with. Their fear was so great that the baby they so wanted was too high a price to pay.

Some women hate every minute of pregnancy, their changing shape, the baby moving; others are happy to be pregnant but dread the inevitability of labour and birth, the process of getting that baby into their arms. This group of women often avoid all things related to pregnancy and birth; they may not read the books and information leaflets given, and are unlikely to attend antenatal education classes. Women who are phobic often will delay buying items for their baby and preparing their birth bag as this makes the whole thing real. It brings the birth closer whilst they are wishing it further away. Their enjoyment of pregnancy is often destroyed and they just try to get through 1 day and 1 week at a time.

4.4 Secondary Fear

Women who develop a fear of birth after a previous negative birth experience are said to have a secondary fear of birth, even though some may have also have had an undisclosed primary fear of birth. It is their perception of that birth which is important and not ours. That cannot be emphasised enough as there is no place for defensiveness or incredulity. In my experience there are many women who have long labours and complicated births who do not develop fear of birth simply because they were treated as individuals and truly involved in shared decision-making, whilst I have met women with quick physiologically normal labours who have been traumatised. I have looked through maternity records to tease out if there has been inadequate care and this is rare, in the physical sense at least. Fetal heart rates and other observations meticulously documented, medications given correctly highlighted; but something else is missing. I know when I go through the record of care with the woman I will be able to say with confidence when she had gas and air or when her epidural was inserted. It is much more difficult to say whether the woman is making fully informed choices, whether she understands fully why interventions are recommend and her right to consent or decline, and whether her psychological and emotional wellbeing is being considered. Good antenatal discussion is preferable to only intrapartum discussion, and there should be detailed documentation of what was discussed including the woman's wishes.

Women with secondary fear may value an opportunity to discuss their previous birth but it is important not to assume that they will. There is a potential that old wounds are re-opened and the woman is retraumatised so it is important that consent is given before embarking on a review of their labour and birth timeline. Whilst

the timeline may assist me to help the women frame her birth in terms of timescales from this time to that it is her ability to say how she felt which is crucial. She may have been told her antenatally voiced choices for labour and birth were not allowed without a full discussion and respect for her wishes. She may react to that by compliance without voicing future needs or wishes. If she wanted care in a birth centre but had a risk factor which presented when in labour she may feel her labour went downhill from then. She may have felt she did not receive enough support physically or emotionally (Cook and Lomas 2012). It is crucial that we acknowledge that loss of trust in one midwife or doctor can result in lack of trust for all professionals and the service itself (Birthrights 2013). Truly listening to her story is the most important aspect of her care as this will help you facilitate a better birth for her this time. PROMPT training emphasises that the woman should be asked if she felt respected, cared for, and listened to when an obstetric emergency has occurred, and these are good principles to guide any discussion after birth.

Figure 4.2 shows the reasons for attending the birth reflections clinic for women with secondary fear.

Control and communication are the two items top of the list of reasons why women felt their birthing experience was a negative one, regardless of mode of birth. This will be pursued further later in the chapter.

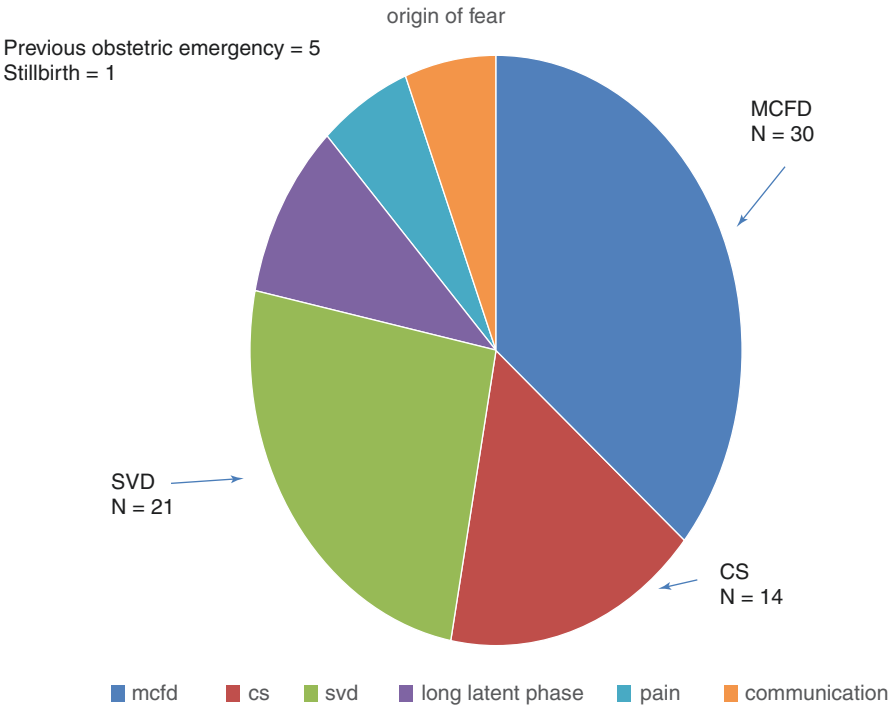

Fig. 4.2 Reasons to attending the birth reflections clinic for women with secondary fear

In trying to reduce the level of fear the individual woman and her circumstances must be considered. Many women will be reassured following explanation of why birth was more difficult, frequently because the baby has been in a posterior position (back to back) and going through how this affects physiology with a doll and pelvis can help. Second births are statistically more straightforward, and one visit to the clinic often helps enough that the woman can see the pending birth in a different context. This won't suffice when the trauma is deeper and some women think the only way out is to have a planned caesarean this time around (Storksen et al. 2015).

4.5 Request for a Planned Caesarean Section

Whether the fear of birth is primary or secondary there is often a thought that a planned caesarean may be a solution to the problem. For some this is fleeting and related to a sense of panic due to fear of the unknown or fear of her story repeating itself. For many it will be seriously considered at some point with a few actually voicing this as a demand for a caesarean, perhaps even at the first antenatal clinic in pregnancy. For the vast majority there is no physical reason for this major intervention but the potential for psychological harm if women with significant fear of birth are forced to have a vaginal birth has to be considered.

If the individual woman's fears have not been discussed, then this should be done before discussion on the risks and benefits of potential/probable vaginal birth over planned caesarean. If having looked at all alternatives the woman's informed choice is to have a caesarean, then this should be facilitated. It is not a lifestyle choice, it is based on being how she's sees she can have the best birth for HER in terms of HER balance between physical benefits and risks and the potential psychological trauma. Her psychological risks may outweigh her physical risks and it is so important for us to get ourselves out of the way and respect where she is coming from, walking 'in her shoes'.

4.6 Maternity Services and Fear Disclosure

When women discover they are pregnant the majority will enter maternity services via the local midwife. A long list of questions is asked to gain a detailed medical and obstetric history, providing information for a risk assessment which will determine their care model. This is a very important visit but tends to consist of very little interaction between the midwife and the woman beyond the scope of the information completion and some public health advice. There is insufficient time to gain much of an insight into who the woman herself is and how she sees this journey she has just embarked on.

If the woman is lucky she will have continuity of carer and meet her midwife regularly throughout her pregnancy hopefully gaining confidence to voice her fear of birth. However, if she meets a different midwife every time or that midwife seems harassed and is rushing through the antenatal check the woman may decide not to confide in her. The woman may not disclose until the pressure of her feelings spill

over and she breaks down at a late pregnancy appointment. Some will never mention it even when in labour, although it may be revealed when pregnant again.

In disclosing fear the woman may wish understanding and support but may meet with disinterest from a busy health professional or is fobbed off with the 'sure you will be fine' statement which is well meant but not helpful. Caring for women with significant fear of birth has two main challenges: the first is time and the second is the system itself.

Time is a precious commodity of which there is never enough. From the beginning of antenatal care we utilise appointment based systems which originated in much simpler times and which bear little or no relationship to the care which is being delivered today. With so many more competing priorities the midwife has the same time to deliver much more information and undertake screening tests. Risk assessments for this and checklists for that, but very few relating to the woman's psychological wellbeing.

A booking visit can take up to 90 min if we are viewing all the items which are incorporated realistically, but in some areas, women may receive an appointment slot of half that time. A standard antenatal appointment may be allotted for 15 min which barely covers the physical tasks of blood pressure, urine testing, abdominal palpation, and listening to baby's heartbeat. Our local midwives worked out that in the current system of care midwives have 3 hours with women across the entire pregnancy in which to undertake physical care, assessment, screening, and provide information. How can midwives build a relationship with women in such time frames? Where do they find the time to ask about the woman's hopes, dreams, and fears for this pregnancy and birth? The midwife races through what she must do to tick the boxes relating to the visit but struggles to really see the woman sitting in front of her in the midst of it all.

National policy promotes continuity of carer (Best Start: Scottish Government 2017); and significant work to ensure implementation is underway, a first despite decades of evidence clearly showing its positive effects. There is an increased emphasis on meaningful relationships which can be therapeutic, which can help us see the woman as an individual and truly provide the woman centred care we have been paying lip service to. With smaller caseloads there should be more time for discussion, and if women thought they may know the midwife caring for them in labour they may be far less fearful (Hildingsson et al. 2018). It can only be hoped that this is appropriately resourced in order that women, families, and health professionals reap its benefits.

4.7 Fear Disclosure and Health Professional's Attitudes

There are probably three ways that health professionals may respond when a woman discloses significant fear of birth: the provision of empathy, the provision of well-meaning platitudes, and denial and defensiveness.

Empathy is good but has to develop into more than that. The woman can derive some understanding and support from empathetic staff but in practical terms she is no further forward. Active listening takes time which is not always available. If it is

not, then at least there should be an offer of another discussion with more time allocated where possible. There may be ways the health professional can help, perhaps even referral to a dedicated clinic or person with expertise in the area if they feel they do not have the knowledge and skills. However, it should be understood that listening may be all we need to do—we don't need to fix it nor indeed can we in some cases.

Well-meaning platitudes are common but serve nothing but to reinforce that nobody is truly listening, and assistance is not available. The health professional may resort to these because they are partly true (second births statistically have quicker labours and less assistance needed). They may also be due to lack of time, knowledge, and skills. Health professionals may feel at a loss to know what to say as we are so programmed to fix problems; the woman is pregnant, and the baby must come out one way or another.

The third type of response (denial and defensiveness) thankfully is the rarest in my experience, but it is definitely present. It may be difficult for some to take on board that a woman may be fearful of birth due to television dramas, negative stories from family or friends, or even worse that care given previously by your service was somehow to blame for the fear.

I have heard a very few health professionals say, 'well she got pregnant so she will just have to get on with it', or 'she can't be that scared she got pregnant didn't she' as if they have forgotten the very strong reproductive imperative and that the end point is a very much wanted baby. Do they say such things because they are at a loss for what to do and that provides a reason to do nothing?

Without a doubt there needs to be more education of maternity health professionals and more research into their beliefs and values (Haines et al. 2012; van Dinter-Douma et al. 2018). They are the gatekeepers to a sensitive, tailored service for women with significant fear of birth, and such soul-searching could be facilitated by self-reflection via Values Based Reflective Practice (http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4087782/0a49abf1-3524-4894-9302-86a976d8ee44.pdf).

4.8 Challenges to Individualised Care

The NHS is a well-established national treasure providing free care at point of contact. It is however a huge organisation and even at local level it can be difficult to provide truly person-centred care. A consultant maternity unit providing care to anything from 1000 to 8000 women must have some processes and procedures in order that chaos doesn't reign. However, those processes have in the past led to the suggestion that modern maternity care is largely a conveyor belt with mums in babies out, as in the Healthcare Commission Report 'Towards better births: a review of maternity services in England' (2007). Systems and processes need to keep the woman at the centre of everything we do.

Some of the processes have a good evidence base, whilst others are based on opinion of those in positions of power only. When I had my first baby admission bath, perineal shave and enema were still in vogue, and midwives thought this was

actually in women's best interests. By the time I was having baby number two opinion had moved on and as research had now de-bunked these interventions, women no longer had them routinely. That doesn't mean the change across 2 years was easy; just that there was enough power behind the midwives and women who were speaking out against them to change practice.

It can apparently take around 15 years for research to be implemented into clinical practice (Morris et al. 2011) but it can take significantly longer. Many women still lie in bed to birth their babies, are continuously monitored with little or no research evidence to say it is in their best interests. The research behind breathing your baby out versus heaving your baby out was present in the 1980s but there is still a significant variation in the experience of women in relation to coached pushing versus the woman doing what her body is telling her.

In the NHS hierarchy medicine still dominates over other professions and the move towards multi-disciplinary decision-making and shared governance has not been swift. Where there is a lack of robust evidence then unfortunately it's the person who shouts loudest who decides what is done. The majority of documents utilised in maternity services are guidelines but in practice they often become protocols. A protocol is there for safety and must be followed, whereas a guideline is based on what evidence exists but can be adapted depending on individual circumstances and the evolving situation (http://www.wales.nhs.uk/sitesplus/documents/861/Wipp%20Using%20Protocols%2Cstandards%2C%20policies%20and%20guidelines.pdf).

When you have that gut feeling the particular guidance does not serve that woman, connect with it and be brave enough to act on it. There can be no doubt that it takes a substantial amount of courage to go out-with the guidance. If the local guideline is based on that of a national body the situation becomes even scarier as that guidance is what the decision-making, and care will be measured against by regulating bodies or indeed in legal cases.

Women should be partners in decision-making but how often do the health professionals say things like 'we need to induce labour because…' or 'you will not be allowed in the birth centre as you are high risk'. Where is the woman's autonomy in that? Where is informed decision-making and consent or refusal? Some women I have seen say that they cried when they left the booking clinic as in one sentence the doctor and/or midwife had removed them from the decision-making process. This is something that needs to be addressed by helping the health professionals involved become aware of the impact their words can have.

When women feel they are removed from the decision-making process it appears to cause one of the three behaviours; they will conform and are less likely to voice an opinion (most common), they will seek support and assistance via advocacy in order to achieve choice in a specific area of care, and in rare cases may show lack of co-operation and compliance in many areas of their care which may include free birthing. Women who don't speak up often feel they are to blame for not achieving the birth they wanted, women who seek advocacy may not get it, and women who are not engaging with health professionals may find that health professionals disengage with them.

This is not to say that maternity care health professionals are unaffected by this. There are many health professionals who feel constrained by clinical guidance as it

does not lend itself to individuality. They know they will be judged by those guidelines if anything goes wrong; that women sometimes regret their choices later and blame health professionals for not giving them sufficient information. They are afraid that the million to one complication is the one that occurs and information giving tends to be based on risks rather than acknowledging benefits, especially if the benefits are more psychological than physical.

Treating everyone as a 'worst case scenario' becomes the norm and supporting normal physiological birth can be seen as an unattainable goal, magically gifted to the lucky few. Defensive and reactive management can lead to increasing interventions and a self-fulfilling prophecy for staff as well as women that birthing is dangerous and must be controlled (https://www2.gov.scot/resource/0049/00492520.pdf). There is of course fear of litigation too, and emerging research suggests many health professionals are also traumatised by witnessing traumatic births in the context of obstetric or neonatal emergencies and this may change their view of birth and affect their clinical practice (Sheen et al. 2015).

The health professional's recommendations may be based on old knowledge, but they have little time to update. Importantly they may not facilitate the women's informed choice because they are afraid of the reaction of their peers. Tall poppy syndrome tends to result in poppies heads being chopped off!

If we can work with women who have fear of birth during the antenatal period and develop a plan of care which aims to help the woman have the best birth possible it is important that during the intrapartum period this plan of care is respected and if it cannot be achieved, then good explanation must be provided.

4.9 Best Intentions Can Lead to Disaster…

One woman who received a lot of antenatal support and attended hypnobirthing classes felt transformed. She had been considering a planned caesarean but was now looking forward to birth. She went into spontaneous labour but every wish on her detailed care plan remained unmet. There was no good reason for the majority of the omissions but where there was, the staff caring for her changed the plan without successfully involving her in the decision-making process. The erosion of her autonomy started at whether or not the lights should be on in the birth room and ended in a forceps birth with a room full of people which was the woman's worst fear. The physical care was documented very well and followed all relevant guidance. The woman and her birth partner were traumatised and the waves (not ripples) caused by this affected their lives for a long time.

4.10 … But When We Do Well We Are Brilliant!

Another woman received similar antenatal input. She wished a normal birth and desperately didn't want to have medical interventions as she felt she could not cope with the environment and routine assessments of the obstetric unit. Labour did not

come… she waited and waited but no baby. A complication occurred which meant that staff had to recommend induction of labour and the benefits definitely outweighed the risks. The midwife caring for her, her consultant obstetrician, and an understanding anaesthetist were all able to see her and take time to discuss her options. The woman agreed that her plan for normal birth now needed changed but she couldn't face induction of labour and all that may entail. She decided to have a caesarean section. She was well prepared, the staff caring for her knew what her anxieties were, and a midwife and anaesthetist she knew stayed with her during the operation.

So why can't we give care that is more based on the second woman's experience than the first? In an unpublished study a qualitative study by Butcher and Rankin into hypnobirthing's effect on fear of birth the following themes were found:

Fear of loss of control which encompasses

- Loss of control over decisions
- Not being listened too
- Lack of involvement in decision-making/denial of informed choice
- Lack of information or no control over type and volume of information
- Fear of antenatal classes (too much of the 'wrong' information)
- Trapped into having hospital birth
- Being vulnerable (leading to humiliation and embarrassment).

4.11 Place of Birth

The Scottish Maternity Survey (2015) highlighted almost one in four women felt they had received insufficient information in relation to place of birth. Personal discussion with student midwives revealed a lot of good practice with midwives assisting women to make a truly informed choice, but also revealed some less than optimal conversations; 'I take it you will be having your baby at hospital', 'you weren't thinking of having your baby at home where you?' 'you have risk factors so home birth isn't possible'. Perhaps the reason some women are not receiving good quality information and discussion is lack of time. It is not the remit of this chapter to look at the probably far more complex reasons that informed choice in relation to place of birth is often sub-optimal but the fact remains many women still feel that their options are reduced or absent.

It is important that women birth in an environment where they feel physically and psychologically safe wherever that may be. In the past this would have meant home for the majority but with the Peel Report in the 1970s the vast majority of women now birth in hospital regardless of risk assessment. The Birthplace Study (2011) showed that home birth is safe for many women, particularly low risk women who have had a baby before without problems. There is a reduction in interventions during labour and birth without any effect on outcomes for babies. It is interesting however that women who have higher risk pregnancies may also benefit from birthing in areas other than obstetric units, and this needs further investigation. Some

women choose home birth because they wish to birth in a social context outwith a medical environment (no matter how homely we make birth centres they are not home). They may believe that they are more likely to birth easier if they are relaxed and in control (it's their territory not ours). However, some choose home birth due to past birth trauma which may have occurred due to lack of choice, information, or involvement in decision-making. Some have other traumas such as a history of sexual abuse which means they can also limit the number of strangers they are exposed to during labour and birth.

For first time mothers there is a low incidence of adverse outcomes for baby in all environments, but a higher rate in home birth. They have a high transfer rate in labour from home birth (45%), free standing (36%), and alongside midwifery led units (40%). We need more research into why these figures are so high and to ascertain if midwives knowledge skills and level of support in relation to home birth affect transfer rates.

In the woman's home she has total control of her environment and midwives are her guests. In a hospital setting she is in unfamiliar territory, largely receiving care from strangers and does not have the same level of control over who is in her birth room. Although it sounds a simple thing I still hear the very occasional report of staff entering the room without notice. Privacy is crucial and there should be no-one entering without knocking and receiving permission. In her own home the woman can create her favoured birth space by having familiar things beside her. She has access to her music, her clothing, her heating, and lighting. She may also rent a birth pool if she can afford this.

In free-standing and alongside midwifery led units the philosophy is to have rooms as home-like as possible. Dimmed lighting, mood music but not always what the woman wishes, surroundings which facilitate mobility, and birth aids such as mats, bean bags, gym balls, and pools. The woman is encouraged to wear her own clothing. It may be harder for the woman to distract herself during early labour than at home.

There is potential conflict between caring for a woman who has complications and the provision of a physiologically focused birth environment. In the typical obstetric unit, the lighting may be difficult to adjust, and staff may prefer the lights to be full 'in case something happens'. Often the woman is encouraged to wear the hospital gown which is lying on the bed when she arrives. There may be no way to facilitate any music or use of relaxation CDs. The room may have a multitude of medical devises 'in case they are needed', leaving little space for free movement during labour. In addition, most women will have continuous electronic fetal monitoring which may reduce their mobility. The bed may be in the centre of the room which is known to make women more likely to lie down. Birth aids may be few and far between and there may be no birth pool.

In midwifery led settings it is likely that the woman and her birth partner will have one main carer. In the obstetric unit, the nature of medical care usually means that whilst still having one midwife with her the majority of the time, the woman will usually meet the obstetric team of several doctors at least once during labour. If she has an assisted birth, there could be four or five health professionals in the room.

Whilst to a large extent this may be unavoidable, the potential impact on the hormonal cocktail necessary for optimum birth should not be underestimated (Buckley 2011; Uvnas-Moberg 2011).

Some women may choose to reject health professionals completely, and whilst for some this may be due to a belief in their bodies and the normalcy of birth, for others it may be fear of our systems, values, and beliefs (Plested and Kirkham 2016).

4.12 Dealing with Strangers and Vulnerability

The Scottish Government Maternity and Neonatal Strategy 2017 promotes continuity of carer and one of the aims is that 75% of women will be cared for in labour by a midwife they know. Whilst there is debate about whether this is achievable in large NHS maternity units, the philosophy is sound and has been achieved to some degree in Australia (Turienzo et al. 2016). The benefits of continuity of carer are well published but it is only now that it is being taken forward. If the midwife knows the woman she will be more likely to understand her fears and wishes for birth. If she then goes on to care for her in labour, there is increased likelihood that she will try wherever possible to comply with the woman's birth preferences. If difficult choices require to be made, then the midwife/woman relationship is more likely to foster trust.

Labour and birth are intimate experiences when the woman can become vulnerable. Her body can be subject to examinations both external and internal; by people she has just met. These examinations are every day to health professionals but for the woman they can bring feelings of humiliation and embarrassment. This is why there should always be a clear reason for any examination but particularly those of an intimate nature, most commonly vaginal examinations. Just because its 2 pm and last examined 4 hours ago is not a good reason. Worries about progress, epidural in situ so other methods of assessing progression limited may be good reasons. The woman must always be involved in the decision and her privacy and dignity respected as much as possible.

Vulnerability can also arise from the hierarchical nature of maternity units and the positional power of health professionals. Whilst some women are happy for staff to guide them and sometimes make decisions for them, many feel it is difficult to voice their wishes when they appear to be contrary to what the health professionals feel is best.

When women come to our service we ask them to share with us very intimate information despite only having met her minutes before: when was your last period, was this pregnancy planned, have you any vaginal discharge? Can you please lift your t-shirt so that I can examine your abdomen? Some of us still anticipate that is you say that the woman 'needs' a vaginal exam or a speculum exam the woman should comply automatically. She may never have had either of those before, and the idea is unlikely to be met with enthusiasm. Exposing the most intimate part of your body to someone you just met is bad enough if you have met them before or had at least some time to get to know them.

A woman told me recently that even though she was a survivor of sexual abuse and had requested female staff wherever possible, a male doctor was sent to do an abdominal examination. It is not always intimate examinations that are problematic; it can be any body contact depending on the nature of abuse. A midwife told her that she had to get used to vaginal examinations as that's what happens when you are in labour and she was going to be a mum soon so she should toughen up.

Looking at women's bodies is part of our role; it is our day to day professional existence, but how awful is it that we forget the impact of those examinations on the women. As a teenager having my first baby in 1980 I was told 'you leave your dignity at the door when you are having a baby'; so sad that in 2018 it sometimes feels that little has changed.

Women often relate that is was really hard or impossible to say no to examinations. Our professional power remains huge, with doctors still having a higher influence than midwives. Women often say they were frightened to say no to a procedure because if the doctor said it was the best thing, then they must be right… they wouldn't want to put their baby at risk. The examination could be absolutely crucial to care planning where labour is not proceeding normally, but what if it's just to tick a box, or 'just in case'.

Maternity care professionals need to understand the thin line we tread between trust and distrust, between confidence and fear, between system driven care, and care that puts women truly at the centre.

4.13 Poor Care

Sadly, maternity healthcare professionals sometimes make mistakes and public confidence in maternity services has been rocked by adverse publicity on television and newspapers. To err is human but in our line of work it can be damaging mentally and physically to women, babies, and families. The sad outcomes of a lack of team working resulting in lives lost was very well publicised after the Morecambe Bay Report was published (Kirkup 2015). Even though national audit suggests the majority of women are happy with their care memories of negative stories seem to take a firmer root in our minds.

Whilst it is clearly crucial that we monitor care standards and put our hands up if errors in care have been made the good care we give can be forgotten. Women have the right to informally and formally complain about care which may be substandard but feelings of being let down carry forward into subsequent births. It may be hard to present for care to a unit or service that has provided substandard care to you or someone close to you in the past. Trust is a powerful thing but very difficult to recover once it is lost. The fear in these cases is not necessarily fear of birth but fear of us.

All maternity care should be of a high standard and this should be the case for both physical and psychological care. This is likely to be the key between difficult birth with good psychological care potentially having no lasting birth trauma, whilst quick birth with poor communication may result in birth trauma. The importance of

making sure communication is optimal and that women are fully involved in the decision-making process is paramount.

The end result of a healthy mum and baby is crucially important… but it is not all that matters. The destination is important but having the right destination after a terrible journey can leave women psychologically bereft, as highlighted by Positive Birth Movement's Milli Hill (https://www.positivebirthmovement.org/eregrgrtg/).

4.14 Survivors of Sexual Abuse

One in four women will have experienced some form of sexual abuse, in Scotland that's around 15,000 of those who give birth each year. Some will have lifetime traumatic effects, and some will think they have put the abuse behind them. However, for many the pregnancy and pending birth reopens the past and there is significant potential for these women to be retraumatised (Garrat 2011). Some may find they sail through pregnancy and birth, whilst for others each day may be a challenge. Their bodies which were once violated are once again exposed. From the first abdominal examination women can fear the maternity care system. Exposing her abdomen may be thought of as non-threatening but what about the woman's perspective. She logically knows that an examination may be necessary for her and her baby's physical wellbeing. The health professional will probably ask for consent, but it may be assumed; she tenses or looks uncomfortable, but you continue. They then recommend a vaginal examination, or even say it must be done, and she complies but becomes very distressed. Her baby is going to be born soon but as his head crowns she becomes very upset and thrashes about the bed. This kind of story may be sadly familiar.

Only 50% of women ever disclose to anyone in their lifetime so every day we are caring for survivors blind. The majority of maternity units don't make routine enquiry into sexual abuse even though the majority of women who have been sexually abused would prefer that we did. Disclosure is unlikely where there is no continuity of carer, when health professionals appear too busy, appear dismissive of other concerns, or time is short. Therefore, universal precautions are needed to minimise the risk of trauma; all women should be treated the same in this respect. Ensure privacy, ensure dignity, ensure consent for all contact, ensure you ask about everything… don't just assume. There are many potential triggers to past trauma in maternity care, from having your blood pressure taken to a forceps birth.

All maternity health professionals should be trained in caring for survivors of sexual abuse; ignorance is no excuse. NHS Education Scotland provides such training via their one out of four e-learning module and materials which can be used in face to face classes (https://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/maternity-care/about-us/maternal-health-resources/sexual-abuse.aspx). However, anecdotal evidence would suggest that such training is relatively rare.

A woman who was a survivor was admitted in possible preterm labour which in itself may be a consequence of sexual trauma (Wosu et al. 2015). She had a vaginal examination as she knew this was important to assess whether or not labour was well underway. The next day, and clearly not in established labour the doctor asked to check her cervix again. The woman declined. The doctor emphasised that the

examination must be done as it was hospital policy. The woman advised that the benefit of the doctor finding out her cervix was unchanged was nothing in comparison to her psychological risk of having another examination. The resulting conversation apparently was so difficult the woman was distraught as all the trust she had in those caring for her to do the right thing had just dissolved. The doctor no doubt was also concerned she would be pulled up due to her omission. The woman was willing to take on board the risk she could be unknowingly going into labour, but the doctor didn't want the risk of not adhering to the guideline. The psychological risk of that particular examination was far higher for that woman than the remote possibility she was in labour. A culture change is needed which will come from listening to women's voices.

I have come across health professionals albeit few who have no compassion for survivors, feeling that the problem can't be that big as 'she must have had sex to get pregnant'. The majority wish to provide the best psychological care possible but their professional need to know more about her physical condition can be in conflict with this.

Around 1 in 12 women attending the birth reflections clinic is a survivor, most commonly of childhood sexual abuse by a relative. If they disclose it is easier to find out what they need personally. I can go through labour and birth, explaining the physical aspects of care, and asking if any of that worries them. Vaginal examination certainly is the most common concern but there are many other issues; ultrasound gel on abdomen in a darkened room behind a closed door, positions for labour and birth, and skin to skin contact immediately at birth are a few.

Probably four in five will opt for a caesarean but it should be their decision based on their physical and psychological safety, after they have had all the relevant information and time to think about it. Even with caesarean, they may feel vulnerable as they will be unable to move from the top of their abdomen down due to a spinal anaesthetic. They have an intravenous infusion in one arm and a blood pressure cuff on another. The insertion of a urinary catheter is likely to be an issue, but it may help if this is done in 1:1 before entering theatre rather than insertion whilst other staff are present. After birth women tend to prefer to have their underwear on and this should not be delayed by sanitary pad checks… the pad can be checked with pants on. Some women prefer only female attendees but don't assume that; be honest on what you can and cannot achieve. For example, it may be possible to provide female carers during office hours, but not at 2 am in the morning.

4.15 Interventions Which May Help Reduce Fear of Birth

Hopefully I have demonstrated that antenatal discussion is integral in assisting women to try and overcome their fears. The components of this can be summarised as:

- Active listening to worries and fears and where relevant reviewing past birth experiences
- Providing information on pregnancy, labour, and birth

- Agreeing with the woman a plan of care which may help her to look forward to birth, handing power over to her to make her own choices, and say no when required
- Advocacy where the woman's informed choices are against the maternity norm

The overarching aim is to help the woman have the best birth for her even when it isn't necessarily a normal birth. It is important to consider the evidence behind a range of interventions which may assist the woman to have the best birth possible.

Larsson et al. (2019) found that a clinic service on its own can be empowers, instil confidence and help facilitate positive birth experiences. We are indeed fortunate in our area as we have a birth reflections service; the clinic does not stand in isolation. The holistic clinic provides complementary therapies for women who are having stressful pregnancies, facilitating relaxation and calm. This opportunity for some 'me time' can give them the space to think through their options and provides additional midwifery support. We also offer hypnobirthing classes to women with very significant fear of birth and have close links with the perinatal mental health service; taking and sending referrals.

A small Turkish study by Isbir et al. (2016) incorporated hypnobirthing techniques and Dick-Read principles into 16 hours of antenatal education and found that women felt more in control, had less fear and less PTSD. Even where resources are restricted Fenwick et al. (2015) demonstrated that two telephone calls of 1 hour duration can potentially reduce the incidence of caesarean section and flashbacks. The addition of a decision aid booklet reduced fear and increased confidence (Toohill et al. 2014).

Although Madden et al. (2016) highlight that more good quality research is needed into the use of hypnosis there is a possibility that hypnobirthing may reduce the woman's fears and help her psychological wellbeing during pregnancy. Hypnosis can be described as a natural state when the conscious mind takes the back seat and the sub-conscious takes over (Howell 2012) and the altered state may assist women to cope with pain during labour and lead to lower levels of medication. There are several models which are based on the work of Dr. Grantley Dick-Read who hypothesised that fear of birth results in 'Fear Tension Pain' cycle; adrenalin levels are inappropriately high taking blood supply away from the uterus to provide a potential 'fight or flight' response. This could precipitate more pain, lower endorphin levels (natural pain killers), and in turn increase pain resulting in more fear (Dick-Read 2004). This could perhaps result in a sub-optimal birth process increase with a cascade of intervention and a negative birth experience (the self-fulfilling prophecy).

The SHIP study (Downe et al. 2015) did demonstrate that even a small amount of hypnobirthing can reduce fear and thus help the woman be in a better place psychologically for giving birth. Sadly, the media only reported on the fact there was no significant reduction in epidural use, and somewhat missed the point that reducing fear has the potential to make for a more positive birth experience with less chance of trauma. The woman may have faced labour albeit with an epidural rather than requesting a planned caesarean or ending up with one as the final point of a cascade

of interventions arising from their fear and its effect on the hormones of labour and birth. She has been empowered.

So, we need to look wider and consider other outcomes. It won't work for everyone, it may still be seen as 'hippyish' and 'new age' therefore not likely to work. If the fear has been present for many years, sometimes decades, it also may not work, but for many normalising birth and the facilitation of coping mechanisms can see them through whatever lies in store (Fyfe et al. 2012).

In 2016, 34 women attended the clinic primarily seeking caesarean section; all had significant fear of birth. Eight women had a caesarean section due to fear in the end. Reducing the caesarean section rate can save money but importantly avoids a medically unnecessary caesarean. We are continuously auditing the service to ascertain if the woman feels that she made the right choice.

In an as yet unpublished study by Butcher and Rankin into the qualitative experience of women who have fear of birth attending hypnobirthing one quote sums out the potentially transformative effects working with women to help them achieve a better birth can have: 'I would describe last time as being in a dark room with a massive storm cloud over me…this time I feel like I am in a rainbow with blue skies; I am outside and have this freedom'.

4.16 Birth Preferences

It is not only helpful to make a realistic birth plan but also to consider who needs to know about it. In short this is anyone who may be participating in the woman's care from triage assessment until the birth itself and beyond. Best Start (2017) has recognised that there are issues when birth planning is only discussed once in late pregnancy, particularly as so many women are still working. It calls for birth to be discussed across pregnancy, and that these discussions should include postnatal care and discharge planning. For those who have one completed there is a suggestion that not all are read by the midwives caring for them during labour and birth. There may be little or no reflection after the birth on whether the hopes and wishes of the woman contained in the birth plan have been met; and if not, why not?

There are many barriers to birth plan completion and whilst lack of time is an obvious one, the fact many women work into very late pregnancy may be another. This may be the last chance to provide information on choices and pick up on any choices which may not be available locally, or which may not be recommended in the woman's individual circumstances. Discussion should be undertaken regularly during pregnancy and not just left to an 11th hour clinic appointment where pressure may be on the woman and the midwife in terms of time constraints.

If the woman is anticipating a water birth and then discovers when in hospital that she doesn't meet the criteria, then this may negatively impact on the rest of her labour and birth. Whereas if the woman is aware of this in the antenatal period she can be assisted to make an informed choice on whether or not she should birth in the midwifery unit. Depending on a risk assessment care may be given as standard or an individualised plan for that woman developed. Midwifery staff may require

additional information, education, and support if it is outwith their usual remit, and the woman must be aware of what staff can and cannot do in the particular birth environment whether it is at home, in a free-standing birth unit, or an alongside midwifery unit. It should be remembered that women who are low risk may choose obstetric led care and her informed choice should be respected.

It is possible with good discussion, active listening, preparation, and staff engagement with the woman and her birth preferences that birth can be a very positive experience. For women who have had a previous traumatic birth a positive birth experience can help heal and empower (Beck et al. 2013). Perinatal mental health is likely to be improved and the wellbeing of the woman, baby, and family enhanced.

4.17 Conclusion

This chapter has explored a little of the impact significant fear of birth can have on the woman, but also the opportunities and challenges for maternity services in trying to provide the best possible care. Society itself however needs to review how media and birth conversations affect young women, but health professionals must learn from women and their stories. We have a chance to help turn what seems to be a relentless tide of fear around by investing in women themselves, by providing time for full discussion, careful planning, and the provision of support and assistance to help overcome the fear.

> The basic intention in any caring, physical or psychological, is to alleviate suffering. But in relation to the symptom itself, observance means first of all listening and looking carefully at what is being revealed in the suffering. An intent to heal can get in the way of seeing. (Thomas Moore, Care of the Soul: Guide for Cultivating Depth and Sacredness in Everyday Life).

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Gathering Storm–Birth in the Media

5

Tracey Cooper and Laura Godfrey-Isaacs

> We must attempt to tell the whole truth about birth, the truth that includes the transformation, mastery, satisfaction, personal power and the difference between pain and suffering. (Van Hoover [2013])

5.1 Introduction

In August 2017, a storm of media 'stories' raged about birth in the UK. Had the Royal College of Midwives (RCM) dropped the use of the term 'normal birth' (Guardian 2017) despite the fact that normal birth is universally used to define a midwife's scope of practice? (ICM 2005; Lancet 2014). Were midwives peddling a 'cult of normal birth' to the detriment of women and baby's safety? Even though the debate about 'normal birth' has died down, it remains on the 'endangered list' (Dahlen 2010), and the contested subject of birth remains a hot topic of media attention. Subsequently, how birth is depicted in the media continues to be a major concern and subject of research and study for midwives and those in the birth world.

We patently live in 'an electronic age' where unprecedented media representations of birth 'converge' in a global digital environment (Marien 2006). These include hugely popular television programmes such as 'One Born Every Minute' (OBEM), big budget Hollywood pregnancy romcom films like 'The Back-up Plan' (2010) and a proliferation of websites, mobile phone apps and social media platforms.

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However, do the depictions we see correspond to our own experiences as women and midwives? When Laura was working as a student midwife a woman she was looking after, who had a BBA (born before arrival) or unplanned home birth, noted that she did not think herself in established labour. In birth programmes she watched the women were screaming so much, which was not matching her own experience, that she ended up having the baby unexpectedly at home, after which she commented 'it wasn't that bad!'.

Lesley Page, former President of the RCM, writing in her editorial 'Birth in the Bright Lights' (British Journal of Midwifery 2013) suggests how she would like to see modern birth as 'not just a scene in a hospital labour ward, but the start of life and the family'.

5.2 How Pervasive Is the Media?

In the American 'Listening to Mother's' report (2013), 82% of first-time mothers accessed media content related to their pregnancy weekly (Childbirth Connections 2013). Similarly, an international survey in 24 countries reported that women used the internet more than ten times during their pregnancy (Langan et al. 2010) and, in the UK, the average time delay for pictures of newborns to be posted onto Social Media was only 56 min (Merz 2013). Furthermore, this trend in 'health-seeking' behaviour is identified in a recent European survey where it was found that 71% of internet use was for this purpose alone (Higgins et al. 2011).

In response to widespread media use by service users, recommendations suggest that Health Care Professionals (HCP's) should readily acknowledge health-seeking behaviour, discuss findings, guide to trusted sources of information, as well as recognise the shifting power balance this engenders (Higgins et al. 2011; Sayakhot and Carolan-Olah 2016). Within maternity, The National Maternity Review (2016) suggests that every woman should have access to a personalised Comprehensive Digital Tool that includes content from public, private and third-sector organisations, which can guide women to (trusted) sources of information, and provide a medium for peer-to-peer support.

Midwives are the key HCP's who work with women in preparation for birth (International Confederation of Midwives (ICM) 2016) and UK midwifery policy and guidelines (Department of Health (DOH) 2004, 2007, 2010; The National Institute for Health and Care Excellence (NICE 2017)) widely promotes the idea of 'woman-centered care, and informed decision-making', which actively encourages partnership working between women, health care professionals and policy makers. Similarly, The Code (NMC 2015b) and Midwifery Standards (Nursing and Midwifery Council (NMC) 2009) outline midwives' professional responsibility, stress the importance of partnership working, communication and the ability to recognise and respect the contribution people make to their own health.

Therefore, with this ubiquitous use and plethora of media images about birth, where 'Birth stories are everywhere and nowhere' (Pollock 1999), it is highly pertinent to explore the messages promoted through these multiple representations,

some fictional and some 'real', and to talk to women about the possible affects this has on their birth expectations and experiences. Also, to consider how women, preparing for birth, and midwives supporting them negotiate this territory of 'real world image-making as political' (Hooks 1994), in order to empower partnership working, informed decision-making and ultimately increase women's autonomy and agency in birth.

5.3 Definition of, and Theories of, 'The Media'

The media is defined as: 'The main means of mass communication (broadcasting, publishing and the Internet) regarded collectively' (English Dictionaries 2018). It has a threefold function: to provide information, to campaign as the 'Fourth Estate' and to provide entertainment (Hundley et al. 2014). However, Herman and Chomsky (1994) also suggest: 'It is their function to inculcate individuals with the values, beliefs, and codes of behaviour that will integrate them into the institutional structures of the larger society'.

Media theory is diverse and complex, from its inception with the 'hypodermic needle' effect, which implies audiences are passive receptors of media messages, to recent 'new audience research' that suggests audiences interpret media texts according to their own individual, social and cultural context (Williams 2003).

Feminist challenges to the 'hypodermic needle effect' include 'Reception Theorists' such as Ang (1985) and Hobson (1982) who carried out research into soap opera narratives. They noted the pleasure women took in 'facilitated fantasy', and their ability to apply this to their everyday life, as well as constructing meanings that often subverted the overly patriarchal and 'encoded' messages inherent in the narrative. Parallels could be drawn with feminist analysis of birth dramas (Morris and McInerney 2010), where media textural messages strongly suggest dominant cultural narratives which can be seen to oppress and disempower women (Hesse-Biber 2014); however, women may also take pleasure in these dramas, whilst constructing their own interpretations and meanings.

Media texts can be polysemic, open to multiple readings (Klein 2007); however, as Hooks (1996) in her seminal analysis 'Reel to Real: race, sex and class at the movies' is quick to point out that even 'resisting spectators' are usually seduced into dominant narratives and images 'have power over us, and we have no power over them'.

5.4 Dominant Media Messages About Birth

We will all experience a 'media-informed' birth wrote Fleming et al. (2014), with information that is 'fragmented, weakly linked and poorly referenced' which highlights the responsibility the media has to portray birth in a balanced way, as most women will not witness birth prior to their own labour. Through our extensive research and experience of midwifery practice, it is evident that media portrayals of childbirth, breastfeeding and motherhood are pervasive and highly influential. These images can set up a discourse where dominant media narratives around birth

negatively effects women, midwives and the wider birth world's expectations, experiences and understandings of birth.

The first and perhaps most pervasive idea is that birth is predominantly about 'fear, speed, pain and danger' explored by Elson (2009) in her study 'Mass Media versus the real thing'. Here we see birth depicted in countless films and TV shows as an emergency event with 'women as powerless, physicians in control and technology as the saving grace for women's imperfect bodies' as observed by Morris and McInerney (2010) in their analysis of reality TV shows in the USA.

Secondly, we see an emphasis on medicalised birth as the norm, satirised by Monty Python in 'The Miracle of Birth' way back in the 1980s with their parody of a CS and the machine that goes 'ping'. This, as Sheila Kitzinger (2001), the famous social anthropologist, suggested, normalises the medical narrative and encourages women to 'submit' to the potential scenario. A view also borne out by recent research on OBEM, from Benedictis et al. (2018), shows the 'dominance of the medical model of birth that overwhelmingly represents women as passive subjects, visualized through representations of women on their backs, with limited if any input in decision-making during labour'.

Thirdly, we see women's autonomy and agency in birth diminished, dismissed or ridiculed, with media texts tending to promote dominant social constructs around femininity with 'the good woman' and by extension the 'good obstetric patient', identified by Williams and Fahy (2004) being highly valued. The implication therefore is that women should 'do as they are told' within a medical paradigm, and not question or have their own choices taken into consideration. In addition, partners (nearly always men) are often cast as the hapless and comedic figure, who similarly should remain unquestioning and compliant.

Finally, we come to the depiction of midwifery, which is often absent from the representations of birth, unless as an historical, harmless, bicycle-riding nostalgic figure such as in 'Call the Midwife' or as 'the bad guy', in distinct contrast to the heroic medical figure. In an analysis of newspaper reporting of adverse birth outcomes, Bick (2010) describes how 'experts' are used to analyse negative outcomes in a highly selective way, are rarely midwives and seldom proffer a balanced view. Furthermore, vilification of midwives and their singling out selectively from reports is commonplace, as this headline from the Daily Mail (Borland 2011) exposes: 'If you don't hurry up I will cut you-what one woman was told at NHS Trust where five died.'

Therefore, the depiction of birth as a dangerous event which should not be left in the hands of midwives, and the vilification of midwives for their support of 'normal birth' could be seen to be part of a long-standing media narrative, which seems to have reached a height recently.

5.5 Analysis of Media Images of Birth

Whilst, in the first part of the twentieth-century pregnancy and birth was only suggested in the media, with film and TV not explicitly naming it—for example in A Streetcar Named Desire (1951), by Tennessee Williams, directed by Elia Kazan and

starring Vivien Leigh and Marlon Brando, in the second half of the century it appeared in all genres.

Many themes have emerged in mainstream films such as pregnancy horror epitomised by Rosemary's Baby with Mia Farrow, directed by Roman Polanski, and then later in sci-fi such as Aliens directed by Ridley Scott. Another familiar genre is The Momcom (or pregnancy romcom) such as 'The Back-up Plan' (2010), 'Knocked up' (2007) and 'Baby on Board' (2009). It is widely thought that Demi Moore's naked pregnant photo 'More on Moore' by Annie Leibowitz for Vanity Fair Magazine (1991) initiated a time where pregnancy was connected with 'glamour and desirability' (Hanson 2004) which ushered in a whole new genre of pregnancy Romcom films and other representations in the mainstream media.

Similarly, the first birth was only shown on British TV in 1957, variously described as 'revolting' and 'tasteless', whereas content analysis of American soap operas as far back as 1988 represented eight times the national pregnancy average, and BBC portrayals in 1993 showed a birth every 4 days (Clement 1997). Fast forward to 2018 and we are used to numerous television programmes and a proliferation of images and portrayals on the internet and social media, from 'YouTube births' and documentaries, to campaigns and commercial projects, with birth seemingly ubiquitous in the media.

Substantial content analysis (Morris and McInerney 2010) and opinion of reality birth programmes suggest that they reinforce and normalise the medical model of childbirth, increase fear and provide few positive examples of the midwifery or social model of birth (Lukasse et al. 2014). This can be seen in many mainstream film representations too, where the narrative often elevates the obstetric discourse and implies that women should fear birth and expect to be assisted with medical intervention, and that 'natural' childbirth is an unrealistic expectation.

> Understanding the content of these depictions is critical because women's attitudes and behaviour during pregnancy and birth are guided by gendered norms of expression, which are often taken from institutions such as the media. (Morris and McInerney 2010)

Feminist scholars such as Camilla. A Sears and Rebecca Godderis (2011) in their analysis of birth in reality TV in America suggest that these shows use 'personal history as spectacle' and 'lifestyle surveillance' to both dramatise birth as well as seek to control women's bodies. They also noted the reinforcement of social norms, by predominantly portraying Caucasian, married, heterosexual, able-bodied and economically secure women with little diversity. Furthermore, medicalisation of birth is reinforced as the norm, with the predominant hospital setting and non-problematicised medical interventions as the essential part of the birth experience.

Birth in television programmes usually emphasises a rush to the hospital at the sign of the first contraction and promotes epidural and caesarean section as being the 'normal experience'. In the majority of 'situation comedies' birth is presented as an emergency, from which, women and babies are only able to be rescued by doctors (Kitzinger 2005; Lothian and Grauer 2003). This conflicts with the autonomous role of the midwife and questions who is informing the programme makers about the role of the midwife. In these programmes if they have a normal birth the baby is

usually 'delivered' by a doctor, in reality a midwife is the senior person in the room at 68% of births in the UK (RCM 2000). If women view the doctor as 'delivering their baby' as a normal event from the perceptions these programmes project, then they may be surprised or disappointed that it is the midwife who helps facilitate them giving birth.

There has also been an explosion in magazines and websites relating to childbirth stories or issues in pregnancy and birth, and some are based solely on parenting and pregnancy, for example Made for Mums (2018). Many of these magazines base their photographs on the image of the 'Madonna', resting her hands on her abdomen showing concern for her baby, looking down at her abdomen expectantly or her head tilted slightly towards the camera. Through these images of pregnancy, the woman is defined as a 'real' woman and expected to find motherhood an overwhelmingly rewarding and enjoyable experience (Kent 2003). Williams and Fahy (2004) looked at how women had been influenced by women's magazines in Australia. They found that women viewed them as trustworthy, informative and were a primary source of information for them. They found that the interests of medicine were well supported within them. They found women viewed ventouse extraction as virtually a normal birth, categorising intervention as a normal physiological process. One of the women was portrayed as a role model for others whose compliance with medical 'orders' promised a pain-free birth and a healthy baby, signifying the cultural promotion of the idea that medicine should be in control of normal childbearing. How women view images of birth and pregnancy may colour their own expectations of childbirth. As discussed above, the media can be an influential source of knowledge for women, so it is important to find out if this knowledge has had any effect on how they perceive the role of the midwife.

Betterton (1996) suggests that the Benetton advertisement in the early 1990s showed the newborn baby apparently still joined to its mother, with the cord still appearing attached to her. This vision was thought to be controversial at the time and would still be now. It destroyed the accepted view of individual bodies being separate from each other. Bodies in the media are perceived as being disembodied.

Betterton says: 'The image represented Kristeva's (1982) idea of the horrific by collapsing the border between inside and outside, self and other, unsettling bodily boundaries and threatening identity' (Betterton 1996). The beauty of the attachment is overlooked, the mother and baby being attached to each other is a visual power of commitment and support to each other, which will never be broken and the baby is fresh from birth, which challenges normal imagery seen. Media images do not show women's breasts leaking breastmilk, very rarely breastfeeding or menstruating, therefore hiding women's normal physiological and biological functions.

The photograph of Demi Moore in Vanity Fair (1991) depicting her nude and pregnant body challenged socially constructed notions of how pregnant women's bodies should be portrayed. This challenged the 'Madonna' picture ideal as it viewed the pregnant body in a sexual way, having pride in her pregnant body (Stewart 2004). More recently other celebrity women such as Beyonce have followed, using the media to help breakdown traditional images of pregnancy (Farmer and Parker 2017).

5.6 Birth Is Not Porn

Ironically, many powerful images of childbirth posted by mothers, artists and organisations that advocate for women are being censored on social media, and labelled as 'porn'.

During World Breastfeeding Week (2018), brelfies (selfies of women breastfeeding) were posted by Laura referencing the #kingsbrelfie (2017) campaign which was run at King's College Hospital in 2017. As a result, she was banned from Facebook for 3 days. Another midwife, Hannah Tizard, was also censored after posting a compelling image of a woman squirting milk from her breast. Moreover, stories have emerged of images of birth, from the Birth Rites Collection (2018) (the largest collection of birth art in Europe) at King's College London, being removed or censored as people saw them as pornographic.

These are not isolated incidents, as The Positive Birth Movement similarly had pictures of birth removed from Facebook back in 2014, and Milli Hill, founder, wrote a robust indictment of the practice in the Guardian (Hill 2014).

Representations of birth and breastfeeding, posted by women, artists, activists and birth organisations really started to explode on the internet and social media environment with the introduction of the Web 2.0 environment around 2004. This allows users to create, interact and share content, for purposes of collaboration, activism and support and also to challenge mainstream media. There has subsequently been a proliferation of sites such as Mumsnet as well as platforms such as Facebook, MySpace, Twitter, YouTube, Instagram, Tumblr and Pinterest (Hesse-Biber 2014). These forms of media content often provide a platform to refute and critically analyse mainstream media representations of birth, such as The Positive Birth Movement (2018a) and Tell Me a Good Birth Story (2015). They also enable women to organise campaign groups such as One Born Every Minute – the Truth (2015).

However, a survey of YouTube birth videos, posted by individuals, found they still tended to reinforce cultural norms, mostly featuring white, nuclear families and perpetuated myths around the 'good or ideal' mother and medicalised birth (Longhurst 2009). In addition, censorship on YouTube is mostly of vaginal or home births, as one commentator expressed: 'I am soooooo tired of beautiful birth presentations being removed off of YouTube for a violation of service! What's with the keeping birth from women?!' (BellyBelly 2018).

It seems therefore that if birth is portrayed in a tightly controlled way that complies with the dominant cultural and media narrative, as a dangerous, painful and medical process, then it is 'acceptable'. However, if it is rendered outside of this, i.e. as a psychosocial, ecstatic experience or conducted at home or under women's own control, then it is deemed unacceptable, and could be censored. It is noteworthy that the image in the Birth Rites Collection (2018) that causes the most consternation is 'Terese in Ecstatic Birth' by Hermione Wiltshire, an image taken from Ina May Gaskin's (2018) archive, which depicts a woman in the throes of an ecstatic birth, the baby crowning and a community of woman around her in support.

Furthermore, censorship of images created by women of their own breasts and bodies, whether as mothers, artists or activists, exposes the irony of a commercial culture saturated with commodified images of women's bodies used for advertising, entertainment and pornography, whilst denying women's own expression.

In this regard, one only has to look at the explosion of internet porn, including birth and milk porn, to surmise that images created by women themselves that challenge a dominant narrative around women's bodies being controlled by and in service to men's and the market's needs are the ones that are censored.

Several campaigns have addressed this and other double standards. Notably, free the nipple, a 'top freedom' campaign, started in (2012) by filmmaker Lina Esco in New York, which has also been co-opted to fight breastfeeding shaming. She created a documentary of herself running through the streets of New York topless. As the documentary was being made, she posted teaser clips with the hashtag #FreeTheNipple (2018). In 2013, Facebook removed these clips from its website for violating its guidelines. In 2014, several celebrities such as Miley Cyrus and Rihanna posted photos on social media to show their support of Esco's initiative.

More hard-core and explicitly political are Femen (2018), a Ukrainian radical feminist activist group who have become internationally known for organising topless protests against sex tourism, religious institutions, sexism, homophobia and other social, national and international topics. Founded in Ukraine, the group is now based in Paris. The organisation describes itself as 'fighting patriarchy in its three manifestations – sexual exploitation of women, dictatorship and religion' and has stated that its goal is 'sextremism serving to protect women's rights'. Femen activists have been regularly detained by police in response to their protests.

Other campaigning groups such as Pussy Riot (2018), the Russian radical feminist, post-punk group, regularly stage interventions and protests and their graphic song and video 'Straight Outta Vagina' is a triumphant ode to the vagina and women's bodily autonomy.

Some of the images that triggered the Facebook ban were also created by artists—such as Venezuelan Argelia Riot (2018). Her image depicts a row of topless women breastfeeding, whilst wearing balaclavas—a deliberate strategy to conflate the rights of mothers to breastfeed with a political action. Here we also see a playing out of the struggle between the way women's bodies have historically been portrayed in art, as the 'subject' of the male gaze, and women artists' reclaiming of their own subjective experience—a phenomena initiated by feminist artists from the 1960s onwards.

There are similar parallels with the medical gaze. A model that tends to truncate, dismember and pathologise birthing bodies, reducing them to mechanical features such as 'the passage, the passenger and the powers'. This does not represent the experience of women giving birth, nor encourage a recognition of their bodily autonomy. A recent awareness of this was expressed by the outrage felt by many midwifery conference-goers who, when seeing female simulation models exposed and displayed, felt it mimicked similar disrespectful behaviour in the birth room. The medical paradigm is culturally dominant and seeps into our consciousness, determining which images of birth are deemed welcome, and which are not.

Table 5.1 NHS Digital

	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017	2017–2018
Induction (%)		23.3	25	26.8	27.9	29.4	32.6
Normal birth (%)	62	61.7	60.9	60.4	60	59.4	58
Instrumental birth (%)	12	12.8	12.8	13	12.9	12.7	12.5
Caesarean section (%)	25	26.2	26.2	26.5	27	27.8	28.8

The CS rate in England increased by 3.8–28.8% in 2017–2018 compared to 2012 and the Induction of Labour (IOL) became 9.3% higher (NHS Digital 2018).

5.7 Evidence

This portrayal of birth is happening at a time where we have the most evidence we have ever had to support birth for women and babies who are healthy in midwifery-led environments, which supports the normal physiological function of a woman's body (NICE 2017). In the UK, we have escalating figures which show increasing interventions year on year (Table 5.1).

Based on the latest WHO systematic reviews, increases in caesarean section rates up to 10–15% are associated with decreases in maternal, neonatal and infant mortality. Above this level, increasing the rate of caesarean section is no longer associated with reduced mortality. As caesarean section rates increased above 10% and up to 30%, no effect on mortality rates was observed; rates were adjusted according to socioeconomic development of each country (WHO 2015).

Evidence points to physiological normal birth as the safest and best option for women and babies, providing there are no complications and weaving normality into care for those who do need intervention has many benefits (Brocklehurst et al. 2011). This includes physical, psychological and social understandings of safety, and optimal outcomes.

5.8 The Safety Agenda

We live in a 'risk adverse' society, which tends to focus on avoiding physical risks, without considering psychological or social risks (Coxon et al. 2013). Pregnancy and childbirth have been brought into this culture which, according to Illich (1976, p. 267), has led to the 'Medicalisation of all life stages to monitor the body and control 'deviant' behaviour'. Therefore, as De Vries argues 'Professional groups gain control by 'creating' risk', they do this by emphasising risk, and redefining life events as 'risky'.

For example, the highly significant Morecombe Bay Report (Kirkup 2015) designed to investigate the tragic death of babies in the Trust's care, over many years, identified three main problems: system failures, lack of multidisciplinary

working and respect for each other's professional roles. However, following publication, the media primarily focused on a comment made in the report stating that a philosophy of promoting 'normal birth at any cost' was present, which ignored the main issues stated above. Silverman (2017) stated in The Telegraph: 'Experts said a "cult-like fixation" on "normal birth" by midwives, with doctors excluded from the delivery room, even when needed had fuelled errors and record negligence claims, and a fierce debate raged on these shores and beyond'. Therefore, it could be argued that media narratives of safety, particularly around 'normal birth', were escalated, and have driven a safety agenda, based around promoting the medicalisation of birth and challenging midwifery care.

Glaser (2015) in The Guardian stated: 'To learn that the rationale behind midwife-led units will now be scrutinised in a review of NHS England's maternity services is to hear the screeching of brakes on the juggernaut that is childbirth ideology'.

This suggests that midwifery-led care and midwifery-led units are to blame for the failings at Morecombe Bay. Interestingly, there were no midwifery-led units at Morecombe Bay Hospitals during the period of time the Morecombe Bay report covered. Women and babies were cared for in an Obstetric Unit, with immediate access to obstetric, anaesthetic and paediatric medical staff. The reporter clearly indicates midwifery-led units and childbirth 'ideology' are to blame for the problems experienced at Morecombe Bay. Conversely, the NHS England review of maternity services supported midwifery-led care and midwifery-led units in its Better Births Report (NHS England 2016), as they provide better outcomes and are safer for women and babies that are healthy (NICE 2017). There was also a ridiculing of the Normal Birth Campaign (RCM) in The Times by Smyth (2017) analysing how the 'cult of normal' became mainstream. The language chosen and used is so dark and disturbing; it is more attributed to a horror movie, a clear agenda to instil fear and mistrust in midwives and birthing normally.

The media's influence on health behaviour has also been recognised by the Department of Health (DOH 2014), with a recent paper 'The Power of Information' and by the NHS (2015), with the online 'Behind the Headlines' initiative, which helps the public unpack recent media health stories. Journalists working in the media have a Code of Ethics (Media, Entertainment and Arts Alliance 2015); however, the recent Leveson Enquiry (2012) questioned the impartiality of the British Press with calls for new published guidelines for policy and regulation, which could further encourage the public to critically question 'birth stories'.

5.9 Research Studies About the Influence of Media on Women

Few research studies that use rigorous quantitative or qualitative methods to explore women's use of the media in relation to birth are found. Nonetheless, analysis of four show results that reinforce the idea of women experiencing a 'media-informed' birth (Fleming et al. 2014; Langan et al. 2010; Martin et al. 2013). A large-scale international survey found 94% of participant women used the internet to

supplement information already obtained from health professionals, 83% used it to influence decision-making about their pregnancy and 63% used information to influence how their birth should be managed (Langan et al. 2010).

Two studies addressed the idea of media representations increasing fear and anxiety of birth: Stoll and Hall (2013) carried out a survey of young female Canadian students, who had not given birth, which showed a statistically significant increase in fear of birth due to exposure to vicarious birth through the media. Martin et al.'s (2013) qualitative descriptive study and Fleming et al.'s (2014) mixed qualitative study also found that American first-time mothers' fears and anxiety about birth were increased through media exposure, and required a process of 'sifting' (Fleming et al. 2014).

However, some positive outcomes of women's exposure to media were also found, where the possibility of gaining knowledge and information to supplement what they found from health professionals (Fleming et al. 2014) could help make decisions about their birth (Langan et al. 2010). Recommendations for practice included that health care providers should be better informed about media use by women, provide sign-posting to evidence-based or trusted sources of media information, and consider providing positive birth stories and more extensive information on their own media platforms (Fleming et al. 2014; Martin et al. 2013).

Overall a review of the research strongly suggests that most women, preparing for birth, are actively engaging with media Fleming et al. 2014 in the same way that health information-seeking behaviour generally is ubiquitous via the media (Higgins et al. 2011; Sayakhot and Carolan-Olah 2016) and therefore that the subject warrants serious consideration and further research. Furthermore, the literature implies that media representations of birth reinforce dominant cultural ideologies around the medicalisation of birth, and that they increase fear of birth. However, media theory suggests women can be 'active audiences' therefore able to take a 'dominant, negotiated or oppositional stance' to media messages, and research also suggests that they want to work in partnership with health care professionals through media use (Langan et al. 2010). Therefore, women's use of and influence by media texts is likely to be far from straightforward, and will be determined by their own individual psychosocial, economic, and cultural position, as well as their degree of 'media literacy' (Elson and Conway 2009).

5.10 A Social Model of Birth

Birth does not fit easily into the medical paradigm, which is the main way in which health is framed in our society. Birth is not a 'procedure', there is no 'cure' and women are generally not sick—therefore comparisons with dentistry or colonoscopy sited (by some journalists) as a rationale for its treatment as a medical process are not useful. Professor Soo Downe (2010) positions birth within a model of 'Salutogenesis' moving to a wellness social model of care, and away from an illness medical model. She also describes how if Continuity of midwifery Carer was a 'pill'

the media would be trying to ensure all women received it, but because it is a social element of care it is not viewed as important. A medicine or use of technology is viewed as far more effective and important and a 'cure' to childbirth than any type of social element could be, intriguing when it is so much cheaper and effective than any 'pill' or machine could be.

We do not know accurately what triggers labour—but what we do know is that birth is a process that involves a subtle and complex interaction between hormones from the baby and the mother, which start it, and it is a physiological process vulnerable to interruption, be that from fear (adrenaline) or medical interventions (Brodrick 2014a, b; Butcher 2014). Midwives who are 'with woman' and go through the whole experience with women are acutely aware of the fragility of the process, which can be heavily influenced by the environment, birth setting and people involved and the dangers of interference with this process.Birth is also not just a process but a major life event for the woman, the baby, the family and by extension has implications for the whole of society—how we are born can have a major effect on our mental and physical health, due to the cocktail of hormones, interactions and experiences we have at the time, and how we give birth as women has major implications on our health, subsequent pregnancies and may affect how we mother and parent. Midwives have a public health role and therefore are aware of the long-term implications of certain birth practices, and have a responsibility towards the health and well-being of the whole family throughout the birth continuum, therefore the outcomes of birth are far reaching, with safety (physical and psychological) a complex consideration.

Birth is also a place of contested ideologies and ownership, historically a space controlled by women, and relatively recently a place shared with the medical profession and politicians (Beech 2011). And, at some times and in some places medical interests and politics have tried to squeeze out women's traditional place and knowledge of birth. Turf wars continue to run and the polarisation of birth can be a cause of conflict between professionals, women and in society over who should really control birth; the doctor, the midwife, politicians or the woman. Of course the best scenario is when all those actors work together to facilitate a woman's birth, where she feels in control, respected and has the best outcome possible, whatever her preferences or needs. This history and these questions point to wider societal struggles over women's sexual, reproductive and bodily integrity and control, which is a symptom of a dominant patriarchal culture within which birth is framed.

Midwives are caught harshly in these debates as they traditionally represent women's power and knowledge in birth, distinct from medical institutions (despite their professionalisation) (Longhurst 2009). Midwives are generally women themselves and are therefore subject to a patriarchal system of control (their response to some media reporting recently called 'hysterical' by a columnist, an insult that implies they cannot think rationally as their wombs are moving around) or identified as 'cultish' and 'radicalised'. We all are subject and bound by a pervasive move towards media opinion rather than facts in our post-truth era, which results in the discrediting of research and experts in any field, compared with those with media or

political power. Donna Haraway (1997) talks about us all being Modest Witnesses believing and promoting points of view that may or not be based on any truth or evidence, but all as equally convincing!

Voices shouting loud about safety are influencing the media talk, but there is no research evidence behind the noise, which has led to journalists reporting fake news about midwives and midwifery. The reports in the media have led to midwives being vilified, characterised as witches and pictures of the RCM Normal Birth campaign being sabotaged with blood-stained hands.

5.11 The Midwifery Model

The Lancet Midwifery Series (Renfrew et al. 2014a) discussed the evidence relating to providing the best outcomes to women and babies throughout the world, with midwifery care being central. They developed a Qualitative Framework that shows all women should receive care from a midwife, in order to provide the best outcomes (Fig. 5.1).

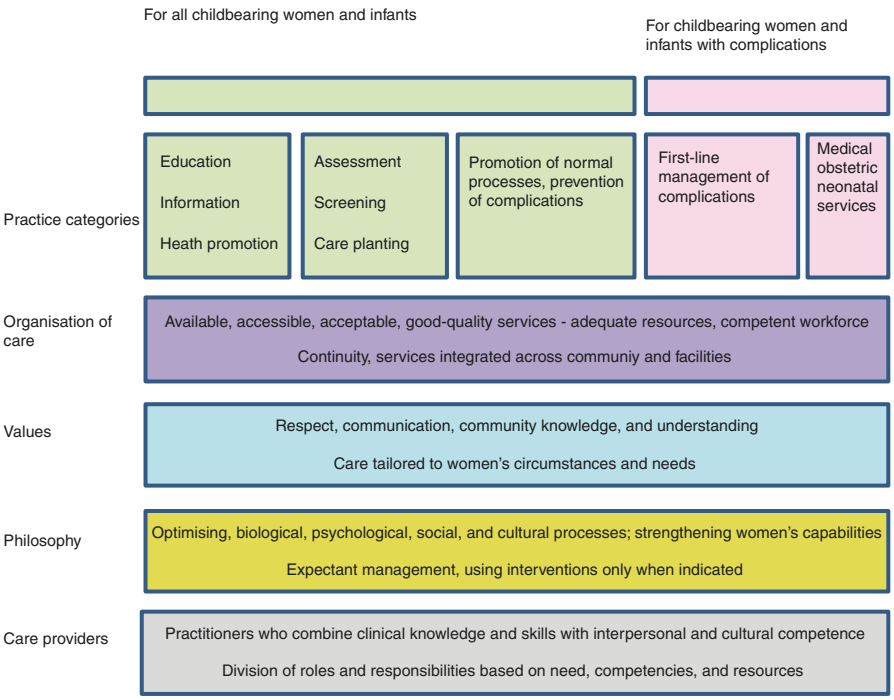

Fig. 5.1 The framework for quality maternal and newborn care (QMNC): maternal and newborn health components of a health system needed by childbearing women and their infants. Reprinted with permission from Renfrew et al. (2014b)

Some women will need the support and care from an obstetrician, and some babies will need the expertise of a neonatologist/paediatrician, but all women need the support and care from a midwife, whether this is midwifery-led care or obstetric-led care. However, this framework has not been covered in any mainstream media reports.

Since the Kirkup report maternity services have become audited and scrutinised (2015). The CQC inspectors check every corner and every aspect of maternity care in all hospitals. If maternity services get a less than good rating the Head of Midwifery generally takes the bullet, when often it is about the culture and systems within the whole organisation not working.

5.12 A Challenge to Mainstream Media?

Representations of birth that do not fit the confines of these dominant media narratives and also explore women's individual subjective experience are often made by independent filmmakers or artists (Boswell 2014; Oliver 2012). Examples include the film Juno (2007) about unplanned teenage pregnancy and feature Precious (2007) looking at sexual abuse and racialised mothering in the USA.

Similarly, documentaries around birth like The Business of Being Born (2008) by American actress Rikki Lake and filmmaker Abby Epstein explore birth in the context of the US system of health care, and Birth Time (2018) currently in production in Australia seeks to address the failures of maternity services, such as rising medical interventions and specific issues for indigenous women 'birthing on country'. Whereas films such as The Premier Cri by Gilles de Maistre explore birth in a more anthropological context.

These are my Hours (2018) by American doula and director Scott Kirschenbaum provides a direct and visceral experience of one woman's labour at home, powerfully exploring the physical and psychosocial aspects of birth and asserting a woman's autonomy over her body. A film yet to be made, 'Mother may I?' by Cristen Pascucci, hopes to deal with birth trauma and obstetric violence.

Another alternative form are the many short films freely available on the internet that address health issues and research that often use animation, illustration and graphics. These films use social marketing methods and creative strategies to promote public health messages and research and are highly effective at engaging a wide audience. Examples of those connected with birth and reproductive health include 'Amina's Story' (2016) by The Service about sex trafficking in Tanzania, 'My Mum's Got a Dodgy Brain' (2016) by ForMed Films about maternal mental health, respectful maternity care by The White Ribbon Alliance (2018), about pregnancy loss by charity Sands and 'Milk for Tiny Humans' (2018) about breastfeeding.

Equally some powerful creative films have been produced by performance poet Hollie McNish (2016) with director Jake Dipla, based on her poems such as 'Embarrassed' about breastfeeding in public.

This growing body of work unpacks the familiar birth story with individualised and politicised positions, which can help midwives positively engage with birth on film and support women to do so too.

5.13 How to Respond to Media Depictions of Birth

What can we do in the face of this onslaught of media 'stories' and opinion, for the sake of the midwifery profession, all birth workers and the women we care for, so that a more balanced view of birth and midwives is promoted in the media.

What we can do is unpack the dynamic, look at our own place within in, and become aware of some of the misogynistic constructs in the media around how a woman gives birth or mothers her children (Kirkham 1986; Kitzinger 2005). We can speak up, and not be silenced. We can carry on with a practice that treats women as individuals, providing them with the best evidence around birth, and keeps asserting the evidence, which is that birth is a normal physiological process, and midwifery is a safe practice, that is highly regulated and controlled, and that there is no guidance that pushes for normal birth 'at any cost'. We can work with our obstetric colleagues and other medical professionals in the maternity team by putting women at the centre of care, and ultimately we need to stress that, as stated by the Lancet (2014) Series on Midwifery, the WHO and many other global health and development organisations, the world needs more midwives not less.

5.14 Moving Forward with Positive Media Messages

New media and feminist media theory suggests that contemporary audiences are 'active'; however, Morris and McInerney (2010) suggest 'Mass culture texts engage in a complex strategy of rhetorical persuasion in which substantial incentives are offered for ideological adherence'. Within discourses of birth, and previous research cited in this chapter, it is suggested that media texts predominantly promote dominant constructs, such as the normalisation of medical birth, fear of birth and erosion of women's autonomy and agency. However, it is also thought that women, midwives and birth workers maybe subverting these messages, actively searching for alternative media texts or using media positively for information, entertainment, connection and activism, which can empower them to work collaboratively and in partnership to increase autonomy and decision-making in childbirth (Garrod 2012).

Strategies that defy the media's predominant messages around birth should be supported. For example another recent media furore in 2018 centred around Harry Kane, the footballer, being criticised for saying he was 'so proud' of his wife, who gave birth without pain relief (Topping 2018). This triggered the #soproud hashtag generated by Milli Hill of the Positive Birth Movement (2018b), and an incredible outpouring of women exclaiming they were #soproud of all types of birth (Positive Birth Movement 2018b), as well as midwives proud of women and their colleagues, a beautiful counter to an otherwise negative, polarised and shaming response.

In Australia, the press printed a statement by an obstetrician who, whilst criticising various CPD courses for midwives that used complementary therapies, used the most inflammatory language describing midwives who use 'dark arts' (Prentice 2019). The media immediately jumped on this 'birth war' and went overboard with

reports and cartoons vilifying midwifery care. This was strongly refuted by individual midwives and organisations with an effective campaign to challenge and correct statements that were misleading and badly evidenced.

Some midwives are already very active through social media and the internet in creating media representations of birth and midwifery, such as Sheena Bryrom in the UK (2016) and Hannah Dahlen (2015) in Australia, or they advise programmes like Call the Midwife (Coates 2015) and as Sheena Byrom states: 'Social media won't prevent the bad or ill-informed news, but it provides a platform for counterbalance, for dissemination of evidence, opinion, and most of all for positivity' (Sheen Byrom 2015).

Enhanced cultural competence and media literacy could also have an application in midwifery education, where partnership working and enabling women's informed choices is part of the pre-registration Standards (NMC 2009). Recent initiatives such as the Arts & Humanities modules at King's College London also have the aim of specifically increasing cultural competence in students preparing for practice. It could also have input into antenatal education, as a topic for discussion and source of information sharing, where it is recognised there is a need for a 'new paradigm for childbirth education in the face of… challenges from health information technology' (Young 2010).

Given the current dominance of media images around birth, it is important for midwives to recognise the phenomena and work in partnership with women in preparation for birth, in line with midwifery principles of 'woman-centered care and informed decision-making' (DOH 2004, 2007, 2010; NICE 2014; NMC 2009).

This could be achieved by asking women routinely, and throughout their pregnancies what their experience is of birth via the media, in order to work to address any fears, hopes and questions generated by this plethora of images and messages (Maclean 2014) and to help them analyse and evaluate information, understand evidence-based practice and distinguish between fact and fiction (Young 2010). This could increase womens' knowledge and information about birth, enhance decision-making, and help them negotiate how to apply this to their individual births (Langan et al. 2010). In addition, health professionals who value information gathering by women can encourage it as a proactive step to increase autonomy, agency and control rather than a possible threat to their professional standing (Langan et al. 2010).

Midwives who are media-informed themselves could also signpost women to trusted and realistic/positive portrayals of birth such as the 'Positive Birth stories' (2015) website, The Positive Birth Movement (2015) or trusted apps such as 'Baby Buddy' (Best Beginnings 2015). Furthermore, those women who might be interested in birth activism can be informed about communities and organisations which have a strong media presence such as Birth Rights (2019), Maternity Action (2015) and RCM campaigns such as 'Better Birth' (2015), which actively address inequalities for women and campaign for women's autonomy, agency and human rights in childbirth. This is further reinforced by the recent National Maternity Review (2016), which suggests the development of a comprehensive digital tool which combines multichannel information via email, video and social media and links to the woman's clinical records, which can be accessed by the woman and HCP's

providing her care. Guidelines around social media use by midwives (NMC 2015a) and policies, guidelines, professional standards and position papers around how media and cultural competence in the midwifery workforce can be used to empower informed choices, partnership working and women's autonomy leads to agency in birth being strengthened.

5.15 Final Word

According to dominant media narratives, birth is a dangerous, dramatic event; women will scream and be out of control and they will be 'delivered' by a doctor or paramedic, not a midwife. Motherhood is idealised, with women expected to be endlessly self-sacrificing and beatific, having lost any 'baby weight' quickly and should conform to a strictly heteronormative view of family.

In contrast to much media and advertising depictions of childbirth, many artist representations can open up more complex understandings of the experiences and practices of childbirth and mothering—from ecstatic birth, such as Hermione Wiltshire's portrait 'Terez crowning in ecstatic birth' (Wiltshire 2018), to the mundane and brutal such as Ana Alvarez-Errecaldo's depiction of her daughter's birth (2005). Famously Mary Kelly's documentation of her son's first few years, 'Postpartum document' (1976–2015) included dirty nappies and documentation of her guilt over going to work. Depictions of breastfeeding are also complex, from the poet Hollie McNish's powerful poem 'Embarrassed' (2016)—which lambasts our culture which is 'covered in tits' but hostile to breastfeeding in public. To artist and porn performer, Maddison Young, whose photographic image 'Becoming MILF' (2011) challenges the dichotomy between motherhood and sexuality by raising the taboo of the erotic in breastfeeding. Whilst Catherine Opie (2004), a lesbian mother, presents a depiction of breastfeeding outside the heteronormative frame. Furthermore, parenting for Trans and queer families raises the issue of how inclusive images (and language) of pregnancy, birth and parenting are if they do not represent these communities and always assume the mother is a 'woman'. New language and terms for those that birth, breastfeed and parent are emerging whereby gender fluid people can be more acknowledged within the birthing narrative, such as adding 'birthing people', chest-feeding and parenting to how we discuss and depict birth (Godfrey-Isaacs 2019).

How can we open up dialogues about different representations of childbirth and therefore encourage women and people that birth to have increased autonomy and agency and be open to choices about their experiences? We need to consider carefully how 'free' women really are to make choices if those choices are either misrepresented or they may be constrained, for a whole range of intersectional reasons. However, through the analysis of media images of childbirth, we can expose damaging and dominant narratives, and through exploring art and other representations by mothers, midwives and activists that depict social and cultural realities barely represented in the mainstream media, we can present multiple readings of birth, breastfeeding and mothering that support women in the complex series of choices available to them through childbirth and ultimately change the narrative around birth.

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Childhood Sexual Abuse, Sexual Assault, Rape and Its Relevance to Childbearing Fear

6

Kathryn Gutteridge

> Then I heard my father say; 'that's a good girl, push a bit more', he was speaking in that quiet whispering voice he always used so that no one else could hear. It was him who was inside my body, him who was causing my pain, him who had filled me with fear and pain.....I was a stranger in my own birth room. (Kathryn Gutteridge Survivor Incest)

As a child we are at the mercy of our parents, they provide all of our foundations in which to grow and develop into the adult in which we will become. Whatever the shortcomings and deficits in our parents characteristics, there is no doubt that we will absorb those into our own behaviours and responses. Many psychologists have long referenced the root of our inadequacies should be placed at the foot of our parents and usually our women. Is that fair or even believable? I believe that there is some merit in this theory; however, there cannot be a simple cause and effect in every life situation.

Nevertheless when looking at survivors of child cruelty, including physical, emotional and sexual abuse, there can be no doubt that those experiences will have life impact beyond childhood. In society today, there is a floodgate of attention highlighting cases of both historical and current abuse of children and young people. The reporting of such abuse is seemingly a daily occurrence in the press, and it appears that survivors are more able to disclose their abuse and bring their perpetrators to the attention of the authorities. What is vital for survivors of abuse is that their personal needs are met and that their disclosures are believed.

Maternity services are busy systems that are currently undergoing root and branch changes so that care is more personalised and sensitive to every woman's needs. This can only make the lives of survivors of child abuse better and establish a relationship with a trusted midwife or health care professional. However, understanding the needs

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of women and their partners where child abuse and adverse life events have dominated their lives is not easy, and it is this that can make such a difference to childbearing women.

In this chapter, I will attempt to unpick all of the issues that survivors of adverse life events involving sexual abuse face during their childbearing episode and give some simple measures that can reassure both survivors and health care professionals.

6.1 Developing into 'Me'

Childhood is a time during which we are shaped and constructed into the adults we will become; any disruption to this critical period risks the child developing deficits in their ego and psyche. Understanding the term adverse life events (ALE), it is worthwhile to examine closely the events that may contribute according to academic studies.

At the turn of the twentieth century, more and more psychologists and psychoanalysts were debating theories around human development and whether behaviours and traits were learnt, observed from the environment or were deeply embedded in our genes. Sigmund Freud (1923) was convinced that babies and children went through several stages that involved pleasurable effects on the body, a controversial theory for some but had strength in many circles. Erikson (1950) took this theory a little further and proposed eight separate stages of development which describe growth and maturity from an infant to an adulthood therefore acknowledging a lifespan approach. Other researchers looked at more specific areas of development such as Piaget (1936), who was the first psychologist to identify that children think differently to adults, quite a basic statement now in our highly educated environment but at the time almost revolutionary.

One of the most modern approaches to psychological development and one which many health care professionals will relate to is the work of John Bowlby. Bowlby (1969) stated that attachment is a major cognitive and behavioural facet of human development and one that continues throughout our lifespan. He stated that children who receive constant warmth and positive feedback in their growth and development will form healthy relationships in life and be successful in family function. Where children have received ambivalent or none caring relationships with their caregivers, then the child will develop characteristics and behaviours that show that deficit; perhaps the term 'you reap what you sow' is one way of describing this.

6.2 Adverse Life Events

It is believable that the way we are mothered or parented creates a framework for our personality to develop into the person we will later become. However if there is only one positive caregiver in our lives, then this can mitigate much of the potential harm that may occur where attachment or love is withheld from a primary caregiver. This is seen in many situations where an adult describing their difficult life as a

child but has a grandparent who offers unconditional care and love despite whatever else is happening in the child's life. Then all is not lost. The importance of love and positive regard on a child throughout their developing lifetime will have a major impact on the developing ego state.

Those children who have witnessed harm to themselves, siblings or a parent will have little in their resources to be able to overcome the fear and terror that is associated with violence being perpetrated on a loved one. Growing up in a home where violence is common and love is minimal will have consequences for later life Rachman (1977). There are some clues in children's lifespan where they may demonstrate aggressive behaviour or display antisocial traits towards other children (Clark 1986). However, these are not diagnostic and must be observed in the context of skilled help. The question is how are these hurt and damaged children and young people able to experience life as they grow into the adults they will no doubt become? This is the challenge and one that will present consequences to women using maternity services, so is vital that midwives and other health care professionals are able to understand and respond.

Gray et al. (2004) constructed a scale of contributory factors that would be useful to predict an individual's character probability to develop posttraumatic stress symptoms when facing serious life-changing events. This self-reporting scale known as the LEC-5 (Life Events Checklist 5 for DSM IV) demonstrated adequate psychometric properties as a stand-alone assessment of traumatic exposure to predict vulnerability to future development of PTSD. The scale is self-reported and asks the individual if they have witnessed or experienced a series of life events as listed below (adapted from Weathers et al. 2013; LEC-5).

- Natural disaster (for example, flood, hurricane, tornado and earthquake)
- Fire or explosion
- Transportation accident (for example, car accident, boat accident, train wreck and plane crash)
- Serious accident at work, home or during recreational activity
- Exposure to toxic substance (for example, dangerous chemicals and radiation)
- Physical assault (for example, being attacked, hit, slapped, kicked and beaten up)
- Assault with weapon (for example, being shot, stabbed, threatened with a knife, gun and bomb)
- Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)
- Other unwanted or uncomfortable sexual experience
- Combat or exposure to a war zone (in the military or as a civilian)
- Captivity (for example, being kidnapped, abducted, held hostage and prisoner of war)
- Life-threatening illness or injury
- Severe human suffering
- Sudden violent death (for example, homicide and suicide)
- Sudden accidental death
- Serious injury, harm or death you caused to someone else
- Any other very stressful event or experience

As may be expected, seeing or experiencing any of the above would increase the child's vulnerability when dealing with life, but the crucial thing here is that we know children may be exposed to multiple risks and have complex reactions in later life Clark and Wells (1995). Weathers et al. (2013) went further, developing a tool that interviewed the individual and explored the issue of sexual abuse; this tool is the LEC-5 Interview with abuse ratings. This is much more detailed and explores the issues about sexual abuse and the impact upon the child to their adult journey.

It is not hard to understand how being raped would affect an individual's ability to trust; however, the tenets are much greater than just trusting people we meet through life. Experiencing the loss of a parent or trusted family member can wreak havoc upon the child's psyche, and this can be detrimental to their life shaping in the next stage of their development. Adults experience crises with many more internal resources than a child has at their disposal that is not to say that they are less affected but the way that an adult understands the crisis is very different to the world view of a child.

6.3 Childhood Sexual Abuse and Childhood Sexual Exploitation

There is much horror when we speak, read or listen to the experiences of survivors describing childhood sexual abuse. Today in modern industrialised societies, we expect that children are safe when they leave their parents for nursery, school and other social activities. This may be true, by and large children are safer now than at any other time in our civilisations' history and yet still unbelievable stories and disclosures fill the news.

During the course of the Home Office review 'People Like Us' (Utting et al. 1997) investigating the lives of children who were in the care of care homes, residential services and boarding schools. Utting's research showed that rates of sexual offending against such children in 1993 was extraordinary and that 110,000 men aged over 20 had convictions for a sexual offence against a child. That equates to 1 in 150 men alone in the UK.

Rates of sexual abuse and exploitation of children appear not to have changed much over the next decade as cases of historic sexual abuse are being reported at unprecedented numbers. In the scoping report by Kelly and Karsna (2017) looking at the nature of CSA and CSE, they found that 'The most serious and repeated offences are more likely to be committed by known persons, with family members more common for girls and young women and authority figures more common for boys and young men' (Kelly and Karsna 2017, p. 16).

McNeish and Scott (2018) report on Interfamilial Abuse shows that a female child is more likely to suffer sexual abuse within the family, for that abuse to continue for many years and that the impact of that abuse would have significant harm on the individual for their life course (Eberhard-Gran et al. 2008). The psychological and social impact of surviving sexual abuse within the family setting is the concept of concealment, betrayal and the stigma that is felt from holding this secret.

Sexual abuse is important for maternity and fear of birth as Hofberg and Brockington's (2000) original study of tokophobic women in a small cohort found that a proportion of them disclosed sexual abuse in their lifetime which was seen as a risk factor for developing a morbid fear of birth Ryding et al. (2007). Further to this, Lukasse et al. (2010) supported these findings in a population-based study. Acknowledging this factor means that pregnancy is a critical moment in a survivor's life cycle and as such women are at increased risk in their psychological well-being.

Child sexual abuse is a violation of a child's physical, emotional, psychological and reproductive life (Kelly and Karsna 2017). It invades the very place that is sacrosanct and destroys much more than the moment of abuse; it prevents the child from developing into the person they might have been. Research tells us that the majority of children are abused in their home which is contrary to that which most of us believe, namely that a child is safe within the walls of their family (Gutteridge 2009; Kelly and Karsna 2017). When an abuser targets a child, it is likely that the place that offers more opportunity is the home and therefore a degree of planning and premeditation is involved. More often than not the abuser is a known and trusted member of the family network, including trusted carers, parents and siblings. With this information, it is invariably difficult to countenance that a child may be at the mercy of such violation in their own homes but this is invariably the truth.

High profile cases that have involved media celebrities have shaken our previous perceptions of trust and belief. Operation Yew Tree was set up by the Metropolitan Police Force in October 2012 as a result of investigations into celebrity Jimmy Savile and other high media profile sex offenders namely Rolf Harris, Stuart Hall and Max Clifford (Giving Victims a Voice 2013; CPS). The case of Savile who had access to the inner workings of hospitals and its most private places such as theatres, bedrooms and even mortuaries beggars belief that his intent was not honourable. The Crown Prosecution Service Report 'Giving Victims a Voice' (2013) showed that he was a prolific sexual offender who preyed on the most vulnerable and damaged young women in settings that were supposed to protect them. The damage that this individual bestowed upon his victims will live with them forever, and their silence was guarded because they believed that no one would take their word against his. Indeed Savile was in liaison with the most powerful people in the UK including the Prime Minister at the time Margaret Thatcher. Indeed he was rewarded for his charity work with a knighthood that caused distress and insult to his victims.

A harrowing BBC TV programme based upon real-life characters and facts called 'Three Girls' shown in 2018 followed the life course of a small group of girls in Rotherham. Although this programme was released in 2018, an Independent Review was commissioned much earlier and showed how the issue had manifested (Independent Inquiry into Child Sexual Exploitation in Rotherham (1997–2013)).

The TV programme itself showed the nuances of grooming, the rewards given to these girls, the isolation achieved from their families and an appalling attitude to young women, the pregnancies that occurred and the absolute despair that these young women experienced. The men were finally brought to justice; however, the programme was not to be the first identification of abuse of young women in this

way. Since these convictions, there have been similar convictions in Huddersfield where 20 men were found guilty, Manchester and Oxford, to name a few.

Abusing a child or indeed an individual is not just sexual abuse, it is a violation of power and trust; the survivor of this abuse will experience a change in the way their world is viewed. Authority and normal respectful power bases have let these children down and they have had their world shaken by abuse, the ordinary expectations and ambitions of childhood are skewed by this experience.

6.4 Impact of CSE on Cognitive Development

Most of our development as a child is based upon learning the norms and nuances of the closest people around us providing a safe and secure environment in which to develop and grow. Where there is a violation in this, a child will form attachments that are insecure and in some ways harmful Rachman (1977). The tenets of a safe secure environment can be described in Maslow's hierarchy of needs (1943), where the foundations of basic human need is explained by receiving food, warmth and a safe place to be. As the hierarchy is examined, it is when we have the foundations of all of the layers that give us a secure ability to face life and all the challenges that it brings.

Bandura (1977a) has long discussed the cognitive adaptation of humankind and suggests that it can be manipulated to change expectation and demand. This simply means that our expectations of life change, given the environmental responses that we receive. For example one famous group of experiments that Bandura undertook in 1961 until 1963 called the *Bobo Doll* series of tests used a rolling wooden toy doll that does not tip over however much the toy is moved (Bandura 1965). Bandura separated young children between the ages of 36 and 52 months into four groups, one of which was a control group and the other three were split into separate groups. In all groups the children participated individually with an adult who displayed different forms of behaviour, aggressive and a non-aggressive display of play against the doll.

Bandura found that boys particularly were influenced by the aggressive play style against the doll and this has also been supported by other researchers and studies. Of course the Social Learning Theory has its critics; however, what we do know is that children at this formative age are vulnerable to adult manipulation, reward and control behaviours that may stay with them for life (Bandura 1977b).

Learned behaviour is a response to an action, it is as simple as rewarding a child when they have done something worthwhile; this could be putting a coat in the correct place when taking it off. This action elicits a favourable response from the parent and so the child is rewarded. A simple analogy but is fundamental in this perspective. However where a child is faced with behaviour or acts that are against its normal frame of reference, then this has the potential to change systems of belief.

This is so when a child is faced with an abusive father or close caregiver; the reference of father is the same; however, the behaviour of the adult is outside of the child's reference of expectation. What is the child to do? This is why sexual abuse is more about the impact and abuse of power rather than the sexual activity that is involved.

Most female children experiencing CSE will not disclose their abuse; in fact, studies show that less than 50% will tell a trusted person within 6 months of the incident (Finkelhor et al. 2014). Where abuse is repeated and prolonged, then there is evidence to suggest that they will go on to keep that secret until they are in fact an adult. If the abuse has involved elements of sadism, ritual or cult behaviours, involvement of animals or other humiliating elements will cause deeper and more destructive personality elements (Herman 2001). Questions about why children and victims do not disclose remain and perhaps research has some way to go to elicit answers to this paradigm. Disclosure may be accidental and can follow another life event or crisis such as an unexpected bereavement, making way for the survivor to reach an outlet for their distress.

6.5 How Many Women

It is estimated that female CSE survivors number one woman in every four; this is a globally referenced statistic and seems to be representative across all populations (Finkelhor et al. 2014). From highly westernised communities to deprived demographics, child sexual abuse reaches every corner of our society. Where there is conflict and war, then the number is higher and it is accepted that women and children in these settings are used as a 'weapon of war' (WHO 2000). Questions have to be raised about the inability of modern political and social structures to deal with the prevalence compared to less resourced settings. Basically there seems to be no simple answer to deal with the sexual abuse of children and women.

There were 679,106 live births in England and Wales in 2017, which means that at least 17,000 women will have had some past experience of child sexual abuse (ONS 2018). This equates to more women than will develop gestational diabetes, hypertension and eclampsia collectively. Yet these women are unknown to us and currently using our services. The potential for harm is great, as they will have unmet needs, be at greater risk of being psychologically unstable and at greater danger of a new mental health illness than at any other time of their lives. Screening is not the way forward here as it is likely that these women will not disclose to health care professionals.

In maternity services today we are providing for many women who did not have the benefit of being born into and reared in homes that hold the right of the child as imperative. There are women who have arrived in the UK by many means; some will have sought refuge from their home nation; others will have been trafficked across many countries being used in the sex industry or other such illegal and inhumane industries.

There has been an acceptance in the past that society should turn a blind eye to such human behaviours; however, today there is a greater desire to eradicate and to legislate for these crimes. The Home Office provides legal advice for many of these crimes such as FGM, Child and Forced Marriages, Sexual exploitation, Domestic Violence and Sexual Offences Act 2003. Where any of these offences are suspected to have occurred, then the Home Office has provided guidance to pursue conviction on behalf of the victim Home Office (2003a, b).

6.6 To Tell or Not to Tell

Many times I have heard people ask the question 'Why didn't she say anything when it happened?' This is the same when stories of historical abuse are highlighted in the media and television. Much research has gone into this subject in trying to understand the barriers to disclosure or the constraints that survivors have experienced when making decisions about when or indeed whom to tell Salomonsson et al. (2013).

If we are to understand this phenomenon, then we should look at the dynamics that exists between the perpetrator and the victim. In the UK, the Domestic Violence Act 2004 was introduced through the Home Office following increasing recognition that violence in the home by an intimate partner constituted a crime. However, it became clear in the subsequent years that crime reports and indeed prosecutions were poor with many victims failing to proceed with giving evidence and disclosing information Home Office (2003a). Compared to cases of stranger rape and random acts of violence, then the numbers were startlingly rare. This was further investigated and the issues of fear and reprisal were noted to be the core reason to failures of using the DV Act to its full potential Gilchrist et al. (2003). Reasons that victims failed to disclose fully and to pursue prosecution of the perpetrator were loyalty, still feeling emotionally tied to the abuser, fear of further violence and children in the family having benefits of the family (ONS 2017). This information gives insight into the complex emotional and psychological tenets of how an abuser uses many forces to gain and maintain power over the victim.

When a child has experienced sexual abuse and unwanted sexual attention, it is usually someone known to them and the abuse will generally occur within the network of the home setting. If the act has been committed by a close family member, then the child has the additional stress of constantly being overseen by her abuser. Every time the child speaks or is in a confiding situation in the home, this will be monitored and controlled (Ellenson 1988). The central tenet of sexual abuse is not about sex—it is about power and the ability to control one individual over the other.

It may be assumed that coercion and threats are part of the control that an abuser uses to maintain the secrecy, usually the perpetrator will ensure that they use both reward and punish in their grooming strategies. If the child is very young, less than 5 years old, they may not realise that what is being asked of them is unusual and so some of their behaviour may be observed as precocious or sexually exhibitive. However as the child starts school and mixes with other children, they will be able to compare their own 'normative' life with their peers. Disclosure therefore may happen at school or with a friend, but if the abuse has been long standing at this point they are less likely to speak out (Ellenson 1988).

Walker (1999) compares the memories and silences that survivors keep in parallel with Holocaust survivor experiences. When stories of horrific human cruelty are examined and survivors have participated in some of those acts to save their lives, then their silence is almost complicit with the act. The survivor is trapped in a memory of being a participant; however, they fail to acknowledge that they themselves were ensnared and imprisoned. This behaviour is also seen in survivors of hostage

situations. Where an individual has been taken from their ordinary life, kept in isolation, tortured and threatened over a period of time, the expectations of the hostage is altered, some may even develop a sympathy with their hostage taker (Herman 2001). This is often referred to as Stockholm Syndrome (Adorjan et al. 2012) *when the victim develops a degree of sympathy and loyalty to the captor. This is particularly relevant to survivors of sexual abuse* who have experienced abuse over many years and cannot find a reason to disclose or seek legal redress.

Natasha Kampusch (2010) was abducted at the age of 10 years and kept in a cellar by her captor for 3096 days until she escaped, she has since described her many feelings of empathy and confusion as she grew up in isolation. Other high profile cases where young people have been kept within a hostage setting unknown to the world, perhaps lost to their parents have been met with disbelief and horror when these stories come to light. Marsh and Pancevski (2011) describe the story of Josef Fritzl who kept his daughter Elisabeth prisoner for 24 years, raping her over and again. She had more than seven pregnancies and bore seven children of which six survived with one child dying in captivity. It is truly unbelievable how this young woman survived and has shared her experiences for many of us to learn from.

In understanding disclosure we should expect that there is no norm, it is a purely individual process. Although it may feel that in telling, the pattern of abuse will stop—that is not the case. The control and manipulation is an inherent psychological response of absolute survival that the victim will work hard to let go. In fact many survivors will tell that they still feel fear and reprisal from their abuser despite that fact that they may not still be a threat to them. In any pattern of recovery, there will be facets of captor loyalty and deep questions of trust and sympathy Julich (2005). These factors alone mean that the journey of recovery is long and arduous with many crisis points along the way. Psychological recovery may take many years and should not be undertaken by an inexperienced therapist.

6.7 What Has This to Do with Maternity?

This has everything to do with maternity and those providing childbearing care. If a woman has experienced any element of abuse, once or even over a lifetime then she may be deeply damaged by the impact of this abuse. In Hofberg and Brockington's (2000) seminal study of tokophobia at least a quarter of women disclosed that they had experienced sexual abuse, this means the correlation between past experiences of rape and sexual abuse has contingency.

In modern maternity systems, there are so many pitfalls that women may fall into during their 9 months of exposure Schroll et al. (2011). This is evident from the first meeting with her midwife where intimate and intrusive questioning is the norm, to the complete invasion of the woman's body as she grows her foetus. Some women will avoid even presenting to their maternity health care professional and complete a whole pregnancy without any care, guidance or support; although this is unusual. It is important to remember this may be the woman's first foray into the world of health care services and as such will not have any experience of what we do or why.

The vignettes used in this chapter are extracted from survivor stories using a platform called Sanctum Midwives, set up by the author many years ago in response to a seminal article called 'Failing Women: the Impact of Sexual Abuse on Childbirth' (Gutteridge 2001). As a psychotherapist and a midwife, it became clear to me that many women were not only suffering in silence from their past experiences but also many of them were midwives too. Sanctum Midwives then was established and was to offer a safe space to discuss what it felt like to have survived sexual abuse and also the issues within maternity care that were likely to cause them further trauma. This continues to this day despite some health care professionals being better informed, many are not. Education in this particular arena is sparse and does not prepare clinicians for the issues they will be confronted with.

The following is one such example.

Vignette 1: Sanctum Survivor—Selina

> I knew I had to go to see the midwife and I knew he (her stepfather) would come with me. I tried so hard to pretend that I was excited about the baby because if I didn't I thought the midwife would be suspicious and ask me more questions. My mum was at work and he said that he would take me so on the face of it—it looked 'normal'. When the midwife said to me she wanted to see me on my own I can't tell you how scared I was, my heart was beating so fast, I was hot and sweaty, I thought I would pass out. He looked at me as he left the room in the way that I knew he was threatening me if I said anything. I was just so scared and my voice was quiet and I just answered quietly and quickly so I could get out of there. When we got home because it was in the day no one was around, he raped me again just to show me that he was the one in charge and that was what I could expect.

Selina was in her last trimester when she was admitted to Triage with vaginal bleeding; she was 16 years old and had no boyfriend although she was living at home with her woman, stepfather and two stepbrothers. She was a bright and happy girl until 10 years old when her stepfather started to come into her bedroom and 'play games' with her. By the time she went to secondary school she was struggling to keep up with her school work and appeared to be distracted in class. She always wanted to go to school because she felt safe there but did not know how to cope with her feelings about home. She started to self-harm secretly when she realised that her stepfather was not going to stop abusing her.

When she realised she was pregnant her woman was very angry and this isolated Selina further, she wouldn't disclose the baby's father and therefore was totally alone in her abusive world. During the Triage admission where no bleeding was found she was asked if she felt safe at home as she had disclosed spurious symptoms that did not add up. Selina was reluctant to answer the question at first and then when the midwife showed her to a small quiet room she broke down and disclosed the nature of her abuse. She was terrified of being examined and had not spoken about the vaginal discharge that she had been experiencing, her labia were swollen and sore. She was able to explain to the midwife that she was a victim of abuse and had no one to support her as she got nearer to giving birth. She was planning to run away and protect herself and her baby before her labour started as she was afraid of what her future may hold.

The almost incidental nature of this disclosure is not unusual and in some ways was predictable. The pregnancy was becoming ever more real, her growing fundus was visible and accessible, but the part of Selina that was most vulnerable was her 'secret'. The midwife was able to stumble on the hidden story of rape and abuse which gave Selina an opportunity to disclose and seek help and support.

The next case study example further demonstrates how a survivor may be taken completely unaware and placed her in a frightening and embarrassing situation.

Vignette 2: Sanctum Survivor Katy

This was Katy's first pregnancy; she was a health care professional and therefore was knowledgeable about what might be necessary during her first meeting with an obstetrician. However what Katy did not have any preparation for was what she felt when having her first trimester ultrasound scan.

> I was on my own for the scan, my partner was not able to get back from work so I promised him that I would get a photograph; it was before we had mobile phones like we do now. I had drunk a lot of water as you do and was called into the scan room. I felt nervous but was not sure why apart from I hoped that everything was alright with my baby. I go onto the couch and it was dark of course, the sonographer explained what she was going to do for the scan. I lay there looking at the screen as she said, then I felt a wet and sticky substance on my abdomen. I screamed and jumped up, I was shaking and crying. Obviously she was shocked and thought she had done something bad. Someone came running in and wanted to see if I was okay, by this time I was crouching in the corner of the room. I was back in my head as a little girl of about 9 years old when I used to have choir practice. The rector at the church would ask me to stay behind because I needed more help with some of the music. He would make me lie on the pews in church, it would always be dark and ejaculate over my tummy; I never told anyone even to this day I have only told my partner and you. It is the first time something like that has happened and reminded me of it in that way.
>
> I was so ashamed and couldn't explain to the sonographers, I said my tummy was hurting so I could get out of there. Of course when I got home I felt stupid and afraid because I would have to go through it all again. I spoke with my partner later that night and he contacted my midwife so we could talk more about how I could have a scan and not be so distressed. In the next appointment he was with me talking me through it, holding my hand and saying; 'I am with you can you hear my voice, it is okay'. This worked and I was able to let them do everything. I was still worried about other a thing in my pregnancy but that was something I had not thought about for many years until that happened.

Katy describes here how her body remembered an experience or event but her brain was not giving her any signals that she may be at risk of harm. In Rothschild's work she speaks of trauma as 'a psychophysical experience, even when the traumatic event causes no direct bodily harm' (Rothschild 2000, p. 5). As discussed in a previous chanted the relationship between the body and the mind is complex, and Van der Kolk explains this in the triggers and somatic protection that can be used in trauma-related work (Van der Kolk 2014). Although Katy had no cognitive memory of this past abusive event when she attended for her ultrasound scan, her body recognised the dark room, the power element of someone standing over her and ultimately the substance that was used on her abdomen. An unpredictable set of circumstances but important to understand this in the work that is undertaken in maternity for all women, disclosed or not.

Vignette 3: Sanctum Survivor Lecie

Maternity antenatal care is focussed upon recognising and optimising the pregnancy to avoid serious medical problems that may occur and also to screen for other problems that can affect the woman or foetus.

Lecie is pregnant for the first time; she is excited about her pregnancy. She is married and has been trying for a baby for some time and was about to engage in a fertility programme but found she was pregnant when going through some preliminary tests. She was in maternity services systems quite quickly and met her midwife at 6 weeks pregnant. Lecie was by this time 31 years old and although by most standards that is not old to have a baby she was definitely worried about her age. When meeting with the midwife she was asking many questions about her age-related risks in terms of screening tests and particularly foetal anomalies that are more likely the older the woman is.

As the pregnancy progressed, Lecie became much more anxious and was asking to see the midwife almost every week. She was researching her own questions and this was generating more anxiety and fewer assurances so she felt that she had to cross question her midwife. When Lecie was 28 weeks pregnant her anxiety was so heightened that she became tearful, distracted and could not focus on her work (she was a lawyer). She was advised to work at home and to take some time out. During this time, Lecie was showing much lower mood and she started to talk about her baby in less positive ways. 'This baby would be better with someone else as its woman'; 'I know getting stressed will affect this baby's development so it would be better for me not to be pregnant'.

Lecie's midwife referred her for some psychological support; she accepted the referral and began to speak about her feelings and worries. 'I wanted this baby so much and I thought I could do it but now I can't. Every time it moves I feel sick, literally it makes me remember what happened to me when I was raped at school. I was in the playground walking out to go home; I was about 15 at the time. Some of the older boys in the school were hanging around and were just doing what boys do. When I started to walk across the field to the pavement one of them ran up to me and pushed me to the ground, I fell over on my face. Then the others ran up to where we were and they started laughing and shouting at him to "do it". He pulled my pants down and the others held on to my legs and arms then he raped me. Once he had finished they were all laughing and running away, but hate boys who had done it showed me he had a knife in his jacket. He didn't say anything but I knew what he meant.

I went home and got straight into a bath, scrubbing myself clean. I didn't tell anyone at all and although I was about to leave school and go to college and then university I put it out of my mind. I never even thought it mattered but it is all I can think about now that I am pregnant and I am so worried about what my baby thinks in the place that was supposed to be so pure and clean. I keep thinking that the baby is moving around all the time trying to get out of the womb because it is so dirty and unclean. Why did this have to come back to my mind now?'

Well it is hard to determine why Lecie remembered so vividly now when she was pregnant with her first baby. However there is a connection with most women and their fertility, sexuality and body awareness during pregnancy. It is a time when

questions are asked about sexual history and relationships so there is no doubt this can be a trigger. The movement of the foetus however denotes a deeper psychological connection that has associated her most intimate parts and the horrific impact of rape and the surviving body. In a rape particularly in a public place with onlookers and where the woman is held down has many trauma elements that can be triggered when similar situations arise. Although Lecie was not held down during her pregnancy, she admits to feeling trapped and that her foetus was also trapped in her unclean womb. She interpreted her foetus's behaviour when moving as such and she was convinced that her developing foetus was unhappy. She was showing signs of becoming psychologically unwell and increasingly fearful and anxious.

It is evident that Lecie would need treatment and therapy for her experiences and that pregnancy had been a precipitating factor. She did go on to have her baby by normal means and although she felt elated by this she developed a perinatal psychosis 3 days later and need some expert support for her recovery.

6.8 Stranger in the Birth Room

Whilst there are many antenatal moments that will fill survivors with dread perhaps the birth process and all that it involves has the potential to illicit fear in greater quantities. Birth is a primal process that can shock and surprise many women at the intensity and power of the female body. The mysteries of how labour starts have not yet become a process that obstetrics has managed to effectively harness despite the many synthetic drugs and procedures that are employed. The trigger for labour is as much biochemical as pathophysiological and yet women who labour naturally and normally can achieve so much by having confidence in their bodies.

The 'switch' of hormones that predicts labour will start is more likely to happen when a woman is content and at one with her pregnant body. Anxiety, stress and fear are natural antagonists to the hormones of labour and much more likely will produce stress hormones discussed in previous chapter. Avoiding stress and worry is not achievable; however, other factors can reduce the impact of these effects. These are environmental factors that are cleverly used in birthing environments to mimic soothing settings; this allows labour to progress and culminate in a good outcome.

When considering birth environments, it is critical that privacy, space and freedom are considered, particularly when in the early phase of labour to establish regular contractions that will progress cervical dilatation. Knowing that a woman has a midwife who recognises the sanctity of a birthing room and what it has to support so that elements of safety and respect are incorporated into the care is priceless to a survivor. The freedom to move, eat and drink, rest, cry and be uninhibited is a recipe for labour to work as it should. The woman's mind will be freed of worry and negative thoughts that can get in her way but also change how she feels about her body as she prepares for the birth of her baby.

Madsen (1994) and Felitti (1991) caution the midwife and obstetrician that a sexual abuse survivor may find her labour longer and more painful. This may be overcome if the caregiver shows compassionate and person-centred care

throughout, however not guaranteed. Gutteridge (2001) warns against the use of endearments and performing any clinical interventions without full agreement and consent, this will ensure the woman is aware throughout of her needs being met.

Even benign procedures can elicit both psychological and physical reactions. As a survivor of incest I was paralysed with fear during a very ordinary procedure with my GP. I was having a health check and that involved my blood pressure being checked. For no apparent reason as soon as the cuff was inflated on my upper arm, I began to feel a heavy weight on my chest and rising panic in my head. I started to fight instinctively not even aware who was in the room, of course my GP was taken by surprise. As a trainee of person-centred therapy, my GP was interested to help with what had happened. I was able eventually to tell him that I was restrained when being abused by my father, he would always hold me down by my right arm. We resolved this issue for future checks when I would hold and inflate the cuff myself as he listened to the sound with his stethoscope.

This reaction is not uncommon. Rothschild (2000) and Bessel van der Kolk (2014) reveal that we hold the trauma of our terror and abuse in the very tissues of our body, particularly those women exposed to incest. This is why we are able to respond in such unconscious and dissociative ways, even to the point of entering another reality. Rothschild (2000) particularly speaks of the trauma being absorbed in the body and has the potential to be awakened by somatic means when faced with a similar situation. For instance being in pain around the genital area, seeing blood on underwear or even when the membranes rupture and blood and liquor trickle down her legs; this can be reminiscent of the rape or violation (Gutteridge 2009).

Listening to what women want from midwives during labour is vital to avoid trauma and helplessness at the woman's most primal time.

Vignette 4: Sanctum Survivor Kea

This woman gave birth many years ago but remembers her birth in absolute detail; although this is not unusual, her story is powerful and teaches us many things.

> I gave birth in 1980, this time of year (autumn). My waters broke at home at around about midnight, it was like a 'pop' sensation but I knew what it was. My husband had not long come to bed but I woke him to get up so we could go to the hospital. I knew something wasn't right I could feel something inside my vagina but wasn't quite sure what it was until I arrived at the maternity unit. When the midwife came to check me over she said that my waters had broken and that my baby was coming by the breech (bottom first). I wasn't surprised as my GP had said that he thought this but in those days nothing else was done. I was having a lot of backache and didn't want to lie down but the midwife said I needed to stay on the bed because she was going to give me an enema and some Pethidine. I was not sure why I needed both those things but have them I did. After I had spent half an hour in the toilet I came back to the bed and she put me in another dark room where there were about four other women who were in labour. I could hear them moaning and trying to be quiet, my husband was with me and he was lost at what he was there for. The night wore on and I became more and more uncomfortable, my back felt as if it would break in two. I was the last person in the room by this time (it was about 6 am). My husband had fallen asleep in the chair and I was trying to move for comfort. No one had listened to my baby since I had arrived so I thought that perhaps she had died and that is what happens when you have a breech labour. I kept my eyes closed because I was having flashbacks now and I could see his face in front of me laughing. It was him my father, the man who had abused me since I

was 3 years old. "Why are you tormenting me now", I remember shouting and my husband woke, wondering what I was saying.

Not long afterwards at about 7.30 am the day midwife came to me and said she was taking me into the birth room. It was an old delivery room, very sterile and the delivery table was in the middle of the room. She told my husband he could not come in because he wouldn't like what they were going to do. I was alone on my back with my legs in stirrups and there was a sliding door that was wide open, I saw a porter walk across and glance in. He must have seen my bottom because I had no way of making myself decent. I remember then looking down upon myself on that table, I saw the doctor put his large forceps into my vagina which was to protect my baby's head he said. I knew this doctor because I had worked with him previously—he had really big hands. Then I heard my father say; 'that's a good girl, push a bit more', he was speaking in that quiet whispering voice he always used so that no one else could hear. It was him who was inside my body, him who was causing my pain, him who had filled me with fear and pain.

As I looked down I saw my body empty of my baby, blood over me and my eyes were hollow, my baby was put straight into an incubator, legs blue and in a frog-like position because of her breech position. I didn't even ask if she was alive because I had entered another world, the one where no one could reach me, my only protection from him. It was 09.35 on Saturday the 22nd November the sun was bright and the day was beginning to warm up and melt the frost. My husband was ushered into the room and he was told that he was the father of a baby girl and what was her name to be. He looked shocked when he looked at me, I was not there but I was. I was a stranger in my own birth room.

This vivid and distressing story describes when the brain and body are under duress that past events can re-enter the scene. The dehumanising environment, the lack of empathy, the loneliness of being in labour and in pain, the separation of a loved one and the stripping away of dignity and privacy were all a recipe for harm and retraumatisation (Kendall-Tackett 2002). Any of those events alone could cause trauma; however, when there is previous sexual abuse, together with facets of humiliation, there is a high degree of potential for retraumatisation to occur (Klein 1991). Where there are no protective factors for a woman to draw upon, she will be exposed to risks of being further psychological harm.

Kea did not hold out any hope for her baby as she knew something was wrong when she arrived, however no explanation or confirmation of that was given. It is common for women to have fears about their unborn baby dying however in labour it is even more terrifying particularly where there are no professional explanations or reassurances. When fear then becomes terror as the time moves on there is no more sense to be made and a state of complete dissociation occurs (Rothschild 2005). This is illustrated when Kea describes looking down on her own body and describing what she saw. The body and mind are no longer in harmony and the brain does what it can to protect by removing any sense of reality. If this is not recognised and responded to, the woman will remain passive and unresisting as was the case here.

Ensuring that dignity and privacy are respected during the childbirthing experience is vital and cited by many women as important to them; however, it was evident that this was not the case in Kea's story. Humiliated by the porter passing by the room, the doctor whom she knew were triggers in the experience of developing shame and guilt. In fact Burton (2014) and Klein (1991) both relate that humiliation is as a key factor in the psychological destruction of the human psyche. Kendall-Tackett (2007) has long supported the fact that women who have lived with

long-standing trauma experiences such as violence and sexual abuse are at particular risk during birth and the early perinatal period. Herman (2001) and Kendall-Tackett (2002) goes further and states that victims of childhood sexual abuse were more likely to experience posttraumatic stress disorder, depression and a range of other health morbidities compared to individuals without that history as they are likely to be retraumatised by their experiences.

6.9 What Is to Be Done?

How can we help the women we do not know? It is impossible to screen all women in a sensitive and non-invasive way. By listening, reading and learning how survivors cope with childbirth is one of the most effective ways to prevent further harm.

Given that most medical and midwifery training programmes are unlikely to spend much time on preparing clinicians to recognise and predict the women we are focussing on here, it is really up to the enlightened to share these stories and practical ways of supporting women.

6.10 Disclosure of Sexual Abuse

Any woman disclosing a history of abuse has placed a huge element of trust in the relationship and honesty is paramount, she then remains in control. Some survivors will have disclosed earlier in their lives and have suffered disbelief and been dismissed, this is detrimental to the process of dealing with abuse (Elliott and Carnes 2001). However, there is evidence to support midwives giving women the opportunity to disclose abuse; domestic violence is a good example. Research has shown that women value the information even though they will choose when to use it and how to incorporate it into their lives (Handelzalts et al. 2012). This method of information giving places the woman at the centre of the dynamic and not the professional.

There are a number of tools available for screening women survivors; however, few are validated and none are widely used in maternity services. An example is the NorVold Abuse Questionnaire (Swahnberg and Wijma 2004), a validated instrument measuring emotional, physical and sexual abuse in the health care system amongst women. This tool was found to have good reliability and validity in detecting prevalence rates in a Swedish population. However using any detection tool has implications for services, training and for midwives personally, therefore consideration is needed prior to adopting any screening mechanisms.

6.11 Advice for Disclosures

- Most important is to believe and not dismiss
- Do not ask for detail as this may be too difficult

- Ask if she has had help in the past and what that was
- Ask the gender of her abuser (if relevant) to avoid harm
- Ask what she would like help with (if anything)
- Ask if she wants this to be documented and available to other caregivers
- Ask if her baby is likely to be exposed to harm from her abuser

6.12 Antenatal Risks

As some of the case study examples show antenatal care maybe hampered or enhances by a relationship that is formed with the woman. If kindness, trust and compassion are evident early on then this will make way for disclosure and sharing of information.

The impact of sexual abuse upon the development of personality and psychological well-being is detrimental to the survivor's life. There are a wide range of psychological illnesses and behavioural problems highly indicative of sexual abuse. This suggests that the midwife taking a history should focus on the woman's psychological well-being and ask relevant questions (Handelzalts et al. 2015). Where fear of birth is a feature of the early antenatal assessment, Lukasse et al. (2014) suggest this alerts the midwife to the possibility of past child abuse. Jokić-Begić et al. (2014) state that any anxiety noted during the antenatal period is indeed a predictor of fear of birth that may be significant to the woman and gives a sign that further support is required from the health care professional.

Sexual abuse is rarely observed physically unless the survivor has been raped or sexually assaulted and sought early health and legal support. Even prolonged sexual abuse will be difficult to substantiate by physical examination; however, it is associated with a range of substantial indicators. These include poor dental health, acute and chronic pain, self-harming, non-specific ailments, sleep disturbances and incontinence (Garratt 2011; Gutteridge 2014). Midwives should also be aware of subtleties associated with body language and the visual physical well-being of women, such as how they dress and present when coming to clinic (Hildingsson et al. 2017)

It is inevitable that the experience of sexual abuse will influence sexual development and intimate relationships. The impact of this may manifest in a variety of ways, ranging from problems rooted in the psychological to the physical and gynaecological. Common problems associated with survivors of sexual abuse are as follows: dysmenorrhea, vaginismus, chronic pelvic pain, endometriosis and general menstrual disorders (Mayer 1995). Recurrent sexually transmitted diseases and miscarriage have a stronger correlation with sexual abuse, as is abortion as a means of contraceptive control.

Women who present in pregnancy requesting a particular mode of birth should give the midwife an insight into the mindset of the woman (Handelzalts et al. 2012; Lukasse et al. 2011). There is increasing evidence that some women will request a planned caesarean section so that she can cope with her body and the way it feels (Bewley and Cockburn 2002; Lukasse et al. 2011).

6.13 Advice During Antenatal Care

- Avoidance of clinic or medical appointments
- Hyperemesis gravidarum (not uncommon with a range of psychological disorders)
- Declines blood testing (may cite fear of needles or blood taking)
- Declines screening
- Declines any physical examinations such as blood pressure measurement (can remind of being held down as the arm is squeezed)
- Declines abdominal palpation (may be hands on the abdomen but may tolerate over her clothes)
- Declines foetal auscultation of heartbeat (offer to use a Pinard Stethoscope)
- Is insistent on having a planned caesarean section
- Is insistent on having a planned home birth even with risk factors that would normally entail labour ward care
- Ensure the woman is part of all of the discussions and planning for care
- Continuity of carer is vital and gives the woman confidence and builds a relationship

6.14 Labour Risks

Fear is a major dynamic for this group of women, a need to be in control at all times is crucial to them. The place of birth may give insight into the survivor's life; home birth against advice or request for caesarean section without medical indication is synonymous.

The labouring survivor will display behaviours that may alert the midwife, refusal of vaginal examination, refusal to lie on the bed, childlike behaviour, dissociation to name a few. Words used in labour are powerful triggers as are the tools of the birthing room, and awareness of the environment is crucial (Gutteridge 2001, 2009).

Evidence that some survivors experience cervical dystocia, dysfunctional labour and failure to progress compared to control groups is unclear; however, the emotional impact of pain and fear is difficult to assess but evident in women who recount their birth stories (Eberhard-Gran et al. 2008)

After birth the survivor may be reluctant to handle the baby, refuse to breastfeed and even request the child is adopted. There is a high incidence of postnatal depression and posttraumatic stress disorder in this group of women (Gutteridge 2014).

6.15 Advice During Labour

- Midwives should understand the powerful psychodynamics of labour and birth.
- All care should be central to the woman's wishes, with consent for each procedure sought.

- Declining any procedures should not be an opportunity to coerce or bully but respected as a wish of the individual.
- Language is a powerful dynamic—choose words carefully.
- Avoid using pet names such as 'pet, darling and sweetie'.
- Let the woman be in control.
- Avoid changing midwives if possible.
- Do not withhold any pain relief requested.
- If no vaginal examinations are in her birth plan, then the midwife needs to be observing progress in labour by other means.
- Protect her dignity at all times—prevent others from walking into the room.
- Inform the woman when she will feel or experience certain parts of her labour as it changes.
- When the presenting part if crowning inform the woman beforehand what she may feel
- Ask her if she wants her baby passed to her straight away.
- Ask if you usually offer women mirrors to visualise the presenting part.

6.16 Postnatal Risks

It is no surprise that when a survivor has gone through the rigours of labour, she will be in a state of shock at what she has done. Spend some time with her quietly after the birth observing how she is responding to her new baby. This can provide insight into maternal/infant attachment and how this is likely to proceed.

Becoming a new mother is daunting and challenges most women; however, there is a critical period in the first few hours where her ability to birth her baby can reinforce the attachment process. The midwife can provide supportive feedback at how well she has done in her labour that will give the woman confidence to connect with her newborn baby.

As a survivor many thoughts and memories can be stirred when holding a newborn baby, its helplessness and dependency can cause fear and anxiety in the survivor woman. Following birth, the woman may show disinterest in the baby and be reluctant to breastfeed (Kendall-Tackett 1998). Handling the baby creates a sense of fear, unexplained panic especially when the baby cries and an extreme reaction might be to be separated from the baby and even put the baby forward for adoption. Some survivor women even think the baby does not like or even hates them and interprets the normal crying as a sign of this.

Postnatal women may display a range of psychological symptoms: unexplained anxiety, posttraumatic stress disorder, depressive disorders, obsessive behaviours especially around their own and baby's health (Garratt 2011). The survivor woman may be reluctant to take their baby out in a pram wishing to avoid people touching or being near their baby. Some survivors will not want anyone else to change their baby's nappy or bathe them, this could even be their partner or husband. There are even situations where the father of the baby is an abuse survivor and is scared of caring for his newborn baby for fear of touching and being interpreted as sexualised behaviour.

There are so many facets that can present that the midwife, health visitor and GP must be alert for signs of not coping or changes in mood.

6.17 Advice for Postnatal Period

- Observe for normal maternal attachment in first few hours
- Observe for any signs of rejecting baby, not performing caring tasks, holding baby away from breast when feeding
- Gives the baby to others to care for
- Mood changes and lowers with high levels of anxiety around baby and her own health
- Attending GP for small and inconsistent reasons associated with her or baby's health
- Reliving birth event and telling the experience over and again.

6.18 Finally

It would appear that caring for survivors of childhood sexual abuse has so many elements that might cause further suffering or indeed harm. However that is not really the case. It is possible to be well read and informed about the impact of abuse and what growing into adulthood with this background may mean so that the health care professional is prepared. In simple terms, it is just as important to be informed about this issue as it is to be knowledgeable about hypertension and diabetes in pregnancy.

One way of ensuring this is to adopt what Tudiver et al. (2000) call a 'universal precautions model' when offering care to women. They suggest that it should be expected that all women are survivors of sexual abuse and as such no one will be at risk of retraumatisation or future harm. This is the standard to aim for and surely all health care providers would aspire to this.

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'Who's Afraid of the Big Bad Birth': Childbirth Trauma, Fear and Tokophobia

7

Kathryn Gutteridge and Yana Richens

> Making the decision to have a child – it's momentous. It is to decide forever to have your heart go walking around outside your body—ANON

7.1 Introduction

Giving birth in the UK today is deemed to be a safe event where a mother and her baby can usually expect a high standard of care with good outcomes. However in a report *Surviving the First Day—State of the World's Mothers 2013*, the UK was placed lower in the ranking than previous years and more concerning, the report found that currently in the USA more babies die in the first day of their lives than in the entire western world (Save the Children 2013). This suggests that there is a misconception of safety around maternity care from the perspective of current maternity models in westernised society.

Approximately 900,000 women give birth in the four countries of the UK, the majority of those in hospital. In 2007, a Kings Fund report was published reporting on the safety of maternity services and found some emerging themes that would have implications for women's health and morbidity during childbirth (Smith and Dixon 2007). These findings showed that women are older having their first baby, there is an issue with obesity, multiple births are more common, there are more medical interventions particularly caesarean sections, more migrant and refugee women using services without English as their first language and finally women

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with serious medical conditions are surviving into adulthood and successfully achieving a pregnancy (Smith and Dixon 2007). The burden of disease and the burgeoning of services designed to provide for 150,000 fewer births per annum means that we are seeing a shift in the maternity culture and care provided.

With this background and since the 2016 emergence of Better Births report, a focus on maternal or perinatal mental health has emerged (National Maternity Review 2016). Poor services for women with emotional and mental health dysfunction have existed for decades with lack of funds, service provision and possibly worse than any other issue, patchy awareness in both health care providers and society as a whole. In the general public, there has traditionally been distaste for acknowledging mental health illness and emotional well-being despite the burgeoning number of people seeking help. Cumberledge (National Maternity Review 2016) in her report acknowledged this and made better mental health provision a mandatory part of care provision for both women and their families.

For those very ill women with severe perinatal illness, there has been a traditional pathway to accommodate them under specialist services in perinatal liaison, Mother and Baby Units; these valuable resources though are postcode dependent and unavailable to many women in some regions of the UK. The changes within Cumberledge's report should improve this and help to find equality for women and their families throughout England and Wales. However, these number a small group of women, whereas 'worried well' women in the perinatal period are unknown and largely not provided for. It is this group that has hidden women with phobias, labile emotional baggage and psychological problems as yet undisclosed and fearful and terrorised women who view pregnancy in a very different way.

7.2 Into the Deep

The nature of fear is relentless; it invades and consumes every waking moment. Childbirth is deemed a normal life function of womanhood and society rarely associates fear with this maternal event The Times (2006). However, women commonly present to maternity services with a range of anxieties and fear-based symptoms. Research into this arena is limited and therefore health care professionals working in British maternity services are often poorly prepared to deal with this group of women (Gutteridge 2016 unpublished thesis).

Western women are identified as more fearful of childbirth in approximately 20% of the total pregnant population (Hofberg and Ward 2003; Zar et al. 2001) with a range of symptoms from mild anxiety to severe phobic pathology. The degree of phobic intrusion ranges from negligible to extreme with modification of daily life and adaptation of various coping strategies. Causes for this fear are again wide in spectrum and may be attributed to loss of control over the body, changing body shape, fear of a stillborn baby and even their own death, (Eriksson et al. 2006; Geissbuehler and Eberhard 2002; Sjorgen and Thomassen 1997).

Women who have birthed before are more at risk of re-experiencing previous trauma from past birth experiences including those who have a stillborn or damaged

baby (Eriksson et al. 2006; Saisto et al. 2001; Sjogren 1997). A further group of women who are at greater risk of developing fear around childbirth are those who have experienced negative or adverse life events particularly during the formative years of their childhood (Ryding et al. 2007).

A seminal paper first recognised by Marce (1858) identified tokophobia as a recognised psychiatric disorder which is 'a condition that is harrowing and needs acknowledging' (Hofberg and Brockington 2000). Although psychiatry has documented this area of maternal dysfunction, it has done so within a medical paradigm. This has had little impact within maternity services where many women present with a range of psychological and behavioural symptoms that go unrecognised and are rarely under the umbrella of psychiatric care.

One of the very first documented accounts of tokophobia was Hofberg and Brockington (2000) in their sample of 26 cases, where they reported women fell into two groups: primary and secondary tokophobia. Those women in the primary group were found to have never previously experienced childbirth and yet displayed an 'unreasoning dread of the event' (Hofberg and Brockington 2000). Hofberg and Brockington (2000) also concurred that a significant number of women have a persistent dread of childbirth that predates pregnancy—they named this as primary tokophobia. Hofberg and Brockington (2000) classified tokophobia in three ways:

1. Primary—nulliparous
2. Secondary—previous to a traumatic delivery
3. Tokophobia as a symptom of prenatal depressions

Previous to the pregnancy, these women were more likely to use stringent methods of contraception, often double methods (contraceptive pill and condoms), and would present with acute anxiety symptoms on confirmation of the pregnancy (Ryding 1993). Despite relatively normal sexual intimacy, their use of contraception may be described as obsessive even to the point of requesting sterilisation (Ekblad 1961). Delayed childbearing is common in this group of women and then as age progresses sadly their reproductivity is compromised with a higher proportion of interventions.

Secondary tokophobia was distinguished by a previous pregnancy where the outcome was described as 'traumatic' in some measure, and this could be due to some emergency event, threat to life of self or baby and even a difficult experience of the pain associated with labour.

Whilst the sample size of Hofberg and Brockington's group might be deemed small and in some respects not reproducible against the wider maternity populations, there is a growing trend of women who express anxiety symptoms and some who request caesarean section early in pregnancy which could indicate a underlying psychological issue (Penna and Arulkumaran 2003). The impact of fear upon pregnant and labouring women is difficult to anticipate or quantify. However, organisations that provide advice and support during this phase in women's lives suggest that maternity organisations underestimate the effect (Birth Trauma Association 2019). Studies show women's expectations of their labour or indeed of giving birth

are more often associated with a negative birth experience and as such will admit to feeling dissatisfied with their care and birth (Green et al. 1990; Slade et al. 1993; Melender and Lauri 1999; Green and Baston 2003).

UK maternity services are driven by risk-based service provision, and the focus is largely on safety and evidence-based care; the counter side of this is that technologically driven care has encroached upon the physical aspect of caring DeVries and Barroso (1997). It may even be said that the care is only provided for the foetus and therefore the care model may be described as 'foetocentric', whereas the woman is viewed as an incubator of her foetus.

Whilst caesarean sections and clinical interventions are undoubtedly necessary in many situations, the commonality of these procedures has created a culture of childbirth as a dangerous and fear-inducing event (Wagner 2006). This assertion is further supported within the modern media machine. Many health journalists write accounts of childbirth using emotive language: 'The trauma of childbirth' cites Carol Midgley Times June 2006 being one example. The media arena has adopted childbirth and writes frequently about the dangers and pitfalls of pregnancy and birth; given the power of the modern media, this has no doubt increased public anxiety (see Chap. 5).

Anxiety in pregnancy is positively associated with increased maternal and foetal morbidity and more likely to result in premature births and significantly lighter at term newborn infants (Field et al. 2005). Whilst anxiety is a good indicator of general apprehension around childbearing, it is those women who admit that their anxiety is more akin to fear and even developing phobias that this chapter is interested in Gutteridge (2002).

Wijma (2003) asserts that some of the symptoms of severe anxiety and fear are present early in pregnancy and are easily detected, such as nightmares, rumination, requesting termination of a pregnancy. In some women, the fear is specific, and only concerns the event of childbirth. In others, the fear exists in parallel with other types of anxiety problems. Various studies have shown that women who suffer the most during pregnancy are likely to experience a greater intensity of fear during the birth, and also suffer a range of psychological sequelae afterwards, notwithstanding the mode of delivery (Zar et al. 2001).

Whilst childbearing is a female function, the wider context shows that this experience is influenced by intimate partners, family and friends and social networks (Melender 2002). It is perhaps only raised as an issue where women present early in their pregnancy requesting caesarean section or in rare cases a termination (Saisto et al. 2001). In Finland, Sweden and the UK, fear of childbirth or maternal request is the reason for about 7–22% of planned caesarean section births, and moreover the fear of childbirth in this group is as common in nulliparous as in parous women (Saisto and Halmesmäki 2003).

Women who admit to a fear of other procedures such as blood sampling, injections or clinical activities which are likely to involve blood will be more likely to present in this group of women (Zar et al. 2001). Moreover, studies show that women who express a fear and distrust of maternity services and particularly delivery suite staff are likely to fall into the group of women who have subsequent

negative and traumatic experiences of birth (Saisto et al. 2001; Sjorgen and Thomassen 1997). Research has shown that these women are likely to avoid antenatal care, screening and health promotion programmes with obvious consequences. The technological basis of current medical maternity model is cited by leading midwives and anthropologists as diminishing the art of motherhood (Donnison 1988; Silverton 1993; Taylor 2001 Wagner 2000). Therefore the messages that women receive are that they cannot control birth and they will not be able to cope with the pain and process of childbirth. This reinforces the cycle of medical technology and deepens fear for women as yet unknown to maternity.

7.3 The Pregnancy Confirmed and Fear Is Realised

Fear of birth (FOB) is becoming increasingly recognised as a clinical issue that can have profound effects on the mother and her experience of pregnancy and birth. Failure to identify women with FOB could potentially lead to them feeling isolated and unsupported, and impact on their psychological health and the health of their baby.

In the UK, FOB and anxiety are not assessed during pregnancy, despite the evidence that FOB is increasing, with one in five women reporting fears at the beginning of their pregnancy and one in four women at the end of pregnancy (Zar et al. 2002). In one study of a London-based population, 3.7% had symptoms severe enough to be diagnosed with fear of birth at 28 weeks in their pregnancy, suggesting that these women had not disclosed their fears to their midwife or other health care provider (Lewis 2018). As already identified, increased anxiety and fears during pregnancy are associated with preterm births, increased length of labour, poor pregnancy outcomes, antenatal and postnatal depression, and negative birth experiences. These negative emotions can disrupt early bonding with the baby. Therefore, it is essential that any fears and anxieties are identified, so they can be addressed at an early stage of the pregnancy.

As the term tokophobia is used all too frequently in cases where women have fear of birth/and or anxiety, it is common that fear of birth and tokophobia are used interchangeably whereas they are different and distinct. As reported by Fenech and Thomson (2014), women can experience serious and enduring morbidities following a traumatic birth, which can impact on infant and family well-being, but others may find their birth event tolerable and within their norm of expectation. It is well documented that following a traumatic birth, women are likely to request a caesarean section for subsequent births (Melender 2002; Nerum et al. 2006; Tsui et al. 2007; Wiklund et al. 2008). This request can be viewed as a manifestation of FOB or indeed PTSD. Health professionals who come in contact with pregnant women need to be mindful of this.

Clinically, it is important to establish if a woman has FOB, PTSD or indeed tokophobia. The reason is that a woman may have FOB, but not everyone is susceptible to PTSD (Kendall-Tackett 2005). Although predisposing factors are similar for those with FOB, PTSD is strongly associated with negative birth experiences (Bydlowski and Raoul-Duval 1978 cited by Ballard et al. 1995; Ayers et al. 2006),

pain experienced during labour, concerns over well-being of baby (Ballard et al. 1995), assisted birth or emergency caesarean section (Creedy et al. 2000) and in some cases, non-obstetric events such as sexual abuse or domestic violence (Ayers 2004). A meta-synthesis of qualitative evidence on the impact of traumatic birth by Fenech and Thomson (2014) highlights the negative effects of PTSD for women by including powerful narratives from women following a traumatic birth.

Therefore, it is essential that midwives acknowledge the existence and are able to distinguish between tokophobia, FOB and PTSD. Tokophobia is a complex rare condition and is cited to affect 0.0032% of the population UK wide, and it is these women who will demonstrate the classic signs and symptoms of avoidance and phobic traits (Howard et al. 2014)

Just to be clear and concise:

- Fear of birth—an escalating anxiety that is present during pregnancy which has intrusive functioning elements such as bad dreams and rumination
- Primary tokophobia—is a severe phobia of pregnancy/birth that has caused a woman to avoid pregnancy, terminate a pregnancy and where she has avoided motherhood
- Secondary tokophobia—is a response to a traumatic birth experience increasing the woman's anxiety and stress levels to develop acute, chronic trauma symptoms following birth.
- Posttraumatic stress disorder following childbirth—birth trauma that has arisen due to an event at the time of birth where the women felt her life or that of the baby was in danger or that she was left to deal with her pain alone or that she was not listened to or heard.

7.4 Primary Tokophobia

It is the case that some women in high resource countries, with good obstetric care, free at the point of delivery, continue to express anxieties about childbirth; to such an extent some women avoid childbirth. This fear may remain so intense in a proportion of women that they will avoid pregnancy rather than risk parturition even when wishing for a child. Sometimes the drive for motherhood is so strong, the woman will conceive despite this fear. She must then contend with a pregnancy and delivery that she is terrified of.

When a woman has never experienced pregnancy or childbirth, this is now recognised as primary tokophobia. For a gravid woman with primary tokophobia, her GP may be her first point of contact. However, it is the midwife who will be the first health care worker who may ask the questions that lead to the understanding and diagnosis of this condition. Here is a woman in early pregnancy expressing extreme terror sometimes with tears, distress and panic. This will be significantly at odds with the experience of her partner and family who will often celebrate her gravid state. If a pregnancy has been avoided yet longed for by partner and grandparents, this further alienates the woman and her emotional experience and distances her

from those closest to her. These feelings carry shame and guilt which may also trigger a depressive response.

For a non-gravid woman, considering pregnancy with primary tokophobia, the GP then gynaecologist/obstetrician are likely to be the first points of contact. A woman planning pregnancy with this phobic condition may seek out the commitment for her choice of delivery prior to conception.

To elaborate this condition, a case vignette will be used.

7.5 Vignette 1

7.5.1 Primary Tokophobia: Alyssia (CM London)

Alyssia is a 36-year-old arts director, committed to her work and ambitious to achieve. She has been married for almost 10 years to a man she met when they were both undergraduates. As a new married couple, they were both career orientated and her husband was happy to postpone parenthood, knowing that his partner had repeated through their relationship she would never have a child. He believed her views would ameliorate over time. After almost 20 years together, he became more desperate for a child. Alyssia felt close to her husband, ambivalent about motherhood but terrified about pregnancy and childbirth. She had no previous history of mental ill health or significant psychological disorder. However, she recognised in her character some obsessive traits in her work, her social planning and her home. These had enabled progress in her career and efficiency in organisation.

Alyssia was referred to a specialist NHS obstetrician prior to conception to discuss the options available to her should she become pregnant. Her obstetrician agreed to perform a planned caesarean section at 39 weeks gestation, an effort to perform the operation plus named midwifery care through the pregnancy.

Alyssia had a physically uneventful pregnancy. She had an intense dislike for the physical changes of pregnancy, the attention this brought her and the fact that others would know pregnancy meant she must have been sexually intimate. Despite her high level of education, she chose to receive no information on pregnancy or caesarean section. She declined copies of her hospital correspondence to her home. She found the scan images distasteful and the foetal movements unpleasant and 'alien'. She planned to bottle feed and found the thought of breast feeding abhorrent.

Throughout her pregnancy, she continued to work full time and perform well there. She had no emotional attachment to her foetus. All preparations were done by her husband and mother in law who were both very excited. She felt guilty that she could not be happy with her husband and felt she was depriving him of an entitlement.

She felt emotionally well if she did not think about the pregnancy. She worked as long as she could, to remain distracted. She dreaded the last weeks of pregnancy when she was on maternity leave and would be alone with her thoughts, her unfamiliar body and her foetus.

Alyssia had an uneventful caesarean section operation. She was pleased to feel emotional warmth towards her new infant although recognised this was not as intense as her husband's feelings. In the weeks post-delivery, her mental health remained stable, the anxiety remitted and her attachment to her baby developed. As a couple they decided their family was complete with one child.

Alyssia's experience highlights some of the repeatedly reported features of primary tokophobia. However, it remains uncommon, even in specialist services to work with a woman with this history and presentation.

7.6 Vignette 2

7.6.1 Primary Tokophobia Pascha (CM Birmingham)

Pascha was 42 years old married to a professor of philosophy in Birmingham UK. She was originally from Italy and met her husband during a holiday he took to Milan, she was 36 when they married and both were happy with their relationship. Pascha immediately informed her husband she was terrified of pregnancy and childbearing and would never be able to have a child of their own, but she was prepared to foster or adopt children. They decided quickly to follow that course and had four children; three they adopted and at the time of the impending pregnancy a 4-year-old girl they were fostering.

Pascha presented to my clinic at 16 weeks in a highly hysterical state. She was with her husband, who was almost carrying her through the antenatal clinic such was the degree of emotional paralysis. She was crying constantly throughout the conversation and was largely coherent, but her husband gently explained the terror she was experiencing. Ever since her amenorrhea she had become hysterical and was hitting her abdomen with her fist, she was repeatedly using pregnancy test kits with a hope of it being a mistake. She desperately wanted to terminate the pregnancy, but her religion and faith prevented her from doing so.

Pascha refused all screening tests, including routine scans and blood tests and spent hours praying for her body to abort the pregnancy. Of course her age and her parous state was a cause of concern for her obstetrician; however, she and her husband were counselled appropriately and they declined any screening.

Pascha entered the second trimester and at 25 weeks she reported to her midwife that she could not stand the changes her body was showing. She felt 'dirty' and 'promiscuous' and that the world knew what she had done to get pregnant. She further stated that the foetal movements were 'disgusting' and she 'hated' them with a vengeance, she would not speak about foetal movements to her husband or to her midwife.

Joint care was being provided at this time with consultant midwife who is also a trained psychologist and psychotherapist, perinatal psychiatrist and specialist obstetrician. She struggled through the pregnancy, and although coming to the hospital was difficult for her she got better and managed it well. We began to explore the issue of birth planning; her husband had virtually taken over any preparation for the

baby's arrival. He had prepared the nursery, packed bags in readiness, attended birth preparation on his own and was incredibly supportive to Pascha. We began a programme of exposure to the maternity unit, walking around the corridors, introducing her to places and people. She appeared to be coping with this.

I wanted eventually to get her into obstetric theatre so she could be exposed to how clinical it was but also to introduce her to the team who routinely worked there. She resisted this and wanted to spend more time on the alongside birth centre as she felt 'it was not anything like a hospital and I feel safe there'. I had also referred her one of our complementary therapy midwives who practiced reflexology. Pascha tolerated these sessions well as she had no difficulties exposing her feet to be touched, whereas she could never expose her abdomen, allowing palpation over her Tshirt.

As her due date approached Pascha became agitated again, was experiencing vivid and intrusive thoughts and nightmares. We met and discussed what she felt she would like to happen at this stage. She bounced from 'I want the baby out of me' to 'I can't do this anyway and I want to go to sleep and wake up with my body back'. I explored the idea of membrane sweep which she totally decided against but she was open to the idea of coming into the birth centre and having some therapy for stimulating labour.

With this plan in mind and declining induction of labour despite the evidence of stillbirth and older primiparous women Pascha waited.

I arrived one day to a call from the birth centre to say that Pascha's husband had arrived with her in labour; she had been contracting in the night but had not woken him. She told the midwife that she didn't want to acknowledge that she was going into labour so she left him to sleep and took her mind to another place. She declined any vaginal examinations but allowed the midwife to palpate her abdomen and to use the pinnard stethoscope to auscultate the foetal heart. I informed her obstetrician that she was labouring in the birth centre and the state of play. She asked theatre team to stand by just in case mentally Pascha could not cope.

Pascha did not want anyone in her room other than her midwife (myself) and her husband. She took herself into the ensuite and sat on the toilet for most of her labour, I could see she was approaching transition so I knew this may be the start of a different behaviour for her. I looked her in the eyes and asked her to trust me as she went through this next stage, I stood her up and asked her to put her arms on my shoulders as I held her and we walked and swayed. She coped so well with this, I was using so Frankincense oil at this stage which is well known for its properties of addressing fear. Pascha looked up alert and said something is happening, I reassured her what was happening and said that she was in control her body knew what to do and to trust herself and me.

She breathed her baby out into her husband's hands in the quiet dim room. The female baby quietly opened her eyes as he caught her safely and looked at her daddy. It was a moving moment and was validation that birth is all encompassing even to a woman who was so terrified of what it may hold for her. Pascha was stunned into silence and was standing upright with her arms in the air. 'I did it' she repeated to anyone and everyone who could hear, she was amazed at what she had achieved and no wonder.

She breastfed her baby as her origins and culture (IKean catholic) dictated, she was helped ably by her sister who came to her home to stay for a few weeks after the birth. Her sister was astounded that she had done this as her family members were all aware of Pascha's fear (tokophobia); they thought she would never be a mother in her own right.

These two case vignettes demonstrate the complexity but also different manifestations that primary tokophobia will show on women. Similarities were the long history of denying pregnancy and achieving motherhood, shock and terror at confirmation of pregnancy, disconnection from the routine of antenatal care, abhorrence at the pregnant body and its changes, dissociation from the in utero foetus and its well-being and preparation for the final event.

The mode of birth may be different in each case but what was not is that each woman was in control of their own plans and wishes. The locus of control is really the issue for care planning in these situations and should be meticulously planned with the involvement of the woman.

7.6.2 Secondary Tokophobia

Hofberg and Brockington (2000) classify secondary tokophobia as occurring, after a traumatic or distressing birth of childbirth experience. They describe 14 women with secondary tokophobia, 10 had assisted deliveries for foetal distress, 12 women stated they that they thought they would or their babies would die, and one woman who had accidentally conceived had arranged a termination of pregnancy rather than face another birth.

Women who have given birth previously are more at risk of re-experiencing previous trauma from past experiences including those who have a stillborn or damaged baby (Eriksson et al. 2006; Saisto et al. 2001; Sjogren 1997). These groups of women are shown to prefer caesarean section for subsequent mode of birth more often than other women who gave birth normally with their first child; this choice was based upon fear of death either of their infant or themselves (Ryding et al. 1998). The reasons for this choice of birth method was given as lack of control and a belief that their bodies would fail them, lack of health professional trust and betrayal; pain was not referred to as a single reason (Sjogren 1997).

A woman with secondary tokophobia is very clear what the cause of her fear is although she will likely resist the idea she suffers from a phobia. She has already experienced childbirth and for her the experience was traumatic. Women may experience trauma in childbirth in many ways including instrumental delivery, emergency caesarean section or infant loss. Some women experience childbirth as traumatic when the clinical team reports an uneventful delivery, but she has felt dismissed, not listened to or was abandoned when in pain or distress.

Most women prepare a birth plan, and many have expectations for the birth of the baby. For women who develop secondary tokophobia, the reality of childbirth did not meet the expectation. Prior to the personal experience of childbirth, the woman had no unusual fear of parturition. For some women, antenatal care does not prepare

them for childbirth. A few women have notions of birthing care and support in labour that is hard to fulfil and place them at higher risk of an unsatisfactory birth experience.

Women who develop secondary tokophobia want to understand better the index delivery that was the trigger for their emotional pain and subsequent fear and avoidance of a future pregnancy. She may request either a meeting to debrief or access to her health records. Sometimes she may wish to seek redress. Without a doubt many of these women have birthing experiences that can be recognised as traumatic. The nature of the trauma may impact on the woman for years affecting her family life, relationships and return to work. Women may suffer depression, anxiety or even posttraumatic stress disorder following traumatic childbirth.

For others, the birthing documentation contains no detail on trauma so does not reflect the woman's feelings and recollections about the event. What can seem normal and routine to professionals does not always meet the emotional and psychological needs of the woman.

Some women in this group have suffered miscarriage or stillbirth. Other women have babies who have survived but experienced their own difficulties such as birth injury with extended time periods in a neonatal unit. A great proportion of women experiencing secondary tokophobia have suffered both physical and psychological consequences of childbirth. At the specialist clinic in London, women in this group also included those who experienced instrumental birth with poor perineal healing. Many of these women had resulting vaginal and pelvic floor scar tissue that leading to enduring dyspareunia. It is not the presence of third and fourth degree tears that appears significant; rather it is the healing and recovery that causes distress. Many of these women cease to trust their own bodies. They fear a future pregnancy will make their symptoms worse. They have no trust in the service provided to them. They recall doctors and midwives lacking any empathy. Their experience of childbirth and the post-delivery recovery as a loss they have had to grieve.

Where women have sought refuge and asylum in the UK as in the Birmingham Consultant Midwife's cohort, they are placed at even greater risk of re-experiencing trauma. They may have suffered acutely during their journey to the UK and perhaps have seen and experienced the very worst of humanity. Some women will have been trafficked across continents, been raped and humiliated, suffered birth alone in terrible settings and then arrive in the host nation pregnant again. It is important that these women receive constant and continuous compassionate care through pregnancy and birth.

7.7 Vignette 3

7.7.1 Secondary Tokophobia Bryony (CM London)

Bryony was a healthy 35-year-old woman expecting her second baby. She presented at the hospital for booking during the first trimester of pregnancy. Although the pregnancy was planned and progressing uneventfully, she appeared distressed and

tearful. Bryony explained that the delivery of her first child was very difficult. She had tried to put this behind her, but returning to the same hospital had brought a resurgence of her emotional pain.

She was referred to the Consultant Midwifery Team facilitating the FOB care pathway. Bryony had the opportunity of further time with a specialist midwife. She explained that she felt 'silly for crying' but dreaded the inevitable birth process. She shared her birth story from 2 years previous. She had a healthy and straightforward pregnancy so booked into the midwifery-led birth centre. She went to hospital with contractions every 3 min. On examination, her cervix was three centimetres dilated. She was advised to return home as her labour was not established. Bryony was convinced she was in labour and insisted upon staying in hospital. Her pain was intense but she felt the staff did not believe her. She spent the night walking on the maternity unit corridors with her husband, in pain and frightened. She felt unsure who to ask for help. She felt disbelieved and 'unloved'.

When the morning shift came on duty, one of the midwives noted her distress and supported her return to the birth centre. She was 6 cm on examination and in intense pain. She was advised to remain mobile before considering the birthing pool. As the shift progressed, the midwives were evidently busy. She continued to walk the corridors. She was nervous about approaching the busy staff and worried about 'bothering' them. She was afraid of her labour and did not know what to do. Whilst she climbed a flight of stairs she could feel something between her legs, she saw blood running down to her shoes and she knew the baby was coming.

Her husband virtually carried her back to the birth centre; the midwife visibly gasped when she saw and then proceeded to reprimand her for walking so far. She was helped onto a platform where her baby was immediately born. Bryony heard no sound from her baby and saw no movement. The midwife silently cut the cord and left the room with her baby. Bryony believed her baby was dead. Her husband left her so he could investigate the whereabouts of their baby. He located their infant on a resuscitation machine, being busily attended to by the paediatric team. He remained with their baby, accompanying him to the neonatal unit. In the meanwhile, Bryony had no update on her baby. A midwife attended Bryony to deliver her placenta. The midwife offered no information on her baby. For over 2 h, Bryony believed her baby had died. It was her husband, finally returning to her bedside who informed her that their baby was alive and showing signs of recovery.

Bryony's story was harrowing. She felt no trust in midwifery care. Maternity services felt unsafe, unsupportive and frankly dangerous. She wished a caesarean section believing that a planned operation would negate the risk of being disbelieved, rejected or abandoned by midwifery staff. She had not been let down by doctors the way she had been by midwives. Caesarean section felt a safe and controlled option with a profession she could trust.

When Bryony spoke of her ordeal, she expressed feeling of guilt and regret. Even though she had not felt empowered to alter the course of her first delivery, she still felt some responsibility at the outcome. Bryony was open about her experiences. She was able to be frank with the consultant midwife. They discussed the option of working towards a different birth experience. Bryony needed a midwife she could

engage with and trust. She needed to maintain this relationship through pregnancy and into the delivery suite. She needed the option of psychotherapy for fear and panic symptoms.

Bryony agreed to continue with the Consultant Midwifery team. She accessed support as she required this and delivered vaginally by choice in the same birth centre. She felt proud at this achievement and relieved to avoid an unnecessary operation.

This case demonstrates that being believed is important if not vital, having choices about what to do when there is doubt and having relationships with compassionate health professionals who are providing care.

7.8 Vignette 4

7.8.1 Farah CM2 Birmingham

Farah was in her sixth pregnancy when I met her; she had been referred to my Psychological and Emotional Wellbeing Service. She was unknown to me and her community midwife thought she would benefit from my expertise.

She was 24 weeks pregnant when we met and she was 5 years since her last child and this pregnancy was unplanned. Farah was Asian Pakistani and knew she could not terminate her pregnancy as it was both against her faith and also her family customs. Her emotions were obviously heightened when we met as she was re-experiencing some of the trauma she had felt after her last child.

She told me that she had called the hospital for advice and was invited in to be assessed. Her contractions were mild, but she knew that she would probably advance quickly in her labour as this had happened with her previous three other births. Her husband, a taxi driver, was working and she told one of her children to 'call for daddy' as she needed to go to the hospital. The child (who was 8 years old) tried repeatedly to get her daddy but to no avail. Farah was panicking now and she tried to call other family members to come and assist her; the hospital was only half a mile away in the city, but she knew she needed help to get there.

After an hour and still no help arriving, Farah contacted the hospital again and said she couldn't get anyone to come to her and was now panicking as her contractions were getting closer. The labour said they were sending an ambulance to her home and to wait until it came for her. All of her children were present with her in the home and she knew that her neighbours were away on holiday so couldn't call them. She tried hard to keep her children happy so they wouldn't be frightened but she knew her labour was advancing rapidly.

After a further 15 min, she heard an ambulance siren and asked her eldest child to open the front door which opened onto the street. The child stood by the door as she was told, but Farah did not hear anyone coming, so she made her way with difficulty to the room where her front door was. At this point her membranes ruptured and she immediately felt her baby's head advancing, she knelt down as she was afraid her baby would fall onto the floor. Her children were around her frightened,

and Farah was now shouting ‘help’ through her open front door. She could see people on the other side of the road, but no one came to her.

She knew that her baby was about to be born and screamed, it was at this point a woman who had just got off a bus came to her door and saw immediately what was happening. The ambulance arrived just as Farah was birthing her baby into her hands.

She said she felt abandoned, scared and terrified that she could not get any help to take her to hospital. She also said her dignity and privacy was compromised as she was ‘virtually giving birth on my doorstep’. People in her family laughed about it when she had gone home, but she felt ashamed and humiliated and her children had seen her at her worst. She struggled for many months until her GP had recognised her mood was not as it should be referring her for treatment.

As Farah stated she had avoided getting pregnant since that child and now at the age of 38 she was terrified of being both pregnant and also of her body ‘letting her down again’. I said that her body did not let her down and she had done nothing wrong, but she was up against circumstances that were outside of her control.

I met with her regularly through the pregnancy and we planned for either a home birth so that she had the surety of someone coming to assess her at home when her contractions started or coming into the birth centre when she felt that she wished to be in hospital. This was acceptable to Farah.

However as the pregnancy neared 36 weeks, she became increasingly anxious and had intrusive thoughts about giving birth again in the street. She asked if she could come into hospital and wait until her labour started; I listened to her but we looked at the impact of this on her family and emotional well-being. I asked her if coming to see someone for assessment and reassurance every week might help which she accepted for 2 weeks. Her community midwife also visited in between so that she felt more secure.

At 38 weeks and 3 days she rang and asked to speak to me, she said that she knew she was going to go into labour today. I questioned her about what had changed and she couldn’t articulate this but ‘just knew’. I invited her in and she was indeed highly anxious, flushed and looked agitated. I felt her abdomen which was showing signs of irregular tightening and her foetus was happy with good movements. She stayed in the birth centre happily on her own and told her husband to go home and look after the children. Later in the afternoon she came to the birth centre office and said her labour was now starting and she was having regular contractions. Indeed she was every 3 min. She was examined by her midwife and was showing signs of good labour with her cervix paper thin and 3 cm dilated.

The midwife said she was doing well and she would now stay with her and help her if she needed that. The midwife told me she thought that it may be a few hours before she showed signs of established labour but as if often the way Farah said, she needed the toilet and as she sat to use it her membranes ruptured. She was initially panicked but her midwife was on hand to quietly guide her thorough the next stage.

She said the birth might have been much quicker, but Farah was mentally not ready to let go of her foetus as the head crowned and she sensed she was holding back. Her midwife said ‘it is okay Farah you are in hospital, I know what to do and

you are safe'. It was only then that Farah pushed her baby into the world. She had achieved a birth that she had dreaded and in the privacy and safety of her birthing room, a completely different ending.

Farah was well after her birth and her baby required no extra care, she chose to go home within 4 h and be with her family. When she came back to see me in clinic for her postnatal follow-up, she was a woman transformed and looked so different from the Farah whom I first met.

7.9 Trauma: 'An Extraordinary Event That Happens to an Ordinary Person'

There is no doubt that the impact of a birth that renders the woman helpless, in fear of hers or her baby's life, is not listened to or ignored and treated by dispassionate carers, then she will suffer the consequences of trauma. That may resolve with time but more likely it will manifest and be intrusive to a new mother who is trying to come to terms with her new role as carer to her baby.

More often than not she becomes sleep deprived and suffers a range of psychological sequelae. Future pregnancies will most certainly be avoided if recognition and treatment are not commenced.

7.10 The Manifestation of Birth Trauma

Giving birth is a complex human experience involving the physical, psychological, sociological and the transition of one human state to the next. It might be defined as the 'greatest leap of faith that a woman makes in her lifetime' (Gutteridge 2000, unpublished dissertation). That said it also has the potential to destroy the core of womanhood and manifest in disruptive and dysfunctional mothering.

Childbirth is described as a 'normal life event'; however, Van der Kolk (1994) contests this stating it is a 'life crisis or life transition requiring substantial intrapsychic and interpersonal reorganisation and adaptation'. Those around who fail to recognise this often confuse women who are traumatised by this natural event; health professionals may even contribute, minimising, mislabelling or mistreating her condition (Gonda 1998).

The degree of pain in labour and loss of control association may contribute to greater trauma and psychological sequelae. Medical interventions at this juncture are retrospectively described as 'intrusive and violating', further Rose (1992), Benedict et al. (1999) describe sexually-abused women having longer labours with greatly increased pain during intimate examinations and throughout labour. If women are surviving birth experience with such trials and tribulations, it must be expected they may need to seek refuge in some form of psychological respite. Orchbach and Eichenbaum (1995) described post-birth women coming to therapy with a wide range of psychopathological symptoms: depersonalisation, fragmented self, feelings of loss, disturbing and irrational anger, a sense of doing for others but

bereft of self caring. If this is generalised, then there are implications for women, families, attachment processes and ultimately the society in which they live.

One commonly accepted postpartum illness is postnatal depression (PND), usually attributed to women with a range of emotional/psychological symptoms. However, the variance of symptoms and diversity of the medical profession to agree on causation contributes to society's unacceptability of this illness. However, Scott and Stradling (1995) believe it is 'easier to engage the patient in treatment for depression than to treat a trauma'; this can be recognised in post-parturient women who use disassociative coping structures to avoid disclosure (Crompton 1996). Whilst there have been improvements over the last two decades in the recognition and treatment of postnatal depression, the same cannot be said for recognition of birth trauma and subsequent PTSD.

Crompton (1996) suggests a 'trauma of human origin has more psychologically potent effects than natural disasters'; this generates discussion that childbirth might be a primary trigger for PTSD. Women who are vulnerable and risk potential trauma might experience flashbacks, dissociation, submission or extreme emotional distress from events hidden from their daily lives (Drauker 1995). Some midwifery services offer 'debriefing after childbirth' as a structured part of postpartum care, suggesting women need to consolidate and validate their experiences (Smith and Mitchell 1996; Charles and Curtis 1994). Murphy (1993), writing as a midwife and mother, warns 'it is how situations in the delivery room are approached and handled that can affect the whole family'. It is more the way care is delivered that defines quality.

Women know so much but often stay silent because of power inequalities; this is inherent in maternity culture. Scott and Niven (1996) describe medicalisation of childbirth by 'the changing relationships of power between pregnant women and their professional carers'. The language used by medical practitioners is exclusive and confusing to women, a woman pregnant for the first time is described as 'primigravida'; we even change her name and identity. Coppen (1995) explores the concept of names by which we call women, she is supported in this by Kitzinger (1992) and Kirkham (1989) who use the term 'verbal asepsis' in depersonalising women.

Obstetricians and midwives often speak of women in terms of 'normal and abnormal', indeed Fawdry (1994) speaking of the complexity of the body states: 'there cannot be a clear-cut division between normal and abnormal mothers'. Medical practitioner's flippant use of words in describing pregnant women is not without its psychic consequences, Raphael-Leff (1990) cautions, 'women are perceptive and able to distinguish between legitimate regard and professional involvement'. Indeed 'language gives identity by constructing and reinforcing beliefs, values and attitudes' (Shirley and Mander 1996), this is further supported by Miller (1973) who *describes language as*: 'the most subtle and powerful technique we have for controlling people'. If language is a form of control, then it is perhaps the most overwhelming and subversive tool in modern maternity care and reduces women's voices to a whisper.

Motherhood is not a solitary experience; it involves families, societal changes, accommodation of feelings and a reassessment of the woman's philosophy of life leading to a position of self-actualisation when she reaches motherhood. Knowledge

of motherhood is absorbed from many precepts; one of the first is a woman's recollection of her own mothering, in this context the formation of values and accepted norms are laid down as the building blocks of her premise to motherhood (King 1992). Taking account of cultural and societal discourses is critical, these influence the world in which the woman lives and seeks to explain her position in terms of 'socialisation' and 'cultural pathology' (Ribbens 1994). Powell (1995) states that women's expectations of childbirth are formulated by all their life experiences, education, family upbringing and cultural belief systems.

Understanding these constructs is vital if care is to be delivered in humane and compassionate ways. This will protect and serve to enhance women's experiences of birth and reduce trauma.

Kendall-Tackett and Kaufman-Kantor (1993) described a four element framework necessary to constitute birth trauma (Table 7.1).

It is easy to see how women may be affected by their birth experience and subsequently succumb to an acute trauma state.

In studies examining the prevalence of birth trauma and PTSD following childbirth, rates were between 4.6 and 6.3%, and a further clinically significant group with PTSD symptoms was identified in up to 16.8% of women in community samples of high-quality studies (Dekel et al. 2017).

Typical features include episodes of repeated reliving of the trauma in flashbacks, dreams or nightmares. Hypervigilance and anxiety symptoms occur, with avoidance of activities and situations that are reminiscent of the trauma. Emotional numbing and detachment are common and depression with suicidal thoughts might occur. Diagnosis of PTSD is based upon experiencing a life-threatening event and re-experiencing the event in the form of nightmares or flashbacks.

Table 7.1 Useful framework to consider when discussing trauma in childbearing

Physical trauma	Range: from episiotomies to emergency caesarean sections. Perception: maternal perception of being damaged and/or maternal perception of the necessity or otherwise of relevant intervention/s	This may be more important than the actual extent of the trauma
Stigmatisation	The woman feels blemished or marked in some way because of an aspect of her birth experience	Post-delivery indwelling catheter The baby may have been taken to the neonatal unit
Betrayal	The woman perceives herself to have been let down or abused by the health professionals associated with her delivery	Pain relief not given when requested or trust being breached
Powerlessness	Maternal perceptions relating to lack of, or loss of, control may be central to birth-related trauma	In some cases of urgency to deliver or women may become frightened and relinquish control, e.g. survivors of abuse

Symptoms of PTSD:

- Avoidance of situations similar to the stressful event
- Inability to recall the event
- Increased arousal or hypervigilance
- Sleep problems
- Irritability and/or anger outbursts
- Poor concentration
- Exaggerated startle response
- Dissociation or emotional numbing

The onset is usually within the first few weeks after the traumatic event but occasionally might be delayed by months or years. Women may not admit to the trauma initially, and might present instead with unexplained physical symptoms, depression or complications of PTSD such as substance misuse and other self-harming behaviours.

7.11 Risk Factors for PTSD in Childbirth

Previous psychological problems, anxiety, obstetric procedures, loss of control and lack of partner support are known risk factors for PTSD (Olde et al. 2006; Crompton 1996). Miscarriage and stillbirths can also result in PTSD (Turton et al. 2001).

- Emergency procedures such as cord prolapse
- Complicated deliveries and emergency caesarean section
- Stillbirth or intrauterine foetal death
- Catheterisation or other procedures
- Intimate clinical procedures, e.g. vaginal examinations
- Attitude and behaviour of health care professionals

Women with PTSD symptoms after childbirth become preoccupied with their birth and develop anxiety, flashbacks and nightmares. They may avoid situations that remind them of the event. Some women are at greater risk and more likely to develop symptoms of PTSD because of previous traumatic life experiences. Their symptoms may re-emerge or worsen in childbirth.

- Rape, sexual assault, childhood sexual abuse
- Domestic violence
- Victim of torture or war
- Refugee or asylum seeker
- Previous female genital mutilation
- Victim of violent crime
- Occupation—armed forces, emergency services

7.12 Vignette 5

7.12.1 Cara CM 2 Birmingham

Cara was originally from Albania and she came to England after she was trafficked across Europe and used in the sex industry. She had lived a simple life and was the middle daughter of an Albanian shepherd. They were poor and had little money, and she was schooled until she was 11 years old and then worked with the family. She spoke about her mother lovingly, but she had little love or respect for her father because he was abusive and violent when he drank.

She recalls being outside of the village one day with the herd of sheep and goats when a car approached, there were three men in the car. She remembers they stopped and asked her directions, as she turned to gesticulate to the road she was grabbed and bundled into the car. She remembers driving for thousands of miles until they reached Italy where she was sold to another group of men. She was taken to a house where other girls were present and she was told she would be used for the sex industry, she was 14 years old. She thinks she was there for 18 months and one of the men took pity on her after she saw him a few times; he said he would help her escape. Nothing happened and she thought she would die in that place with no one helping her. The language she spoke was not common, Gorani, but a rare dialect from the mountain region and she struggled to be friends with the other girls. There were times when she was beaten and she suffered broken bones and bruising.

One day she was aware that the door which led out to the street was not manned by the old woman who was paid to sit there, she decided to make a run for it and escape. She ran for many minutes and found herself near to a bus terminal. She tried to ask for help but couldn't be understood. An elderly woman on the bus took pity on her and paid her fare to the next town. Over a period of days and weeks, she moved from place to place until she found her way to a port in southern Italy, here she stowed away in a lorry and hid. She eventually arrived in the UK at Portsmouth and was taken to Border Services. She was processed through the Home Office asylum system and ended her journey in Birmingham. She was able to speak very little English and although she was a minor she was assumed to be older simply by her looks. Once an interpreter had managed to find out what language she spoke eventually a Gorani translator retold her story. Her health check revealed she was at least 28 weeks pregnant with significant malnutrition and other illness.

This was how I came to meet Cara. I knew she would be traumatised from what had happened to her and that she was at increased risk of developing acute trauma and PTSD during her birth.

It was a slow process of gaining Cara's trust and giving her care throughout her pregnancy that would enable her to cope with everything that would come with her birth. Once again she was seen in my clinic every 2 weeks as the pregnancy progressed with her support doula and an interpreter. She was introduced to the birthing centre and a small number of midwives whom she would meet when she attended for care. We arranged for a maternity support worker and her doula to provide her with antenatal education and preparation for birth. Although simple language was

important, she was able to understand the changes she was to experience and expect when labour started.

She started to smile and to look forward to visiting for her care; she said she was not afraid of the birth only of people touching her body. We planned that she would have minimum vaginal examinations if her labour proceeded normally.

She laboured quickly and had only one vaginal examination which was to confirm the labour was advancing and that she was established in labour. She used a birthing pool and gave birth to a son who weighed 4.450 kg; she breastfed him exclusively and was a very proud young mother. She remains in the UK and is currently at college trying to combine her studies with motherhood as her son is in the nursery. She avoided any trauma symptoms, there was time to plan her labour and care well, and this is not always the case.

7.13 Fear Associated with Body Image and Function

There are a number of women who express fear about the consequences of birth upon their bodies. Interestingly, this category is populated by ordinary women with a range of body shapes and sizes. It is not the arena of supermodel figures or sculpted cosmetic surgery. Over 2 years of work in this care pathway, just two women in London presented with a history of aesthetic surgery and a wish to retain this physical shape have presented.

Many mothers speak of their bodies 'tearing apart' and being 'forever changed' and 'horribly damaged' from childbirth. Some women speak authoritatively of other women's experiences, such as friends and relatives who have retold birthing horror stories. Women fear and focus on the appearance and functionality of their genital area after birth. They report fear of faecal and urinary incontinence as well as reduced libido, painful sexual intimacy and a subsequent detrimental impact on their personal relationship.

A small number of these women report third or fourth degree tears with delayed and/or painful perineal healing following a previous childbirth. They are fearful of recurrence and further pain and damage. Their fear is valid with scant reliable research to predict reoccurrence of tears and consequent sequale.

7.14 Vignette 6

7.14.1 Hayley CM 1

Hayley had a normal healthy first pregnancy and she planned to give birth to her baby in the birth centre, hopefully in water. At term plus 2 days, Hayley had a membrane sweep and just as the midwife predicted she went into labour the next day. Labour was slow, gradually building up but she knew this could happen and she kept herself busy at home until she felt she must be examined. She arrived at the hospital and on examination was told her cervix was thin but her dilatation was the same as

the day before. She was strongly advised to have some pain killers and to go home. Hayley went home, but she did not rest, her discomfort grew and the pain got stronger. Sleep was impossible and eating uncomfortable, immersion in water helped briefly. She started to get frightened, she felt this must be labour and returned to the hospital. The midwife was kind but firm, she was not yet in labour and should return home, have stronger painkillers and go to bed. Hayley was despondent but she went home and took the tablets, she bathed and went to bed, she was very tired. She slept fitfully, aware all the time of the pain and discomfort. Her waters broke at home and she returned to hospital. The duty midwife confirmed her cervix was still 3 cm dilated but appeared more favourable for delivery. She was admitted to the antenatal ward which was very busy. Hayley began to feel she should have stayed home, she was given more painkillers and tried to sleep. Eventually the next morning after a restless night, she was moved to the labour ward. She was told she needed stimulation to help labour along and antibiotics prophylaxis because her waters had broken. Her plans for a water birth were now changed and she knew she had to adapt to the changes.

Here, the staffs were kind but the environment was sterile, noisy and busy. Hayley was treated with a syntocinon drip but too exhausted to labour. She gratefully accepted an epidural. Progress in labour was very slow and the epidural top-ups were sometimes late, so she shifted from comfortable to pain but was mostly rested. After 12 h in the labour ward, Hayley's cervix was fully dilated, the baby's head was high and she was told that everyone would wait.

Occasionally a doctor or midwife would come into the room and look at the baby monitor, but no one said anything. Suddenly three doctors arrived together, told Hayley they were worried about her baby and she must deliver soon. She was transferred urgently to the operating theatre. She was frightened and cold. Hayley was prepared by the midwife for a caesarean section and told to sign the consent forms. Her legs were raised into stirrups and her epidural topped up. The obstetrician considered that a forceps birth was possible and the procedure was performed. Her baby was pulled out safely and was healthy; Hayley cuddled her new daughter, and the doctor told her that she had an extensive perineal tear that extended to her anus.

Hayley told her story through a veil of tears. She explained that she could not go through this again. She wakes in the night in a cold sweat, reliving the fears she suppressed in her exhausted labour state. Hayley does not particularly want an operation for her next birth, but that feels safer and vaginal birth may undo the healing that her perineum has already under gone. Hayley could not enter the hospital building without feeling tearful.

Not being able to predict absolute outcomes for vaginal birth after a third degree tear hampered Hayley's decision-making for her next birth and made her think more positively about section as an option. Due to Hayley's level of anxiety, she was referred to a clinical psychologist. Hayley learned to control her fear and gentle detailed planning for the birth built her confidence. Hayley gave birth to her baby in water, in the birth centre with constant support, kindness and encouragement, with a 7-h labour; there was no reoccurrence of perineal trauma. She had a follow-up plan for further assessment in the birth injury clinic.

7.15 Challenges: Request for Caesarean Section

This is a controversial but increasingly common issue where women without any history of gynaecological or obstetric problem feel that a caesarean section is the mode of birth that is right for them. Their fear is largely undefined but real and principally expressed by professional women with high levels of knowledge.

Generally women who present in this way do not express fear of childbirth, panic or discontent. The woman may present her 'case' stating she has read widely on the options, weighed up the pros and cons and decided a planned caesarean section is the best and only choice for her. She does not want psychotherapy services or other additional support but would wish for antenatal care and a named midwife.

These groups of women are often cognisant of their 'rights' within relevant NICE guidelines on childbirth and caesarean section choices (NICE 2019). They are the least likely of all women to waiver in their decision or consider a trial of labour instead of elective caesarean section. Unlike other fearful women, there is no evident shame about their decision and pregnancy may be enjoyed with the assurance of the desired and controlled outcome.

7.16 Vignette 7

7.16.1 Annabel CM London

Annabel is a 41-year-old white British woman, working as a Barrister in London. She is pregnant, expecting her first baby, a planned pregnancy and presented at her booking appointment at 12 weeks gestation, requesting an elective caesarean section. At booking the midwife advised her that she would need to discuss this request with a psychologist in line with current NICE guidance. She initially declined this service, later conceded them and changed two appointments dates citing work pressures.

> At 32 weeks of gestation, she attended antenatal clinic primarily to arrange her elective caesarean section date. She appeared to present with efficiency and detachment. The midwife in clinic took time to engage Annabel as she wanted to understand the thinking behind the request for caesarean section. Annabel reiterated that she 'just wants an operation date'. She felt clear that she had read widely and considered carefully. She had midwifery and obstetric friends who all agreed with her decision and choice.
>
> She was asked to look specifically at the Royal College of Obstetricians and Gynaecology and Royal College of Midwives statements about caesarean section and normal birth information. She was asked to consider what she would do if she went into labour before a caesarean section was done and to have a plan for this as well as planned caesarean section. Annabel was initially unwilling to consider this information, appearing irritable and defensive. However, she relaxed through the meeting and advised she had not considered the possibility of spontaneous labour before a planned caesarean section date. Annabel agreed to spending time on developing a birth plan and also attending more practical parenting classes. As she became engaged in the discussions, developing rapport with her midwife, she was able to consider with increasing confidence in her different options for childbirth.

Annabel valued the parenting classes and learning from other prospective parents who had enthusiasm for vaginal birth. She reflected on her own impending delivery and ways she could retain control of the birth process whether operative or vaginal. She attended appointments every 2 weeks and was encouraged to share what she understood of both 'natural' and surgical birth.

At 37 weeks Annabel booked her caesarean section 2 days post-term rather than at 39 weeks gestation as previously planned. She was motivated to try normal birth in the birth centre but was sufficiently risk adverse to not wait long past her due date. She was in agreement to early membrane sweeps to encourage a natural labour. She delivered uneventfully and vaginally at 39 + 6 weeks attended by her the specialist midwifery team she was familiar with at the Birth Centre.

Post delivery she reported that she had regretted the decision at times during labour, wanting to ask for a caesarean section. Overall, however, she considered her previous planned avoidance of vaginal delivery had been out of proportion to the experience she later had. She was proud of her birth choice and outcome with no regrets about the decision.

7.17 Finally

This chapter has given the reader a wide understanding of fear and childbirth. There has been clarification around what fear of birth is and also the way it manifests in some women's lives. Fear may be common in the pregnant population and to some degree is normal. However, primary tokophobia is rare and does not present commonly in maternity services. It is important that women are not misdiagnosed with labels that are not appropriate.

Another group of women who are at risk of developing secondary tokophobia are those who have experienced birth trauma and or developed PTSD following childbirth. This is a more common group and will be seen in the majority of maternity settings. Provision of pathways and care plans are vital to enable these women to birth without fear.

The final challenge is to identify those women who are at risk of developing trauma in their index pregnancy and birth. Understanding adverse life events and their implications upon the pregnant woman is necessary so that care may be compassionate and psychologically protective. Women who request caesarean section to avoid birth may be invited to explore why they feel this way so that they have a real choice and control over their births.

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Working with Worry and Inspiring Hope: Relationships with Anxious and Fearful Women

8

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It is better to light a candle than to curse the darkness—(Eleanor Roosevelt [1884–1962])

One in five women experiences high levels of anxiety in pregnancy; this appears to be increasing (Dahlen et al. 2018a; Kingsbury et al. 2017) and can impact on women and their babies (Austin et al. 2017). For many women, worries about pregnancy, birth and parenting are a normal response to a new and daunting role as mothers to be. There are a range of responses women have, from occasional worry all the way through to extreme anxiety requiring medical management. Being apprehensive and having heightened concern are actually normal responses to the changes pregnancy, birth and parenting bring. This worry motivates women to find support and ensure they have resources and knowledge to make the job of parenting easier. However, other factors are also at play today in the modern world that may contribute to the higher prevalence of anxiety, whether that be perceived or real. These include raised expectations, social media, contradictory information, isolation and the increased surveillance of mental health issues and hence recognition and treatment as well as a very fragmented and risk-focused health system (Schmied et al. 2018).

Women can fall between the gaps of our complex medicalised systems, and often humanity and social support are lost from care and this can be most damaging of all to women and their families. We often with our care rob women of any sense of agency and hope when it comes to childbirth. Relationship-based care (midwifery-led continuity of care) appears to be a way of modifying this worry and building relationships of trust (Teate 2018) as well as improving outcomes for mothers and

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babies (Sandall et al. 2016). Unfortunately, this model of care remains a minority option for women in many parts of the world.

In this chapter, we will use the term 'worry' to encapsulate the way women may feel and act, but we recognise there is actually quite a range, from mild and quite functional worry, what we term 'normal worry', to highly concerning maternal anxiety requiring medical management. Significant maternal worry (especially anxiety) can have serious consequences for women, their children, families and communities. Anxiety in pregnancy is associated with prematurity and low birth weight (Eastwood et al. 2012), as well as deficits in neurological development resulting in physical and psychological, language-development and emotional and behavioural problems, possibly caused by epigenetic mechanisms in pregnancy (Babenko et al. 2015). Following birth, anxiety can disrupt the parental capacity to respond to the infant in an empathic way (Fox et al. 2015).

It is not just women and their partners who worry but health providers as well, and this worry can infiltrate the language they use and the actions they take. Relationship-based care appears to be a way of modifying the worry and inspiring hope. Hope is essential for humans to move through life productively and with meaning. There is mounting evidence on the benefit of some complementary therapies that can also assist pregnant women with depression, though they have less success in moderating anxiety (Smith et al. 2019).

In this chapter, we will explore why anxiety may be rising, what the effect of women being worried/anxious may have during pregnancy and birth; how relationships between health providers and women impact on worry and inspire hope and how we can work positively with women to moderate worry as well as manage our own worry as providers of maternity care.

8.1 What Is Anxiety and Worry?

One in five women experience a significant level of anxiety during pregnancy and after birth (Dennis et al. 2017b), and this appears to have increased over the past decade (Dahlen et al. 2018a; Kingsbury et al. 2017). Worry is considered to be a chain of thoughts and images or set of behaviours that often occur simultaneously or act as triggers for each other (Borkovec et al. 1983). This worry process is believed to represent an attempt by the individual to solve problems when they are exposed to issues of uncertainty, such as risks or the possibility of negative outcomes. Consequently, worry is not only an aspect of anxiety but also relates to the fear process (Borkovec et al. 1983) and an inability to tolerate uncertainty (Ladouceur et al. 2000).

Worrying is a natural emotion and helps us to prepare and adapt to change and possible threat to our well-being. It has evolutionary, protective purposes as part of the flight-or-fight response to dangers that are real or perceived. Increasingly today it is these perceived dangers that are absorbing much of our energy as many of the real dangers decline. Some Darwinians believe that historically humans who were most afraid were most likely to survive (Dahlen 2010). The result, says De Becker (1997), is 'the emergence of man as we know him: a hyperanxious animal who

constantly invents reasons for anxiety even when there are none' (De Becker 1997, p. 278). Klein says the human psyche is skewed to the negative (Klein 2002). We have six main emotions (fear, anger, distrust, sadness, happiness and surprise) and four of these are negative and one has the potential to be negative (surprise). These authors argue that in relative terms it has not been long since we crawled out of the cave and felt safe enough to interact. The human race has evolved in an age of adversity so people naturally or even instinctually lean towards tragedy. Losses appear to inflict hurt and impact more than their equivalent gains bring joy. For example we all know that bad news in the media gets a stronger headline than good news and these headlines dominate (Baumeister et al. 2001). It is ironic that while life is in fact getting better for people and people are living longer, many people believe it is actually getting worse (Dahlen 2010; Easterbrook 2003).

Worry can move into anxiety and this can be a serious health issue. At the other end of this continuum, significant pathological anxiety can have symptoms such as irritability, restlessness, tense muscles, tight chest or heart palpitations (Highett et al. 2014). Women may have feelings of inner turmoil, anger or agitation. They may feel 'wound up' or have problems sleeping. Some women will worry about their baby's development, safety and well-being. Women who are anxious may believe something catastrophic will happen and some experience panic attacks (Highett et al. 2014). If women do not recognise these symptoms as anxiety, or worry about the associated stigma, they may not discuss them with maternity care or child health professionals. This is why in Australia we are aiming to ask all women questions about their mental health and psychosocial well-being to bring it out and make it okay for them to talk about their worries (Beyondblue 2011; NSW Department of Health 2009).

8.2 Which Women Are More Likely to Experience Worry or Anxiety?

A report released by the American Psychiatric Association in 2018 found that anxiety had increased by five points in 1 year on a 0–100 scale to reach an average of 51. While all age groups had higher levels of anxiety, millennials were more anxious than Gen Xers or baby boomers and more than half (57%) of all women aged between 18 and 49 years of age said they were more anxious than the year before. This was significantly higher than men (American Psychiatric Association 2018). Similarly, in Australia the Women's Health Survey in 2018 spoke to 15,000 women from across Australia and found 66.9% of women felt nervous, anxious or on edge on several days or more in the last 4 weeks (Women's Health Survey 2018).

More and more childbearing women are meeting the criteria for the diagnosis of conditions such as generalised anxiety disorder, social anxiety, phobias, panic disorder and post-traumatic stress disorder (American Psychiatric Association 2013). The high prevalence of subclinical levels of anxiety worldwide may produce detrimental physical and psychological outcomes (Remes et al. 2016).

Research across diverse disciplines (biomedical, epidemiological, population health) has focused on the risk factors and predictors of anxiety with a view to

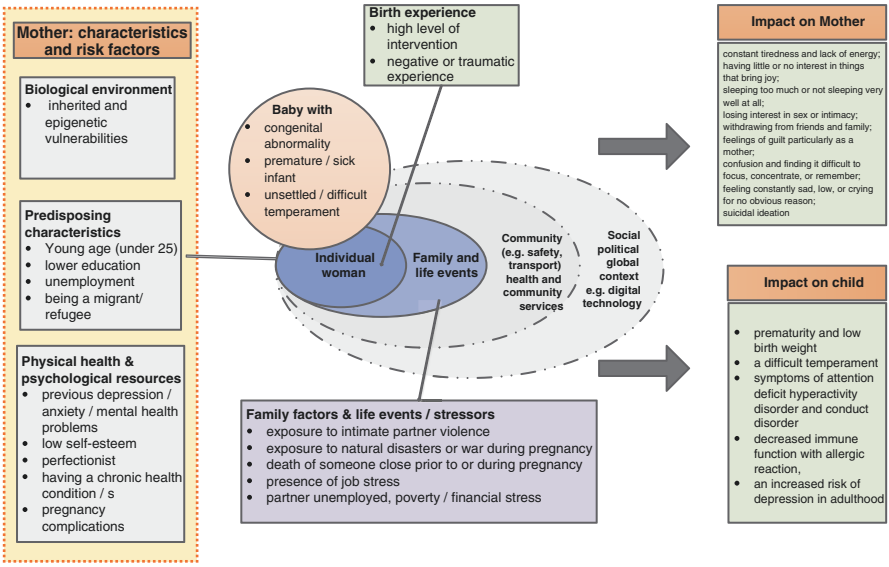

Fig. 8.1 Risk factors for perinatal anxiety and impacts on mother and baby (Schmied et al. 2018). Published in: Schmied et al. (2018) with permission

developing screening tools, and appropriate and acceptable treatments. We have recently modelled these risk factors (see Fig. 8.1; Schmied et al. 2018). Risk factors include a previous history of depression or anxiety (Clavarino et al. 2010; Dennis et al. 2017a; Rubertsson et al. 2014); birth interventions which are associated with post-traumatic stress disorder in the mother following birth (Dennis et al. 2017a; Rubertsson et al. 2014; Simpson et al. 2018); difficult socio-economic circumstances, with low level of social support or migrant and refugee backgrounds (Rubertsson et al. 2014), and women who report perfectionist characteristics may also strive to meet the ideals of the 'good mother' (Goodwin and Huppatz 2010; Hays 1996; Liamputtong 2006; Maher and Saugeres 2007; Pedersen 2012).

8.3 The Impact of 'Good Mother' Discourses

The rise in worry/anxiety during childbirth and the early years of parenting is a sociocultural phenomenon and should be a feminist concern. Social commentators argue that we live in an 'age of anxiety' where many women, particularly middle-class women in high resourced developed countries, are caught up in the discourse of the 'good mother' (Schmied et al. 2018). The good mother is a person who is all-giving, always available and can expertly and intuitively meet their child's needs. Ideals of the good mother vary across cultural groups and socio-economic class and can lead to mothers being aware of being judged by others or feel they

are the subject of surveillance by other mothers, medical professionals and family members (Liamputtong 2006). Some women experience motherhood as very overwhelming leading to guilt, shame, loss and exhaustion (Hays 1996; Liamputtong 2006; Pedersen 2012; see Fig. 8.2). The 'good mother' imperative may also be felt by mothers living in poverty with little support (Armstrong 2006; Shepherd 2014), mothers from culturally diverse backgrounds (Liamputtong 2006), or those with babies who are unwell or have special needs (Feeley 2017; Harvey et al. 2015).

Constant information from diverse sources can also increase anxiety (Fleming et al. 2014; McDaniel et al. 2012; Slomian et al. 2017). While the internet is a valuable tool that enables women to source information for themselves so that they feel in control of their decisions (Fleming et al. 2014), it is also a double-edged sword. Virtual communities provide important support networks for new parents, but

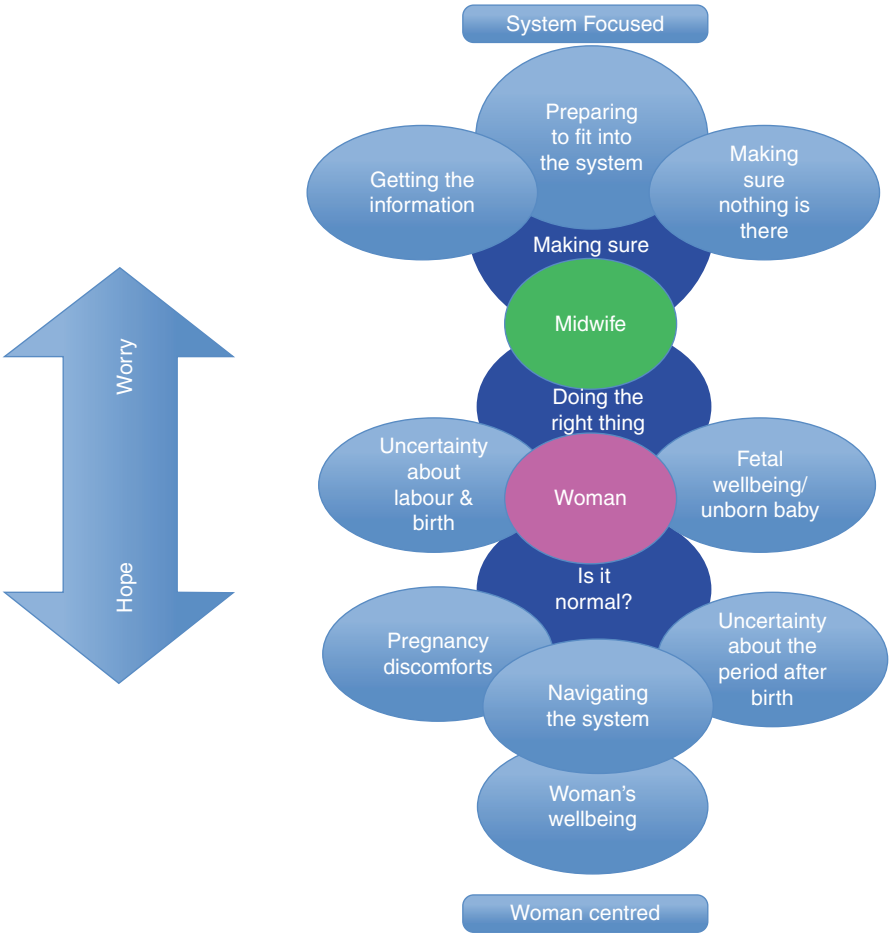

Fig. 8.2 The interrelationship between worry and hope (Teate 2018)

comments made by others online can have negative impacts on women's self-concepts as mothers (Coyne et al. 2017; Slomian et al. 2017).

Pregnant women and new mothers in particular are increasingly exposed to a variety of media (including social media) which can be enormously helpful on the one hand (Lupton 2016) but potentially anxiety producing on the other (Luce et al. 2014). As we become busier and busier and social media enables us to engage with many people on many issues, the stress of multitasking can increase the production of the stress hormone cortisol as well as the fight or flight hormone adrenaline and this can overstimulate the brain causing a mental fog or scrambled thinking (Levitin 2015).

8.4 Our Health Systems Are Manufacturing Worry

Becoming a mother can be worrying time for women and their partners. This is a major life transition and one that will leave women changed forever. Being surrounded with good support and having easy access to the right health professionals can help to moderate this worry. Unfortunately, health systems are large, complex and often fragmented with women receiving care from many different providers and this can all exacerbate worry. Increasingly women are being screened and tested for a variety of possible physical and mental health issues (Austin et al. 2017; Noonan et al. 2017). In antenatal appointments, for example, worry has been identified as a central feature (Teate 2018). Intervention in childbirth is rising to levels never seen before in human history. All this serves to reinforce the dangers and risks associated with childbearing rather than the reality that this is a normal physiological function that women have been experiencing for hundreds of thousands of years (Dahlen 2014).

While modern childbirth has bought many advantages for women in developed and developing countries in terms of safety, it has also bought with it an increasing focus on risk. A doubling in the caesarean section rate worldwide in the past 15 years is evidence of this with a recent Lancet series identifying fear of litigation as one part of the problem (FIGO 2018). Health providers are caught up in this risk agenda and can be a part of fuelling women's worry rather than moderating it (Dahlen 2010). The risk agenda in health care has also affected midwifery models of care and leads to restrictions in practice with midwives often affected but standing on the fringes of the debate (Scamell 2011; Scamell and Alaszewski 2012). As guardians of normal birth, midwives have often been left out of the debate with risk being the domain of medicine. The meaning of risk in modern maternity care is actually relatively new and it has shifted from a focus on women to a focus on the baby in more recent years.

8.5 Asking Women About Worry Is Exposing the Worry

There is little doubt that in countries like Australia, where all four authors are from, and where universal psychosocial assessment and depression screening is becoming the norm (COPE 2017), we are seeing higher rates of anxiety and/or depression recorded. If we ask the question as we now do in our country, and

women disclose their concerns, we get an insight into what women are dealing with. This will impact on rates. In society it is also now more acceptable for women to disclose anxiety and seek counselling/treatment. In certain cultural groups, it is also more acceptable to discuss psychosocial issues than in others (Dahlen et al. 2018b).

8.6 Dealing with Uncertainty

Historically childbirth was viewed as part of life's uncertainty and in many ways handed over to the determination of a deity, but science introduced a systematic way of finding solutions to major health concerns, and in this process concepts of certainty and ways of calculating risk became a central consideration. We are now in a place where we can provide women with 'precise uncertainty', as described by van Wagner (2016). However, we are still essentially unable to tell women if they will be the one who experiences the adverse event and therefore this 'precise uncertainty' in health brings with it worry and anxiety for women and health providers that was previously not experienced. It is also apparent that humans find it very difficult to comprehend risk when it is put to them in numbers (van Wagner 2016) as humans tend to lose their ability to comprehend large numbers when it comes to risk or the chance of something happening. When dealing with risks of 1:1000 or 1:10,000, it is not surprising that women focus on the one.

Risk is culturally defined and constructed. What is seen as a risk may be different in different countries, hospitals and even with different health providers. Andrew Kotaska (2017) noted recently that that if you are an astronaut your risk of death is 1.8% and that is considered acceptable but if you are a woman wanting to have a vaginal birth after caesarean section, then a 0.05% foetal risk is considered by many to be unacceptable (Kotaska 2017). Kotaska (2017) argues that astronauts face 40 times the risk than a woman seeking a VBAC, but we celebrate them as heroes while women who seek a VBAC are sometimes viewed as irresponsible and not good mothers as they are not sacrificing their needs for their baby (Dahlen and Homer 2011).

8.7 How Coercion Can Result from Marketing of Fear

There is an escalating echo coming from the drum beat of fear surrounding childbearing women today. Sometimes fear is used by health professionals to coerce women into making choices that many not want to make.

Kotaska (2017) exposes coercion as taking several forms in maternity care under the guise of risk management:

1. Magnifying risk estimates to dissuade a patient from an option
2. Exaggerating benefits or withholding risks of a recommended treatment
3. Demeaning a woman for putting her foetus at risk

4. Asserting a woman's decision makes her a 'bad parent' and threatening to involve child protection services
5. Threatening to withdraw care if a woman refuses medical advice.

Kotaska (2017) goes on to provide guidance for clinicians faced with women who accept or choose additional risk:

1. Clearly recommend against the 'risky' course of action
2. Have a second practitioner counsel the patient, if possible
3. Document informed refusal, using a preprinted form if desired
4. Reassure her that she will continue to receive courteous, professional care.

There is no place for coercion that instils fear and vulnerability in modern maternity care, and continuing to take a coercive approach will only drive women to potentially riskier options such as freebirth (Jackson et al. 2012; Rigg et al. 2017). This constant focus on risk also adds to women's worry.

The information women are given to make decisions is inevitably swayed by the attitude of the health provider to this risk. This is clearly evident in the private sector in Australia where we have shown that when care for low risk women is led by private obstetricians as opposed to midwives and obstetricians in the public sector, the rate of vaginal birth is 20% less (Dahlen et al. 2012) and that this added intervention has significant consequences for the baby (Dahlen et al. 2014) and intervention in birth can have ongoing physical and psychological consequences for women (Simpson et al. 2018).

8.8 How Do Relationships Impact on Worry/Anxiety

The care we provide women during pregnancy, birth and the postnatal period can impact on whether worry is modified, amplified or rectified. Lack of access to midwifery-led continuity of care models and the fragmentation of services may lead to increasing maternal anxiety. It is not just a matter of having continuity of care as the paradigm around childbirth held by the health provider will shape the care provided. When women receive maternity care from a risk-averse, professional expert, taking an authoritarian, advice-giving stance, they are left feeling unsupported, with their confidence undermined (Possamai-Inesedy 2006; Rollans et al. 2013; Schmied et al. 2015). Additionally, there is limited community discussion aimed at raising awareness to support mothers or to help those who support or advocate on behalf of mothers who might be in crisis.

There is now substantial high-level evidence of the benefits of midwifery led continuity of care and midwifery continuity of carer for mothers and babies (Sandall et al. 2016), but we still do not fully understand the micro components of what makes relationship-based care so successful or how relationships can moderate worry for women. Furthermore, midwifery continuity of carer models often described as caseload midwifery, or models of maternity care where the midwife is

the lead care provider, struggle to gain recognition and are still not embedded in many contemporary health care systems as a mainstream option for all women.

The midwifery continuity of carer model is a modern-day approach to maternity care based on a historically traditional way of working and developed on the assumption that women do better and are more confident when supported by someone they know and with whom they have formed a relationship with is built on trust and rapport. Changes to publicly funded midwifery care to incorporate this way of working in developed countries, such as the UK, Canada, New Zealand and Australia, have been part of a controlled 'renaissance of midwifery' (Shroff 1997) that began in the 1980s. As Flint (1986) so fittingly identified with the emergence of midwifery continuity of care in the UK, the relationship and the getting to know each other during the woman's childbirth experience seem to be fundamental to midwifery care:

> Mothers and midwives are intertwined, whatever affects women affects midwives and vice versa – we are interrelated and interwoven … To be a midwife is to be with women – sharing their travail and their suffering, their joys and their delights (Flint 1986, p. viii).

How then does this midwife–woman relationship, which is sustained across the childbearing continuum, work to modify worry? It has been well argued that what is central to the positive outcomes seen under midwifery led continuity of care, and midwifery continuity of carer models is the philosophy of woman-centred care and the power of the midwife–woman relationship. The midwifery philosophy of care that underpins the practices and behaviours that midwives espouse and demonstrate in their daily practice is conceptualised by the ability of the midwife 'to be with' woman (Guilliland and Pairman 1994; Kirkham 2010; Leap and Pairman 2010). Woman-centred care relies on attributes of a social relationship or a partnership, for example choice, control, and a relationship where individual needs are valued and respected (see Table 8.1). Taking this approach, the woman (and her partner/family) is the focus of care (Pope et al. 2001). 'Woman-centred' care relates to a midwife's ability or skill 'to be with', to provide support and compassion, to share in a common experience with the women when providing care and being part of a reciprocal relationship. More recently it has been described as 'working alongside' or 'walking alongside' a woman (Australian College of Midwives 2017).

Table 8.1 Woman-centred care is midwifery that

• Focuses on the woman's individual needs, aspirations and expectations rather than on the needs of the institution or professionals
• Recognises the need for women to have choice, control and continuity from a known caregiver or caregivers
• Encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself
• Follows the woman across the interface of community and acute settings
• Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations
• Recognises the woman's expertise in decision-making (Leap 2009, p. 737)

It is not too surprising then that there would be an impact on or moderation of a woman's worry when she has built up a trusting relationship with a midwife. From a sociological point of view, society, societal institutions and the relationships or social structures that arise between individuals, groups and institutions inevitably influence all human activity leading to and influencing all health care activities and policies (Kingdon 2014). This is as at odds with Western scientific medicine which institutes itself as being objective and value-free, where doctors base their care in medical science and objectivity and see their patients as subject matter (Abbott and Wallace 1997). Centralisation and fragmentation of public health care has destroyed many of the previous championed notions of quality care being individualised, relationship-based and provided by a known health care provider (Safe Motherhood for All 2017).

There is now emerging evidence of longer-term benefits of midwifery continuity of carer models for women and babies. A number of participants in a large Australian trial examining outcomes for women under midwifery continuity of care compared to standard fragmented models (known as the M@NGO trial) (Tracy et al. 2013) participated in a longitudinal cohort study examining the effects of the floods that happened in the Australian state of Queensland in 2011. This was a large natural disaster that flooded vast areas in and around the city of Brisbane. This flood occurred during the M@NGO study recruitment period in 2011 (Kildea et al. 2018). The study, known as the Floody Study, included women enrolled in Midwifery Group Practice (caseload midwifery) ($n = 55$) and Standard Maternity Care ($n = 71$) and asked the women to complete a number of stress scale questionnaires, both objective and subjective, and the Edinburgh Postnatal Depression Scale (EPDS), at recruitment then at 6 weeks and 6 months. Data from the six-week questionnaires showed that Midwifery Group Practice (MGP) mitigated the effects of the high-level stress created by the floods. Women in the Standard Maternity Care (SMC) group had increased depression and anxiety scores compared to the women who had MGP. The authors attributed this difference in mood to the number of postnatal home visits that women in the MGP group received, 5.93 ($n = 43$, SD = 2.24, range = 2–12), compared to the women in SMC in this study cohort, 1.90 ($n = 49$, SD = 1.29, range = 0–6). The benefit of midwifery continuity of carer model and the development of a supportive and caring midwife–woman relationship was also considered an important influencer of the women's ability to manage the stress of such large natural disaster.

Other studies on the midwifery continuity of carer model show a modifying effect that this model has on worry. A questionnaire undertaken as part of the South Australian MGP study (Fereday et al. 2009) with 120 of the women who had MGP care and a 70% response rate showed women were satisfied with their care, reported less anxiety and responded positively about their care. The women reported that 'accessibility' and the 'personal and professional attributes' of the MGP midwives were important factors associated with a positive experience of childbirth. Likewise, a six-week postnatal questionnaire asking the women about their experiences with the MGP in the Western Australian study by Lewis et al. (2016) also had a high response rate of 97%, with 98% of the women stating they would recommend the

MGP service to friends and family (Lewis et al. 2016). An interview with 62 of these women, which was analysed thematically, showed an overarching theme of 'Continuity with Midwives' informed by six sub-themes that reflected the women's experiences with the MGP as positive and one of connection and support: 'only a phone call away'; 'home away from home'; 'knowing me'; 'a shared view'; 'there for me' and 'letting it happen'. This would all have a significant impact on moderating worry.

8.9 Working with Worry in the Antenatal Period

A study we have just been involved with and was led by Alison Teate is shedding some light on the power of relationship-based care in moderating worry (Teate 2018). This study used video ethnography framed by feminism and a critical approach. A number of midwife–woman interactions in 18 late pregnancy antenatal appointments were observed and filmed at two Sydney hospitals with either the midwifery continuity of carer programme (MGP) or the standard maternity care (SMC). Focus groups and interviews were undertaken. Thematic and content analysis techniques were used.

In this study, worry was observed to be a common feature of the antenatal appointment. Both the midwife and the woman came to the appointment with worry. The worry the pregnant women demonstrated and reported was 'functional' worry. It was worry about their pregnancy, their baby, an uncertainty about birth and their transition to motherhood. 'Dysfunctional' or 'iatrogenic' worry occurred with system-focused midwives invested in standardised/medicalised tasks, whereas 'functional' worry occurred with woman-centred midwives invested in the woman. During the appointment, this worry was influenced by factors such as environment (setting and structure), time (rigid or flexible) and investment (relationships that make caring happen), which are in turn influenced by the system, the model of care and the midwife's approach resulting in a standard health care interaction or more of a social interaction. The style of interaction and communication then influence the worry to be addressed or not and for hope at times to be created.

Worry was the key feature of the antenatal appointments observed in this study. Midwives' worry in the appointment resulted from their actions 'to make sure' and to be 'doing the right thing'. For women the worry was different. They were influenced by three things: a need to gain certainty and reassurance about their pregnancy, for example asking, 'is it normal?' the sociocultural expectations of a pregnant woman to 'do the right thing' and to be 'making sure' by attending antenatal appointments. A woman in the study said that the midwife 'worried for me'. This sharing of their worry with their midwife was an example of how worry could be modified in relationship-based care.

The worry identified in the antenatal appointments in this study was both functional and dysfunctional. As described by Breznitz (1971) and Bruhn (1990) worry has both of these qualities. When worry was functional, it helped the women to manage their thoughts about their upcoming childbirth events and the transitions

associated with these. Dahlen (2010) reports that functional worry is a productive and positive process assisting people to manage painful, threatening situations or change, and it is a protective mechanism, as it motivates individuals to avoid danger and seek safety (Dahlen 2010). In this study we observed that when the midwife worry was functional and focused on the woman and her worries, it activated the midwife to become woman-centred. In these situations, the midwives adapted the standardised and medicalised features of the antenatal appointment and how they interacted with the woman.

In contrast, the dysfunctional worry seen in the antenatal appointments was linked to a state of helplessness, passivity and a lack of authority. This type of worry is recognised to increase levels of anxiety and depression for women during their childbirth experiences (Affonso et al. 1999; Austin et al. 2008). For the midwives, their experience of dysfunctional worry was linked to their practice being standardised and routine. Although not reported in the literature as a direct causal factor, dysfunctional worry is associated with burnout, a mismatch between what you aspire to in your work and ability to achieve this and the emotional burden of maternity care work and poor work retention (Catling et al. 2017; Curtis et al. 2006; Hildingsson et al. 2016). In part, this level of dysfunctional worry can be seen as an 'iatrogenic' product of the standardised and medicalised system, an inadvertent outcome associated with medical treatment or diagnostic procedures.

8.10 Creating a Sense of Hope

Hope creation was also seen in this study, although less frequently. It occurred when worry was moderated and linked with adaptation of standardised and medicalised appointment factors, including environment, time, and midwife investment (how the midwife interacted with the woman). Regardless of where they worked, some midwives were 'adaptive experts', but in most instances the midwives in continuity had greater opportunity to adapt. This adaptation resulted in midwife–woman interactions being bidirectional and shared, with discussing and storytelling taking place, rather than one-way midwife telling. These shared interactions created connection or reflected the connection created by continuity of carer. In maternity care, the need to focus on or create hope is rarely talked about or reported on. Stereotypes associated with pregnant women and pregnancy (Green et al. 1990; Morrissey 2007) are of assumed joy. However, in reality many pregnant women experience anxiety and worry about their upcoming labour, birth and postnatal period (Alderdice et al. 2013). In general, interactions and activities in maternity care and particularly in antenatal care rarely promote, support or enable women to have hope or hopeful aspirations for their upcoming labour, birth and postnatal period.

This study showed the benefit of the midwifery continuity of carer programme. It provided opportunity for midwives to adapt, worry was moderated, and women appeared more hopeful. Being more hopeful may enable women to better manage their labours and parenting, creating these improved outcomes.

8.11 How Midwives Use Time to Work with Worry

The way midwives construct or manage their practice has been described as being along a continuum between 'linear' and 'relational' time (Deery 2008; McCourt 2009). 'Linear' time is aligned with the system where a time-driven production line thinking dominates and promotes work practices that rely on the clock and tasks (Walsh 2006). 'Relational' time is the alternative or resistant discourse of time that is bound by relationships, both with women and with their colleagues (Choucri 2012; Thachuk 2007). The effect of 'repeated' time seen in midwifery continuity of carer models enable the midwife and woman to also have a connection across the continuum of the woman's childbirth experience: her pregnancy, her labour and birth and her early postnatal period (Homer et al. 2008). This enhanced connection and ongoing or 'repeated' time associated with the MGP model in this study fostered even more changes to the 'linear' routines and rituals of the standard antenatal appointment creating greater 'relational' time between the midwife and woman and enabling worry to be discussed, explored and modified.

In this study being woman-centred was linked to spending more time with the woman and interacting and relating through discussing and even storytelling, which facilitated worry moderation and reassurance. Women in this study appreciated a midwife who used her time in the appointment to focus on her and her needs or worries as well as the assessments and tasks. The simple action of the midwife spending time relating to the woman through more discussing and storytelling rather than simply telling the woman provided reassurance, a finding that has been identified by other studies. For example with the examination of communication practices in antenatal care in a London hospital (Raine et al. 2010) women reported positive experiences and were reassured when the midwife and doctor spent time talking through concerns and talked in an open and empathetic way. In contrast, these women from the London study reported negatively when the midwife or doctor did not pay attention to them, which was abrupt and discourteous and lacked compassion. Likewise, in a study that examined women's decision to disclose domestic violence, women reported that their decision to disclose relied on a number of factors that included the midwife spending more time relating to her. For example being asked in a way that the midwife showed she 'cared' and that they 'trusted' her enough to disclose (showed interest and was non-judgemental) (Spangaro et al. 2016).

Additionally, in an Australian study that examined midwifery practice in the antenatal appointment, midwives reported using a number of communication techniques to maintain a wellness focus, to be woman-centred, to facilitate a woman's capability, to employ worry usefully and to reduce anxiety (Browne et al. 2014). These communication techniques relied on 'relational' time that included being 'calm' and 'unhurried', using 'chat' about 'nice stuff' and stories to communicate to women about the broad range of normal in pregnancy to balance out the 'risk stuff'. From a feminist perspective, a relational model of midwifery care where the individual and the relationship are prioritised highlights that the way a midwife interacts with a woman is also key to a woman's ability to become empowered and able to maximise her autonomy (Thachuk 2007).

8.12 How Can Complementary Therapies Help Moderate Worry?

Complementary medicines (CM) and therapies are frequently (Frawley et al. 2013; Steel et al. 2012) and increasingly being utilised by Australian women (Adams et al. 2011; Frawley et al. 2013), for a variety of pregnancy-related ailments including mental health concerns (Adams et al. 2009). As the evidence of effectiveness for many of these modalities still remains to be established, caution in relation to antenatal use has nonetheless also been expressed (Adams et al. 2011; Steel et al. 2012), along with the suggestion that conventional approaches with proven effectiveness, such as medications and psychotherapies, are likely to provide superior outcomes (Ride and Lancsar 2016). Despite this, however, recent surveys demonstrate that perinatal populations continue to display interest in and substantial use of CM products and services. A survey conducted in Australia for example revealed that 33% of the 217 surveyed perinatal women would choose a 'natural, herbal or traditional Chinese medicine' if they became aware of experiencing depression or anxiety Ride and Lancsar 2016). Similarly, in the USA, 84% of 1032 pregnant women suffering from depression stated they 'would consider using a complementary health approach for weight and or stress management during pregnancy' (p. 81) (Matthews et al. 2016). The greater interest displayed in the latter case is possibly reflective of experienced dissatisfaction with conventional options, rather than hypothetical considerations (Battle et al. 2013), and indeed studies do demonstrate that continued disruption to normal social functioning is a major reason for seeking out CM and therapies (Solomon and Adams 2015). Other motivations also specified include the desire to avoid unpleasant side effects (Mancini et al. 2005; Ormsby et al. 2018), and particularly in the case of perinatal populations, not expose babies to psychotropic medication risk (O'Mahen and Flynn 2008; Ormsby et al. 2018). Along with the possibility of gaining benefit (Collinge et al. 2005; Mancini et al. 2005; Russinova et al. 2002), other attributes of CM and therapies considered desirable include the psychologically inclusive holistic approach (Bishop et al. 2007); the potential for more satisfying interactions with empathic caring practitioners (Berger et al. 2012; Mancini et al. 2005); the longer consultation times and the greater opportunities to be heard (Berger et al. 2012; Kadam et al. 2001).

Perceptions of benefits described by participants are also encouraging, not only in relation to symptom relief and enhanced moods but also with respect to broader ranging improvements in energy, motivation, sleep quality, functionality and interpersonal relationships. In addition, enhanced empowerment, resilience, ability to buffer stress, cope, and make positive behavioural changes have also been reported (Grant and Cochrane 2014; Greene Prabhu et al. 2009; Ormsby et al. 2018; Russinova et al. 2002). A further benefit described is a renewed sense of hope (Greene Prabhu et al. 2009; Ormsby et al. 2018), as having an additional option in times of need can facilitate a better sense of control over health outcomes (Berger et al. 2012). Hope is reportedly also a utilisable self-empowerment resource, which can assist with coping and the buffering of stress (Betts et al. 2014), as well as provide an additional component to symptom relief and recovery, in much the same way as the placebo effect (De

Craen et al. 1999; Miller et al. 2009). For perinatal women attempting to balance the complexity of their mental health issues whilst also attending to the needs of children, hope may play a particularly important supplementary role.

Whilst the evidence from reviews assessing randomised trials of CM and therapies for stress, anxiety and depressive disorders in both general and perinatal populations is still emerging; findings are also promising and reflective of the benefits reported by recipients (Amorim et al. 2018; Beddoe and Lee 2008; Deligiannidis and Freeman 2014; Hollifield 2011; Kim et al. 2013; Smith et al. 2019; Stub et al. 2011; Wu et al. 2012). The mechanisms by which these effects may be exerted also remain inconclusive; however, they are thought to be a product of homeostatic regulatory influences to central nervous system and neuroendocrine functioning (Cabioglu et al. 2012; Qian-Qian et al. 2013; Tiran and Chummun 2004). Consequently, when women have preferences for safer and more holistic, patient-centred treatments, CM may indeed provide a valuable additional therapeutic option for women suffering from worry and other perinatal mental health concerns.

A recent systematic review of 22 randomised controlled trials (1092 women) examining the effect of complementary medicines and therapies on maternal anxiety and depression in pregnancy showed there were now some promising therapies. Massage, bright light therapy and acupuncture may reduce depressive symptoms though this was not the case for anxiety. More high-quality trials of CM in pregnant women with depression and anxiety are needed (Smith et al. 2019).

8.13 How Can We Work Positively with Worry/Anxiety?

Some women need pharmacological therapy and others will benefit psychological and complementary therapies (Bystritsky et al. 2013; NICE 2016). Mindfulness training may be effective for women with a history of depression during pregnancy (COPE 2017). Recent Australian clinical guidelines for anxiety and depression following birth indicate that psychosocial interventions such as psychoeducation, cognitive behavioural therapy (CBT) and psychotherapy (IPT) have limited, preventive effects (COPE 2017).

Most importantly we need to work out ways to build resilience and hope in women and identify ways the system of care can support women. As we have discussed above, midwifery-led continuity of care with good consultation and referral pathways is one good way to do this. We also argue that consideration needs to be given to the broader sociocultural context within which women live their lives.

Recently we launched a programme of work at Western Sydney University to look at tackling maternal anxiety in the perinatal period with the goal to reconceptualise mothering narratives. We also wanted to return the ‘village’ to women’s lives as so many new mothers where many new mothers are devoid of, older women as role models and younger women as companions and support.

To do this we are taking a different transdisciplinary approach aiming to examine, understand and address the prevalence and associated impacts of maternal anxiety, specifically in order to:

- recognise the roles played by biology, culture, societal circumstances, economics and public discourse, among other contributors;
- illuminate the interplay of risk and protective factors at the individual, familial and societal levels;
- transform the narrative from one that pathologises mothers, and those who support them, to one that normalises and embraces the diverse, natural concerns about parenting (Schmied et al. 2018).

One of the first projects we embarked on in May 2018 was the Mother's Day Letters project in Australia. As part of our commitment to promoting resilient motherhood and celebrating diverse approaches to parenting, we wanted to challenge the stereotype of the perfect or 'good mother' and the pressure this places on women. We decided that one way to do this was to get women who have become mothers to share their tips and support with women who are on the journey into motherhood. We launched the first-ever Mother's Day Letters Initiative and received over 150 letters from Australian mothers sharing their congratulations and words of encouragement and support. On Mother's Day (which is in May in Australia), letters were hand-delivered to new mothers at one Sydney Hospital and were also posted on our website. Our aim is to extend this novel initiative to reach mothers nationally in 2019 and hopefully internationally after this. We believe positive messages from one mother to another can contribute to transforming dominant narratives of the 'good mother' and make women realise they are not alone and this helps normalise what may seem like a lonely and worrying journey for many women. We analysed these letters and developed ten top tips for mothers. These are listed below.

Top ten tips: Congratulations Mamma—You've got this!

1. Listen to people who give you advice but trust your instinct. You and your baby will figure it out together.
2. Cherish the moments that give you joy and hang on tight when you feel out of your depth.
3. Don't forget to ask for help and please don't say 'no' when help is offered.
4. Sleep is your greatest challenge, so prioritise sleep for yourself over everything else.
5. Eat well, be kind to yourself and take time to breathe. Housework is not important.
6. You are not alone and there is great advice and support out there.
7. Feeding is a full-time job and don't let people make you feel bad.
8. Don't isolate yourself. Get out and go for a walk or a coffee and find your tribe.
9. Nothing prepares you for the love you will experience, so try to soak it all in. Inhale their smell, relish their soft warmth and remember the giggles.
10. You are an awesome mamma and you are everything your baby needs. You have got this gig!

Table 8.2 Tips for dealing with fear (Dahlen and Caplice 2014)

• Identify the fear
• Take responsibility for it (it's your fear)
• Do an obstetric emergency course
• Don't forget to breathe
• Visualisation
• Watch the self-talk and practise thought stopping
• Talk to someone about how you feel
• Move (take a break from the situation and ask someone else's opinion)
• Have a cup of tea
• Knitting at birth can reduce adrenaline and keep anxious hands out of mischief
• Write about how you are feeling and reflect on it
• Get some evidence to support or refute your fear
• Centre yourself with affirmations such as 'trust in birth'
• If the fear will not go away or gets stronger, then take note it may be real. While birth should be trusted, it also needs to be respected
• Shed the fear and do not carry into the next birth

8.14 Working with Fear and Not Against It

As health providers we need to work on our own fears in order to support women who are fearful and to make sure we care not creating or amplifying fear in women. In Table 8.2 are some tips we have developed and published previously that may be of assistance to midwives and doctors when trying to deal with their own fears around birth.

8.15 Conclusion

Becoming a mother was never meant to be done in isolation. The journey of pregnancy and birth and early mothering was never meant to be done with strangers. We have forgotten the social aspect of nurturing new mothers and this matters so much to us as humans. We have traded the 'village' for a biomedical, fragmented, industrialised approach that may in part save lives but it is also destroying souls and minds, and this can never be an acceptable trade. Returning the 'village' to world of mothering and the known 'village' midwife to the community women live in is one way to address the loneliness and confusion many feel on this journey into what should be one of the most rewarding experiences of their lives. The 'worry' we see in childbearing women today is a natural response to an unnatural world we offer mothers. St Augustine said, 'give me other mothers and I will give you another world'. Perhaps what he should have said was 'give me another world and I will give you other mothers'. It is time to reclaim and reconstruct that world for the sake of the future of humanity.

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9 'Getting it Right First Time': The Effects of Anxiety and Fear on a Birthing Woman

Helen Shallow

> And yet, to bear you I had to look on death. To nurture you I had to wrestle with it. Death fought with me for you. All women have to fight with death to keep their children. Death, being childless, wants our children from us. Gerald, when you were naked I clothed you, when you were hungry I gave you food. Night and day all that long winter I tended you. No office is too mean, no care too lowly for the thing we women love - and oh! how I loved YOU. Not Hannah, Samuel more. And you needed love, for you were weakly, and only love could have kept you alive. Only love can keep anyone alive.
> Oscar Wilde: A Woman of No Importance (1893).

9.1 Freya's Story: A Case Study

9.1.1 Introduction

Midwives are known storytellers, and I would like to share a story with you. To be exact, three stories all inextricably linked and experienced by Freya. Before I share her birth stories, I will place Freya, and my relationship with her, in time and place by providing background details of how I came to interview Freya as part of a PhD research study entitled, 'Are you Listening to me' (Shallow 2018; Shallow et al. 2018).

9.2 Background

In my second consultant midwife post, in 2005 I was appointed to a Trust in the North of England to lead on midwifery-led care and to develop and open a new birth centre. The Trust catchment area included two urban and rural geographical areas. After

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reconfiguration and the merger of two obstetric units into one site in 2008, we opened a freestanding birth centre on the site without obstetric services, and a co-located birth centre on the other site with the newly merged obstetric services. I deliberately refer to our midwifery-led units as birth centres, as they were set up and developed to follow the social model of care that puts the relationship between mother and midwife at the heart of care (Kirkham 2003). More recently, all birth centres are now called midwifery units; however, I am not convinced that all midwifery units are set up to promote the social model of midwifery care for women.

This Trust had a long tradition of midwifery-led care and we were proud that up to a quarter, that is 1500 women, gave birth in either of our birth centres or at home. We were able to show that the birth centres were economically sustainable and safe, as well as positively evaluated by women and families.

After the merger, I also became the head of midwifery, a post I held for 4 years. At the time and unforeseen was the devastating economic crash that began in 2008. The effects of the financial downturn were incremental at first, with a corresponding, unrelenting demand for year on year savings that whittled away at staffing and supplies and increasingly placed maternity services under considerable pressure.

By 2012 I became ever more concerned by the number of complaints and incidents from women and families who reported that they were not being listened to or believed, when women reported that their labour had started. Some of these women had repeated admissions and were told they were 'not in labour' and sent home, despite experiencing pain and distress. Other women deterred from admission, arrived in advanced labour and a rising number of women gave birth unexpectedly at home or en route. Whichever way, all these women were denied the support and pain relief and foetal surveillance that they had been assured of throughout pregnancy and this is and continues to be a safety and quality concern, linked as it is to fragmented care systems (Edwards et al. 2018).

9.2.1 Meeting Freya

One such complaint came from Freya's mother who was deeply unhappy about the lack of care for her daughter before and until Freya's first baby was born. I recall with absolute clarity my feelings when I and the risk manager left Freya's house in 2011. I stood in the fresh cool air feeling despondent, and declared to my colleague that I could not carry on saying sorry to women. I had to do something. To this end I stepped down from the head of midwifery role, kept my consultant post part-time for a further 2 years and registered to undertake a PhD in October 2012.

9.2.2 Study Synopsis

The main aim of my research was to explore the interactions between women and midwives after labour onset, to determine what factors contributed to or inhibited satisfactory interactions between women and midwives. The study sought to

increase awareness of the significance of these interactions, and seek ways of interacting differently, by providing participants with opportunities to engage with the research findings.

I chose feminist participatory action research for its emancipatory and collaborative potential (Brydon-Miller et al. 2011; Gatenby and Humphries 2000; Glassman and Erdem 2014; Hooks 2000; Milligan and Woodley 2010). This approach has not been used before in midwifery. Participants' active involvement gave voice to their issues within the context of contemporary NHS maternity care provision. After a series of separate interviews and focus groups, first with women and then midwives, participants came together in a one-day workshop to consider preliminary findings. Together they were asked to consider a co-constructed narrative of their accounts and explore ideas for improvement. Later, the voice-centred relational method of analysis known as the 'Listening Guide' (Gilligan 2015; Mauthner and Doucet 1998) was used for interview analysis and overall interpretation. Some of the quotes from Freya in this chapter take the form of 'I poems' whereby her expressions prefixed with 'I' afford the interviewee the opportunity to talk of her/himself before others speak for them.

The main findings from my study showed that where women found interactions perfunctory, midwives described unreasonable workload pressures, which resulted in taking calls amongst other tasks. Where women said personal interactions were fragmented, midwives described being overwhelmed. Midwives described rationing care to all, in order for all women to receive some care. Women' subjective experiences of labour did not accord with the midwives' objective diagnosis of labour. This conflict resulted in women subjugating their embodied knowledge in deference to professional knowledge. Overall, cognitive dissonance theory, which I describe in more detail later in this chapter, became the theoretical framework upon which to understand the conflicts between women and midwives and between groups of midwives themselves (Shallow et al. 2018).

9.2.3 Freya as Research Participant

I interviewed thirteen women affected by being turned away or who had their admission deferred. I had met six of the women before in my clinic. I purposefully enrolled them to the study, as I was confident that taking part would help them on the road to recovery and closure, after what had been harrowing experiences for them. One of these women was Freya. As serendipity would have it, Freya received my letter and information sheet the same day she found she was pregnant for the second time. She was excited and frightened in equal measure and was keen to be involved in the research study. With the exception of one woman and her partner who came to see me at my clinic, the other women I interviewed, seven in total, I had not met before and were women who had all given birth unexpectedly out of hospital/birth centre. It is beyond the remit of this chapter to describe my study in detail; however, I also interviewed five midwives who had been involved in 'in labour'/'not in labour' dilemmas and held a series of six focus groups with women and four focus groups

with midwives whose views were entirely unknown to me. In total 72 participants contributed to the 'Are You Listening to me?' study.

Freya's Story The birth of Ella—Holding on and not feeling safe enough to let go.

In 2014 the Guardian newspaper reported 740 cases of women being turned away from their chosen place of birth in the UK, due to temporary maternity unit closure caused by lack of staff or beds. I have reason to believe this number is rising as I write. Back in 2010/11 our maternity unit had never closed before. However, on this day, the day Freya went in to labour I as the head of midwifery and the clinical director for obstetrics made the decision to temporarily suspend services. At the time there were no available beds across site and insufficient staff to care for the women and babies we already had.

Lack of capacity was as a direct result of reducing bed numbers, post-merger two years earlier, combined with the aforementioned financial constraints. There was quite literally 'no room at the inn' on that morning, and we decided we would have to divert any potential admissions to a neighbouring Trust until beds became available. The maternity service remained suspended until late morning.

Meanwhile, Freya's waters broke in the early hours and she described how she 'held on' at home as she was too scared to let go and enable her labour to progress, for fear the baby would be born at home. I want to emphasis here that the women in my study, including Freya, held unquestioning beliefs that the hospital was the only safe place to give birth. Even after birthing unexpectedly at home or en route, women still maintained that hospital would be their choice next time. Such is the culturally dominant narrative around birth and safety, despite the overwhelming evidence that attended birth at home or in birth centres is as safe for babies with significantly improved outcomes for women (see Birth Place in England Study 2011).

This was how Freya described how she felt after her waters broke:

I was trying to keep really really calm because
I still didn't know what was happening at the hospital
I remember sitting on the sofa and actually thinking
I daren't move a lot here – in case anything sort of happens
They kept saying, 'no we are still shut. Ring later'
I was trying not to have a reaction because
I was trying to keep calm, but it would be so easy for
me to freak at that point because
I didn't have a clue what was happening

Freya described how it was 'like a motorway of thoughts' as

I couldn't do anything
I couldn't even go to the toilet,
I was so worried
You're in a complete utter state of panic
Every worry and every fear and if something goes wrong
I felt totally frozen and not daring to move

> You don't feel like, it's not a relationship, it's not a relationship [with the midwife] where you're felt at ease to ring and to speak to…

Later in the morning Freya decided she had to go to the birth centre. She described how she felt after seeing the midwife who told her she was not in labour. Still holding on, she described how she was

> … shocked but it wasn't an issue for them…So eventually I got to be seen…
> We went along to the hospital…
> I already felt awkward but
> I was in pain, again, not serious pain but enough to think something is going to be happening soon.
> She, [the midwife] actually said to me "Your actually in pain now?" and it made you feel, shouldn't I be?
> I didn't feel welcomed.
> I'd been this woman who had been on the phone all morning trying to ask, "are you open?" "no".

Freya was advised to go home again. A decision she bitterly regretted but felt powerless to challenge. And still holding on all the way home she described how

> it just added to me feeling awkward about [going in]. Anyway she did an examination and she said "no, you need to go home" and I was a bit unsure about stuff then but obviously you're a first timer, [I] went with exactly what she said and my turning point was before I even got to the car park and I said "Craig, this is wrong, this is not right" because then I was in almighty pain.

About how she felt, she lamented:

> I didn't feel like I was welcome,
> I felt stupid enough to go [back] in because she'd say "oh, you're feeling pain?".
> I would [not] have dared, never in a million years.
> Now on a second child,
> I'd have gone straight back,
> I thought there was no way they was going to take this seriously but yet
> I knew this was not right
> I knew, I really knew I was in trouble. (cried)
> I remember driving home
> I remember crying, having contraction after contraction, after contraction.

At home Freya asked her mother to leave work to be with her. Sue was shocked by how she found her daughter and telephoned the birth centre. The midwife protested that she had not long seen Freya. Sue responded that if her daughter did not return to the birth centre immediately, she would be giving birth at home with no midwife. The midwife agreed to see Freya. This is how Freya experienced the journey back in:

> I remember the whole journey there.
> I have never, ever felt any pain like it and …
> I think that's my whole thing was the amount of pain but over such an amount of time and being so uncomfortable.

I mean the back of the car
I remember every acceleration, every slow down, which was minute but felt so terrible.

Freya reported that the midwife was shocked when she saw her, realising the birth was more imminent than she had anticipated. The pool was filled and Freya takes up the story:

There was no time to relax, there was nothing that was relaxing about any of it because then it was sort of rushed in, checked again and then the birthing pool was full. I remember running down the corridor and just literally jumping in, still with my socks on, just to try and relieve some of the almighty pain that I was in.

Looking back Freya described how:

I didn't tear but
I grazed all inside and again
I don't know and no body [will say],
I just know that everybody who's had a child… you know after a week they are usually up and about and
I was in absolute pain and it was like my insides were bruised, really truly bruised and whether that was the stress of trying to hold something in, you'll never know,
I don't know

However, Freya did know. Had she been able to be in the place she believed was safe, that is, the birth centre, she would have relaxed and let go, and just maybe would have given birth earlier than she subsequently did, without the weeks of pain and internal bruising that she experienced afterwards.

I reflected on women I have met in the past who have arrived in advanced labour, and in attending a 'nice quick birth' I never fully realised, how traumatic this may have been for some women, especially when they have tried to come in earlier. This is a different experience to those women who *want t*o stay at home, who are *happy* to be at home for as long as possible. The issues arise when women end up feeling unsupported, rejected and deeply fearful for the safety of their babies, as their ability to 'cope' is impaired due to the absence of support only available in the hospital setting, which has been sold to them throughout pregnancy, as the safest place to give birth and where support will be provided.

Processing women, whilst at the same time gatekeeping admissions, has serious implications for the future integrity of midwifery as a caring profession in general, and as a safe profession within the context of midwifery-led care in birth centres as well as in obstetric labour wards. Many months later Freya described the hallmarks of post-traumatic stress (Greenfield 2016) as she was

… still so shaken up by that.
I remember afterwards having these terrible, was like nightmares but not, and
I felt I was contracting again.
I could have bet my life I was going in again.
I remember thinking "oh my god, it's happening again" and absolutely feeling a contraction coming on

Freya's closing comments during our interview reflected the voice of many women when she said

> I just hope it doesn't happen to other people and obviously you know, I don't know how it goes for you know, when somebody has been through this, how do they then get help when they are going through this again? (Emotional)

I will return to Freya's experience at the close of this chapter to discuss how we could have improved her experience despite the temporary closure, and what measures midwives and managers might take to ensure women are not left stranded and isolated in the future.

9.2.4 Alice's Birth

With a sense of guilt and shame for our maternity services, I also felt personally responsible for the situation Freya found herself in and so vividly described. I did not hesitate to offer her on-going support throughout her second pregnancy along with her community midwife. She had my phone numbers and knew she could contact me for advice or reassurance at any time. She knew I lived over two hours away from the maternity unit; however, I said I would do my best to be with her at her birth and that I would pave the way for her, to ensure that what happened before would not happen this time. Her community midwife also agreed to be on call for Freya. Freya had a high degree of continuity throughout her second pregnancy.

Despite her obstetric history reporting her first birth as 'normal', nothing we could say about her potential to have a positive birth experience in the birth centre or even at home reassured Freya. She decided that the labour ward would be the best option for her, as she wanted to ensure that an epidural would be available. Her concern was '*that pain*' '*that holding on pain*' that she suffered when she did not feel safe enough to let go. Not feeling safe in order to let go and let labour progress is a phenomena unravelled by the late Tricia Anderson in Mavis Kirkham's edited book on the importance of the mother–midwife relationship (Anderson 2010; Kirkham 2003).

It was important that Freya felt listened to and her decisions respected, in order to build her confidence and self-belief. Nevertheless, I was worried that on the day, the labour ward might be overly busy, or there would be staffing problems. Would the anaesthetist be available if Freya asked for an epidural? Would the pool be ready and available to use? Would she arrive in time for an epidural if she decided she wanted one?

All these thoughts coursed through me. Yet at the same time I was confident that Freya would labour well and straightforwardly and probably quickly. To this end, together, we planned for birth on labour ward and I communicated Freya's wishes to the labour ward team and explained why I was involved with her care.

I was driving home one Friday, late afternoon, when Freya called to tell me she thought, '*something is happening*' and that she, '*didn't know what to do*'. I stopped

the car and listened to her describe her contractions but heard that, '*they weren't too bad*' and as I was on my way home, she didn't know if '*this was it*' or '*what … should we do*'?

Without hesitation I turned back and told Freya I was coming to see her at home. As I drove passed the hospital, she called me again and asked me to meet her at the labour ward. Without question I diverted to the maternity unit, donned my uniform and headed for labour ward. After greeting the team, I prepared Freya's room just in time for her arrival. Freya said afterwards

> As soon as I saw your smiling face at the entrance
> I knew I would be okay

The following couple of hours passed quickly as I welcomed Freya, her husband and Sue to the labour ward. Freya was clearly in active labour. I wondered whether I would get all the procedural work completed and documented before the baby arrived! Very soon Freya started to have expulsive contractions at which time she asked for the pool. I asked for the pool to be prepared and filled. Meanwhile back in her room the tension was rising, and Freya told me to get the anaesthetist; however, I knew the baby was very close to being born. Nevertheless I spoke to the anaesthetist and asked him to stand by.

Freya was pushing and at the same time protesting that she could, 'NOT DO THIS'. Her mother soothed her, her husband supported her quietly, and I reassured her that the baby was coming, and it would not be long. Her reply was a brusque

> How Long?

I asked Freya to move on to her hands and knees and very soon we could see her baby emerging. I talked Freya through, and Alice glided in to my hands. I passed her through to Freya and she cried with amazement and delight as she cradled Alice for the first time.

A short time later I filled the bath and we sat together as Freya reflected on what had just happened that she '*could not believe*'. I thought she would talk more about the birth but instead she said

> I just cannot believe you listened to me
> you came back, I didn't ask you to, you just did
> I can't believe you did that. You trusted me!

Freya was elated after Alice's birth. Later she described what a happy post-natal period she had, and how Alice was such a settled and calm baby.

> '*not like baby Ella*' who had been unsettled and fractious for a long time.

I felt relieved and satisfied that I had atoned for the wrong Freya had experienced. I hoped that this positive birth experience afforded closure and would strengthen Freya's belief and confidence in herself. I thought I witnessed healing.

Two months later I held the joint workshop with women and midwives to analyse preliminary data and Freya joined the day with Alice. She, like so many of the other women and midwives involved, were moved by the data and contributed wholeheartedly with their recommendations for a way forward which I discuss in my closing comments at the end of this chapter.

9.2.5 The Birth of Grace

Freya stayed in touch with me intermittently and gave me much needed encouragement when I expressed my own self-doubt about bringing my PhD to fruition. Whereas I had been Freya's midwife, she now midwifed me.

In 2017 when my studies were complete, I received a call from Freya informing me that she was pregnant once more. Delighted, I congratulated her and although I no longer worked in her local Trust, I reassured her that I would be happy to provide support, but that I could not this time be her midwife. I lived too far away, and my work circumstances did not enable me to take on her care independently. Freya had no expectation and was delighted that she could still call me, as and when, for advice and support.

In the third trimester Freya's calls became more frequent. For much of the pregnancy she informed her community midwife that she would give birth on the birth centre. It was evident now that giving birth was straightforward for Freya. However, how she anticipated giving birth was not as clear as we anticipated, as she repeatedly expressed doubts about whether or not the birth centre would be open and whether she would get there in time and '*no*' she would not consider birth at home.

As term approached, I received a text from Freya. She had had a

> Really crap night, couldn't sleep at all very anxious and upset, just horrible, got myself in such a state not good for anyone, so scared, It's torture for me… I've spoken to [MW] this morn. I want to go straight onto labour ward, she's written it on my plan. I want to have my options open, to be able to get in early.

All Freya's concerns focussed on getting in at the right time or not, and that 'right' time was dependent on having an epidural. Ella's birth was still haunting her. The fear of the pain of 'holding on' was overwhelming her with anxiety about admission timing. Both her mother and her community midwife and I were becoming concerned for her. Freya described how

> [I'm] Back in that place again by the fire, in almighty pain and mum calling the hospital and they don't want me to go in, it's like I am back in that place.

Whereas I had hoped Alice's birth had helped Freya, it became apparent that she was again experiencing the symptoms of post-traumatic stress.

Long and complex conversations with Freya ensued, as she sought to explore all her options. Intellectually she knew she was likely to have a straightforward birth; however, her embodied-self felt at odds with this more cerebral logical knowledge

(Wilson and Golonka 2013). This embodied dissonance related directly back to her first birth and experience of abandonment. I found myself listening very closely to what she was saying as she contradicted herself in circular dialogues as to what the right course of action would/could/should be for her. Standing back a little, it was fascinating to listen to her working through her options. She considered all the pros and cons, as she ultimately rejected awaiting spontaneous labour, which was, in my view, her best chance of an uninterrupted labour and birth. When considering induction, she cited her anxiety as a not unreasonable rationale, with a timely epidural to obviate '*that terrible pain*'. *S*he emphatically did not want an elective caesarean section.

Freya's community midwife arranged an appointment for her to see an obstetrician who agreed to a date for induction around her due date. Freya was fully informed of the risks of induction, but for her it became the only way she could take control of the anxiety plaguing her. Once she had the date, she said that she felt much calmer. So much so, she asked for the date to be extended in the hope that she might go into labour herself.

I then got a call from her to say she had changed her mind. The bad weather was coming, and she could not chance going in to labour at home and getting held up by the snow. On a Sunday evening in February 2018 she agreed to go in and begin the induction process. I had long said that I would do my best to be present at the birth in a support capacity. Knowing how lengthy the induction process can be, I agreed to meet Freya and her mother on the labour ward the following morning.

Image 1 Induction day: Helen, Freya and Sue getting ready for the day

I cannot give a detailed account of what then transpired. Suffice to say after Freya's waters were broken, the baby's head moved out of the pelvis briefly and a hand then presented itself. The epidural was commenced, and Freya felt very sick from that point onwards. It became clear that the induction could not proceed, as baby's hand became an extended arm. The decision was made to proceed to caesarean section.

Freya looked to me for reassurance that all was well. I recall feeling sick with worry and devastated that all my fears for Freya had been realised. I believed that this whole situation had been avoidable. Nevertheless, I stayed by Freya's side and gave her the positive words she so needed as we transferred to theatre. I had reason to believe that Freya's mother felt the same as myself. Our commitment had always

been to support Freya and embrace her choices; however, this outcome resulted in a feeling of powerlessness on our behalf.

The point I want to make on Freya's behalf, and this is key, Freya was happy. She remained happy about her decision to be induced despite:

- Near collapse after the epidural was sited and Freya felt awful
- The first vaginal examination to break her waters resulted in complications
- Compound presentation resulted in emergency caesarean section
- Very unsettled baby, even after 2 months
- Five weeks on, Freya needed antibiotics for a wound infection
- Freya gave up breastfeeding
- Posterior tongue tie not diagnosed for the first '*four feeding nightmare weeks*'.

Freya set out in her first pregnancy with positivity and confidence; however, incrementally as her story shows, her confidence eroded. She had to change her narrative to restore a sense of order and control in her life. I described this in my study as embodied dissonance caused by the conflict between what a woman feels to be right and what she then experiences or is told that contradicts her own embodied knowledge. In the following, I briefly explicate this further, as midwives too suffer cognitive dissonance when they cannot work according to their values and beliefs (Shallow et al. 2018).

9.2.6 Cognitive Dissonance and Contentions

The contention that it is better for women to stay at home hides a more serious difficulty with the organisation of midwifery. Current practices, based on assumptions from out-dated evidence, are no longer fit for purpose. There is potential for more women to opt for birth at home or in birth centres, even though the home birth rate remains variable throughout the UK. Currently, the number of women booking to birth at home is rising, although still only about 2.5% of pregnant women in the UK choose this option. But this rate varies greatly—from less than 1% in Northern Ireland to just over 1% in Scotland and 3.5% in Wales. In West Somerset the figure rises to over 14% (NCT 2010).

Most of the women in this study were happy to stay at home for as long as possible, but not without support. It is conceivable that if midwives were able to provide more support at home, some women might consider staying at home or moving to the birth centre at a more optimal time. However, in the current fragmented service, midwives are reluctant to promote change in the status quo, for fear of being even further overwhelmed.

The neoliberal attack on the welfare state and public services is directly affecting women and midwives. UK NHS maternity services have lost direction, and according to Save the Children in 2015, the UK lags behind as the '24th safest place in the world for a mother to give birth' (RCM 2016, p. 22). Directed as midwives are, to conform to organisational demands, midwives are unable to fulfil their potential to

provide holistic care across the 'pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life' (Renfrew et al. 2014, p. 1).

Midwives are increasingly unable to exercise the autonomy unique to their mandated role. Midwives in the obstetric unit and birth centres in my study were pressured to adopt labour ward, process-driven practices and this ultimately impacts on midwives' confidence to attend births away from obstetric settings (RCM 2011). Holistic assessment and support for women, wherever the mother needs it, appears to be curtailed due to capacity and establishment limitations, and pressures to conform to standardised, processed care, irrespective of an individual mother's need. This places women at risk wherever they plan to give birth.

9.2.7 Embodied Dissonance

Women who gave birth at home unexpectedly, or who arrived late in labour, or experienced multiple pre-admissions, all exhibited embodied dissonance. Their lived experiences were undermined by the midwives, whose often distracted, 'normalising' of events were not experienced as normal by the women. Explaining away that which 'cannot be explained away' compounded distress and left women and partners feeling conflicted.

9.2.8 Maintaining Consonance

In order to survive the rigours of a busy labour ward that does not have enough midwives to provide holistic, 'idealised' care, midwives have adopted formulaic responses to women who do not satisfy the rules for admission. I use parenthesis here, as providing holistic care is seen by many midwives and managers as a luxury, and idealistic. They maintain that holistic care cannot be afforded, rather than lobbying for it as an essential element of safe care, which I, and many others, argue in the longer term would be more cost effective and would improve outcomes.

Midwives uphold a belief that their advice is in the woman's best interests because to acknowledge service failings openly would cause them severe discomfort and even censure. Midwives therefore maintain cognitive consonance in order to avoid feeling internal conflict. However, the findings in my study show that their 'coat of armour' is wearing thin, and that they too are worried about the safety of women, as well as their own safety as registered practitioners.

9.2.9 Unresolved Cognitive Dissonance

Midwives who endeavour to adopt a more social model, where the mother is more central to decision-making, described severe cognitive dissonance. Organisational pressures and unreasonable workloads in the community and in birth centres (Deery 2003; RCM 2015, p. 5) are threatening the integrity of birth centre standards (RCM 2009)

and meaningful/effective community midwifery. Some midwives in my study exhibited cognitive dissonance when they could not practise according to their values and beliefs, despite being supported by the evidence-base. For example, where they would happily have had women spend time in the birth centres, enabling the women to determine for themselves whether to stay or go, they were under constant pressure to examine women vaginally and send them home if they did not meet the four-centimetre rule. The result of unresolved cognitive dissonance is that midwives' mental health suffers and in order to self-protect, they either conform or leave (Curtis et al. 2006a, b).

9.3 Discussion

9.3.1 Paying the Price for Not Getting it Right First Time

This is what Freya said when she agreed to me sharing her experience. Reflecting on Ella's birth she said it was not about cost

> I think actually just things that don't cost, just to be talked to well and nicely and to be believed. She could have simply said "listen, you know, again if you want, once I have checked you, you're all right now and it doesn't look like there are any problems … but if you want why don't you go to the canteen, get yourself a cup of tea and just see how you feel after that, and if you feel alright go home for a bit but if you don't, come back and see us". It doesn't cost anything that.

Midwives in my study who supported women's decision-making said

> women get bored of us before we get bored of them

So why not enable women to make the decision about where they need to be when they have opted to birth in either the labour ward or the birth centre? One senior labour ward midwife refused to implement my recommendation that all women should be asked as part of call screening, 'what do you feel you need to do?' She asserted that if they did that, '*they would all want to come in*'. Such is the midwife's pre-occupation with bed capacity, lack of space and not enough midwives. However, putting the decision to the woman would give her the opportunity to say what she really feels, even if her decision to come in turns out to be premature, she will work this out for herself.

9.3.2 The Final Paradox When We Don't Get it Right First Time

Freya finally concluded that the midwife, who eventually admitted her during labour with Ella, just could not quite believe what had happened. She said

> and again you feel like saying, "if you had listened in the first place…" I wouldn't have been SO scared that I opted for interventions that have resulted in an awful time 'til now, but was still the right decision for me because of what happened with Ella.

9.3.3 Recommendations

In the event of unit closure, the following six recommendations address the issues identified by Freya:

1. Identify a liaison midwife to establish and maintain rapport with women in 'early labour' who have made contact.
2. Schedule follow-up contact with women who have called in seeking support after labour onset to ascertain their well-being.
3. Give detailed directions on how to access neighbouring Trust maternity facilities. Ensure the woman/family have understood directions and have means of transport.
4. Ascertain whether the woman requires ambulance transfer from home to neighbouring unit. Arrange if necessary.
5. Ensure the woman and family have phone numbers of receiving unit should they need to transfer in.
6. Notify the woman when the unit reopens.

During the analysis phase of my study I held a joint workshop with women and midwives. They worked with their own data in the guise of 'Jane's story'. Jane's story was a co-constructed account of a mother, who was repeatedly deterred from admission. Her story culminated in Jane giving birth unexpectedly at home and what this meant for her. Although semi-fiction, the account was produced entirely from extracts from the women' and midwives' data. As a result, everyone in the room could relate to Jane's story from one perspective or another, and it afforded them all the chance to see what it was like for others.

After animated discussions, working at their tables, women and midwives were asked to vote on a number of recommendations they had compiled together. Figure 9.1 shows verbatim which factors for improvement they prioritised.

I found participants' recommendations to be measured, given the experiences they described. Nevertheless, their recommendations can be addressed by focusing on three areas for improvement as Fig. 9.2 shows.

Without imagining possibilities of organisational change, women and midwives made suggestions to graft on to an already ailing service. Participants took account of busy midwives and an overstretched service (Bonar 2015). Women did not insist on a known midwife throughout their pregnancy and birth, even though continuity of care is known to improve outcomes, as extensive reviews of the evidence have shown (Hodnett et al. 2012; Sandall 2015). Similarly, midwives did not insist on continuity models either as they already felt overwhelmed.

Whereas the latest maternity service reviews 'Better Births' and 'Best Start' use the evidence to promote a whole system change in maternity services, whereby continuity models of care will ensure that the mother and family are at the centre of

Fig. 9.1 Women' and midwives' prioritised recommendations

care and decision-making, with women working in partnership with their known midwife (Cumberlege 2016; Scot.Gov 2017).

Importantly, the evidence from participants' and Freya's narratives strongly points to the need for radical repair and restoration of the midwife–mother relationship, not because it would be nice to have, but because the evidence consistently shows that it improves safety, quality and satisfaction (Kirkham 2003; Sandall 2015; Sandall et al. 2013; Spiby et al. 2008).

9.4 Conclusion

Sensing and responding to the needs of women throughout the pregnancy continuum is the midwife's core role. However, despite the evidence of factors that contribute to high quality maternity care (Sandall 2015), the findings from my study and Freya's experiences illustrate that safety is being compromised and that women' dissatisfaction is an overt expression of not feeling safe. The issues highlighted by Freya and the women and midwives in my study cut across midwifery models and lead me to conclude that despite some progress towards a more

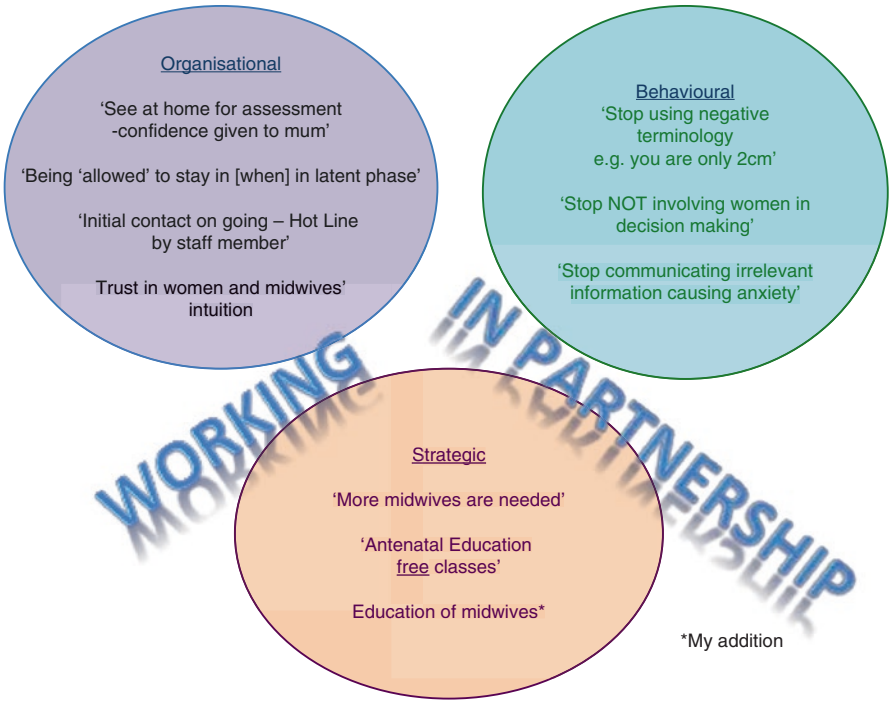

Fig. 9.2 Three areas for improvement

woman-centred approach, the delivery of personalised care remains problematic for all but the fewest of women. In other words, without restoring the mother–midwife relationship, women and midwives will continue to experience cognitive dissonance between the political/media/health service rhetoric and the realities in the birthplace.

Freya's expectations and lived experiences did not fit stereotypical, positivist 'in-labour' constructs (Dahlen et al. 2013; Gross et al. 2003, 2009). Put another way, as Freya's cervix had not dilated to more than four centimetres, she and countless women like her are denied access to midwifery support, even when birth is more imminent than some midwives anticipate. In addition to this, for Freya and many other women, was and is, temporary unit closure, that seriously undermined women's confidence. In her first pregnancy, if Freya had had a known midwife whom she could have contacted and seen or liaised with, much of her fear and subsequent trauma could have been avoided. Fragmented and standardised care creates barriers that prevent meaningful mother–midwife relationships and leads to disjointed, detached and unbalanced interactions that both midwives and women in my study experienced and described.

When we don't get it right first time, Freya's experience shows the far-reaching effects on women, children and families.

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Maternity Policy and a Generation of Anxiety and Fear

10

Julia Lidderdale and Kathryn Gutteridge

> Mothers have as powerful an influence over the welfare of future generations as all other earthly causes combined
>
> John S C Abbott 'The *Mother* at Home' (1833)

10.1 Introduction

As consultant midwives a core part of the role is clinical work and the evidence which is so importantly combined so that any narrative is firmly rooted in the work that we do. However it is alsoF essential to use our own experiences of life to bring a realism and personal element to our everyday work. One of the authors works in a busy south of England maternity unit and the other in a large central Birmingham maternity service. Unusually both of us have additional skills that we have gained through undertaking postgraduate academic studies and are clinical psychotherapists. It is through this lens that we will look at policy in maternity settings but also the implications that it may have on the experiences of women.

We will use a unique personal narrative approach to place each policy or government mandate in time so that it has realism in the childbearing experience. This means we will use vignettes from our own family as examples of when those policies were felt and the implications it had on the lives of our ancestors and relatives.

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The history of birth is documented by many authors, some clinical, other sociological and even anthropological (Kitzinger). Alongside women throughout the ages has been a woman, in fact men in the birthing room is a modern concept and well documented as the changeover to obstetrics from midwifery (Donnison 1988). Women with women has been scrutinised and criticised for the lack of scientific evidence but also for the power it yielded (Heagerty et al. 1997). In the early part of the twentieth century women in the UK did not have the right to vote so birth and protecting women was low priority (McIntosh, 2012) . However that did not stop the 'handywoman' or midwife from being vilified and demeaned. It is at the start of the twentieth century we shall begin to tell the story of birth as is personal to the authors, the expectations of those women Mary Ellen and Ethel Maria. The priorities that they faced; putting food on their 'breadwinner's' and children plates before themselves; and finally the stark differences of their emotional and psychological journeys into motherhood unlike women today.

10.2 In the Beginning: Julia

To begin, I want to take glimpse at the past and look at maternity policy between 1948 and 1970 through the experience and eyes of my own mother and midwifery inspiration, Maria (born 1930) and also that of my grandmother Mary Ellen (born 1900).

10.2.1 Vignette Grandma Mary Ellen

Grandma, Mary Ellen was born in Carrick on Suir, Tipperary, but held a British passport as she moved to Wales when she was 6 years old. She came from a devout Irish catholic family, during the First World War she cleaned seaplanes in the RAF and later became a cook in the local hotel. She met my Grandfather, Peter, who worked as a fireman on the cross-channel ferries. They settled where the ferry terminated in Goodwick, Fishguard.

They lived in a cottage owned by the railways. They grew vegetables in extensive plots and kept a herd of goats for milk, grandpa always smelled of them, mingled with a whiff of rolling tobacco and polo mints. They paid rent but eventually bought the cottage where all of their ten children were born. Their first child of ten was born in 1923 and their last child was born in 1942.

Although the past is over, it does offer us opportunities to extract valuable lessons and use them to create the future we want. If we don't revisit the past and reflect, there is a risk that we will overlook some essential lessons, lack innovation and advancement of ideas and remain stuck, 'repeating history' in the future. Instead of always looking back at things that did not go well for us, we can use our past to acknowledge our successes. We can learn from our fore runners.

Historically, the women in my family had simple expectations of childbirth, and little fear not unlike many women of that time. They felt it was a process you just

had to endure in order to reap the finest rewards. They almost surrendered their bodies and minds when giving birth and all that mattered was in that moment. They seemed to have no great desire to control every aspect of what was going to happen. They did not have parent education classes but knew that all labours were different. Long, short, very painful, some easy, tragic, good outcomes and poor outcomes but all of that was accepted.

One of my mother's earliest memories, aged 2 years, was when my grandmother was in her bedroom upstairs giving birth to her sister Patricia. Nurse Grey was in attendance. Maria had to drag a stool from the kitchen, and climb on it to open the door to her older sister Greta (6 years) who had raced home from school ahead of the three boys. My mother was heard to proclaim to her that Greta had a birthday present called Pat as the two sisters were born on the 29th May.

There was no birthing partner, doula or husband in attendance and Nurse Grey only came in well-established labour. Grandma would have been doing housework and cooking until she knew she was in established labour before she would call Nurse Grey from the phone box down the road. My grandfather was at sea in Guernsey, so Mrs. Edwards from a few doors away helped the children with a meal that night. It was business as usual the next day grandma was up but did not go out.

My Grandma's first child was born just 21 years after the first midwives act 1902 which actually did not become effective until 1905. A policy created at an extraordinary time when it was common practice for women assisting with childbirth to be prostitutes, commonly remunerated with Gin. The act was created to improve the training of midwives and regulate their practice. In order to practice as a midwife, a woman had to be certified under the act. My grandma had ten home births in all at home in a rural village in West Wales, she was attended to by a local community nurse who did deliveries under the indirect supervision of a doctor.

Pre-war, insurance schemes witnessed a rise in maternal mortality and the majority of working-class women like my grandma were still not attended to by midwives but by lay midwives even up to the 1930s (Leap and Hunter 1993, p. 1). In 1905 all midwives were required to register as 'bonafide' however and after 1910 even 'bonafide' midwives could not practice legally unless under the supervision of a certified midwife or physician (Heagerty et al. 1997).

10.3 In the Beginning: Kathryn

10.3.1 Vignette Nana Ethel Maria

Ethel was born too at the turn of the century and was an unassuming, quiet and slightly awkward child. She was born in a small Midlands village as part of a large family. Her father and mother had each been married before and had older children that were near working age. In all when her parents remarried there were over 22 children in the family. Ethel was the youngest child, she had a sister Daisy and an older sister who was a twin called Olive. Olive's twin sibling died when he was less than a year old. In all in the family there were three sets of twins.

Ethel left school when she was around 11 years old and worked as did most of the young females of the time 'In Service', cleaning and doing domestic duties for more affluent families. She met Patrick Luby her husband when she was around 15 years old. Patrick was the son of an Irish family from a small village near Knock. He was a normal boy playing and working to earn extra money for his family. Sadly he became known to the Republicans at the time of the 1920 'Easter Rising' for being involved with British soldiers, his life was threatened and he knew he had to get away.

He stowed away on a boat headed for Liverpool in early November 1920, he remained hidden for 2 days with little food and drink. When he arrived he was disorientated saying to me many years later; 'I thought I had landed back on the Ireland side, the skies were full of smoke and there were bonfires everywhere'; it was Bonfire Night. He had an address of someone in the Midlands and walked from Liverpool to Tamworth, he cannot remember how long it took; he was just 15 years old. It was outside of Tamworth that he found a job as farm hand. He met my Nana at a fair and they became friends eventually marrying. He never went back to his Ireland but he did manage to let his family know he was safe and happy.

When married they moved to the village which was to become their home for the rest of their lives, in fact their eldest son still lives in their house. They bore four children two boys and two girls and all were born at home. Ethel's sister lived in the same street and would be her doula or supporter when she was pregnant and in labour. When my mother Olive was pregnant with her five children her mother Ethel and her sister would be with her too. No hospitals just a nurse/midwife and the women of the family caring for each other in the home.

Although a different story there are similarities that there was little money, healthcare had to be paid for during their early lifetime, women did not make a fuss about labour and other women came to be at their side.

However safe as Ethel and Mary Ellen were in their childbearing experiences that was not the case for many women who were terrified of dying in their childbearing.

10.3.2 Giving Birth: Risking Women's Lives

In 1928 Queen Mary is quoted to say '*the Queen views with grave concern the continued high rate of maternal mortality. Her majesty feels that a very real endeavour should be made to remove this reproach from our national life*' (Williams 1997, p. 1, Chap. 1). This very unusual statement at the time is referring to the statistics that in 1928 almost one in every 200 women had died during childbirth.

The national picture of late twenties and early 1930s showed a poor and sorry state of affairs. Not only was the country struggling to understand the challenges that were before them post war, it had to contend with mass unemployment, deprivation and poverty, but some areas of the nation like South Wales were living starvation. It was clear that women's health and that of their children would suffer (Hope 1917). Any man that had work would inevitably be fed so that they could support their family.

It was at this time in 1928 that the National Birthday Trust Fund for Maternity Services was founded by Lady George Cholmondeley and Lady Londonderry with the aim to reduce maternal mortality (Williams 1997). They were largely benevolent in their aspirations but soon realised that they must influence government and policy makers. The esteemed baronesses were keen to include the current Prime Minister's wife Lucy Baldwin; she became a passionate and influential member. She gave a speech that said that labouring women of the day were at equal risk of death as the soldiers who had fought in the trenches. Using their heritage and fortunate positions in society the trust grew and included women from across both Houses of Parliament and took on the establishment. This group of powerful women was keen to improve and raise the standards of care for all childbearing women, give them access to pain relief and notably the aid of a salaried midwife.

In 1934 the trust created a Joint Council of Midwifery. This was instigated with reports of maternal deaths reaching the worst recorded at 460 mother dying for every 100,000 births. In the background to all their efforts of raising awareness of maternity matters the nation was witnessing hunger marches and unemployment rates of escalating proportion. In 1936 the Midwives Act was passed firmly placing midwives in women's lives until this day.

The Birthday Trust was concerned about research and wanted to ensure that when changes happened it was grounded in solid evidence. In 1935 the trust applied for money to support families and women in areas where hunger and starvation had ravaged the community. A committee of experts were called and the task of investigating the effects of hunger on childbearing women was referred to the Joint Council of Midwifery in 1937. Women's health would continue to be observed during pregnancy and nutrition was a focus that has not waned to this day (Beier 2004).

In addition to giving birth was the issue of infant feeding. It is interesting to witness the authority maintained by physicians at the beginning of the twentieth century who were mainly accountable for the spread of disease through their work practices and hospital settings. To further affirm their influence and power, they led the research into epidemics of diarrhoea which was at the time a deadly killer. From the research into contaminated milk and bacteriology, modern infant feeding policies were born and women and society were educated (Wolf 2011).

Today we have highly skilled infant feeding teams led by midwives and public health consultants. Historically, most women breast fed or employed a wet nurse until the introduction of formula in the 1920s (Fomon 2001). Of course, it is not just about infection control, we now know from UNESCO Baby Friendly and Baby Friendly Gold initiatives that the links between getting the feeding right for woman and baby are everlasting in the prevention of disease for woman and child and very importantly, forming close and loving relationships starting with bonding and attachment. Nutritionally we know from evidence that breast milk is the superior product above all others but we have to respect and support women's choice and what is best for them.

All of the children born to Ethel and Mary Ellen were born healthy apart from Frank (son of Mary Ellen) and most lived well past 8 years of age apart from one who died in infancy. This child Monica was born in 1942 and succumbed to

pneumonia that she contracted from the youngest boy as a toddler who fully recovered. Dwork (1987) and also Davis (2013) has documented the plight of wartime women's pregnancy and childbearing experiences, harrowing and a stark reminder of how war affects even those not on the front line of action.

10.3.3 Frank's Birth

Frank was the fourth child born after a reported week of labour pains. The contractions started and stopped for days, a breech presentation and a difficult and painful birth, Frank was required to have 'quiet care' and because he could not breast feed, they took him to Ireland to find the best milking cow, 'the one cow!' who exclusively fed Frank her boiled and sugared milk from then on. Using animal's milk for infant feeding has been well known from as far back as 2000 BC. Subsequently, alternative milk sources have developed to include the synthetic formulas of today. Artificial formula grew in popularity aided and abetted by advertising campaigns. This resulted in disastrous effects on breastfeeding trends, notwithstanding the evidence and research showing the many deleterious effects on artificially fed infants and the health benefits for breast feeding (Greer and Apple 1991; Wolf 2011).

From Frank's traumatic and difficult birth and early start in life, you would have expected some hypoxic ischaemic event, cerebral palsy, lactose intolerance, obesity, diabetes and a raft of other disease or health problems but Frank's start in life must have instigated his fight reflex, he was a top scholar, joined the marines and was jettisoned into a full and active military career in Vietnam, Burma, and The Suez to name a few battles. He had a fruitful marriage and fathered four very successful sons. Frank, a very keen walker had recently guided us all with his grandchildren on the family annual gathering around the Pembrokeshire coast just before he died peacefully in his chair aged 86. Half of grandma's children continue to live into their late 80s.

What we have to convey to women who have chosen to use artificial formula, the evidence shows that it is not as healthy a choice as breast feeding but we should be mindful about inflicting a fear that they are guaranteed to incur or experience the diseases mentioned if they choose this method. A happy woman who is responsively feeding by her chosen method will have a superior bonding experience with her baby and a healthier long term relationship with her child.

10.3.4 The NHS Arrives

In 1948 the establishment of the NHS resulted in a revolution for maternity services and generated a rise in the awareness in maternal health. After 1948, both maternal and infant mortality rates continued to fall and are now negligible in England and Wales. Even with enhanced outcomes for women and babies, a well-defined, commonly agreed concept for maternity care did not exist. Between 1948 and 1974 maternity services reflected the tripartite system of the NHS with the responsibility

for maternal care divided between hospital services. Care was free at the point of delivery for all.

The world was different place post war in the 1950s compared to the previous war, men and women both worked for the war effort and social classes were less distinct. Science was emerging more in everyday life and was respected as one of the reasons that the war was won. Life in the home was improving with the emergence of electrical goods and certainly maternal and infant health was improving with the ascendance of antibiotics and immunisation programmes.

The 1956 report of the Guillebaud inquiry into the cost of the NHS identified a 'state of confusion' in maternity services and recommended a thorough review (Chester 1956). This resulted in the 1959 Report of the Maternity Services Committee; The Cranbrook Report (Ministry of Health 1959). A target for 70% of all births to take place in hospital was set. Given correct selection for hospital or home confinement, the committee felt that the remaining 30% of women could safely give birth at home. However, the medical community continued to debate this, as more pregnancies were being classified as 'high-risk' through new obstetric knowledge and methods.

10.3.5 Vignette Maria (Mother of JL)

When Maria had her first baby in 1958, she was booked into a cottage hospital in the Welsh Countryside. There was no continuous fetal monitoring apart from intermittent auscultation with a Pinard stethoscope. After a long and protracted labour, she was advised to have morphine and following a pudendal block my brother was eventually delivered by high (Kielland) forceps. This dangerous and highly skilled procedure could necessitate a caesarean section today.

My brother was born in very good condition weighing 8 lb. 3 oz., a good weight she was told for an elderly primigravida. At this time in history it was fashionable to smoke and public health messages regarding smoking and drinking in pregnancy were lacking. My mother smoked throughout all of her pregnancies as did her mother before her.

My father was at sea during my mother's next confinement in 1960 and although she had been advised to attend hospital following the difficult forceps delivery of my brother, she chose to go to her mother's house, for support and child care, she returned to her former home, away from the city to give birth to my sister. Maria felt this baby was smaller than my brother and believed that second births were easier. She had a spontaneous labour and vaginal delivery without complications.

10.3.6 Swinging 60s

In 1967 the Standing Maternity and Midwifery Advisory Committee was asked to consider the future of the maternity services including domiciliary provision (Davis 2011). The resulting Peel Report (Department of Health and Social Security 1970),

named after the committee chair and consultant obstetrician recommended 100% hospital deliveries with medical and midwifery care provided by consultants, GPs and midwives working as teams. The report suggested that hospital birth was safest, though it was criticised for a lack of evidence. A dramatic shift from home to hospital birth followed over the next decade. Before the war, most women birthed at home like both grandmothers cited, with hospital births only rising significantly during the war. There was no discussion with women of the time and what their preferences would be so a shift was seen in a relatively short period of time. By the mid-1970s very few women were choosing home births and even many *Nursing Homes* as they were known became under threat. GP units, small hospitals based in a community and manned by the local GP workforce, were still available but as time moved on even these were to suffer from the effects of The Peel Report despite excellent care and services.

10.3.7 Vignette (JL)

I was always told that it was 'a good thing' that my mother was persuaded to go to hospital for my birth as I was in a persistent occipital posterior position and a long and difficult delivery, although, I dutifully co-operated and turned to an occipital anterior position just before birth. From what I can gather this was probably due to my mother having good contractions and being mobile in labour so that a powerful 'Ferguson' reflex result occurred when my fetal head hit her pelvic floor causing the pivot.

My youngest sister was in a breech position up until a few days before birth and was also delivered in hospital, but not the countryside cottage one where I was born, the move was away from homebirth and community hospitals to larger and more technically equipped teaching hospital. In paying close attention to the life accounts of our parents and grandparents particularly to the social and historical setting we can observe how they responded to the economic and political circumstances. This allows us to discover how their resilience, mentally and physically developed despite adverse traumatic events and poverty. Women are prepared for pregnancy and childbirth today by many factors, one of which is transgenerational transmissions.

10.3.8 Vignette (KG)

In the summer of July 1968 my youngest sister Lesley was to be born. My mother who was a former nurse was convinced by her GP that she should go to hospital when she laboured for her fifth and last child. Despite my mother being well, having birthed all of her four other babies at home she listened and appeared to agree. However events don't always follow the plan.

At the time I was about 12 years old and I remember my mother had more recently taken delivery of an electric washing machine, no longer the copper and tub in the was house part of the home. She had four children and clothes always needed

washing. It was around 5 pm in the evening, she was standing over her prized washing machine that was swishing away; she said to me 'Kathryn can you ask Mrs O next door to call for an ambulance please and watch the others when it comes'. I was dutiful and did as asked, when the 1960s ambulance pulled up my mother walked out of the door with her handbag to the chair waiting. As she waved goodbye to me I went inside to pull rank over the other three siblings until help arrived.

It was not long before I heard a knock at the door (30 min exactly), and there stood an ambulance driver asking me to open the door. My mother was sat in the chair baby sister in her arms and a midwife appearing from behind on her bike. My mother literally had stood up in the ambulance, her membranes ruptured and Lesley followed in about 3 min, they had driven 400 yards. My mother smiled and she told me that no way was she having her baby in hospital when she had managed well enough before. She knew what she was doing as I suspect are many women past and to come who will too.

Interestingly as with many women my mother smoked throughout all of her pregnancies, went without some meals when she had to, struggled with the challenges of motherhood and succumbed after my sister Kerry to *'nerves'*. She was advised by her GP at the time to have a raw egg in a small glass of sherry every day until she felt well again. She did as told however not clear about the evidence for that medicine for what I know now was postnatal depression.

10.4 The Impact of the Peel Report

It did not take long before the medicalisation and interventions of birth were to be rooted in everyday normal practice. Although some women were still able to give birth in settings where they chose, with people they knew that was not to be the case for thousands of women. The generation of '*Doctor knows best*' was still in evidence and if you were told to give birth in hospital then you would.

Later in the 1970s the emergence of the Association for the Improvement in Maternity Services was born; however, it began much earlier before that. In 1958, after a distressing stay in hospital for the birth of her child, another woman, Sally Willington sent a letter to a newspaper, enquiring if other women were also dissatisfied with their experience on 1 April 1960, that her letter was eventually published in *The Observer*. When it appeared the reaction prompted a new voluntary organisation, the Society for the Prevention of Cruelty to Pregnant Women, renamed subsequently as the Association for Improvements in the Maternity Services (AIMS). AIMS crusaded for better maternity care within hospitals. Their work has led to huge changes in maternity care and has had an enormous impact on the fear faced by many women treated on their own and feeling vulnerable. AIMS fought for the admission of husbands and later partners and later same sex partners and friends to join women in labour, this has become the norm in labour.

However one piece of their work though would challenge maternity services like never before. During the 1970s AIMS and other groups campaigned for the right to a home birth on the basis that the woman had a right to decide where to give birth,

primarily because they had no research evidence to refute claims for hospital safety. In 1980, Marjorie Tew, a respected statistician, published her analysis of mortality rates at home and in hospital and found that, even for women who had been considered high risk, home was a safer place to give birth (Tew 1980). AIMS changed tactics and began campaigning on the grounds of safety, as well as choice.

10.5 The Evidence Breaks Through

Maternity services and doctors have a long history of subjecting women and their babies to uncontrolled experiments and routinised use of unevaluated interventions, just because it seemed to be useful. Indeed one of its own, Professor Wendy Savage highlights the power that obstetrics yields over women (Savage 2011). Using women as a ready cohort for research, or worse subjecting women to care that was purely barbaric such as enemas when in established labour. Even before that there were concerns raised from the link between X-rays in early pregnancy and childhood leukaemia, and this remains a continuing concern today (Oakley 1984). During the 1980s, Archibald Cochrane's work on randomised health trials was the basis for the Cochrane Collaboration Database which remains at the forefront of effective and appropriate medicine and care (Cochrane 1971).

Latterly clinical collaboration with statisticians and epidemiologists formed the National Perinatal Epidemiology Unit (Oxford) and they have maintained research and confidence in clinical care and treatment for maternity services. In fact NPEU highlighted the benefits and hazards of routine maternity interventions such as shaving and enemas (Chalmers et al. 1989). The assumption that the increased use of medical technology was responsible for a decline in mortality rates had been questioned and found wanting (McKeown 1976).

The impact of research evidence has been profound on the policy-making process in the UK during the 1980s and 1990s. Apart from increasing evidence on the effectiveness of childbirth interventions, reviews of the evidence on safety and the place of birth (Tew 1980) suggested that planned home birth in a low-risk pregnancy had a better or at least a similar outcome (Campbell and Macfarlane 1994, Second ed). This epidemiological and the social science research reporting on women's experiences of maternity care were drawn upon to inform the conclusions of important parliamentary reviews of maternity services (Tew 1995).

10.6 The Winterton Report

In 1992 MP Nicholas Winterton chaired the Health Select Committee and revealed that '*There is no convincing or compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary may be the case*' (House of Commons 1992 ibid, p. XII). Interestingly in the UK context maternity health policy up until the 1970s officially endorsed the link between birth and fear of potential harm to the woman and her

baby. Whereas the ground-breaking Winterton Report Winterton (1992) marked a departure from such explicit mandates. Furthermore, it has been suggested that maternity health policy since that time has a potentially subverse discourse (Walton and Hamilton 1995), where childbirth need no longer be seen as hazardous. In finality, the House of Commons Health Select Committee on Maternity Services reported that: '*This Committee must draw the conclusion that the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety*' (House of Commons 1992, p. XII).

The government appointed Baroness Julia Cumberledge to head up an expert advisory group to modernise maternity services and improve choices for women and midwives.

10.7 Changing Childbirth: Choice, Control and Continuity

Into the next decade, the next reform and report publication Changing Childbirth, an opportunity to give women and midwives the chance to work together again (Expert advisory group 1993). We know from Changing Childbirth (Expert advisory group 1993) that women were asking for more choice and greater control over their bodies so midwives were challenged to respond. And they did, but no funding was allocated and it had to happen with innovation and goodwill.

Springing up all over the land were midwifery models of care, continuity from a group of midwives and choice to birth in a place with someone women knew. It was a new brave world of midwifery and those who can remember the time speak about the lasting and emotional relationships that were forged with women and their families. There is no doubt that women loved this kind of service but it was impossible for managers to fund and for midwives who were working in traditional models alongside group practices or case loading models, there was trouble brewing.

However where Changing Childbirth was embraced and innovation blossomed both midwives and women were happy. Little pockets of enthusiastic midwives working in these ways were able to see a reduction in interventions like induction of labour and caesarean section. One such group, The South-East London Midwifery Group Practice led by Jill Demilew had revolutionised the way midwives worked. Speaking to the Expert Advisory Group and indeed hosting Baroness Cumberledge she was able to demonstrate the autonomy in which such midwives worked. She had negotiated a contract similar to ones that GPs or dentists would employ and had a base in the heart of the community where women would recognise as 'The Midwife Shop'. Jill was keen to target those women who were reluctant to use services such as deprived or socio-economic issues which place these women at higher risk. Jill was passionate that this model was reproducible and that if supported could be a way forward for full implementation of Changing Childbirth and its aspirations.

In the annals of time we now know that the appetite for such radical community based care was not to be. The power of the 'hospital' is pervasive and gradually

community midwives were called in to support busy labour wards, whilst managers and providers expected them to continue their one-to-one relationships with women. It would not survive.

10.8 Caesarean Section in Ascendency

In 2001 a report was published that at the time would clearly show the state of maternity in the four countries of the UK. It was a collaboration of the Royal College of Obstetricians and Gynaecologist, Royal College of Midwives, Royal College of Anaesthetists and the National Childbirth Trust. It surveyed every maternity unit in the four countries and data was collected to understand the nature of birth at that time. In addition to this national survey, opinion and discussions were taking place both in academic and clinical corridors, examining attitudes and tolerances for caesarean section in modern maternity settings (Stoll et al. 2009).

The National Sentinel Caesarean Section Audit Report (Thomas and Paranjothy 2001) looked at birth modes, decision-making in performing caesarean section, outcomes and timings in emergency situations, organisational factors and clinicians views. Using the World Health Organization (WHO) as its basis following a consensus conference, *which concluded that there were no additional health benefits associated with a CSR above 10–15%* (WHO 1985). In Nordic populations there was no significant rise in caesarean rates and yet here in the UK sequential rises year on year was observed.

The Minister for Health at the time wrote; '*Concerns about the rise in the number of caesarean sections and possible variation in rates between maternity units have quite properly been a matter of public debate*' (Thomas and Paranjothy 2001). Where one-to-one care was provided in labour with a midwife, then the risk of a caesarean section was reduced. The evidence was now clear and irrefutable; NHS Trusts and other agencies had to take note.

10.9 But in the Background

As if watching by the sidelines many women's groups were forming or shaping throughout the late 1970s through to present day. One of those groups was *AIMS* as already discussed earlier in the chapter but of course they were checking the data, receiving letters and phone calls from women who did not feel they had a voice.

Beverley Beech the incumbent Chair of AIMS wrote in the journal published at the time that Midwives who question interventions are much more likely to be sanctioned by their managers and risk institutionalised bullying (Beech 2009). She further pointed out that The King's Fund in 2008 reported '*that an estimated 62,746 safety incidents were recorded in English maternity units between June 2006 and May 2007, with moderate harm in 11% (6,902) of cases; severe harm in 1.5% (941) cases and death in 0.5% (314) cases*' (RCOG, RCM, RCA, RCPCH et al. 2008). This was a poor state of affairs with the then current shortage of midwives at approximately 3000; the sisterhood of midwives was being run into the ground.

Alongside AIMS another pressure group had lots to say about the state of maternity services. The principle aims of the *NCT* concept encourage friendship networking, information sharing and of course competition to NHS providers for provision of knowledge. It is often assumed that women who use the NCT are by and large affluent, middle class and use its services to foster a certain belief. The NCT sometimes has a reputation for raising women's expectations in an optimistic manner and the issue here is that the leaders and teachers are not experts, not midwives but women who have had children and undertaken a course to facilitate groups. However that is not the case. They are and always have been concerned at the welfare of all women and their families.

Natural childbirth advocate and obstetrician, Grantly Dick-Read had claimed since the 1930s that most women did not need medical intervention to give birth safely (Dick-Read 1942). Opposition to the medicalisation of childbirth continued to grow after the foundation of the NHS. Prunella Briance, whose baby who sadly died following conventional obstetric care, launched the Natural Childbirth Association of Great Britain in 1957 to promote Dick-Read's teaching. After a period of internal conflict, it became a charitable trust, changing its name to the National Childbirth Trust or NCT in 1961. The NCT aimed to teach pregnant women skills for relaxation and breathing in labour, but also tried to persuade medical authorities to facilitate home births and provide a homelier environment for institutional births, including allowing fathers or other birth companions to attend (National Childbirth Trust 2012). At first, they tried to work with the medical profession, but increasingly found itself in opposition to it.

Further pressure groups fighting for an improved approach to maternity care were also developed at this time. They helped with the discontinuation of routine procedures such as the shaving of pubic hair, enemas, vaginal and breast examinations at booking and promoted the retention of dignity of women, handing back more control in an era of medicalisation and paternalism. Organisations over the next decade were more vociferous and political which helped to advance changes for women in a positive way. The governments of the time had to sit up and take notice and the interest in childbirth grew from increasing public and media interest.

Other groups such as *Birthrights* started in January 2013 to promote human rights in pregnancy and childbirth, have extremely similar aims to previous organisations such as AIMS, and petition the unceasing need to promote dignity and choice in birth (Schiller 2013).

PANDAS, for example, is one such organisation which offers advice and gives support to people suffering from pre- and postnatal mental illnesses and includes the family. Importantly it also raises the awareness of mental health issues. Another really dynamic group is *SANDS*, The Stillbirth and Neonatal Death Society Baby Life Support Systems who work collaboratively with experts to support and offer care constructed on evidence along with experience.

Maternity Action is a charitable organisation that has campaigned for equality and childbearing women's rights to be upheld. Originally starting its life as Maternity Alliance in the early part of 2000 they were integral in pushing government departments and employers to recognise and support women's employment rights citing discrimination in the workplace (EOC 2005).

In 2008 the organisation became the Maternity Action and focussed on inequalities and the plight of women arriving in this country for refuge. They have highlighted the effects of higher mortality rates in some ethnically deprived groups and latterly have raised the issue of charging migrant women for their healthcare (Bragg 2008; Maternity Alliance 2018). As an organisation they have been steadfast in their support of women's rights and inequities in the UK.

There is a multitude of support and pressure groups in existence and many emerging and they undoubtedly all have their place. Women's stories are vital however, and we should encourage our women to speak about their experiences so that we can shape our services. We must bear in mind that we can and do raise women's expectation levels of our services and it is important that women know about our adversity to risk and the extent of our interventions. Then women can discuss their birth plans and hopes realistically. The balance is information, education and a calm expectancy that things may deviate from a chosen plan but for a well explained and researched reason. Everyone will have a different experience; it depends on who they are and where they psychologically start from.

10.10 And Yet More Evidence

In the space of 6 years and following a harrowing report of 'Why Mothers Die'; the Confidential Enquiry into Maternal and Child Health (CEMACH) and its predecessor organisations the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths (Lewis 2007) recommended that a change in the organisation of maternity care be undertaken (2007). Thus follows the publication of a collaboration between all of the Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health (2007), (concerned *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour* (Lewis, 2007).

Once again findings showed an organisational picture of increasing interventions in acute maternity settings. Some of the features that were apparent and a number of factors influencing staffing levels which have serious implications for the service. These include:

- Greater focus on woman-centred care.
- An extension to the midwife's teaching role with multidisciplinary staff.
- Recruitment and retention crises in midwifery staffing.
- Changes in the experience of medical staffing at junior level.
- Demand for increasing consultant involvement in the labour ward (Joint publication, Standards 2007).

So it was clear that busy labour wards were not coping with the hospitalisation of women to birth and fewer women were giving birth outside of hospital. This meant that women were not receiving the *Choice, Care and Continuity* so promised by Changing Childbirth and their chances of having a caesarean section was increasing.

10.11 Morecambe Bay: Kirkup 2015

Tragedy often informs progress, such is the case here. All modern maternity services would wish to avoid the eye of the world on their mistakes yet this is the case in modern society; opinions and comments are manifold.

There is no doubt that the majority of midwives and doctors care deeply about what they do and work together for the good of the woman and her baby. And yet some cultures are deeply influential and a way of working and of unprofessional behaviours will emerge under scrutiny. This was such a case and the sad deaths of women and many babies was the result. All midwives and doctors wish this were not so and work hard to promote the best care and attention. It should never be the case that poor care and dysfunctional working relationships exist in a critical dynamic such as birth.

Newspapers around the world reported this case and the ramifications of those families are still being observed to this day. Learning from these reviews is the most important facet so that improvements are sustainable and not repeated.

As a result of this review and report we would see the scrutiny on maternity continues and the government under the auspices of Jeremy Hunt Minister for Health seek a reduction in deaths and severely brain damaged babes in 'Each Baby Counts' (RCOG 2015). This is a long programme of work that seeks to monitor and investigate each death so that a reduction of such deaths is reduced by 50% by 2025.

10.12 Better Births 2016

The circle of maternity meets again, another policy, another report written sometimes by a different author but in this case Changing Childbirth meets Better Births under the careful eye of Baroness Cumberledge.

This work is under the umbrella of a 5 year forward plan to reorganise and restructure existing maternity care. The vision is that maternity care is safer and accessible to all women, kinder and compassionate; the woman is at the centre of any care and has all the information she needs to be informed about her choices (NHS England 2016).

The report is structured under seven separate headings:

- Personalised care.
- Continuity of carer.
- Safer care.
- Better postnatal and perinatal mental health care.
- Multiprofessional working.
- Working across boundaries.
- Fairer payment system.

Work in progress, and beyond this chapter to comment upon, however, if aspirations are met, then women will be happy and cared for, their emotional wellbeing secure.

10.13 Women's Choice and Policy Today

Some would say we offer the illusion of choice at best, NHS Trusts may agree to a home birth as long as on the day a midwife is available. Trusts have an obligation to provide one but understaffed units are often forced to invite women into the unit when staffing is short. Women may choose from consultant and midwifery led care in an alongside or stand-alone unit depending on their catchment area otherwise they are forced to argue their case and transfer their care which may put them immediately under the gaze of safeguarding. Women may wish to opt for a water birth but only if they meet the criteria and there are enough midwives appropriately trained in it. Sometimes even the choice of birth partner is a challenge, again if a woman wants a male relative this raises safeguarding concerns and some places limit the numbers due to space and health and safety regulations. Coxon et al. (2017) note that the choices women make for their birth place and other associated practices is complex and often different than what the clincian may recommend; all in all when choice is considered it is a unique element of childbirth.

In midwifery practice it is vital to identify and ameliorate as much risk for women and families as possible, we are governed by NHS directives, government legislation, clinical guidelines, policy, audit and research, evidence based recommendations, codes, rules, position papers, supervision, operating procedures, instructions, regulations, ethics and law. Somewhere amidst all of these prescriptions and our own clinical and scientific knowledge, we need to find room for our instincts, our feelings and our senses if we are to really offer individualised woman-centred care.

Indeed it is much easier for midwives to give clear information to women about place of birth since the publication of the 'Birth Place Study' (Brocklehurst et al. 2011). This large study compared the perinatal outcomes of low-risk women and their babies postbirth in all settings including home, alongside or freestanding birth centres and obstetric units. The results were convincing and showed that healthy low-risk women planning a midwifery led birth either at home or in a birth centre would encounter fewer interventions with no detriment to themselves or their baby (Brocklehurst et al. 2011).

Women have a right to make choices about the circumstances in which they give birth. Fear can come from not being involved, losing control not being the decision-maker along with a hospital or a doctor or midwife. There must be proportionate reasons for all their decisions based on the individual circumstances of the woman and if necessary their reasons can be tested in court before a judge.

10.14 Women: Being Informed

Throughout all of the important stages of maternity development and every document, report, expert advisory group and recommendation women's right to have information is upheld. And yet we still see and hear that this is often not the case. The culture of the healthcare professional yielding the knowledge which is held as power is the common denominator in many stories. But this has to change.

We know from the legal case Montgomery v Lanarkshire (2015) it is considered good practice for doctors to anticipate what women would want to know rather than decide what they think women need to know. This case demonstrates clearly that medical assumptions are deeply embedded in practice and often used in dialogue with women.

A pregnant woman called Nadine Montgomery was short in stature, had diabetes and was having a large baby. She recurrently voiced concerns in the antenatal period about giving birth vaginally. The obstetrician omitted to fully discuss the risks of shoulder dystocia explaining that this was her usual practice. The obstetrician chose not to discuss the risk of shoulder dystocia to diabetic women as she considered the risk of serious injury to the baby was very small and suggested that by explaining the risks, '*then everyone would ask for a caesarean section*'.

In this case, Mrs. Montgomery delivered vaginally and a shoulder dystocia did occur. Whilst staff performed the appropriate manoeuvres to deliver the baby, there was a 12-min delay and her baby was deprived of oxygen resulting in cerebral palsy. Lady Justice Brenda Hale the judge in this case announced '*Gone are the days when on becoming pregnant, a woman lost not only her capacity but also her right to act as a genuinely autonomous human being*'. This is a revolutionary conversion from the 'Bolam test', which asks whether a doctor's conduct would be supported by a responsible body of medical opinion. Although this test will be used in other cases, it will no longer apply to the issue of consent.

In practice, during a birth debrief session or reflective consultation about birth, one of the most common complaints regarding a woman's negative experience of childbirth arises from induction of labour. Although women complain about it being a painful and lengthy process it is something else that is the main cause for their discontent; the majority of women are affected by how unprepared they felt and that it was not what they were expecting (savage).

Maternity providers cannot rely on printed information leaflets to provide information; there should always be a documented personal discussion. In other words, a bespoke, individualised consultation is essential as one size does not fit all. In addition, the court emphasised that material risk is one to which a reasonable patient would attach significance. Giving statistics in isolation will not determine whether a risk is significant for a specific woman. For example, the risk of complications for future pregnancies after a caesarean section may be statistically less for a woman wanting one more pregnancy than it would be for a woman who wished to have many more pregnancies. Importantly, the court highlighted that the doctor's obligation will only be liberated if information is given in a way that the woman can understand. '*The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form*' (*Montgomery*, para 90).

We all have our own world views and attitudes, we have to suspend them and employ the rule of 'Epoche'. In order to keep an open mind about the person consulting us, we must bracket off our own feelings, set aside our biases and prejudice and do not attempt empathy as we cannot ever walk in their shoes, our assumptions and expectations will be different.

If a woman requests a caesarean section after a previous traumatic vaginal birth and explains to her midwife and obstetrician that she is afraid of giving birth vaginally again, the reasons given to her for refusing to offer a caesarean section can be scrutinised and balanced against her reasons for requesting a caesarean section (Therese et al. 2015). If a woman requests a caesarean section following a third or fourth degree tear, a prolapse or a long and traumatising induction of labour, even if they experienced a vaginal delivery, all evidence must be explored before the clinician can recommend any mode of birth and the woman involved in all of the decisions.

Conversely there are women who do not wish to comply with medical or obstetric care, sometimes even midwifery care in these cases careful discussions and documentation is the way forward (Miller 2009; NMC 2013). All too often women are coerced, controlled and even threatened if they do not wish to accept the advice. Telling a woman that her 'baby will die' is barbaric and simply untrue; we have no idea if that is the case until she progresses in her pregnancy or labour.

There are those women who are informed that they are 'carrying a big baby'; hardly a scientific description. However if we distinguish that the woman has a well grown fetus and its growth is consistent and following its own growth trajectory, then we can feel confident that the fetus is not an undiagnosed macrosomic fetus. However if there is evidence of rapid increased growth, increased liquor volume and blood values suggest undiagnosed gestational diabetes, this is different. The risks to the woman and her fetus are very different as highlighted in the Montgomery case.

Every woman deserves to be treated, assessed and supported individually. She will be distrustful and fearsome when clinical conversations do not take this approach. Every risk, all policy and guidance should be individualised to form a framework of safe clinical care, rather than 'this is the way we do it here'. Women who are treated this way will seek choice and care that wraps around her elsewhere. She should not have to make these difficult journeys in her pregnancy; it is maternity services that have to change to focus on that woman. It is never good enough that one service or obstetrician or midwife can offer care in a certain way and yet in a neighbouring unit the culture is 'we don't offer that'. No wonder women are confused, frightened and worried; this what Better Births seeks to change.

10.15 Conclusion

We know that fear is a complex and multi-layered feeling. It can be brought about by perceived or imagined danger or threat. Fear can cause a change in metabolic and organ functions and ultimately a change in behaviour, such as fleeing, hiding, or freezing from perceived traumatic events or panic attacks. It can devastate experiences, lives and relationships. It can shape our world view of things for the rest of our lives but also the world in which we live generates threats and facilitates panic.

Fear can influence both parents and put a huge burden and strain on their lives and relationships. We know that good enough parenting and warm, stable and loving relationships are essential for children's development, starting in the womb. If

we listen to our individual women's back stories and ascertain what influences their choices and decisions, what bothers them or affects their behaviours, we have so many different means and abilities of addressing their individual needs.

That is why midwifery is an art, a craft and a science. It is all about the relationship between the woman and her care giver and improving the psychological aspect of clinical practice. Staff must also be cared for so that they can listen and communicate more effectively and attend to the emotional content of each and every clinical relationship. By being flexible we can respond compassionately when relating to different women and families. We must attend to and identify our own thoughts and feelings. If we can deal with our own fears first, then we can get to know each individual woman within their own social context.

This is the key to reducing fear for women and their families.

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Never Safer; Never More Afraid: Women's Voices and Stories of Childbearing and Fear

11

Cathy Williams

Childbearing and childbirth has never been safer. Women and babies in the UK have the lowest rates of mortality in all of our history. Women no longer need to worry about dying in childbirth, as their great grandmothers did, yet fear of birth is increasing.

Women fear the pain, the interventions and the lack of control over their bodies, but most of all they fear something happening to their baby. Birth trauma is increasing and this is raising the anxiety and fear among women who have already given birth, and their friends and family who have yet to get pregnant.

Women's fears and anxieties in these times are both complex and simple, as we have seen from the previous chapters. In this chapter I will explore these threads, using women's stories to illustrate the themes and theories of the previous chapters, to weave them together. I am grateful to these women for sharing their stories and giving me permission to use them here. I am in no doubt that these stories reflect the stories of many women across the nation. There is no way to completely cover every experience of worry and anxiety around pregnancy and childbirth, but I hope that this representative sample gives a true picture and leaves you with a greater understanding and an opportunity for reflection.

Women giving birth now are the daughters of the first few generations to give birth in hospital, to be exposed to high levels of intervention, who had shaves and enemas in labour as standard protocol of admittance to labour ward; daughters of women who laboured and gave birth under active management of labour.

They are the daughters of the first generations of the 'nuclear family', 2.4 children, and dispersed family living. These are the first generations not to see birth happen in the home, not to have birth talked about except in terms of fear of how often it 'goes wrong'. These are the first generations whose image of birth comes

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not from home but from the warped version of childbirth portrayed by the television, whether it is the drama of fiction, with birth speeded up, or the highly edited reality tv, with intervention and doctors saving the day in both scenarios.

Simone was born in 1985. Her mother doesn't talk about it. She told Simone it was dangerous to have a home birth. Hospital is safer. Even Simone's grandmother agrees, despite having four children at home.

> My mum, and my Nan, said to me 'Get the epidural.' 'Don't be a martyr.'

The message many women have from family and from our culture is that birth is pain, birth is danger, and birth is emergency. Birth is an ordeal to endure, to hand over to the people who know, and you will be rewarded with a healthy baby. Pregnancy and birth is the only area of modern life where women are expected to be submissive; the only area we accept handing over important decisions. In the era of female empowerment, it is the only area where women don't have a loud voice, where we accept the handling and intrusion of our body, our most intimate parts, where questioning these intrusions, or withdrawing consent, is considered unbalanced, irrational, harridan, hysterical. Shouts of #metoointhebirthroom are countered by claims that women are putting their experience above their baby's well-being, as if it is either/or.

Women today have more freedom than their grandmothers and great grandmothers. They have more freedom in work and in the home. Women are gaining power in politics and achieving in sports and arts. Women giving birth today do have more freedom than the past. Their mothers were expected to give birth lying down, expected to dilate a cm an hour, given drugs to speed up birth, drugs to expedite the third stage, with immediate cord cutting. Women were not expected to give consent. They were not asked. Despite this, women now are less likely to get a straightforward, low intervention birth. The rate of inductions and caesareans has exponentially increased, way above the increase in complexity.

One of the issues that increases women's fear and anxiety is that though they have more freedom and more education about birth, the freedom and choice can end up being nothing more than notional. They still end up giving birth lying down, still given drugs without much discussion, and still give birth against the clock. Whilst they may have the freedom to decline an intervention, they may not know this, or may not feel able to say no.

Birth trauma, for women, and for their partners, is increasing. There is tremendous fear of birth among women, but there is also fear among professionals: fear of a poor result; fear of being investigated; or of being sued. Women pick up this fear. Women hear this. Partners hear this.

Teresa was being induced. 'During pushing the monitors kept losing contact with the baby's heartbeat. It was really scary and tense. Senior midwives and doctors coming in and out. Every time the baby's heartbeat was found it was healthy and strong. Then the heart rate dropped to zero. I knew our baby was alright, I could feel him moving. My partner's face was awful. He thought the baby had died'.

The buzzer was pressed, again. Everyone rushed in. Teresa and her partner overheard her midwife muttering to herself, 'I'm sure the baby's fine, but I don't want to

have to explain to the coroner'. The foetal heart electrode had fallen off the baby's head. His heart rate was perfect. But by the time they had found the heart rate again Teresa was on her back, legs in stirrups, and episiotomy. The doctor paused, forceps prepared, and Teresa gave birth a moment later to a healthy boy with Apgar scores of 9 & 10. Both Teresa and her partner needed counselling after the birth.

I can feel the fear in that room just from Teresa's retelling of the story. It is a huge responsibility for midwives and doctors, the safety of mother and baby, and we are thankful every day for their care and expertise. But I am sure you can see there are steps that could have been taken to help this situation be less scary for the woman, her partner, and for the professionals. If the focus in birth is solely getting the baby out alive, then fear wins.

I hope maternity staff are supported to deal with their trauma, to support each other, and to have reflection time that isn't only on how well the interventions worked but also on how that could have been a more positive experience for all. It is important to talk about how the effects of clinicians' fear, and also to recognise that among these professionals are birthing women and their partners. Their stories matter too.

This chapter will follow a woman's journey, from pre-pregnancy, through antenatal care and experiences, to birth and postnatal, with examples and stories of common and individual worries and anxieties. It will examine how the care women receive from their midwives and the other caregivers influences those fears and worries, to increase or decrease them. Looking to the future we will lay out a pattern of how maternity care can reduce and support women's fears in pregnancy and birth, and better reflect the needs and wants of women in the twenty-first century.

11.1 Pre-existing Anxiety

There has been a growing awareness of mental health issues during pregnancy and birth, and postnatally, for women and men. Many women have anxiety or other mental health conditions that obviously continue during their pregnancy, and can be exacerbated by pregnancy. Women with pre-existing conditions are very aware of their mental health during pregnancy. For example, they worry about the effect of medication on their baby, their ability to manage pregnancy and care for their older children, the toll on their partner and their relationship, and their ability to be a good mum.

Women hope that they will get support for their anxiety from their midwife and doctor. Sometimes this happens and sometimes it doesn't. It is especially hard for women with mental health issues when they don't see the same midwife at antenatal appointments and have to explain their situation over and over. Women worry that they will not be considered stable enough to care for their baby and that their baby may be taken away from them.

> I had the best support. After my booking appointment my midwife referred me to the mental health midwife. She was great. Understanding. Listened. There were a couple in her team

and I had a few extra appointments with them, as well as seeing my community midwife. My problem came when I was meant to have a community midwife appointment and saw someone new. But this only happened twice.

I got no support from the midwives at all in terms of mental health, to the extent I complained to the reflections midwife about it. Their way of apparently asking about mental health was "how are you?" as I walked in the door which resulted in a tick in my notes that mental health had been discussed. I'd finally worked my way up to being the one to raise the topic at my next appointment because my anxiety was horrendous but then there was a problem with my bump so never got to it!

My anxiety went sky high during pregnancy, but the thoughts weren't related to the pregnancy and I had no anxiety about the appointments except talking about my mental health.

My midwife asked how I was feeling. I told her I was feeling really anxious and had been having my bad dreams (part of my condition). She wrote in my notes that I was feeling fine.

Social services was actually called because I was so afraid of hospital and midwives/doctors I felt I had to decline any care. They didn't take action but even having to speak to them made me defensive and even more terrified of trying to access help!

Looking back they really did make it worse when all I needed in reality was perhaps time and reassurance that my birth and pregnancy experiences didn't have to be the same as the first two times.

I had an appointment with the mental health lead obstetrician because of diagnosed PTSD from my first birth. We did not discuss my mental health at all. She spent the whole time agitated and aggressive, trying to persuade me out of a home birth. Her reasoning was they could monitor my mental health better in hospital. Oh, and I have high BMI. It was the treatment I had last time, because I have high BMI, that caused the PTSD. I am not going to put myself through that again. I left her office shaking and upset.

The mixed experience of support for mental health in pregnancy can be confusing for women. Gloria has a history of anxiety and depression. Her first birth, in hospital, went well. She is otherwise healthy. Being pregnant with baby number two, she spoke to her midwife about wanting a home birth.

The midwife said that wasn't possible. My mental health history means that they want me to give birth in hospital. I don't understand. I am not currently on medication. Surely having a home birth will help with my anxiety levels? I found it really stressful last time having a stranger caring for me at such a stressful and intimate time. I want a home birth because there is a small chance I would know the midwife, as there is a small home birth team. I was told I should give birth at hospital so they can monitor me as I am more at risk of postnatal depression. But that is not going to show itself immediately. How long are they thinking of keeping me in? It just doesn't make sense.

Danni has bipolar. 'I want a home birth or at least midwife led unit as I want to avoid intervention. My medication and conscious lifestyle choices mean the symptoms are minimal. I don't see why that should be any barrier to me being at home. It is something I have thought a lot about. My midwife is very supportive, so is my psychiatrist, but the obstetrician is only seeing my diagnosis, not me'.

11.2 Sexual Assault Survivors

For survivors of sexual assault, childbirth is full of fear and anxiety. Phoebe experienced child sexual assault. It is something she is very open about. It affects everything, including her relationship with her own body. She found herself frustrated by the lack of awareness.

> The midwives were kind and sympathetic, if they had read my notes, but seemed to lack awareness of the impact. So when I asked them about vaginal exams in labour, they stuck to their script and didn't tell me I could say no. I was very anxious about the labour.

Some women with previous sexual assault, such as Phoebe, want to have a natural birth and avoid interventions; others want to have the ultimate control and opt for a planned caesarean.

> I hadn't even told my partner about the sexual abuse. I didn't want to have to 'come out'. I said I had fear of childbirth, because my aunt had died in childbirth, which was true. The first consultant I saw said no. But my best friend's mum is a midwife and she told me to ask to see someone else. Eventually I told my partner and he helped me to stick to my ground.

11.3 Fear and Anxiety About Labour and Birth

With or without existing anxiety and mental health, thinking about giving birth is scary. Most women haven't seen anyone gives birth, unless on the telly. Some have heard 'horror stories'; others just don't feel they know what to expect at all. I have met many women who are surprised that contractions are not continuous, but come and go. Women have fears about how they will cope with labour, will baby be okay. Many women have fears of specific aspects of birth, such as tears, or poo-ing, of having an epidural, of an epidural not being available. There is an element of birth meaning being out of control.

> How was this melon going to come out of my bottom? I mean, seriously?

> Anxieties about early labour: going in too early and being sent home (which happened); clinical lights in my face and unnecessary examinations.

> I was the last of my friends to have a baby and they seemed to have some kind of competition to outdo each other with their horror stories about birth. Tearing. Forceps. Hours and hours of labour. Uncomfortable examinations. Ring of fire. Cracked bleeding nipples. I was terrified. I don't think one of them got the birth they wanted. That's what frightened me most.

> I was really worried about doing a poo in labour. I thought that it only happened to a few people and I didn't want it to happen to me. I couldn't find anything about how to control it. It meant that my second stage was longer than it needed to be because I was holding on. Until then I hadn't told anyone about my fear. I half whispered to my midwife 'I'm going

> to do a poo.' I was horrified but she was great and just said that it was okay and it would just be a little bit. If I had known it would just be a little bit I would have been less worried.

> I had a fear of instrumental delivery such as the use of forceps or having to have an episiotomy, strangely enough I had no fear of having a c-section.

To me that doesn't sound strange. Instrumental birth and episiotomy involve damage to our sexual organs. Cutting into our bellies is much less intimate. Women may not want to end up with a caesarean, but they will do anything for their babies. For some women they would rather the bigger intervention of a caesarean, than the indignity and damage of trauma to their bottom. I wonder how many male obstetricians might reconsider their practice with episiotomies if they had an experience of lying on a bed, naked, feet in stirrups, with someone coming towards their genitals with scissors. Obstetrician Florence Wilcock, part of MatExp, has started a Lithotomy Challenge, which she did on an NHS Change Day (Whose Shoes 2015, https://whoseshoes.wordpress.com/2015/03/15/nhs-change-day-matexp-lithotomy-challenge-a-blog-for-mothers-day/). This gives professionals the opportunity to have a window into the experience of women in birth. Look it up.

We must remember that perineal trauma can have lasting physical and emotional effects. Incontinence is just one potential consequence.

> It was a conveyor belt. Rush us through, and stitch us up, then send us home with pain killers. Talking to the other women on the postnatal ward, all of us had our labours speeded up in some way. All of us had torn or had episiotomies, or both. I had a fourth degree tear. I'm scared for my next birth now. After that I will need surgery to correct.

> To decrease my fears of an instrumental delivery, I had read "a Guide to childbirth" by Ina May Gaskin (Gaskin 2003), and did a lot of self work on visualisation. I had a YouTube playlist of hypnobirth songs as well as relaxing music, which I would listen every night before falling into deep sleep.

11.4 Fear of Baby Dying

This is the ultimate fear. Sadly one that comes true for some.

All women know that childbirth is an experience that brings them to the line between birth and death. That is the big worry: is my baby alright? What if something goes wrong/needs help?

> My partner's sister's first baby had been stillborn. This made us extra anxious, especially near the end of the pregnancy. I was so keen for our baby to be born, but also then worrying that something would happen during labour. Every twinge, every false alarm was excitement and fear. And then more fear and anxiety when the contractions faded away. As my pregnancy continued in my mind the chance of the baby dying increased. My due date came and went. I didn't want to be induced. I had convinced myself that that would put extra stress on the baby, but I didn't want to wait any longer. In the end my water broke at ten days past my due date and there was meconium so we were induced. The monitoring machine was reassuring when the baby's heart rate was fine, but it increased my anxiety, and especially my partner's, everytime the connection was lost.

For women who have already had a pregnancy loss, stillbirth, or death of their baby/child, can obviously have increased levels of anxiety and fear. Sensitive, personalised care is so important. Trying to brush away their fears, or ignore them, doesn't help.

> My first baby died during labour at 39 weeks. I really appreciated the extra scans and check ups the second time around. The midwives really listened to my wishes. I was given options for birth and chose a caesarean at 38 weeks. My midwife really encouraged me to make a caesarean plan. I was finding it hard to look ahead and think of actually having a live baby. They made the birth very special.

> I was terrified going for the 20 week scan as that's when we had found out that our last baby had died. My partner was more confident. He didn't think we could be that unlucky. But I knew women from the internet forums who had more than one loss. My community midwife was lovely and I was glad to have sweeps and I gave birth to my rainbow baby on my due date.

11.5 Pre-existing Fears About Birth

Some women have pre-existing fears about giving birth which come from family, from their own birth, and from prevailing culture, and media portrayals of birth.

Childhood experiences can be pivotal. I have met a number of women and a number of midwives, whose first experience of birth was watching a sibling's birth at home, setting their expectation, and understanding of birth. It is always interesting to talk to women who witnessed their cat or dog, or other animal, gives birth.

> When I was pregnant I just thought back to watching my cat give birth. She didn't seem phased by it, a little surprised to see the first kitten maybe, but then she got in her stride. I thought 'if she can do it then I can too'.

Experiences from childhood are not always positive. A number of women have told me that the video of birth they saw in sex ed at school made them fearful. I have a friend who is intentionally childless because of the video she saw. For many women the only other births they experienced growing up were what was portrayed in tv and film.

> I remembered watching a tv drama where a woman had died from pushing her baby out. She'd had a stroke. I became obsessed in pregnancy with pushing. I did hypnobirthing which helped but even then, when I was in labour I was terrified of pushing and looking back can see I was holding on.

A recent reality TV programme (Nov 18) featured a woman with cord prolapse. Voice over describes the danger and how the baby was born in 30 s (obviously not accurate). The woman in the episode had certain factors that increased her chance of cord prolapse. She was high risk, had several previous pregnancy losses, a cervical stitch, removed for induction, and artificial rupture of membranes; as a result she was giving birth in hospital, and was continually monitored. The prolapsed cord was

discovered on VE, and the woman rushed to theatre for caesarean birth. A clip of the show shared online caused worry and anxiety, especially for those planning a home birth. Women wondered if it was too dangerous to give birth at home. Their families contacted them begging them to reconsider. How many young women who haven't started a family yet will see this and be left with a lasting fear of birth from this one programme?

Shared experience from family and friends is a factor in women's attitude to giving birth.

> My mum and my two sisters all had caesareans. I just don't think we are made to give birth naturally.

> I didn't want forceps. My friend's son was left injured from his birth. I said in my birth plan I want to go straight to caesarean. I know people think that is odd, but I didn't want that to happen to my child.

11.6 Choosing an Elective Caesarean

Some women's fear of birth is so great they chose to have an elective caesarean. The experience of some of these women is that they are not always met with compassion.

> I had extreme phobia of giving birth. I wanted children and heard that you could ask for a caesarean but when I saw an obstetrician I was told 'No'. The doctor kept saying that I would be well looked after but if he didn't listen to me now, why would I think he would listen when I was in labour. I was in bits. I didn't know what to do. I even thought about abortion. My midwife was great though and got me an appointment with a different doctor, who said 'Yes'. Knowing I was having a caesarean helped me to relax and enjoy my pregnancy.

11.7 Previous Difficult Birth

One of the biggest groups of women with anxiety and fear about birth are those who have had a previous difficult or traumatic birth. For some they cannot face another birth and limit their families to one child. Others can take a long time to face giving birth again. There is no one standard response. Some women decide to opt for the control of a planned caesarean, whilst other women choose to give birth at home, or even to free birth.

After Anita's traumatic birth, it took her a year of counselling before she could contemplate getting pregnant again.

> I think I probably went in too early. But with your first you just don't know. My partner Paul had dropped me at the front and gone off to park the car. The midwife seemed annoyed that I was there. I was three cms. I was left in a room on my own for ages. I was in pain. I didn't know what to do. I didn't know that Paul hadn't been able to find a parking space and had actually driven home and got a taxi back. I felt I didn't know what was going on, what I should be doing. It was twelve hours before I got to seven cms. By then I was exhausted and in so much pain I asked for an epidural. When the midwife came back with the anaesthetist

I told her I felt like I wanted to push. She told me I was silly. It had only been 30 mins. I asked her to check me. She said that I couldn't have gone from 7 cm to fully dilated in 30 mins. After the epidural was in, the midwife agreed to do another examination. I was 10 cm. She started telling me to push, but I couldn't feel anything. After an hour my boy was getting distressed, so we went for a caesarean. When I made my complaint and met with the head of midwifery she agreed that the unit had been overstretched. She said that sometimes all we can do is the bottom line, a healthy baby. She said that night I got the bottom line.

Next time I was determined things would be different. I opted for a homebirth, and decided to hire an Independent Midwife as I was now considered a high risk because of my previous caesarean (they wanted me to go to hospital) and couldn't face a battle to get a homebirth on the NHS, especially one fought in labour. I had a fantastic homebirth. It was so different to my hospital birth. It was the most difficult challenging thing I've ever done; it was a truly special experience I will treasure forever.

Sandra had planned a home birth with her first baby. When her waters went she went into hospital to get checked out. By the time she was in hospital she was in strong labour. Within a couple of hours she was 8 cm, with a surprise breech. Shortly after she was starting to push. She was advised caesarean was safer and she was rushed to the operating theatre.

With my second I wanted a hospital birth, as I knew unexpected things could happen. I also wanted a midwife with me all the time, as I know that can help you avoid a caesarean. When I had an appointment with the obstetrician he said they couldn't guarantee a midwife with me all the time. I had to think about it but in the end chose a home birth, as it was the only way to have a midwife with me all the time, and that was the most important thing, in my mind, to help me avoid another caesarean and she would also see early on if the unexpected was to happen again.

Sometimes women fear specific events reoccurring.

I feared during my 3rd pregnancy that I would have a retained placenta again and need to have a manual removal. After my 2nd baby was born the placenta wouldn't come away, after all attempts to get it come away on its own it wouldn't! So I had it manually removed by a doctor, which was not a very pleasant experience I felt like a cow with her whole arm up there, and it took 90 mins to remove with just gas and air for pain relief because there was no anaesthetist available to give me a spinal block and they deemed it had already taken too long so needed to get it out when I think about it now it still sends shudders down my spine!

Sensitive, individualised care from a midwife or two, which the woman has come to know and trust, is so helpful for women in dealing with, and reducing their fears and anxieties after a previous difficult birth.

When Pippa was expecting her second baby she sought counselling. She was extremely anxious about giving birth again, after her first traumatic birth which left her feeling raped. Following her counselling she felt confident enough to write to the head of midwifery and ask for support. She was assigned to two lovely midwives who took over her antenatal care and went on call for her birth. She wanted to give birth in the midwife led unit, which they arranged for her. They also offered to give her an opportunity to visit the main unit prior to labour, with them, in case there would be a need to transfer, to reduce the chance of panic attack. They were very sensitive and let her take her time. She found it really helpful, though fortunately she didn't need to and had a lovely birth, with both the midwives she had grown to know and trust, on the midwife-led unit.

11.8 Other Individual Situations

Some women have very specific individual circumstances that can lead to increased anxiety. Young parents can feel anxious and worried about being judged. Body changes, putting on weight, lack of control over their body can raise anxiety levels in women who have, or had, eating disorders.

Anyone with additional needs and/or disabilities has extra anxiety in their lives. Lack of understanding by others and difficulties accessing equitable care are common frustrations.

Increasing numbers of women are identified as being on the autistic spectrum. Women are less likely to have been diagnosed as children, with many women self-identifying due to problems getting diagnoses as adults. Anxiety is a key element of ASD (autistic spectrum disorders). Women on the ASD spectrum can be overloaded by the sensory input, and by instructions and information; they take longer to process information; and may have a literal understanding of what is being said. It is worth remembering that there are many autistic women who do not know they are autistic. Again this highlights the importance of individualised care.

> Being on the spectrum, anxiety is always high for me. My midwife at the GP was an angel with explaining things in a way I understood but by the time I could see her after hospital appointments, I'd already forgotten a lot of what was said and seen. An unfortunate worse effect to the anxiety issue. She also commented that hospital staff didn't write enough in the book for her to go off. Definitely better communications and better understanding of people's personal needs would be beneficial.

Black and minority ethnic women may also experience increased anxiety. Assumptions, stereotyping, and prejudice, whether overt or hidden, can leave women feeling patronised, unheard, and anxious about their care.

> My blood pressure reading was always higher at doctors or hospital. It was fine with community midwives at home. The appointments generally always bring anxiety as they will say things like Caribbean/black people have xyz, therefore I will need an induction or be monitored etc. No choice. They use a lot of 'risk' and 'danger' language. The first time I listened to them and had a horrendous experience. The last two births were fairly quick and no intervention. Only since becoming a doula I realised how much was not told to me or how I wasn't given ANY options with my first child.

11.9 Going into Labour

Many women have fears about going into labour. Will they know when they go into labour? Will their waters break in bed, or when out in the supermarket? When should they go into hospital/call the midwife? What if they leave it too late? Antenatally this is high up on the list of worries for women, and their partners.

> When I was pregnant I thought that you only had contractions when labour started. So I was really confused by getting contractions on and off for a day and then nothing, and then a few days later some more. I thought it meant my body wasn't working. What was wrong with

> me? Was my body trying to go into labour and something was wrong, something stopping it? Nobody had told me that was normal. I wish I'd known what to expect.

> I had anxiety that I would be sent home for being 2 cm, which I was and they did say go home... but instead I threw up in the waiting room and was unable to move, so they kept me in.

When women go into labour there is an urge to get to where they are giving birth, which often results in women going into hospital early. Partly that may just be a biological drive, but it is also to get to support. The influence of media doesn't help, with births in fiction featuring a rush to hospital with waters breaking and first contraction.

> I was really confused by the messages. We went into hospital when my contractions were five minutes apart, which is what I'd been told, but I wasn't even 1cm dilated. So we were sent home again. I was told not to come in until I couldn't talk during contractions (but that was already). And then in the next breath told I would know when to come in. But I had thought I did know when to come in. I didn't know what to believe. I was really worried about leaving it too late. But also didn't want to get sent home again. As a first time mum, and dad, it is a really difficult thing to judge. We didn't know.

Midwives can help women be better prepared for early labour at home, by telling them about latent labour, in a positive way, and by giving them tips for coping at home. Ideally if women could have midwifery support at home, this would take away a lot of the anxiety about when to go in, especially for first timers.

11.10 Pain of Labour

Talking to women, their greatest fear, after the well-being of the baby, is the pain of labour. Will they be able to cope with the contractions and will they be able to cope with the pain of the baby coming out of their vagina. Women are surprised to hear that contractions are not continuous, but come in waves, and that in between them you feel perfectly normal. This is very reassuring, especially for women who were previously induced, when contractions are almost continuous. Women are also surprised to find out that most women get through with just gas and air, and that the epidural rate is around 25%. Most women think it is much higher. That's because of how birth is portrayed: birth = pain.

Dick-Read (1942) Hypnobirthing reframes labour by renaming contractions as surges, contraction being negatively associated in our subconscious with pain and tension, and 'pain' with 'discomfort'.

> Before I did hypnobirthing classes I was dead set on an epidural. I thought 'Why do women put themselves through the pain if they don't have to?' It seemed barbaric. We are modern women, we don't have to suffer like women in the past. We're not 'housewives'. For an independent, professional woman it was the right thing to. I think there are a lot of women who think like that. Hypnobirthing was more than learning a skill. It was an education, and not as 'hippy' as I feared. I had a waterbirth in a midwife led unit. Not something I would have ever considered before. I just used hypnobirthing, not even entonox. I was the only one of my friends not to end up with a caesarean.

Simkin (2011), the US antenatal teacher and advocate, talks about the difference between pain and suffering. We accept pain in certain situations, or even see it as a positive, like at the gym. Reframing birth pain is a positive discomfort. You can watch Penny's video about pain and suffering on YouTube.

Helena was using Penny Simkin's three Rs to help her cope with labour (relaxation, repetition, and ritual) and hypnobirthing. Each time a surge came she got into a leaning forward position, relaxed her body, and welcomed the surge with these words 'Welcome surge. I thank you for coming to help my baby move down and out'. At the end of each surge she let it go with thanks. 'Goodbye surge. I thank you for helping my baby move down and out. Now you can fuck off!' Towards the end of her 3-day-long labour she stopped telling the surge to F off. 'I was grateful for my surges'. She describes giving birth as 'the most empowering thing I have ever done'.

It is not that birth is not painful but that there are things we can do to reduce the pain, the discomfort: warm water, moving about, heat, rocking, swaying, singing, humming, massage, kissing, relaxation, visualisation, affirmations, breathing. Women don't know that gas and air and pethidine work by relaxing the muscles. Just knowing that helps women to have confidence they can also reduce their discomfort by relaxing.

11.11 Other Fears

Sometimes women's fear and anxieties come from other experiences in their lives. It is important not to make assumptions and to treat each woman has an individual.

Jodie wanted to give birth in hospital but had a lot of anxiety about it because she associated it with the deaths of her parents, which happened close together within the past two years. She had spent many visits to the hospital and the smell of hospital, the sound of the doors, all were triggers for her anxiety.

> Just going for the scans was difficult. Parking in the same car park. Walking down the corridors. Sitting in the waiting room on the same type of chairs. My midwife was great. She arranged for us to have a private tour of the labour suite with her, and showed us the midwife led unit. That really helped though I was still really anxious. On the day it was alright, and I gave birth in the midwife led unit.

Chanelle's fear of hospital and needles had a significant impact on her birth choices and on the birth.

> The moment I found I was pregnant I was absolutely over the moon, but at the same time I was filled with fear of going to hospital. So when the midwife came round for a home visit and casually suggested a home birth I knew this was definitely an option for me. My fear of needles is even greater than my fear of hospitals, so much so that I've actually been referred for CBT therapy. At both my blood tests during pregnancy it took 5 adults to hold me down whilst I screamed the GP surgery down. I think at this point the midwives thought how on earth is she going to cope with the pain of labour if she can't even cope with a simple blood test? But for me the pain of needles isn't an issue, it's just needles full stop.

> As my pregnancy continued and I told more people about potentially having a home birth I got a lot of crazy looks. People would say, 'You're mad, you'll want an epidural!' I just nodded politely because I knew I'd never be in that much pain that I'd willingly ask for a needle in my back. I absolutely knew that I could birth my baby without any form of medication or pain relief other than water. The only people who supported me fully about having a home birth were my husband, my mum (who knows how much I hate hospitals) and my grandma (who birthed 3 out of her 4 babies at home).

When Chanelle went into labour and called the midwives she was told,

> If the baby was to come tonight I'd have to go to hospital as there were not enough staff on duty to attend a home birth. I knew that wasn't an option for me so I made sure the baby was hanging on until the morning! That night my husband went to bed and I just curled up in different positions around the house. By 6am the pain was getting much worse and so my husband rang the hospital. I got a text from my favourite community midwife saying she'd be with me shortly.

Chanelle laboured in the pool and out, using different positions supported by her partner and midwives.

> I'd been pushing for an hour by now and there was no sign of the baby. The other midwife called her senior at the hospital to keep them updated and she literally begged them to 'allow' me another hour of pushing before a transfer for forceps, which is what was being suggested! There was no way that was happening so I pushed with every fibre in my body and eventually the head was crowning. Suddenly, I felt a sharp sting as the head came out and then a huge wave of relief as the body followed.
>
> I'd declined a managed third stage (obviously!) and after 57 minutes the placenta had still not arrived! I knew there was a risk of blood loss if it didn't arrive within an hour so I handed our baby to my husband and made my way to the toilet where I sat down and 'plop'. It was delivered with a minute to spare!

(Note: whilst this hospital's guidelines were to intervene if placenta is not birthed within an hour of birth, this is not the same in other places and it is the woman's choice in the end.)

11.12 Experiences of Maternity Care/Antenatal Care

Antenatal appointments are an opportunity for the woman and her midwife to build a relationship, and for any fears and anxieties to be addressed. However, sometimes women's experience of antenatal care is the opposite.

> I found my experience of antenatal care actually increased my anxieties. The midwives knew I had anxiety caused by trauma of my previous two births. I was desperate to have control over this birth, and to avoid being bullied into interventions. Yet there were raised eyebrows and scornful looks if you don't act the perfect patient! This attitude was one of the reasons I was considering free birth. One midwife told me at an unanticipated checkup for reduced movement it was 'illegal' to not have any care and to deliver my baby without a midwife before signing me off without checking my blood pressure or urine and not monitoring the

> heartbeat for more than a few seconds. I didn't want to free birth, but I didn't have confidence in the midwives listening to me.
>
> Midwives are supposed to support you through pregnancy, their job isn't only to stick you with needles and measure you, they also need to ease your worries and guide you.

Anna had a difficult first birth and had some trauma counselling. For her second baby Anna decided she would like to go for a home birth to help her have control, and to reduce the likelihood of the interventions being needed again. She felt very frustrated that every antenatal appointment the midwife talked about Anna's weight, and didn't seem to want to talk through her worries. She was classed high risk because of her high BMI and so was referred to an obstetrician. Anna was happy to go along, she thought this might help the midwife support her home birth, and the consultant, after recommending a hospital dryland birth, listened to her and was generally supportive. However, the midwife still brought up Anna's weight at each appointment. Anna felt anxious about future appointments and about being supported for a home birth. It got to the point that Anna didn't want any more antenatal check-ups, just one at 37 weeks, and she didn't want her weight to be discussed any more. She wrote to the head of midwifery setting out her concerns and what she wanted from her antenatal care.

> The head of midwifery was fantastic. She agreed to my plan. From then on I felt really supported. I had my antenatal appointment at 37 weeks, with a midwife in a different surgery. All was fine with baby. The same midwife dropped off the home birth pack a few days later. I felt such a weight off my shoulders after speaking to the head of midwifery. For the first time in months I could feel positive about my pregnancy again, and look forward to meeting my baby.

Anna had a speedy 3 h labour at 40+3, giving birth in the bath with the midwives and paramedics still on their way.

When women feel respected and listened to their anxiety is reduced; when they are not it is increased.

> I wanted a homebirth with my first and the midwife said 'You have to understand with your first it's not recommended because we don't even know if your body can birth a baby yet.' That left me feeling anxious about giving birth, and confused.
>
> My midwife spelt out B.R.E.E.C.H. to the other midwife in the room like we were children and not able to piece together a word! As a side note, he wasn't breech and I had to tell her that! It wasn't a good experience.

The language used by health professionals can increase anxiety. An obvious example is the label 'high risk'. To women and their partners it can sound that the bad outcome has a high chance of happening, when in reality it is an increased risk, and may still be statistically a low probability. We wouldn't consider less than 1% chance of snow as putting us at a 'high risk' of snow. Women can find the way statistics are presented confusing too. To say that the chance of something has doubled

can sound like it is much more likely to happen, when it could be the difference between 1 in 1000 and 2 in 1000.

> Each HCP I came into contact with was an opportunity for them to comment on my birth choices (vbac with 10m gap).

Every antenatal appointment is an opportunity to help women feel listened to and respected, through the language used and the attitude of the midwife/doctor. This in turn will reduce unnecessary anxiety and fear.

11.13 Experiences of Screening

Screening is often seen as a positive and reassuring experience, especially ultrasound scans, and hearing the baby's heartbeat.

> I was extremely fearful throughout my first pregnancy about every potential negative outcome. I had no reason for this- I'm just a worrier by nature. My scans reassured me greatly and I looked forward and needed every single one of my midwife appointments and scans. They never increased my anxiety once, only helped put me at ease.

> With my second pregnancy after a twin miscarriage I had many scans and yes, they reassured me. I had a large subchorionic hemorrhage with my twins causing loss just into the 2nd trimester that I had no idea about until attending a scan. So yes, having scans to reassure me that this was not present in my subsequent pregnancy alleviated my fears. I did feel that every month or so, the anxiety would start to build again and I needed to be reassured again. I did have a third pregnancy and didn't feel this need so much, as perhaps the trust I had lost in my body with my first pregnancy had been restored.... Hadn't thought of it that way until now.

However, not everyone finds scans and screening reassuring, and not every situation results in reducing anxiety.

> Every scan detected something worrisome that was then unfounded. Then the amount of scans became a concern for me. On one day we had 3 scans of nearly an hour long each. Where are the guidelines for how many & how long is safe?

> I had a growth scan due to dodgy fundal height measurements suggesting slow growth - had to wait two weeks for it and then the estimate was for a big baby which made my consultant even more twitchy (first was 9lb11oz with no intervention so I wasn't worried!) and then I had weekly LFT and BA tests for 3 weeks due to itching and repeatedly borderline test results. Neither made any difference to my birth and were stressful but I guess in some cases might have led to a different outcome?

Sometimes scans and listening in to the heartbeat are seen by women as purely ways to be in touch with the baby, and parents don't necessarily consider that the tests might raise issues.

> I had the combined screening, very naively, as a matter of course for reassurance, which was fine with babies 1-5 but came back high risk with baby 6, something I'd never considered. We were then faced with a difficult decision of expensive private NIPT testing or the potential risk of miscarriage for amniocentesis. It was the worst week of my life waiting for the results of the NIPT (which were ridiculously low risk). I would never have routine screening again without seriously thinking of the consequences.

Often scans and routine antenatal screening are presented as a fait accompli, with many women not realising that they have a choice. Whilst most women would choose to have the tests, others decline all or some of them. It is an important part of women-centred care, and individualised care, to give them the choice of every aspect of their care without assuming they accept.

> I got extra ultrasounds because they found my baby's too small when they felt with the hand on my belly. It didn't occur to me/us that we could decline. I had trust in my body growing a healthy baby (not that nothing could be wrong but I'm a bit fatalistic about that maybe: when it's wrong, it's wrong and there's not much you can do about that) and the ultrasounds were a confirmation of that feeling which showed that the baby's were doing excellent. With the second baby/pregnancy however, this didn't ease the anxiety of the midwives and gynaecologists. They wanted a medicalised birth; I didn't. The anxiety strictly speaking was about the aftermath but if I would have realised these consequences from the beginning I probably would have declined all the measuring.

Women with previous pregnancy losses often find the tests positive, but even then they have individual circumstances and opinions and may not universally accept every aspect of care.

> I found all the tests and scans extremely reassuring, although if I'd had a 3rd trimester scan it might have picked up the issue that caused my son to be stillborn so I wish I'd had the opportunity to have that. In subsequent pregnancies I paid for extra early scans and a 4d scan. With my 3rd I didn't realise how anxious I had been until I'd had my 20 week scan after which I found myself crying and thanking and thanking the sonographer! We didn't have any of the downs screening tests as we felt it wouldn't give us any definitive answers and feared being put under pressure to terminate the pregnancy which we wouldn't have considered.

Giving women adequate information about the scans and tests is really helpful, both what the tests involve and what they are looking for, and what the consequences might be. This is part of a positive relationship and reduces anxiety by helping women feel in control and supported. As with every other aspect of maternity care, how women are spoken to and how they are treated are fundamentals to their anxiety or lack of.

> I wasn't really told much about what the scans and tests were for. I had to have extra scans for a low placenta, and extra tests for iron and glucose. The scans I didn't mind although the person doing them didn't explain much and at one point tilted me upside down so I couldn't see things. I have terrible anxiety (autistic spectrum) and none of the staff helped ease my worries at all. The glucose one was a fasting blood test and I went in early in the morning for them to tell me I didn't have an appointment so I was told to wait. By the time I was seen I had been for 16 hours with no food, at 7 months pregnant. For me it is not the tests themselves that give me anxiety; I think the way that appointments are handled is very stressful.

Language is so important. Off the cuff, throw away statements are unhelpful and can be anxiety inducing.

> I had a scan last week. The lady doing the scanning found that my baby is rather large. Her first response: "That's why I don't have kids - I know too many secrets".

Women need the results to be presented in a way that helps their understanding and decision making, and feelings of being supported, without increasing their anxiety.

> A debrief with midwife would have helped me I think. I did mention my worries to her, but did not really get any answers. I had a placenta scan at 36 weeks, which confirmed the placenta was up and out of the way, but showed an unexpected drop in the babies growth rate instead. This was a shock for us and we were then waiting for two weeks for a follow up growth scan at 38 weeks, which showed that all was well. Deep down we knew that everything was fine, but it gave me a wobble in confidence and spiked my paranoia all the same. More information about what this meant for the baby and for the home birth I had booked would have been helpful, so that I could have prepared myself for all eventualities.

> I would really like to see continuity of care, seeing the same trusted practitioner for each appointment, instead of having to explain my history and validate my choices at EVERY single appointment, because we never see the same person twice.

> Sonographers should have better training... they often say things completely out of line with their training (e.g. you're having a homebirth, you're brave, I couldn't do that!) or spot things and then the follow up to talk about them is days later.

> I would have liked more information about what they are looking for and why they are doing it. So often things are just done to us - and then left wondering/worrying what's wrong as we naturally tend to focus on the negatives. Growth scans can be a big trigger for people but seem to be so common these days and with really questionable accuracy. For first time mums this can be anxiety provoking if not explained fully.

11.14 Antenatal Classes

Antenatal classes have the opportunity to reduce anxiety and answer the worries of women. However, in places NHS antenatal 'parentcraft' sessions have been reduced to one 2-hour session, or nothing at all. Many units no longer do labour ward tours, but have virtual tours online.

> In one of the antenatal classes someone asked how many women don't have any pain relief. The midwife laughed and said, 'For a first baby, no one.' You could feel everyone in the room tense up. And actually I know two of us did, so it wasn't even truthful.

> I joined in the parentcraft classes as there was a big gap since my eldest and I was feeling anxious. It was my community midwife taking the class. One week we watched a video of a birth. I thought it was quite good example. The woman was being active, not just on a bed. She was making normal labour noises, I thought, but the midwife said 'If she was one of my women making that noise I'd have slapped her.' I thought that was really bad. Now those women are going to think it is wrong to make noises. I actually complained about it and the next week we had a different midwife.

> One session we did a caesarean scenario. I was the woman and sat on a chair in the middle of the room and other parents-to-be had other cards, with different job titles on and they stood around me, in certain positions. I remember thinking 'what a lot of people'. I am really glad that we did that exercise as it was just like that when I had my caesarean. If I hadn't known it was normal to have so many people in the room I would have thought something was the matter, that something was wrong with my little boy.

11.15 Late Pregnancy

Late pregnancy is a time of increased anxiety and fears. Women worry about knowing when labour has started, when to go in or call the midwife. They worry about childcare and timing of labour. As the weeks go on they start to worry about not going into labour. Women can feel a dread coming on them, as their EDD comes and goes, and the threat of induction hangs over their heads.

Some women want to be induced. They are fed up of being pregnant, or they are uncomfortable or impatient to meet their baby. Some have anxiety or worry about the timing of the birth. Some women who have had lost babies in pregnancy or labour, or postnatally, can choose induction to stop them have a very stressful end to their pregnancy. Women who have specific situations, like a partner who is about to go on a tour of duty with the armed forces, may request an induction in order to have some certainty.

Many women want to avoid induction. For women there is very little apparent flexibility. Most women are told at 40 weeks that an appointment will be made for them to speak to a consultant about induction. It is not usually posed as an option. The stress of the upcoming appointment can hang above them, dominating each day, as they try different 'natural methods' to get things going. At the appointment they may be met with 'here is the date for your induction', rather than a discussion of the pros and cons. Questioning the need, asking for more time, can be met with emotional blackmail. Talking to partners, even arranging additional meetings when partners can be present, in order to get them to put pressure on women to accept induction is coercion, which increases anxiety. Women can feel stuck between a rock and a hard place: wanting their baby to come and be healthy, and alive; and wanting avoid induction and a potentially long and painful labour with interventions.

> 'Induction' and 'stillbirth' was spoken about. As I was refusing to be induced they heavily implied that my baby may be stillborn not only to me but my partner too which or extra pressure on me to make that choice. You can easily decline a midwife or doctor but when your family are begging you to listen it makes it a little harder.

> I didn't know enough about the options and my rights. I wasn't afraid of labour or birth with my first but I was terrified of induction and didn't know I could refuse. I managed to avoid it but ended up with emergency forceps, cut, 3b tear (which later became infected when the stitches split), baby had latch issues. I'm fairly certain the fear and going into hospital unnecessarily early contributed.

When clinicians focus more on the benefits of induction and the risks of waiting women can feel ill served, and it breaks the trust. This is not informed choice.

> The Head Registrar said I'm at increased risk of stillbirth due to suspected polyhydramnios (after scans suspecting sga baby, both were wrong). When I asked her what the increased risk was she got flustered and said she didn't know. She was very keen to induce me at the end of the week though (37 weeks) with no discussion of the risks involved with induction.

Sweeps are offered as a way to avoid induction. Some women are very happy to have sweeps and like to feel they are doing something. Women may find them comfortable, and others that they were uncomfortable. They can also raise anxiety. Women can have feel a failure if they don't go into labour after having a sweep. Women can also feel their body is not working if they have contractions after a sweep, but don't go into labour. Some hospitals have a policy of offering sweeps from 38 weeks. I met a woman who had had seventeen. She was still induced at 40+10.

> I had three sweeps. I felt that my body was letting me down. Why wasn't I going into labour? Was my body no good at labour?

With the admirable intention of reducing stillbirth rates, it seems there are more referrals for late pregnancy scans, whether for baby's size or for amniotic fluid levels. These can all increase anxiety. Obviously when a woman goes for a scan for one reason, another issue may be raised. Women are not always prepared for this.

> My midwife thought I was having a big baby so I was sent for a scan at 38 weeks. I was happy to have another chance to see my baby and I appreciate the extra care. I knew I would refuse induction if that was offered as a result of the scan. However the scan showed baby was within range, but I had extra fluid. There always seemed to be something else to worry about.

11.16 Labour

As well as worrying about all of the aspects of giving birth that we have already mentioned in this chapter, labour is powerful, and this can be scary. All the language used to describe labour, to prepare women, talks about labour from the outside, what can be measured: how long the contractions last; how many centimetres dilated. Or it talks about what will be happen, or be done, on the outside of the body. No one talks about what labour feels like on the inside, except to say it is painful. No one prepares women for the overwhelming waves of power that radiate out from the uterus, or how labour takes over your body. The natural reaction is to try to control it, to stop it, to hold on, to tense up. Yet in order for labour to progress women need to let it happen, to ride the waves. It is scary to do that. It feels out of control. This is why women need support and encouragement.

I had planned a hospital birth with my first. I wanted to be near help should I need it, and pain relief. It made sense to me to be in hospital. But I was not prepared for labour really. It took over my body. Before labour I wanted to be in the bright, cleanliness of hospital. In labour I didn't like the bright lights, or the smell. We went in quite early, because I was scared and wanted to get there. But when I was in hospital every thing my body wanted was the opposite. I needed dark and quiet, not the bustle of the ward. I thought I would feel more supported in hospital but the midwife went in and out. And other people came in and out. All the interruptions disturbed me and made me anxious. I wanted to move and walk. At home I had had surfaces to lean on and wandered from room to room. We even went out for a walk. In hospital I felt constrained and self-conscious. It really surprised me. My labour was okay. I had great care from the midwives. None of that was a problem. But throughout my labour in hospital I felt on edge, anxious, unable to relax. Next time I stayed at home.

When I was pregnant I just assumed I would get the support I needed in labour, so I didn't worry about it much. The midwives and doctors do this all the time. They know what they are doing. I'll just show up, get pain relief, push a bit, have baby. But it wasn't like that. I thought the midwives and doctors would do everything they could to give me a straightforward birth. Yet it seemed that what they wanted me to do, and what my body wanted me to do, were two different things. My body was telling me to stand up and walk about. The midwife wanted me to be still so the monitor wouldn't move. When I was having a contraction my midwife was asking me questions. I wanted a bath, I was told 'No', because of the monitor. I wanted the light off, the doctor came in and got cross that it was off and turned it on. I was getting more and more confused and anxious. I thought I was pushing okay. My body was doing it actually. But the midwife told me to put my chin on my chest. The doctor said it was taking too long. I wanted more time, to get off the bed, to be on my own. The doctor gave me half an hour then I was in stirrups and had ventouse. Even then, when I was trying to help and push my baby out, I was told not to lift my bottom off the bed. I could just tell from my body that this was the most difficult and ridiculous position to push in.

Women are particularly vulnerable in labour, especially if this is their first labour, or if they had a difficult birth before. There are some common anxieties that arise for all women. Psychologically women are 'highly suggestible', which means that they easily influenced and affected by what is said, or not said.

I remember arriving in hospital. I was excited and pleased with how well I was coping. The midwife said I wasn't in labour because I wasn't 'falling apart enough'. 'It's going to get much worse than this.' It really deflated me, and scared me. I thought she thought I was silly and wouldn't be able to cope. I've had three children now and I don't fall apart in labour.

I was coping alright with the gas and air. It didn't do a lot but it gave me something to focus on. Then the midwife asked me if I wanted something else for the pain. I thought she meant I wasn't coping well, or that the pain was about to get much worse. So I had some pethadine. I wish I hadn't. It didn't take away the pain, just my ability to speak and tell anyone. It made feel nauseous and my legs went all wobbly so I was also stuck on the bed, which actually made it more painful. I didn't get off the bed after that. I ended up with ventouse. At the time I was so grateful. I sent a thank you card and box of chocolates to the midwife. It was only when I was approaching my daughter's first birth that I started to get panic attacks and flashbacks. Then I realised that I wasn't okay; that the birth hadn't been great. The way I was treated by my midwife, who I think meant it all with kindness, actually traumatised me, because it took away the control, and undermined my confidence. From the moment I had the pethidine I was out of control and in fear. I had handed over the process. No one listened to me. I couldn't talk. I was frightened, sick and in pain.

The treatment that women receive is fundamental to their experience of birth. It can increase anxiety or lower it. When midwives are talking quietly in the corner, a woman or partner might think something is wrong. It might be that the midwives are doing a handover, or talking about who is covering their antenatal class. When the monitor loses the heart rate, because the belt has slipped or the baby has moved down, women's anxiety leaps. Continual interruptions, checks, especially when rushed, can increase anxiety and this obviously this can slow or stop labour.

> When I arrived in labour I went to triage. I was coping fine, or thought I was, especially when I was sitting on my ball. The midwife thought I was too calm to be in labour but I was 3-4 cms. I was transferred to the labour ward. I was booked for the midwife led unit. No one told me why we didn't go there. I was confused but we didn't ask. I had to stay on the bed. The monitor kept slipping. I don't know why I was on the monitor. When I sat up or laid on my side my baby's heartbeat was fine. But every now and then it dipped or the trace was lost. The midwife would press the button and the room would fill with people. I couldn't get comfortable and the contractions were really painful so I had an epidural. This made my blood pressure dip. I lost count of the number of times the button was pressed. I had got to 7cm within three hours of getting to the hospital but five hours later I was still 7cm. So it was a caesarean. Throughout the labour I was so worried about my baby, so was my partner. I didn't know what was going on. I didn't feel in control. Nobody helped me get into different positions, or suggest a bath, or music or do or say anything to calm me down.

> I had an amazing midwife, Lisa, and during my labour there were three occasions when what she said really stayed with me!! First one - as we arrived and she checked me and said I was 7cm, I commented that I was 8cm when I got to hospital before I gave birth to my daughter. Her reply - "Well you're a bit of a super star, aren't you?!!" - it made me feel over the moon! Second - once I got in the birthing pool, she said - "Now Gabriela, all I'm going to do is sit here and observe." Loved this, so powerful!! Thirdly and probably the strongest oxytocin releasing one - as I was breathing through my contractions and didn't even realise quite how close my son's birth was, she looked at me and said "I'm just in awe of how well you're doing". (I do remember I was in this weird position in the pool, half on my side, half with my head on my husband's knee!) It literally made me feel on top of the world. My son was born roughly 1h15 after we reached the birthing centre and took pretty much everyone by surprise - Lisa, me, my husband, we couldn't quite believe how quick it all was!! Blessed to have had her as our wonderful midwife that night!

11.17 Postnatal Ward

On the postnatal ward women are recovering from giving birth, exhausted from labour and lost sleep, physically hurting, bleeding, trying to care for their new born baby and to get feeding going. Staffing on postnatal wards often means women don't get the care the midwives would like to give. Women can feel overwhelmed, especially if, after the life altering experience of birth, they are left by their partner.

> I knew nothing about what staying in hospital entailed, I wasn't expecting to because there was so much talk about being out within 6 hours. My husband was kicked out as soon as we left recovery and I was left alone at 3am with no idea what to do. Long-term I had ptsd, pnd and really struggled to bond with my baby.

My anxieties were mostly about actually being in hospital, having never had a hospital stay in my life, it was a really big unknown. I was right to be anxious, the loneliness I felt on that ward was awful.

I think expectant parents, especially first-time parents, should be FAR better informed about their options and supported to make informed choices. And there should be a lot more empathy involved in post-birth care.

I just felt overwhelmed. I was luckier than some in that partners could stay on the ward. But neither of us slept. We were already missing two nights' sleep from the long labour, and then another being on the ward. The birth hadn't gone as I'd hoped. I was sore, stitched up from one end to the other, trying to respond to my baby and get feeding off to a good start. The ward was noisy and hot. The midwives really put pressure on with the feeding. Twice I was told that if I wasn't giving my baby enough then I should top up with formula. 'We're only thinking about the baby. She's our patient too.' I'm on the autistic spectrum and that meant I worried about everything that was said, to every woman in the bay. The noise, the smells, the heat, were all overloading me. By the time we left I was almost hysterical with exhaustion. All I could think about was getting home and having a sleep in my own bed. My sister had come to give us a lift home. During the discharge the midwife realised I hadn't done a poo since the birth. She told me I couldn't go home. She went and got a doctor who also said I couldn't go home. I was beside myself. Everything had been measured, except how much sleep I'd had, and how I was feeling. Fortunately my sister reminded me that I could discharge myself, which I did, much to the displeasure of the staff.

11.18 Partners

Birth partners and life partners can be affected by some of the same worries as the women mentioned here.

11.19 Meera's Story

Meera's story illustrates the complexities of the fears and anxieties of many women. Pre-existing worries about childbirth, anxieties about pregnancy and the impact on her life, combined with the attitude and treatment she received, especially postnatally, layered upon each other, turning a beautiful, life-enhancing time into one filled with fear and stress.

I was very afraid to start off with because I didn't rest very much during my pregnancy - I was being a bit silly and wanted to do everything and be everything- clean up, cook dinner every night, work long hours and give 110% to work, push myself on the social calendar and I suddenly realised in the last few months that I had to stop and rest in order to help this baby grow. He came out smaller than I had expected - perhaps because my mum said she expected his weight to be much higher - which of course made me worry at the final scan.

I was worried that my employer would think I was giving less than my usual amount and I worried about who would cover me. My team is really supportive but I was doing the lion's share of the work because I didn't want to say it was too much. The fear comes from old firms I have worked for - nothing related to my current employer.

> Next - I worried immensely about the actual birth - I just couldn't figure out how a human would pop out from that small space! I used to dodge smear tests because I found them painful and I find waxing painful so you can just imagine my threshold! I had done the NCT and not really read anything else - and I honestly was the most nervous in my group about the physical pain.
>
> I suppose it was fear of the unknown, but my partner helped - even though he was googling the definition of contraction at 3am to check whether that was actually what was happening. I wanted to punch him in the face at that moment!! I do love him- just to clarify!
>
> For all my worry about the birth, and my fear of the pain, on the day I didn't actually get time to think and just sort of got on with it. If I am honest, six months on, I have almost forgotten what it felt like - bizarre that!
>
> Lastly, postnatal care is not what I had hoped. Everyone cares for the mother before the baby is due bit afterwards you feel left by the wayside. Nobody once asked how I felt, they just checked my blood pressure, got angry when I didn't want to eat the yucky food I was served and kept pushing me get better at breastfeeding - a bit of actual warmth and care for me would have gone a LONG way!

11.20 What Would the Future Look Like?

From the stories above you can see there are some common themes when it comes to what increases or decreases their fears and anxiety: continuity of carer, support for mental health, individualised care, and language.

11.21 Continuity of Carer

Continuity of carer through pregnancy, birth, postnatally, and even into the next pregnancy is a game changer for women with anxiety and fears around childbearing. Some women would just like to see the same midwife at every antenatal appointment, rather than a string of different ones. Having a midwife that knows you, knows your history, knows what is important to you, that you can develop a relationship, a trust with, is a thread that runs through the stories.

> I was really surprised that you don't get your midwife with you in labour. I just thought that's how it would be. I am quite an anxious person. It was really important to me to have someone with me that I knew. That's why I had a doula.

11.22 Support for Mental Health

Hopefully we are all getting better at talking about mental health issues in a non-judgemental way. Listening to women to find out their individual worries and needs is central to helping to reduce their anxieties. Some women are more confident in their knowledge of their condition; others worry about the stigma and being judged. The wonderful Out of the Blue (2017) series of videos by Best Beginnings, launched by the Duke and Duchess of York as part of the Heads Together (2019) campaign on

mental health was a very public message that maternal mental health matters. The videos feature women, and their partners, talking about their stories of perinatal mental health. If you haven't seen the videos there are readily available through the free, non-commercial Baby Buddy app. Through tools such as these we can expand our understanding, and meet the needs of women with pre-existing mental health conditions and those whose mental health is affected by pregnancy, birth, and life with a new baby.

11.23 Individualised Care

I hope, above all, that this chapter has highlighted the diversity of experiences. Some women find scans and screening reassuring, others don't. Some want one thing; others something else. Individualised care, rather than blanket policies, routine care, and assumptions, is the key to reducing anxiety. Individualised care means giving women autonomy: autonomy in decision making and autonomy over their body. Listen to women. Find out what matters to them. Give them choices.

> Anxiety is lack of power.

> Midwives could prepare women better by explaining their rights/BRAINS to them, empowering women to feel in control rather than passive. And also about transition, when you have those minutes of 'I can't do this'. I was glad I'd had hypnobirthing sessions!

> I think that explaining things in terms of options and making it far more obvious that the things they're talking about are options and that women choices. I remember language like "we're going to" and "we'd like to" which just didn't make it obvious that I had the choice.

Taking a rights-based approach gives women their autonomy. It gives them the control and the responsibility.

> In one sense I can't fault the midwives I had but I feel I was better prepared second time around. I knew what I wanted, what I didn't and I was firmer. I asked more questions.... Maybe that's how they could help, encouraging questions and sticking to facts rather than scaremongering.

11.24 Language

Throughout the stories in this chapter women have said that how they were treated, and what was said to them, was at least as important as the care they received. Language can be used to express respect, partnership, and trust.

> Midwives and doctors should use the word woman not mother, and be inclusive, recognising that not all people who give birth are women, and not all partners are men.

> Avoid language that contains assumptions of consent or lack of power.

On the 'to ban' list: 'pain', 'lie on your back ', 'Would you like something for the pain?', 'You're nowhere near fully dilated', 'PUSH!', and anything that makes a woman feel like she doesn't understand her own body. And labelling women as 'high risk' - such negative language. Giving arbitrary lengths of time that a woman will be 'allowed' to push before intervention is made.

'You must'
'You should'
'You can't'
'You're not allowed'

Incompetent cervix - such a mean thing to say to a woman.

Fear inducing words or pain inducing language - talk of BIG babies. Like women need to be frightened of these.

As a 37 year old mum I'd ban geriatric mum, also any language that makes you feel inferior or silly also agree with the above around should/shouldn't/can/can't.

So what language would help women with their anxiety and fears?

More of: 'Move around, dance, laugh and get the oxytocin flowing', 'How do you feel most comfortable?', 'Would you like us to examine you or are you happy with the way your body feels', 'Here are some actual statistics about what we're recommending. However, it's your body, your choice so do some research and let us know what you decide'.

(Obviously, in the case of a medical emergency, I appreciate that many of these aren't possible.)

Phoebe, whose story we heard about earlier, has some useful advice for midwives and doctors about language, and its importance, when supporting women with previous sexual abuse. As she says, not all survivors will disclose this, so being aware of the language you use with all women is vital.

When I was pregnant, I had debilitating fear and anxiety because I am a survivor of sexual violence. I wasn't frightened of birth and I hadn't been frightened at first - it was the language used by midwives during my appointments - and learning about interventions - that caused my fear. Given the number of women in this country who are survivors of sexual violence or previous birth trauma, it boggles my mind that there is no routine assessment or care plan to support women with this issue during pregnancy. None of my doctors or midwives really knew how to deal with it.

Women should be asked during their booking in appointment if they have survived sexual violence or birth trauma, and what (if any) extra support they need relating to this. The right to refuse any intervention - and alternative treatments and options - should be made clear to these women especially, as well as their right to request a different midwife or doctor without explanation. They should be taught about the key principles of natural and active birth for avoiding interventions - particularly not having to lie on your back with a bunch of strangers between your legs. And the basic principle of 'your body, your choice, at ALL TIMES' needs be made very clear. Being taught these simple things could transform a survivor's experience of pregnancy and childbirth.

Imperative language (should/allowed/must/etc) should be banned generally but especially in this context, I think. A woman who has survived sexual violence needs to know

> that she is fully in charge of her body—especially considering the parts of the body being focused upon during birth. Phrases I would like to see banned are 'good girl' and 'if you relax it will make this easier'. These phrases are exceptionally triggering for survivors of sexual violence and they are used so routinely and habitually that even though they were written in red pen on my birth plan, my midwife couldn't stop herself from shouting them during my labour.

It would be wonderful if this could be raised in all units and some discussion and perhaps a policy on working with survivors of sexual assault.

11.25 Working with Women Who Have Fear and Anxiety

Most of my clients have anxiety and fears. Over the years I have found the following to be the most effective steps.

1. *Acknowledge the fears*. Listen. Ask. Encourage them to write down their thoughts or verbalise them. Keep listening.
2. *Give them knowledge*. Knowledge of their body and the birth process. Knowledge to make sense of their understanding, their story. Knowledge to give them confidence. Listen to their expectations, and work with them realistically, but always giving them options.
3. *Give them control*. Lay out the options, even the far out ones. Find out what they need to make their decisions, what is important to them. Recognise individual differences. Don't make assumptions.
4. *Build and support their team*. Create an environment of mutual respect, with the women, her partner, and other clinicians. The woman is the CEO. Support their partner, their mum/friend/sister. Don't make assumptions. Not every woman feels better when her mum arrives.
5. *Build her skills*. She will have some already. Find them out and relate them to giving birth/her situation. Encourage her to get new skills such as relaxation, hypnobirthing, or yoga. Find out what works for her, whether it is movement, music, breathing, touch, pictures.

11.26 Conclusion

Women, and other pregnant people, and their partners, are as varied and as individual as each snowflake or grain of sand. Childbearing is a time for anxiety and fear, but this can be met with compassion and skill by their midwives and doctors.

The message women currently get from obstetrics is not about collaboration, it is that women should be grateful that obstetrics is around to save their babies. And society pushes that message too. When women voice their concerns about interventions or want to try a different approach first, they are shut down, whether by a family member telling them to listen to the doctor or their clinician waving the 'dead baby card'. This increases anxiety.

Women know their bodies, their minds, and their mental health. They know what helps them and what hinders, and that is different for different women, though we know some common threads that are universal.

We also know that midwives and doctors, though midwives in particular, make a difference, and are hugely important to women.

Obstetrics came of age after the Peel report of 1970 paved the way for the vast majority of births to happen in hospitals. Obstetrics practised and learnt from these births. Gradually, through research, the learning and understanding is coming back to what midwives have known for millennium. Slowly the focus is turning away from a healthy baby (read live baby) to a mutually healthy dyad. Now it is time to learn from the women's stories.

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Shifting Tides—from Storm to Salvation

12

Sheena Byrom and Anna Byrom

Darkness cannot drive out darkness: only light can do that. Martin Luther King Jr.

12.1 Shared Stories

Fatu is a 17-year-old African woman, pregnant with her first baby. As the eldest child with 6 younger siblings, she is well versed with the rituals and issues of pregnancy and childbirth. Fatu's mother Kadiatu had lost 3 children during their first year. As she grew bigger, Fatu regularly woke from her sleep rigid with fear about her approaching birth. It wasn't the fact that her remote village in Zimbabwe was 100s of kilometres away from a hospital, but that she'd overheard her mother discussing the beatings she had received from the staff there, during her labours. Kadiatu had cried. Fatu was preparing to tell her husband and family that she wasn't prepared to go to the hospital when labour began, and that she would rather stay home, risking potential complications and even death.

Lola lives in Sydney, Australia, is 32, and her second baby is due in 2 weeks. Lola was induced in her last pregnancy at 41 weeks, for postdates. Her baby boy was born by caesarean section after a long labour. Lola attended an antenatal appointment with her midwife, and told her she wanted a VBAC this time, and she would like to give birth in the alongside midwife-led unit. The midwife informed Lola that this wasn't allowed, as she was 'high-risk' according to local guidelines. Lola asked to see the obstetrician, and after a full discussion it was clear to Lola that her choice in place of birth would not be facilitated. Lola told the staff that she would stay at home to give birth.

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These accounts, whilst fictional, are based on anecdotal accounts of women's experiences of childbirth. They are common scenarios, reported in various formats, on a regular basis. The details represent violations of human rights, dignity and respect—and reflect the global political position of childbirth in the twenty-first century. Both stories demonstrate a fear of institutionalised birthing practices, in high- and low-income countries, and it could be argued that fear is what drives institutions and caregivers to deliver dehumanised services that are non-responsive to individual needs.

12.2 Background

Fear of childbirth is a growing epidemic, as carefully charted throughout this book. The more information, technology and access to medical care we have, the more fearful we become, fuelled by our desire, and capacity, to locate the incremental risks associated with childbearing. Throughout previous chapters' important insights have been shared, into the drivers and basis our fear of childbirth, including bio-psycho-social and cultural influences, the impact and consequences, and some of the core dilemmas that face the users and providers of maternity services. As midwives and mothers, we (the authors) have experienced the growing phenomena where women, maternity workers and maternity services feel frightened, not only of birth but of being with birthing women.

Childbirth, like death, is a human right of passage. How birth happens, and how mothers experience the event matters to humankind, at a global, national and individual level. Internationally, this is being recognised, with a move to collate evidence (Lancet 2014, 2016, 2018) and develop policy (WHO 2016a, b, 2018a, b) and initiatives (EWEC 2015; IMBCO 2018) which promote safe, humanised, respectful and personalised maternity care. However, whilst there is continuing acknowledgment and pressure for action to reduce maternal and perinatal mortality and morbidity, there remains a varied response to implementing standards.

Disparities in access to maternity care and health outcomes between low-, middle- and high-income countries exist. In some parts of the world, resources and appropriate interventions during pregnancy and childbirth are 'too little too late' (TLTL), and mothers and babies are suffering and dying (Miller et al. 2016). Yet in some middle- to high-income countries interventions are over used, and there is 'too much too soon' (TMTS) (Miller et al. 2016). This is evident in the USA, where the caesarean section rate has increased by 500% in the last generation or two. The stark rise is frequently blamed on maternal age, obesity, medical problems and IVF. But Shah is adamant that these demographics are not the cause, but the health and social care systems from pregnancy to parenting (Shah 2019). In addition, although this country is one of the richest countries in the world—the maternal mortality rate is rising. American women today are 50% more likely to die in childbirth than their mothers (Shah 2018). Lack of social support during the postnatal period, racism and the rising caesarean section (CS) rate are contributing to the problem (Shah 2019).

Caesarean section is recognised globally as a maternal health care indicator, and although high levels are usually associated with high-income countries like the USA, there are variables and rates are rising in some low-resource settings partly due to weak regulatory factors and lack of adherence to evidence-based guidelines (Miller et al. 2016).

Miller et al. (2016) propose the urgent implementation of a global strategy where respectful, evidence-based care is supported and maintained throughout the childbirth continuum, and the WHO (2016b) envisions transformational health care that requires maternity services to go beyond survival during childbirth. Even so, implementation is poor although we know that women prefer relational models of care (Sandall et al. 2015), maternity services are being driven into large centralised hospitals, where there is a greater chance of care being depersonalised.

Childbearing women and those who serve them have to navigate this complexity. There is a need for extraordinary courage, based on compassion—a recognition of the injustice that prevails. We are all in this together. We have the evidence. We have the global commitment. But we are policy rich, implementation poor. Now we need to take up arms and continue to be 'persistent activists' so that the tipping point for change will be realised at least, in generations to come.

This chapter offers some practical guidance for those who commission, who work in or use maternity services to be the change they want to see. We don't propose to have all the answers. We would like to present the chapter as a manual or tool kit to support a revisioning of maternity practice and organisation from an international, national, local (service) and individual perspective, with the rest of the book as the foundation to what we propose.

12.3 Country-Level Change

In this section, we present a series of practical approaches that can be adopted across national policy and practice to mobilise positive transformation across maternity services and settings. These recommendations will work to strengthen national policies and guidance to encourage radical shifts in the way maternity services are conceived, designed and funded, in keeping with current evidence and research. This section focuses on the macro-perspective, the society-level response required to develop, revision maternity settings and care.

12.3.1 Everybody's Business: Embracing an Ecological Evolution

To address the systemic and institutional fear that can pervade us all, societies everywhere need to think big and involve everybody. It is essential that we harness the perfect policy storm and utilise the global evidence and guidance to optimise outcomes for childbearing women, babies and their families. Focusing on the practice principles promoted throughout global policy, we can help to alleviate fears and generate positive

actions. Whilst many individual acts can culminate in social revolution, it is also vital that Governments take a whole-systems approach to improving maternity services.

There are some fantastic examples of evidence-informed advocacy for successful implementation of complex health interventions, such as the approach being taken to adopt country-wide promotion, protection and support for breastfeeding (Perez-Escamilla et al. 2012). The 'breastfeeding gear model' for scaling up and sustainability of breastfeeding programmes could be a useful template for policy-makers and leaders when legislating and coordinating nation-wide change and policy implementation regarding childbearing and birth. The 'breastfeeding gear model' articulates an approach to sustainable change centred around intersectional, national and local, coordination and monitoring of appropriate breastfeeding interventions supported by seven core factors:

1. Political will
2. Legislation policies
3. Funding and resources
4. Training and programme delivery
5. Promotion
6. Research and evaluation
7. Advocacy

These are areas that can be considered for all aspects of maternity service policy and practice development—both at the societal level and at the local, individual service level. This model offers an ecological framework that considers the interaction between factors, treating them with equal value when considering how they interrelate and influence how childbearing and birth is conceptualised and approached. The framework allows individual, relational, community and societal factors to be considered helping to select and group appropriate intervention strategies. This fits with the social-ecological model (see Fig. 12.1).

Alongside taking a social-ecological approach, Unicef recommend using Communication for Development [C4D] (Unicef 2009). C4D is a structured, organised and evidence-based approach to encourage positive and measurable behaviour and social change (Unicef 2012). Table 12.1 specifies the key features and group impact of the C4D model. It engages communities and decision makers across national, regional and individual networks in conversations to build collective action that, for maternity care, would centre around individual childbearing women and families. Advocacy and engagement of and for service-users must be at the heart of all we do in health care, as captured in the next section.

12.3.2 Prioritising Women and Family Perspectives

At the centre of national maternity policy, guidelines and research development should be the childbearing women and families that they aim to support and serve. To transform maternity services, it is crucial that policy-makers, academics and

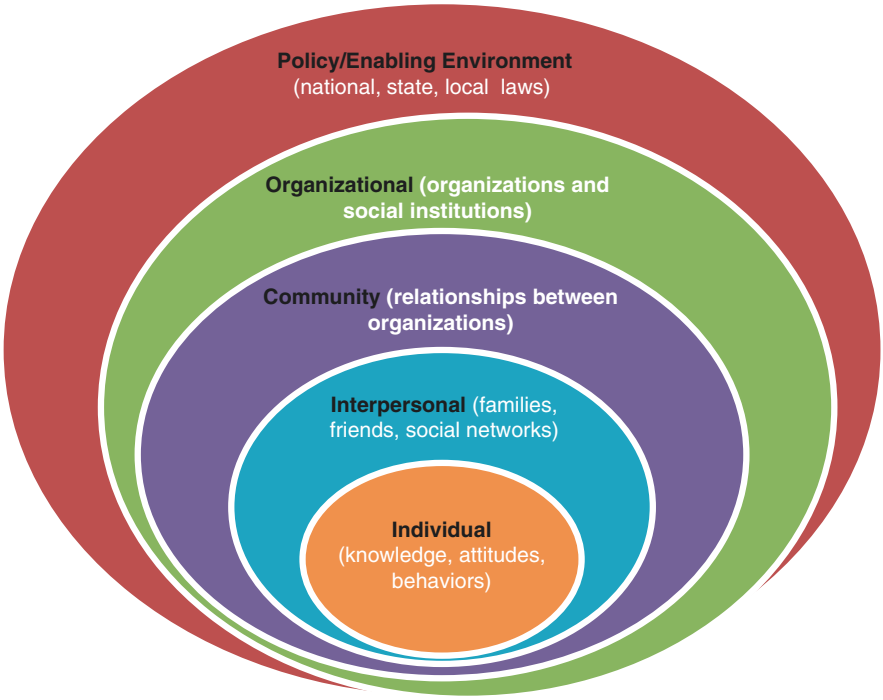

Fig. 12.1 The social-ecological model (Adapted from the Centers for Disease Control and Prevention (CDC), The Social-Ecological Model: A Framework for Prevention, http://www.cdc.gov/violenceprevention/overview/socialecologicalmodel.html)

leaders engage with service-users at every level to ensure policies meet their needs whilst enabling effective engagement. Successful approaches to service-user engagement have been developed from a range of perspectives, and we share some dynamic ideas for inspiration.

In the UK, co-production, with service-users, is recommended throughout the NHS. For maternity services specifically, Maternity Voices Partnerships [MVPs] are levied as an important part of the recent Maternity Transformation Programme (NHS England 2017). Inviting service-users to help shape the future of maternity care is not a new concept, but strengthening collaboration and effectiveness of partnership working is at the heart of the Better Births recommendations. NHS maternity service commissioners have received guidance, and local services, incentives to enhance and support the MVP. Practical guides for running a successful MVP can be found via the national MVP website (see resources and links below). Fostering close collaboration and positive relationships between commissioners, providers and services-users can help to drive positive action and change improving the development, utility and dissemination of care initiatives and transformations (James and Brintworth 2018). Prioritising service-user perspectives should also be developed alongside building and enhancing professional midwifery.

Table 12.1 Key features and groups of the C4D model

C4D approach	Key features	Participant groups
Advocacy	• Focuses on policy environment and seeks to develop or change laws, policies and administrative practices • Works through coalition-building, community mobilisation and communication of evidence-based justifications for programmes	• Policy-makers and decision-makers • Programme planners • Programme implementers • Community leaders
Social mobilisation	• Focuses on uniting partners at the national and community levels for a common purpose • Emphasises collective efficacy and empowerment to create an enabling environment • Works through dialogue, coalition-building, group/organisational activities	• National and community leaders • Community groups/ organisations • Public and private partners
Social change communication	• Focuses on enabling groups of individuals to engage in a participatory process to define their needs, demand their rights and collaborate transform their social system • Emphasizes public and private dialogue to change behaviour on a large scale, including norms and structural inequalities • Works through interpersonal communication, community dialogue, mass/social media	• Groups of individuals in communities
Behaviour change communication	• Focuses on individual knowledge, attitudes, motivations, self-efficacy, skills building and behaviour change • Works through interpersonal communication, mass/social media campaigns	• Individuals • Families/households • Small groups (e.g. mothers' support group)

12.3.3 Strengthening Professional Midwifery

An important approach to addressing the complexities outlined throughout this book, with regard to reducing unnecessary intervention and ensuring safe, maternity care revolves around strengthening professional midwifery. The Lancet Midwifery series (Renfrew et al. 2014) outlines how midwifery care can enhance many outcomes for women and newborns. Evidence establishes how midwifery care offers an affordable and effective solution to address the sustainable development goals, supporting women and their families to not only survive but also to thrive (Lancet series). Reducing mortality and morbidity alongside enhancing well-being are crucial for sustained improvements to public health. Effective midwifery care enables these improvements to be achieved, as outlined in previous chapters.

To increase access to midwifery care, it is cardinal that governments invest in effective midwifery education, regulation and association for practice, the three pillars of midwifery as outlined by the International Confederation of Midwives (ICM 2010). The ICM have specified a set of global standards, competencies and tools with associated guidelines for implementation. These resources can help to ensure that midwives in all countries have effective education, regulation and associations that can strengthen professional midwifery practice for all.

Connected to these national perspectives, it is important to consider the ways individual maternity services can positively address the fear levied from individual to societal level. Considering the meso-perspective helps to link the global and national priorities with the local context and individual practice.

12.4 Service-Level Shifts

As in the previous section, above, we will explore some practical ways you can promote practice development by considering the wider maternity service issues, opportunities and concerns.

12.4.1 Cultivating Effective Cultures

Maternity services are increasingly focused on risk avoidance, which potentially increases fear. Whilst it is imperative that all known risks are minimised, midwifery researchers are calling for organisations and individuals to turn their attention to a 'salutogenic' health-promoting approach to care as opposed to a pathogenic focus (Magistretti et al. 2016).

Maternity care, more than any other, relies on the relationships built between mother, family and the maternity workers. Getting it right at the beginning of life for the mother and her baby is fundamental (Campling 2015), yet many women feel that their maternity care is depersonalised, and increasingly, traumatic (Ayres et al. 2016). The reasons for this are multifaceted, but maternity services functioning in an industrial model where restrictive regulation, efficiency and fear of legal backlash are potentially limiting the ability to deliver humanised care (Walsh 2006). Negative or even toxic environments perpetuate the fear that prevails, and punitive approaches to managing services result in vicious circles, where staff burnout is more prevalent and mistakes may happen. Enabling change needs collaborative approaches, the gathering of available evidence, enabling leadership and caring for staff. Hammond and Foureur suggest that attention should be given to staff-well-being, organisational culture, physical environment, model of care and socio-cultural issues to improve maternity services and that there is an interconnectivity between all elements (2019).

Organisational culture can be difficult to define and challenging to address. The following suggestions offer some practical ideas for transforming maternity care culture in your service and beyond.

12.4.2 Using the Evidence

Managing and leading maternity services can be challenging; balancing the direction of the organisation and the needs of the employees and women and families they serve isn't simple. Whilst evidence-based care is essential for maximising optimal health outcomes, caution must be taken in the over-zealous use of guidelines

and protocols. Services must be reminded that evidence-based practice is a combination of the '*integration of clinical expertise, patient values and the best research evidence into the decision-making process for the care of the patient*' (Sackett et al. 1996). Clinical guidelines based on available evidence should be developed and used to support the process of decision-making, not to dictate it. Often clinicians use clinical guidelines as a smoke screen for their fear when deliberating women's preferences or plans. But when fear infiltrates service delivery, women's autonomy, their choices and potentially their childbirth experience, is jeopardised.

Using evidence-based resources such as the Quality Maternal and Newborn Framework (Renfrew et al. 2014) is an excellent way to plan and benchmark service delivery. The framework identifies optimal care and services for childbearing women and newborn infants in all settings and offers information on planning workforce development and resource allocation.

Although there is a plethora of international evidence and policy guidance relating to maternity care, implementation continues to be a stumbling block for maternity service providers. This may be due to bureaucratic systems that fail to acknowledge research or directives, or cultural disparities including weak leadership. On the other hand, it may be lack of access to current knowledge and progress due to insufficient resources or lack of ability to appraise and implement research evidence. Global and national policy and directives can help to make the case for change, but individual maternity services need to know they exist. Information channels are opening up via social media platforms, and whilst there must always be caution of 'fake news' and disreputable sources, social media is a means of communication with the world. Connecting via social media offers other opportunities too, such as sharing good practice, using hashtags to search support groups, and finding communities of expertise and practice (Byrom and Byrom 2017).

12.4.3 Leading the Way

The need for authentic effective leadership is imperative for organisations to be successful, and maternity services are no exception. Often local maternity services exist as part of a larger health care system. This may limit access to senior organisational leadership, adequate decision-making and financial security when competing with vast departments with perceived greater need. Leaders of maternity services often find access to board level within an organisation difficult, and communication is stifled.

In England, the National Maternity Review (2016) recommends that there should be a 'champion' for maternity services participating at Board level, which is encouraging. Managers should ensure this directive is implemented, and leaders in other countries use the example to influence their organisations. Leadership should be nurtured and role modelled at all levels. Everyone holds the potential to be a leader, from ancillary staff to executive board members, without the connection to hierarchy. We have seen superb leadership at ancillary and clinical levels, and poor direction from senior management. For midwives and maternity workers to feel safe, leaders need to be both courageous and able to challenge, and to be compassionate.

Challenging negative organisational and departmental culture needs a collaborative approach, based on a philosophy of respect, of kindness and compassion (Byrom and Downe 2015).

In their study, Byrom and Downe (2010) identified characteristics of a 'good' midwifery leader:

- The ability to act 'knowledgeably, safely and competently' is a basic requirement for midwife leaders
- The added element which makes the midwife leader 'good' is the extent of her 'emotional capability'
- In addition to being technically competent, a midwife with 'good' emotional capability is able to use, communicate, recognise, describe, learn from, manage, understand and explain emotions
- 'Good leaders' are also transformational leaders

For clinicians moving into leadership roles, organisational and group support is essential (Divall 2015). When leadership is strong and reassuring, staff members are more likely to flourish and provide safe, high-quality care.

12.4.4 Safety First

In an attempt to maximise safety, maternity services must consider the physical, physiological, cultural and spiritual well-being of the mothers, babies and families. This involves paying attention to the environment, workforce issues, the overall culture of the service, and departments, and the education, support and general well-being of the staff.

Suzette Woodward, an experienced UK campaigner for safer health care services, suggests the safety agenda needs a rethink, and be inclusive of joy, gratitude, kindness and well-being in the workplace (Woodward 2019). On her blog, and in her forthcoming book, Woodward (2019) proposes the following for new thinking to help health staff work safer:

1. Create a balanced approach to safety
2. Urgently address the culture of civility and blame
3. Build a 'restorative just' culture
4. Value the values of kindness, empathy, appreciation and gratitude
5. Care for the people that care and bring joy to their lives as well as care for their well-being

12.4.5 Birth Settings and Space

Maintaining a positive working environment includes the physical space too. For mothers and families, welcoming surroundings and comfortable non-technological settings are important for promoting physiology and a feeling of well-being instead of fear. Birth

rooms where the bed is the focus and medical equipment on view give visual messages that childbirth is risky and the bed the most appropriate place to give birth (Bowden et al. 2015). The aesthetics of birth rooms matter to midwives and maternity workers too. For example environments that have the characteristics of friendliness, offer freedom of movement and free from surveillance and are functional, enhance support for midwives and may therefore increase effective care provision (Hammond et al. 2017).

12.4.6 Workforce and Models of Care

Having an adequate number of midwives and support teams to care for mothers and babies should be a basic requirement for all maternity services. Using a validated acuity tool such as Birthrate Plus (2015) is useful in helping to ensure the ratio of midwives to childbearing women, for example, is sufficient. Continuity of midwifery carer is known as the 'gold-standard' model of care, and the evidence is clear that this benefits mothers, babies and midwives (Sandall et al. 2015). Women are more likely to share their fears and concerns with a known carer, and this type of care optimises opportunity for the midwife to really understand what the woman wants, and to advocate for her. Where continuity is lacking and when women feel afraid of the forthcoming birth, doula services are often employed. Doulas provide continuity of supportive care and advocacy, without any clinical input. Obtaining feedback from women and families who use maternity services is imperative, and a sense check of how care is received as described in other chapters.

It is easy to think that it is the role of our managers and service-leaders to create the changes we would like to see in our practice. Yet, we each have scope to provide effective care and enhance the services we contribute to. Certainly, our actions and behaviours become the cultures we work hard to develop and, at times, overcome.

12.5 Individual Maternity Worker

As individual midwives, birth or maternity workers, we can each take steps to facilitate the shifts required to change practice through our own actions and behaviours. The greatest way to overcome fear is to accept our own vulnerabilities and practice self-care and compassion (Brown 2015). Acknowledging our own insecurities and locating our fears can be a useful place to begin. Identifying what frightens us, when supporting childbearing women and families and where these fears stem from can be helpful to working through and alleviating them or finding strategies to overcome them, in practice. A great way to tackle fears is to talk them through with a trusted colleague, friend or peer.

12.5.1 Relational Care and Communication

The value of relational care has already been considered above, in terms of continuity of carer. Building effective relationships with women and families and also

with our colleagues and peers helps to ensure optimal partnership working and outcomes for mothers and babies. Woman and family-centred conversations, utilising appropriate communication skills, help to enhance collaborative working. Developing our own approaches to communicating with service-users is vital. There are a range of useful frameworks that can support effective communication. It has been recommended that health professionals adopt a guiding approach to communication, avoiding direction and using verbal and non-verbal skills. Childbearing women have heightened right brain dominance (intuitive, subjective), especially in the postnatal period. As such, it is helpful for us to adopt a person-centred approach offering practical and visual health promotion information. Unicef UK has provided a list of tips for keeping conversations woman-centred, which could help guide your practice:

1. Agree an agenda for the conversation, being led by the woman and family
2. Ask open questions to explore feelings and perspectives
3. Listen actively
4. Reflect back key points to gain clarity
5. Build on information already known
6. Show compassion and empathy
7. Remain neutral
8. Avoid collusion—stay focused on the evidence and offering individual support

It is also crucial that we share evidence in a relative and meaningful way. Coxon (2012) shares useful ways to frame evidence and share information about risks and benefits with parents. She encourages us to consider absolute as well as relative risk and quotes NICE guidance (see Table 12.2).

Alongside relating effectively with those in our care, it is also important that we communicate and collaborate effectively with our peers and colleagues.

Table 12.2 NICE guidance principles when discussing risks and benefits

• Personalise risks and benefits as far as possible
• Use absolute risk rather than relative risk (for example the risk of an event increases from 1 in 1000 to 2 in 1000, rather than the risk of the event doubles)
• Use natural frequency (for example 10 in 100) rather than a percentage (10%)
• Be consistent in the use of data (for example use the same denominator when comparing risk: 7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5)
• Present a risk over a defined period of time (months or years) if appropriate (for example if 100 people are treated for 1 year, 10 will experience a given side effect)
• Include both positive and negative framing (for example treatment will be successful for 97 out of 100 patients and unsuccessful for 3 out of 100 patients)
• Be aware that different people interpret terms such as rare, unusual and common in different ways, and use numerical data if available
• Think about using a mixture of numerical and pictorial formats (for example numerical rates and pictograms).

Source: Recommendation 1.5.24, Patient Experience in Adult NHS Services

12.5.2 Authentic Appreciation

Offering our work peers positive, authentic feedback can help to generate meaningful working environments and cultures. Robin Youngson has developed a dynamic range of resources, Hearts in Healthcare, which promote the importance of compassionate care, practice and working with kindness and connection. We highly recommend you to take some time to look through his free online resources. Online websites are among other digital platforms that can help us to create global communities to transform maternity care around the world.

12.5.3 Building Learning Communities

Harnessing social media and developing digital literacy and skills can enable rapid sharing of good practice and foster disparate learning communities to develop. The majority of the women we care for are accessing social media, as a way to canvas information, support and insights into childbearing and birth. It is crucial, as maternity workers that we help to provide safe and educational resources that support evidence-based recommendations whilst also enabling us to stay in touch with the generic needs of the childbearing population.

In addition to connecting with our service-users, social media can also be an amazing support network and offers every midwife with up-to-the-minute news and updates for practice development and progress. WeCommunities is an amazing social network for professional groups, including midwives, which offers a great place to begin or extend your social media professional networking (Byrom and Byrom 2014).

- Sharing good practice
- Collaboration
- Research confidence and skills

12.5.4 Embracing Change

Change is inevitable and contrary to popular belief is actually enjoyable. Think about how much you enjoy all the new things you experience in life: a new family member, purchase or experience. We live in a world where knowledge and information shifts rapidly; to sustain our practice it is essential that we develop a disposition for life-long learning. It is crucial that we recognise our leadership capacity and our positional power as policy implementers Brown (2017). We have the discretional ability to choose, moment-by-moment whether or not, to implement the policy, as described brilliantly by Lipsky (1980). If we want to see sustained change in practice we must, as Gandhi famously suggested, ‘be the change we want to see in the world’.

12.5.5 Women and Families

And what about those using maternity services? As mentioned above, how will they negotiate their childbirth journey? The book has provided some of the reasons for the fear women often feel during pregnancy, leading up to the birth of their baby. There is an abundance of negative stories, and whilst those accounts need to be heard and validated, a societal shift is needed in how childbirth is perceived. We can contribute to this via sharing and encouraging positive stories, via mainstream media and social media whenever the opportunity arises. Organisations such as the Positive Birth Movement established by mother and journalist Milli Hill, a global network of free to attend antenatal groups, are linked up by social media (PBM 2019). Encouraging and supporting women and their partners to attend antenatal education to gain as much knowledge as possible via books and websites. Birth planning is an excellent way of informing maternity care workers what women prefer, and what she wants to avoid. Hill (2017) has published the perfect solution with her The Positive Birth Book which includes a toolkit with icons for birth plan development. The icons are freely available from the book publisher's website even if the book is not purchased! There are organisations dedicated to helping women and families understand their rights and choices during pregnancy, childbirth and following birth—some are listed for reference at the end of the chapter.

We are all needed to enable change to happen. Alone we feel powerless, together we are strong.

12.6 Top Tips to Support Change

- Seek out and use current international and national evidence and directives to plan and benchmark services
- Establish a group of positive like-minded individuals to help you to develop a business case for new direction
- Ensure adequate staffing levels, using an acuity tool such as Birthrate Plus
- How are leaders being supported to drive forward improvements?
- Use social media to share and gain knowledge and encouragement. Set up a Twitter account, and follow leading maternity organisations such as @WHO, @world_ midwives, @WRAglobal and @FIGOHQ
- Invite mothers and families to become involved in designing and/or improving maternity care. Support them to help you make changes happen. Explore the UK MVP to strengthen service-user engagement with your maternity service or practice: http://nationalmaternityvoices.org.uk/
- Seek out positive birth stories via organisations such as the Positive Birth movement.

More Links to Useful Organisations

- White Ribbon Alliance: https://www.whiteribbonalliance.org
- International Confederation of Midwives: https://www.internationalmidwives.org
- Human Rights in Childbirth: https://humanrightsinchildbirth.org

- Association for Improvements in Maternity Services: https://www.aims.org.uk
- National Maternity Voices: http://nationalmaternityvoices.org.uk
- Make Birth Better: https://www.makebirthbetter.org
- Birthrights: http://www.birthrights.org.uk

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