How are post-birth reflective conversations experienced by those involved?

Nimisha Waller

A thesis submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Doctor of Health Science

2018

School of Clinical Sciences

Faculty of Health and Environmental Sciences

Auckland University of Technology

Abstract

This hermeneutic phenomenological study seeks to uncover the lived experiences of post-birth reflective conversations as experienced by midwives and women. Fourteen Lead Maternity Care (LMC) midwives along with twenty women were interviewed in this study. All of the women apart from two, received continuity of care from an LMC midwife they had registered with.

The findings reveal that space for dialogue needs to be created before post-birth reflective conversations can occur. Various non-threatening strategies are used to create this space. Midwives and women need to be willing to enter the space and/or be able to negotiate an appropriate time to have the conversation. The space is not only created with women; other members of the family/whānau also need space to share their experiences. Without a space for conversation, relationships are fragile and can be easily broken. Practitioners often raise lack of time as a barrier to post-birth conversations. However, 'time' is the key component of quality care.

'Mood' often prompted the conversation. Both women and midwives 'waited' for the 'right' time, hence patience is essential. Being open, receptive, courageous and having hope enables the participants to learn and grow from the post-birth conversation experience. It is the woman's conversation that prompts the many roles that the midwife assumes. The midwife must understand the woman/whānau and respond with specific expertise. 'Tact' is essential to enable the conversation to play out with sensitive attunement to the 'as' kind of practice that is most needed.

Finally, there is a need to extend the focus of the post-birth 'reflective' conversation to include 'prospective' conversations that allow for the possibility of 'anything' being discussed.

Table of Contents

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Dated: 31st May 2018

Acknowledgements

My sincere thanks to the 14 midwives and 20 women who participated in this study and shared their experience of post-birth reflective conversations. Your stories inspired and motivated me to keep going when things became tough during this journey.

My heartfelt thanks to my supervisors, Professor Liz Smythe and Dr Deb Spence, for their immense patience, advice, ideas, wisdom, and knowledge. I acknowledge the frustrations you may have felt at times in this journey. However, your invaluable guidance and support helped me throughout my research and writing of this thesis. Your ‘take a deep breath’ and ‘let the tension go’ in middle of dramas encouraged and helped me to re-focus on what I was trying to achieve. Your help in negotiating time to complete this pertinent research is very much appreciated.

My heartfelt thanks go to Associate Professor Judith McAra-Couper (Head of Midwifery) for applying for sponsorship and freeing up time for writing during this journey, as well as to all the midwifery staff for cover when I was not at AUT. Thank you also to midwifery colleagues and friends who, at various times, have discussed where I was and what was I finding. Having lively discussions with you helped clear my thinking, provided valuable feedback, and enabled me to grow as a midwife and as a person. All of you directed and influenced the way of my research. My appreciation and thanks to Shoba Nayar, for being available at short notice for editing and formatting of this thesis.

Last, but certainly not the least, my appreciation goes to my family, Philip, Priya, Sunil, and Rhianna as well as my mother (Mrs. Shantaben Rasiklal Lakhani) and my late father (Dr. Rasiklal Haridas Lakhani). They all influence my work and life. I dedicate this work to them.

This journey has taught me the transformative power of ‘being-with’. I acknowledge that I have not been fully ‘there’ for most of you over the last months, as I had to remain focused to complete this journey. Time has now come to be there ‘with’ you!

Chapter One: Introduction to the Study

Context of the Study

This hermeneutic phenomenological study rests on the assumption that when, in the six weeks following birth, a midwife invites a woman to talk about her pregnancy/birth experience, there is a potential for something useful to happen. Pregnancy and the postpartum period though joyful and exciting can also be considered to be highly vulnerable for the possible development and exacerbation of postnatal depression (PND) and other mood and anxiety disorders (Biaggi, Conroy, Pawlby, & Pariante, 2016; Viguera et al., 2011). Further, anecdotal evidence suggests that lingering distress from a pregnancy/birth experience can influence a woman's decision about having more children. The midwifery continuity of care relationship afforded by the New Zealand (NZ) maternity service offers a unique context in which to investigate the experiences of a reflective (or 'de-briefing' or 'de-fusing') conversation because the lead maternity carer (LMC) midwife who attends the birth also provides the postnatal care. LMC means "a person who is a GP, a midwife or an obstetrician who is either a maternity provider in his or her own right or an employee or contractor of a maternity provider and has been selected by the woman to provide lead maternity care" (Ministry of Health (MOH), 2007, p. 1043).

This study aims to reveal what happens in and following such post-birth reflective conversations. The research question is "How are post-birth reflective conversations experienced by those involved?" Data were generated through audiotaped interviews with 34 participants – 20 women and 14 case loading midwifery practitioners. To avoid a breach of trust, neither the midwives nor women who participated knew each other. This study seeks to make visible women's and midwives' experience of post-birth reflective conversations. It is hoped the insights from this study will further contribute to midwives' ability to reflect on their practice and enhance the quality of post-birth reflective conversations.

Hermeneutic Phenomenology

Heideggerian hermeneutic phenomenology has been widely used in health research to understand the meaning of lived experiences (Miles, Francis, Chapman, & Taylor, 2013). According to Cohen, Manion and Morrison (2007), the broadest definition for phenomenology is that it is a theoretical point of view advocating the study of individuals' experiences. Human

behaviour is said to be determined by the phenomena of experience rather than an objective, physically described reality that is external to the individual (Sloan & Bowe, 2014). This approach is a methodology used to gather meanings for individuals through the analysis of their language as spoken or written (Kvale & Brinkmann, 2008; Langdridge, 2007). Phenomenology supports the view that people make sense of their world from the 'inside', or the lifeworld (*Lebenswelt*) (Elley-Brown, 2015). Phenomenological stories of the 'lived experience' of women's and midwives' reflective conversations were crafted from audiotaped interviews. The findings were hermeneutically interpreted using the philosophical writings of Heidegger [1889-1976] and Gadamer [1900-2002], informed by the human science approach to phenomenology outlined by van Manen (1990; 2014); by using Buber's [1987-965] philosophy on the encounter and dialogue as well as Levinas's [1906-1995] philosophy upon the nature of the relationship between the individual himself and the Others. I chose this approach because it enables deep understanding of post-birth reflective conversations and 'gives voice' to experiences of the participants. (See Chapter Three p. 44-45 for definition of phenomenology and justification of using Hedeggerian hermeneutic phenomenology in this study).

The Impetus for the Study

Since 1998 I have been involved in raising awareness of women's experience of post-traumatic stress disorder (PTSD) following childbirth through the organisation Trauma and Birth Stress (TABS). During these workshops, the midwife's role in preventing or minimising trauma and development of PTSD has been presented. Related working groups have suggested that services available in the United Kingdom (UK) should be available in NZ. This would enable women to meet with practitioners to go over their clinical records and gain an understanding of what may have caused feelings of trauma during their labour and birth. However, maternity services in the UK are very different from NZ. Maternity care in NZ comprises of continuity of care to the woman from time of registering with an LMC to four to six weeks postpartum. Anecdotally, midwives and women in NZ speak of the value of having reflective conversations following the birth of the baby. However, there is nothing written/published regarding this aspect of care. This study is about the phenomenon of post-birth reflective conversations from the viewpoint of women and midwives experiencing them. When exploring 'experience', researchers have traditionally turned to the phenomenological perspective to develop insights into those experiences.

Assumptions and Pre-understanding

van Manen (1990) suggested that in phenomenological inquiry it is important to "make explicit our understandings, beliefs, biases, assumptions, presuppositions and theories" (p. 47). To do so is to recognise and acknowledge the influence these may have on the research process and, in particular, the analysis of data and interpretation. So what are the assumptions and pre-understandings brought to this study that have shaped and influenced my analysis?

Fundamental to my research is the premise that understanding the experience of reflective conversations will contribute positively to ensuring quality care for women and enable them to have a smooth transition to parenthood.

My pre-understandings have been shaped by what I have observed happening in my family during and following birth, as well as having been a midwife for 33 years. My maternal and paternal grandparents were Indians who immigrated to East Africa. Both of my parents were born in East Africa – my father in Uganda and my mother in Tanzania. My brother and I are second generation Indians born in East Africa and emigrated with our parents to the UK in 1972. Rituals around the time and following birth remain very connected to our cultural and religious heritage. In our family, extended family, and community, It is normal for women to ‘fall’ or be ‘drawn’ into conversations about pregnancy, labour, and birth experiences with each other whenever opportunities arise. That is, these conversations are not planned but happen spontaneously. I remember my aunties and cousins discussing the benefits of having such conversations because it validated what had actually occurred during that time. It provided them with a narrative that acknowledged their feelings and supported them in finding ways to manage concerns, anxieties, and changes in life. Following the birth of my children, I was privileged to have such conversations with my mother who had been at the birth of all three of my children, and those of aunties and cousins in our extended family. I found such conversations to be helpful and affirming. It also enabled me to keep the family tradition, relevant because I had chosen not to have an arranged marriage. Philip, my husband, is British and has a different cultural and religious heritage.

In contrast, I have friends who have never had such conversations about childbirth with their family or friends. In my midwifery practice, both in the UK and NZ, since 1996, I have always

ensured that I remain open to women/whānau[1] so they can talk about their experiences of pregnancy, labour, and birth, and what has been happening during the postnatal period. Women have always provided positive feedback about the value of such conversations when they have occurred. My interest in postnatal distress in the UK and in NZ with women who had perceived their births as being traumatic and having symptoms of PTSD has affirmed the value of such conversations in my practice.

I also make the assumption that the majority of the midwives would, during the four to six weeks of postnatal care, have a conversation with women and/or whānau regarding their experience of pregnancy, labour, and birth, and anything that is happening during postnatal care.

Since 2004, I have been providing LMC care to approximately 10 women a year, alongside my work as a midwifery educator. With my involvement as a speaker at TABS workshops and my personal experience of post-birth conversation in our family, I am always aware of some women wanting to talk about their labour and birth experience or anything that may be happening following the birth of their baby. Su (not her real name) asked during one of the postnatal visits why her baby would not come down which meant she had to have a caesarean section. With her clinical notes, we discussed the baby's head being asynclitic. I could see her and her cousin appearing confused with the diagram I had drawn. I decided to take a doll and a pelvis at the next visit. Su had some of her family around and her husband. You could see the delight on their faces once they understood what asynclitic head meant. They all mentioned about visions they had been having about how the baby had got stuck, and were confused that he did not have any visual marks from ‘being stuck’ at birth. Su decided she was going to be active and not sit on a sofa in her next pregnancy. She would use the swiss ball during her labour to ensure baby remained in the right position. The conversation with the visual aids gave her and some of her family members an understanding of why she needed to have a caesarean section, and enabled her to make a plan of what she would do differently. They all enjoyed handling the doll and pelvis and learning about how babies manoeuvre their way in labour. They continued to share their insights with each other and with others they came in contact with for a long time. Such conversations take midwife/woman/whānau relationships to a different level. These relationships sustain me in practice.

[1] Whānau is often translated as 'family', but its meaning is more complex. It includes physical, emotional, and spiritual dimensions and is based on whakapapa. Whānau can be multi-layered, flexible, and dynamic. Whānau is based on a Māori and a tribal world view.

Prior to commencing the study, an interview with my supervisor highlighted the following assumptions relating to midwives and women's experience of having reflective conversations:

- Self-employed midwifery practice in NZ offers a unique and valued service for women and an opportunity to have a reflective conversation because of the assumed trust that is developed in the relationship.
- Most women want to talk about labour and birth experience at some stage during the four to six weeks of the postnatal period, even if it is only to say thank you.
- It is essential that midwives offer this space for conversation, especially where the mode of birth was not what was expected because the woman/whānau could perceive the experience as traumatic. The use of analgesia/anaesthesia may have affected their ability to remember all aspects of their care; a conversation thus enables gaps to be filled in and confusion to be clarified.
- It is essential for women and midwives to understand that these are not debriefing/counselling conversations and to refer appropriately if such services are required.

These pre-understandings shaped and influenced my initial approach to this study. They, along with the other assumptions and pre-understandings I have ongoingly brought to the study, have been reflected on and questioned as my understanding of the phenomenon of 'reflective conversation' has expanded during the course of the research.

There are also limits to my understanding in that I have not lived with a mode of birth that I perceived as traumatic or one that challenged my transition to becoming a mother. Those reading this thesis are also likely to bring assumptions and pre-understandings of the phenomenon of reflective conversations based on their own experiences. I invite the reader to reflect on these while remaining open to new understandings of the phenomenon.

Background

Pregnancy, chilbirth and transition to parenthood are generally viewed by women/whānau as positive or rewarding though likely to be a life changing event. However, an extremely positive birth may enhance women's self esteem and her ability to manage challenges resulting in a smooth transition to parenthood (Thomson & Downe, 2010). While many mothers may

transition through parenthood without postnatal distress, they may face other challenges such as shorter length of stay in a hospital/primary unit, overwhelming information during initial postpartum days, lack of support from health professionals or family/whānau, induction/augmentation of labour, postpartum haemorrhage, perineal discomfort, issues regarding breastfeeding or newborn care (Olson, Bowen, Smith-Fehr, & Ghosh, 2018; Wiklund, Wiklund, Pettersson, & Boström, 2018). These events can potentially increase physiological, social and emotional demands (Alderdice, McNeill & Lynn, 2013) and have been associated with psychological morbidity (Darvill, Skirton, & Farrand, 2010; Fryer & Weaver, 2014; Sjöström, Langius Eklöf, & Hjertberg, 2004; Wiklund, Wiklund, Pettersson, & Boströmb, 2018). The perinatal period and up to year after childbirth are considered to be highly susceptible to development and exacerbation of postnatal depression (PND), mood and anxiety disorders and severe postnatal psychiatric illness (Beck, 2004a, 2004b; Beck Gable, Sakala, & Declercq, 2011; O'Hara & Wisner, 2014; Ross & Dennis, 2009; Silverman & Loudon, 2010). Childbirth experiences can have far-reaching traumatising consequences for up to 30 percent of women. (Ayers & Pickering, 2001; Czarnocka & Slade, 2000; Fenech & Thomson, 2014; Maggioni, Margola, & Filippi, 2006; Söderquist, Wijma, & Wijma, 2006; Soet, Brack, & Dilorio, 2003). Postnatal distress has been linked to poor childbirth outcomes on both a short and long-term basis (Beck et al., 2011). Adverse effects of these disorders after childbirth reported in studies include: ongoing tension in relationships with partners; blaming of traumatic births; initial feelings of rejection towards their baby; feeling isolated from the world of motherhood as they distance themselves to avoid possible triggers; and hindering their attempts at breastfeeding (Ayers, Eagle, & Waring, 2006; Beck, 2004a, 2004b; Beck & Watson, 2008; Fenech & Thomson, 2014; Webb et al., 2008).

The purpose of postnatal care is to provide 'the highest possible quality of care and medical treatment with the least possible intervention to optimize the health and well-being of the new family' (World health Organisation [WHO], 2013). Irrespective of any challenges faced, women welcome the opportunity to talk about their birth experiences and especially where the experience was different from one that was expected because it can be therapeutic (Bluff & Holloway, 1994). However, literature highlighting the evidence regarding the usefulness of labour and birth debriefing or counselling is conflicting (Gamble, Creedy, Webster, & Moyle, 2002; Gamble et al., 2005; Lavender & Walkinshaw, 1998; Ryding, Wirén, Johansson, Ceder, &

Dahlström, 2004; Selkirk, McLaren, Ollerenshaw, McLachlan, & Moten, 2006; Small, Lumley, Donohue, Potter, & Waldenström, 2000; Small, Lumley, & Toomey, 2006). The review by Lapp, Agbokou, Peretti and Ferrerri's (2010) revealed inconsistencies regarding the therapeutic effect of debriefing and counselling. Nonetheless, it has been suggested that midwives should provide a service that offers women a safe place to talk about their fears, memories, and anxieties (Axe, 2000; National Institute for Health and Clinical Excellence [NICE], 2015); and that women find the opportunity to discuss their birth experience to be positive and cathartic (Bailey & Price, 2008). However, no explanation has been provided about why women find the experience cathartic (Baxter, McCourt and Jarrett, 2014). Given that it is likely that the women's birth experiences will be discussed postnatally, midwives are in a unique position to "talk with and observe women on a daily basis" (Anderson & Podkolinski, 2000, p. xi). Various listening services have, therefore, been established in the UK to enable women to 'talk' or discuss their childbirth experiences. These services are set up within an institution although it is mainly the midwife who is involved in the administration of the service (Madden, 2002). Such services are used when there is possibly lack of continuity of care; however, the NZ women-centred maternity model of care is world leading in terms of the on-going midwife-woman relationship (New Zealand College of Midwives [NZCOM], 2013).

New Zealand Maternity Care

Because this research has been undertaken in NZ, an understanding of midwifery scope of practice and background understanding of the maternity system is essential. The New Zealand College of Midwives accepts the International Confederation of Midwives [ICM] definition of a midwife. The ability of NZ midwives to practice across the full scope of midwifery practice enables them to meet the International Definition of the Midwife and Definition of Midwifery (ICM, 2017). The scope of practice in NZ is defined by the Midwifery Council of New Zealand (MCNZ). The scope states that the midwife works in partnership and autonomously for women during pregnancy, labour, and postpartum up to six weeks, to facilitate births and provide care for the newborn. Furthermore, the midwife promotes physiological childbirth, identifies complications and accesses medical assistance, implements emergency measures as necessary, promotes health and wellness, education for women, whānau and community as well as aspects of women's health and family planning (MCNZ, 2010a). The scope of practice in NZ is similar to the ICM scope of practice (ICM, 2017).

New Zealand's maternity system is unique (Grigg & Tracy, 2013), different in many ways from the UK where I qualified as a midwife in 1982. The existing model of care in NZ is an integrated woman and family-centred maternity service with lead maternity carers (LMC's) (Guilliland & Pairman, 2010a, 2010b; Ministry of Health [MOH], 1990). The LMC is a named person, usually a midwife (92.2%) (MOH, 2017, p. 24), but it can also be an obstetrician or a general practitioner, who provides comprehensive maternity care, free of charge to all NZ residents and citizens (MOH, 1996). A small proportion of midwives (2.3%) are employed by maternity facilities to provide care to a caseload of women (MCNZ, 2016). Since New Zealand Nurses Amendment Act, midwives have gained the right to practice autonoumously (MOH, 1990). LMC midwives in NZ are contracted by the MOH to provide midwifery care to a case load of women throughout pregnancy, labour, birth and postpartum period up to six weeks (MOH, 2007). Women and whānau in most cases can choose the LMC and a place of birth that suits their needs (New Zealand Health Information Service [NZHIS], 2012).

LMC midwives provide care in the community and have legal access to local maternity facilities. The care during pregnancy is usually provided in clinics or in the woman's own home; intrapartum care is provided at home, in primary birthing units or in hospital; and postnatal care in the woman's own home. LMC's refer and/or transfer care when indicated according to agreed Consultation/Referral guidelines (MOH, 2012). This means that LMC midwives are on call throughout the childbirth continuum. To sustain 24 hours 7 days availability (MOH, 2007), LMC midwives usually have a practice partner or belong to a practice group, who provides backup and cover for time off. There are few groups in which LMC midwives will only provide primary care (low risk women) or where the caseload is shared between the LMC midwives in the group. In these groups the woman's ability for continuity of carer is affected when they require secondary care (high risk women) as care may be transferred to Obstetric team and midwives working in the hospitals or in a case of caseload being shared, they may see more than one midwife from the group during the childbirth continuum.

Obstetricians can work in the hospital setting and/or as a private practitioner. Some women may choose to have a private obstetrician who may have a midwife in his/her practice or women may book an LMC midwife for additional midwifery care. The midwives who work exclusively within the hospital setting are employed by the District Health Boards (DHBs) and are known as 'core midwives'.

The NZ maternity service is built on the principles of partnership, protection, and participation (Guilliland & Pairman, 2010a). This places women and whānau at the center of care and in decision making. Women/whānau have the choice to either birth at home, in a hospital, or at a stand-alone birth centre or on-site birth centre's available in some regions.

Communication in Midwifery

Effective and constructive communication skills need to be developed by midwives for use in their practice (Hollins Martin, 2011; McGuinness, 2006). Yelland (2013) emphasised that midwifery is about communication, communication, communication. The Midwifery Council of New Zealand (MCNZ) Competency 1.9 for Entry to Register of Midwife states "communicates effectively with the woman/wahine and her family/whanau as defined by the woman" (MCNZ, 2007, p. 2). The word 'communication' means to share or make common (Manojlovich, Squires, Davies, & Graham, 2015). Hence communication plays a significant role in the midwife-woman relationship.

The midwife and the woman are said to work in partnership (NZCOM, 2015). They share pregnancy, labour, and birth, and the four to six weeks of postpartum experience. The midwife has a role of 'care' which one assumes involves being attuned to how the woman 'is'. Having reflective conversation/dialogue is one way of providing responsive care to the woman.

The meaning of conversation

The word conversation comes from the Latin *'conversare*', to converse (Goble, 2017). In earlier times, the conversation had a more general meaning, the action of living or having one's being in a place or among persons, the action of having dealings with others, of living together in commerce and society (Oxford English Dictionary, 1971). The Oxford English Dictionary (1971) draws from 1594, "That natural instinct which man hath to live in conversation" (p. 546). Conversation is a manner of conducting oneself in the world or in society (Halsey & Slinn, 2008), to be in the conversation, to share in an interchange of thought or word, to be in familiar discourse.

Gadamer [1900-2002], a key philosopher within the hermeneutic paradigm, discussed the nature of conversation (1989). When he spoke of the genuine conversation, he was referring to a fundamental way of being with another. The word 'genuine' comes from the Latin word

'ingenuus', meaning native, free-born, authentic, real, pure, not counterfeit, unadulterated. Thus, there is a quality of authenticity, unaffectedness, and sincerity which is brought to the discussion of the genuine conversation when explored through the lens of Gadamer's philosophy.

Gadamer (1989) further suggested that genuine conversations are not 'conducted' by either the woman or the midwife. It is more appropriate to say that the woman and the midwife are 'drawn' or 'fall' into the conversation, becoming involved in it. It may appear that the conversations are conducted as one word follows another, with the conversation taking its own twists and reaching its own conclusion, but the woman and the midwife conversing are far less the leaders of it than the led. Neither the woman nor the midwife knows in advance what will 'come out' of a conversation. "Understanding, or its failure, is like an event that happens to us … it allows something to 'emerge' which henceforth exists" (Gadamer, p. 383).

At the start of the conversation the woman and the midwife may well have an idea of what they intend to say, and the direction they intend the conversation to follow. The understanding or failure between the woman and the midwife is more akin to a happening than a planned, directed occurrence (Gadamer, 1989). It is in the language with which the conversation is conducted that Gadamer (1989) found the key, which "bears its own truth within it" (p. 383). The quality of permanence of the spoken word, once it has been uttered, received special significance from Gadamer. In a conversation, something emerges which from that time has its own existence. In this research inquiry, it is these kinds of conversations or events, which reveal the phenomenon being researched.

Gadamer (1989) stated further that to understand a person (woman in this instance) is to understand the matter being talked about; to understand what she is saying, not to relive her experience or the description of her experience. The purpose of interpretive work in both dialogue and textual interpretation is not to duplicate the other, but to understand what is said, and to create a new understanding of the phenomenon in question. Collectively, the fusion (Miles et al., 2013) of the woman and the midwife's understandings reveal a truth about the matter being conversed that elevates the conversation from a single representative or perspective to a universal topic (Warnke, 1987). Ideally, neither the woman nor the midwife presupposes to know the truth; "rather each is open to the possibilities inherent in the other's views" (Reist, Jenei, Dyck, & Asgari, 2017, p. 2). Gadamer also emphasised three essential

considerations about the genuine conversation: openness to the other's position, the essence of questioning, and the concept of possibilities. Each of these three elements is a part of the genuine conversation and helps to make the conversation what it is. Reflecting on these elements reminds me that not all conversations described in this study will necessarily be 'genuine' in nature. This is congruent with the lived day to day nature of the conversation.

Literature suggests that reflective conversation can be conducive to personal and professional learning and development (M. Haig, 2005; N. Haig, 2005; Senge, 1994). The term 'learningful conversation' was coined by Senge to distinguish conversation that engages the process of reflection, in particular reflection on mental models. These are "deeply ingrained assumptions, generalisations or even pictures or images that influence how we understand the world and how we take action" (Senge, 1990, p. 8). Senge (1990) stated:

> The discipline of working with mental models starts with turning the mirror inward; learning to unearth our internal pictures of the world, to bring them to the surface and hold them rigorously to scrutiny. It also includes the ability to carry on "learningful" conversations that balance inquiry and advocacy, where people expose their own thinking effectively and make that thinking open to the influence of others. (p. 9)

Senge (1994) further suggested that "learningful conversation" is more likely in the form of dialogue than in discussion (p. 245). A discussion is defined as conversation confined to participants stating and giving reasons for their positions (advocacy) while dialogue involves the participants exploring and critiquing reasons and assumptions associated with their positions (inquiry). M. Haig (2005) and N. Haig, (2005) suggested that in discussion one person influences the shape of the direction and character of talk while another person(s) may find it difficult to say what is in or on their mind as openness, permissiveness, risk-taking, and storytelling diminish.

Zeldin (2000) observed:

> Conversation is a meeting of minds with different memories and habits. When minds meet, they don't just exchange facts; they transform them, draw different implications from them, engage in new trains of thought. The conversation doesn't just reshuffle the cards; it creates new cards. (p. 14)

The reflective conversation between a mother and her midwife enables them to create and shape the meaning of the experience, i.e., "create new cards" (Zeldin, 2000, p. 14). Reflective conversation is therefore seen as an act of collaborative meaning-making (Ghaye, 2011).

Conversation between a woman and midwife is central to the relationship because it encourages development of rapport and perception of knowing each other (Kennedy, Shannon, Chauhorm, & Kravetz, 2004). An important aspect of midwifery care is to ensure there is quality and effective communication between midwife, woman, and her whānau. It appears that professional communication between woman and midwife is likely to be more affected by differences in efficiency and quality of care rather than the technical aspects of maternity care (Teutsch, 2003). Midwifery literature suggests that high calibre conversation/dialogue results when there is genuine interest, respect, optimal listening with a focus on the woman (Attree, 2001; Wendt, Marklund, Lidell, Hildingh, & Westerståhl, 2011). This collaborative knowledge-building about pregnancy, labour and birth, and/or postpartum experience can be a driving force in ensuring that care provided to the woman is holistic, professional and ethical.

Debriefing, which can involve conversations, covers a range of interventions that usually comprise of a single, semi-structured intervention that occurs within four weeks of a traumatic event. Despite controversy over the efficacy of debriefing (Meades, Pond, Ayers, & Warren, 2011), there are areas of healthcare where debriefing is still used. One such area is postnatal maternity care in the UK. Postnatal debriefing typically involves a midwife going through a woman's birth events with her, usually with the medical notes available. Postnatal debriefing, under various guises such as 'postnatal debriefing', 'birth afterthoughts' or 'birth reflections', is offered by up to 78% of hospitals in the UK (Ayers, Claypool, & Eagle, 2006a; Steele & Beadle, 2003). In practice, these interventions range from active listening to women's birth experiences to more structured interventions (Steele & Beadle, 2003). However, evidence on the efficacy of postnatal debriefing remains inconsistent (Ayers, McKenzie- McHarg, & Slade, 2015).

Avoiding crucial conversations

From my own life experience, I recognise that the inclination to avoid difficult conversations can be mutual. Midwives and women can be equally unwilling to consider other possibilities, hoping that the status quo will suffice which, it often does, but at the cost of missed opportunities. Without addressing what is of concern, missing, or what could be done better, there is little room for growth in the midwife's practice or in a woman's ability to make the transition to motherhood. Thus my thesis rises to the challenge of shedding light on the experience of the midwife-woman post-birth reflective conversation – that which is often hidden behind closed doors and seldom discussed in terms of the meaning of the conversation itself.

Overview of the Thesis

This thesis consists of eight chapters:

Chapter one introduces and contextualises the thesis, my pre-understandings, the purpose, aim and justification of the study, as well as introducing central philosophical notions, key words, and the rationale for using hermeneutic phenomenology.

Chapter two is a literature review using a hermeneutic/phenomenological lens to uncover what is alr`eady present in the literature and other key documents pertaining to the phenomenon of this study.

Chapter three explores the methodology and philosophical underpinnings that inform the processes used in this study and how these guided interpretation and analysis.

Chapter four describes the research methods used to undertake this study acknowledging the influence of hermeneutic phenomenology on these methods including the judgment of rigour.

Chapter five draws on the participant data to reveal how space is created (or not) for reflective conversations

Chapter six highlights how mood prompted the conversations; conversations happening after birth itself and conversations that ‘wait’ for the right time.

Chapter seven illuminates how conversation calls-out the midwife-as, showing she takes on many roles during post-birth care. Within this is the notion of tactful care.

Chapter eight presents and discusses the key findings. Implications and benefits for those involved in the reflective conversation are explored and recommendations for practice, education and further research made.

Chapter Two: Exploring the Literature

Introduction

Exploring the literature helps to locate a study within the context of existing writing that is relevant to the focus of the study. In hermeneutic phenomenology, it also, very importantly, situates the phenomenon and the researcher within their past and present historical contexts. Postnatal debriefing has been examined and analysed in three developed countries (United Kingdom, Australia and Sweden); however, the phenomenon of post-birth reflective conversations does not appear to have been researched. There are therefore no previous studies on the experience of post-birth reflective conversations with the NZ midwives who provide LMC care to women in the community. Existing literature on debriefing following labour and birth has predominantly used a quantitative methodology apart from three studies that had used qualitative approaches (Baxter et al., 2014).

Hermeneutic Phenomenological Approach to Explore the Literature

The aim of a hermeneutic approach is to seek an understanding (Gadamer, 2004) rather than explanation (Kinsella, 2006), of the factors (for e.g. pre-understandings) that may influence the researcher's interpretation of writings/texts in a particular way.

Husserl (1931) invites us to "set aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizons of our thinking... to learn to see what stands before our eyes" (p. 43). Gadamer (2004) argues forcefully that our prior understandings always influence our interpretations and thus the purpose of surfacing these is to engage with them through questioning rather than denying their existence or setting them aside. Therefore, a researcher needs to take a fresh look at things "in a conscious, deliberate and disciplined way" (Wilson, 2017, p. 362). This assists illumination of what is hidden due to the way one interprets the world and its texts. The researcher therefore has to be open to acknowledge what may prevent her/his ability to see what is there.

Hermeneutics welcomes openness to more than one interpretation (Kinsella, 2006). For Gadamer (1996) "to understand a text always means to apply it to ourselves and to know that, even if it must always be understood in different ways, it is still the same text presenting itself to us in these different ways" (p. 398). Hermeneutics is not laid out to be conclusive and all

encompassing. It acknowledges that what is there in relation to truth will be partially revealed (Gadamer, 2004). Rather than pretending to hold the answers it seeks to draw the reader into emergent thinking.

According to Gadamer (1960/2000), “the essence of the question is to open up possibilities and keep them open” (p, 299). When reading the literature, the questions I asked included: What is unsaid about post-birth debriefing? What is concealed during those conversations? Who instigates the post-birth conversations? What is the meaning/experience of having such conversations? What impact do these conversations have on women and midwives? Being receptive/aware of the questioning enabled clarification and added depth to my understanding.

Hermeneutic literature review enabled me to review a range of literature as it encourages deviation for the research question to evolve and deepen during the research process (Boell & Cecez-Kecmanovic, 2010). The search to look at what was ‘out there’ on post-birth reflective conversation took me to libraries, educational bookshops, internet, social media to talk to others about the topic and AUT databases (accessed through the AUT library database link). Friends of friends who were using reflective conversations in education and healthcare shared their knowledge and wisdom, book collections and literature. One that I inclined towards and it in turn inclined towards me (Smythe & Spence, 2012) was the book Fierce Conversation (Scott, 2017). The book set me thinking and provoked further thinking. The quote from this book is used at the beginning of Chapter Eight.

Although postnatal debriefing is predominately mentioned in midwifery and occasionally in the nursing literature, I looked beyond this literature for work relating to reflective conversations. The disciplines of education (Smith, 2016) and medicine (Jordan et al., 2009) also provided the sources of this literature. The lived experience of post-birth reflective conversations is absent in most published papers because of the dominance of reductionist scientific focused research (Berg et al., 2008).

In my literature search I used key words from my own understanding and experience of the topic and those of the participants. Search phrases included, but were not limited to, pregnancy, labour, birth, labour and birth, postnatal care, postpartum health, health after childbirth, postpartum depression, PTSD, postpartum talk/conversations/dialogue, conversations between women and midwives, Trauma symptoms in women and midwives, patient and health

professionals conversations, relationship between women and midwives, maternity care, women's views, listening, debriefing, diffusing, discussion, listening, talk, counselling, conversation and reflective conversations. The search also included less formal explorations such as Post-natal Depression support group newsletters, newspaper and women's magazines. Policy documents from the World Health Organization on Postpartum Care of the Mother and Newborn and the Ministry of Health Primary Maternity Services Notice also informed the review (MOH, 2007; World Health Organization [WHO] on Postpartum Care of the Mother and Newborn, 2013; WHO Technical Working Group, 2010).

According to Heidegger (1927/2011) the understanding and the fore-having I bring to the review of literature, helps to form understanding of my research topic and the original formulation of what I am seeking to discover. The call for my research came when I was asked whether debriefing services such as 'Birth Afterthoughts' and 'Post-Stress clinic' should be funded/considered within NZ Maternity care. Anecdotally there has been information of midwives and women having post-birth reflective conversation although nothing formally had been written/published in the NZ literature.

What is Visible Within the Literature?

Post-birth debriefing – a correct term?

The most common term used to discuss postnatal intervention that may help to reduce postnatal distress is 'debriefing'. It usually consists of one session within four weeks of a traumatic event (Boyle, 2017). In this session the woman is encouraged to talk about her experience so that she is able to understand and emotionally process the event and prevent development of PTSD. 'Debriefing' was originally used in the military as a structured reflection to enhance experiential learning (Pearson & Smith, 1994). The idea of debriefing being psychological debriefing was formed in 1980's and evolved with emergency workforce who were exposed to critical incident or disasters (Phillips, 2003; Meleis, 2010). 'Debriefing' as a term has been used by number of authors within the midwifery literature over the last two decades (Baxter et al., 2014; Fryer & Waever, 2014; Meades et al., 2011), although there is some discussion about the inconsistent use of this term. The Cochrane review suggests that the term 'debriefing' includes a variety of post-birth discussions (from listening to structured psychological intervention) that provide women an opportunity to talk about their birth

experience (Bastos, Furuta, Small, McKenzie-McHarg & Bick, 2015). Other authors have also highlighted ‘debriefing’ being a broad term that is used very loosely (Alexander, 1998; Ayers, et al., 2006a). However, there appears to be a consensus that ‘debriefing’ is a structured psychologcal intervention (Ayers, et al., 2006a; Baxter, et al., 2014; Rowan, Bick, & Bastos, 2007).

Alexander (1998) suggested that the term “defusing” should be used to describe the act of giving “postnatal women time and space to talk about their labour and birth” experiences (p. 122). Apparently `defusing' offers the opportunity for women to discuss in detail their labour and birth experience with a midwife. Although the findings from this study and others tend to suggest that `defusing' is valuable for women, further research needs to fully describe the advantages and disadvantages of its use in post-birth debriefing (Gibbins & Thomson, 2001). Within the literature defusing appears to be similar to conversation however, it can also be perceived as reconciling of differences in presence of tension (Friedman, 2016).

Madden (2002) prefers the term ‘listening’ for post-birth discussions/conversation, while for Boyle (2017) ‘listening’ appears to be similar to ‘defusing’ and ‘discussion’ but the emphasis is on listening. The study undertaken by Cummings and Whittakar (2016) found that Health Visitors use a range of formal assessment tools with open coversations to help women disclose thoughts and feelings during weekly listening visits. The skills required by practitioners that offer listening visits for perinatal mental health are that of reflective listening and problem solving (Segre, Stasik, O’Hara, & Arndt, 2010).

Anderson and Podkolinski, (2000) suggested that midwives are in a unique position postpartum to ‘talk with and observe women on a daily basis’ (p.xi). This potentially enables them to discuss with women their birth experience. Various other authors have used the term postpartum talk but no definition of ‘talk’ has been given nor why the word ‘talk’ was used (Fenwick, Butt, Dhaliwal, Hauck, & Schmied; 2009; Olin & Faxelid, 2003; Barimani & Vikström, 2015).

Conversations are considered more informal than debriefing and counselling. There is gap in the knowledge regarding the usefulness of conversations in identifying ‘unhappiness’ or distress and referring appropriately or its usefulness in facilitating recovery and reducing psychological morbidity. According to Balin (2005), conversation is perceived as one being open and listening to each other in order to understand the experience (Chapter 1, p. 9 under ‘the meaning of conversations’ provides additional information regarding ‘conversations’).

Within healthcare simulation ‘debriefing’ is defined as an interactive, bi-directional, and reflective discussion or conversation (Eppich & Cheng, 2015; Meakim et al., 2013). According to Sawyer, Eppich, Brett-Fleegler, Grant & Cheng (2016) identifying debriefing as a facilitated reflective conversation is an important distinction between ‘debriefing’ and ‘feedback’. Apart from healthcare simulation the use of reflective conversation or reflective dialogue is evident in psychotherapy and in education. Crow and Smith (2005), in context of co-teaching in education, refer to reflective conversation as being collaborative, leading to new meaning and enabling teachers to explore the tacitness of their understanding of what they do. Smyth and Cherry (2005) state that for reflective conversations to be effective there has to be high level of trust among those involved, a need to be open ‘to the whole range of experiences, be willing to explore whatever comes up; to lean into experience together and to learn together” (p. 274). Zeldin (2000) observed that “conversations doesn’t just reshuffle the cards but make new cards” (p. 14), (Chapter 1, p. 11 under ‘the meaning of conversations’ provides additional information regarding ‘conversations’). It is therefore reasonable to assume that post-birth reflective conversations enables shared meaning and learning from the experience. Hence the study seeked to illuminate how post-birth reflective conversations are experienced by those involved.

How does post-birth debriefing occur?

Gamble et al. (2002) reviewed the literature on debriefing or non-directive counseling to prevent postpartum emotional distress. The findings suggested insufficient evidence to conclude the effectiveness of debriefing following childbirth due to limitations in studies reviewed. The limitations included absence of an exact description of the intervention in any of the studies reviewed and that the outcome measures did not match the intention of a debriefing intervention (Gamble et al., 2002). Though debriefing was originally designed to reduce trauma symptoms and prevent PTSD (Mitchell 1983), three studies reviewed by Gamble et al. (2002) measured depression rather than trauma (Hagan et al. 1999; Lavender & Walkinshaw 1998; Small et al. 2000). There is a potential for depression and PTSD to co-exist. Not being able to reduce symptoms of depression does not mean there was no affect on trauma symptoms (Gamble et al., 2002). The finding of single session debriefing being unable to reduce psychological morbidity and might cause further problems has been identified by Wessely, Rose and Bisson (1999) and Friedman (2000), though there were issues in the way intervention had been defined and the studies had been designed. However, the participants found the intervention helpful in

reducing emotional distress. The Cochrane review (Rose, Bisson, Churchill, & Wessely, 2002) analysed six RCTs that included two in the maternity context (Baxter et al., 2014). They concluded that no evidence was found that debriefing carried out on an individual basis and delivered in a single session was of value in preventing post-traumatic stress disorder after a traumatic incident (Rose et al., 2002).

Baxter et al. (2014) undertook a critical review of the literature on what is current practice in offering debriefing services to postpartum women and the perception of women accessing these services. They found the randomised controlled trials (RCT) were not comparable creating challenges when determining outcomes from these studies (Baxter et al., 2014). The service enables the woman to meet with the midwife to discuss the birth experience (Baxter et al., 2014). Within the literature it is unclear whether the midwife involved in the care of the mother during labour and birth provided debriefing. Majority of the research reviewed was silent on the subject of post-birth debriefing services for women who did not consider their birth to be traumatic.

Within the literature, critical incident stress debriefing (CISD) has also been used for women whose birth was perceived as traumatic by the woman, midwives and other healthcare professionals (Parkinson, 1997). CISD is based on the psychoanalytical assumption that talking helps and usually takes place within a group setting (Baxter et al., 2014; Parkinson, 1997). Niven (1992, 2013) suggests that not all post-birth debriefing is structured. Apparently, a range of approaches to post-birth debriefing has been recognized.

The use of structured format for post-birth debriefing was found in about half of the RCTs reviewed by Baxter et al. (2014). Structured format includes either Critical Incident Stress Debriefing (CISD) (Priest, Henderson, Evans, & Hagan, 2003; Kershaw, Jolly, Bhabra, & Ford, 2005; Selkirk et al., 2006), or counseling model created by Gamble et al. (2005). However, Baxter et al. (2014) found that the use of CISD format was not clear by some authors of the RCT's (that is stating clearly that the CISD model was being used) though they used the same heading to guide the session used in CISD format.

In an original counseling model created by the researchers, the midwives implemented the intervention and did not require psychotherapeutic skills (Gamble et al., 2005). The aim of the intervention in the counseling model was to reduce psychological morbidity. Therefore, the

voices of women not at risk of psychological morbidity appears to be silent in this RCT, that is, the ‘everydayness’ of the conversation midwives and women have following the birth of their baby.

The ability for the woman to ‘talk’ about her labour and birth experience with a supportive listener is supported and considered useful by some authors (Affonso 1977; Berg & Dahlberg 1998; Creasy, 1997; Eden, 1989; Hammett, 1997; Reynolds, 1997). Some authors of RCT and other studies have suggested an approach for post-birth debriefing that is not structured, (Dahlberg, Haugan, & Aune, 2016; Gamble et al., 2002; Lavender & Walkinshaw. 1998; Meades et al., 2011; Ryding et al., 2004; Small et al., 2006). The terms that have been used by these authors are postpartum ‘talk’, a ‘discussion’ or a ‘listening service’ to describe the services provided to post partum women in Norway and the UK. The literature appears to highlight the importance of discussions surrounding labour and birth. The importnace of such discussions surrounding pregnancy and post partum concerns appears not to be as visible.

Who is offered post-birth debriefing?

The offer of post-birth debriefing to women appears to vary. According to Baxter et al. (2014) while some offer debriefing to all women following birth (Bailey & Price, 2008; Inglis, 2002; Selkirk et al., 2006), other studies offer was restricted to certain groups of women (e.g. those who had an operative birth) (Kershaw et al., 2005; Small et al., 2006), or those who were considered to be at high risk of psychological morbidity or exhibited trauma symptoms (Gamble et al., 2005; Meades et al., 2011). There is a sense that the professional caregivers are making decisions about who should be offered post-birth debriefing rather than the woman.

Post-traumatic stress disorder (PTSD) can also occur in women who have had spontaneous vaginal birth and it is the subjective experiences of the events that are most important (Gamble et al., 2005; Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013; Gerkin & O’Hara, 2014; Yildiz, Ayers & Phillips, 2017). PTSD is a trauma and stressor related disorder. PTSD develops when a person experiences (from their perspective) a highly traumatic event (Beck, 2004a; Furuta, Sandall & Bick, 2012). It is caused by exposure to actual or threatened death, serious injury or sexual violation to self or others and the four main strands of symptoms associated with PTSD are in the Diagnostic and Statistical Manual of Mental Disorder – Fifth Edition (DSM-V) (American Psychiatric Association, 2013). What is offered to women whose

birth is not traumatic or has not had an operative or instrumental birth is at times confusing due to lack of clarity around the use of term ‘debriefing’.

Very few authors appear to have identified the need for post-birth debriefing for significant others (Dennett, 2003; Olin & Faxelid, 2003). NICE (2015) guidelines focuses on the woman having the opportunity to talk about her birth experience and any questions she may have about care in labour to be answered. This recommendation remains unchanged since the guideline was published in 2006. In NZ the focus is on respecting and supporting woman and her whānau (NZCOM, 2015). Further reflection is required to ensure voices of fathers and significant others are or need to be included/heard during post-birth debriefing.

Women’s need to have conversations about their birth experiences in order to develop an understanding of those events is not new. In a study undertaken thirty four years ago 86% of women who had a vaginal birth could not reconstruct their childbirth experience because they could not remember or lacked a detailed understanding of events (Affonso, 1977). Women reported that they often felt frustrated, anxious and angry about their lack of recall of important birth details. The author at the time argued that women need to reconstruct the birth experience through a series of complex psychological tasks and may require assistance by health professionals to do so. The need for discussion about the birth has also been confirmed in studies with women who have had complicated births (Berg and Dahlberg, 2001; Cowan, Smythe, & Hunter, 2011). The women in these studies wanted to be acknowledged, have opportunity to talk and be affirmed. They did not want a factual chronology of events but deeper understanding and critique of events surrounding the birth, including insights into the maternity services culture (Creasy, 1997). Post-birth reflective conversations would appear to hold much potential in such situations.

Gibbins and Thomson (2001) suggest that it is important to investigate how women feel about their experiences in the postpartum period. ‘Investigate’ can be perceived as a structured approach to establish the truth. However, post-birth reflective conversation should help in providing information needed and enable shared undertstanding.

When should post-birth debriefing occur?

The timing of the post-birth debriefing session being variable is supported by the review undertaken by Baxter et al. (2014). Within the literature there is a suggestion that an opportunity

for post-birth debriefing with a health professional should be provided before women leave the hospital to up to first year following birth of their baby (Bailey & Price, 2008; Dennett, 2003); Inglis, 2002; Priest et al., 2003). However, no explanation/rationale is provided for the timings they have suggested. As cited in Baxter et al. (2014) Cochrane review of debriefing interventions in general population groups considers a month to be the minimum time an intervention should take place following a traumatic event (Rose et al., 2002). NICE recommends that those individuals who have experienced a recent traumatic event should not be offered debriefing that focuses on traumatic incident to reduce risk of post-traumatic stress, anxiety or depressive symptoms (NICE, 2018). In view of this women should access the service when they feel ready to have post-birth debriefing session (Bailey & Price, 2008; Inglis, 2002). There is a sense of healthcare professionals making the decision of the suitable time for post-birth debriefing. The voices of women and their thoughts on the appropriate timing for post-birth conversation appear not to have been addressed.

Women in Norwegian study felt it was easier to talk about labour and birth with little distance following birth (Dahlberg et al., 2016). The women also mentioned that there was opportunity for more than one session if the midwife had provided continuity of care or was known to them. Within the literature a single session of post-birth debriefing has been offered to women (Baxter et al., 2014). As highlighted by Gamble and Creedy (2004) women who experienced birth as traumatic, single session may not be sufficient and could be harmful. Baxter et al. (2014) found in their review the importance of post-birth conversations to validate the woman's experience. According to Dahlberg et al. (2016) women require validation even when they felt they had coped with the birth well. They appreciated confirmation and praise from the midwife. The opportunities offered by the New Zealand partnership model of care in relation to the ongoing relationship from the booking visit through to the end of post-natal care, thus offering opportunities for reflective conversations, appears to be silent in the literature.

Who should provide post-birth debriefing?

The review of literature highlighted the midwife carrying out the post-birth debriefing. Continuity of care enables a personal relationship with the midwife (Dahlberg et al., 2016). Knowing the midwife who had been supporting them helped to bring up any issue with confidence even when they had challenges during their childbirth experience. The communication appeared to be more open, women could discuss emotional aspects of labour and birth experience and they could

accept guidance and advice easily (Dahlberg et al., 2016). However, if the woman viewed her birth as traumatic, it was important for the midwife having a conversation with her to remain calm and be interested in the woman's birth experience (Dahlberg et al., 2016). Baxter et al. (2014) review found that participants in the grounded theory study (Bailey & Price, 2008) highlighted the qualities in the midwife that enhances post-birth debriefing, such as, understanding, caring and empathy. Should the midwife who was present at labour and birth undertake post-birth debriefing? The literature suggests this being important, as the midwife would have shared the birth experience with the woman and know more about it as well as for conversations/dialogue to occur/happen (Dahlberg et al., 2016; Dennett, 2003; Olin & Faxelid, 2003).

Both (women and midwives) felt they had no personal relationship during a postnatal home visit, when they had not known each other during pregnancy (Dahlberg et al., 2016). The visit therefore was considered by women to be more medical and practical (the I-It relationship suggested by Buber, 2010, discussed in Chapter 3). Such relationships resulted in lack of conversation and dialogue. The woman felt only absolutely necessary issues/areas were discussed, though the midwife attempted to encourage dialogue by asking them what they wanted to talk about (Dahlberg et al., 2016). Lack of prior relationship prevented women to discuss labour and birth experiences with the midwife they did not know. The study suggests that conversations about labour and birth occur when the midwife and the woman have known each other (Dahlberg et al., 2016). Dennett (2003) highlights that for some women it was appropriate to talk with a midwife who was known to them but was not present at the birth. Perhaps the woman should be offered an option to decide who the appropriate person/midwife would be for post-birth debriefing session?

Further training on counseling techniques and how to undertake critical incident stress debriefing (CISD) had been provided to some midwives (Kershaw et al., 2005; Meades et al., 2011). This has been for women who experienced their birth as traumatic. This provoked further reflection and thinking during the literature review regarding the role of the midwife. Should a midwife provide such techniques/CISD or identify women who require these interventions and refer them to appropriate practitioners/services? What affect does availability of such resources have on women's needs and midwives' roles?

Four of the women in the study undertaken by Gibbins et al. (2001) were given the opportunity, after birth, to talk to the midwife who was with them for labour and birth and two others talked to a midwife involved in their postnatal care about what happened during labour. The women felt this was beneficial because it helped them to clarify some issues and helped them to remember the 'hazy' parts of the labour. While the concept of conversation was not used in this study participants reported that the talk was helpful to generally discuss their experiences. Two women who talked to the midwife involved in their postnatal care felt it would have been valuable for them to have been able to discuss their labour with the midwife who delivered their babies, because they felt they wanted to discuss their experiences and needed reassurance that they had done well and coped with their labour. Only two of the women in this study had been looked after by a midwife they had met antenatally and had midwives who were not providing continuity of care. Thus two women could not discuss their labour experience with the midwife involved in their care as they were not at work the days after their birth of their babies.. The women in this study who were given the opportunity to discuss the events of labour with a midwife all felt this was beneficial to them because it helped them to clarify certain aspects of labour. Diffusing has been considered to be valuable for women, however, exploring 'diffusing' fully will enable understanding of the advantages and disadvantages of this intervention (Gibbins et al., 2001). Diffusing appears to be similar to conversation. it appears that defusing can also be perceived as reconciling of differences, there is presence of tension while conversation is a perceived as one of openness and listening to each other in order to understand the experience (Balin, 2005).

Women may also choose personal networks (Thomson & Downe, 2016) as well as other professionals, such as GP, midwifery counsellor, an obstetrician or psychotherapist to debrief (Baxter et al., 2014).

Where should post-birth debriefing be provided?

Two surveys undertaken in the UK suggest that majority of the hospitals offered the debriefing services to women (Ayers et al., 2006a; Steele & Beadle, 2003). As provision of these services included obstetricians and psychotherapist one assumes that that these service were provided at the hospital. Debriefing is likely to happen in the hospital/birthing unit if it happens immdiately following the birth or prior to discharge home, unless the woman birthed at home.

Women who had debriefing at home felt that midwives had time for them during postnatal home visits and had personal interest in them and their family (Dahlberg et al., 2016). The conversation/dialogue appeared not to be rushed, making them feel less stressed and occurred at the time they were not distracted by other issues such as being discharged from the postnatal ward. A home visit to complete the relationship was viewed positively by women and were perceived to go beyond “medical follow up” (Dahlberg et al., 2016, p. 59).

Womens’ perspectives

Support during labour and birth

Historically women have been cared for and supported by other women throughout labour and birth experience, that is they have received ‘continuous support’ (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017). WHO (2018a) recommends continuous support for women during labour and birth, though the practice appears not to be implemented in all maternity settings (Lunda, Minnie, & Benadé, 2018). The literature suggests ‘support’ may improve outcomes for women and infants, such as increase in spontaneous vaginal birth, shorter duration of labour, decreased caesaren sections and instrumental births, less use of analgesia, decrease in number of baby’s born with low Apgar scores and positive feelings about childbirth experiences (Bohren et al., 2017; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Sauls, 2002). In a meta-synthesis undertaken by Lunda et al. (2018) support from husbands, female relatives and friends enabled women to retain some control over the birth process and enhanced their security in an unfamiliar birthing environment. Lundgren (2004) and Kennedy (2002) suggested that professional support can also provide strength for the woman to birth without losing control. Lack of support during birth has been associated with symptoms of PTSD following birth (Creedy, Shocket, & Horsfall, 2000; Czarnocka & Slade, 2000; Fenech & Thomson, 2014). Support is therefore important in reducing anxiety and trauma reactions but how this influences physical and psychological outcomes is not known. Ford and Ayers (2009) suggest that support may buffer the emotional consequences of obstetric events by reducing fear and anxiety and increasing the woman’s sense of control. There is evidence that negative responses increases labour pains and affects the progression of labour thus increasing intervention (Hodnett et al., 2011).

Woman's perception of being in control has been associated with satisfaction while perception of low level of control has been associated with PTSD symptoms (Czarnocka & Slade, 2000; Goodman, Mackay, & Tavakoli, 2004). The feelings of helplessness, hopelessness and powerlessness have been associated with the perception of birth as being traumatic (Soet et al., 2003). Maternity and obstetric care is unpredictable and women may perceive lack of control during this experience. Various authors have hypothesized that if women are well supported, treated with respect (care that is not inhumane and degrading), and receive supportive behaviour from health professionals then they may continue to feel in control even when unexpected events unfold (Elmir et al., 2010; Green & Baston, 2003; Lundgren, 2005; Melender, 2006; Nystedt, Hogberg, & Lundman, 2006). Maximising such behaviour may help to reduce postnatal distress and trauma related symptoms (Elmir et al., 2010).

Little is known of whether post-birth reflective conversations enable women to feel less anxious, feel better physically and psychologically and continue to make uninterrupted transition to motherhood when they have been faced with unexpected obstetric interventions, feeling of lack of control as well helplessness and powerlessness.

Postpartum care and emotional wellbeing

Becoming parents is the most challenging transition experienced in life (Wiklund, Wiklund, Pettersson & Boström, 2018). WHO (2013) suggests that postnatal care should be of high quality and should focus on mother/whānau and newborn. According to Smythe, Payne, Wilson & Wynyard (2013) the midwives and women are aware of the importance of postnatal care. However, the busy work load/environment may affect the quality of care. For Dennis and Dowswell (2013) emotional wellbeing is influential in maternal health following birth.

As has been stated previously women are vulnerable to psychological disorders such as depression, anxiety, attachment disorders, PTSD and onset or relapse of a mental illness during post-partum period (Biaggi et al., 2016; Brockington, 2004; Fenech & Thomson, 2014; Smith, Shao, Howell, Lin, & Yonkers, 2011; Thomson & Downe, 2016). Focusing just on PND, mood and anxiety disorders, PTSD may inhibit our understanding of postnatal unhappiness which is likely to affect greater number of women than 10-15% quoted for PND in high income countries (Czarnocka & Slade, 2000; Deverick & Guiney, 2016; Gibb & Hundley, 2007; Wenzel, Haugen, Jackson, & Brendle, 2005; White, Matthey, Boyd, & Barnett, 2006). The qualitative study

undertaken in Europe described ‘morbid unhappiness’ and that some involved in the study thought of it as an illness that required intervention from health professionals (Oates et al., 2004). Current research of women’s views of their in-patient postnatal care has reiterated the acute recall women have of their birth experience and the importance of communication/conversation to their overall experience (Conesa Ferrer, Canterase Jordana, Ballesterous Meseguer, Carillo Garcia, & Martinez Roche, 2016; Fenech & Thomson, 2014). How women were spoken to during their contacts with health-care staff was crucial to their perspective of care as being a positive or negative experience (World Health Organization [WHO], 2018). Some of women who perceived care as negative later reported PTSD symptoms and relationship issues with their partners and infants (Fenech & Thomson, 2014). It also affected their confidence in their mothering abilities, with respect to support for breast feeding (Dykes, 2005). Hence women do not have to develop postnatal distress or have mental illness to consider their birth as being traumatic and have less positive effects relating to their childbirth experience that may affect them and their baby in the long term.

Number of authors have raised the importance of midwives emotional care of women and that much more needs to be uncovered about ‘emotion work’ in midwifery to address the needs of childbearing women (Barker, 2011; Carter & Gonzalez Guittar, 2014; Hunter, 2001, 2010). Beck et al. (2011) mentions the importance of documenting women’s postpartum experiences and informing relevant stakeholders. This may enable those involved in provision of maternity care to understand the extent of the burden of physical and mental health morbidity and develop care that facilitates the innate capabilities of women and babies and avoid invasive interventions when possible (Carter, Grigoriadis, & Ross, 2010). It is likely that post-birth reflective conversations may help to address the needs of childbearing women and enable practitioners to understand the effect childbirth has on women’s physical and mental health.

The adverse consequences of postnatal distress are not just felt by the mother. They substantially impact her partner, the whānau, mother–baby interaction and on the longer-term emotional and cognitive development of the baby, especially when depression occurs in the first year of life (Chisholm, Sanderson, Ayuso-Mateos, & Saxena, 2004; Hewitt & Gilbody, 2009; Slomian, Honvo, Emonts, Reginster, & Bruyère, 2019; Underwood et al., 2017). High prevalence of psychological morbidity following childbirth suggests more needs to be done to identify factors that influence women’s emotional reactions to birth. Postnatal distress can be

debilitating and identification of risk factors and strategies to minimize psychological distress during birth as well as how positive emotions can be enhanced require further attention. Post-birth (postnatal) debriefing services have been available in some countries, for example, UK, since the 1990s. The main emphasis of the service has been to reduce psychological morbidity, especially preventing post-traumatic stress disorder and PND after a traumatic event (Baxter et al., 2014; Gamble et al., 2002). Rowan et al. (2007) suggest that these services may be supported by policy but lack robust evidence. Hence, post-birth reflective conversations may be a way of identifying women's emotional reaction to birth.

Research undertaken since 1990 to determine women's different aspects of childbirth expectations and experiences has shown that there is a direct correlation between positive expectations and positive outcomes (Green, Coupland, & Kitzinger, 1990; Waldenström, Borg, Olsson, Sköld, & Wall, 1996). Fixed-scale questionnaires were used and seemed to elicit fewer negative responses than if open-ended interviews had been used, highlighting a difference between value of quantitative and qualitative studies (Waldenström et al., 1996). Women's recall of their birth experience immediately after the event appeared to be more positive than months or years later, which Waldenström et al described as the 'halo' effect. Their finding that "negative and positive feelings can coexist, thus confirming the multidimensional character of the birth experience" (p. 144) is of relevance because negative feelings can prevent positive feelings becoming visible during reflective conversations. This has implications for NZ midwives who are professionally and contractually bound to provide postnatal care up to six weeks (MOH, 2007; NZCOM, 2015). According to Ghaye (2011) focusing on what went well and articulating the reason for positive experience enabled mother and midwife to talk about their experience which strengthened, broadened and built on provision of intrapartum care. Experiences do not have to be negative for change to occur and conversations may be a way to ensure that women continue to perceive their experience of labour and birth as positive, resulting in positive outcomes for themselves and their babies.

Midwives' perspectives

Midwives and psychological distress

For the majority of their time midwives are involved with births that have joyful and happy outcomes. Afiirmation from such births enables midwives to rekindle their belief in the physiological process of birth as well as inspiring and sustaining them in practice.

A New Zeland study, on midwives emotional wellbeing found that self-employed midwives, providing continuity of care in a caseload model, either full-time or combined with some employed work, had much better emotional health (lower levels of burnout, anxiety, stress and depression) than midwives working in an exclusively employed capacity (Dixon et al., 2017). The findings demonstrate that working in a caseload model, with supportive midwifery partners, work flexibility and autonomy, is potentially protective. However, Young (2011) showed that the burden of professional obligation in provision of midwifery care as a self-employed midwife is invisible and there is high chance of burnout due to being on call and the heavy responsibilities of practice, at times carried when the midwife is exhausted.

There are occassions when midwives encounter an adverse event/critical incident, hostility from colleagues and/or from whom they provide care, workplace bullying and poor organisational support/culture that may result in significant emotional stress (Pezaro, 2016). Various authors have suggested that being 'with woman' and providing holistic care requires midwives to be physically and emotionally present. This can put them at risk of suffering significant distress and developing traumatic stress responses (Carolan & Hodnett, 2007; Leinweber & Rowe, 2010; Wilberforce, Wilberforce, Aubrey-Bassler, 2010). Traumatic stress responses include compassionate fatigue from everyday dealings with trauma, illness and death (Austin, Goble, Leler & Byrne, 2009; Meadors, Lamson, Swanson, White, & Sira, 2009); Secondary Traumatic Stress (STS) may also result, wherein the midwife empathises with the woman's trauma and vicarious traumatisation (Figley, 1995; Rice & Warland, 2013; Sabin-Farell & Turpin, 2003). Midwives may be at greater risk of traumatic stress responses than other caring professionals because they have a highly empathetic realtionship described as being a 'friend/professional friend' (Pairman, 1998). Research by Austin, Smythe and Jull (2014) highlighted the lack of structured support for midwives. Leinweber and Rowe (2010) highlight the harmful effects of STS on the midwives own mental health and their ability to provide care in their relationship with

women. It is likely that midwives may not be able to be fully present for women's need for post-birth reflective conversations.

Midwives' interactions with women

The quality of the provider interaction (QPI) has an impact on the development of post-birth PTSD (Sorenson & Tschetter, 2010). The features of QPI that contributed to the development of Post-birth PTSD include interpersonal difficulties, midwifery care factors and lack of support. Affirmation by the midwife (Sorenson & Tschetter, 2010), respecting women's views (Nyberg, Lindberg, & Ohrling, 2010) and inclusive rather than a dismissive (Beck, 2004a) attitude correlated positively with women's post-birth PTSD.

Lack of communication leading to poor understanding (Ayers, 2007) and inability to make decisions or ask questions had significant impact on women while being encouraged to ask questions lessened post-birth PTSD symptoms (Nyberg et al., 2010). It is the midwife's 'way of being' with the woman rather then her clinical care/skills that can impact on women developing post-birth PTSD.

Beck (2004a), Harris and Ayers (2012) reported that women felt isolated, alone and abandoned when there was lack of support and Cigoli et al. (2006) have shown that this also contributes towards development of post-birth PTSD.

Midwives' feelings on debriefing

According to Baxter et al. (2014) there are only two studies that relate to midwives views on post-birth debriefing. Qualitative research by Gamble et al. (2004) identified the following themes: 'Opportunities to talk about the birth', 'Developing an understanding of events' and 'Minimise feelings of guilt'. The midwives felt that postnatal debriefing should be unstructured and should be led by women. They also believed women needed to come to terms with a past negative birth experience to prevent an adverse effect on a subsequent pregnancy. According to these midwives, women need clarity about what happened during the childbirth experience and part of the midwife's role is to mitigate any unease/guilt women may have about their previous experience.

Kershaw et al. (2005) reported that just fewer than 50% (7 out 16) of the midwives felt postnatal debriefing benefited women following traumatic childbirth. Yet just under 50% of midwives, did

not share their views on debriefing. 75% of midwives felt comfortable offering debriefing. However, 20% of midwives were not comfortable, 6% offered the postnatal debriefing on the first postnatal visit to the woman and 12% of midwives believed they required more training (Baxter et al., 2014). The factors that helped community midwives to provide debriefing were continuity of care, the training for the postnatal debriefing intervention they received as part of RCT and quietness in the woman's home. Walsh (2007) has suggested that care/interactions with women need to be less vigilant and more indicative of trust and generosity, focusing on engagement and responding to women. Lack of time, women not wanting to debrief and inappropriate referrals prevented the midwives from undertaking postnatal debriefing. The majority of the midwives in these two studies believed postnatal debriefing was beneficial for women, including those women that may have perceived their birth as traumatic (Baxter et al., 2014).

It is important to note that the literature focuses on midwives' feelings on debriefing rather than the experience of debriefing or having post-birth reflective conversations.

Summary

The review of the literature suggests that in some countries debriefing and CSID has been offered to reduce psychological morbidity. The offer to debrief following birth appeared to vary with some countries offering a service when birth is considered to have been traumatic. The Cochrane system review found no evidence of debriefing reducing psychological morbidity and single session debriefing interventions appear to be ineffective. NICE (2015) suggest that women should be offered an opportunity to talk about labour and birth experience with a midwife. Though there has been some reporting in the literature about postnatal talk/listening services none have formally evaluated the benefits or experience of these services. This upheld a gap in the literature and an opportunity to research what happens in everyday conversations that occur between midwives and women.

It appears that the information about post-birth reflective conversations within international and New Zealand literature is either minimal or not evident. Thus it is appropriate for the study to illuminate/uncover the lived experience of post-birth reflective conversation on the case loading midwives and the women. This will contribute to deeper understanding of this experience it has on the conversation participants. The New Zealand context is significant in this study as it brings

the assumption that the continuity of care relationship facilitates reflective conversation. In the next chapter I detail the philosophical understandings that underpin this study.

Chapter Three: Philosophical Understandings

Introduction

This chapter explores the philosophical pre-supposition and methodology underpinning the study, and the decision to use hermeneutic phenomenology. The philosophers who have guided my work are Heidegger (1927/1962), Gadamer (2004), Buber (2010), and Levinas (1991). Their key notions are discussed in this chapter. The examination of the theoretical philosophical basis will help convey the appropriateness of the research question and the method being used in this research.

This study is about the phenomenon of post-birth reflective conversations from the viewpoint of women and midwives experiencing them. When exploring 'experience', researchers have traditionally turned to the phenomenological perspective to develop insights into those experiences. With its roots in philosophy, psychology, and education, the key terms used in the description of phenomenology are "essence" (Dahlberg, 2006, p. 11), "experience" (Giorgi & Giorgi, 2003, p. 27), "understanding" and "meaning" (Koch, 1995, p. 828).

Transcendental Phenomenology – Husserl

Phenomenology is both a philosophical discipline and a research method (Geanellos, 1998; LeVasseur, 2003; Lopez & Willis, 2004). The word 'phenomenology' is derived from the Greek word "phenomenon" (King, 2001, p. 109) meaning, something appears, manifests itself or shows itself (Ray, 1994). According to Heidegger (1927/1962), phenomenology means "to bring to the light of day", "to put in the light" (p. 51). In research, phenomenology is used to seek the core of experience, the essence of the phenomenon (although Heidegger would argue that we never quite grasp the pure essence). Jones (2001) suggested that phenomenology is a way of uncovering experience that enables a researcher to surpass factual accounts in order to illuminate life experience. Defining phenomenology is not easy (Davidsen, 2013). For Morse and Field (1996) it is the study of experience; while for Cohen (1987) and Parse (1981) it is the study of phenomena as they unfold or description of the appearance of things. The approach attempts to uncover the rapid change and unpredictably of human life and experience. Roberts and Taylor (1997) defined phenomenology as the study of a thing (or entity) while Polit and Hungler (1999) define phenomenology as a qualitative research tradition that focuses on the lived experiences of human beings.

Edmund Husserl, a German mathematician of Jewish origin, who was born in Austria, is recognised as a founder of the phenomenological movement (Christensen, Welch, & Barr, 2017; Speigelberg, 1994; Thorne & Collocott, 1974; Walters, 1994). Husserl sought to separate philosophy from science by suggesting openness, a non-judgemental stance to things that may come to 'light'/'be visible' rather than having to explain why and how it may have come to 'light', become 'light'. He stated: "pure phenomenology analyzes and describes in their essential generality...the experience of presentation, judgment and knowledge" (Husserl, 1970, p. 249). Husserl's position is of the research being methodical, where the researcher is a detached observer (Walsh, 1996). The earlier phase of phenomenology defined through the work of Husserl is sometimes reported as "transcendental" (Maharana, 2009, p. 3). It means everything in the world, including the world itself acquired its meaning from consciousness and its intentionality (Maharana, 2009).

Husserl's main focus was, therefore, the study of phenomena, that we become aware of/respond to or the way we experience it and the meaning it gives to our experience. According to Husserl, personal biases stood in the way of achieving pure consciousness and needed to be overcome (Wojnar & Swanson, 2007). Husserl (1982) suggested that "we make a new beginning, each for himself and in himself" indicating the extraordinary personal context of epochē (p. 6). In a phenomenological sense, epochē indicates suspension of whatever "blocks the way to the phenomenon" (Taminiaux, 2004, p. 9). This means suspending all considerations of their objective reality or subjective association (Nellickappilly, 2015). The researcher sets aside presuppositions through the process of "reduction" and "bracketing" (Chan, Fung, & Chien, 2013, p. 1). As a researcher, once one has made a commitment to the epochē, one cannot use previous understandings regarding the phenomenon. Putting aside natural understanding, that is dissociating the mind from assumptions held about one's own experiences, enables new understanding of the phenomenon; the essence of experience (Butler, 2016). Husserl (1960) uses the term "apodictically certain" (pp. 14–16) which means the phenomenologist is involved in a search for certainty. According to Husserl (1982), during the reduction process the consciousness (experience) is preserved and it is only through this pure consciousness that world can be presented as meaningful.

Husserl placed intentionality at the center of his analysis (Larkin, Eatough, & Osborn, 2011). Spinelli (2000) stated that "intentionality" originates from Latin word "intendere" meaning "to

stretch forth" (p. 11). This key concept is not about what a person is planning to do. For Larkin et al. (2011) it is about our relationship with the world and, as conscious beings, our experience is of something or someone (quality of "about-ness") (p. 324). Being conscious of something means that this something is "there for me" or "appears to me" (Fasching, 2012, p. 125) either as being actually present, as past, or as possible (Husserl, 2014). Hence human consciousness also has the quality of "mine-ness" (Larkin et al., 2011, p. 324). Pure human consciousness is intentional and object-directed (Mabaquiao, 2005).

Several frames of reference are used to define the phenomenon under investigation plus "the transcendental subjectivity (neutrality and openness to the reality of others), eidetic essences (universal truths) and the live-world plane of interaction (researcher and participants must interact)" (Wojnar & Swanson, 2007, p. 174). The lived experience described by participants is used to provide a universal description of the phenomenon (Tymieniecka, 2003). The participants' testimony that the researcher's description of the phenomenon represents their personal experience validates the quality of a descriptive phenomenological investigation.

The next section describes Martin Heidegger's hermeneutic phenomenology, the key notions/concepts fundamental to my work, and why Heidegger's interpretive approach was chosen for this research.

Hermeneutic Phenomenology – Martin Heidegger

Martin Heidegger, a student and later an assistant to Husserl, published his own ideas of phenomenology in 1927, which were that "we and our activities are always in the world" (Woodruff Smith, 2003, p. 387). Heidegger expanded Husserl's theory (Valle & King, 1978) and articulated that our understanding serves as an ontological base for "being-in-the-world" (Heidegger, 1988, p. 298). Heidegger rejected the theory of knowledge known as epistemology and adopted the science of being (Cerbone, 2009; Dreyfus & Wrathall, 2007; Healy, 2011).

The question "what is the meaning of being", with various changes in meaning, remained the focus of Heidegger's thought until the end of his life (Frede, 1993, p. 55). Heidegger viewed phenomenology as the way into ontology (Heidegger, 1927/1962): "Phenomenology is our way of access to what is to be the theme of ontology, and it is our way of giving it demonstrative precision. Only as phenomenology is ontology possible" (p. 60).

Heidegger believed that humans are hermeneutic beings capable of finding significance and meaning in their own lives (Draucker, 1999). For Heidegger, the context was a central concern rather than of peripheral importance. In Heideggerian phenomenology “the understanding of individuals cannot occur in isolation of their culture, social context, or historical period in which they live” (Kumar, 2012, p. 794).

Heidegger advocated his own phenomenology as one that interpretation of experience and illuminating the essence of a person. For Heidegger the subject and object are inseparable, rather than the human being regarded as a spectator of objects.

The assumptions of Dasein (the human way of being in the world) and situatedness form the basis for pre-understanding or, as Heidegger (1962) called it, a fore-structure of understanding. Kumar (2012) explained:

> The fore-structure of understanding consists of: fore-having (all individuals come to a situation with practical familiarity or background practices from their own world that makes interpretation possible); fore-sight (the sociocultural background gives a point of view from which to make an interpretation); fore-conception (sociocultural background provides a basis for anticipation of what might be found in an investigation). (p. 795).

In relation to understanding human experience, hermeneutic phenomenology goes beyond knowledge of core concepts and essences. Heidegger (1962) introduced the concept of *Dasein* to emphasise that individuals cannot abstract themselves from the various contexts that influence their choices and give meaning to lived experience. Therefore, Heidegger’s phenomenology attempts to address the situatedness of an individual’s Dasein in relation to the broader social, political, and cultural contexts (Campbell, 2001). When we consider what is it like to experience post-birth reflective conversations, we cannot ignore the participants’ (women and midwives) lives outside of their childbirth continuum or as health professionals. Their very experience of wellbeing, health and understanding is in the context of family traditions, community values, and the broader socio-political context.

Heidegger’s phenomenology is sometimes described as “existential phenomenology”, or following Gadamer (2004), “philosophical hermeneutics”. According to Heidegger, the hermeneutical processes of understanding and interpreting reveal the hidden meanings of phenomena (Dahlberg, Dahlberg, Nyström, 2008).

Key Heideggerian Notions

An ontological view of being is the dwelling place of Heideggerian phenomenology, a familiar place to start presenting the basic notions of Heidegger's phenomenology. A number of key concepts presented in Heidegger's work, *Being and Time* (1927/2011), are central to the study and are presented as a base for reading this thesis.

Being

The question of the meaning of Being (existence) is the foundation of Heidegger's philosophy. In his '*Letter on Humanism'*, Heidegger (1947/1993) offered this insight on Being:

Yet Being - what is Being? It is itself. . . Being is farther than all beings and yet is nearer to man than every being, be it a rock, a beast, a work of art, a machine, be it an angel or God. Being is the nearest. Yet it remains the farthest from man (p. 234).

Thus, Heidegger recognised the elusiveness of the meaning of Being. It is here, there and all around us and yet, in its closeness, it is intangible, hidden from us. It can only be approached indirectly and grasped intuitively (Kohl, 1965). Being just 'is'.

Being is a phenomenon and, as such, may remain hidden or covered up so extensively that it becomes forgotten (Heidegger, 1927/2011). Heidegger suggested, however, that light can be shed on Being through exploration of human existence in its everydayness. Heidegger, then, in his quest for Being analysed the conditions for being-in-the-world as a human being (Kohl, 1965).

Dasein, Being-in-the-world

Dasein, the distinctive human mode of being (though not the biological human being) is translated as "Being-there" (Warfield, 2016, p. 66), "Being-in-the-world" (Heidegger, 1962, p. 13) or "Being-the-open" (Sheehan, 2001, p. 12). Dasein's type of being is existence, "being which everyone of us is" (Heidegger, 2008, p. 27). Dasein is ontological because of its focus on understanding of the meaning of Being and can raise questions of beings (Heidegger, 1962). The most basic state of Dasein is "being-in-the-world" and understands itself and the world as having a range of possibilities (Heidegger, 1962, p. 78). Dasein understands the world and engages with other entities in the world so Dasein is being-with-others. Dasein, an ontological construct refers to a person's prereflective, pretheoretical existence and engagement with the

world (Heidegger, 1962; Wheeler, 2011). Heidegger used ‘being’ to signal existence, and Being to signal existentiale (ontological existence). Dasein is in the world of not just things, but with other people. Daesin “Being-the-open” (Sheehan, 2001, p. 2) suggests that Dasein is not just ‘there’ but is ‘open’ for encounters in that world. How are the meaning of those encounters and the possibilities that result in Dasein’s encounters revealed?

The view of Dasein ‘being-in-the-world’ (Heidegger, 1962, p. 13) suggest that the person and the world are inseparable – we have our own world as well as we are in the world with others. According to Smythe, Ironside, Sims, Swenson and Spence (2008) in encounters with others we are always in the middle of specific situations that are not static but constantly changing. How are those situations experienced by women and midwives during post-birth reflective conversations? For Heidegger (2008) “Being-in-the-world is care” (p, 237). I need to consider the world of the participants and understand/realize how the encounters reveal not just the women and midwives’ experiences of post-birth reflective but also how care is revealed during those encounters.

Being-with (Mitsein)

According to Heidegger (1996) we are not isolated individuals but our being (Dasein) is entwined with the world and with other people. Hence, we are “being-with-others” (Heidegger, p. 115). In being-with our individual self is maintained, though our entire being may be engaged with the other person (Moustakas, 1995). For West (2018) being-with is not just with a person but can be with an ‘idea’ we may have. We may have a person in mind (thinking of them) rather than being physically present with them. Being-with-others means that the ‘others’ may have some influence on us (Heidegger, 1927/2011). What is the extent of that influence by others? According to Heidegger ‘they’ (culture, society, individuals) can state or suggest what needs to be done and the way it should be done. By conforming, our ‘being’ (Dasein) may become ‘inauthentic’ loosing our ‘mine-ness’ and what we have potential to achieve. We may become like others loosing our own (self) identity/individualism, or we may rise above how others expect us to think/behave to be our authentic self.

The hermeneutic circle

Hermeneutics refers to the process of creating interpretive understanding (Verstehen) (Paterson & Higgs, 2005). The process of Heideggerian hermeneutics as a method of inquiry is circular

because it adheres to the basic principle of the hermeneutic circle which highlights the relatedness of the phenomena under investigation to its surroundings. As described by Palmer (1969), “The part is understood from the whole and the whole from the inner harmony of its parts” (p. 77). Schleiermacher (1998) credited Friedrich Ast (1778-1841) with asserting the principle “...that everything individual can only be understood via the whole” (p. 70). Heidegger adopted the hermeneutic circle to make interpretation possible and, in doing so, developed, as described earler, a three-fold structure he called “the fore-structure of interpretation”: fore-having, fore-sight, and fore-conception. Fore-having, according to Heidegger (1962), recognises that the interpretation is always based on “something we have in advance” (p. 191), the background context in “which Dasein knows its way about... in its public environment” (p. 405). For example, a woman may know being a new mother may generate panic/anxiety. Fore-sight refers to the fact that we always enter a situation or experience with a particular view or perspective (the woman plans to ensure there is support if this happens). Fore-conception is exemplified in this thesis when, for example, a midwife asks if a woman could be ‘anxious,’ assuming a shared understanding of the meaning of this concept.

What is most important, as emphasised by Heidegger (1962), is the “working out of these fore-structures in terms of the things themselves” (p. 195) ensuring rigorous interpretation. It “is not to get out of the circle (of understanding) but to come into it in the right way” which is essential (Heidegger, p. 195). The interpretive process is therefore always reflexive and never-ending. Essentially, the researcher must continually examine the whole and parts of the transcript while frequently listening to the data (if it is in an audio recording format) and with reference to the participants to ensure that the interpretations are reflected in the findings (Diekelmann, 2001). The interpretive process undertaken in this study is outlined in detail in chapter 4.

Care (Sorge)

For Heidegger (1996) care is at the very center of his philosophical thinking. Care is described as the central “character of being” (p. 114). When we care we are in the world with others, we are concerned for them and want to take care of them. *Sorge*, the German word used by Heidegger, translates as ‘care for’ ‘concern for’ a feeling similar to anxiety. Being-in-the-world and being-with-others mean that we care ‘for’ those who are with us and this gives meaning to our way of living. Heidegger described two extremes of positive modes of solicitous caring

(Fürsorge): “leaping in” (inauthentic solicitude) or “leaping ahead” (authentic solicitude) (Heidegger, 1996, p. 114).

One can “leap in” and take over for the other. This has a potential to dominate and make the other dependent in the caring relationship as well as lose their autonomy. Through doing what the other can do for herself, the ‘solicitous’ practitioner is taking ‘care’ away from the other. This may be appropriate, for example, if the woman or baby become seriously unwell. In contrast, Heidegger speaks of solicitous care that ‘leaps ahead’ of the other. The ‘leaping ahead’ anticipates the other’s potentiality, not in order to take away her ‘care’ but rather to give it back. This kind of solicitude is authentic care, because it helps the other to know herself in care, and to become free for care (autonomous) (Bishop & Scudder, 1991; Heidegger, 1973). Heidegger also contrasted Besorgen (taking care of, in the sense of supplying the needs of others) with solicitous care. Fürsorge (‘caring for’) suggests one is about tending to, nurturing, caring for fellow human beings (women/whānau) as opposed to merely ‘taking care of’ them. In ‘taking care of them’ we take care of ‘what’ needs to be done for the other, in a rather functional way. To provide care of ‘what’ requires fewer qualities, mainly those of being wary and not willing to take risks, being prudent/cautious.

However, Heidegger’s view on care is not of warmth or of being helpful that we may want to believe. Heidegger (1973) reminded that care is often revealed as lacking or indifferent. In indifference we simply pass others by i.e. we ignore, neglect, are unconcerned or uncaring (Heidegger, 1927, 1962). In this mode we can fail to respond appropriately by closing off and making ourselves unavailable to others. In these monological modes we can be closed to the ‘call of others’. Hence indifferent or concerning care can also be revealed in midwife-woman relationship.

The Heideggerian view of care is applicable for this research. Midwifery is a caring profession. Therefore, caring for the woman during her childbirth continuum is central to the midwife-woman relationship. Heidegger’s interpretation reminds me to consider that ‘being-in’ and ‘being-with’ are interconnected and hence will influence the way in which participants show ‘concern for’ or ‘care for’ each other. It summons me to consider how care presents itself in different modes, that is, whether care revealed is authentic or is inauthentic/deficient in a woman-midwife relationship.

Mood

According to Heidegger (1962), mood is disclosed by Dasein's "thrownness" ... into its "there" (p. 174), into its situatedness by "Being-in-the-world as a whole" (p. 176), and by how "what [Dasein] encounters within-the-world can '*matter*' *to* it" (p. 176) in a particular way. Elkholy (2008) suggested that the mood of "angst" (p. 4), has the power to reveal the whole: the whole of how one is in the world and the whole of the world at large. For Capobianco (2010) "Heidegger's privileging of anxiety in *Being and Time* gives way in his later work to an emphasis on other ontologically revelatory ground moods, such as awe, wonder and astonishment" (p. 107). These moods are expressed by participants in this study.

In life we are always together with others, but "the self" is also created in the company of others (Heidegger, 1927, 1962). Within a midwife-woman relationship more than support for each other is provided; however, it can also result in a relationship where we can objectify the other, walk past each other, and increase vulnerability in the other or in each other. Mood is always present and we are "tuned" in its existence. The midwife and the woman are in certain mood during the encounter and the situation they are in also creates the mood.

Heidegger (1962) wrote: "A mood assails us. It comes neither from 'outside' nor from 'inside' but arises out of Being-in-the-world, as a way of such Being" (p. 176). The mood present will strengthen or deprive us of strength, as well as contribute to the closeness of emotions. Within our relationship the woman's mood may be linked to her life situation while ours will be in relation to our role as a midwife in caring for that woman. Awareness of each other's mood helps to make the relationship more open to authenticity. However, overwork, insufficient time, too much stress, and lack of engagement with each other can result in mood characterised by inadequacy and vulnerability. The mood can thus adversely affect the midwife-woman relationship. There is a potential for each to fail to ask for clarification and/or support. Ignoring each other's moods can also affect the relationship. However, acknowledging the mood we are in can create a caring and supportive encounter. In such encounters a shared vision and understanding is gained by the woman and the midwife.

Chapter 6 highlights how ongoing mood informs either the woman or the midwife whether or not a post-birth conversation needs to occur.

Thrownness

> Thrownness is neither a ‘fact that is finished’ nor a fact that is settled. (Heidegger, 1962, p. 223)

Heidegger (1927/2011) introduced the concept of thrownness (Geworfenheit) to describe human’s individual existences as "being thrown" (geworfen) into the world. If you take the perspective of Dasein ever “moving forward” then this state of mood is the “past in the present”. Our past way of Being ‘threw’ us into the current way we find ourselves. It is a way of saying we have been put in a situation beyond our control, where we cannot control how we are feeling now but can try to feel a different way in the future. We cannot always determine these situations, i.e. they are unexpected and not anticipated but they affect us and our experience.

Chapter 7 highlights how a participant’s (Paige) lack of sharing of information during pregnancy “threw” the midwife during a postnatal visit and put her in a vulnerable position.

Notion of tact

According to van Manen (1995) tact, originally connected to music, represent a special form of human interaction. For Gadamer (1989) tact refers to a special mode of knowing and being in dialogical encounters. The Latin words for tact are ‘tactus’ and tangere’ meaning touch, the sense of touch, “in touch with” and “effect of one human being on another” (van Manen, 1991, p. 134). One can be in touch by touching the person, ‘with a word”, with a gesture”, “with the eyes”, “with an action” or “with silence” (van Manen, 1991, p. 134). Gadamer (1989) suggested that tact can be understood as “a special sensitivity and sensitiveness to situations and how to behave in them” (p. 16). It can also be understood as attunement, practical moral intuitiveness, a kind of knowing, openness, listening, thoughtfulness, mindfulness, an active confidence, deep sense of responsibility, and sense of humour (Smythe, Payne, Wilson, Paddy and Heard, 2014; van Manen, 2015).

Tact can also be shown by ‘holding back’. van Manen (1991) states “a tactful understanding of when to hold back, when to pass over things, when to wait, when “not to notice” something, when to step back rather than to intervene, draw the attention, or interrupt” (p. 151) is a gift. Tact differs from tactic as it essentially cannot be planned. There are no set rules, theories, models, specific technique or skills that can be used to act predictably or consistently to show tactful practice in situations we may encounter as a midwife (van Manen, 1991). Though tact

primarily manifest itself through observable behaviours, one can also describe and reflect on how tact revealed itself (van Manen, 1991).

Symthe et al (2014) state that “tact is always within the relationship” (p. 168). Just as a midwife needs to I as a researcher also need to remain open as I read and interpret the stories of “what is happening for ‘this’ woman at ‘this” moment” (p. 168) to illuminate tactful practice.

Why Heidegger’s Hermeneutic Phenomenology for this Study?

Despite being influenced by Husserl, Heidegger fundamentally disagreed with Husserl’s theory of human consciousness (Dreyfus, 1991). According to Laverty (2003) Heidegger’s focus was on ‘Dasein’ (mode of human being) while Husserl considered it important to understand beings; for Heidegger (1927/2011) consciousness was part of the world, rather than being separate from the world and that understanding is about “the way we are” in the world rather than the way “we know the world” (Laverty, p. 24).

Wojnar and Swanson (2007) add that in hermeneutic phenomenology the emphasis is on understanding phenomena in context; viewing the person as a self-interpretive being. Researchers’ and participants’ active understanding, co-creation, and interpretations of the phenomenon make the interpretations meaningful. Heidegger (1962) talked of hermeneutics as the art of interpretation in the specific context. In hermeneutics the researcher and the participants are collaborating to determine meanings. The meaning is therefore created jointly; yet what is presented in the research report by nature privileges the researcher’s interpretations. (Murphy, 1989).

Sheehan (2005) suggested that Heidegger’s phenomenology separated from Husserl’s due to Heidegger’s hermeneutic shift to “identifying the world as the source of all meaning” (p. 197). Whereas Husserl wanted a phenomenology untainted by interpretations, Heidegger’s phenomenology is hermeneutic; it is interpretive. Heidegger’s philosophy is not concerned with the maintenance of objectivity. Background practices and the natural standpoint are integral, and therefore inseparable, elements of being. They cannot, and should not, be bracketed.

In Heidegger’s phenomenology, the researcher brings her own experience to enter the world of the participant, shares the experience with the participant by being present, and seeks an interpretation of that experience (Lucock, 1997). Husserl, on the other hand, aimed for an

isolated theoretical analysis (total bracketing) to gain true meaning of the phenomenon (LeVasseur, 2003). As a researcher it was difficult to understand how I could successfully remove myself from the situation and then re-insert myself for the purpose of analysis. Husserl's 'bracketing' to completely remove my biases has therefore not been adhered to as such. Nevertheless, I have tried to articulate my assumptions and be open to how they influence my interpretations.

Phenomenology is not used to highlight what is obvious or clear to us but what may need an effort to bring to light (Clark, 2008; Inwood, 1997, 1999). Post-birth reflective conversations, for example, may happen everyday but may be taken for granted. Taking something for granted conceals it and hence is not explored/questioned (Heidegger, 1927/2011). Phenomenological perspective may therefore be relevant in making the taken for granted/everyday areas of practice meaningful.

The meaning of the reflective post-birth conversation, the phenomenon in this study, is not always questioned. In everyday midwifery practice, time to pause, acknowledge that a post-birth conversation may have just happened or question the meaning of such conversations is limited. Hence Heidegger's phenomenology offered a way to interpret what was being revealed through the voices of women and midwives. The phenomenon of reflective conversations on those involved can only be understood when what is hidden is brought to the light.

According to Smythe et al. (2008), phenomenological insights reveal themselves to the researcher through "a journey of 'thinking' in which the researchers are caught up in a cycle of a reading-writing-dialogue which spirals onwards" (p. 1389). Thus, phenomenology deepens the understanding of post-birth reflective conversations.

For a methondology to be trustworthy the researcher needs to be attuned to the texts, be open-minded, keep questioning, and allow interpretations to declare themselves. In this type of research. essentially it is the reader that makes the judgement on whether the research is trustworthy or not.

For this study van Manen's (2007) definition of phenomenology being the study of lived experience or the life world and Heideggerian philosophy provided the context in which to understand the human lived experience. Heideggerian philosophy recognised that what

constitutes our personal world and how we live in that world were inextricably related and sought to gain a combined understanding of the two (Heidegger, 1962). Heidegger accepts that the pre-conceptions (for example, what it means to be in the world of midwifery practice following the birth of the baby) can be used to shape the research question. Thus my pre-conceptions are infused in my interpretation of the experiences of women and midwives in this research, albeit that I have sought to be open to the pre-conceptions that I bring. Heideggerian phenomenology enabled me to enter the world of women and midwives to better understand their experiences of post-birth reflective conversations.

Hermeneutics – Gadamer

Heidegger built on Husserl's phenomenology and Gadamer [1900–2002], in turn, built upon Heidegger's foundation (Walsh, 1996). Both Heidegger and Gadamer agreed that meaning is found in lived experience so scientific method was not an appropriate way to reveal this (meaning), and that language and understanding cannot be separated (Laverty, 2003). For Gadamer hermeneutics was about interpreting the text/language rather than existence and understanding things from someone else's perspective (Pokorny & Roskovec, 2002; Clark, 2008). Hermeneutics is not about developing a step by step process of understanding but to explain the conditions that enable understanding to occur (Gadamer, 2004; Laverty, 2003).

Grondin (2002) said "to understand is to grasp something, to see things clearly and able to integrate a particular meaning into a larger frame" (p. 37). Language enables us to understand (Gadamer, 2004) and this understanding can be taken into our life and can applied to our practice situation. Language is used to uncover the phenomenon. The conversation at the time of interviewing and interpretation of the texts provided the knowledge of the experience of having a post-birth reflective conversation and the impact on the participants.

Clark (2008) suggested that for Gadamer 'horizon' is as far as we can see or understand. Our horizon/view encompasses our pre-understanding, prejudices, any ideas we may have formed, language and openness to meaning that may result (Clark, 2008). As midwives and women, we each have our own horizon and following our interaction/contact we may each leave that interaction with our own new horizon (Clark, 2008). Gadamer states that when we come to an understanding during our contact with each other, our present horizon/view is changed by coming to shared understanding. This enabled me to reflect on what I bring of myself, as a

person and as an experienced midwife, in my interaction with women. I reflected on what views hold about post-birth reflective conversations as a midwife and as a presenter at TABS (Trauma and Birth Stress) workshops so I was clear about those influences in my interpretations. In this study Gadamer's philosophical perspectives are as applicable as Heidegger's, as they enable revelation of meaning of post-birth reflective conversations that may be hidden in our everyday conversations/interactions with women. To understand horizon, as detailed by Gadamer, several additional ideas need to be explored.

Pre-understanding

We already have ideas as we enter an encounter. Essentially, we have a history and an understanding of the world before we begin to think about it (Gadamer, 1975).

Prejudice

As per pre-understanding we take attitudes into a situation. Gadamer called these 'prejudices'. It is not meant to have negative connotation, but as "judgement that is rendered before all elements that determine a situation have been finally examined" (Clark, 2008, p. 58). For instance, a woman may have already decided she does not think her midwife is 'good enough' based on her own prejudices of what 'good' care should encompass.

Fore-meanings

During an encounter human beings are constantly trying to look ahead to find meaningful understanding. This happens before we settle on our interpretation (Clark, 2008). A woman may ask for pain relief which a midwife might think is a straightforward request but it may open out into a more significant dialogue about her feeling overwhelmed. Gadamer stated we cannot blindly hold on to our own fore-meanings if we want to understand the meaning of another. "All that is asked is that we remain open to the meaning of the other person" (Gadamer, 2004, p. 271).

A fusion of horizons

'Understanding' is or occurs when there is fusion of our past and present views/horizons. Past is needed to form the present. Past and present cannot exist without each other and thus "understanding" is always the merging of these views/horizons (Clark, 2008, p. 59; Gadamer,

2004). It is also the merging of one person's horizon with that of another during dialogue or conversation.

Language

A deep awareness of language is central to the hermeneutic inquiry. We express our understanding of the world and we understand others through language/spoken word. For Gadamer (2004) language was a key component of philosophical hermeneutics. He stated "nothing exists except through language" (p. 295). Hence language is the source of meaning. According to Wittgenstein (1922/1960), "the limits of my language means the limits of my world" (p. 62). The language enables us to discover the world we live in and share that discovery with others thus enriching the world. Through language/spoken word the understanding of the world can be extensive/profound. Without language our worldview would be insular and closed. Gadamer's philosophy has allowed me to understand language as always hermeneutic. Language enables conversations/dialogue and understanding as well as revealing how "step-by-step unveiling of being comes about" (Gadamer, 1998, p. 57). For Gadamer (1998) "language is the reply" (p. 112). Hence to 'reply' means that one is engaging with the other. The word "play" used by Gadamer (2004, p. 330) suggested that language is not about us just being heard during conversation, but the back and forth process of language/spoken word enables reflecting and questioning that results in new understandings during conversations.

Dialogue

For Gill (2015) "dialogue is always dialogue about something" (p. 19). You may have dialogue by yourself in which case the words are yours or often with someone else. In this study dialogue is with women and midwives who have experienced post-birth reflective conversations. Hence all are concerned with a common topic. Gill who quoted Linge said "equality and active reciprocity" are involved in hermeneutical dialogue (p. 19). During dialogue both have to be equally concerned about what motivates the conversation they are having and meaning they are trying to reveal. Reciprocity suggest 'dialectical' – that there is 'interplay' of back and forth between the people involved in dialogue (questioning/reflection/thinking) as well as in relation to our past and present understandings and views (Gill, 2015). Neilsen (2013) suggested that each dialogical encounter enables us to revise our horizon, that is, it expands and enriches it. Hence, we must remain open to change.

There are “sudden phrase” or “word patterns” during dialogue that may suddenly speak to us (Davey, 2014, p. 37). It is suggested such phrases in dialogue enables thinking, interpretation and new understanding. According to Davey, we are the interpretive process, we continuously replace our previous understandings with new understandings. This creates change and limitless possibilities. The next section focuses on what is considered as quality dialogue according to Gadamer.

Authentic dialogue

Authentic and meaningful dialogue are unconstrained and allowed to flow (Gadamer, 2004). Authentic dialogue highlights the robustness in the conversation and enables thinking and understanding (Gadamar, 2004). However, we need to be open to hear what is being said and have willingness to understand what has been said. Gadamer described the idea of authentic dialogue requiring certain conditions during listening. He suggested that:

> One is prepared for a conversation only when one is prepared to listen, that is, when one is prepared to let the other say something... Listening to one another and addressing one another are essential aspects of a conversation. These provide an openness that simultaneously renders a conversation both unpredictable and fruitful. (Figal, 2002, p. 107)

How do human beings know that they are truly listening and not focusing on only what they want to say in this conversation? In such instances we may not hear each other because we listen for an opportunity to say our thoughts during the conversation. It is therefore essential that our focus remains on what is being said rather than what we may want to say.

Gadamer reminded us that the quality of listening is important when seeking understanding. Spontaneity allows a conversation to lead us, even if the conversation is not of particular interest to us. It is essential not to control or lead such conversations but enable them to flow freely so we can access what the conversation is trying to unveil to us. Gadamer’s philosophy about language therefore holds wisdom that is vital for this research as the plan is to interview the participants and working with their stories so meaning of post-birth reflective conversations can be revealed.

Gadamer's philosophy of interpretation

The focus of Gadamer’s (2004) influential work, *Truth and Method*, is the phenomenon of understanding and what has been understood during interpretation. Gadamer said that “what he

meant by the famous proposition of Truth and Method, that 'Being that can be understood is language,' is that 'Being that can be understood begins to speak to us'" (p. 29). Therefore, Being is surrounded in language and is declared to us through the spoken word. Understanding of the spoken word occurs among individuals (women or midwives), of the self with itself (by women or midwives individually) and the self with another (between midwives and women where shared understanding may result).

Respect for other and the rights of others are essential during listening and interpretation of the stories. In hermeneutics the aim is to reveal the lived experience of other appropriately, taking into consideration how the experience unfolded and impacted through language used by the participants. There is an assumption, in this study, that the people most able to reveal the phenomenon in question are the midwives and women who have experienced post-birth reflective conversations.

The methodological process to uncover the meanings was to listen to the stories that were audiotaped and then transcribe them into text. Once the transcriptions were verified as accurate by me, I started to analyse the text until the knowing that lay in the stories shared began to show/speak to me.

The Other in the relationship

Gadamer's philosophy, which advances language as part of the hermeneutic experience, guided the hermeneutic listening and interpretation. The analysis of Gadamer's "I-Thou" relationship has been articulated by Scheibler (2000) as a "very un-conservative insistence on safeguarding the rights of the Other at a most fundamental level: it seeks to demonstrate that the Other might be right..." (p. 61).

I approached this study without assuming what was right or wrong about the post-birth reflective conversation. Scheibler (2000) commented that "by remaining open, we can train the self to a level of sensitivity where we are told something that we could not know ourselves" (p. 61). In my experience I have noted that positivity, trust and respect of the Other enables conversations that go beyond superficial level. Gadamer (2004) advised that "this kind of sensitivity involves neither 'neutrality' with respect to content nor the extinction of one's self, but the foregrounding and appropriation of one's own fore-meanings and prejudices" (p. 269). I believed that post-birth

reflective conversations might be challenging for some participants so as an interviewer I needed to return to the transcripts with mindfulness and sensitivity.

At times we may have to alter the focal point of the conversation as further questions are considered in light of what has been said and bring forth further analysis of the insights that has been expressed within that response. I came to understand different approaches for engaging with dialogue and text which enhanced the hearing of what was shared and not shared. As my hermeneutic listening skill improved, I learnt what I could not have otherwise come to know. The more in-depth the conversation that acknowledged the knowing of 'Other' the greater the learning and depth was observed.

Politics of Heidegger and Gadamer's hermeneutics

According to Oltermann (2014) and Sheehan (1988) many people have been inspired by Heidegger's writings. Though there had been documentation of Heidegger being part of the Nazi Party (joined the party in 1933) and that he sympathised with the regime, the publications of the 'black notebooks' (Oltermann, 2014) challenged whether his anti-Semitic ideas touched the core of his philosophy. The question that has been asked is to what extent was his philosophy compromised due to his association with the Nationalist Socialist (Nazi) party during the Second World War? Arendt and Derrida felt it tainted his character rather than compromised his philosophy (Oltermann, 2014). It appears that nothing in Being and Time (Heidegger, 1927/2011) can be read as Heidegger aiding the National Socialist aims/position based on biology or race, or that supports anti-Semitic ideals (Wolin, 1993; Young, 1997). Since the publication of the 'black notebooks" numerous books have debated Heidegger's affiliation with the National Socialism (Kirsch, 2010).

Gadamer and Heidegger were closely aligned, with Gadamer being a pupil of Heidegger. Hence questions have been asked about Gadamer's sympathy or resistance to the Nazi party (McLemee, 2003). Gadamer says, "feelings of solidarity (experienced for his Jewish friends) enabled me to hold out during this time" (Palmer, 2001, p. 130). There is a sense of Gadamer feeling torn between what his Jewish friends had to experience and his own personal freedom. According to Grondin (2003), Gadamer kept a low profile during Third Reich/regime and remained untainted regarding his relationship to Nazism. However, Orozco and Wolin suggest

that Gadamer's relationship to Nazism was closer than publicly admitted (Lawn, 2006). Grondin (2003) provides plausible explanations that counteract Orozco and Wolin's claims/suggestions.

Water (2008) mentions that it is essential to look at the social and political context following the First World War and the influence this would have had on the philosopher's relationship with Nazism. She further states that according to Gadamer (2004) to understand the circumstances one needs to consider the 'mood' during that time.

Heidegger's supporters and critics agree that his philosophical thought is important and cannot be dismissed (Rockmore, 1992). Heidegger and Gadamer's writings, though challenging have stimulated my thinking. Becoming aware of Heidegger and Gadamer's political involvement reinforced how essential it is to continue to question any reading or literature to ensure it enhances rather than compromises the study.

Buber

Martin Buber, an Austrian and prominent 20th century philosopher, is best known for his 1923 book, *Ich und Du* (*I and Thou)*, which distinguishes between "I-Thou" and "I-It" modes of existence (Buber, 2010). These two modes of relation are considered by Buber as respectively reflective of dialogue and monologue. His writing has challenged some philosophers including Heidegger. According to Olesh (2008) Heidegger mentioned 'Being-with' (Mitsein) when exploring Being. Buber (2002) challenged this component of Heidegger's philosophy. For Heidegger Being-with Others defines the existence of Man and the exploration of the question of Being is an exploration of question of Man. According to Buber (2002) such a question should be addressed by anthropology. However, the study of Being of Man involves man studying or thinking about man i.e. man studying himself and hence has a relationship with himself. For Buber man's study of himself is not possible and cannot be a true relationship as it will never form an essential relation to being. Hence, Buber concluded that Heidegger's work in Being and Time cannot be considered to be anthropology (Olesh, 2008).

Though misconceived Buber also suggested that Heidegger's self (Dasein) is a "closed system" (Buber, 2002, p. 203). However, Buber's statement was not correct as "Heidegger describes the basic state of Dasein as Being-in-the-world, and this state includes Being-with other Dasein's in the world" (Gordon, 2001, p. 6; Olesh, 2008).

According to Olesh (2008) though Buber provided convincing argument that Heidegger's work should be addressed by anthropology he did not correctly interpret the way Heidegger understood the relationship between Being and Being-with and state of Dasein and what this state includes. Buber also influenced Emmanuel Lévinas. In all of his writings Buber carries through the notion: "to be in relation," "in dialogue" (Buber, 1958, p. 137). According to Buber, there is no such thing as a person being single or separate, that is, "I" because as human beings we are always in relation to the world around us. The "I" only becomes meaningful in relation to the world around us.

"Genuine dialogue" (Buber, 2002, p. 22) enables understanding of the women we provide care to. However, understanding in "genuine dialogue" can only happen if we are willing to have a relationship with them and respond by "making the other present" (Friedman, 1955, p. 97; Levinas, 1998). Such encounters illuminate what happens in the relational or interactional space between two people – midwife and the woman (Buber, 1998). For Buber the relationship with the other is not ethically driven however, there should be a desire to be fully engaged in the relationship (Kohanski, 1982). Such engagement enables us to understand the other (woman) and that our understanding may change during the dialogue we have with each other. Meaning is therefore found mutually as dialogue continues between each other. According to Buber (2010) these are the "I-Thou" conversations. Buber (2010) suggested the relationship needs to be reciprocal for such exchanges to happen. "I-Thou" dialogue/relationship shows genuine interest in the uniqueness of the other person to whom one is relating.

However, it is not possible to sustain such deep conversations/dialogues between two people all the time. Hence Buber (2004) suggested that other mode of dialogue, "I-It", exist. These are referred to as "technical dialogue" "monologue" "debate" "conversation" and the "friendly chat" (Buber, 2004, p. 22). The "I-It" mode is pertinent when objective information/understanding (O'Dwyer, 2008) needs to be gained from the other but has a potential to objectify the person and not appreciate/consider them as human beings. Though these two modes of relationships relating to genuine dialogue, "I-It" and "I-Thou" do enable us to come to understand the other, we also need to acknowledge that we cannot completely understand the other person.

Buber's modes of dialogue/relationship are used in this study to understand how we (midwives and women) come to experience our relationship with each other and whether the relationship

is reciprocal. This will aid when examining what occurs “between” midwives and women during post-birth reflective conversations and how this impacts on their experiences.

Levinas

Emmanuel Levinas [1906–1995] was a French Philosopher born in Lithuania. The focal point of his theoretical framework (Levinas, 1991) is on the call, how we respond to that call and the relationship with the other. According to Levinas it is the “face” that “invites me to the relation” (p. 198). When we see a “face” as structured object in the relationship we are objectifying the “face” (Robbins, 2001, p. 49). In a “face to face” encounter we need to see beyond the objective structure of the face and to what is occurring. This enables us to be in “proximity” (Tallon, 1978, p. 304) with Other, linking our lives together. In “proximity” the Other (woman) is engaged/open with us, demanding an immediate response from us (Beavers, 1995, p. 5; Tallon, 1978). We therefore have ethical responsibility to respond to this demand.

The face to face encounters with women and their whānau are fundamental to midwife-woman relationship and in other areas of healthcare (Edgoose & Edgoose, 2017). What happens in this encounter to prompt me, as a midwife, that I am being ‘called’ into a relationship with a woman? According to Davy (2007) the call does not have to be verbal, there may be something in that ‘face’ that compels me (awakens ethics, my responsibility to the Other) to act/provide care as a midwife. How do we each present our “face” to each other? How do the women maintain “Otherness”? Both women and midwives can take a lead in inviting the other in a relationship but how does this happen? Levinas (1991) suggested that just because the “face” has been exposed, does not mean we get to learn everything about that person (woman or midwife), irrespective of the length of time we may have known them. There may be something that may not be mentioned or may remain hidden. In the “face to face” encounter the person maintains her “Otherness” (Levinas, 1998, p. 185). This separateness, secrecy is called “alterity” by Levinas (Critchley, 2002, p. 26). We must therefore acknowledge that the “Other” (woman) is separate from us; not doing so could impact on the midwife-woman relationship.

Summary

The philosophical notions that guide my research have been discussed in this chapter. The writings of Heidegger and Gadamer have principally informed the study; however, those of Buber and Levinas have also provided congruent philosophical notions to assist analysis of the

experience of post-birth conversations. The emphases of these philosophers may differ, but they echo, as well as provide contrast to, each other, highlighting the possibility that multiple interpretation may exist/be apparent. The following chapter will outline how I applied the philosophical underpinnings to my research.

Chapter Four: The Pathway to Research

Introduction

Following the exploration and articulation of the Heideggerian (1927/2011) and Gadamerian (2004) notions guiding the study, I needed to find the path that would enable me to access and reveal the phenomenon of post-birth reflective conversation and the experience of those involved.

According to Smythe et al. (2008), the ongoing dialogue of philosophical understanding with the method shows one the way of research, as well as the researcher's role in the research. The attunement to pre-understandings and how these may influence the research is essential (Smythe et al., 2008; van Manen, 1990). There are no signposts or recipes in hermeneutic phenomenological research. The relationship with the text helps to guide the path forward (Heidegger, 2003). According to Gadamer (1994), the focus should be on the phenomenon rather than the research techniques. There should also be a demonstration of scholarship (van Manen, 1990) that passes the "so what" test (Sandelowski, 1997).

The pathway to research outlines the process, how the participants were approached and selected, how the stories were acquired, and the process of hermeneutic analysis. Issues related to trustworthiness and rigor will also be discussed. In hermeneutic phenomenological research, the planning ahead is never with full confidence, as we do not know how precise it will be. The researcher is always "confronting choices and wrestling with the restlessness of possibilities" (Smythe et al., 2008, p. 1391).

Research Question

"How are post-birth reflective conversations experienced by those involved?"

Phenomenon of Interest

The phenomenon of interest for this study is 'post-birth reflective conversations.' When selecting a methodology, the initial consideration by the researcher is of an area of interest, in particular, an aspect within that area (van Manen, 1990). This enables the researcher to think/focus or make sense of one thing within that particular area of interest. This study is a hermeneutic phenomenological exploration of women and midwives' experiences of post-birth reflective

conversations. The midwives who participated in the study were not the LMCs for women who consented to be part of the study, i.e., there was no relationship between women and midwives who participated. The intent was not to compare or verify their stories but to illuminate their individual experiences and make visible the taken for the granted phenomenon of 'post-birth reflective conversations'. Further, it felt inappropriate to 'know' the 'other' that the midwife or woman was talking about. That midwife could have read a woman's story of 'poor' midwifery care. Similarly, when a midwife reflected on a challenging situation with a woman, the woman could have read that story. Confidentiality would have been breached. According to van Manen (1990), phenomenology is "to make sense of a certain aspect of human existence" (p. 30) that is situated within the social, historical context of the individual. This research sought to make sense of the stories offered by each participant, seeing the 'other' through their eyes.

My past and present experience, curiosity, and involvement with TABS motivated me to investigate post-birth reflective conversations. I was interested in the lived experiences of women and midwives who had experienced the phenomenon in the two years prior to the time of the study. "Phenomenological research aims to re-establish contact with the original experience" (van Manen, 2016, p. 31). Ethical approval was required before gathering the stories of lived experience (van Manen, 1990)

Ethical Approval and Other Considerations

The research proposal for "How do post-birth reflective conversations impact those involved?," was approved by the Auckland University of Technology (AUT) Ethics Committee (Reference number 13/301, Appendix A). On reflection, the word 'impact' used in the title of the research proposal and the participants information sheet should have been amended during the Ethics approval process to "How are post-birth reflective conversations experienced by those involved?". I understand that the word 'impact' has association with quantitative variables and felt that midwives and women may be affected by the phenomena of post-birth reflective conversations. The indicative questions for the interview submitted in the ethics application reflect the intention of the study, that is, women and midwives were asked to share their experience of post-birth reflective conversations. A safety protocol for research involving one to one interviews to be conducted by a researcher in private homes in Auckland was included with the application (Appendix B).

Under New Zealand's commitment to the Treaty of Waitangi[2] I adhered to the principles of partnership, participation, and protection (MOH, 2014; NZCOM, 2015). Consultation with a Māori midwifery advisor was sought to ensure research processes were culturally appropriate. However, none of the participants in this research identified themselves as Māori.

Participants

The sampling was purposive. which led to snowballing. Information sheets were given to the manager of the primary units to discuss with midwives during a meeting or were offerred/left in staff area for midwives who used their facility for care during childbirth continuum. Midwives contacted me if they were thinking of participating or once they had made the decision to participate. Recruiting women was by word of mouth. Women with whose care I had been involved (who could not participate) as well as part of local community groups passed the information to other women and local coffee groups. They contacted me if interested in participating with some coming as a group of three-four. The participants also connected the researcher (me) to other potential participants (snowballing). Purposive sampling ensured participants had rich information about their lived experience of post-birth conversation (Patton, 2002). It was their knowledge of the experience of the phenomenon that was of interest in the study (Creswell & Plano Clark, 2011). It was essential that participants were willing to participate and that their communication was articulate and reflective. As a researcher I intended to achieve depth rather than breadth of understanding (Patton, 2002).

In hermeneutic phenomenology the emphasis is on obtaining a comprehensive understanding of the lived experience and phenomenon. According to Kafle (2011) "the researcher is a signpost pointing toward an essential understanding of the research approach as well as essential understandings of the particular phenomenon of interest" (p. 189). The plan was to gather stories from 12 women and 12 midwives. With this small number, it would not be possible to generalise the findings or minimise the potential for bias in the selection of participants (Bernard, 2002). Nor would a phenomenological study assume such objective rigour. The participants had to meet the following criteria to be eligible for the study:

[2] New Zealand's founding document.

- Women who had their first or subsequent baby who was born alive in the last 24 months.
- Midwives who have been involved in midwifery care for more than one year.
- Able to converse easily in English.
- Living in the Auckland area of New Zealand.
- Women who had not had the researcher as their LMC midwife.
- Participants who had not been diagnosed with postnatal distress or were being treated for postnatal distress.

The benefit for the participants in the study was to be able to talk about their experience of post-birth conversation. Those who agreed to participate were eager to share their experience of having such conversations. There were some who questioned whether the study would open a 'can of worms' i.e. create a series of other problems that were not there in the first place. However, none of the participants required support from AUT Health, Counselling, and Wellbeing Centre as a result of sharing their stories.

Working with a midwifery participant population who are often busy and can become unavailable at short notice made, in some instances, organisation for interview challenging. However, being an LMC midwife with a small caseload, I could understand their need to cancel the interview at short notice and reschedule for another day/time. The women were more able to plan an interview time, although had the issue of arranging childcare to consider.

Midwife participants

There were two groups of midwives (3 in a group) who all wanted to participate individually. The initial two interviews were getting familiar with the interview technique and process. This resulted in interviews of 30 minutes. The data from these two interviews revealed one story each that could be crafted for analysis. Though my initial plan was to interview 12 midwives, 14 midwives contacted me to be part of the study. It was not possible to say 'no' to midwives or women.

Table 1: Midwife participants

Midwife participants (14)	Years of experience
Dee	Five – Ten
Tammy	Five – Ten
Dell	Ten plus
Cali	Ten Plus
Lily	Two – Five
Hine	Two – Five
Cate	Five – Ten
Val	Five – Ten
Ingrid	Ten Plus
Nicky	Ten Plus
Dina	Five to Ten
Marie	Ten Plus
Tina	Five to Ten
Prue	Two – Five

Women participants

Bina and Mayuree were friends and both wanted to share their stories. Rosa, Jie, Febe, and Dina were in the same coffee group. They decided they would all share their experience and informed me of this when they contacted me. It was impossible to say 'no' as it would have been perceived as being interested in one person's story and not the others. They had shared their experiences with each other many times so during an interview their stories were succinctly articulated. Interviews for each of these four participants lasted approximately 25 minutes. Discussions between themselves had resulted in stories that required very little crafting. A summary of women participants can be found in Table 2 (p. 60).

Getting consent for participation

Prior to agreeing to participate in the face-to-face interview, midwives and women who agreed to participate, were given information about the nature of the study verbally and in writing. They were also informed of their right not to participate. They were made aware that they were free to withdraw at any time without explanation or penalty, and could omit answering any questions if they wished. No coercion was used to encourage participation in the study. Opportunities were provided for participants to ask questions at any stage. Participants were required to sign a consent form. The information sheet and consent form are presented in Appendices C and D.

Table 2: Women participants

Women participants (20)	Number of baby
Jane	Second baby
Mel	Second baby
Isla	First baby
Bina	First baby
Eva	First baby
Casey	Second baby
Brea	First baby
Fina	First baby
Jo	Second baby – had moved to Auckland
Meg	First baby
Leah	Second baby – had moved to Auckland
Nita	Second baby
Rosa	First baby
Jie	First baby
Febe	First baby
Adelina	First baby
Dina	First baby
Mona	First baby
Paige	First baby following a previous miscarriage
Mayuree	Second baby

Beneficence, non-maleficence and justice

The rule of beneficence (value of research to midwifery community) and principle of non-maleficence (do no harm) are of paramount importance (Haahr, Norlyk, & Hall, 2014; Koch and Harrington, 1998). The benefits of participating in the study should outweigh the risk to the participants. The principles of justice refer to fairness, equity and what is entitled by each participant (Haahr et al., 2014). The women and midwives in this study knew they did not have to participate but wanted to share their experiences hoping they would enable reflection and sharing with other midwives and students.

Protecting data and confidentiality

Data from the interviews will be securely held for six years. All participant information collected during the research was kept strictly confidential. Individual participant names have been removed so that they cannot be recognised. At no time has, or will, the participants' personal data be stored with the interview data. The participant's personal data, which included the name

and phone number, was acquired for the sole purpose of arranging the interview. All data, including copies of the digital recordings, have been locked in a filing cabinet, on the University premises, during and following completion of the study.

The interview data were accessed by the researcher and the two research supervisors during the analysis stage; however, participants' actual names were not included in the interpretations. To further maintain data security, the raw interview data will be destroyed after six years. While I believe that other people should not be able to identify the participants, it is possible that participants themselves may recognise aspects within the thesis.

Gathering the Stories

In hermeneutic phenomenology the processes of gathering and the interpretations of the participants' stories occur simultaneously (van Manen, 2001). Once I developed confidence in interviewing, I started to ponder what the words in participants stories might be referring to or saying. I began to notice that in their stories there was sameness as well as differences, and in relation to my own understandings. The term 'gathering stories' is in keeping with hermeneutic phenomenology (van Manen, 2001) and honours the participants' sharing of their experience and stories.

Before gathering information and interpretation, I had an interview with one of my supervisors to identify my pre-understandings. Listening to this recording numerous times and reflecting on the conversation helped me to examine and clarify my own biases, assumptions, questions, values, and the way i thought about the phenomenon. According to van Manen (2001), this is an essential part of the research process since naturally we are already under the "spell of our own fore-meanings" (Gadamer, 2004, p. 270). Although we are often oblivious of the fore-meanings that support our understanding (Gadamer, 2004), hermeneutic phenomenology asks us to be attentive to how those fore-understandings shape our interpretations. In this study my own experience and understandings of post-birth reflective conversations were sometimes made more clear while at other times were 'between the lines' (Koch, 1999). I referred to my pre-suppositions regularly during the interpretation phase as they were integral to the process of interpreting participants' stories (van Manen, 2001). I could not put them aside, but I could maintain ongoing vigilance about how they were 'colouring' my interpretations.

The first interview was arranged once ethical approval had been granted and a participant had volunteered. The person determined her workplace for the interview so she did not have to travel and felt comfortable in familiar surroundings. Privacy was easily maintained because the room was not being used by another practitioner that day. All other participants also invited me to their own environment where a separate room was available for privacy. The interviews were recorded using a digital voice recorder. The interviews were between 25 and 90 minutes long.

The interview started by asking if there were any questions relating to the study and/or from the information sheet that had been provided. This was followed by the signing of the consent form. The first three interviews occurred within a short timeframe so the opportunity to reflect on the process began a week after these interviews. Supervision occurred about two to three weeks following the first interview. The discussion during supervision and comments about the quality of the stories helped develop confidence and increased my interviewing skills for this methodology. Changes that were made in my interview technique included not jumping in with a probing question when there was a long silence, and using participants' words to probe for further clarification or expansion on what had been said. According to King (2001) this kind of interview is in agreement with phenomenological research, being able to 'light' the phenomenon that is hidden from the everydayness of participants' experience of post-birth reflective conversations.

Initially an interview guide needed to be used so that I could ensure the interaction was open, relaxed, and conversational, while also focusing on appropriate probing of the topic. I tried to maintain a sensitive openness to the participants' words, and probed for depth and richness (van Manen, 2014). The questions were asked in a way to encourage a response with as much information as possible about the experience (Walker, 2011), but were kept open to allow for the conversation to include experiences that may not have been considered for sharing. The opening question used for women and midwives are in Appendix E; these open guiding questions were used to give scope for all possible meanings to be illuminated in the phenomenological research process (Smythe, 2011).

Developing confidence in this methodology enabled me to get stories with more detail. Asking probing questions using participants' words resulted in the deeper description of a particular

aspect of the experience. For example, I asked Dee “tell me more about how you felt when Jess started walking towards her (Jess’s) front door” (see Dee’s story Chapter 5).

While I was gathering stories, I realised that I started to trust that the experience and meaning of having a post-birth reflective conversation would reveal itself through participants’ words. When they started talking about the conversation, in general I would remind them to recount a specific example of their experience. This is an important element of hermeneutic phenomenology because the meaning of lived experience may be hidden in the language used by the participants (van Manen, 2014). The participants’ were also invited to share their understandings or any meanings of things, as encouraged in Gadamerian hermeneutics, for example: “Can you tell me how your conversations differ when there is openness in the relationship?”

Crafting the Stories

Following the first interview I decided to transcribe the recording to become familiar with the content. I did have a person to transcribe, however, I believed that transcribing the interviews myself immersed me in the data. This was particularly helpful when I had to have a break from my research due to unexpected family commitments. At the time of transcribing, participants’ names and names of any places mentioned were modified and additional sounds such as ‘ums’ and ‘ahs’ were deleted in the transcripts. There were no emotional pauses at the time of the face to face interviews or, hence, in any of the interview data I transcribed. It was evident that prior to participating in the study the participants had already had the opportunity to talk about their experiences with practitioners, partner, colleagues, and family members. The participants’ experiences of having post-birth reflective conversation ranged from 6 months to 18 months prior to making the decision to participate in the research.

Gadamer (2004) states that the reader and the author “doesn’t have to know the real meaning of what he has written” (p. 296) because it is the process of interpretation that counts in search of the meaning of the written word. When the interpreter makes sense of what is written, the text is reawakened (Gadamer, 2004). Discussing the interpretation with colleagues and supervisors helped to ensure that I remained faithful to what the participant was saying in the language they used.

According to Gadamer (1960, 1975) “understanding begins when something addresses us” (p. 299). The participants’ stories addressed me and helped to illuminate previously unnoticed phenomenon of post-birth conversation when the LMC provides continuity of care during the childbirth continuum. For Caelli (2001) “crafting” meant deriving “narratives from transcripts” (p. 276). Crafting of stories, therefore, comprises excerpts from the participants’ interview data (Crowther, Ironside, Spence, & Smythe, 2017). Being aware and receptive to what was in the data enabled the researcher to see more than words in the transcript including momentary glimpses of the phenomenon (Crowther et al., 2017; Smythe, 2011). The discussion at supervision provided feedback about how well the story was crafted. For the researcher, a well-crafted story aids clarity to the paticipants experience as well as the researcher’s own dialogue with the text. Who we are (being), our thinking, how we act, and what is covered over or forgotten, what the experience of the phenomenon ‘is’ can all be brought to light in such a story (Crowther et al., 2017). Through crafting, we start to make the story our own and begin to make sense of it (understand it). As Gadamer (1976) explained, we are at once interpreting and making the story our own; understanding a story is to ‘always and already’ understand and recognise ourselves within it.

I crafted excerpts from the transcripts that provided rich detail of the participants lived experiences of post-birth conversations. My initial experience was of feeling challenged, as I started to work with the transcripts/data. I felt I could have probed more in those initial interviews to get much richer detail from the participants. One transcript, for example, had only one story that could be crafted to reveal the experience and the phenomenon. The other challenges I faced were to ensure that in crafting the story I included all the relevant material. I had to maintain my focus on the phenomenon (post-birth reflective conversation) so stories crafted did not include conversations that occurred during pregnancy or at the time of labour and birth. See Appendix F for how the stories were crafted from the transcript.

Analysis – Interpreting the Stories

Once I had gathered the stories of the participants’ experiences, and re-confirmed its resonance, it was time to uncover the meaning of the phenomenon of post-birth reflective conversations, within individual stories and across the whole of the text (van Manen, 2001).

According to Heidegger (1927/2011), we always already have a pre-reflective understanding of a phenomenon as we are in it, experiencing and living it. I was also very aware of this as I have been involved in workshops with TABS and provide midwifery care as an LMC midwife. However, the hermeneutic process of interpretation did enable me to examine and challenge my pre-understandings so that I could come to a new understanding/insights (Finlay, 2003; van Manen, 2001).

This understanding occurred as I developed confidence in the interpretation process, where I could sense the meaning of the experience. I needed to learn how to move beyond simply describing a participant's "subjective experience of" or "their particular view [or] perspective" (van Manen, 2001, p. 62) of the phenomenon.

The hermeneutic circle and dialogue of question and answer were two key strategies drawn from the hermeneutic literature and incorporated in this research. The hermeneutic circle is a metaphor for understanding and interpretation viewed as a movement between parts (data) and whole (understanding of the phenomenon), each giving meaning to the other such that understanding is circular and iterative. Therefore, the researcher remains open to questions that emerge from studying the phenomenon being investigated and allows the text to speak; the answers are then to be found in the text. In this context, the text is a creation by the researcher from the participants' data. Understanding emerged in the process of dialogue between the researcher and these texts. The act of interpretation itself represents a gradual convergence of insight on the part of the researcher and the text (Bontekoe 1996).

One of my challenges was to remain focused on post-birth reflective conversations. Some participants had shared conversations relating to pregnancy and/or labour and birth before focusing on post-birth conversations. My supervisors suggested having a big sign that said 'post-birth reflective conversations' with me whenever I was analysing the data. Family illness/dynamics created challenges at times distracting me from giving full attention to analysis. This considerably slowed the process of interpretation.

Following the descriptive analysis of all the stories, I started to look for meanings in relation to each participant's entire section and finally amongst all of the stories of all participants. van Manen (1990) suggested a pocess of "phenomenological reflection" (p. 77) that was used for all stages of text interpretation. Symthe et al. (2008) suggested a circular process of reading, while

engaged in a process of a “circling discipline of reading, writing, talking, mulling, re-reading, re-writing and keeping new insights in play” (Smythe et al., 2008, p. 1393), identified as being engaged in the “hermeneutic circle” (Gadamer, 2004, p. 291).

The approaches that assisted me in coming to deeper understanding and meaning within the participants’ stories were: 1) Supervisors suggesting that I question what was the story about, what was it saying or hinting at? Who instigated the post-birth conversation? What was happening in the story? What were the feelings, words that were used? What understandings lied behind the words?; 2) What was I feeling from the whole text, what in the story touched or generated a response from me. This was extremely challenging until I revisited my pre-understanding, remained focused on conversations being post-birth and either just wrote or talked to others to initiate deeper thinking. Heidegger (1996) suggested that writing, thinking and immersing in stories and being responsive to what the stories were saying to you, enable deeper understanding of the meaning of post-birth conversations shared by the participants. According to Gadamer (2004), the understanding and insights that you come to happen when horizons initially meet and then fuse to give new understanding/insights.

Member Checking

Validation by participants of the accuracy of the data in the transcripts ensures/enhances trustworthiness of the study (Birt, Scott, & Cavers, 2016). The offer of return of transcription to participants was discussed on the day of data collection when they were asked if they had any questions regarding the information sheet and prior to signing of the consent form. When discussing the consent form they were asked if they wished to receive the stories crafted from their transcript to enable them to edit or change their words. Their choice was documented on consent forms and participants were aware that they could contact the researcher if they changed their mind. Eighteen participants indicated they wanted to receive crafted stories. One participant via email communication clarified the context of the crafted story.

During the process of analysis, I realized that the participants and my interpretation will be different as we both have our own pre-understanding, experience and understanding to bring to the interpretation. My uncovering of the unknown or what is not visible does not mean they will uncover it too. We may both interpret what is unknown or concelaed differently as there can be

multiple possibilities. Hence I realised that I needed to be comfortable with my interpretation and own it.

The intention in this study was not to replicate my interpretation with that of the participants. Hence the analysis were not returned to the participants to confirm its accuracy. My original conversations with the participants at the time of the interview would also not be applicable as new understanding/interpretation would have resulted from analysis of the transcripts and the dialogues that results during analysis between the transcript and myself as a researcher. My dialogue with the texts could never replicate the participant's own dialogue of self-interpretation. Interpretation of the data was based on my understanding and experience at that time and did not seek to challenge any other interpretation or that the other interpretations were not to the level of my interpretation. The idea of the hermeneutic circle of understanding is that pre-understandings influences the interpretation, the smallest part of the text interpretated will also be looked against the whole text to ensure understanding and that the meaning of the text is being revealed. Moving back and forth between small parts to whole helped refinement and validation of the meaning of the text. Hence the knowledge was continuously evolving.

This study, in seeking to understand the impact of post-birth conversations, does not profess to have all the answers but aims to deepen how we come to understand the phenomenon of post-birth reflective conversations in the circumstances that surround midwife-woman relationship.

By showing the process of the dialogue between the texts, myself, and the influential persuasions, my assumptions are accessible to others. Gadamer (2004) stated: "The important thing is to be aware of one's own bias so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 269).

Trustworthiness and Rigour

To collect data that is robust, it was essential for the researcher to build and maintain trust (Lincoln & Guba, 1985). Trust between a researcher and the participants had a possibility of generating open and candid data, facilitating a detailed description of lived experience (Attia & Edge, 2017; Geertz, 1973). Such data enabled research to be trustworthy.

The standards of trustworthiness and rigour are essential in phenomenological research. It is important that the findings 'ring true' for those who will read the thesis. According to Smythe et

al. (2008), the researchers are the first to know if their research is trustworthy. Feedback from my supervisors, audiences following several doctoral presentations, and with colleagues who had an interest in this topic area helped to confirm the trustworthiness of the study. The “phenomenological nod” (Munhall, 1994, p. 189; van Manen, 1997) following presentations and discussion indicated the trustworthiness of research.

When the analysis of the excerpts clearly speaks to the essential meanings of the phenomenon, a “phenomenological nod” (Munhall, 1994, p. 189) further suggests rigour and trustworthiness of that particular interpretation. This is when the “essence ... of an experience has been adequately described in language, if the description reawakens or shows us the lived quality and significance in a fuller or deeper manner” (van Manen, 1990, p. 10). The phenomenological nods during the process of this study have confirmed that my comprehension and understandings was drawing near/close to what others might mean/come to understand the phenomenon. However, I was also aware that my interpretation was not the only way to understand the experience of post-birth reflective conversation. According to Schmidt (2006), It “must be left to the thoughtful reader to decide on the accuracy of the phenomenological description” (p. 66).

In this research, rigour has been revealed in a more reflexive way which allows readers to decide for themselves whether the findings are credible or not.

Reflexivity

Reflexivity means that I acknowledge that, as an LMC midwife with a small caseload, I am part of the primary care setting in which such conversations occured. I understand the context and culture of midwifery practice. Such comprehension helped me to understand and analyse the lived experience of the phenomenon. My own pre-understandings are integral to this research. Reflecting on my pre-understandings and my experiences gave me deeper and meaningful insight into the phenomenon and the fact that not all participants think of post-birth conversations in the same way. My professional position in relation to the phenomenon of post-birth reflective conversations and my practice experience has been discussed in previous chapters of this thesis. Shacklock and Smyth (1998) stated: “To not acknowledge the interests implicit in a critical agenda for the research, or to assume value-free positions of neutrality, is to assume “an obscene and dishonest position” (p. 6–7).

Reflexivity was brought to the interview process and when engaging with/considering the participants' stories. It was about being thoughtful about what they were sharing and acknowledging their knowledge and experience of the phenomenon. Their words guided me when I was asking "what are they actually saying?" "What lies behind what they said?" Conversations and feedback from supervisors and colleagues triggered further reflection and analysis. Reading around the topic further helped me develop the concept of meaning. van Manen (1990) suggested that there are other possibilities, other interpretations, which may be much richer reminding me that my interpretation is not the only way of describing the phenomenon of post-birth reflective conversations.

Credibility

The fundamental notion in hermeneutic phenomenology study is of the potentiality of multiple meanings related to the phenomenon. In this study the participants' lived experience has provided the truth or value of post-birth reflective conversations rather than my own experience. I have attempted to represent the participants' realities. According to Sandelowski (1986) the phenomenological study is credible when interpretations are accurate and resonate with people who have had similar expereince, that is they would immediately recognise the experience they had. For Beck (1993), credibility is shown by vivid and faithful descriptions of the lived experience. Such descriptions provide insight that is self-validating, with other recognising the text as a statement of experience (Husserl, 1970). According to Lincoln and Guba (1985) accurately identifying and describing the topic and detailed description of complexities of experience demonstrates credibility.

Both the supervisors have provided comments on my interpretation as well as in writing of the findings. I hope women, midwives, and any other practitioners who engage in post-birth reflective conversations feel their experience resonates with those shared by the participants.

Transferability

A relatively small number of midwife and women participants shared their experience of post-birth reflective conversations. This may result in findings not being able to be applied to a wider population. However, the insights may be of relevance for practitioners who provide care to women throughout the childbirth continuum. Lincoln and Guba (1985) suggested that if the context and assumptions central to research are well described then midwives and other

maternity carers can relate the findings to their own practise areas. Attempt has been made to share wealth of information relating to the phenomenon so readers are able to understand it. This may enable them to see similarities and differences in the interpretation and whether it resonates with their situation/experience.

Summary

This chapter describes how the philosophical approach guided my research question and methods that will be used to meet the requirements of this research. I have talked about gaining ethical approval, considered how participants will be recruited, and the process of interviewing. I have sought to protect and respect the participants. The aim of this research is to draw the reader closer to the women's and midwives' lived experiences, and to illuminate the phenomenon of post-birth relfective conversations and present my interpretations of their experience. The trustworthiness of the findings has to be addressed and confirmed to ensure they resonate with the wider audience. Authenticity of the data and anaysis/interpretation of the stories that preserves/remain faithful to the phenomenon will help to incorportate findings into midwifery practice,

The following chapter begins the analysis of the data collected from the 20 women and 14 midwives who participated. It comprises verbatim narrative excerpts and my interpretation of their stories of post-birth reflective conversations.

Chapter Five: Creating Space for Conversations

"Make time, have an open heart, just let it naturally evolve." (Dee, Midwife)

Introduction

Midwifery literature suggest that consideration should be given to creating space for women, partners, family/whānau, as well as colleagues to have conversations with each other that matter (Baxter, McCrae, Dorey-Irani, 2003; Baxter et al., 2014; Beck, 2004a; Darwin et al., 2017; Fryer & Weaver, 2014; Kitzinger & Kitzinger, 2007; Sheen, Spiby, & Slade, 2016; Thomson & Downe, 2016). These spaces should not be hierarchical, of privilege and power, if working in partnership (NZCOM, 2015), but ones that welcome everyone's input. Space for Heidegger (1927/2011) refers to a relational space; not the geometric or physical environment that we may speak about in the first instance. The phenomenal space is different from the others in that it cannot be measured. According to Heidegger, we can know space in a variety of relationships. Lived space (spatiality) is a felt space, often difficult to communicate, as it is pre-verbal; we do not ordinarily reflect on it. However, we know that the space in which we find ourselves can affect the way we feel (van Manen & Adams, 2011). For example we are likely to feel 'out of place' (Patterson, 1988), anxious, excited, apprehensive when we first enter a birthing unit; while at home we may feel comfort, familiarity, and protection. Home has been described as that secure inner sanctity (Bollnow, 1961; Heidegger, 1971), yet such security can never be assumed.

A space for conversation enables the woman, her partner, whānau, as well as midwives and other practitioners to share their thoughts, raise issues/problems, or seek clarification about the experiences they have had. The experience of interaction often results in mutual understanding and consensus about the way they should move forward (Kemmis, 2001; Kemmis, McTaggart, & Nixon, 2014).

This chapter explores how space is created for conversation and reflects on the experience of women and midwives who engage in that conversational space. Participants (women and midwives) have shared their stories of what was beneficial for them when they engaged in the conversations during postnatal visits. They also talked of experiences that restricted having post-birth conversations.

Feeling Heard

According to van Warmerdam (2015) there are times when we feel we are not being heard. This feeling may be an accurate assessment or it may just be us. Many reasons make us feel like this such as previous experience or people just not hearing or understanding what we say. Not feeling heard can affect our relationship/connection with the other person. Here Jane informs us about her experience of a conversation resulting in mutual understanding with a midwife at the beginning of her second pregnancy:

> *I tried with my midwife to have conversations about the bleeding and fainting that occurred following birth of my first baby. Every time I tried to raise the topic I was met with silence. In the end it became frustrating and she decided that care could be completed at four weeks after Zara's birth.*
>
> *I made sure that when I was pregnant the second time I contacted a midwife who would be open to have conversations. I didn't feel I could move without talking about the previous experience. So my post-birth conversation happened at the beginning of my second pregnancy. I met the midwife and she listened to my experience. It was the first time I felt heard. We planned to meet again once full information of the past event was available. Once we got the notes – I think it took about a month to get all the records, we planned an appointment that was longer than the other appointments to discuss what was written in the notes.*
>
> *The bleeding may have resulted from the uterus that may have been tired due to long labour and hormone not working efficiently anymore. We were able to make a plan with the midwife regarding birthing again in hospital, having fluids and not getting up from bed following the birth too quickly.* (Jane, woman participant)

Jane appears to have been unable to have the conversation about her experience following the first birth. She mentions *"I tried with my midwife to have conversations"* but was met with silence from the midwife. Yet silence is paradoxical. It is suggested that the specific context in which silence occurs will influence the overall conversation as well as impact how it is experienced and interpreted (Madonik, 2001; Muldoon, 1996). Silence in a strong relationship may bring non-verbal messages that speak more than words. In this case, however, it seems to say 'we will not talk about that'. The silence was speaking loudly. Silence can be an easy way to ignore someone or it may convey disinterest. We may hide aspects of ourselves such as knowledge and confidence when we remain silent (Fallon, 2015; Katty & Shipman, 2014). Some suggest that silence is a mystery and it can only be unravelled if you break the silence. It appears that the midwife may not have been silent all the time but when Jane wanted to have conversation about her "*bleeding and fainting"* as she says "*Every time I tried to raise the topic...".* It may be

that the midwife wanted to consider those aspects alone before having the conversation with Jane; however it appears that it was not just one attempt at the conversation because Jane says: "*I tried with my midwife to have conversations....".* Wolff (2011) in his book "*Original Wisdom*" wrote about the 'overload' of our modern environments. Was the midwife overloaded with her practice commitments? There is a sense of exasperation. The decision to end care at four weeks postpartum was not mutual. Jane explains: "*It became frustrating and she decided that care could be completed at four weeks after Zara's birth".* The breakdown of this relationship (from Jane's perspective) meant that her values and needs were not taken into consideration, resulting in being ignored by the midwife.

Jane arranged the appointment with the midwife at the beginning of her second pregnancy. She instigated the creation of a space for communication. However, at the first meeting it was agreed by both Jane and the midwife that once the notes were obtained an appointment should be organised. The creation of the space was with mutual understanding. The planning of the appointment suggests negotiation of a space suitable to both to discuss a previous birth experience with the information now available from the clinical notes. There is a sense of openness to communication, openness for communication, and openness through communication. It feels as if a genuine conversation resulted, because there appears to be mutual understanding *"the bleeding may have resulted from the uterus that may have been tired due to long labour and hormone not working efficiently anymore".* There is a sense of Jane and the midwife coming to unforced consensus about the way to respond to previous concern/issue, in that Jane will *"birth again the hospital, have fluids and not getting up from bed…..too quickly".* There is participation, non-judgmental stance (confirmation), and genuine close relationship suggesting the midwife working in partnership with Jane. In this participation the midwife is reflecting and being self-reflective. She is able to inquire and act upon what has been evaluated as not being a positive experience previously to ensure Jane's next experience is different. There appears to be unity, an agreement of feeling, between Jane and the midwife. There is evidence of common will in this interaction. There is a strong sense in this relationship of being heard. "*It was first time I felt heard".* Being heard is important for both parties. It is a part of healthy communication and empowerment. Ignoring another person or each other has the potential to prevent mutual understanding and the development of trust and support resulting in feelings of vulnerability.

There was a space to reflect and strategise before Jane's next pregnancy. Jane was able to identify the qualities of a midwife she would choose for her second pregnancy. She says "*I made sure that when I was pregnant the second time I contacted the midwife who would be open to have conversations. I didn't feel I could move without talking about the previous experience".* There is a sense of personal growth and purpose in Jane.

According to Heidegger (1962) when we remain slient, we are closing off and making ourselves unavialable to others. Hence, the first midwife was closed to the 'call of other' i.e. Jane, showing the midwife to be unconcerned/uncaring.

Gadamer (1989) said that to understand the person (woman) is to understand the matter being talked about – understand what she is saying rather than relive her experience or describe her experience. Such dialogue creates new understanding of what matters. The difference between the first midwife and the second is that the first shut down the space for conversation, while the second made space for the woman to feel heard and have her concerns addressed.

Being Open

Being open to others is at the heart of being human (Siegel, 2016). It is to live with a sense of curiosity, where every moment is an opportunity for learning, where our existing ideas and beliefs are temporary and flexible. We find what others say interesting. A good dialogue/conversation is one where we learn something new or are persuaded to think differently in some way. Being open means seeing things both as they really are and also as how they could become. We view the world as something that is alive, dynamic, and full of opportunity. However being open can also be exhausting. There are times when we may prefer to be closed and not want to challenge the ideas that are being presented to us. To be in a state of openness requires that we have time for the conversations that may follow.

For Tammy, being open to a conversation results in both the woman and herself coming to deeper understanding about the birth:

> *I was having a conversation with one of the women who had just had her first baby and had come home the day before. Conversation just started about how was it being at home the first night. In the middle of fairly long conversation during the visit I suddenly thought of the conversation's seamlessness and depth. It was one of those moments that neither one of us wanted to end. We were able to talk about our beliefs, thoughts and*

> *stance about birth with such understanding. So different from when you discuss a birth-plan in pregnancy as you have been on a journey together.* (Tammy, Midwife)

There is a sense that although the conversation may have started as a talk *"how was it being home the first night",* it resulted in a deeper communication that was meaningful for Tammy and the woman. The *"seamlessness" of the* conversation suggests that it was not forced. There is a sense of both having open minds as Tammy says "*We were able to talk about our beliefs, thoughts and stance about birth with such understanding".* It feels as if there is a middle ground, agreement, and a feeling of not being judged. Open minds can result in countless areas to talk about as Tammy says *"neither one of us wanted to end".* The "*fairly long conversation" also* suggests both had time or made time to continue to converse. The conversation could have gone the other way. It could have been shallow. Going into the existential depths could have been uncomfortable for both of them or one of them. There is a sense of both being driven to find and create meaning. Both want to connect with each other. Sharing of the birth experience has changed their relationship. Tammy says "*so different from when you discuss a birth-plan in pregnancy as you have been on a journey together".* Would the subsequent relationship have been different if Tammy was not able to experience the woman's birth? Perhaps trust and mutual respect grows through experiencing the vulnerability and intensity of labour and birth?

Buber (1965) perceived open and honest communication as a true encounter between equals. He termed such rare meetings "dialogical moments*"* (p. 158). In I–Thou (Encounter) there is willingness by both to being open. They include the other in their own experience and listen for responses. This reciprocity only comes when you can see into the eyes of an 'Other' and 'Other' looks back into your eyes confirming for both of you the real presence of each other (Buber, 2010). The conversation relating to discussion of the birth plan may have been I–It (Experience) as suggested by Buber (2010) because Tammy recognises the post birth conversation as "*so different from when you discuss a birth-plan in pregnancy".* In the birth plan conversation the relationship is often more one sided and can be manipulated/controlled by the midwife. The midwife may see 'Other' as a pregnant woman needing a birth plan rather than as 'this woman' in 'this' situation. When a relationship has grown into one of knowing and trusting each other, conversation is free to flow more open and honestly.

Making a Space for Conversations

Participants described how they made the transition to a space for conversation by offering a cup of tea, a glass of water, or looking through the clinical notes.

> *After the midwife had finished what she needed to do with Simon* (baby) *and me during one of her visits I asked her if she had time for a cup of tea. If her answer had been 'no' I would have asked her to see if she could make a time for cup of tea at the next visit as I wanted to talk about how I had felt when Simon needed an urgent admission to hospital for high temperature.* (Mel, woman participant)

Mel appears to have thought about the timing of suggesting a cup of tea to the midwife, as she says "*After the midwife had finished…"*. This would ensure that the midwife had time to devote to the issues Mel wanted to open up for discussion. In offering a cup of tea Mel created a space in which they could make a transition from what they were doing previously to having a conversation regarding Simon's admission. In this instance, the midwife accepted the offer, acknowledging Mel's need for conversation. The midwife seems available/open to the uncertain and unpredictable way this conversation could unfold. She accepts the tea likely knowing the woman wants to talk. The midwife is attuned to the cue that the offer of a cup of tea is an unsaid invitation for conversation. Mel was mindful that the midwife might not have time in which case she would have tried to set up a time for the next visit. She reminds us that one person needs to call for 'space' and another needs to agree.

Dell, a midwife, shares her story about opening a space for conversation by offering a glass of water:

> *At some of the postnatal visits when I walk in and I see that the woman is breastfeeding or going to sit down after settling her baby I will ask – a glass of water? When was the last time you had something to drink or eat? When as a midwife I did this the first time, I felt the change in the mood of our appointment so I have continued to do this at some of the visits over the six weeks and shared some very valuable conversations with women that I may have not done so otherwise.* (Dell, Midwife)

There is a sense that Dell is initially surprised to discover that offering a glass of water changed the mood of the visit, opening the opportunity for conversation "*When .... I did this the first time, I felt the change in the mood of our appointment".* Dell learns that in giving her time to the woman she creates a space in which relationship can develop. There is sense of coming

together as equals wherein she shares *"some very valuable conversations with women".* However, there is also an awareness that is not always possible. Dell explains: "*at some visits".*

The offer and acceptance of tea or water enables the woman and the midwife to disconnect from what they were previously doing and transition to a space for conversation. There is a sense that the space they have moved to enables them to feel more at ease. Not accepting tea or water may have a potential to close the space for conversation. It is not the drink itself that matters. This very simple act of hospitality may make the person feel valued as well as put the person at ease and open conversational space. Life is often hectic and the ritual of the offer of tea or water enables each person to slow down and connect to the present moment. It provides a space where boundaries dissolve a little and there is a receptiveness that enables the woman to voice her fears, concerns, and/or confusion.

Gadamer's (1989) description of 'hermeneutic conversations' as 'dialogue' and 'fusion of horizons' is pertinent in bringing to consciousness/light the various contexts that shape the woman's and midwife's perspectives. According to Gadamer, horizons comprise all the values, beliefs, experiences, norms, expectations, interactions, and the context in which these occur. The conversation can lead to joint creation of new understanding about our self, Other, the topic that is being discussed and the encounter as well as the limits of our knowledge. Gadamer perceived understanding as a "melting together of horizons" (Hogsbro & Shaw, 2017, p. 82), because a fusion comes from the dialogue between midwife's horizons and woman's horizons. Gadamer acknowledged, furthermore, that we can never achieve full understanding in conversation(s). Understanding is a never ending process.

Cali describes how such conversations start in pregnancy and then post-birth through using clinical notes to create the space:

> *I give them a full copy of the notes at birth time and ask them to have a read when they feel up to it. It is usually not the first day as they are pretty tired but the second and third day they often say they have read the notes and have comments. Sometimes they are not interested and just say I have read it and that's about it. Over the six week period we do talk more and more about the details. The conversations actually starts antenatally by me creating the atmosphere where they feel comfortable to talk to me, asking about their previous experience and writing the birth plan, things they would like to happen at the birth. This opens the door for them to feel more comfortable talking to me afterwards.* (Cali, Midwife)

Cali begins to create a space for conversation during pregnancy when she seeks to develop an atmosphere in which it is comfortable for the woman to share her concerns. Then she gives women a copy of the notes at time of birth. She is providing the woman time to read the information and raise any questions or concerns. Most women feel confident discussing their emotions and experiences because they have an established relationship with Cali. It is likely that trust has been built in these earlier conversations. Cali shows that she is attuned to the fact that for each woman there is a right time to have this conversation about the birth. Experience has taught her that it is likely to be once the woman is no longer so tired. There is a sense that she knows women should control whether and when to read and comment. The purpose of this conversation, if it happens at all, is to meet the needs of the woman.

Conversations usually seem to start a few days following birth but appear to increase in their depth over time *"Over the six week period we do talk more and more about the details".* Is this because there is further development of trust between Cali and the women? The increasing depth of the conversations suggests engagement and interest in learning more about their experience. But what about the women who are not interested and just say they have read it? How are they feeling? How did they engage in discussion of their previous experiences during pregnancy and in writing their birth plan? Could strategies have been considered to ensure their participation in conversations following birth? Or is it the midwife's assumption that reading the notes is important when, for some women, it may not be something that matters.

Various literature suggest using clinical notes to assist recall of events and note that women expressed the wish to see and read the written record. Others have found that it can help 'mediate' the story enabling negotiation of one version of events from another (Baxter et al., 2003; Dennett, 2003; Madden, 2002). It is important that the woman is heard and her recollection of events acknowledged. Further, that this recollection is not undermined. Yet it is also important to respect the woman's right to simply move on from the birth without specific discussion. As Cali demonstrates, the responsibility of the midwife is simply to open the space for conversation.

Being Creative – The Art of Conversations

There is a growing body of knowledge about the healing power of art (Staricoff & Loppert, 2003; Stuckey & Nobel, 2010) to visualise, understand, and make meaning. Women do not have to be

talented or skilled to benefit from creative activity. Carleton (2017) suggested that “it’s the process not the product” (p. 7). Engagement in artistic activity encourages self-expression and reflection; has a potential to enhance mood, emotions, aid communication, and transport the woman and a midwife to a space of heightened awareness (Christenson, 2013; Pappne Demecs, Fenwick, & Gamble, 2011; Stuckey & Nobel, 2010). It provides a distraction that allows those affected to focus on something positive instead of their health. In the following stories Jess and Suri found solace when creating visual art. It seems they felt safe among their creative work to converse in a different way.

> *I had met Jess as a back-up midwife when she was about 37 weeks pregnant with her first baby. For some reason we seem to develop a really good relationship at this meeting but I was hesitant to ask why she appeared to be on edge. I did ask her whether she was feeling ok and whether there was anything that she would like to talk about and how she was feeling about her first birth experience. I mentioned to my colleague who was Jess’s LMC if she had felt at any time that Jess was on edge but hadn’t noticed anything apart from Jess being hesitant about abdominal assessment initially but was fine now.*
>
> *My colleague was on leave once Jess had her baby and I was involved in Jess’s postnatal care. She appeared tearful and while I was documenting mentioned that being examined in labour was the worst thing she had to go through until she had some pain relief. I asked if it had felt the same when she had smear tests. She mentioned she had never had one and was definitely not having one. I was just going to provide information about smear test when she mentioned let’s leave that for later time. She started walking towards her front door indicating that the visit was coming to an end.*
>
> *As we passed a room I noticed some art pieces on the table and spontaneously said, ‘Gosh that is beautiful’. Jess who was walking towards the door stopped and said, “Would you like to look at them?” I asked, “May I?” to which she turned and took me into the room. Jess became very animated as she talked about each piece of glasswork some still awaiting completion. She called it a hobby that relaxed her where she did not have to think about dark parts of her early life. I continued to let her talk about the hobby where she opened up about her experience of being abused by a family GP who was trusted by all her family members as she was her mother’s friend from their school days. At the time she felt very unsettled and decided to do her nursing overseas so she could be away from the situation.*
>
> *Her husband wanted to have children where their parents were so there was support and she had heard that the GP had moved out of the area. Tom her husband was supportive and knew of her experience. I asked whether she was aware of services that could help with any support she required and nodded – Jess said she would be in touch with them if needed but hasn’t felt the need so far. I raised the issue of support networks again with her later on as I was caring for her for four weeks but she felt she had all the information she needed at that time.* (Dee, Midwife)

During this visit Dee realised that Jess was wary of vaginal examinations and did not want to discuss this further. She had quickly closed the conversation. As they walked towards the door, Dee noticed the glasswork and said "*Gosh, that is beautiful".* Jess invited Dee to examine the glass artwork more closely and, in doing so, opened a space for ongoing conversation. Maybe among her creative work Jess felt safe and empowered to speak in a different way. They first talked about the glass-work and their excited, mutual appreciation changed the mood of the visit.

Heidegger (1971) believed the most fundamental character of dwelling to be sparing and preserving. Jess preserved a safe place for herself by getting involved in glass artwork. *"It is a hobby that relaxed her where she did not have to think about dark parts of her early life".* Jess's response is "to dwell, to be set at peace" (Heidegger, 1971, p. 149). It is a place where she could be herself (van Manen, 2016). Jess's preservation of the space reveals her hidden strength in coping with a difficult past experience.

The relationship between Jess and Dee suggests connectedness in that a 'good relationship' has been formed quickly. What contributes to development of a relationship? Is it sincerity, openness, being more comfortable yourself so you are able to express your true self to other (Jess)? Is it about the midwife being tolerant and accepting of others enabling Jess to feel understood? Even though the LMC had noted Jess's initial hesitance about abdominal palpation she does not appear to have thought that this was significant. Did the LMC unintentionally convey that she was not open? Jess appears not to have shared her previous experience before the birth of her baby. These relationships happened during the pregnancy yet the relationship with Dee postnatally seemed to help Jess to feel more comfortable with Dee's care. The relationship that appears to have developed with ease may have enabled Jess to invite Dee *"to look at them".* Jess could have continued to open the door for Dee to leave.

Earlier in the visit Dee had provided information about a smear test perhaps trying to create a space for further conversation. Jess ensured the space did not open by saying *"let's leave that for later time".* If they had not passed the artwork what would have happened? Would the space have been created later? However, in inviting Dee to come and look at her glass-work, Jess was in control of "her space". Rather than a conversation lead by the midwife's questions, Jess was able to choose what and how much of her past she would reveal. This conversation was on

her terms. In order to speak of her deep vulnerability, she first needed to be in her own safe space.

Perhaps it was Dee's reaction to the glass art-work that enabled this conversation to open? There is a sense of Dee being very wise, insightful and intuitive. A mood opened where for the first time in her relationships with midwives Jess felt safe to talk. Similarly, Lily's question about the artist and where the paintings were bought opens a conversation about experience of pain and anxiety in labour:

> *I went to see Suri for a postnatal visit. She had a normal birth a couple of weeks before, which I thought had gone well. In the end she did have an epidural and her baby needed some support due to distress in labour – there was a time when caesarean section was being considered. In the room in which I was doing the assessment of Suri and the baby, one I had not been in before, there were couple of beautiful paintings of open spaces. Following the assessments I asked Suri "who is the artist and where did you buy them?" Once she finished dressing the baby she said, "I am the artist and the whole process of painting and cleaning helps me cope with the feelings relating to pain and anxiety from labour". I automatically sat down. Suri started talking about her birth experience.* (Lily, Midwife)

Everything initially seems unproblematic to Lily because Suri has had a normal birth, although there were some challenges during the labour. It appears that the "*epidural, baby needing some support"* and discussion of possible "*caesarean section"* were regarded as 'normal' by Lily. They are things that often happen or are expected at the time of birth. However, for Suri, this is something unexpected and unusual, hence her perception is different. A birth considered normal to the professional might be considered traumatic to the woman herself (Axe, 2000).

Lily was seeing Suri and baby in a room she had not been in before. Was this room a place Suri felt more at home in, a place to bring people she trusted? There is an often-quoted line by the American poet Henry Wadsworth Longfellow (1988) "*Every man had his secret sorrows which the world knows not*" (Estes & Sirgy, 2017, p. 16). Perhaps Suri is trying to signal her disquiet by bringing her to this particular room? She seems to want to be clear of the birth experience when she says: *"the whole process of painting and cleaning helps me cope"*. Skov (2015) suggested that one can be trapped in one's own world of cleaning as a way of denying feelings. The statement: "*I automatically sat down"* suggests that Suri's revelation of pain and anxiety was unexpected/shock to Lily. But, by sitting down, Lily made herself available to listen to Suri's experience; she sensed this was the beginning of an important conversation. Skov suggested

that allowing the person to reconnect with her inner feelings enables her to *'feel'* instead of focusing on cleaning. Being able to feel and being allowed to open up and share their feelings no matter how they developed activates people (Lily) to come to her rescue/support. The open spaces in her paintings may be a way of expressing the spaciousness Suri needs to be able to work through her feelings of anxiety and pain.

Gadamer (1989) used the notion of 'play' as a form of self-expression that creates a special kind of lightness and relief by means of expression. Playing helps us to enter art/creativity making free from set directions and goals, so we can be challenged to expand our thinking and achieve greater well-being (Steel, 2015). The significance of the relationship for both Suri and Lily is the conversation they have had about pain and anxiety, both moving together to create new meanings. Suri initiated the space-making play. Lily caught the cue opening the space for the conversational encounter.

Space for a Significant Other

NICE guidelines (2017) suggest that every opportunity should be provided to women, partners, and other relevant family members with information and support they need. Standard nine of the NZCOM (2015) Handbook for Practice states that the midwife *"ensures the woman has had opportunity to reflect on and discuss her childbirth experience"* (p. 26). However Standards one, five, and seven also suggest that a midwife *"recognises contribution of both partners"* (p. 18), *"involves and respects the woman's significant others...* (p. 22) and *"the midwife is accountable...to the wider community"* (p. 24). Midwives therefore also have a role to create conversational space for others. Hine shares her experience of a fantastic birth in a secondary facility:

> *I was at a fantastic birth of a primigravida that I was an LMC to. The birth was so peaceful and calm and everybody supporting her knew what to do without having to talk to each other. It was the most beautiful birth I had been part of for a while – it was in a secondary facility but you wouldn't have known that's where we were. When I visited the woman and whānau after the birth not once but many times I asked "how was it for you all?" All I got was so many big smiles! I kept saying to her and them "you all did so well" and again it was more smiles.* (Hine, Midwife)

The space to have a conversation was made not just for the woman but whānau as well as Hine explains "*When I visited the woman and whānau... how was it for you all?"* They all responded with big smiles, suggesting they were pleased with the experience. There is shared joy in this

experience. Hine appeared to be surprised at having a fantastic birth in a secondary facility. Towle (2015) suggested that the birthing space is sacred, it is where a woman comes into her power, and where a new life is born.

The relationships appear to be reciprocal and positive between all those at the birth. There is a strong feeling of presence, availability and participation – "*everybody supporting her knew what to do without having to talk to each other".* Heidegger (1927, 1962) lists anxiety, love, boredom, and joy as the various primordial attunements (*Befindlichkeit*) in *Being and Time*. According to Heidegger we do not have moods rather we are in moods (Freeman, 2014); we are always attuned in one way or another to how we find ourselves feeling. What we are feeling in turn shapes our experience. It is our mood that brings us the understanding about the events we find ourselves already living through. The mood in which this experience was lived is one of joy. There is no need for verbal conversation. Yet the space is still there, the space of sharing delight.

Isla shares the story about her mother needing to talk about her past experience after seeing her grandson being supported to breathe following his birth:

> *Our son needed to have support to breathe when he was born due to his heart rate playing up in labour. Pete and my mother were with me at the birth. Pete and I had a chance to talk to our midwife and the paediatrician while he was being cared for on the ward but my mother hadn't. When our midwife visited following our discharge home she asked "how is everyone now that you are home?" Pete and I said "fine – great" when my mother asked if she can talk to her about the baby needing support at birth. The midwife asked if she was happy to talk with everyone or go somewhere else. My mother was happy to talk with everyone present. The midwife sat next to my mother and listened to her feelings of watching the resuscitation. She had lost my brother in similar circumstances as he was born early.* (Isla, woman participant)

Asking *"how is everyone..."* enabled a space to be created for Isla's mother to ask if she could talk about her past experience. The midwife had been with all of them at the birth. She also had involvement in talking to Isla and Pete with the paediatrician. Had the midwife sensed Isla's mother's angst at the time of resuscitation that prompted her to ask *"How is everyone...?"* She seems to be open to listening to any one of them who wanted to talk about the event.

There is a sense of a trusting relationship as Isla's mother felt confident and comfortable to ask if she could talk about her experience. Did the journey of birth deepen their relationship further? Heidegger (1927/2011) suggested that the sense of 'Other' is quite broad and includes

ourselves: there is an intimacy with others. Intimacy refers to inner knowledge, presupposes wisdom and connectedness within the relationship. According to Heidegger Being-in-the-world involves Being-with-others. Being-with-others presupposes the possibility of Being-with (*Mitsein*).

The midwife asked where Isla's mum would feel comfortable to talk. Going to sit next to Isla's mother suggested that the midwife was interested and ready to listen attentively. Helping someone open up can be like opening a flood gate. One needs to safely help open gates that may have been locked for some time. The midwife had "*listened to her feelings..."* knowing she may have an unpredictable conversation. There is a sense of being attuned and an understanding of being-with (Heidegger, 1978). The midwife may not be able to take the fear and anxiety away but can ensure that Isla's mother is not overwhelmed by these feelings.

Timing of Conversations

Different timeframes exist in relation to 'debriefing' following labour and birth. Some literature recommends this takes place within hours of birth so that the memories of events are fresh for the midwife and woman. Others suggest 48 hours or up to 16.5 weeks following birth. Phone-based services have discovered that women may contact them 12 months after the birth of their baby (Axe, 2000; Hatfield & Robinson, 2002; Inglis, 2002). Dennett (2003) suggested that women wanted to debrief later rather than sooner after the birth of their baby. Gamble et al. (2002) agreed that debriefing later may be appropriate as women were often coping with the physical demands of childbirth and may not be ready to fully engage in earlier conversations relating to labour and birth. It needs to be noted that women in these studies often had experienced challenges in pregnancy or at the time of labour and birth and may have viewed their experience as traumatic.

The timing is dictated by each specific situation. Cate shares the eagerness that is present to share and listen to a story when one has had to transfer care:

> *We only offer primary birthing so if secondary care is required in labour we transfer women to the secondary facility. It's highly variable when the conversation following birth is started. If the woman is transferred I would probably do it earlier because I am very curious what happened in there – sounded kind of crazy but it turned out so well. When they come back to primary unit they want to engage you in what happened and tell you too – you come to the front door and you are walking by and they are not in the room*

> *yet – they launch on you and they say about their PND and gosh those stitches in the public domain because they so need you to know what happened next in their story – so those conversations happen quickly.* (Cate, Midwife)

Space for conversations appears to be negotiated individually. It happens when the woman and the midwife are ready to talk. There is sense of this woman being eager to share the story as soon she returned to a familiar environment, or perhaps more importantly to a place where she felt 'known'. Cate, the midwife, also shares the eagerness to hear the story of what happened. In a transfer situation something is 'not right' which precipitates the need to move a woman already in labour. It is likely that both the woman and the midwife, although recognising the need to ensure safe care, are disappointed with this turn of events. Their relationship is torn apart amidst the relational experience of labour and birth. On return, it is hardly surprising that when the woman reconnects with 'her' midwife she is keen to tell her what happened. Similarly the midwife wants to be reassured that the labour and birth went well.

There is a feeling of familiarity felt by women on return to a primary unit, perhaps a sense of feeling 'at home' amongst people who know them by name. It is likely that even if the midwife at the tertiary hospital was wonderful the women may still be eager to tell their stories. In a UK study, women became passive participants when transferred and felt they were 'transported' rather than cared for and the care was different from one they experienced in the primary unit (Rowe, Kurinczuk, Locock, & Ftizpatrick, 2012). One imagines it is harder to build a conversational relationship with a stranger when one is in the midst of labour, concerned for the issue that has provoked the transfer. From a phenomenological perspective, there appears to be a 'felt' difference when transferred back to a primary unit, leading to an eagerness to share birth stories. The time for this to happen, from the woman's perspective, is 'right now'.

Cate mentions how creating a space for conversation is different when you have been personally involved in labour and birth care:

> *When it is the birth I have been involved in at the primary unit then it is different and depends – probably let that filter through even for me as I am making decisions the whole birth. I have been changing this as my practice evolves and bringing it a little earlier when they are not tired and snoring away. I try and say 'Is there anything now that you didn't understand happened and usually partners are still there too' – so they are able to bring up anything they didn't understand or say no. Sometimes that say 'you know when you said about the placenta' so you are able to clear up information they didn't understand. Generally around two weeks the other aspects and detailed*

> *conversations happen as they have chance to think back to the event.* (Cate, Midwife)

Cate feels that time for reflection is needed following birth before creating a space for conversation. There is a sense of a need for processing the experience she had been part of before talking about it. The initial question of *"Is there anything now that you didn't understand happened"?* is used to open a space for conversation for women and significant others. The "I–It" conversation according to Buber (1965) allows us to classify, function, and navigate. It gives us the scientific knowledge and is indispensable for life. As Cate says "*you are able to clear up information they didn't understand".* The "I-It" relationship gradually moves to "I-Thou" relationship. Cate says "*Generally around two weeks the other aspects and detailed conversations happen as they have chance to think back to the event".* According to Buber (2010), we enter deeper relationships when we have shared a space and some personal experience together. Such experiences enable us to interact with each other and form a mutual bond. We are face to face (Levinas, 1991) and the distance between us recedes to create a mutual bond. However, in such relationships we both (midwife and the woman/partner) forego some of our freedom to enter the relationship. This relationship may be brief and turn into "I-It" relationship but one that has a possibility to have it turned to "I-Thou" again. Cate's experience suggests that the space for conversations can also happen earlier. However, it needs to be when women are able to be fully engaged in those conversations.

It is not always only the midwife's involvement in labour and birth care that affects the timing of creating a space for conversation. How you or the group you are part of work, and what you consider as quality midwifery care, will affect whether you make time to create a space for conversations. Val tells us about her experience:

> *I have practised in number of group practices over the years. There are some groups where there is an undertanding that postnatal visits should not be longer than 15 minutes and you are questioned by your group members if they note you were there longer than what is the group's decision. While some practice groups including the one I am working in now has no such understanding which is important for me as I do try to open up conversation by asking "how are you feeling?* (Val, Midwife)

There is a sense that Val was not able to create a space for conversation when working with a previous group. The questioning by group members when one has spent longer than 15 minutes at postnatal visit can impact on midwives being able to sustain such practice. Postnatal

care has been called the ‘Cinderella of maternity care’ due to the low priority it is given in many countries (Fenwick, Butt, Dhaliwal, Hauck, & Schmeid, 2010; Waldenström, Rudman, & Hildingsson, 2006). Time constraints have been perceived as a major barrier to effective care (Jones, Creedy, & Gamble, 2012).

In New Zealand, the Maternity Consumer satisfaction survey 2014 (MOH, 2015), found that 99% of women were visited at home by their LMC. Of these, 92% of women received between 6 to 12 home visits after birth. Women with a first baby, young mothers, and women who had given birth at home were more likely to have received 12 or more home visits following the birth. There is therefore opportunity to create space for conversations during some of these visits. Yet, it is important to remember that there needs to be adequate funding to support the time a midwife needs to spend with a woman. When funding systems are divided into time slots of 15 minutes there is no room to open an unpredictable conversation. Without space to sit and listen, women are likely to leave with their concerns unresolved.

Hindering Creation of Space

The three factors identified by the participants that hinder the creation of space for conversation are text messaging, language barriers, and defensiveness.

Text messaging

According to a Midwifery Council NZ (2016a) pamphlet “Be safe – text messaging”, avoiding communicating by text may not be an option as it may make it harder for some women to contact their midwives. Bina shares her experience of how texting impacted on her ability to have a conversation with her midwife:

> *I didn’t notice it so much during pregnancy as most visits were about half an hour but I noticed the constant arrival of text messages to my midwife during labour and at the time of postnatal visits. There was ‘ping, ping’ noise all the time. I felt she was busy and I shouldn’t start any conversation of importance with her as she may have to leave. I did mention once ‘it seems you are busy’ to which she replied ‘yes’. I felt guilty thinking about making her more busy with my concerns about when to start the relationship, how to settle the baby and what should I do if she* (baby) *was unsettled.* (Bina, woman participant)

Ali (2018) suggested that non-verbal communication, including tone of voice, facial expressions and body language, are a crucial when interacting within healthcare setting. None of these communications forms, however, are conveyed via text, and this affects how people

communicate with each other. There is also an expectation of having to reply promptly to each text. Bina feels that the alert sounds that is set when a text message is received *"ping, ping"* can be disruptive. Bina feels she did not have the full attention of her midwife in labour and following birth of her baby, saying: "*There was 'ping, ping' noise all the time. I felt she was busy...*". There appears to be a lost opportunity to create a space for conversation as her midwife answered "*yes*" when Bina asked about her being busy. Pertinent conversations had not occurred because the midwife seemed unaware of Bina's feelings of guilt. Bina, who has had to compete with the phone, has not been able to share her concerns. Nor has she been listened to with empathy and consideration. They might have been together in one physical space but there is potential for Bina to feel overwhelmed because the support she required regarding her own and baby's wellbeing was not provided. According to Heidegger (1962) indifference to another shows our care as being neglectful and uncaring.

Language barrier

According to Statistics NZ Census (2014), 2.2% of the population did not include English as one of their languages. The majority of the adults in this group were born overseas. Complaints about care may arise due to lack of communication relating to informed decision making (Health & Disability Commissioner, 2017).

Ingrid, a midwife, shares a story of trying to explain newborn metabolic screening to the parents who spoke little English:

> *They did not want an interpreter, they felt that confidentiality would not be maintained in their community. The resource is good with visuals so I used it with one of the nurses on the postnatal ward to ensure they had information to make informed decision. The nurse herself wasn't sure of some of the words she could use in their language to explain some of the conditions in the pamphlet. I wasn't sure at the end their decision was fully informed. The paediatrician also came and talked to them but in English and they kept saying 'no' to the test. We had a friend, medical researcher, same ethnicity staying with us and I asked him that if they agreed would he be interested in talking to them. When I visited them at home the next day I asked and to my surprise they agreed. They had a long chat with the pamphlet and to my amazement agreed for their baby to be tested. When I later asked why they looked at him and said 'he is good – names for all these' pointing at the conditions on the pamphlet. The names of the conditions in their language enabled them to understand the condition and the impact on the baby.* (Ingrid, Midwife)

There is sense that Ingrid is working hard to ensure the parents have the information they need to make an informed decision. It appears that the nurse may have been of the same ethnicity but possibly did not share the native language or dialect. She could not think of the words for some of the conditions tested as a part of screening. This is likely to affect the quality of the interpreting. The paediatrician conversed in English and appears to have accepted their "no" because there appears to be no further plan from him. Ingrid suspects, however, that adequate information has not been shared because the paediatrician spoke in English.

What made the parents accept Ingrid's plan to talk to the medical researcher? Was it that they knew that she was trying hard to give them the right information? Was it that they knew that the decision they made was without fully understanding about the test? Did the word 'medical' or the ethnic background of the researcher have an influence? They had a "*long chat*" suggesting connectedness and development of trust, something that did not appear to happen with the nurse or the paediatrician. There is a sense that the final decision was appropriate as the family say *"he is good – names for all these"* suggesting they found him reliable and someone whom they could trust. The person who could speak their native language and dialect helped to create space for meaningful communication.

Being defensive

Steinhaur (2015) suggested that decision making is a complex process which shapes practice and determines the provision of quality of care. Being able to justify our decisions is a professional and legal responsibility. Eva shares her story of having difficulty in conversing with her midwife about breaking her waters in labour:

> *In my birth plan it said to break my waters if it was absolutely necessary. However, my waters were broken when we got to the hospital at 5cm dilatation. I tried to have conversations with my midwife why that decision was made. All I got each time was 'you should be pleased to have had a shorter labour'.* (Eva, woman participant)

There appears to be a deflecting response by the midwife when responding to Eva. Is she trying to avoid a deeper conversation about her decision? Is this because she is feeling insecure with the decision made? What conversations had they had about what was considered "*absolutely necessary?*" What had made the midwife change from the plan that had been made? Was she rushed at that time of Eva's labour and birth? Was she conforming to what may be the culture of

that facility? Eva says "*All I got each time was you should be pleased to have had a shorter labour".* There is no space for a conversation and no sense that Eva had a part in the decision made. There is no reciprocal dialogue and no sense that the relationship is equal or mutual (Gadamer, 2000). Eva's attempts to create a space for conversation were repeatedly foiled.

Summary

This chapter set out to explore how space is created for reflective conversation postnatally. The participants' stories have highlighted that 'the conversation is the relationship'. Without space for conversation, relationships are fragile and can be easily broken.

The stories reveal that it takes one person to initiate the conversation, but the other person has to respond with openness. Such involvement by two people results in creation of space for authentic conversations.

The participants have highlighted strategies which help to create space in non-confrontational ways. They use different types of opening questions to create space; they sit down to document their assessments in ways that are perceived by the other as being available for conversation. Drinks may be offered as a means to transition from the clinical space and comments about the immediate surroundings can also assist movement towards such conversation. These strategies result in a change of 'mood' that opens space for safe conversations. The possibility that the person may not have the time 'right now' may also be considered along with strategies for creating future opportunities.

Where there are strong relationships between the woman and the midwife, conversational spaces flow out of simply being together. One gets the sense from these stories that time is not a problem and there is reluctance to end the conversations by both participants before any issues are resolved. As Jess and Suri's stories illuminate, space is required to talk about things that are otherwise hidden and may persist as a burden for the woman. Furthermore, such space is not just created with women; other members of the whānau also need space to share their experiences.

Heidegger's term for humans "being" in the world is "Dasein", which at one point he describes as "nothing but...concerned absorption in the world" (Heidegger, 1985, p. 197). Dreyfus (1991) explains this Heideggerian concept by saying:

> Current Dasein then is always in the world by way of being in a situation – dealing with something specific in a context of things and people, directed toward some specific end, doing what it does for the sake of being Dasein in some specific way. (p. 163)

It is this idea of humans together "being-in-a-situation" towards specific ends in which spaces for safe conversations are made possible (Heidegger, 1971). In his efforts to bring clarity to his use of the word 'space', Heidegger (1971) explored the meaning of the ancient German word for space (i.e., raum): "Raum means a place cleared or freed for settlement and lodging. A space is something that has been made room for, something that is cleared and free" (p. 154). This quote makes the connection between 'the clearing' and raum. There are the physical boundaries from which a social mood may begin its presencing. For Heidegger there are both physical and non-physical approaches to space (sensed aspects of space). In this quote here Heidegger is addressing physical locations and spaces and the manner in which they are deemed as such by human beings (French, 2015).

The creation of space and conversations within it happen when we "*make time, have an open heart and just let it naturally evolve*" (Dee, a midwife participant). In the next chapter, I focus on the interview material revealing how one 'awaits the moment' for conversations once the space has been created.

Chapter Six: Awaiting the Moment

Introduction

The previous chapter illuminated the ways in which space for post-birth conversation was created by the participants. It highlighted that both (woman and the midwife) need to have the willingness to enter the space before reflective conversation could take place. Within any space, there is always 'mood'.

"Mood" [Stimmung] makes a substantial contribution to the sense that we have of belonging to a world (Heidegger, 1995, p. 67; Ratcliffe, 2010). Although our moods change, we are always in some kind of a mood. According to Heidegger (1995), "moods are a fundamental way of Being, indeed of being-there and this always directly includes being with one another" (p. 67). Heidegger likened moods to atmospheres. He suggested that moods, like atmospheres, are already there, and we exist in them. Moods reveal how we are affected and how things appear to us. That is, moods are a background horizon against which the world is made present to us (Elpidorou & Freeman, 2015). Heidegger's term *Befindlichkeit* refers to the German phrase *Wie befinden Sie sich?* which means "How are you?" (Gendlin, 1978). The term *Befindlichkeit* has sometimes been translated as "state-of-mind" (Wisnewski, 2013, p. 61); however, Embree (2013) suggested that it should not be, because wellbeing, anxiety, and fear are not states of mind. Svendsen (2012) agreed on the basis that this indicates "a form of mentalism altogether foreign to Heidegger's thought" (p. 421). Svendsen suggested that it could perhaps be translated as "disposedness" (p. 421) or, according to Dreyfus (1991), as "affectedness" (p. 169). Ratcliffe (2010) highlighted other translations such as "attunement" (Stambaugh, 1996, p. 134) and "sofindingness" (Haugeland, 2000, p. 52).

Heidegger (1986) emphasised that existence matters to us and anything that matters to us is inextricably tied to meaning. Being in the mood is being outside of one's self as the mood discloses how we are affected by what surrounds us (Svendsen, 2012). Svendsen adds that in absence of mood we would not be 'in the world' and hence things would not matter to us. By not being affected we would never understand our experience.

Not all moods are noticeable. We may, for example, not pay much attention to being nervous when we are doing something unfamiliar. This does not mean we are not in a mood or that a

mood is not there. Svendsen (2012) suggested that strong moods such as grief may make us overlook fainter ones.

This chapter highlights women and midwives' experiences of post-birth reflective conversations related to 'what happened previously'. One or other party in the conversation holds something from "before" and waits for the moment to open a conversation about that event. An ongoing mood informs one or other party that something needs to be said (or not).

Celebrating Birth

For some participants, giving birth was a celebration for them, their whānau and their community. Casey (woman, participant) explains that within their whānau, celebration is about observance, trust, hope, and honouring each other. Niequist (2013) suggested that celebration is a practice of choosing to be truly present in the moments in our lives. She further stated that life can be beautiful, unpredictable, sacred, and chaotic and that celebrating in the midst of these makes the sacredness much clearer. Niequist's suggestion of sacredness becoming much clearer is in the context of Christian celebration. However, it is applicable to celebration of birth. Birth can be beautiful, unpredictable, sacred, and chaotic all at the same time; and celebrating it may make the sacredness of birth much clearer.

Casey shares her story of a birth that was unpredictable, chaotic but beautiful at the same time:

> *I talked to my midwife the following day after the birth of Mia, about how appreciative we were of her taking charge and making an unpredictable birth such a positive experience. She provided care that was just amazing when I was freaking out. Her words following the birth of Mia are ones we will never forget – she looked up at me and said "here's to a strong woman who has just birthed a gorgeous baby". The couple of ambulance staff just outside the room clapped. I had a previous caesarean section and so the plan was to have the baby in hospital. I was getting some back pains but nothing I thought I needed to worry about. Suddenly my waters broke and I could feel pressure. I called my midwife who asked me to call an ambulance and was on her way. When she arrived 20-25 minutes later I wanted to push and when I heard the ambulance arrive I didn't wait. We had Mia within 10 minutes of the midwife arriving. Everybody was running around helping her but she was in control. In our whānau, celebration is about observance, trust, hope, and honouring each other and this birth matched it. It is one I will never forget.* (Casey, woman participant)

Casey had a conversation with her midwife the day after Mia's birth. It appears that the midwife was also open for a conversation, perhaps because it was an unpredictable birth. Appreciation of the midwife, the perception that she was amazing, and the positive birth experience for

Casey, suggests good midwifery care during this unexpected homebirth. This was affirmed for the midwife by Casey the next day. Casey felt safe and able to trust her. Despite what appears to have been some chaos, with the unexpectedness of birth, there is a strong sense of the midwife being in control. There is also a sense of everyone working together.

Casey mentions freaking out; perhaps during the transitional phase of labour. During birth we step into the unknown and fear is a normal part of birth (Reed, 2013). Casey seems to have been well supported when she felt fearful. She says "*She (midwife) provided care that was just amazing when I was freaking out".* There is also recognition and honouring of Casey's power and trust as the midwife makes eye contact, encouraging Casey's strength and telling her that Mia is gorgeous. There is celebration of Casey as a woman and of the birth that was accompanied by clapping from the ambulance staff. Casey claims "*this birth matched it"* in relation to what her whānau considers a celebration. There is a feeling/mood of joy in this unexpected birth. The midwife was attuned to Casey's immediate needs during the phone call in that she could have suggested to Casey to make her way to the hospital rather than calling an ambulance. The feeling of being "at one" with each other (Casey and the midwife) is present throughout this birth. Ratcliffe (2005) suggested that "feeling" is not restricted to emotional feeling but to being part of something and "being there" (p. 43). He further stated that these are all ways of "finding ourselves in the world" that is we are "in it" (Ratcliffe, p. 43). The midwife arriving in time and "being there", being "in it" made the birth a positive experience for Casey. She wanted to let the midwife know this the next day. Their conversation was in the mood of celebration. They each needed to acknowledge their relief and delight that it all turned out well.

Jane shares her story of a positive second birth experience, following a plan made in early pregnancy:

> *My midwife visited us the next day and said "well, how do you both feel with the birth in a primary birthing facility?" We just had beaming smiles for her – we were made to feel even with change in place of birth* (when Jane was in second stage and wanted to push, the decision was made to go to the nearest birthing centre) *that we were expected in that facility, we felt safe and protected by the midwife and the other staff who cared for us for a few more hours after our midwife had left. The blood loss this time was less – 500mls. Our midwife discussed this while I was having skin to skin with my baby as she was weighing the pads to get an idea of the blood loss. My plan to get up slowly after the birth when I felt comfortable was supported – there was no indication of hurry by anyone that was involved in our care. The place may*

> *have been busy but we were not made aware of this.* (Jane, woman participant)

I introduced Jane in the previous chapter, seeing the midwife in early pregnancy to discuss the plan of care for the present pregnancy once the clinical notes were available. Jane had not been able to converse about her experience with that midwife following the birth of her first baby. In this story, the new midwife had encouraged a reflective conversation with Jane and Nath by asking *"well how do you both feel?"* Perhaps, all of them wanted to have the conversation; Jane and Nath because of their previous experience, and the midwife because of the change in the place of birth.

The post-birth conversation was instigated the day after the birth. This may be due to the midwife being aware that for Jane and Nath the experience needed to be different from their previous experience as well as the fact that the birth occurred in a different facility from what had been planned (hospital). Perhaps if the plan had been to birth in a primary birthing facility, and Jane and Nath's previous experience had been different, the timing of the post-birth conversation may have been different.

"Beaming" by both Jane and Nath suggests a smile that is radiant, wide, and happy, lighting up the conversational space. It conveys a sense of being thoroughly pleased/glad, happy and proud of what has been achieved. It may also indicate their readiness to open-up and expose part of themselves, that is, talk about their experience/achievement. Or maybe the beaming smile 'says it all', that there is no need for a post-birth conversation. Perhaps being open was easier for Jane and Nath given that they had been able to talk about their last experience with the midwife before making a plan for the present pregnancy? The feeling of pride, in this instance, is conveying Jane and Nath's sense of feeling well pleased, satisfied and very appreciative of the latest experience.

It appears that the midwife and the staff in the primary birthing facility knew the care they needed to provide as Jane mentions "*we felt safe and protected by the midwife and the other staff who cared for us".* The feeling of being safe and protected suggests the midwives followed the plan made by Jane and Nath. There appears to be the presence of trust and confidence enabling a positive birth experience for Jane and Nath. There is engagement by all involved in the care. There is a sense of the midwife being present even though she had later handed over

the care. Prior to the birth the ‘mood’ was one of ‘anxiety’; however after the birth the ‘mood’ becomes one of celebration.

Buber (2010) suggested that when we engage with others in the mode of ‘encounter’ (I–Thou / I-You), we have a deeper understanding of each other and our world is transformed due to shared understanding. The mode of I-Thou / I–You, is fleeting but we are more likely to enter the mode if we have encountered it before. Heidegger (1962) argued that engaging is a pre-condition of “being-in-their-world” (p. 26). It is only by engaging with others in a caring and attentive way that we discover common opportunities and shared goals/vision. This enables us to create common contexts and ‘worlds’ that enable shared understanding. Jane, Nath, and the midwife experienced ‘being on the same page’. The essence of Heidegger’s care is expressed in authentic existence (Heidegger, 2005). It is active, assuming its responsibility, and manifests itself in its daily life through the possibility of openness to the world (Cestari et al., 2017). Jane was vulnerable due to change in place of birth. The condition of vulnerability calls for authentic care, in which the Being has the possibility of recognising his anguish and transcending, to go beyond his own existence. Authentic being with others is to “care for” (Fursorge). When we engage in caring in an attentive way we enable them to be who they are or what they are capable of becoming. Authentic engagement ‘lights’ up people. It makes them feel supported, understood and opens them to their ultimate possibility. Such connection between a midwife, woman, and her significant others results in richer and rewarding experience which sustains the midwife in her practice and leaves the woman/family feeling satisfied and grateful for the care they received.

Nicky, a midwife, shares an experience of a joyous birth:

> *When you have a birth that you buzz about and we have shared that birth – a primip birth – I went about smiling for a long time. It was a beautiful birth. We didn’t need to tell Cassie that – she didn’t need that either. She had moved on as well. There are women who will take it in their stride. I don’t think it is necessary to have conversations all the time and not all women need a big blurb about it.* (Nicky, Midwife)

The ‘buzz’ suggests that the birth was stimulating, exciting, beautiful, and exceptionally good for all involved. Perhaps the ‘buzz’ was present as it was Cassie’s first birth or perhaps something extraordinary had happened at this birth. There is a sense of elation and reciprocal relationship. There is affirmation of full participation by all in this experience. According to Nicky, the woman

did not need to have the conversation; she knew the buzz the birth created. There is a mood of joy in this birth and being-in-the-world. Attunement is being aware of and responsive to another. During such experiences there is no need for conversations. It can establish a sense of security within a relationship enabling a new mother to explore her world of motherhood.

Casey, Jane, and Nicky's stories suggest the mood of joy at birth is visible for all to see. Crowther, Smythe, and Spence (2014a) speak of the experience where there is atmosphere or mood surrounding the occasion. Such births may not need verbal conversation to affirm their positive outcome.

Being Supported

A woman may need to acknowledge a need for support and accept support available for her. Personal and societal expectations of parenthood can make a woman and whānau feel that they are failing when they recognise they cannot cope without support. It may also be difficult for a woman to ask for support if she has not needed help during her previous childbirth experiences.

Dina shares the story of a woman whose second childbirth experience was challenging:

> *I got this beautiful card and a present from a woman I had provided care to for the second time. First time her pregnancy was normal. Near the end of the second pregnancy her blood pressure went up and they had to induce her. Following birth of her baby she remained unwell with her blood pressure being high and not passing urine well. Her lactation was affected. She was really concerned as she had not had these problems in the first pregnancy. I visited her daily while she was in hospital which was 10 days and then at home, gradually seeing her once a week before completing the care. With expressing three hourly we managed to increase lactation and apart from few days of topping up she was back to breastfeeding. In the card she said "thank you for being with me, affirming I had the capability and strength to do this in spite of being unwell initially".* (Dina, Midwife)

This post-birth feedback had been given by the woman sending a thank you card to the midwife. Dina appears to have provided not just physical support but emotional support (continuous presence, reassurance, and praise), information and guidance to the woman. The fact that the woman says *"thank you for being with me...."* suggests that Dina provided continuous support from labour and birth to postpartum over four to six weeks following the birth of her baby. Dina may not have even realised that the manner of her care affirmed the woman's ability and strength to meet the challenges she was facing. Was this influenced by her looking after the

woman before or were her strength and capability evident in the presence of recent challenges? There is a sense that Dina and the woman worked together as Dina says, *"we managed..."* Perhaps being able to breastfeed without giving formula top-ups provided affirmation of being a capable mother in spite of challenges the woman faced. There is gradual spacing of visits prior to completion of care, as the woman develops confidence suggesting Dina being attentive/attuned to the woman's ongoing needs.

The card did not just say "*thank you*" but articulated what the woman had gained from the experience, i.e. realising her own capability, resourcefulness, and strength. The woman did not need to write a note for Dina. Writing requires thought and effort. There appears to be a strong bond/relationship between Dina and the woman. The card affirmed that Dina provided good quality care to the woman. Bergum (1992) stated that the midwife and the woman affirm each other when they collaborate as two living "I" beings.

Perhaps writing a letter enabled this woman to express her thanks in a way that was easier and more formal than in a conversation. The card accompanied a gift. Presumably the 'cost' of this gift was such that Dina felt comfortable receiving it from a client. Together, the letter and the gift, demonstrated this woman had 'taken the trouble' to express her thanks. Maybe in conversation a 'thank you' is brushed aside, quickly forgotten. The gift and the letter have been remembered long after the moment.

Being Closed to Another

Open communication occurs when we are able to express ourselves to each other. Gibbon (2010) suggested that to communicate openly, the relationship needs to be genuine, non-judgemental, respectful, and empathetic (being able to feel what the other feels).

Brea shares her story about being unable to talk to her midwife:

> *I had a conversation following birth of my son* (first baby) *with my GP and a counsellor. This was about 8 weeks after his birth. I couldn't have the conversation with the midwife I had as when I mentioned to her that I hardly saw her but saw her different group colleagues* (they worked in group of 6) *she replied that she had mentioned about working in a group and that though she was my midwife I would see her colleagues at times. I mentioned that what I had not expected was to see her only twice over 9 months. There was no response to this comment from her. I subsequently spoke about feeling anxious and panicky, about the third week following the birth of my son. Her response was that every first mother feels like that and it disappears as*

> *confidence increases. I felt she didn't want to discuss any real issues that I had so I raised no further concerns with her.* (Brea, woman participant)

Brea attempted to have conversation(s) with the midwife in the first three weeks following the birth of her baby. However, because the midwife did not appear receptive to such conversations, Brea finally had a conversation with her GP and a counsellor when her son was eight weeks of age.

What was the quality of the relationship between Brea and the midwife? Brea mentioned "*she hardly saw her but saw her group colleagues and had not expected to see her midwife only twice over 9 months".* It appears that the midwife's ability to develop meaningful relationship with Brea was compromised by the way this group worked. Perhaps it may be that within the group's philosophy the emphasis was on midwives being able to sustain themselves in practice rather than the women being the central focus? Brea certainly appears to sense that she was not the central focus in this relationship. Brea remembers feeling "*anxious and panicky".* The midwife's response that "*every new first time mum feels anxious and panicky*" may have affirmed for Brea that she was not unique in having such feelings but she felt dismissed as a person. If a midwife is to be supportive, she also needs to be supported and nurtured. This raises questions about the group's capacity for creating an environment of nurturing/support for each other and/or whether the midwife herself feels supported in her private life.

To be open we need to hear the 'voice' of the other, understand voice dynamics and body language so new understanding/meanings are created together. When someone is silent, still (motionless), and expressionless (unresponsive) they may be perceived as being inscrutable, unreadable, unemotional, unavailable, guarded, and closed. We learn early in our life that ignoring another person is impolite and disrespectful so when we do not get a response we feel hurt, resentful, frustrated, and puzzled. Some people can be reserved or uncommunicative (taciturn) and terse while others can be talkative (verbose).

The midwife in this story evoked an ongoing mode where the woman felt as if her concerns were not taken seriously. It seems that mood now went before the midwife, meaning the woman no longer made any attempt to seek her support. Mood becomes comportment (Heidegger, 1995), the way a person is perceived to be. Being closed to the 'call of other' the care demonstrated by the midwife is one of being unconcerned/uncaring.

Meaning of Good Practice or Not

Receiving good care can encourage the person to feedback without having to wait for the right moment. Being satisfied with care increases the feeling of pleasure, interest, and mood (Diener, Fujita, Tay, & Biswas-Diener, 2012).

Fina shares her experience about being able to be involved in decision making during pregnancy, labour and birth:

> *I decided to have the conversation with my midwife, I think it was the second day following the birth. I couldn't wait. We were so pleased with how every aspect of care and any plans made were fully discussed with us. We were given relevant written information that helped us make decisions about pregnancy and birth. We didn't at any time get a feeling of – ok we have discussed that area, let's move on – it was always open for discussion and our decision to change. We knew we could call her or the midwife backing her up if we were concerned. We made the decisions. We really valued that.* (Fina, woman participant)

Fina decided to open the conversation with her midwife on the second day following birth of her baby. She expresses a strong feeling of being pleased and valued. Both she and her husband were able to participate in decision making: *"We made the decisions. We really valued that".* Such participation reveals that Fina was at the centre of care. "*We were given relevant written information"* and *"we didn't at any time get a feeling of - ok we have discussed that area, let's move on".* There is openness on the part of the midwife and Fina is aware of choices during pregnancy, labour and birth, and able to influence the decisions made. Perhaps not all women and whānau are interested in being actively involved in making decisions about care. Being able to make decisions suggests being in control of their pregnancy and the birth experience.

Fina made a point of opening a conversation with her midwife just two days after the birth to affirm the manner in which she had involved them in decisions. She clearly wanted her to know how important this was in giving them a positive experience. She did not take it for granted that all midwives would work in this way. Fina thus helped to show her midwife the meaning of 'good' practice, and how it shows itself from the woman's perspective. The mood of pleasure overrides Fina's needs to await the moment to have the conversation – for her that was the right moment.

Fina's story exemplifies the midwife 'being-with' as care. Dreyfus (1992) suggested authentic caring is through a stance of "serene openness to a possible change in our understanding of

being" called *Gelassenheit* (p. 339). According to Heidegger (1996) when you experience *Gelassenheit,* you experience the openness where being – being of midwives and being of women – reveals itself. There is a clearing where being is no longer concealed. This is how we come to understand our "being-in-the-world" (p. 125).

Jo, in contrast, shares her story of how her needs were not met by the midwife's decisions:

> *After talking to my mother I got the courage to have a conversation with my midwife. I needed to wait for the right time so she had time to hear what I had to say. I felt her care was not flexible and tailored to meet my needs. It wasn't just during pregnancy when timing of the appointments were made to suit her. In labour I didn't have her support to be upright but had to be on the side as she birthed women on the side. I felt the care even following birth was not flexible and tailored to meet my needs but as a checklist that was gone through at each contact. Her response was that women had appreciated what she suggested and hadn't provided any negative feedback to her suggestions. I felt she wasn't open to discuss what I had wanted and how I felt. However, at one of the visits she sat down to complete her documentation. As soon as she had finished the documentation I asked if I could have a conversation with her. She nodded and I carried on. I got the opportunity to share with her how I felt.* (Jo, woman participant)

Jo made the decision to have the conversation with her midwife, but waited until she knew the midwife had time to have conversation with her. It is a decision that appears to have needed some thought as Jo says "*After talking to my mother I got the courage*..." and "*when she completed the documentation".* Perhaps talking with her mother enabled Jo to connect to her feelings as she got the courage to open up the conversation. Just as Fina wanted to help shape her midwife's practice by affirming it, Jo wanted to shape this midwife's practice by telling her what had not worked in their relationship. There was the danger that the midwife might hear this as criticism and become defensive.

This midwife's mode of engagement with Jo reflects an I–It manner of relating (Buber, 2010). Jo says it felt like *"a checklist that was gone through at each contact.".* Saying care was inflexible suggests Jo experienced a lack of atttunement to her specific needs. From Jo's perspective there appears to be a lack of "*active listening"* and not *"being there*" suggesting a relationship not built on trust. Jo was left feeling she was not being considered in the decisions as well as not being acknowledged as to how she felt. Perhaps the midwife lacked the confidence of supporting birth in an upright position. Perhaps she had simply developed 'her' way of doing things and had not recognised the need to involve the woman in the options of care. There

appears to be a sense of this midwife being closed for conversation – is this because of lack of time or lack of confidence or that she did not perceive the need for openness. Such interaction by the midwife made Jo wait for the right moment when the midwife was going to be more receptive to Jo.

Daesin means “being-there” (Heidegger, 1996, p. 112). Dasein, for Heidegger, can be a way of being involved with and caring for the immediate world in which one lives, while always remaining aware of the unexpected element of that involvement, of the priority of the world to the self, and of the evolving nature of the self itself. The opposite of this authentic self is everyday and inauthentic Dasein. Authentic existence involves an element of choice not found in inauthentic existence (Heidegger, 1962).

Caring can be more prescribed than authentic, for example, using the checklist to complete postnatal care/assessments for the woman and her baby. The checklist may not always be there in front of the midwife as an item to complete but it may be in her head/mind that she is using to complete a set of tasks. This may help to ensure all areas of care are considered in provision of care. However, this type of prescribed human relationship lacks sincerity, collaboration, connectedness, reciprocity, trustworthiness which are important for developing meaningful relationships with women/whānau (Kirkham, 2010). Carmack (1997) suggested that such detachment can enable us to make conscious choices of what we can handle emotionally and practically at that particular time. We may therefore provide care that is task orientated or not personalised. Such care in the short term may be beneficial but can lead to stress, burnout, and lack of satisfaction in the midwife in addition to women and whānau feeling unhappy about their care.

Jo had the courage to approach the midwife on what she had experienced as poor practice. The initiative, in this post-birth conversation, lay in the hands of the woman. While women are able to give feedback about their midwife to the College of Midwives (NZCOM, 2015), Jo chose a face-to-face exchange. Perhaps in doing this she was demonstrating her own ‘care’. She wanted the midwife to understand in a manner that would help her to provide better care to other women. Nevertheless, a conversation is always “in play” (Gadamer, 2000, p. 101). She would have no way of knowing how it would play out. Would the midwife listen, or become defensive and close down the conversation? Jo could only try to get her voice heard.

Meg shares her story of not wanting a caesarean section but having to have one:

> *I had a conversation with my midwife in the first week following caesarean section. She had gone an extra mile to ensure that the caesarean section did not proceed until I consented to it and I wanted to thank her for being an advocate for us. I wanted her to understand the reason behind my firmness not to have caesarean section. On the day I had found out I was pregnant an extended family member had not survived surgery. My labour was 16 hours as progress was slow I had all the interventions to speed the labour up with no success and a decision was being made by the doctors in the room to go for caesarean section. I had been firm with my midwife in pregnancy that I was not going there. She asked numerous times "what if" and did I want to have conversation with the doctors but I refused to go there. My midwife knew I was not happy with the discussions and decisions being made in the room during labour. As the baby was fine she asked if the family and I could have some time to talk this through and come to a decision. A number of staff members were not happy, as they wanted to get on with it. However, my midwife persuaded that giving time to us would be appreciated. I came to a decision with my partner and family 2 hours later, the time we would not have had without her persuading the staff.* (Meg, woman participant)

Meg decided to have the conversation with her midwife in the first week following the birth of her baby. There is recognition/acknowledgement that the midwife had made a special effort to ensure that Meg had been given time to come to her own decision. She mentions wanting to thank the midwife for being her advocate. It appears that going through the experience during labour and birth had enabled Meg and the midwife to develop a trusting relationship that laid the basis for the post-birth conversation. Perhaps it is easy 'not to go there' or confront any anxieties during pregnancy because contact between the woman and midwife is shorter than during labour and birth, especially if the labour is long. Longer time with each other exposes each to their own and other's vulnerabilities and reveals how we behave, conduct ourselves. There is a sense that the midwife puts Meg's case professionally to ensure good communication with all involved. Perhaps this was possible because the midwife knew what Meg wanted and needed. Meg mentions that the midwife had to persuade the staff for more time so she could make the decision about caesarean section. This suggests that the midwife had to convince/coax the unhappy staff why it was important for Meg to come to/make her own decision. It also suggests that she may have had to make sustained effort to convince them of more time because it took two hours for Meg and family to come to the decision. Perhaps negotiating further time was possible by the midwife because the baby was fine. There is a feeling of the midwife being 'at one' with Meg, who says: "*my midwife knew I was not happy with discussions and decisions...".* Different communication style or behaviour from the midwife could

have resulted in a tense situation resulting in negative outcome/feelings for all concerned. Instead there is a lifting of the mood and hopefulness. It appears that the attitude and the behaviour of the midwife contributed to these moods. Thanking the midwife affirms that the care and support she provided during this time was appropriate for Meg.

Meg mentioned that she could not respond to the midwife's 'what if' and meet with doctors during pregnancy. She had lost an extended family member during surgery just as her pregnancy was confirmed. However, she was able to do this with the midwife before she completed care.

Heidegger (1962) suggested that moods have an effect on the atmosphere and can indicate "how we are doing" (p. 173). There is a sense of the midwife ensuring that the relationship was maintained to enable a positive outcome; allowing Meg to open up about her anxiety in her own time in the first week following birth. The way the midwife conducted herself during labour and birth enabled Meg to open up about why she was reluctant to discuss caesarean section during pregnancy.

Marie shares a story of a woman who did not have the time to make the decision for caesarean section:

> *I looked after a woman who was adamant of not having a caesarean section. During birth-plan meeting I could see her not connecting to the conversation about the possibility of caesarean section though her partner Jeff was asking all the questions. I tried number of times over the weeks to see if anything might help her to talk about how she would feel if this happened in her labour without success. In established labour she suddenly had a big bleed and was rushed to theatre for emergency caesarean section. Everybody accepted her silence as consent, she got her partner to sign the form as she was shaking and closed her eyes when I said you can tell me how you are feeling. Following birth of her baby over weeks I gently filled the gaps she may have due to having a general anaesthetic about what happened with little response. Around week four postpartum she said "thank you" as I was getting things together to end the visit. As I looked up she said, "I needed time to think things through as a friend of ours lost her baby after a caesarean section". I couldn't talk about it before as my sister laughed at me when I raised my concern to her in pregnancy. I thought others might feel the same though Jeff was saying "no". I have been listening to you and talking with Jeff so I have really appreciated you engaging with me and talking with me about the experience and after your care where to seek help if needed.* (Marie, Midwife)

The woman opened up the conversation a month after the birth of her baby by simply saying "*thank you*". There is some sense of Marie being frustrated with no response about caesarean

section as she says, "*I tried number of times over the weeks..." and that the woman had "closed her eyes when I said you can tell me how you are feeling".* Perhaps there was some self-doubt on Marie's part in relation to the woman not engaging with her about the caesarean section. However, Marie continued to share information and maintain professional engagement with the woman. The woman's appreciation would have affirmed for Marie that the way she continued to engage with the woman met the woman's needs. It appears that the woman did not feel she could talk about the real issue until she felt safe to do so. Perhaps the woman had not talked to Jeff about her sister's reaction when she shared how she felt about her friend's loss. There appears to be some relationship issue with a sister, which may have affected the woman's ability to trust others. However, the woman trusted her partner Jeff and she had trusted Jeff to sign the consent form at the time of caesarean section. There is a sense of a strong relationship between the woman and her partner.

Jeff has not appeared to 'talk' for his partner. Perhaps, in their conversation, they came to a decision for the woman to talk when she was ready or he felt that she needed to have the time to talk on her own terms.

Once the conversation was opened, Marie seems to have been listening because she looked up, suggesting that she stopped getting her things together to end the visit. Marie is silent as the woman is talking. There is affirmation that the woman had been listening all along. The relationship between Marie and the woman was maintained as perhaps there was engagement from the woman in other aspects of care. The continuous information sharing by Marie, demonstrates her persistence in maintaining professional engagement with the woman. There is a sense of Marie being patient - showing the importance of waiting for the woman to open up when she is ready.

For Heidegger there is distinction between the subtle mood of anxiety and fear (Critchley, 2009a). Heidegger's claim is that fear is always fear of something threatening, in this instance the loss of the baby following caesarean section. The loss of the baby was likely to be attributed to something other than the caesarean section. Anxiety is being anxious about being-in-the-world. We glimpse our authentic self in anxiety – that is we are self-aware. This woman needed four weeks to feel free to open up to a conversation. Four weeks had reassured her that her baby was safe and well.

Breaching Trust/Confidentiality

According to Flores and Solomon (1998) trust is a dynamic aspect of human relationship. It is always relational. Trust has to be initiated, maintained, and at times we may need to restore it. Flores and Solomon further suggested that the word "trust" (p. 206) is misleading as it seems to point to an entity, a thing. It is better to use "trusting" (Flores & Solomon, 1998, p. 206) as an activity, a decision rather than a noun. To be trusting we need to know, recognise that the person is trustworthy, yet that is always open to change. The participants share the story of trust within the woman-midwife relationships.

Tina, a midwife, shares the story of a woman making a decision without discussing it first with her:

> *I was really frustrated with a woman who made a decision without talking to me first. The decision was of engaging an obstetrician for shared care without talking it through with me. Luckily the obstetrician was happy for me to continue to be an LMC and remained in the background in case the woman needed any specialist input. A few days following the birth of the baby I raised with the woman her reasoning for having a specialist in the background. She said her friend advised her to engage a specialist just in case. I further probed "did you not feel you could talk to me?" She replied that her friend had informed her that midwives do not like working with private obstetricians and since I didn't ask her the rationale at the time of engaging the specialist she assumed that may be the case.* (Tina, Midwife)

This is another courageous conversation, this time initiated by the midwife. A few days following the birth of the baby, Tina asked the woman for her rationale for engaging a specialist in her care. It appears that the conversation did not happen at the time Tina was informed of the specialist's involvement in the woman's care. Perhaps there had not been a conversation about choices in childbirth often shared at the first meeting? Perhaps the philosophy of the woman and Tina were not similar, hence the woman taking her friend's advice rather than first having this conversation with her midwife? Guilliland and Pairman (1995; 2010a) suggested that partnership relationship should be based on trust, mutual sharing of knowledge, informed decision making, and reciprocity. In making the decision the woman's action suggests a potential challenge to their trusting relationship, perhaps undermining the ability to openly share information with each other and reciprocal respect. Perhaps the woman sensed Tina's frustration at the news of her involving a specialist in her care and felt uncomfortable and at a loss for what to say? Tina may have felt that saying anything further while she was frustrated

would jeopardise the ongoing relationship and may not resolve the tension. It could also instigate or indicate distrust. It appears the trust within the relationship may have been stabilised by the specialist being happy for Tina to remain as the LMC and for him to be in the background for any specialist input if required. It seems that the quality of the initial relationship between Tina and the woman may have affected the quality of their communication. The woman initially appears to be influenced by her friend. As Tina did not ask for a rationale for engaging an obstetrician the woman assumed that her friend was right about midwives not wanting to work with private obstetricians. Such assumptions have a potential to hinder effective communication when the relationship was still developing.

In choosing to raise this conversation after the birth, perhaps Tina, like the woman in the previous story, is focused on helping the woman understand how to handle this situation 'next time'. Perhaps with both now knowing that the birth had gone well there was an increased level of comfort in asking this question. It seems that Tina has been considering this question for several months. Perhaps bringing it up was for her own sense of 'need' to clear the residual tension.

Dealing with tension is a strong catalyst for challenging conversations. Leah, a woman participant, shares her story about the midwife breaching confidentiality with a friend they both knew:

> *It was following the birth of my daughter. I was having a hard time adjusting to being a mum. Due to the general anaesthetic for caesarean section I didn't initially feel a good bond with my daughter. I shared this with my midwife. Within couple of days a friend called me to say she was coming over as I needed support. It appeared my midwife had talked to her* (friend) *without asking me if this was ok. I was really angry and said this to the midwife when I next saw her. She apologised straight away and said she could see how it was not appropriate. It would have been easy to have ended care with her but she had so many special qualities and we had a really good relationship so far that I did not want to lose her as my midwife.* (Leah, woman participant)

Within a relationship there is an expectation of privacy. Leah highlights a breach of the privacy when she says, "*It appeared my midwife had talked to her (friend) without asking me if this was ok".* It seems to have affected their relationship of trust as Leah was really angry. Special qualities suggest that for Leah her midwife, in other regards, fulfilled her expectations of good care. When Leah challenged the midwife about how inappropriate it was to share personal information with her friend, it seems that the midwife recognised afresh what she had done and,

in hindsight, recognised *"it was not appropriate".* There appears to be a reflection by Leah following the anger. It seems that the ongoing relationship was maintained because the midwife apologised without hesitation and the woman was reluctant to end the relationship on one negative aspect of care, suggesting acceptance of the evolving nature of trust. The paradox of this tension is that it was likely born of 'care'. The midwife's concern for Leah prompted her to encourage a friend to visit. She is unlikely to have meant harm. Yet Leah felt harmed. The conversation has begun to reveal how that situation came about.

Flores and Solomon (1998) suggested that when we create a relationship of trust we take a risk. In a trusting relationship some power is transferred or given up to the person who is trusted (a woman or a midwife). They may therefore make a decision that may not always be what you may make. Trust defines our relationships – our 'being tuned' – to the world. 'Being tuned' to the world comes from Heidegger who talked more about mood than emotion or 'affect' (Flores & Solomon, 1998). 'Being tuned' in the interaction/relationship creates trust. Authentic trust is the trust that is reflected upon, its risks and vulnerability understood. According to Flores and Solomon (1998) authentic trust not only accepts distrust but "embraces it, transcends it, absorbs it, overcomes it" (p. 213). Authentic trust sees clearly what trust remains in the relationship.

Summary

In all the stories either the midwife or the woman or at times both had been affected by the other and it mattered to them. The mood that resulted from being affected has prompted the conversation. This opened up an area within which something could be represented. Mood reveals something about the participant(s) and about the world as a whole, all the things experienced in light of that mood. However, the conversations did not happen at the time of the event itself. They happened after the 'big event' of the birth itself. There are conversations that 'wait' for the 'right' time, so patience is essential. Some of the stories have related directly to the birth, while others to an issue that had pervaded through the pregnancy care.

The participants have all thought about the effect on them of something said or done, becoming self-aware, at times talking to others about it, before raising the issue with the 'other' (midwife or woman) to address the impact on them. There is deliberateness in these conversations. The participants have already in their mind decided they want to talk about 'this'. There is a sense of

them having almost ‘rehearsed’ it in their mind. They have remained resolute – ‘I am going to do this.’

Perhaps having continuity of care enabled the woman and the midwife to see other positive/good qualities in each other. They have been present to what it is, noticing the special qualities that exist even in the midst of care that may not have been ideal. They have moved from thinking about themselves to other-centeredness and the emphasis on practicality and the wholeness of the relationship as identified by Heidegger (1962). This appears to have influenced their decision not to end the relationship on an issue that adversely impacted on care. They have instead decided to have an open discussion that could result in change for the future interactions/care. To open a specific conversation is to choose hope, not knowing where the conversation may lead. This requires courage and enabled each to learn and grow from the experience. Relational continuity is a paradox. It can bring expectations that could become challenging to meet. However, the participants have shown awareness of what they appreciated within the relationship. This is evident by the relationships being maintained and the feelings of self-worth usually held.

Within the stories of ‘specific matters,’ there is possibility for openness, receptiveness, and authentic responses between women and midwives. This has the possibility of resulting in affirmation of unique selves, recognition of the dependence on others, and appreciation of otherness. To care and be cared for is only possible within such relationships (Brown, Kitson, & McKnight, 1992). Nevertheless, there is also the possibility for indifferent or negligent care (Heidegger, 2005) in which the courageous feedback is disregarded, seen as criticism, creating underlying tension in the ongoing relationship. It is not surprising that both the woman and the midwife seem to leave such a conversation until a time when the relationship is soon to end anyway. Relationships matter; one that is tense can become untenable. Conversations are the means of building, maintaining, and disrupting relationships. The risk is that the legacy of any conversation can only be known ‘after’ the preceding events.

Chapter Seven: In the Moment – 'Taking Something As'

Introduction

Sheehan (2001) stated "there is no such thing as "the" being of entities; there is only the current being of entities" (p. 190). The current being of an entity is what and how we happen "to take this thing as" (p. 90) at the present moment. This suggests that when we see a 'midwife' we see her 'as' something. Meaning is interpreted from all our pre-understanding of midwives and midwifery care. This chapter explores the 'as' dimension in the relationship between a midwife and the woman in the context of the post-birth reflective conversation.

Midwife as a Midwife

Nita, a woman participant, had high praise for her NZ midwife. The American Heritage® Dictionary of the English Language (2016) suggests that the prefix 'mid' in the midwife means 'together with.' Nita shares her story of the postpartum midwifery care in which her midwife was 'with her':

> *My conversation with the midwife was to thank her for her care following the birth of our baby. I had this conversation in the fourth week following the birth of my baby. There is no such aftercare by the midwife in America where I had my first baby. My midwife always assessed both of us when she visited. It did not just include physical check to ensure we were both well but she also asked how I felt emotionally and the support I had in a new country. I felt that I was not giving full attention to my new baby as I had a toddler to look after. The midwife affirmed for me that I was a good mother, second time round, by encouraging me to reflect on things I was doing with a toddler, with the baby and with both of them. I really appreciated her care and looked forward to her visits. I needed her to know this. She even negotiated all the visits including the final visit and contacted me to make sure Plunket had visited.* (Nita, woman participant)

The conversation was about the care Nita received following the birth of her second baby. Nita had to experience the care before having the conversation at four weeks postpartum. Nita felt respected, supported, and professionally cared for by her midwife. The negotiation of visits suggests the midwife working in partnership with Nita. The provision of holistic/woman-centred care seems to have helped Nita to develop confidence as a mother, enabling her smooth transition to motherhood in a new country. There is a sense of Nita receiving continuity of care and a timely handover of care. Nita says the midwife "*contacted me to make sure Plunket had visited".* Perhaps the midwife had sensed that completion of care might make Nita vulnerable?

There appears to be understanding and concern by the midwife that Nita was new to NZ. Nita says that the midwife assessed "*how I was feeling emotionally and the support I had in a new country".* The midwife tried to ensure Nita had developed supportive relationships/networks. Their relationship appears to have been close and based on trust because Nita says she "*appreciated her care and looked forward to her visit".* Nita anticipates the midwife's visit with eagerness and pleasure, suggesting a beneficial relationship. She needed the midwife to know that she appreciated the quality of her care. It seems that Nita had not received quality midwifery care previously. She had commented: "*there is no such aftercare by the midwife in America".*

According to Langan (1971) "care" is an atmosphere in which Being is revealed because 'Dasein' is open to what is real (p. 126). Heidegger (1927/2011) says, when we are a being-in-the world-with-others, caring can be displayed on primordial ground as a self-to-be-with-others. The midwife's suggestion that Nita reflect on what she did with her toddler, with her baby and with both of them, gave Nita responsibility and choice. Perhaps it opened up numerous possibilities to consider what being a good mother means? This leaping-ahead-of liberates the person (Nita) rather than dominating or patronizing her. Kidd (1990) suggests that caring and sharing enables development of self-worth.

In this story, the midwife has not just focused on the physical assessments of Nita and her baby. She has provided emotional care and support; ensured Nita recognised her own self-worth; made sure Nita was on a path of smooth transition to motherhood and provided seamless hand over of care to other providers.

Nita had experienced the wholeness of care. The hermeneutic attempts to understand man (sic) as a cultural being and as a whole, by observing body, soul, and spirit in interplay with the surroundings (Hummelvoll & Barbosa da Silva, 1994). Sneller (2017) suggested that we consider phenomenological 'holistic' approach to health/wellbeing. He stated that frequent focus on diagnostic and task orientated care may enable us to show empathy but has a potential to reduce attentiveness to patients (women). According to Sneller, lack of attentiveness impacts self-awareness/self-worth. In this story the midwife has been attentive to Nita's needs holistically.

Ethics and sociality go hand in hand for Levinas; the “Other” for whom I am responsible is also the “Other” to whom I respond (Garza & Landrum, 2010). Levinas (1984) suggested that in “face to face encounter with the Other” (p. 13) we are made aware of the other person’s vulnerability and thus during the relationship called upon to respond ethically. The face-to-face encounter illuminates connection and separation with the Other (Smith, Turkel, & Wolf, 2012). The midwife recognises Nita’s potential vulnerability as a mother in a new country. She has listened to Nita with an open-mind, used knowledge, kindness, and compassion when interacting with Nita during post-birth conversations. These ‘conversations’ opened the way for the midwife to ‘be-with’ Nita. It appears sensitive care enabled Nita to speak out her concerns and affirm her capabilities. Thoughtful conversation is thus at the heart of ‘care’. When the midwife is attentive ‘as’ midwife, she discerns the questions she needs to open.

Midwife-as-midwife, being with the woman in a discerning manner, is perhaps taken for granted in the expectation that this is the beginning and end of the story. However, stories from both midwives and women reveal the complexities within relationship. Sometimes there is a sense that the midwife has ‘got it right’ often demonstrating the diversity of skills in her repertoire of care. Other times the woman is very clear that the midwife did not listen, understand, take the time, or did not feel as if she was ‘with’ her.

Effective Care as ‘Leaping Ahead’

Breastfeeding is considered to be natural, implying that success comes easily. However, the MOH (2017a) acknowledges it can take some time to learn how to breastfeed. Leurer and Missskey (2015) reported that some mothers desired further information and guidance on positioning and latching the baby the right way. The midwife needs to discern the most effective way to support the mother in learning ‘how’.

Rosa shares a story about developing the confidence to latch her baby to the breast as a new mother:

> *I had a conversation with my midwife in the first week following the birth. I came home on the third day and was trying to latch the baby when my midwife visited. She observed while standing beside me. As a new mother it made me nervous. After 5 minutes of watching, she bent over, held my left breast while showing how to latch and latched the baby. I couldn’t latch the baby while she was there as I was so nervous to get it wrong. The back-up midwife visited me while she was on weekend leave. She sat down while I*

> *started to feed, noticed my struggles and talked me through the latch. It took a while but she was very patient. She suggested soothing the baby in-between trying to latch. It took 10 minutes but we got there. When baby needed latching the other side, she continued to document and didn't say anything while I was attempting to latch. Once the baby was latched, she noted it was a deep latch and said "it gets easier each day as we learn and develop confidence". When my midwife visited next, I suggested to her she might like to sit down. I mentioned that her being there and talking me through if it was needed would be helpful for my confidence. I noticed the change in her subsequently so I was pleased that she had heard me.* (Rosa, woman participant)

This was a courageous conversation by Rosa in the first week post-birth. Rosa appears to realise that her behaviour with the midwife needed to be sensitive. The behaviour of the back-up midwife towards her seems to have given Rosa the confidence to have the conversation. She had previously been unable to articulate what felt right for her and may have felt undermined. She says "*I couldn't latch the baby while she was there as I was so nervous to get it wrong".* However, she summons the courage to have the conversation with the midwife. The change in the midwife's behaviour suggests she has genuinely listened to Rosa's concerns. Rosa felt heard.

Burns (2016) suggests that strict instructions on how to hold and latch the baby has a potential to make women feel inadequate. They have a perception of being tested in their technique. Various authors have suggested that 'hands-off' (demonstrated by the back-up midwife) rather than unexpected 'hands-on' (demonstrated by the first midwife) helps women to maintain their integrity, feel less shy and exposed as well as reinforces self-confidence during breastfeeding (Dykes, 2005; Weimers, Svensson, Dumas, Navér, & Wahlberg, 2006; Bäckström, Wahn, & Ekström, 2010).

Heidegger (1927/1962) spoke of "leaping-in [as the first midwife did] and leaping-ahead" (p. 122) (the approach taken by the back-up midwife) to express two fundamental ways in which human beings express concern for each other. Heidegger called this innate human concern "care" or "solicitude" (p. 121). According to Heidegger, "solicitude" is essentially about being caring towards other (Rosa), as opposed to being concerned about oneself or worldly things. Heidegger defined two ways of caring for others, as "authentic solicitude" and "inauthentic solicitude" (p. 122). "Authentic solicitude", (Heidegger, p. 122) shown as an act of "leaping-ahead", (Inwood, 1997, p. 36) is a form of caring which supports and encourages growth, independence and autonomy in another human being. A midwife who leaps-ahead is prepared

to support the woman while she makes mistakes and journeys on to become a confident mother. “Inauthentic solicitude”, shown as an act of “leaping-in” is where we tend to dominate, takeover or take charge in concerning situations (Heidegger, 1927/1962, p. 122). Heidegger suggested “leaping-in” can result in the disempowerment of another human being. Rosa recalls that feeling nervous adversely affected her confidence. Perhaps the midwife felt responsible and concerned regarding how Rosa was going to cope with breastfeeding once she left that made her “leap-in”? (Heidegger, 1927/1962). “Leaping-ahead” takes time as Rosa recognises, “*she was very patient”.*

To return our focus to the ‘conversational nature’ of these encounters we see it was the back-up midwife who showed Rosa the effectiveness of leaping-ahead, of talking with Rosa ahead of the ‘problem’ in a way that helped her get it right. Rosa brought this same skill into her encounter with her own midwife. She leapt ahead in asking her to sit down, in telling her of the kind of support that helped her most. Thus leaping-ahead may come from midwife or woman. It is the ‘as’ of forward thinking, planning and educating.

Midwife as Channelling Information

Being pregnant and giving birth seems to prompt women’s interest in knowing more about how their bodies work and the meaning of the medical terms. Tania, a midwife, shares the conversation a woman had with her about her body and her baby:

> *I had a Tongan woman having her third baby with me. Every single time we talked following the birth she had lots more questions. She felt more comfortable to ask the questions and learn about her body changing following birth and about her baby’s growth and development. She has used time during three babies to learn. It is hard when there is a language barrier. Her sister-in-law came over and had a baby with my group partner and spoke English well but had no clue of medical language and used the woman who I was caring for to learn the medical terms – channelling information from me to her sister-in-law and back again.* (Tania, Midwife)

The post-birth conversations appear to be instigated by the midwife and then by the woman. This seems to have happened following all three births, suggesting an ongoing and open relationship. There is a sense that as the woman developed confidence and felt comfortable with the relationship, more questions were asked of the midwife. The woman then shared this knowledge with her sister-in-law. There are many ways women may gain knowledge; in this story the knowledge is sourced from the midwife.

Furthermore, the sharing of knowledge woman-to-woman and, in this case, between sisters-in-law, is valued in traditional knowledge systems. The midwife's relationship is thus extending beyond the woman with whom she is working. As Tania explains: "*channelling information from me to her sister-in-law and back again".*

Heidegger (1927/2011) emphasised that "being-in-the-world" ... "is a being-with" (p. 152). The self "is never alone in its experience of Dasein (Being-in-the-world)" (Heidegger, p. 152). The world is always experienced with 'Others'. The world of learning and supporting each other is experienced by the midwife and the woman together and then onward through the woman having a relationship with her sister-in-law.

This woman had lots of questions and felt comfortable to ask them during the time spent with her midwife over three babies. These engaged dialogical encounters (Gadamer, 1989, 2004) moved beyond the existing understanding. Only the women knew what they did not understand. They were women 'as' questioners. The midwife was midwife-as-responder. Such conversations are about helping women understand, especially when the language used by medical staff and midwives is unfamiliar. An attuned midwife is able to discern misunderstanding and shed light. Conversations open a channel wherein a woman is able to voice her 'unknowing' and the midwife can respond in a way that enables her (and others) to understand. The 'as' in such a relational exchange is in the 'to and fro' of question and answer.

When a midwife is not attuned to receiving the woman's questions there is potential to stifle woman's voice and for her concern, or lack of understanding, to be passed over.

Seeing a Woman as an Object – An 'It' in a Relationship

In contrast Jie's story tells of how a woman feels when her requests for help are not heeded in a personal way:

> *We were the first couple in our family and group of friends to be parents. Everything was new and you forget what was mentioned in classes you attended in pregnancy. I asked my midwife if I could bath the baby when she visited next in the first week post-birth. Her response was that we would have been shown this in one of the classes and there were fun You-Tube clips that were useful to watch. It was the same when I asked about baby's sleeping behaviour, what should the baby be able to do over six weeks and starting solids. Her suggestions were to look at sleep consultant websites, read the Well-Child book and talk to Plunket or ring Plunket line about starting solids as that happened after she handed over the care at six weeks post-birth. In the*

> *end I decided not to ask after she had completed routine checks on us. I fed back how I felt on the midwife's feedback form that I requested from the College of Midwives.* (Jie, woman participant)

It is as though authentic conversation never really happened in Jie's relationship with her midwife. This is evidenced by Jie's conversation with the midwife happening with the use of a feedback form. It is possible that such care could have impacted Jie's confidence leaving her feeling vulnerable. However, Jie had the confidence to access the feedback form and provide feedback regarding her experience.

Within the story there is a sense that Jie's explicit requests for help are being passed on to generic information sources. The midwife seemed to be undertaking routine checks, getting through the work resulting in minimal contact between Jie and herself. This type of midwifery care suggests a lack of support with Jie (as a woman with unique needs, as are all women) and care not being woman-centred. Perhaps the midwife was busy or did not feel it was her role or had the knowledge on those areas to share with Jie.

The midwife had informed Jie of further resources for her learning/education instead of being there for the baby's bath or sharing the information with her. It appears that Jie was not able to create her own learning opportunities or promote/share her ideas. The suppression of Jie's voice is evident as she says "*In the end I decided not to ask".* Hence Jie had to use the feedback form to let the midwife know how she felt. No consideration appears to have been given as to whether the further resources suggested would meet Jie's needs. Learning is particularly effective when constructed using each other's experience and shared knowledge/understandings.

It is not only 'what' the midwife does that is important to ensure the woman feels worthy but also 'how' she does it. Educating women and birthing families is considered to be an integral part of midwifery care. There is a lack of presence and openness by the midwife in this relationship. There is no willingness to engage in the type of conversations that opens the way for 'care'.

According to Buber (2010) there are two fundamental ways of relating to the other. In an I-Thou relationship the midwife would have joined in Jie's world of relation as it was being shared with her. Not being present suggests that the midwife was not fully (as a whole) engaged with Jie. When one is wholly engaged, we establish a world of concerned relation and the conversations

are deeper. Buber stated that our awareness of time ceases in I-Thou relationship. The I-Thou relationship describes a form of 'being-with' that is mutually rewarding.

The midwife had engaged with Jie for the purpose of undertaking routine checks. In I-It relationships only the part of the self is used. The I-It relationship ensures that relevant information is sought/gathered. In such relationships one is doing things for or with the woman. Collecting/providing objective data/information is useful for understanding the world (Buber, 2010). We can hardly live without the encounter of the I-Thou because it would shallow the depth of human existence. The genuine I-Thou encounter is not found by 'seeking' but rather springs from the relationship itself (Buber, 2010). Although the I-Thou encounter does not last eternally, Buber believed that both persons (I and Thou) grow mutually by their reciprocal commitment within the relationship. In I-Thou mode we view the other as a person with needs and desires as real to us as our own (Warner, 2001). In most conversational relationships a back and forth movement takes place between I-Thou to I-It engagement. When the relational event has run its course it is bound to become an I-It. The particular I-It, by entering the relational event, will become I-Thou (Buber, 2010). Buber contended that I-Thou relationship can only be established 'in the moment' which means they cannot last forever. Hence relationships are characterised as a continuous alternation between I-Thou and I-It (Westerhof, van Vuuren, Brummans, & Custers, 2014). In Buber's eyes, the choice is not to be I-It or I-Thou but finding a healthy alternative between the two (Friedman, 1976).

When Jie asked if she could bath her baby at the next visit, she was told she should already know how to do this. It was an I-it conversation. If in contrast the midwife has said something like 'tell me how you have managed so far' chances are the conversation would have moved on, encouraging the woman to talk about her struggles and fears. In such conversation, trust is built and there is disclosure of deep, more private aspects of ourselves. Personal agendas are more likely to be put aside and there is real listening to what the other is saying. Such mutual exchanges can deepen, heal, and maintain partnership in midwife-woman relationship. The I-Thou conversation can move back to I-It by the midwife further saying 'so you seem to be managing fine'. The woman may respond with 'yes' or because trust has already been established and open conversation has occurred, she may confess that she is fearful and needs the midwife to watch what she is doing, thus moving the conversation back to an I-Thou relationship.

In Jie's story it seems the midwife has seen Jie through the lens that fulfils her needs, rather than fully understanding Jie's needs and desires. The midwife appears closed to the 'call of others', hence care that is indifferent (Heidegger, 1973). Conversation is 'empty talk' when the other (Jie) is left to feel like an 'it'. This highlights a question that every midwife needs to ask herself at every visit: who is this woman I see?

The Midwife as One Who Does Not Seem to Care

The following story seems to be another example of the woman left feeling like an 'it'. Febe shares her story about being a mother in the absence of a positive role model:

> *I knew I would struggle with mothering my son as I had a mother who was abusive* (physically and emotionally)*. Instead of learning about what I would do, I learnt more about what not to do. We did not have a mother-daughter relationship that was filled with love. I got a sense of what a possible good role model could be from various books I had read. I did not feel I could talk to my friends, as we were the first couple to have a baby in our group. My midwife knew my history though I met with silence when I mentioned it before birth. So I decided to have a conversation with her in the first week about how I can be a good mother to my son. We did not get very far as she kept saying "there is no right or wrong, do whatever feels right for you". Eventually I phoned Plunket who suggested various coffee groups and parenting sessions. These helped and introduced me to other women who I used as role models.* (Febe, a woman participant)

Febe decided to have the conversation in the first week post-birth. More than one attempt at the conversation had been made as Febe says "*She kept saying*" and "*Eventually I phoned Plunket...".* The midwife's response to Febe suggests reluctance to explore Febe's thoughts on mothering and provide any emotional support required. Febe says "*My midwife knew my history".* She also appears dissatisfied with the midwife's response as she contacted Plunket. Perhaps the midwife has not had an experience of caring for a woman with such vulnerability? Was the number of attempts at conversation by Febe an indication of wanting the midwife to acknowledge her past experience? Febe mentions that she was met with silence when she shared her past history during pregnancy. There is a seeming lack of attentiveness and concern by the midwife for what Febe had experienced during pregnancy as well as in this moment. Perhaps the midwife was too busy or distracted to support Febe's transition? Perhaps she had fallen into a mode of technical practice where most of her clients became 'its', assessed, treated, discharged? Fortunately, Febe had the confidence to contact Plunket.

Heidegger (1962) described the nature of being human as Dasein which he defined as ‘Care’. He suggested: “Care is always concern and solicitude” (Heidegger, p. 239). Concern relates to the person’s capacity to think of possibilities for self and others. Solicitude involves moving toward others. Care as thinking of possibilities for self and others and as moving toward others, is understood as Being-in-the-world (Heidegger).

Fursörge, ‘caring for’, is the fundamental characteristic of Dasein (a person) in relation to other beings in the world (Being relating to other beings) (Heidegger, 1927/2011). Dasein, an entity, is in a world among other beings, with beings, and in the presence of other beings. Dasein already knows other beings and has some understanding with which it approaches them. This implicit understanding or attunement, is the antecedent that makes it possible for Dasein to encounter the beings around it. Dasein’s ‘being-with’ other beings takes the form of ‘caring about them’ or ‘caring for them,’ and, because it knows them as itself (Demske, 1970), it is able to attune to their subjective experience.

Within the post-birth conversation above the midwife appears not to acknowledge Febe’s vulnerability, is unengaged, neglecting/unconcerned regarding Febe needs, and not attuned to Febe. The opportunity has been lost to understand, to support, empower, and provide holistic care. The midwife’s challenge is to discern how past history may influence a woman’s current experience, and then provide relevant information and support to help the woman meet her specific needs.

Midwife as-one-who-cares can never been assumed. Care also reveals itself in indifferent and negligent modes (Heidegger, 1927/2011). Such is the nature of being human. Febe’s midwife reveals herself as-one-who-did-not-discern and therefore did not seem to care.

Midwife as Sensitively Attuned

Having a baby is a major life event. New mothers have to adjust to being a mother. Their newborn baby may not be what they had imagined (Melo, Souza, & Paula, 2014; Stern & Bruschweiler-Stern, 1998). Such adjustments may be exacting in certain situations. Adelina shares her experience of needing a special kind of care:

> *We had a conversation with our midwife in the first week and subsequently following the birth of our first child, Claire. She was born with anencephaly and myelomeningocele and lived for six hours. We knew of her diagnosis*

> *following an anatomy scan at 20 weeks of pregnancy. We decided to continue with the pregnancy knowing that she may not be with us for long. Our midwife supported us all the way. It was just so warming to hear her congratulate us on becoming parents as soon as Claire was born and commenting on how gorgeous she was. She used words such as "mum" and "dad" as she continued to provide care immediately following birth and subsequently over the weeks. She would say "would mum like to have skin to skin, would dad like to put the nappy on or how is mum feeling today?" She helped us over the days to bath Claire and dress her for the final farewell. I remember her saying that she knew we were only able to hold Claire for a short time but she would be in her parent's hearts forever. Her acknowledgment of us as Claire's mum and dad made us feel we were parents. Her care ensured that we were not left feeling lonely and with a sense of failure. We really appreciated that and wanted her to know.* (Adelina, woman participant)

Adeline and David initiated the post-birth conversations. They wanted to thank their midwife for acknowledging them as parents and ensuring that they did not feel they had failed. Continued care and support by the midwife has enabled them to get to know each other and develop a trusting relationship. Adelina says: "*Her care ensured that we were not left feeling lonely and with a sense of failure".* It seems that this midwife was a constant source of care and support throughout their childbirth experience, even more so in the preciously short time they had with baby Claire.

The midwife has talked about Claire from the time of her birth. It is as if the midwife knew that talking about Claire would be helpful for Adelina and David's transition, their grief and healing. In doing so, the midwife has acknowledged the life that was lost. The midwife continues to provide care helping them bath and dress Claire. The relationship appears to be warm, open, and strong for conversations to occur. The midwife is present (in both an emotional and a physical sense) and affirms Adelina as a mother. Adelina says: "*It was just so warming to hear her congratulate us ..... she used words such as 'mum' and 'dad' as she continued to provide care immediately following birth and subsequently over the weeks".* Perhaps the midwife was making sure that Adelina felt she was a mother even though she was not going to see Claire grow and have a future?

The midwife's empathy demonstrates her 'being-with' the woman; however, the act of 'being' can leave the midwife distressed/vulnerable in the event of such outcome. It is suggested that the ability of 'being-with' the woman is linked to the midwife's perception of her experience and her relationship to the world she is in (Heidegger, 1927/2011). It is unclear whether the midwife has had any previous experience of caring for women in similar situations. The midwife 'being-

with' Adelina is not just about being physically present but travelling a journey together with her. The sensitive care by the midwife appears to have helped Adelina be a mother to Claire rather than feeling guilty for having failed her.

A midwife-as-attuned watch, listens, discerns, ask with such sensitive perception that time and again she 'gets it right'. It is no one conversation that stays in the woman's memory, rather the ongoing comportment of compassion and care in every encounter. Such care embraces the family and gives them precious memories to hold forever.

Midwife as Caught-Between

Prue, the midwife, finds herself in a tricky situation. Prue says:

> *I noticed that Bella and Pete wanted to talk about something but were holding back. I had finished Bella and Adam's* (baby) *assessment and sat down to complete the documentation. I saw Pete nudge Bella. After completion of documentation I stayed and watched Bella breastfeed and settle Adam. Once Adam settled Bella piped up that though she had said no to being examined she felt I should check her perineum. Following the assessment I mentioned that the perineum looked fine – "would she like to look at it in the mirror and was there something that was concerning them?" Pete mentioned that Bella's perineum was painful at times and wondered if the suturing had been done as it should have been, as the doctor had to leave to attend the emergency and then come back for finish the suturing. My aim was that both Bella and Pete were aware that the interruption during suturing did not appear to have affected the perineum.* (Prue, Midwife)

Prue recognised that Bella and Pete wanted to have a conversation. She sat down to complete the documentation perhaps hoping this would instigate the conversation. By sitting down she leapt ahead to create an environment (stayed to watch the breastfeeding and settle Adam) where Bella felt safe to raise any concern. Prue saw Pete nudge Bella but had not realised/sensed that it was Pete who wanted Bella's perineum checked. However, her actions of checking the perineum, determining it looked fine, and inquiring if Bella would like to see the perineum potentially put Bella in a vulnerable position. Maybe Bella had been using her tender perineum to delay having sex.

Heidegger (1962) refers to the notion of "leaping ahead" (p. 159) as one of liberation for the person to be free to be themselves. In so doing, this then frees others to realise their potentiality-for-being. Prue is "there" for Bella and Pete to open the conversation they wanted to have.

However, the actions taken by Prue, when requested by Bella to check her perineum, had the potential to compromise Bella. Caring is revealed in our relationship with the other. As midwives we need to recognise vulnerability in women and ensure we respect their integrity in the presence of vulnerability. Prue seems to have discerned what lay behind Pete's nudge, but did not open up the discussion between Pete and Bella about when was the right time' to resume sexual relationship. Maybe she felt embarrassed? Perhaps she thought she was crossing into private matters. Yet, at the same time, there is a sense that Bella may now no longer have the excuse of a still-healing perineum in response to Pete's desire for sex.

The midwife can find herself as-caught-between. Yet in telling this story, between the lines one senses her regret that she did not offer more advocacy to Bella. She could have made it clear that only Bella would know when it was time.

Midwife as an Encourager and a Listener

In NZ maternity system, responsibility for the woman's care may transfer from primary to secondary or tertiary care. However, the responsibility of co-ordination of care remains with the LMC (MOH, 2007). Dina describes her experience of being a mother when her son, Rand, was admitted to neonatal unit (NNU):

> *Rand was born at 30 weeks gestation. With all the equipment around him I felt an outsider, not his mother, as I could not be involved in his care. I left the hospital not feeling like a mother, as I had to leave Rand behind in the NNU. It was distressing, disappointing and disempowering – not what I had imagined being a mother would be. The visit by my midwife was a few days later after Rand's birth as we were both under secondary care. Until encouragement and support was provided to be involved in Rand's care I was really anxious. I could not relate to being his mum – that came about the end of the week following his birth, as I was then encouraged to be more involved in his care. My conversation, few weeks later, with my midwife was about how I had felt in the initial days and subsequently of Rand being in the NNU. For me, midwifery support when visiting NNU for the first time or staff being made aware of the support I needed at the first visit would have made me feel included. I only felt I was Rand's mother when I was later encouraged to be involved in his care. I discussed with the midwife the impact of my negative feelings on my ongoing relationship with Rand. I am not sure she understood as she said "there is no need to be worried. You are both fine".* (Dina, woman participant)

Dina talked about her experience with the midwife a few weeks after Rand's birth. The conversation was about feeling an outsider, that is, not at home, affecting her ability to be a mother to Rand. There is a sense of Dina being 'thrown' into an unfamiliar environment (NNU)

and an unexpected situation. Not being able to care for Rand, as a mother normally would, following the birth appears to have contributed to her anxiety and bonding with Rand. Her feeling of not being a mother appears to be affirmed by having to leave Rand in the NNU when she was discharged home. Dina says "*It was distressing, disappointing and disempowering – not what I had imagined being a mother would be".* There appears to be lack of discussion with secondary care about the support Dina may require when visiting NNU for the first time and of continuity of care by the midwife due to involvement of secondary care (obstetric care provided by specialist or a facility upon referral by primary care practitioner, LMC midwife). Dina had the courage to discuss her experience with the midwife. The anxiety appears to have lessened once she was encouraged and supported to care for Rand. Dina says: "*Until encouragement and support was provided to be involved in Rand's care I was really anxious".*

It appears to have taken a week for Dina to relate to Rand as a mother. The lack of instant connection with Rand concerned her. The midwife's response of *"there is no need to be worried. You are both fine"* suggests she was still intent on encouraging Dina and boosting her confidence when what Dina was looking for was an opportunity to voice her fears.

In the facticity of being thrown into the world of the NNU, Dina faced a new environment that was unfamiliar to her, not knowing what to do in her first moments with Rand. The expression 'thrownness' (Geworfenheit) is meant to suggest the individual is delivered over or exposed to different life situations (Bonevac, 2014). There is a sense that Dina is not in control of her being, her most basic aspect of her life and feeling out of place. The baby arriving early and where he had to be to receive care, was not under her control. The 'feeling' of out of place, of strangeness, is in German called Unheimlichkeit, literally not-at-home-ness (King, 2011). There is a sense of Dina not initially being positively attuned to the environment/place (NNU). It appears that Dina feels her experience could have been different if the midwife had been with her at the first visit to the NNU.

Furthermore, it would seem that Dina did not initially have any relationship with the staff or her baby. Heidegger (1998) stated that the most fundamental way of being in the world means relating "with" the other. Solicitude is a way of relating to each other, of taking care of the other's existence, which is only possible through an engaging and significant relationship. "The being-

there-with others is unveiled in the world for being-there with us, because only the being-there in itself is essentially being-with" (Heidegger, 1998, p. 26).

When Dina became familiar with the staff, the environment, and the usefulness/handiness of the equipment that was around Rand she started to feel like a mother. Dina says: "*I could not relate to being his mum – that came about the end of the week following his birth, as I was then encouraged to be more involved in his care".* The NNU staff later encouraged Dina to be involved in Rand's care. The physical closeness appears to have helped in establishing emotional closeness between Dina and Rand (Flacking, Thomson & Axelin, 2016). According to Heidegger, this is more llikely to be authentic care (Bonevac, 2014). It restores the other person's essential role in relation to things in the world. The role of the NNU staff and the midwife is to ensure this happens. The conversation with the midwife happened a few weeks later. Dina needed to restore her essential role as a mother to Rand before having the conversation about her experience.

Midwives as co-ordinators of care liaise with other practitioners to ensure women's/whānau needs are met. This helps to ensure seamless care, transition to motherhood, and timely maternal attachment when infants require special care. Yet, in this coordination, there is still the challenge of getting-it-right. Dina needed both midwife-as-encourager and midwife-as-listener. When the encouragement came without her also feeling listened to, it did not work. Dina was left with her fear that she had not adequately bonded with her baby, which in itself would impact on ongoing bonding. This situation required the midwife to both encourage and listen.

Midwife as Confidence Builder

The physical, psychological, and social changes during pregnancy and following birth have a potential to enhance vulnerability in women (Barlow, 2015; Briscoe, Lavender, McGowan, 2016). Not being in a heterosexual relationship was never an issue for Mona until she had the baby. A particular moment in the postpartum period made Mona feel vulnerable. She says:

> *We chose a midwife who knew us and we had a great relationship with her. Our pregnancy and birth was a breeze. My conversation with the midwife was about an interaction I had following birth that made me feel vulnerable. This was in second week post-birth. I was so upset that I had to ring the midwife as soon as I got home. She couldn't come for couple of hours but that was fine. We had been out for coffee* (first time out with our new baby)*. Various people stopped by to look at the baby and have a conversation with us. This*

> *particular woman kept mentioning the word 'father' – presuming that he was at work etc. I eventually mentioned that we were a couple. From then on she totally ignored my partner* (Sue) *and turned away from her. Sue felt rejected and I started to feel uncomfortable and unsafe with the looks the woman was giving her. Once the midwife arrived I told her what had happened while sobbing at the same time. The midwife gave us both a big hug and listened. She asked us how we had handled such encounters before. She suggested reflecting on how we had managed some of the interactions positively over the months with others and could we use those strategies. She made us feel confident again. We appreciated her coming and being with us at that time.* (Mona, woman participant)

This conversation with the midwife happened in the second week post-birth. The midwife appears to have sensed that she needed to make time for the conversation. Mona says: "*She couldn't come for couple of hours but that was fine".* They knew the midwife and had a great relationship. Good relationship suggests inclusiveness, acknowledgment of the roles, trust and openness to conversations. The midwife restored their self-confidence by being there, giving them a hug, listening, enabling them to think of the situations they had managed before and strategies they had used. There is a sense of comfort, ease, and reciprocal relationship in this conversation. The midwife has affirmed Mona and Sue's identity. What would be their experience if the midwife had been unable to create space for conversation the same day? The feeling of vulnerability appears to have eased following the conversation with their midwife. Perhaps knowing the midwife as they did resulted in the positive outcome for Mona and Sue?

Gadamer's view of dialogue is not as confrontation but the seeking of mutual understanding (1989). Authentic dialogue is listening to what the other has to say. The central issue for Gadamer is the conversation itself rather than the subjectivity of the participants. In conversations with the others (Mona and Sue), the subject matter comes more fully to the forefront and, as a result, a better understanding takes place (Mangion, 2011).

According to Heidegger (1927/2011) in existing as Dasein we are aware of our own being and we are always with others. This creates for Dasein a sense of familiarity and security of being-in-the-world. Mona is familiar with the midwife, as they have known each other, she felt secure/safe in contacting her as soon as she gets home.

I return again to Heidegger's (1962) two kinds of concern – 'a leaping in' and 'leaping ahead' of the other. The midwife has not taken away Mona's autonomy by leaping in. She has enabled

Mona and Sue to recall how they previously handled such situations. In suggesting this she has increased their self-confidence once again.

Midwives-as-confidence-builders, describes drawing on the inner strength the women already hold, the strategies they already know, and resilience that is already proven. No one can 'give' confidence to another. A midwife can only nurture the conditions that will enable confidence to build.

Midwife as One Who Now Knows

Paige shares a story of how lack of sharing information with her midwife increased her own vulnerability and also impacted the midwife:

> *The midwife met my partner following the birth of our baby. I attended appointments in pregnancy alone and my sister-in-law was with me during the birth of our son. At the midwife's first visit at home, my partner was being overprotective and the midwife sensed this. I knew straight away what she was thinking but talking to her about it would have got my partner angry. When she left I noticed my partner going into the kitchen. I quickly wrote a note; put it in one of the pamphlets she had left, opened the front door and called her. She was surprised but took the pamphlet. She arrived the next day as I had mentioned in the note* (while my partner was away shopping)*. My sister-in-law and my mother were also present. We talked about her sensing right that I was in a vulnerable situation especially when my partner drank. The family/whānau were aware and my partner was being supported towards his recovery. He was overprotective but as yet not physically violent. The midwife felt awful that she had not picked this up before. I reassured her that she did at the first visit. She asked what I knew about keeping the baby and I safe. During the conversation we discussed about our awareness of her role in such situations. Over the weeks my partner's attitude became more relaxed in her presence. Her noticing I was vulnerable was reassuring for me. She wanted to make sure we were well during her care.* (Paige, woman participant)

Paige had been courageous, while in a vulnerable situation, to organise a space for conversation. It appears the conversation may have been in the first week post-birth. Paige says "*at the midwife's first visit at home",* which in NZ occurs within 24 hours following discharge from the birthing facility (MOH, 2007). There was an initial non-verbal conversation between Paige and the midwife. Paige says "*the midwife sensed this (partner being overprotective) - I knew straight away what she was thinking but talking to her about it would have got my partner angry".* There is a sense of both being aware of what was observed. The midwife may have been thrown by what she observed and how she missed getting the information earlier. Paige says "*midwife felt awful that she had not picked it up before".* Perhaps Paige's silence indicated

that now was not the right time to have the conversation? The midwife possibly needed time to think about the best way to open a challenging conversation. Paige gave the note to the midwife. According to Paige, the midwife was surprised to be called back and given a pamphlet. Perhaps she had not anticipated Paige would create an opportunity for the conversation? Paige may have been concerned about the outcome now the midwife had observed her partner's behaviour. Perhaps this gave her the courage to organise the conversation?

The conversation was about how Paige and family/whānau were managing the situation by supporting her partner in the recovery. There is a sense of the midwife feeling the guilt of not being aware of situation earlier. The midwife sought Paige's knowledge/awareness about keeping baby and herself safe while her partner was recovering. Perhaps the midwife was trying to help Paige understand the importance of sharing such information early for optimal care? The conversation does not appear to be rushed or concern expressed of the partner returning sooner than expected. There is a sense of a professional relationship being maintained by the midwife. The partner's relaxed manner during the midwife's further visits suggests that trust is developing within the relationship. Perhaps it was not just the partner feeling relaxed but also Paige? She has appreciated the midwife being observant and interested in their wellbeing. The midwife's encounter with Paige's partner increased both Paige's and the midwife's vulnerability. Lack of full information could result in the midwife not providing appropriate care, threatening the midwife's reputation as a good midwife. On the other hand, if the midwife had said anything that may have upset Paige or her partner, this could have exacerbated the situation. Such encounters, when handled well, increase a mutual effect. Within the core in their vulnerability lies in the possibility to be the persons they both want to be, and the persons they have not yet become. In such situations, Paige and the baby would be the most vulnerable, though the encounter also exposes the midwife's vulnerability. The responsibility rests with the midwife to ensure continuation of a caring relationship. Recognition of the mutual vulnerability calls for collective acknowledgement of the demanding nature of caring relationships. Care is based on Being-there, giving meaning to existence, because it is a way of being in the world, in the relationship with oneself and with others (Heidegger, 2005).

Midwife-as-one-who-now-knows rests first on the woman sharing sensitive information, in this case not directly related to childbirth. This opens a tension of what to do with such information. The midwife now knows this mother and baby are vulnerable to abuse and perhaps violence.

On the other hand, she knows there is family support and that the partner is seeking to address his issues. How does she know when to wait and watch, or when to break confidentiality and report this situation to the appropriate government agency? Relationship can mean that the midwife is left shouldering a heavy weight of responsibility for which guidelines are lacking until the situation worsens. Then comes the question 'why did she not act in a more timely manner'? Midwife-as-one-who-knows can be the consequence of building open, trusting relationships. That is what midwives seek; yet being trusted can take one to a hard place. Perhaps that is what has led some midwives to keep the relationship on an I-It level?

Midwife as a Protector

Clear communication is vital to ensure effective and sensitive midwifery care. Yelland (2013) stated that midwifery is about communication with women and families as well as with colleagues and other practitioners. To provide quality care it is essential that we are attuned to our communication skills and try to discern what to say and not to say in a given situation.

Mayuree shares her experience of the communication with her midwife when she became very unwell post-birth:

> *I had a conversation with my midwife around the third week following the birth of my baby. I needed to tell her how I appreciated the way she talked to me throughout the time I was unwell with post-partum pre-eclampsia. I suddenly developed a headache on the third day after the birth of my baby. She came and checked my blood pressure, which was high. I was absolutely fine during pregnancy and birth so was shocked to be told of the high blood pressure and was admitted to the hospital straight away. Things got worse with my head feeling fuzzy. Medical staffs were in and out and talking to me and about me. I was scared and so confused at times. My midwife always explained what was happening, what plan had been made and why so I knew what to expect. She informed the midwife in the hospital to keep me informed in her absence. She helped me to feel safe and understand the condition.* (Mayuree, woman participant)

The decision to have a post-birth conversation was made by Mayuree. She wanted her midwife to know how her ongoing communication helped her to make sense of her condition, what was suddenly happening to her and feel safe. Mayuree says "*She helped me to understand the condition".* The sudden onset of complexity appears to have thrown Mayuree as she mentions being shocked at having a high blood pressure. The information sharing by the midwife suggests respect for Mayuree's feeling when she felt unwell. Perhaps this helped to maintain Mayuree's dignity? It is possible that without the midwife's ongoing information Mayuree may

have felt unsafe and vulnerable. She says "*Medical staffs were in and out and talking to me and about me. I was scared and so confused at times".* There is a sense that Mayuree feels out of control because she is scared and confused. The ongoing conversation by the midwives enabled Mayuree to know what to expect. Perhaps this protected her from any lasting psychological effects of her complexity?

The midwife is experienced as a protector. Her ongoing communication informed Mayuree of what to expect from staff involved in her care and from post-partum pre-eclampsia. The midwife kept the woman safe physically and emotionally. She protected her from unnecessary fear while at the same time ensuring Mayuree understood the seriousness of the situation. Again, this is a fine line to maintain in terms of both reassuring and ensuring accurate understanding.

Summary

The general perception of the midwife in the media and in the community is one who assists childbirth. In these stories the midwife is seen 'as' someone who does more than assisting a birth. There is a danger of missing the intricate and inter-related layers of hermeneutic 'as' and hence misunderstanding midwifery by only thinking of midwife 'as' a midwife who assists childbirth (Horton & Astudillo, 2014). The acceptance of the ICM definition of a midwife by the NZCOM and the scope of midwifery practice in NZ has been specified on p. 7 Chapter One. Renfrew et al. (2014) in their four paper series on midwifery in The Lancet defines midwifery as:

> skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post partum, and the early weeks of life. Midwifery includes family planning and the provision of reproductive health services (p. 1075).

The above definition suggests that the role of the midwife is not just one of assisting childbirth as perceived by media and the community. Midiwves have a role during pre-pregnancy, in family planning and in provison of reproductive health. This chapter highlights the many different ways in which the midwife is involved during post-birth care, revealed through the nature of the post-birth conversations. The midwife can enable the woman to become confident as a mother, acting as something of a coach. She can inform her about how her body changes following birth, acting as teacher. In encouraging learning about baby care and feeding, the midwife acts as mother-craft teacher. In protecting the woman from challenges faced following birth of the baby, and acknowledging and affirming her as a mother, the midwife acts in the manner of a

caring guardian, watching over and supporting. Examining the post-birth conversations through the lens of the 'hermeneutic as' shows that midwives need to have an ability to read the needs of the woman/whānau, and respond with specific expertise.

Schmied, Cooke, Gutwein, Steinlein, and Homer (2008) suggested the importance of "starting where the women are" (p. 101) and being flexible in one's approach to their care. When women were challenged in their transition to parenthood, help was a gift; in contrast when they were tentatively finding their confidence, help sometimes undermined them. Tact helped in reading the situation and responding appropriately. Smythe, Payne, Wilson, Paddy, and Heard (2014) show that to be tactful is to first engage in openness to what is going on for 'this' woman in 'this' moment. The spirit of care, mood, and commitment to work through the challenges faced by the woman strengthens the midwives' attunement. Conversation is the means by which attunement is most often achieved and opens the way for what needs to happen next.

According to Heidegger (1962) tact cannot be predicted, ordered, or controlled in advance of "being there" (p. 60). Instead, being tactful comes to each situation when we are open and have patience. It flourishes when there is time, energy and spirit of care (Smythe et al., 2014).

Tact, paradoxically, enables the woman to be autonomous from professional care; yet can also give her the confidence to seek help. Practice that is not tactful results in inauthentic care. The notion of tact may present an alternative way to relate with women as the post-birth conversation plays out with sensitive attunement to the 'as' kind of practice that is most needed.

The next chapter will discuss the findings from this research and suggest recommendations for midwifery practice.

Chapter Eight: Discussion

"The conversation is the relationship" (Scott, 2017, p. 5)

The above quote, from the author of the book *Fierce Conversation*, came to my mind as I started to dwell with the data. The author makes the point that when the conversation stops, the opportunities for individuals, as well as for relationships, are lessened. Conversations are not about the number of times we engage in talk with another or number of times we talk about a particular topic. It is about the degree of authenticity we bring in our conversations. For Gadamer (2006) "authentic conversation is experienced when it draws a person into being fully engrossed in an event of specific meaning" (p. 352).

As midwives I make the assumption that we need to care about our relationship with woman and whānau and acknowledge that these relationships matter in our midwifery practice. Using the stories of women and midwives I have sought to uncover the phenomenon of post-birth reflective conversations and the experiences of those involved. How and when do the conversations happen? Who decides that the conversation needs to happen? What are the conversations about? What is the experience of having such conversations? A number of meanings have been uncovered which, when brought together, bring to light the experience of these conversation on women and midwives.

The study arose from discussion about whether initiatives such as 'Birth Afterthoughts' or 'Post Stress Clinic' (Ayers et al., 2006a; Bailey & Price, 2008; Charles & Curtis, 1994) set up in the UK were required in the NZ Maternity Care system. At the time, there were anecdotal reports of such conversations happening in practice. In this chapter I bring back my understanding to midwifery practice with an aim to complete a hermeneutic circle. I mention 'aim' as I am aware it is not possible to complete the circle as new understanding will continue to evolve and develop in this area of midwifery practice. I bring the understanding gained to the practice world as a way of affirming, informing, and challenging an area of midwifery practice. The discussion in this chapter focuses on the need to create a space for conversation and what happens in that space and during conversations. I re-circle the insights that emerged from the findings: the affect of mood on the conversations; midwife being seen 'as' a person whose role involves more than being present during childbirh and that conversations can be about issues prior to and beyond labour and birth.

Pre-Understandings – Being Aware, Remaining Open

From the beginning I have been open to my pre-understandings. I came to this research cognisant of the opportunity for the LMC midwife to create a conversational space for post-birth reflective conversations. My personal story showed that it was normal for women in our family to 'fall' or be 'drawn' into conversations about their childbirth experiences. There are examples of such conversation in this study. When they encountered 'openly dialogical conversations', both women and midwives were initially unaware of the depth of their conversation and the length of time they were in conversation. For some midwife-woman realtionships this seemed to arise when they were together in a safe conversational space. However, I came to see that one cannot assume it will happen. Some women were left feeling not heard and not understood. Some midwives were left with unresolved concerns about the woman for whom they had cared over pregnancy and through to the final six week post birth, time of closure of their relationship. This strengthened my belief that post-birth conversations do matter while at the same time it has heightened my awareness that midwives need opportunities to stop and consider both the importance of these conversations and how they may be faciilitated.

My belief that trust is only developed when there is continuity of carer has been challenged. Dee's story highlighted that it is possible to develop trust when meeting the woman only once during pregnancy as a back-up midwife. In this instance it was not continuity of carer but the 'relationship and 'being-with' the woman that enabled meaningful conversations. If the midwife-woman relationship becomes mistrustful, then the continuity may simply grow the mistrust. A midwife with attuned communication skills who steps into a situation as a 'stranger' may well become trusted in a way that a known midwife is not. Continuity in itself cannot be assumed to mean 'effective relationship'.

The stories also highlight that women and midwives who paticipated in this study wanted to have a conversation, however, the conversations were not always about labour and birth but what was also happening in the weeks following the birth of their baby. The responsibility of motherhood raised questions for them about the ongoing care of their baby. The conversations therefore need to be both reflective and also prospective. Such space was creatively achieved by those who participated in this study. There was an awareness by the paticipants that these were not necessarily debriefing conversations. The assumptions brought to this study was that the conversation that mattered was about how the labour and birth had been for women. My

thinking has changed to recognise the need to create a much more open conversational space where anything that was/is troubling the woman is free to emerge.

Key Findings

The findings that are unique from this research are the need to establish openly dialogical conversations. Such conversations emerged in a kind of 'space' that was often unrelated to the tasks of midwifery practice. It calls for midwives to be willing to stop for a 'cup of tea', to linger over something of interest so conversation is free to go wherever the woman takes it. What post-birth conversations are about has a much wider scope than the experience of labour and birth. To achieve an open, trusting relational encounter calls for tactful practice.

Openly dialogical conversations

Buber's (2010) concept of 'I-It' and 'I-Thou' focuses on the relationships and relational attitude between two people (midwife and woman) rather than on individuals. These two modes of interaction provide understanding of how we respond and communicate. In 'I-Thou' conversation the relationship is reciprocal and meaning is found mutually as dialogue continues while "I-It' mode is pertinent when objective information/understanding needs to be gained from the other but has a potential to objectify the person and not appreciate/consider them as human beings. Both modes of communication are essential in effective midwifery practice. One participant felt as if the midwife was going through a check list every time they were together. She suggests a lack of connectedness between the two of them as the conversation was 'technical' or in 'I-It' mode (Buber, 2004). Midwives may have to maintain this disconnectedness to protect themselves, especially when busy. Being able to sustain deep conversations/dialogues (mode of 'I-Thou") between two people all the time is likely not possible and hence Buber also writes of the 'I-It' mode of dialogue. Heidegger (1962) argued that engaging is a pre-condition of "being-in-their-world" (p. 84). It is only by engaging with others in a caring and attentive way that we create common context and 'worlds'. In our authentic being with others we engage in caring that is attentive and thus enable women to be who they are and reach their potential. In this research, when there has been an 'encounter' (I-Thou communication) between the midwife and the woman, the relationship is deeper. It is direct and dialogical. Both participants have a posture that is open-hearted and open-minded. There is a feeling of support, being understood, and opening up of numerous possibilities. This has

resulted in a rewarding experience for the midwife, the woman, and her whānau. Such practice is likely to sustain the midwife in her practice and leave the woman/whānau feeling content with the experience.

Creating a space for conversations

The space for conversations and, for some women, a safe space for sensitive conversations, is essential before the actual conversations can happen. The creation of the space gives a message that honest conversation is valued in the relationship. Participants in this study talked about creating space not just for themselves but also for significant others, such as partners and the woman's mother. Various authors have suggested/recommended partners involvement in post-birth discussion following birth and for family members in presence of complications or adverse event (Bria, 2013; Fryer & Weaver, 2014; NICE, 2015; WHO, 2017). My study showed how 'space' came about to enable honest, open conversation. It was most often when the midwife put aside her own midwifery agenda.

The art of conversations

Some participants were inventive in the way they created a safe, undisturbed place for conversations. The use of art as a hobby (glass work art and painting) and a place/room where the artwork was created or displayed, provided a sanctuary for Jess and Suri to have meaningful conversations with their midwife. Showing their artwork and/or talking about their hobby created a 'mood' that enabled them to open up about the challenges they were managing as they made transition to being a mother. Ashaba et al. (2018) suggested that participants (pregnant) in their study explained the use art as a coping strategy in the process of accepting their HIV positive status. From the stories told, it seems unlikely that Jess or Suri pre-planned a conversation in their 'art' space. Yet when they happened to find themselves 'there' with their midwife, they found themselves in a safe place to talk freely.

Other participants used the offer of cup of tea, a glass of water, clinical records, simply asking 'how are you feeling' or 'how is everyone' to create a space for conversation. A participant was surprised that when the first time she offered a glass of water it changed the 'mood' of the visit and opened up a space for conversation. The offer of tea, a glass of water, or looking at their clinical records helped them make a transition to a space for conversations. It indicated to the other person that the clinical aspect of care had been completed.

Williams and Bargh (2008) suggested that experiencing physical warmth promotes interpersonal warmth. Perhaps the hot drink does something toward warming the relationship, opening a way for 'really talking?'

During conversations with colleagues about the initial findings from the study, questions were raised about the appropriateness of practitioner and client sharing hospitality. Various media reports overseas have also reported on Hospital Trusts banning tea and coffee due to staff shortages, to give better impressions to patients and avoiding the perception of staff not working hard enough (Jones-Berry, 2014; Smith, 2014). The participants' stories suggest that it is not having the drink that matters (although it is likely welcomed by the breast-feeding mother and the busy on-the-road midwife); rather it is the change of 'mood' that makes the difference. One sits down to drink; it takes time to drink a cup of hot beverage. It opens a window in which an issue can be raised. Not accepting the hospitality may upset the person who may feel 'thrown' off track. A refusal may result in closing off the conversation which may not be opened again. There is limited mention of the use of these strategies to make transition to a space for conversations within midwifery literature. Dahlberg et al., (2016) mentioned that during a home visit from the midwife, women looked forward to a good chat over a cup of coffee.

Various authors have used clinical notes to open a conversation as women expressed the wish to read their notes (Dennett, 2003) and to retrace the birth experience (Baxter et al., 2003; Madden, 2002). For Collins (2006) clinical notes may help to validate a woman's experience; however, should not undermine the woman's story. Midwives in this study gave the women a full copy of their notes in the postnatal period. Some recognise this as a way for important conversations about 'what happened'. They let the woman take the lead but keep the possibility of talking open.

Being open

In the space created for conversations, both parties' willingness to participate is the premise of a dialogue. For Gadamer (2004), dialogue is about being open, equal, and sincere. Hence, participants show that they are able to release their feelings, thoughts, and questions about an experience. They let each other know their thinking and why they think in that way. They have been willing to open their 'mind' to the other and allow the other to give opinions which may be different from their own. The majority of the participants involved in dialogue/conversation

engaged in the play (Gadamer, 2004) of working-through what was being talked about. The value of reflective conversations and listening to different ideas has the possibility of making them consider how the experience, the knowledge, or the practice can be enhanced. As they have shown, it is not about what is the best solution, but about finding a better one. The process of getting to a better experience, knowledge, or practice required their participation and openness during post-birth conversations. Equality and sincerity are two other statements of openness. The nature of dialogue has been shown as equal communication in that each is seen as having rights to lead the conversation, mutual exploration, and coming to some degree of shared understanding. It has enabled barriers of power/authority to fade (somewhat) resulting in space with open atmosphere. A participant highlights how openness in space created is different during discussions in pregnancy and following the birth of the baby. It appears that continuity of care and seeing the vulnerability in each other brings deeper conversations within the space created. This has been reported in previous midwifery and nursing literature (Berg, 2005; Crowther, 2014; Heaslip & Board, 2012).

Being closed, rather than open with another hinders conversations. It is very hard for a woman to break through such barriers. When a midwife is not willing to pick up a cue, to respond to a direct question, or to engage in the back-and-forth of on-going conversation, the woman has ‘no place to go’. Enforcing an issue may mean making a formal complaint (HDC, 2018; MOH, 2015). To be able to expand and develop midwifery practice and experience, we need to have conversations together, feel comfortable about our understandings, be open to being questioned and to have our beliefs challenged and broadened. Being able to talk and listen together, to redefine our initial thinking of the situation is more likely to result in mutual understanding of the experience.

Gadamer (2004) said that when we are surprised we begin to see things from a new perspective and come to know with more clarity and experience what experience ‘is’. The negative/confrontational manner in which the participant raised her concerns could have resulted in productive meaning if the midwife had been open to that negativity or disappointment and willing to explore what lay behind the mood.

Timing of conversations

Space for conversation was created by the participants from the second day up to four weeks following the birth of the baby. Unexpected homebirth, a change in place of birth, women being transferred in labour from primary units, for example, resulted in the early creation of space for conversations. As a participant mentions, timing of the conversations depends on the situation. However, for one participant the conversation regarding her experience of the first birth happened at the beginning of her second pregnancy with a different midwife. The participant did not feel her concerns were heard by the midwife who cared for her during her first pregnancy. A woman, cared for by a midwife, needed four weeks to feel reassured that her baby was safe and well before she could engage in post-birth conversation, while another woman participant needed four weeks to experience midwifery care in NZ before having the conversation with her midwife. Various authors suggest that the most appropriate time for conversations appears to be prior to discharge from the hospital or, at home by the case loading midwife, soon after the birth (Axe, 2000; Mercer, Green-Jervis, & Brannigan, 2012; Olin & Faxelid, 2003). Dennett (2003) however, suggested a break between birth and debriefing, although the evidence and rationale for this timing is not provided.

Time can restrict information sharing, collaboration, optimum engagement, and quality of care (Sandall et al., 2015; Malott, 2017). It can be hard for midwives to create a space for authentic conversation when the postnatal visits have time restrictions. Rigid time limits enforced during postnatal visits result in less dialogue. Less dialogue affects the relationship with women and hence the quality of midwifery care provided. Heidegger (1927/2011) described the influence of those with whom we are 'with' in the world. A midwife's story highlights the influence of other group members on her to conform to what was expected during postnatal visits. Conforming and influencing another in the group reduces their potential and creates "averageness" (Heidegger, p. 119). It appears that the midwife realised the affect this had on her practice because she moved to another group which had no time constraints. Dahlberg & Aune (2013) stated that when there is quality in the relationship there is a possibility for women to experience positive and holistic care during the childbirth continuum. My findings suggest that 'time' is the key component of 'quality' care.

The conversations highlight that women and midwives have often reflected on the issue and waited for the right moment to have the conversation. There is a sense of them thinking about

how the conversation would sound. A midwife (participant) waited throughout the woman's pregnancy before having the conversation with the woman about her rationale for engaging an obstetrician in her care. The conversation was needed to clear residual tension before completion of care with the woman. This would also have enabled the woman to reflect on the appropriate way to plan such input in future pregnancies. Such courageous conversations are visible within the participants' stories.

Factors that Hinder Conversation

The participants have highlighted how texting, language barriers, and defensiveness have potential to or can inhibit the creation of space for conversation.

Texting

There has been a change in the way midwives and women communicate with each other. Text messaging has become more prevalent in life generally as well as in healthcare (Hall, Cole-Lewis, & Bernhardt, 2015; Lau et al., 2014; Leahy, Lyons, Dahm, Quinlan, & Bradley, 2017). For NZ midwives the regulatory advice on texting is in the code of conduct (Midwifery Council of New Zealand (MCNZ), 2010) and in '*Be Safe* Paper 02 (MCNZ, 2016a). The constant alert noise from the phone to indicate an arrival of text message can be distracting and affects our ability to create a space for conversation. To one participant, it indicated her midwife was busy. This was confirmed by the midwife when she was asked, by simply stating 'yes'. The one-word response prevented the creation of space for conversation. There is a sense that the participant had to compete with the phone. An opportunity to discuss the affect of such distraction would have strengthened their relationships.

I have argued that conversations can be rich, authentic and rewarding for the midwife and the woman. Weisberg (2016) highlighted the negative impact of texting on human interpersonal relationship. For NZ midwives the MCNZ (2016a) *'Be safe'* Paper 02 identifies the strengths and weaknesses of texting and applies guidelines to support midwives to be safe in practice. However, at present, there appears to be no midwifery literature on how use of texting (sending and receiving text messages) affect post-birth conversations.

The very nature of LMC practice means the midwife needs to be 'always available' to women in her caseload. At times a woman coming into labour may need to take precedence over 'this

woman, with whom I am doing a postnatal visit'. It is no surprise that a text message, or a phone call may distract the midwife and cause her to hurry away, with no time for conversation. It is likely that most women are accepting of this. But perhaps midwives fall into the trap of replying to 'all texts', accepting distraction as a normal part of practice. There needs to be a system that offers text-free space. Perhaps it is to establish and maintain a culture where anything urgent is communicated in a phone call, not a text.

Language barriers

English as a second language can affect the ability to create a space for effective conversation, especially when the use of an interpreter is declined. A participant (midwife) sensing that a decision being made by the parents was not fully informed enabled her to persist in seeking the right person to share the information with them. The person's ability to speak in the parents' native language and dialect while also having a medical background, helped to connect and develop trust. This resulted in the creation of a space to provide information and discussion so parents could make an informed decision. The midwife was not satisfied that appropriate information had been shared by the nurse or a paediatrician and wanted to ensure that space was created for informed consent. She has demonstrated working in partnership with the parents (NZCOM, 2016). For women/parents to be autonomous their actions and decisions need to be their own. Midwives need to act in the best interests of women/parents to ensure informed consent is obtained (Godbold, 2010). Yet, practice is about much more than 'consent'. The question is raised of how conversations can happen in more private space, where the woman is free to talk about the things that matter to her. That calls for ethnic diversity within new intakes of midwifery students.

Defensiveness

Deflecting responses and lack of reciprocal dialogue can prevent creation of space for deeper conversations. This is highlighted in one participant's story. In deflecting conversation we are choosing not to listen to the woman/whānau. The midwife may feel that she knows what is best for the woman. This may be true for emergency situations where our aim is to prevent further harm to the woman or baby. The women in this study make it clear they need to feel they understand why their wishes have not been considered, in situations when it would have been relatively easy to accommodate this.

The lack of time or space for conversation affects our ability to make sense of our experience and learn from it. When we are busy, we may consider conversation to be a waste of time, especially when everybody should know what happened or is happening. Not being there and not listening during conversations lessens our ability to make sense and learn from the experience. Effective communication is therefore essential (Murphy & King 2013; Yelland, 2013).

Once the space is created by one person, the other has to enter the space with openness for conversations to occur. The relationship should be such that either the midwife or the woman is able to negotiate an appropriate time for conversation if this is not immediately possible when the space is created. This requires trust, confidence, and willingness within the relationship.

What the Conversations are About

The research question for this study was: "How are post-birth reflective conversations experienced by those involved?" The interview questions specifically asked about the last conversation they had about labour and birth. Some participants did discuss labour and birth experiences while a number of other women participants did not feel a need to discuss their labour and birth experience. However, they did want to have conversation about issues coming up in the postnatal period. I now recognise there is a need to extend the focus from 'reflective' conversation to include 'prospective' conversations. The women were keen to spend time talking about what was happening during postnatal time and what was ahead. At the same time, for some women their 'issue' went back many years or was part of the ongoing relationship not directly related to their childbirth experience. It is important for midwives to be open to whatever issue the woman decides she wants to bring into a conversation.

The Cochrane review suggests that postnatal debriefing involves a nurse or midwife going through a woman's birth events with her, usually with her chart available (Bastos et al., 2015). NICE (2015) guidelines agree that women should be given the opportunity to ask questions and talk about their birth experience and the care they received during this time, because "formal debriefing of the birth experience is not recommended" (p. 14). The NICE (2018) mental health guidelines also advocate supporting women who want to discuss their experience. My study reveals that when woman have an opportunity to engage their midwife in conversation in the postnatal period, the topic may not necessarily be about the birth itself.

Being responsive

'What the conversation is about' is ideally left to the woman to decide. Meeting the woman/whānau where they are, being flexible, supporting rather than undermining, can ensure care is personalised and holistic (Walsh & Steen, 2007). The relationship is therefore beyond meeting the physical needs and experiences during the childbirth continuum. Being open, being attuned, having time, patience, and passion to care enables the midwife to see what is happening for the woman in that moment of time. According to Smythe et al. (2014), being tactful helps the midwife to read the situation and act appropriately. It may enable the woman to be autonomous but seek help when needed. Tact flourishes when there is time, energy, and spirit of care (Smythe et al., 2014). It cannot be predicted, ordered or controlled in advance of "being there" (Heidegger, 1962, p. 60). The notion of tact enables the post-birth conversation to play out with sensitive attunement to the 'as' kind of practice that is most needed. A conversation that is authentic is seldom predictable; it emerges in the context of the situation and the people involved. The challenge for the midwife is to respond to the call that a conversation is needed, and then to stay attuned to understanding the woman's needs as the conversation plays from one to the other.

Creating a space does not mean women necessarily want to have the conversation or that the conversation may happen at that particular time. Some women were happy to read their clinical notes but did not feel the need to have further conversation about their experience. We should respect the right of women to simply move on from the birth without specific discussion. The responsibility of the midwife is simply to offer the space for conversation.

Continuity of Care by NZ Midwives

The role and the scope of midwifery practice in NZ is discussed in chapter one (p. 7). The government funding (MOH, 2007), enables midwives in NZ to work as an LMC to a case load of women. Continuity of care is provided to women from time of registration to up to six week postpartum. The midwife needs to be available to her caseload at any time of the day or night – to provide care during labour or for any urgent or emergency issues (MOH, 2007). In majority of cases the women and midwives have built a relationship of trust, openness and attentiveness during the childbirth continuum. The woman already knows in the postpartum period how the midwife is likely to respond. Within the stories the 'quality' relationship showed the experience of

post-birth reflective conversations clearly. In contrast, where trust had been already broken minimal conversation occurred. The affect was 'lack' of relationship with the woman, leaving her issues unresolved. Even if the woman was brave enough to confront the midwife, she did not experience the 'care' one would expect.

Linking to Existing Research

When there is collaboration in the conversations between women and midwives there is understanding of each other. For Gadamer 'understanding' is the fusion of our horizons (Hirsch, 1967). Vessey (2009) explained that for Gadamer, fusion of horizons is when "our original understanding is surpassed and integrated into a broader, more informed understanding" (p. 540). We come to a new understanding from what our previous and present view on that subject may have been. Such exchanges lead to meaning being created in jointly constructed conversations. According to Weick (2005) "sensemaking is an issue of language, talk, and communication" (p. 51). During conversations we make sense of our situation, the events that affect us and create a plan to manage/move forward with those circumstances and events (Taylor & Van Every, 2000).

This study has revealed that the conversation that helps in making sense of what is happening depends on the willingness of the woman and midwife to trust each other. Further, it is about the midwife being responsive in her interactions through empathetic listening, attentiveness, asking questions and being non-judgemental. The stories highlight that both women and midwives need to be courageous to have and resolve conversations. However women are often more vulnerable than midwives and though both need to be courageous women probably need to be more so than the midwife. As Jane (woman participant) mentioned *"for a midwife it is going to an office while for a woman especially during first childbirth experience everything is new"* (suggesting vulnerability). Whenever there is tension in a relationship it takes courage to be the first person to bring this tension into conversation. Perhaps it is harder for the woman who recognises that if she upsets her midwife she is still somewhat trapped in this relationship until the 6-week postnatal visit. For the midwife, any woman is one amongst her larger caseload. She walks out of that encounter and on to the next client. This 'one' relationship is not so dominant in her everyday world. The ideal situation is for a midwife as a health professional to foster openly dialogical conversation where there is a shared sense of responsibility for resolving any issue or tension.

Women and midwives have to know each other to trust each other, to be sensitive to each other's needs, and to ensure discussions are happening at the right time and pace for all involved. To ensure women have a trusting relationship the majority of the LMC midwife groups would provide an opportunity for the woman to meet with the back-up midwife at some stage during pregnancy. For some women and midwives knowing each other and developing trust was essential, for example, a story where a midwife talks about how conversations in pregnancy are different to post-birth when you have shared journey of labour and birth. However, the other stories highlight that this is not the case e.g. Jess who was able to develop good relationship with a back-up midwife (Dee) and disclose her previous history when Dee visited post-birth. Under Recommendations for further research (p. 157) bullet point two highlights need for further research in this area.

Once trust is established the woman and the midwife can engage in reflective conversations that are authentic and show mutual understanding. Such dialogue can include information and also the hopes, desires and wishes that affirm women's experience and help them to move forward. Gratton and Ghoshal (2002) affirmed that under such conditions the way we make sense of our experience and learn from it are enhanced. Dahlberg et al. (2016) suggested that there is no personal relationship and hence dialogue when the woman and the midwife do not know each other.

Conditions that appear to hinder our ability to make sense of the experience include not focusing on the other and to what they are saying, especially when we are busy and going from one task to another. Do and Schallart (2004) suggested we may also feel we know what others are going to say and so lose focus. Agreeing too quickly with the other person or giving a one-word response has also been shown to shut down a conversation. Chan, Burtis, and Bereiter (1977) stated that conflict may have been prevented but so has the sharing of ideas and discussion that could have created other possibilities. The findings of these authors are congruent with my findings.

According to Jordan et al. (2009) conversations are not easy to have, although it is easy to say, "the issue is communication" and "we have to talk to each other" (p. 14). However, collaborating, making meaning within the context of the situation, and avoiding barriers to conversation can be challenging. Midwives need to engage in conversations to ensure high

quality midwifery care is provided to women/whānau. Time as a barrier to conversation is often raised by practitioners. As mentioned previously, 'time' is the key component of quality care.

Some of the other components of quality care highlighted by the Lancet series in midwifery provides a helpful lens to reflect on care that is provided to women, newborn and whānau in NZ. It says good care is human rights based approach, is respectful, meets the women's needs, optimises physiology, psychology, social and cultural processes of childbirth and that the focus should be on meeting the needs of all women and babies rather than considering them as low risk/high risk (Renfrew et al., 2014). Some of the stories in this study highlight care that was not optimal. There is a need to reflect on how this could be done better. Everyone who accesses health care in NZ has the protection of the Code of Rights (HDC, 1996), though they may not be aware of it. The midwife has the responsibility to inform women/whānau of their rights. Hence the human rights approach should be incorporated in care provided by all healthcare practitioners in NZ. The Primary Notice (MOH, 2007), a contractual agreement with LMC midwives specifies on p. 1051 the manner in which primary maternity services should be provided that includes the quality highlighted by Renfrew et al. (2014). Midwives may often reflect individually or with group members and during professional development sessions the care they provide. They also participate in a quality assurance process developed by the NZCOM. This professional development process supports the midwife to reflect on her practice formally with educated reviewers and formulate a professional development plan. The process often results in further reflection by the midwife regarding her own development and meeting the needs of women/ whānau.

The definition of midwifery provided in the Lancet series is confusing. It has a potential to undermine midwives strong sense of professional identity and the ability to work autonomously within the primary healthcare. According to Guilliland (2014) It is a reminder of how midwifery is seen globally and the importance of ensuring the word midwife is recognised in other countries. Her critique calls the ICM to make the goal of midwifery clear. Unless we are all clear and use the word 'midwife' and 'midwifery appropriately' we can weaken what we do as midwives and this will further impact on the outcomes for women and newborn locally, nationally and globally.

Strengths and Limitations of the Study

This study has explored an aspect of NZ LMC practice previously not researched. It has uncovered what it means to experience post-birth reflective conversations with the midwife, who provided continuity of care from time of registration (usually in first trimester of pregnancy) to four to six weeks following the birth of the baby. Twelve midwives provided continuity of care as LMC midwives. Two women who participated in this study did not receive continuity of care. A woman participant had her conversation with a back-up midwife she had met once during pregnancy. In majority of groups a back-up midwife is also an LMC midwife with her own caseload. It was during the time of gathering her story it became evident that her involvement in woman's care was as a back-up midwife. The other woman participant had registered with an LMC midwife, however the way the group worked affected here having continuity of carer.

A researcher takes a particular philosophical stance when undertaking a hermeneutic phenomenological study. This will likely influence the meanings revealed. The findings are therefore limited to the philosophical approach that underpinned this study.

The research was conducted in a defined geographical area of New Zealand and therefore did not include the experiences of LMC midwives in other areas of New Zealand. There were no women who identified themselves as Māori. Auckland is a diverse city and this was reflected to some extent in the women who agreed to take part in the study. There were twenty women interviewed for this study. Two identified as Indian, one as Swiss/Pacifica nationality, two as European and fifteen as NZ European. All fourteen midwives identified themselves as NZ European. Midwives from other ethnicities have therefore not been represented in this study. The midwives had to be providing midwifery care for two years or more at the time of participating in the study. None of the DHB named LMC midwives participated in the study. The voices of these midwives may reveal another view. Generalizability is a measure of how well a researcher thinks their experimental results from a sample can be extended to the population as a whole. A phenomenological study, because of its small number of participants and the interpretive nature of the analysis does not suggest the findings could be generalised. Transferability is the process of other people transferring experimental results to real life. For example, from this study readers may transfer the notions of openness, giving time and tactful practice into their own practice.

The study's focus was on post-birth reflective conversations that happen between women and midwives. In provision of midwifery care there is a relationship/partnership between women and midwives. The 'I' therefore does not stand alone or exist alone. It takes two to have the conversation. According to Buber (2006) every interaction must be considered as a 'You' speaking to 'Me', an interaction that requires a response. Hence, it was essential to illuminate both midwives and women's experiences. As stated on p. 56, there was no relationship between midwives and women who participated so that confidentiality was not breached. The intent was not to compare or verify their stories but to illuminate their individual experiences.

In interviewing the emphasis was on letting the 'story unfold.' However, with some participants an occasional prompt was required. In doing these questions that could have been asked on related issues may have been missed. Letting the 'story unfold' without disruption may have prevented me from asking questions that could have explored the issue further. The challenge is in staying within the hermeneutic circle and not moving away from the research question. Noe (2007) suggested that understanding what phenomenology is and can be is essential. This enables one to recognise/accept the findings to be genuine source of knowledge that can also add to the findings of any quantitative studies. Hermeneutic phenomenology is a way to observe the richness and complexity of the experience and illuminate the phenomenon. It is debatable whether recruiting more participants would have provided additional information. For this particular group of participants, the stories are authentic. Many in wider midwifery community will be able to understand the experience of post-birth reflective conversations and the implications to women and midwives.

Implications for Practice

The midwife-woman partnership model of care is the cornerstone of midwifery care in NZ (Guilliland & Pairman, 1995). This is the only research on lived experience of post-birth reflective conversations where twelve midwives provided care from registration/booking the woman in first trimester of pregnancy to four–six weeks following the birth of her baby. Hermeneutic phenomenological research invites those reading this thesis to join in the thinking that has been shared through the writing (Smythe et al., 2008; van Manen, 2007). In light of that understanding, I suggest some possible implications for practice:

- The midwife needs to offer/create a space for a conversation to happen. Both (woman and the midwife) need to be free to enter the space. Creating a space does not mean women necessarily want to have the conversation or that the conversation may happen at that particular time. The midwife and the woman working in partnership should be able to negotiate an appropriate time if the conversation is not immediately possible.
- The presence of trust, willingness, and confidence within the relationship should enable the woman to decide 'what the conversation is about.' It is important for midwives to be open to whatever issue the woman decides she wants to bring into a conversation.
- The midwife and the woman should have the confidence to have an authentic conversation, knowing it can be unpredictable. This enables the midwife to respond to a call that a conversation is needed and stay attuned to understand the needs of women/whānau as the conversation plays from one to the other.
- The conversation should result in shared understanding of the experience they had. Hence there is willingness by both to open their 'mind' to the other and allow the other to give opinions, which may be different from their own.
- 'Time' is the key component of 'quality' care. Time and undivided attention (focused attention) is a pre-requisite to authentic conversations. It means caring. During four to six weeks of postnatal care time should be made to have quality conversation(s) with women/whānau.
- Both the woman and the midwife need to be aware/mindful of the factors that can affect creation of a space for conversation and be open to 'making time' at a later date.
- There is a need to extend the focus from 'reflective' conversation to include 'prospective' conversations. The findings suggest that the topic may not necessarily be about the birth itself. Meeting the woman/whānau where they are, being flexible, supporting rather than undermining, can ensure care is personalised and holistic.

Implications for Education

- The role of the midwife being more than one who 'births the baby' and a woman being more than 'having a baby' needs to be acknowledged and further discussed. What is the 'as' kind of practice that the women needs, requires further exploration.
- The notion of tact and what is meant by tactful practice should be included in midwifery education and practice. What strategies can be used to communicate with tact? Tact

allows us to be honest while respecting feelings of others. How we read the situation and act appropriately is key to maintaining midwife – woman partnership. Tact is strongly influenced by culture and requires us to be culturally aware/sensitive when communicating with and providing care to women/whānau.

- Authentic conversations, effective communication and quality of care can enhance midwife-woman relationship and improves outcomes and safety for woman, baby, and whānau. Communication is a critical component of high-quality care. What is meant by authentic conversation and how do our attitudes and behaviour inform our conversations need to be discussed within midwifery education and practice. What amplifies or lessens our authenticity during conversations. Are we prepared/have confidence for the unpredictable nature of authentic conversation in our practice? Such are the challenges of preparing midwifery graduates.
- Entry to midwifery programmes needs to ensure ethnic diversity of students, increasing the opportunity for women to have a midwife who shares her language.

The above Implication for practice and education need to be disseminated by discussions, seminars, group work, undergraduate programme, and post-graduate programme as well as in on-going educational days with students and midwives. How do we make "authentic" connection with women/whānau as these connections lie at the heart of midwifery practice, how we portray openness for reflective and prospective conversations with women, what is tactful practice, and practice that considers mindfulness, what may help or hinder such tactful practice or incorporation of mindfulness in practice and what have they seen that worked or did not work in their practice environment.

Recommendations for Future Research

- Although NZ is a diverse country, the voices and experiences of Māori women and midwives (Tangata whenua[3]) are missing from this study.
- The experiences of hospital based midwives in NZ who are LMCs and DHB midwives who provide labour and birth care for women under DHB care ('closed unit') as well as midwives who may be providing antenatal and postnatal care for women with or without complexity and complications need to be heard as their voices are not represented in

[3] Tangata whenua is a Māori term that literally means "people of the land" (http:// teara.govt.nz). From Maori Dictonary "local people, hosts, indigenous people - people born of the whenua, i.e. of the placenta and of the land where the people's ancestors have lived and where their placenta are buried."

this study. Their voices are important as they may provide further insight into how they quickly develop relationship and trust, provide/maintain woman centred and holistic care in absence of continuity of care.

- The voices of GP's, obstetrician, counsellor's and psychotherapist that may be used by women when unable to have conversations with midwives may be helpful in uncovering stories that are not being told to midwives.

Final Thoughts

This hermeneutic phenomenological study has shown what it means to have post-birth reflective conversations with the midwife who has provided continuity of care and insight from two women who did not have continuity of carer. The relationship between the midwife and the woman is a professional one, with clear boundaries and expectations, but is still based on warmth and mutual acceptance. Scott's (2017) quote "the conversation is the relationship" (p. 5), can be helpful when reflecting on the conversations shared with the woman and the effect this had on the relationship.

Reflecting on the lived experience of women and midwives in this study shows that there is no end as new understanding alters our prejudices (pre-understandings) and hence the knowledge we gain and need to gain. The original question is continuously redefined as we learn and understand more about the lived experience of post-birth reflective conversation. Heidegger (1927/1962) stated that in the question of the meaning of being there is no 'circular' reasoning but a "remarkable relatedness backward or forward" (p. 28). New possibilities are seen as the original question gets redefined with more knowledge and understanding. For Gadamer (2004), there is no such thing as absolute truths. The knowledge gained from my study regarding post-birth reflective conversations will continue to evolve.

How are post-birth reflective conversations experienced by those involved? When there is openness and trust; when the midwife is attuned to both what the woman is saying, and not saying; there is opportunity for mutual understanding that embraces the woman's experience. Such conversations 'matter' to women. They affirm her as a 'mother', respond to her specific issues, and resolves tension. They are too important to 'let slip by'. It is the challenge for every midwife to seek to create space and mood that makes such conversation possible.

Gadamer (1989) talked about the three essential considerations of genuine conversations: openness to the other's position, the essence of questioning, and the concept of possibilities. Each of these three elements is a part of the authentic/genuine conversation and helps to make the conversation what it is. That is, we come to understand the essence of the conversation. We understand ourselves and others (women/whānau) through conversation. To be open to other means being self-aware of our own prejudices and knowledge; what we bring to the relationship as a midwife and a woman; and acknowledging the challenges we may face in genuinely engaging with each other in all our difference and complexity. The ability to question results in experience and flourishes thinking. Openness and questioning results in new ideas and possibilities to understand/respect each other (Heidegger, 1962), grow and develop as a midwife or a woman. Dee (midwife participant) at her interview said, “relationships where you fall into a conversation (with women/whānau) when least expected, get to know each other at a deeper level and have shared understanding of the experience, that is, have a sense/feeling of having been on a journey together are the ones that really sustain me in practice”.

References

Affonso, D. (1977). Missing pieces—A study of postpartum feelings. *Birth Fam J*, 4, 159–164. https://doi.org/10.1111/j.1523-536X.1977.tb01234.x

Alderdice, F., McNeill, J., & Lynn, F. (2013). A systematic review of systematic reviews of interventions to improve maternal mental health and well-being. *Midwifery*, 29(4), 389–399. https://doi.org/10.1016/j.midw.2012.05.010

Alexander, J. (1998). Confusing debriefing and defusing postnatally. The need for clarity of terms, purpose and value. *Midwifery,* 14, 122–124. https://doi.org/10.1016/S0266-6138(98)90010-9

Ali, M. (2018). Communication skills 3: Non-verbal communication. *Nursing Times (Online)*, *114*(2), 41–42.

American Psychiatric Association. (2013). *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Arlington, V.A.: Author. Washington, DC: American Psychiatric Publishing.

Anderson, T., & Podkolinski, J. (2000). Reflections on midwifery care in the postnatal period. In J. Alexander, C. Roth, V. Levy, (Eds*.), Midwifery practice: Core topics three. Midwifery Practice. (pp. 1–18). Retrieved from https://doi.org/10.1007/978-1-349-15038-0_1*

Ashaba, S., Kakuhikire, B., Vořechovská, D., Perkins, J. M., Cooper-Vince, C. E., Maling, S., Bangsberg, D. R., & Tsai, A. C. (2018). Reliability, Validity, and Factor Structure of the Hopkins Symptom Checklist-25: Population-Based Study of Persons Living With HIV in Rural Uganda. *AIDS Behav,* 22(5), 1467–1474. *https://doi.org/10.1007/s10461-017-1843-1.*

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: A developmental approach to research methodology. *Open Review of Educational Research,* 4(1), 33–45. *http://dx.doi.org/10.1080/23265507.2017.1300068*

Attree, M. (2001). Patients' and relatives' experiences and perspectives of 'Good' and 'Not so Good' quality care. *Journal of Advanced Nursing,* 33(4), 456–466. *https://doi.org/10.1046/j.1365-2648.2001.01689.x*

Austin, D., Smythe, E., & Jull, A. (2014). Midwives' wellbeing following adverse events—What does the research indicate? *New Zealand College of Midwives Journal,* 50, 19–23. *https://doi.org/10.12784/nzcomjnl50.2014.3.*

Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion Fatigue: The Experience of Nurses. *Ethics and Social Welfare,* 3(2), 195–214. *https://doi.org/10.1080/17496530902951988*

Axe, S. (2000). Women's issues. Labour debriefing is crucial for good psychological care. *British Journal of Midwifery,* 8(10), 626–628. *https://doi.org/10.12968/bjom.2000.8.10.8063*

Ayers, S. (2007). Thoughts and Emotions During Traumatic Birth: A Qualitative Study*. Birth,* 34(3), 253–263*. https://doi.org/10.1111/j.1523-536X.2007.00178.x*

Ayers, S., & Pickering, A. D. (2001). Do women get post-traumatic stress disorder as a result of childbirth? A prospective study of incidence*. Birth,* 28(2), 111–118. *https://doi.org/10.1046/j.1523-536X.2001.00111.x*

Ayers, S., Claypool, J., & Eagle, A. (2006a). What happens after a difficult birth? Postnatal debriefing services. *British Journal of Midwifery,* 14(3), 157–161. *https://doi.org/10.12968/bjom.2006.14.3.20577*

Ayers, S., Eagle, A., & Waring , H. (2006b). The effects of childbirth-related post- traumatic stress disorder on women and their relationships: A qualitative study. *Psychol Health Med,* 11(4), 389–398*. https://doi.org/10.1080/13548500600708409*

Ayers, S., McKenzie-McHarg, K., & Slade, P. (2015). Post-traumatic stress disorder after birth. *Journal of Reproductive and Infant Psychology,* 33(3), 215–218. *https://doi.org/10.1080/02646838.2015.1030250*

Bäckström, C. A., Wahn, E. I. H., & Ekström, A. C. (2010). Two sides of breastfeeding support: Experiences of women and midwives. *International Breastfeeding Journal,* 5(1), 20. *https://doi.org/10.1186/1746-4358-5-20*

Bailey, M., & Price, S. (2008). Exploring women's experiences of a Birth Afterthoughts service. *Evidenced Based Midwifery.* 6 (2), 52–58*. Retrieved from The Royal College of Midwives website: https://www.rcm.org.uk/sites/default/files/Evidence%20Based%20Midwifery%20-%20June%202008.pdf*

Balin, R. E. (2005). *Trends in Midwifery Research.* New York: Nova Science Publisher.

Barimani, M., & Vikström, A. (2015). Successful early postpartum support linked to management, informational, and relational continuity. *Midwifery,* 31(8), 811-817. *https://doi.org/10.1016/j.midw.2015.04.009*

Barker, S. (2011). *Midwives' Emotional Care of Women becoming Mothers. Retrieved from https://pdfs.semanticscholar.org/9a53/bd2b9a687c6cbb66e6f1555c307cfc5f967e.pdf*

Barlow, J. (2015). Vulnerable mothers in pregnancy and the postnatal period. *Nursing in Practice. Retrieved from https://www.nursinginpractice.com/article/vulnerable-mothers-pregnancy-and-postnatal-period*

Bastos, M. H., Furuta, M., Small, R., McKenzie-McHarg, K., & Bick, D. (2015). Debriefing interventions for the prevention of psychological trauma in women following childbirth. *Cochrane Database of Systematic Reviews, (4, Art. No.: CD007194). https://doi.org/10.1002/14651858.CD007194.pub2*

Baxter, J., McCrae, A., & Dorey-Irani, A. (2003). Talking with women after birth. *British Journal of Midwifery,* 11(5), 304–309*. https://doi.org/10.12968/bjom.2003.11.5.11228*

Baxter, J., McCourt, J., & Jarrett, P. (2014). What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services: A critical review of the literature*. Midwifery,* 30(2), 194–219. *http://dx.doi.org/10.1016/j.midw.2013.12.013*

Beavers, A. F. (1995). *Introducing Levinas to Undergraduate Philosophers.* Presented in 1990. Online Paper. Presented at the Undergraduate Philosophy Association, The University of Texas at Austin*. Retrieved from http://faculty.evansville.edu/tb2/PDFs/UndergradPhil.pdf*

Beck, C. T. (1993). Qualitative Research: The Evaluation of Its Credibility, Fittingness, and Auditability. *Western Journal of Nursing Research,* 15(2), 263–266. *https://doi.org/10.1177/019394599301500212*

Beck, C. T. (2004a). PTSD due to childbirth: The aftermath*. Nurs Res,* 53(4), 216–224. *http://dx.doi.org/10.1097/00006199-200407000-00004*

Beck, C. T. (2004b). Birth trauma: In the eye of the beholder. *Nursing Research,* 53(1), 28–35. *https://doi.org/10.1097/00006199-200401000-00005 ·*

Beck, C. T., & Watson, S. (2008). Impact of birth trauma on breast-feeding: A tale of two pathways. *Nurs Res,* 57(4), 228–236. *https://doi.org/10.1097/01.NNR.0000313494.87282.90*

Beck, C. T., Gable, R. K., Sakala, C., & Declercq, E. R. (2011). Post-traumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey. *Birth,* 38(3), 216–227. *https://doi.org/doi:10.1111/j.1523-536X.2011.00475.x*

Berg, M., & Dahlberg, K. (1998). A phenomenological study of women's experiences of complicated childbirth*. Midwifery,* 14(1), 23–29*. https://doi.org/10.1016/S0266-6138(98)90111-5*

Berg, M., & Dahlberg, K. (2001). Swedish midwives' care of women who are at high obstetric risk or who have obstetric complications. *Midwifery,* 17(4), 259–266. *https://doi.org/10.1054/midw.2001.0284*

Berg, M. (2005). A Midwifery Model of Care for Childbearing Women at High Risk: Genuine Caring in Caring for the Genuine. *Journal of Perinatal Education,* 14(1), 9–21. *https://doi.org/10.1624/105812405X23577*

Berg, M., Bondas, T., Brinchmann, B. S., Lundgren, I., Ólafsdóttir, O. A., Vehvilainen- Julkunen, K., & Hall, E. O. C. (2008). Evidence-based care and childbearing—A critical approach. *International Journal of Qualitative Studies on Health and Well-Being,* 3(4), 239–247. *https://doi.org/10.1080/17482620802316089*

Bergum, V. (1992). *The dialectical approach to clinical judgement in nursing.* Paper Presentation presented at the Third International Invitational Pedagogy Conference, University of Victoria, Victoria, Canada.

Bernard, H. R. (2002). *Research methods in anthropology: Qualitative and quantitative*

approaches. (3rd ed.). Walnut Creek, CA: Alta Mira Press.

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders,* 191, 62–77. *https://doi.org/10.1016/j.jad.2015.11.014*

Birt, L., Scott, S., & Cavers, D. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research,* (June 22). *Retrieved from https://doi.org/10.1177%2F1049732316654870*

Bishop, A. H., & Scudder, J. R., Jr. (1991). *Nursing: The practice of caring.* New York: National League for Nursing.

Bluff, R., & Holloway, I. (1994). They know best': Women's perceptions of midwifery care during labour and childbirth. *Midwifery,* 10(3), 157–164. *https://doi.org/10.1016/0266-6138(94)90046-9.*

Boell, S. K., & Cecez-Kecmanovic, D. (2010). Literature Reviews and the Hermeneutic Circle. *Australian Academic & Research Libraries,* 41(2), 129–144. *https://doi.org/10.1080/00048623.2010.10721450*

Bohren, M., Hofmeyr, G., Sakala, C., Fukuzawa, R., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews,* (7). *https://doi.org/10.1002/14651858.CD003766.pub6*

Bollnow, O. (1961). Lived-space. *Philosophy Today,* 5(1), 31–39. *https://philpapers.org/go.pl?id=BOLL&proxyId=&u=http%3A%2F%2Fdx.doi.org%2F10.5840%2Fphiltoday1961513*

Bonevac, D. (2014). Heidegger's Map*. Academic Quest,* 27(2), 165–184. *https://doi.org/10.1007/s12129-014-9417-4*

Bontekoe, R. (1996). *Dimensions of the hermeneutic circle.* Atlantic Highlands, NJ: Humanities Press.

Boyle, M. (2017). *Emergencies Around Childbirth: A Handbook for Midwives.* (3rd Edition). Florida, USA: CRC Press, Taylor & Francis Group.

Bria, K. (2013). *Exploring the experiences of first time fatherhood and paternal postnatal depression: A grounded theory analysis revealing the importance of the concept of "coping".* (Doctor of Philosophy, The University of Adelaide). Retrieved from https://digital.library.adelaide.edu.au/dspace/bitstream/2440/83365/9/01front.pdf

Briscoe, L, Lavender, T., & McGowan, L. (2016). A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing,* 72(10), 2330–2345. *https://doi.org/10.1111/jan.13017*

Brockington, I. (2004). Postpartum psychiatric disorders. *Lancet,* 363(9405), 303–310. *https://doi.org/10.1016/S0140-6736(03)15390-1*

Brown, J. M., Kitson, A. L., & McKnight, T. J. (1992). *Challenges in caring: Explorations in*

nursing and ethics. (1st Ed.). London: Chapman & Hall.

Buber, M. (1958). *I and Thou. 2.* New York: Scribner.

Buber, M. (1965). *The Knowledge of Man.* New York: Harper & Row.

Buber, M. (1998). *The knowledge of man; Selected essays.* Amherst, NY: Humanity Books.

Buber, M. (2002). *Between man and man (R. Gregor-Smith, Trans.).* London: Routledge Classics.

Buber M. *(2004). I and Thou (Trans Roanld Gregory smith) (2nd Ed.).* UK: Continuum.

Buber, M. (2006). *I and Thou.* Hesperidas Press.

Buber M. (2010). *I and Thou.* Martino Publishing.

Burns, E. (2016). Breastfeeding dictator or breastfeeding enabler? Midwives' support styles can make a difference. *The Conversation,*1. https://theconversation.com/breastfeeding-dictator-or-breastfeeding-enabler-midwives-support-styles-can-make-a-difference-53303

Butler, J. L. (2016). Rediscovering Husserl: Perspectives on the Epoché and the Reductions. *The Qualitative Report,* 21(11), 2033–2043.

Caelli, K. (2001). Engaging with phenomenology: Is it more of a challenge than it needs to be? *Qualitative Health Research,* 11, 273–281.

Campbell, R. (2001). Heidegger: Truth as Aletheia. In R. Small, (Ed.), *A hundred years of phenomenology: Perspectives on a philosophical tradition, (pp.* 73–89). Burlington, VT: Ashgate.

Capobianco, R. (2010). *Engaging Heidegger.* Toronto: University of Toronto Press.

Carleton, M. (2017). The healing power of art. *Harvard Women's Health Watch (Online). Retrieved from https://www.health.harvard.edu/mental-health/the-healing-power-of-art*

Carmack, B. J. (1997). Balancing engagement and detachment in care giving. *Journal of Nursing Scholarship,* 29(2), 139–143. *http://psycnet.apa.org/doi/10.1111/j.1547-5069.1997.tb01546.x*

Carolan, M., & Hodnett, E. (2007). "With woman" philosophy: Examining the evidence, answering the questions. *Nurs Inq.,* 14(2), 140–152*. https://doi.org/10.1111/j.1440-1800.2007.00360.x*

Carter, S. K., & Gonzalez Guittar, S. (2014). Emotion work among pregnant and birthing women. *Midwifery,* 30(9), 1021–1028. *https://doi.org/10.1016/j.midw.2014.05.003*

Carter, W., Grigoriadis, S., & Ross, L. E. (2010). Relationship distress and depression in postpartum women: Literature review and introduction of a conjoint interpersonal psychotherapy intervention. *Archives of Women's Mental Health,* 13(3), 279–284. *https://doi.org/10.1007/s00737-009-0136-8. [*

Cerbone, D. R. (2009). *Heidegger: A guide for the perplexed (2nd ed*.). London, England: Continuum International Publishing Group.

Cestari, V. R. F., Moreira, T. M. M., Pessoa, V. L. M. P., Florêncio, R. S., Silva, M. R. F., & Torres, R. A. M. (2017). The essence of care in health vulnerability: A Heideggerian construction. *Rev Bras Enferm [Internet]*, *70*(5), 1112–1116. http://dx.doi.org/10.1590/0034-7167-2016-0570

Chan, C. K. K., Burtis, J., & Bereiter, C. (1997). Knowledge building as a mediator of conflict in conceptual change*. Cognition and Instruction,* 15(1), 1–40. *http://dx.doi.org/10.1207/s1532690xci1501_1*

Chan, Z. C., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process?*) The Qualitative Report,* 18(59), 1–9. *Retrieved from The Hong Kong Polytechnic University website: http://www.nova.edu/ssss/QR/QR18/chan59.pdf*

Chisholm, D., Sanderson, K., Ayuso-Mateos, J. L., & Saxen, S. (2004). Reducing the global burden of depression: Population-level analysis of intervention cost-effectiveness in 14 world regions. *Br J Psychiatry,* 184, 393-403*. https://doi.org/10.1192/bjp.184.5.393*

Christensen, M., Welch, A., & Barr, J. (2017). Husserlian Descriptive Phenomenology: A review of intentionality, reduction and the natural attitude. *Journal of Nursing Education and Practice*, 7(8), 113–118. *https://doi.org/10.5430/jnep.v7n8p113*

Christenson, G. A. (2013). Conceptualizing the arts as tools for medicine and public health. *Journal of Applied Arts and Health,* 4(3), 247–264. *https://doi.org/doi:10.1386/jaah.4.3.247_1[*

Cigoli, V., Gilli, G., & Santa, E. (2006). Relational factor in psychopathological responses to childbirth. *Journal of Psychosomatic Obstetrics and Gynaecology,* 27, 91–97. *https://doi.org/10.1080/01674820600714566*

Clark, J. (2008). Philosophy, understanding and the consultation: A fusion of horizons. *British Journal of General Practice,* 58(546), 58–60*. https://doi.org/10.3399/bjgp08X263929*

Cohen, M. (1987). A historical overview of the phenomenologic movement. *Journal of Nursing,* 19(1), 31-34*. https://doi.org/10.1111/j.1547-5069.1987.tb00584.x/*

Cohen, L., Manion, L., & Morrison, K. (Ed.). (2007). *Research Methods in Education. (6th Ed.).* London and New York: Routledge.

Collins, R. (2006). What is the purpose of debriefing women in the postnatal period?' *Evidence Based Midwifery, 4*(1), 4–9.

Conesa Ferrer, M. B., Canteras Jordana, M., Ballesteros Meseguer, C., Carrillo García, C., & Martínez Roche, M. E. (2016). Comparative study analysing women's childbirth satisfaction and obstetric outcomes across two different models of maternity care. *BMJ Open,* 6(8, e011362). *https://doi.org/10.1136/bmjopen-2016-011362*

Cowan, J., Smythe, E., & Hunter, M. (2011). Women's lived experiences of severe early onset preeclampsia: A hermeneutic analysis: In G. Thomson, F. Dykes, & S. Downe, (Eds.), *Qualitative Research in Midwifery and Childbirth Phenomenological Approaches.* Oxon: Routledge.

Creasy, J. (1997). Women's experience of transfer from community-based to consultant-based maternity care*. Midwifery,* 13(1), 32–39*. https://doi.org/10.1016/S0266-6138(97)90030-9*

Creedy, D. K., Shocket, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms. *Birth,* 27, 104–111*. https://doi.org/10.1046/j.1523-536x.2000.00104.x*

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research (2nd ed.).* Thousand Oaks, CA: Sage.

Critchley, S. (2002). Introduction. In: *The Cambridge Companion to Levinas.* Critchley, S. and R. Bernasconi (eds.). Cambridge: Cambridge University Press.

Critchley, S. (2009a). Being and Time, part 5: Anxiety. *The Guardian - International Edition. Retrieved from https://www.theguardian.com/commentisfree/belief/2009/jul/06/heidegger-philosophy-being*

Crow, J., & Smith, L. (2005). Co-teaching in higher education: Reflective conversation on shared experience as continued professional development for lecturers and health and social care students. *Reflective Practice,* 6(4), 491–506. *https://doi.org/10.1080/14623940500300582*

Crowther, S. (2014). Foregrounding Spirituality and Joy at Birth in Antenatal Education. *International Journal of Childbirth Education,* 29(4), 8–14.

Crowther, S., Smythe, L., & Spence, D. (2014a). Mood and birth experience. *Women Birth.,* 27(1), 21–25*. https://doi.org/10.1016/j.wombi.2013.02.004.*

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting Stories in Hermeneutic Phenomenology Research: A Methodological Device*. Qual Health Res.,* 27(6), 826–835. *https://doi.org/10.1177/1049732316656161.*

Cummings, E & Whittaker, K. (2016). Listening visits by health visitors as an intervention for mild-to-moderate postnatal depression or anxiety. *Journal of Health Visiting,* 4, 264–270. *https://doi.org/10.12968/johv.2016.4.5.264*

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology,* 39, 35–51. *https://doi.org/10.1348/014466500163095*

Dahlberg, K. (2006). The essence of essences – the search for meaning structures in phenomenological analysis of lifeworld phenomena*. International Journal of Qualitative Studies on Health and Well-Being,* 1(1), 11–19. *https://doi.org/10.1080/17482620500478405*

Dahlberg, U., & Aune, I. (2013). The woman's birth experience—The effect of interpersonal relationships and continuity of care. *Midwifery*, *29*(4), 407–415. https://doi.org/doi.org/10.1016/j.midw.2012.09.006

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research (2nd Ed.).* Lund, Sweden: Studentlitteratur.

Dahlberg, U., Haugan, G., & Aune, I. (2016). Women's experiences of home visits by midwives in the early postnatal period. *Midwifery,* 39, 57–62. *https://doi.org/10.1016/j.midw.2016.05.003.*

Darvill, R., Skirton, H., & Farrand, P. (2010). Psychological factors that impact on women's experiences of first time motherhood: a qualitative study of the transition. *Midwifery,* 26(3), 357–366. *https://doi.org/10.1016/j.midw.2008.07.006*

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., Gilbody.S. et al. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: A qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy Childbirth*. 2017; 17: 45. *17(45), 1–15. https://dx.doi.org/10.1186%2Fs12884-017-1229-4*

Davy, B. J. (2007). An Other Face of Ethics in Levinas. *Ethics and the Environment,* 12(1), 39–65.

Davey, N. (2014). Hermeneutics, Structuralism and Post-Structuralism'. In: Malpas, J. (ed.), *Handbook to Hermeneutics.* 35–46. *Retrieved from http://dialoguestudies.org/wp-content/uploads/2015/02/Just_Send_Me_Word_the_Promise_of_Dialogue.pdf*

Davidsen, A. S. (2013). Phenomenological Approaches in Psychology and Health Sciences. *Qualitative Research in Psychology,* 10(3). *https://doi.org/10.1080/14780887.2011.608466*

Dekel, S., Stuebe, C., & Dishy, G. (2017). Childbirth Induced Posttraumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors. Frontiers in Psychology, 8, 560. https://doi.org/10.3389/fpsyg.2017.00560

Demske, J. M. (1970). *Being, Man, and Death: A Key to Heidegger.* University Press of Kentucky.

Dennett, S. (2003). Talking about the birth with a midwife. British Journal of Midwifery, 11(1), 24–27. https://doi.org/10.12968/bjom.2003.11.1.11008

Dennis C. L., & Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Syst Rev,* Feb 28(2). *https://doi.org/10.1002/14651858.CD001134.pub3.*

Deverick, Z., & Guiney, H. (2016). *Postnatal Depression in New Zealand: Findings from the 2015 New Mothers' Mental Health Survey. Retrieved from https://www.hpa.org.nz/sites/default/files/%EF%BF%BCPostnatal%20Depression%20in%20New%20Zealand-%20Findings%20from%20the%202015%20New%20Mothers'%20Mental%20Health%20Survey.pdf*

Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of lived experiences of students, teachers and clinicians. *Career and Technical Education, 23(3), 53–71. https://doi.org/10.1097/00012272-200103000-00006*

Diener, E., Fujita, F., Tay, L., & Biswas-Diener, R. (2012). Purpose, Mood, and Pleasure in Predicting Satisfaction Judgments. Social Indicators Research, 105(3), 333–341. *https://doi.org/10.1007/s11205-011-9787-8*

Dixon, L., Guilliland, K., Pallant, J., Sidebotham, M., Fenwick, J., McAra-Couper, J., & Gilkison, A. (2017). The emotional wellbeing of New Zealand midwives: Comparing responses for midwives in caseloading and shift work settings*. New Zealand College of Midwives Journal,* 53, 5–14*.*

Do, S., & Schallert, D. (2004). Emotions and classroom talk: Toward a model of the role of affect in students' experiences of classroom discussions. *Journal of Educational Psychology, 96*(4), 619–634. http://psycnet.apa.org/doi/10.1037/0022-0663.96.4.619

Draucker, C. B. (1999). The critique of Heideggerian hermeneutical nursing research. *Journal of Advanced Nursing,* 30(2), 360–373*. https://doi.org/10.1046/j.1365-2648.1999.01091.x*

Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time, Division I.* Cambridge, MA: MIT Press.

Dreyfus, H. (1992). *What computers still can't do: A critique of Artificial Reason*. Cambridge, MA: MIT Press.

Dreyfus, H. L., & Wrathall, M. A. (Eds.). (2007). *A companion to Heidegger* (2nd Ed.), Oxford, England: Blackwell Publishing Limited.

Dykes, F. (2005). "Supply" and "demand": Breastfeeding as labour. *Soc Sci Med.,* 60(10), 2283–2293*. https://doi.org/10.1016/j.socscimed.2004.10.002*

Eden, C. (1989). Midwives knowledge and management of PND. *Aust J Adv Nurs,* 7(1), 35-42.

Edgoose, J. Y. C., & Edgoose, J. M. (2017). Finding Hope in the Face-to-Face. *The Annals of Family Medicine,* 15(3), 272–274*. https://doi.org/10.1370/afm.2076*

Elkholy, S. (2008). *Heidegger and the Metaphysics of Feeling: Angst and the Finitude of Being.* London: Continuum Press.

Elley-Brown, M. J. (2015). *Career as meaning making: A hermeneutic phenomenological study of women's lived experience.* (Doctor of Philosophy, Auckland University of Technology). *Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.841.7029&rep=rep1&type=pdf*

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *J Adv Nurs.*, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x.

Elpidorou, A., & Freeman, L. (2015). Affectivity in Heidegger II: Moods and Emotions in Being and Time. *Philosophy Compass,* 10(10). *https://doi.org/10.1111/phc3.12273*

Embree, L. (Ed.). (2013). *Schutzian Social Science.* Dordrecht, Boston, London: Kluwer Academic Publishers.

Eppich, W., & Cheng, A. (2015). Promoting Excellence and Reflective Learning in Simulation (PEARLS): Development and rationale for a blended approach to health care simulation debriefing. *Simul Healthc,* 10(2), 106–115. *https://doi.org/10.1097/SIH.0000000000000072.*

Estes, R. J. & Sirgy, M. J. (Ed.). (2017)*. The Pursuit of Human Well-Being: The Untold Global History.* Switzerland: Springer International Publishing.

Fallon, M. (2015). The Other Side of Silence. *New England Review,* 36(4), 159–171.

Fasching, W. (2012). Intentionality and Presence: On the Intrinsic Of-ness of Consciousness from a Transcendental- Phenomenological Perspective. *Husserl Stud*, 28, 121–141. *https://doi.org/10.1007/s10743-012-9106-5*

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery,* 30,185–193. *http://dx.doi.org/10.1016/j.midw.2013.12.004*

Fenwick, J., Butt, J., Dhaliwal, S., Hauck, Y., & Schmied, V. (2010). Western Australian women's perceptions of the style and quality of midwifery postnatal care in hospital and at home. *Women and Birth,* 23(1), 10–21. *https://doi.org/10.1016/j.wombi.2009.06.001*

Figal, G. (2002). The doing the thing itself: Gadamer's hermeneutic ontology of language. In R. J. Dostal, (Ed.), *Cambridge Companion to Gadamer.* Cambridge: Cambridge University Press.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. *In B. H. Stamm, (Ed.), Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers, and Educators.* Lutherville, MD: Sidran Press.

Finlay, L. (2003). Through the looking glass: Intersubjectivity and hermeneutic reflection. *In L. Finlay, & B. Gough, (Eds.), Reflexivity: A practical guide for researchers in health and social sciences* (pp. 105–119). Oxford, England: Blackwell.

Flacking, R., Thomson, G., & Axelin, A. (2016). Pathways to emotional closeness in neonatal

units – a cross-national qualitative study. *BMC Pregnancy and Childbirth*, *16*(1), 170. https://doi.org/10.1186/s12884-016-0955-3

Flores, F., & Solomon, R. C. (1998). Creating trust. *Business Ethics Quarterly,* 8, 205–232. *https://doi.org/10.2307/3857326*

Ford, E., & Ayers, S. (2009). Stressful events and support during birth: The effect on anxiety, mood and perceived control*. Journal of Anxiety Disorders,* 23, 260–268. *https://doi.org/10.1016/j.janxdis.2008.07.009*

Frede, D. (1993). The question of being. *In C. Guignon, (Ed.), The Cambridge Companion to Heidegger (Cambridge Companions to Philosophy* (pp. 42–69)*. Retrieved from 10.1017/CCOL0521385709.002*

French, J. R. (2015). *Exploring Conversational Spaces of Reflection, Generativity, and Commitment in Family Therapy.* (Thesis, Doctor of Philosophy, University of Calgary). *Retrieved from http://hdl.handle.net/11023/2400*

Friedman, M. S. (1955). *Martin Buber:* The Life of Dialogue. London: Routledge & Kegan Paul.

Friedman, M. S. (1976). Martin Buber: The Life of Dialogue (3rd Ed.). Chicago: University of Chicago Press.

Friedman, M. J. (2000). *Post-traumatic stress disorder: The latest assessment and treatment strategies.* Kansas City: Compact Clinicals.

Friedman, R. (2016). Defusing an Emotionally Charged Conversation with a Colleague. *Harvard Business Review,* (January 12th)*. Retrieved from https://hbr.org/2016/01/defusing-an-emotionally-charged-conversation-with-a-colleague*

Fryer, J., & Weaver, J. J. (2014). Should a postnatal birth discussion be part of routine midwifery care? *British Journal of Midwifery,* 22(2), 118–123. *https://doi.org/0.12968/bjom.2014.22.2.118*

Furuta, M., Sandall, J., & Bick, D. (2012). A systematic review of the relationship between severe maternal morbidity and post-traumatic stress disorder. *BMC Pregnancy and Childbirth,* 12(125), 1–26. *https://doi.org/10.1186/1471-2393-12-125*

Gadamer, H. G. (1960)*. Truth and method (G. Barden & J. Cumming, Trans.). (Original work published in 1960).* New York: Seabury Press.

Gadamer, H. G. (1975)*. Philosophical hermeneutics.* Berkeley, CA: University of California Press.

Gadamer, H. G. (1976). *Philosophical hermeneutics (trans and edited by David E. Linge).* Berkeley: University of California Press.

Gadamer, H. G. (1989)*. Truth and method (2nd ed).* London: Sheed & Ward.

Gadamer, H. G. (1994). *Heidegger's ways (J. W. Stanley,Trans*.). New York: State University of New York Press.

Gadamer, H. G. (1996). *Truth and method (Joel Weinsheimer & Donald Marshall, Trans.)* (2nd rev. Ed), New York: Continuum.

Gadamer, H. G. (1998). The Beginning of Philosophy, trans. by Rod Coltman. New York: Continuum.

Gadamer, H. G. (2000). *Truth and method (J. Weinsheimer, & D. G. Marshall, Trans.).* New York: Continuum. (Original work published 1960).

Gadamer, H. G. (2000a). *Towards a phenomenology of ritual and language. In In Schmidt, L., & Reuss, M. (Trans.), Language and linguisticality in Gadamer's hermeneutics.* (pp. 50–51). Lanham, MD: Lexington Books.

Gadamer, H. G. (2004). *Truth and method (J. Weinsheimer & D. Marshall, Trans.).* (2nd revised Edn.). New York, NY: Continuum International Publishing Group.

Gadamer, H. G. (2006). *A Century of Philosophy: Hans-Georg Gadamer in Conversation with Riccardo Dottori (R. Coltman & S. Koepke, Trans.).* London/New York: continuum.

Gamble, J., Creedy, D. K., & Moyle, W. (2004). Counselling processes to address psychological distress following childbirth: Perceptions of women. *Aust. Midwifery J. Aust. Coll. Midwives,* 17, 12–15. *https://doi.org/10.1016/S1448-8272(04)80012-9*

Gamble, J. A., Creedy, D. K., Webster, J., & Moyle, W. (2002). A review of the literature on debriefing or non-directive counselling to prevent postpartum emotional distress. *Midwifery,* 18(1), 72–79. *https://doi.org/10.1054/midw.2001.0287*

Gamble, J., Creedy, D., Moyle, W., Webster, J., McAllister, M., & Dickson, P. (2005). Effectiveness of a counselling intervention after a traumatic childbirth: A randomised *controlled trial. Birth, 32(1), 11–19. https://doi.org/10.1111/j.0730-7659.2005.00340.x/*

Garthus-Niegel, S., von Soest, T., Vollrath, M.E. et al. (2013). The impact of subjective birth experiences on post-traumatic stress symptoms: A longitudinal study. *Arch Womens Ment Health*, *16*(1), 1–10. https://doi.org/10.1007/s00737-012-0301-3

Garza, G., & Landrum, B. (2010). Ethics and the primacy of the other: A Levinasian foundation for phenomenological research. Indo-Pacific Journal of Phenomenology, 10(2), 1–12. *https://doi.org/10.2989/IPJP .2010.10.2.3.1084*

Geanellos, R. (1998). Hermeneutic philosophy. Part I: Implications of its use as methodology in interpretive nursing research. *Nursing Inquiry,* 5(3), 154–163. *https://doi.org/10.1046/j.1440-1800.1998.530154.*

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

Gendlin, E.T. (1978). Befindlichkeit: Heidegger and the philosophy of psychology. *Review of Existential Psychology and Psychiatry,* 16(1–3), 43–71.

Ghaye, T. (2011). *Teaching and learning through reflective practice. A practical guide for positive action.* (2nd Ed.). Oxon: Routledge.

Gibb, S., & Hundley, V. (2007). What psychosocial well-being in the postnatal period means to midwives. *Midwifery,* 23(4), 413-424*. https://doi.org/10.1016/j.midw.2006.07.005*

Gibbins, J., & Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery,* 17(4), 302–313*. https://doi.org/10.1054/midw.2001.0263*

Gibbon, K. (2010). It's more than just talking. *RCM, Midwives Magazine,* (February/March). *Retrieved from https://www.rcm.org.uk/news-views-and-analysis/analysis/it's-more-than-just-talking*

Gill, S. (2015). Holding Oneself Open in a Conversation" – Gadamer's Philosophical Hermeneutics and the Ethics of Dialogue*. Journal of Dialogue Studies,* 3(1), 9–28.

Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith, (Ed.), *Qualitative psychology. (pp. 25–50).* London: Sage.

Goble, E. (2017)*. Visual Phenomenology: Encountering the Sublime Through Images.* New York: Routledge.

Godbold, R. (2010). Informed consent and midwifery practice in New Zealand: Lessons from the Health and Disability Commissioner. *New Zealand College of Midwives Journal,* 42(May), 12–16.

Goodman, P., Mackay, M., & Tavakoli, A. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing,* 46(2), 212–219*. https://doi.org/10.1111/j.1365-2648.2003.02981.x*

Gordon, H. (2001)*. The Heidegger-Buber Controversy: The Status of the I-Thou.* Greenwood Publishing Group.

Gratton, L., & Ghoshal, S. (2002). *Improving the quality of conversations. Organizational Dynamics,* 31(3), 209-223*. https://doi.org/10.1016/S0090-2616(02)00110-9.*

Green, J. M., & Baston, H. A. (2003). Feeling in control during labor: Concepts, correlates, and consequences. *Birth-Issues In Perinatal Care,* 30(4), 235–247. *https://doi.org/10.1046/j.1523-536X.2003.00253.x*

Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1990). Expectations, experiences, and psychological outcomes of childbirth: A prospective study of 825 women. *Birth,* 17(1), 15–24. *https://doi.org/10.1111/j.1523-536X.1990.tb00004.x/*

Grigg, C. P., & Tracy, S. K. (2013). New Zealand's unique maternity system. *Women and Birth,* 26(1), e59–e64. *http://dx.doi.org/10.1016/j.wombi.2012.09.006*

Grondin, J. (2002). Gadamer's basic understanding of understanding*.* In R. J. Dorstal, (Ed.), *The Cambridge companion to Gadamer* (pp. 36–51). Cambridge, UK: Press Syndicate of the University of Cambridge.

Grondin, J. (2003). *The philosophy of Gadamer. (K. Plant, Trans.).* Chesham: Acumen Press.

Guilliland, K. (2014). The Lancet Series on Midwifery: A ground breaker of more of the same. *Midwifery News*, (September), 17–19.

Guilliland, K., & Pairman, S. (1995). *The midwifery partnership, a model for practice.* Christchurch, New Zealand:New Zealand College of Midwives.

Guilliland, K., & Pairman, S. (2010a). *The midwifery partnership.* (2nd Ed.). Christchurch: New Zealand College of Midwives.

Guilliland, K., & Pairman, S. (2010b). *Women's business: The story of the New Zealand College of Midwives 1986-2010.* Christchurch: The New Zealand College of Midwives.

Haahr, A., Norlyk, A., & Hall, E.O.C. (2014). Ethical challenges embedded in qualitative research interviews with close relatives. Nursing Ethics, 21(1), 6–15. https://doi.org/10.1177/0969733013486370

Hagan, R., Priest, S., Evans, S., Malmgren, S., St Jack, A., Henderson, J., & Sharp, J. (1999). *Stressdebriefing after childbirth: Maternal outcomes.* Abstract A84 presented at the Third annual congress of the Perinatal Society of Australia and New Zealand.

Haigh, M. (2005). The enablers and hinderers of learning to teach during the practicum. Paper Presentation presented at the New Zealand Association of Research in Education, Dunedin.

Haigh, N. (2005). Everyday conversation as a context for professional learning and development. *International Journal for Academic Development,* 10(1), 3–16. *https://doi.org/10.1080/13601440500099969*

Hall, A. K., Cole-Lewis, H., & Bernhardt, J. M. (2015). Mobile Text Messaging for Health: A Systematic Review of Reviews. *Annual Review of Public Health,* 36(1), 393–415. *https://doi.org/10.1146/annurev-publhealth-031914-122855*

Halsey, K., & Slinn, J. (Ed.). (2008). *The Concept and Practice of Conversation in the Long Eighteenth Century, 1688-1848.* Newcastle, UK: Cambridge Scholars Publishing.

Hammett, P. L. (1997). Midwives and debriefing. In M. J. Kirkham, & E. R. Perkins, (eds), *Reflections on midwifery.* London: Baillie` re Tindall.

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum "hotspots". Psychol Health, 27(10), 1166–1177. *https://doi.org/10.1080/08870446.2011.649755*

Hatfield, A., & Robinson, E. (2002). The 'debriefing' of clients following the birth of a baby. *The Practising Midwife,* 5(5), 14–16.

Haugeland, J. (2000). Truth and Finitude: Heidegger's Transcendental Existentialism. *In M. Wrathall, & J. Malpas, Heidegger, Authenticity, and Modernity: Essays in Honor of Hubert L. Dreyfus:Volume 1.* (pp. 43–77). Cambridge MA: MIT Press.

Health & Disability Commissioner (HDC). (2017). *Annual Report for the year ended 30th June.* (p. 78). Retrieved from The Health and Disability Commissioner website: https://www.hdc.org.nz/media/4540/hdc-annual-report-for-the-year-ending-june-2017.pdf

Health & Disability Commissioner (HDC). (2018). *Making a complaint. Retrieved from https://www.hdc.org.nz/making-a-complaint/*

Healy, M. (2011). Heidegger's contribution to hermeneutic phe- nomenological research'. In G. Thompson, F. Dykes, & S. Downe, (Eds.), *Qualitative research in midwifery and child-birth: Phenomenological approaches* (pp. 215–232). London, England: Routledge.

Heaslip, V., & Board, M. (2012). Does nurses' vulnerability affect their ability to care? *British Journal of Nursing,* 21(15), 912–916*. https://doi.org/10.12968/bjon.2012.21.15.912*

Heidegger, M. (1927). *Being and time (J. MacQuarrie & E. Robinson, Trans.).* Oxford, UK: Basil Blackwell.

Heidegger, M. (1927/2011)*. Being and Time (J. Macquarrie & E. Robinson, Trans.).* New York, NY: Harper & Row.

Heidegger, M. (1947/1993). *"Letters to Humanism", in Basic Writings,* ed. D. Krell. San Francisco, CA: HarperCollins.

Heidegger, M. (1962). *Being and Time, trans. John Macquarrie & Edward Robinson. Retrieved from http://pdf-objects.com/files/Heidegger-Martin-Being-and-Time-trans.-Macquarrie-Robinson-Blackwell-1962.pdf*

Heidegger, M. (1971). *The question concerning technology (W. Lovitt, Trans.).* New York: Harper & Row.

Heidegger, M. (1973)*. The End of Philosophy (trans. J. Stambaugh).* Chicago: University of Chicago Press.

Heidegger, M. (1978). What is Metaphysics? (Trans. Krell, D. F.), In M. Heidegger*, Basic Writings (edited by D. F. Krell).* (pp. 93–110). London: Routledge.

Heidegger, M. (1985). *History of the concept of time, Prolegomena. (T. Kisiel, Trans.).* Bloomington: Indiana University Press*.*

Heidegger, M. (1986). The Basic Question of Being as Such. *Heidegger Studies,* 2, 4–6. *https://doi.org/10.5840/heideggerstud198622*

Heidegger, M. (1988)*. Ontologíe. Hermeneutik der faktizität.* Frankfurt am Main: Vittorio Klostermann.

Heidegger, M. (1995). *The Fundamental Concepts of Metaphysics.* Bloomington: University Press.

Heidegger, M. (1996)*. Being and time: A translation of Sein and Zeit. (J. Stambaugh, Trans.).* Albany, New York: State University of New York Press.

Heidegger, M. (1998). *Being and Time (J. Macquarrie & E. Robinson, Trans.).* Oxford: Blackwells.

Heidegger, M. (2003). *Martin Heidegger: Philosophical and Political Writings.* New York and London: Continuum International Publishing Group.

Heidegger, M. (2005). *Introduction to Phenomenological Research (D. Dahlstrom, Trans.).* Bloomington: Indiana University Press.

Heidegger, M. (2008). *Being and time.* New York: HarperCollins Publishers.

Hewitt, C. E., & Gilbody, S. M. (2009). Is it clinically and cost effective to screen for postnatal depression: A systematic review of controlled clinical trials and economic evidence. *BJOG,* 116(8), 1019–1027. *https://doi.org/10.1111/j.1471-0528.2009.02148.x*

Hirsch, E. D. (1967). *Validity in Interpretation.* New Haven: Yale University Press.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C., & Weston, J. (2011). Continuous support for women during childbirth. *Cochrane Database Syst Rev., 2(CD003766),* 1–100. *https://doi.org/10.1002/14651858.CD003766.pub3.*

Hogsbro, K. & Shaw, I. F. (Ed.). (2017). *Social Work and Research in Advanced Welfare States. (1st Ed.).* New York and London: Routledge.

Hollins Martin, C. J. (2011). Transactional analysis: A method of analysing communication. *British Journal of Midwifery,* 19(9), 587–593. *https://doi.org/10.12968/bjom.2011.19.9.587*

Horton, R., & Astudillo, O. (2014). The power of midwifery. *The Lancet,* 384(9948), 1075. *https://doi.org/10.1016/S0140-6736(14)60855-2*

Hummelvoll, J. K., & Barbosa da Silva, A. (1994). Psychiatric Nursing on a holistic – existential basis. *Perspectives in Psychiatric Care,* 30, 7–14. *https://doi.org/10.1111/j.1744-6163.1994.tb00229.x*

Hunter, B. (2001). Emotion work in midwifery: A review of current knowledge. *J Adv Nurs.,* 34(4), 436–444. *https://doi.org/10.1046/j.1365-2648.2001.01772.x*

Hunter, B. (2010). Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *Int. J. Work Organisation and Emotion,* 3(3), 253–269.

Husserl, E. (1931). *Ideas: A general introduction to pure phenomenology (W.R. Boyce Gibson, rans.)(Original work published 1913).* London, UK: Allen & Unwin.

*H*usserl, E. (1960). *Cartesian Meditations.* The Hague, NL: Nijhoff.

Husserl, E. (1970). *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy. The Hague, NL: Nijhoff.*

Husserl, E. (1982). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Translated by F. Kersten. London: Martinus Nijhoff Publishers.

Husserl, E. (2014*). Ideas for a Pure Phenomenology and Phenomenological Philosophy. First Book: General Introduction to Pure Phenomenolog (trans. By D. O. Dahlstrom).* Indianapolis: Hackett Publishing Company.

Inglis, S. (2002). Accessing a debriefing service following birth. *British Journal of Midwifery,* 10(6), 368–371. *https://doi.org/10.12968/bjom.2002.10.6.10487*

International Confederation of Midwives (ICM). (2017). *International Confederation of Midwives (ICM): Definition of Midwifery. Retrieved from https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html*

Inwood, M. (1997). *Heidegger a very short introduction.* Oxford: Basil Blackwell.

Inwood, M. (1999). *A Heidegger Dictionary. Retrieved from https://onlinelibrary.wiley.com/doi/book/10.1002/9781405164641*

Jones, A. (2001). Absurdity and being-in-itself. The third phase of phenomenology: Jean-Paul Sartre and existential psychoanalysis. *Journal of Psychiatric and Mental Health Nursing,* 8(4), 367–372*. https://doi.org/10.1046/j.1365-2850.2001.00405.x*

Jones, C. J., Creedy, D. K., & Gamble, J. A. (2012). Australian midwives attitudes towards care for women with emotional distress. *Midwifery*, *28*, 216–221. https://doi.org/10.1016/j.midw.2010.12.008

Jones-Berry, S. (2014). What do you think of the ban on hospital staff drinking tea and coffee? *BMA. Retrieved from https://www.bma.org.uk/connecting-doctors/bmaspace/f/21/t/672*

Jordan, M. E., Lanham, H. J., Crabtree, B. F., Nutting, P. F., Miller, W. L., Strange, K. C., & McDaniel, Jr, R. R. (2009). The role of conversation in health care interventions: Enabling sense making and learning. *Implementation Science,* 4(15), 1–13. *https://dx.doi.org/10.1186%2F1748-5908-4-15*

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal,* 5, 181–200.

Katty, K. & Shipman, C. (2014). *"The Confidence Gap." Retrieved from https://www.theatlantic.com/magazine/archive/2014/05/the-confidence-gap/359815/*

Kemmis, S. (2001). Exploring the Relevance of Critical Theory for Action Research: Emancipatory Action Research in the Footsteps of Jurgen Habermas. In P. Reason, & H. Bradbury, (eds.), *Handbook of Action Research.* (pp. 91–10). London: Sage.

Kemmis, S., Mctaggart, R., & Nixon, R. (2014). *The Action Research Planner: Doing Critical Participatory Action Research. Retrieved from http://dx.doi.org/10.1007/978-981-4560-67-2*

Kennedy, H. P. (2002). The midwife as an "instrument" of care. *American Journal of Public Health,* 92(11), 1759–1760. *https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.92.11.1759*

Kennedy, H. P., Shannon, M. T., Chauhorm, U. & Kravetz, M. K. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery and Women's Health,* 49(1), 14–23*. https://doi.org/10.1016/j.jmwh.2003.09.015*

Kershaw, K., Jolly, J., Bhabra, K., & Ford, J. (2005). Ran- domised controlled trial of community debriefing fol- lowing operative delivery. *British Journal of Obstetrics and Gynaecology: An International Journal of Obstetrics and Gynaecology,* 112(11), 1504–1509. *https://doi.org/10.1111/j.1471-0528.2005.00723.x*

Kidd, S. D. (1990). *Teaching as Being-with: Caring Itself.* Presentation presented at the Max Planck Institute, International Society of Universalism, Berlin, Germany. Retrieved from http://ww.inbetweenness.com/Sunnie%27s%20Publications/TEACHING%20AS%20BEING-WITH%20CARING%20ITSELF.pdf

King, M. (2001). *A guide to Heidegger's Being and Time.* John Llewelyn (Ed.), Albany, NY: State University of New York Press.

King, M. (2011). *Heidegger and Happiness: Dwelling on Fitting and Being. Retrieved from https://www.bookdepository.com/Heidegger-Happiness-Matthew-King/9781441191298*

Kinsella, E. A. (2006). *Hermeneutics and Critical Hermeneutics: Exploring Possibilities within the Art of Interpretation. Retrieved from Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, (S.1), v. 7, n. 3 website: http://www.qualitative-research.net/index.php/fqs/article/view/145/319*

Kirkham, M. (Ed.). (2010). *The midwife-mother relationship.* Basingstoke: Palgrave Macmillan.

Kirsch, A. (2010). *The Jewish Question: Martin Heidegger.* The New York Times. *Retrieved from https://www.nytimes.com/2010/05/09/books/review/Kirsch-t.html*

Kitzinger, C., & Kitzinger, S. (2007). Birth trauma: Talking with women and the value of conversation analysis. *British Journal of Midwifery,* 15(5), 256–264. *https://doi.org/10.12968/bjom.2007.15.5.23397*

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing,* 21, 827–836. *https://doi.org/10.1046/j.1365-2648.1995.21050827.x*

Koch, T. (1999). An interpretive research process: Revisiting phenom- enological and hermeneutical approaches. *Nurse Researcher,* 6, 20–34. *https://doi.org/10.7748/nr1999.04.6.3.20.c6085*

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing,* 28(4), 882–890. *https://doi.org/10.1046/j.1365-2648.1998.00725.x*

Kohanski, A. S. (1982). *Martin Buber's philosophy of inter-human relation: A response to the human problematic of our time. Retrieved from https://archive.org/details/martinbubersphil00koha*

Kohl, H. (1965). *The age of complexity.* New York: Mentor Books.

Kumar, A. (2012). Using phenomenological research methods in qualitative health research. *International Journal of Human Sciences,* 9(2), 790–804.

Kvale, S., & Brinkmann, S. (2008). *Interviews: Learning the craft of qualitative research interviewing.* London, United Kingdom: Sage.

Langan, T. (1971). *The Meaning of Heidegger: A Critical Study of an Existentialist Phenomenology.* New York: Columbia University Press.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method.* Harlow, UK: Pearson.

Lapp, L. K., Agbokou, C., Peretti, C.-S., & Ferreri, F. (2010). Management of post- traumatic stress disorder after childbirth: A review. *Journal of Psychosomatic Obstetrics & Gynecology, 31(3), 113–122. https://doi.org/10.3109/0167482X.2010.503330*

Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology,* 21(3), 318–337. *https://doi.org/10.1177/0959354310377544*

Lau, Y. K., Cassidy, T., Hacking, D., Brittain, K., Haricharan, H. J., & Heap, M. (2014). Antenatal health promotion via short message service at a Midwife Obstetrics Unit in South Africa: A mixed methods study. *BMC Pregnancy and Childbirth,* 14(1), 284. *https://doi.org/10.1186/1471-2393-14-284*

Lavender, T., & Walkinshaw, S. A. (1998). Can midwives reduce postpartum psychological morbidity? A randomised trial. *Birth,* 25, 215–221. *https://doi.org/10.1046/j.1523-536X.1998.00215.x*

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3). *Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf*

Lawn, C. (2006). *Gadamer: A Guide for the Perplexed.* (1st Ed.), New York and London: Continuum International Publishing Group.

Leahy, D., Lyons, A., Dahm, M., Quinlan, D., & Bradley, C. (2017). Use of text messaging in general practice: A mixed methods investigation on GPs' and patients' views. *Br J Gen Pract,* 67(664), *e744–e750. https://doi.org/10.3399/bjgp17X693065*

Leinweber, J., & Rowe, H. J. (2010). The costs of "being with the woman": Secondary traumatic stress in midwifery. *Midwifery,* 26(1), 76–87. *https://doi.org/10.1016/j.midw.2008.04.003*

Leurer, M. D., & Misskey, E. (2015). "Be positive as well as realistic": A qualitative description analysis of information gaps experienced by breastfeeding mothers. *International Breastfeeding Journal*, *10*(10), 1–11. https://doi.org/10.1186/s13006-015-0036-7

LeVasseur, J. J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research,* 13(3), 408–420. *https://doi.org/10.1177/1049732302250337*

Levinas, E. (1984). Ethics as first philosophy. In R. Kearney, & M. Rainwater, (Eds.), (1996) Reprinted in *The Continental philosophy reader,* (pp. 124-135.). New York: Routledge.

Levinas, E. (1991). *Totality and Infinity: An Essay on Exteriority (translated by Alphonso Lingis). Retrieved from https://trove.nla.gov.au/work/9181280*

Levinas, E. (1998). *Entre Nous Thinking-of-the-other (M. B. Smith & B. Harshav, Trans.).* London: Athlone Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* London: Sage Publication.

Lopez, K. A., & Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research,* 14(5), 726–735. *https://doi.org/10.1177/1049732304263638*

Lucock, R. (1997). *Research methodology: Study guide.* London: Royal College of Nursing Institute.

Lunda, P., Minnie, C. S., & Benadé, P. (2018). Women's experiences of continuous support during childbirth: A meta-synthesis. *BMC Pregnancy and Childbirth,* 18(1), 167. *https://doi.org/10.1186/s12884-018-1755-8*

Lundgren, I. (2004). Releasing and relieving encounters: Experiences of pregnancy and childbirth. *Scandinavian Journal of Caring Sciences,* 18(4), 368–375. *https://doi.org/10.1111/j.1471-6712.2004.00300.x*

Lundgren, I. (2005). Swedish women's experience of childbirth 2 years after birth. *Midwifery,* 21(4), 346–354. *https://doi.org/10.1016/j.midw.2005.01.001*

Mabaquiao, N. M. Jr. (2005). Husserl's' theory of intentionality. *Philosophia: An International Journal of Philosophy,* 34(1), 24–49.

Madden, I. (2002). Midwifery Debriefing: In whose best interest? *British Journal of Midwifery,* 10(10), 631–634. *https://doi.org/10.12968/bjom.2002.10.10.10626*

Madonik, B. (2001). *I hear what you say, but what are you telling me? The strategic use of nonverbal communication in mediation.* San Francisco: Jossey-Bass.

Maggioni, C., Margola, D., & Filippi, F. (2006). PTSD, risk factors, and expectations among women having a baby: A two-wave longitudinal study. *Journal of Psychosomatic Obstetrics and Gynecology,* 27, 81–90. *https://doi.org/10.1080/01674820600712875*

Maharana, S. K. (2009). Phenomenology of Consciousness in Ādi Śamkara and Edmund Husserl. *Indo-Pacific Journal of Phenomenology,* 9(1), 1–12. *https://doi.org/10.1080/20797222.2009.11433987*

Malott, D. A. M. (2017). *Continuity of Care and Shared Decision-Making in Interprofessional Collaborative Maternity Practices in Canada.* (Doctor of Philosophy, The University of Western Ontario). *Retrieved from https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=6120&context=etd*

Mangion, C. (2011). *Philosophical Approaches to Communication.* (1st Ed). Bristol, UK: Intellect Books.

Manojlovich, M., Squires, J. E., Davies, B., & Graham, I. D. (2015). Hiding in plain sight: Communication theory in implementation science. *Implementation Science,* 10(58), 1–11. *https://doi.org/10.1186/s13012-015-0244-y*

McGuinness, F. (2006). Effective communication is the core of effective practice. *British Journal of Midwifery,* 14(8), 452. *https://doi.org/10.12968/bjom.2006.14.8.21681*

McLemee, S. (2003). Questioning the past. *The Chronicle of Higher Education,* 49(45), A14.

Meades, R., Pond, C., Ayers, S., Warren, F. (2011). Postnatal debriefing: Have we thrown the baby out with the bath water? *Behav. Res. Ther,* 49(5), 367–372. *https://doi.org/10.1016/j.brat.2011.03.002*

Meadors, P., Lamson, A., Swanson, M., White, M., & Sira, N. (2009). Secondary Traumatization in Pediatric Healthcare Providers: Compassion Fatigue, Burnout, and Secondary Traumatic Stress*. Omega,* 60, 103–128*. https://doi.org/10.2190/OM.60.2.a*

Meakim, C., Boese, T., Decker, S., Franklin, A. E., Gloe, D., Lioce, L., … Borum, J. C. (2013). Standards of Best Practice: Simulation Standard I: Terminology. *Clinical Simulation In Nursing,* 9(6), S3–S11*. https://doi.org/10.1016/j.ecns.2013.04.001*

Meleis, A. I. (2010)*. Transitions Theory: Middle Range and Situation Specific Theories in Nursing Research and Practice.* New York: Springer Publishing Company.

Melender, H. L. (2006). What constitutes a good childbirth? A qualitative study of pregnant Finnish women. *Journal of Midwifery & Womens Health,* 51(5), 331–339. *https://doi.org/10.1016/j.jmwh.2006.02.009/*

Melo, R., Souza, Í., & Paula, C. (2014). The voice of the woman-mother of a premature baby in the neonatal unit: A phenomenological approach. *Online Brazilian Journal of Nursing,* [S.I.], 13(2), 198–206*. http://dx.doi.org/10.5935/1676-4285.20144415*

Mercer, J., Green-Jervis, C., & Brannigan. C. (2012). The legacy of a self-reported negative birth experience. *British Journal of Midwifery,* 20(10), 717–722. *https://doi.org/10.12968/bjom.2012.20.10.717*

Midwifery Council of New Zealand (MCNZ). (2007)*. The Competencies for Entry to the Register of Midwives (amended).* Wellington: MCNZ.

Midwifery Council of New Zealand (MCNZ). (2010)*. Midwifery Council of New Zealand. Code of Conduct. Conduct Statement 3 Guidance statement. Retrieved from https://www.midwiferycouncil.health.nz/professional-standards/what-conduct-expected-midwives*

Midwifery Council of New Zealand (MCNZ). (2010a)*. Midwifery Council of New Zealand (MCNZ): Midwifery Scope of Practice. Retrieved from https://www.midwiferycouncil.health.nz/sites/default/files/for-midwives/Gazette%20Notice%202010%20-scope%20%26%20quals%20new%20form.pdf*

Midwifery Council of New Zealand. (2016)*. Midwifery Workforce Survey: Midwifery Council of New Zealand. Retrieved from https://www.midwiferycouncil.health.nz/sites/default/files/site-downloads/Workforce%20Survey%202016.pdf*

Midwifery Council of New Zealand (MCNZ). *(2016a). Be Safe. 02—Text Messaging. Retrieved from https://www.midwiferycouncil.health.nz/sites/default/files/images/Be%20Safe%202%20Text%20Messaging.pdf*

Miles, M., Francis, K., Chapman, Y., & Taylor, B. (2013). Hermeneutic phenomenology: A methodology of choice for midwives. *International Journal of Nursing Practice,* 19(4), 409–414*. https://doi.org/10.1111/ijn.12082*

Ministry of Health. (1990)*. Nurses amendment act 1990: Information for health providers.* Wellington, New Zealand: Ministry of Health.

Ministry of Health. (1996)*. Notice issued pursuant to Section 51 of the Health and Disability Services Act 1993 concerning the provision of maternity services.* Ministry of Health, Wellington, NZ.

Ministry of Health (MOH). (2007)*. Maternity Services: Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000. Retrieved from https://www.health.govt.nz/publication/primary-maternity-services-notice-2007*

Ministry of Health. (2012). *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Retrieved from https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf*

Ministry of Health. (2014). *Report on Maternity (p. 79). Retrieved from Ministry of Health website: https://www.health.govt.nz/publication/report-maternity-2014*

Ministry of Health. (2015*). Maternity Consumer Survey 2014. Retrieved from Ministry of Health website: https://www.health.govt.nz/publication/maternity-consumer-survey-2014*

Ministry of Health. (2017)*. Report on Maternity 2015. (p. 80). Retrieved from Ministry of Health. website: https://www.health.govt.nz/publication/report-maternity-2015*

Ministry of Health (MOH). (2017a). *How to breastfeed. Retrieved May 28, 2018, from Ministry of Health NZ website: https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/helpful-advice-during-first-year/breastfeeding-perfect-you-and-your-baby/how-breastfeed*

Mitchell, J. T. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medical Services, 8(1), 36–39.*

Morse, J. M., & Field, P. A. (1996)*. Nursing research: The application of qualitative approaches* (2nd ed). London: Chapman and Hall.

Moustakas, C. E. (1995). *Being-in, Being-for, Being-with.* Plymouth, UK: Rowman & Littlefield Publishers Inc.

Muldoon, M. S. (1996). “Silence Revisited: Taking the Sight Out of Auditory Qualities.” *Review of Metaphysics,* (50)*. Retrieved from https://www.questia.com/library/journal/1G1-19118948/silence-revisited-taking-the-sight-out-of-auditory*

Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research.* New York, NY: National League for Nursing.

Murphy, J. M. (1989). Listening in a Second Language: Hermeneutics and Inner Speech*. Tesl Canada JournallRl:VUr Tfsl Du Canada,* 6(2), 27–44*.*

Murphy, P A., & King, T. L. (2013). Effective Communication is Essential to Being with Woman: Midwifery Strategies to Strengthen Health Education and Promotion*. Journal of Midwifery & Womens Health,* 58(3), 247–248*. https://doi.org/10.1111/jmwh.12080*

National Institute for Health and Clinical Excellence (NICE). (2015). Postnatal care up to 8 weeks after birth. Retrieved from https://www.nice.org.uk/guidance/cg37

National Institute for Health and Clinical Excellence (NICE). (2017)*. Antenatal care for uncomplicated pregnancies. [Clinical Guideline [CG62]]. Retrieved from https://www.nice.org.uk/guidance/cg62/chapter/woman-centred-care*

National Institute for Health and Clinical Excellence (NICE). (2018). *Antenatal and postnatal mental health: Clinical management and service guidance. Retrieved from https://www.nice.org.uk/guidance/cg192*

Nellickappilly, S. (Dr). (2015). *Edmund Husserl's Phenomenology: The Principle of Intentionality and the Methods of Reduction. Retrieved from http://nptel.ac.in/courses/109106051/Module%205/Chapter%2032.pdf*

Nielsen, C. R. (2013). *Hearing the Other's Voice: How Gadamer's Fusion of Horizons and Open- ended Understanding Respects the Other and Puts Oneself in Question. Otherness: Essays and Studies, (September). Retrieved from http://www.otherness.dk/fileadmin/www.othernessandthearts.org/Publications/Journal_Otherness/Otherness__Essays_and_Studies_4.1/Gadamer_on_Hearing_the_Other_s_Voice.pdf*

Niequist, S. (2013*). What Is Celebration? Retrieved from What is celebration? Isn't it more than throwing parties? website: https://www.todayschristianwoman.com/articles/2013/august/what-is-celebration.html*

New Zealand College of Midwives (NZCOM). (2013). *NZ's Maternity Model is World Leading... (Media Release). Retrieved from NZCOM website: https://www.midwife.org.nz/latest-news/nzs-maternity-model-is-world-leading*

New Zealand College of Midwives (NZCOM). (2015). *Handbook for Practice.* Christchurch: Author.

New Zealand College of Midwives (NZCOM). (2016). *Consensus Statement: Informed Consent and Decision Making.* NZCOM.

New Zelaand Health Information Service (NZHIS). (2012). *Report on maternity 2010. Retrieved from Ministry of Health website: https://www.health.govt.nz/publication/report-maternity-2010*

Niven, C. A. (1992). *Psychological Care for Families: Before, During and After Birth* (1st ed.). Oxford: Butterworth-Heinemann.

Niven, C. A. (2013). *Psychologicaclal Care for Families: Before, During and After Birth.* (2nd ed.). Elsevier Science & Technology.

Noë, A. (2007). The critique of pure phenomenology. *Phenomenology and the Cognitive Sciences,* 6(1–2).

Nyberg, K., Lindberg, I., & Ohrling, K. (2010). Midwives' experience of encountering women with post-traumatic stress symptoms after childbirth. *Sexual & Reproductive Healthcare : Official Journal of the Swedish Association of Midwives,* 1, 55–60. *https://doi.org/10.1016/j.srhc.2010.01.003*

Nystedt, A., Högberg, U., & Lundman. B. (2006). Some Swedish women's experiences of prolonged labour. *Midwifery,* 22(1), 56–65. *https://doi.org/10.1016/j.midw.2005.05.003.*

Oates, M. R., Cox, J. L,, Neema, S., Asten, P., Glangeaud-Freudenthal, N., Figueiredo, B., ... & TCS-PND Group. (2004). Postnatal depression across countries and cultures: A qualitative study. *Br J Psychiatry Suppl,* 46(46), s10-16. *https://doi.org/10.1192/bjp.184.46.s10 ·*

O'Dwyer, A. (2008). *Learning styles of first year Level 7 electrical and mechanical engineering students at DIT.* Presented at the In Proceedings of the International Symposium of Engineering Education.

O'Hara, M, W., & . Wisner, K. L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice and Research: Clinical Obstetrics and Gynaecology,* 28(1), p.3-12. *https://doi.org/10.1016/j.bpobgyn.2013.09.002*

Olesh, A. (2008). *Martin Buber's Critique of Heidegger's Being-with: An exploration of a disagreement between two of the most significant thinkers of the 20th century.* Presented at the Thirteenth Annual SUNY Oneonta Undergraduate Philosophy Conference, Oneonta, New York. *Retrieved from https://mercaba.org/SANLUIS/Filosofia/autores/Contemporánea/Buber/Sobre%20Buber/Olesh,%20Andrew%20-%20Martin%20Buber's%20Critique%20of%20Heidegger's%20Being-with.pdf*

Olin, R. M., & Faxelid, E. (2003). Parent's needs to talk about their experiences of childbirth. *Scandinavian Journal of Caring Sciences,* 17(2), 153–159. *https://doi.org/10.1046/j.1471-6712.2003.00105.x*

Olson, T., Bowen, A., Smith-Fehr, J., & Ghosh, S. (2018). Going home with baby: Innovative and comprehensive support for new mothers. *Prim Health Care Res Dev.,* 27(2), 1–6. *https://doi.org/10.1017/S1463423618000932.*

Oltermann, P. (2014). Heidegger's "black notebooks" reveal antisemitism at core of his philosophy. The Guardian - International Edition. Retrieved from https://www.theguardian.com/books/2014/mar/13/martin-heidegger-black-notebooks-reveal-nazi-ideology-antisemitism

Oxford English Dictionary. (Compact Edition). (1971*). Oxford: University Press.*

Pairman. S. (1998). *Professional friendships: An exploration of midwifery partnership.* Biennial Midwifery Conference. Presented at the New Zealand College of Midwives Conference, Auckland, NZ. *Retrieved from https://www.midwife.org.nz/wp-content/uploads/2019/01/Jnl-21-October-1999-min.pdf*

Palmer, R. E. (1969). *Hermeneutics: Interpretation Theory in Schleiermacher, Dilthey, Heidegger and Gadamer.* Evanston: North Western University Press.

Palmer, R. E. (Ed.). (2001). *Gadamer in conversation: Reflections and commentary (R. E. Palmer, Trans.).* New Haven: Yale University Press.

Pappne Demecs, I., Fenwick, J., & Gamble, J. (2011). Women's experiences of attending a creative arts program during their pregnancy. *Women and Birth,* 24(3), 112–121. *https://doi.org/10.1016/j.wombi.2010.08.004*

Parkinson, F. (1997). *Critical incident debriefing: Understanding and dealing with trauma.* London: Souvenir Press.

Parse, R. R. (1981*). Man-living-health: A Theory of Nursing.* New York: Wiley Paterson.

Paterson, M., & Higgs, J. (2005). Using Hermeneutics as a Qualitative Research Approach in Professional Practice*. The Qualitative Report, 10(2), (pp. 339–357). Retrieved from http://nsuworks.nova.edu/tqr/vol10/iss2/9*

Patterson, J. (1988). Chronic illness in children and the impact on families. In C. Chilman, E. Nunnally, & F. Cox, (Eds.)*, Chronic illness and disability* (pp. 69–107). Newbury Park, CA: Sage Publications*.*

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods.* (3rd (Ed.)). London: Sage Publications, Inc.

Pearson, M., & Smith, D. (1994). Debriefing in experience- based learning. In D.Boud, R. Keough, D. Walker, (eds)*, Reflection: Turning experience into learning.* New York: Nichols Publishing Company.

Pezaro, S. (2016). Addressing psychological distress in midwives. *Nursing Times,* 112, 22–23.

Phillips, S. (2003). Debriefing following traumatic childbirth*. BJM,* 11(12), 725–730*. https://doi.org/10.12968/bjom.2003.11.12.11866*

Pokorny, P., & Roskovec, J. (2002). *Philosophical hermeneutics and biblical exegesis. Retrieved from https://trove.nla.gov.au/version/29625532*

Polit, D. F., & Hungler, B. P. (1999*). Nursing research: Principles and methods.* (6th (ed.). Philadelphia, PA: Lippincott.

Priest, S., Henderson, J., Evans, S., & Hagan ,R. (2003). Stress debriefing after childbirth: A randomised con- trolled trial. *Medical Journal of Australia,* 178, 542–544.

Ratcliffe, M. (2005). The Feeling of Being. *Journal of Consciousness Studies*, *12*(8–10), 43–60

Ratcliffe, M. (2010). Depression, guilt and emotional depth. *Inquiry,* 6(53), 602–626. *https://doi.org/10.1080/0020174X.2010.526324*

Ray, M. A. (1994). The Richness of Phenomenology: Philosophic, Theoretical and Methodologic Concerns. In J. M. Morse, *Critical Issues in Qualitative Research* Methods (pp. 117–135). London: Sage.

Reed, R. (2013). *Feel the Fear and Birth Anyway*. Retrieved from Midwife Thinking website: https://midwifethinking.com/2013/03/27/feel-the-fear-and-birth-anyway/

Reist, D., Jenei. K., Dyck, T., & Asgari, M. (2017). *Let's Talk Dialogue Community Conversations about Drug. Retrieved from Centre for Addictions Research of BC website: https://www.uvic.ca/research/centres/cisur/assets/docs/community-guide.pdf*

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., … Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care*. The Lancet,* 384(9948), 1129–1145. *https://doi.org/10.1016/S0140-6736(14)60789-3*

Renfrew, M. (2017). Midwifery Matters. In E. K. Hutton, B. Murray-Davis, K. Kaufman, E. Carty, & M. Butler, Comprehensive Midwifery: The role of the midwife in health care practice, education, and research Subtitle: An Interactive Guide to the Theory and Evidence of Practice. Retrieved from https://ecampusontario.pressbooks.pub/cmroleofmidwifery/

Reynolds, J. L. (1997). Post–traumatic stress disorder after childbirth: The phenomenon of traumatic birth. *Canadian Medical Association Journal,* 156(6), 831–835.

Rice, H., & Warland, J. (2013). Bearing witness: Midwives experiences of witnessing traumatic birth. *Midwifery,* 29(9), 1056–1063*. https://doi.org/10.1016/j.midw.2012.12.003*

Robbins, J. (2001). Interview with Francois Poirie (J. Robbins, M. Coelen & T. Loebel, Trans.). In J. Robbins, (Ed.), *Is it righteous to be? Interviews with Emmanuel* Levinas (pp. 23–83). Stanford: Stanford University Press.

Roberts, K., & Taylor, B. (1997)*. Nursing Research Processes: An Australian Perspective.* Australia: Nelson Thomson Learning.

Rockmore, T. (1992). *On Heidegger Nazism and Philosophy. London: Harvestor Wheatsheaf.*

Rose, S., Bisson, L., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database Syst Rev,* (2)*. https://doi.org/10.1002/14651858.CD000560*

Ross, L. E., & Dennis, C. L. (2009). The prevalence of postpartum depression amongst women with substance use, an abuse history, or chronic illness: a systematic review. *J Womens Health,* 18, 475–486*. https://doi.org/10.1089/jwh.2008.0953*

Rowan, C., Bick, D. E., & Bastos, M. H. (2007). Postnatal Debriefing Interventions to Prevent Maternal Mental Health Problems After Birth: Exploring the Gap Between the Evidence and UK Policy and Practice. *Worldviews on Evidenced-Based Nursing,* 4(2), 97–105. *https://doi.org/10.1111/j.1741-6787.2007.00088.x*

Rowe, R. E., Kurinczuk, J. J., Locock, L., & Fitzpatrick, R. (2012). Women's experience of transfer from midwifery unit to hospital obstetric unit during labour: A qualitative interview study. *BMC Pregnancy and Childbirth,* 12(129), 1–15. *https://doi.org/10.1186/1471-2393-12-129*

Ryding, E. L., Wirén, E., Johansson, G., Ceder, B., & Dahlström, A. M. (2004). Group counselling for mothers after emergency caesarean section: A randomised controlled trial of intervention. *Birth,* 31(4), 247–253. *https://doi.org/10.1111/j.0730-7659.2004.00316.x*

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *2. Clinical Psychology Review, 23(3), 449–480. https://doi.org/10.1016/S0272-7358%2803%2900030-8*

Sandall, J., Coxon, K., Mackintosh, N., Rayment-Jones, H., Locock, L., & Page, L. (2015). Relationships: The pathway to safe, high-quality maternity care. (p. 39). *Retrieved from Sheila Kitzinger symposium at Green Templeton College website: https://www.gtc.ox.ac.uk/images/stories/academic/skp_report.pdf*

Sandelowski, M. (1986). The problem of rigor in qualitative research. *ANS. Advances in Nursing Science,* 8(3), 27–37. *https://doi.org/10.1097/00012272-198604000-00005*

Sandelowski, M. (1997). "To be of use": Enhancing the utility of qualitative research. *Nursing Outlook*, *45*(3), 125–132. https://doi.org/10.1016/S0029-6554(97)90043-9

Sauls, D. (2002). Effects of Labor support on mothers, babies and birth outcomes*. Journal of Obstetric Gynecologic and Neonatal Nursing,* 31(6), 733–741. *https://doi.org/10.1177/0884217502239209/*

Sawyer, T., Eppich, W., Brett-Fleegler, M., Grant, V., & Cheng, A. (2016). More Than One Way to Debrief: A Critical Review of Healthcare Simulation Debriefing Methods*. Simulation in Healthcare,* 11(3)*. Retrieved from https://journals.lww.com/simulationinhealthcare/Fulltext/2016/06000/More_Than_One_Way_to_Debrief__A_Critical_Review_of.9.aspx*

Scheibler, I. (2000). *Gadamer: Between Heidegger and Habermas.* USA: Rowman & Littlefield*.*

Schleiermacher, F. (1998)*. Hermeneutics and Criticism: And Other Writings.* Cambridge University Press.

Schmidt, L. K. (2006). *Understanding hermeneutics.* Stocksfield: Acumen Publishing.

Schmied, V., Cooke, M., Gutwein, R., Steinlein, E., & Homer, C. (2008). Time to listen: Strategies to improve hospital- based postnatal care. *Women and Birth,* 21(3), 99–105.

https://doi.org/10.1016/j.wombi.2008.04.002

Scott, S. (2017). *Fierce Conversations: Achieving Success at Work and in Life One Conversation at a Time.* New American Library.

Segre, L. S., Stasik, S. M., O'Hara, M. W., & Arndt, S. (2010). Listening Visits: An Evaluation of the Effectiveness and Acceptability of a Home-based Depression Treatment. *Psychother Res,* 20(6), 712–721*. https://doi.org/10.1080/10503307.2010.518636*

Selkirk, R., McLaren, S., Ollerenshaw, A., McLachlan, A., & Moten, J. (2006). The longitudinal effects of midwife-led postnatal debriefing on the psychological health of mothers. *Journal of Reproductive and Infant Psychology,* 24(2), 133–147. *https://doi.org/10.1080/02646830600643916*

Senge, P. (1990). *The fifth dimension: The art and practice of the learning organization*. New York: Doubleday.

Senge, P. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization.* London: Nicholas Brealey Publishing.

Shacklock, G., & Smyth, J. (1998)*. Being Reflexive in Critical Educational and Social Research.* London: Falmer Press, Taylor & Francis Group*.*

Sheehan, T. (1988). *Heidegger and the Nazis.* The New York Review of Books, pp. 38–47*.*

Sheehan, T. (2001). A paradigm shift in Heidegger research*. Continental Philosophy Review,* 34(2), 183–202. *https://doi.org/10.1023/A:1017568025461*

Sheehan, T. (2005). Dasein. In H. Dreyfus, & M. Wrathall, (Eds.)*, A companion to Heidegger* (pp. 191–213). Oxford, UK: Blackwell Publishing Ltd.

Sheen, K., Spiby, H., & Slade, P. (2016). The experience and impact of traumatic perinatal event experiences in midwives: A qualitative investigation*. Int J Nurs Stud,* 53, 61–72. *https://doi.org/10.1016/j.ijnurstu.2015.10.003.*

Siegel, D. J. (2016). *Mind: A Journey to the Heart of being Human.* W. W. Norton & Company.

Silverman, M. E., & Loudon, H. (2010). Antenatal reports of pre-pregnancy abuse is associated with symptoms of depression in the postpartum period. *Arch Womens Ment Health,* 13, 411–415. *https://doi.org/10.1007/s00737-010-0161-7*

Sjöström, H., Langius Eklöf, A., & Hjertberg, R. (2004). Well-being and sense of coherence during pregnancy. *Acta Obstetricia et Gynecologica Scandinavica,* 83, 1112–1118. *https://doi.org/10.1111/j.0001-6349.2004.00153.x*

Sloan, A. & Bowe, B. (2014). Phenomenology and hermeneutic phenomenology: the philosophy, the methodologies and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design*. Quality & Quantity,* 48(3), 1291–1303. *https://doi.org/10.1007/s11135-013-9835-3*

Slomian, J., Honvo, G., Emonts, P., Reginster, J-Y., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's Health.* https://doi.org/10.1177/1745506519844044

Small, R., Lumley, J., Donohue, L., Potter, A., & Waldenström, U. (2000). Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *British Medical Journal,* 321(7268), 1043–1047. *https://doi.org/10.1136/bmj.321.7268.1043*

Small, R., Lumley, J., & Toomey, L. (2006). Midwife-led debriefing after operative birth: Four to six year follow-up of a randomised trial. *BMC Medicine,* 4(3), 1–9. *https://doi.org/10.1186/1741-7015-4-3*

Smith, J. (2016). *Listening to Student Voices: Reflective Assessment Conversations Build Student Investment in Learning. Retrieved from All Things Assessment website: http://allthingsassessment.info/2016/01/08/listening-to-student-voices-reflective-assessment-conversations-build-student-investment-in-learning/*

Smith, L. (2014). NHS Staff banned from drinking tea or coffee on the job because it looks like they're not working hard enough*. Independent. Retrieved from https://www.independent.co.uk/life-style/health-and-families/health-news/nhs-hospital-staff-banned-from-drinking-tea-or-coffee-on-the-job-because-it-looks-like-theyre-not-9806903.html*

Smith, M. C., Turkel, M., & Wolf, Z. R. (2012). *Caring in Nursing Classics: An Essential Resource. Retrieved from http://www.springerpub.com/caring-in-nursing-classics.html*

Smith, M. V., Shao, L., Howell, H., Lin, H., & Yonkers, K. A. (2011). Perinatal depression and birth outcomes in a Healthy Start project*. Matern. Child Health J,* 15, 401–409. *https://doi.org/10.1007/s10995-010-0595-6*

Smythe, E. (2011a). Phenomenology. In L. Giddings, & E. Smythe, E. (Eds.), *Qualitative research: A guide for novice researchers* (pp. 51–74). Auckland, New Zealand: AUT University.

Smyth, A., & Cherry, N. (2005). Reflective conversations about supervision: When things go awry. *Reflective Practice*, 6(2), 271–275*. https://doi.org/10.1080/14623940500106377*

Smythe, E., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods,* 11(1), 12–25. *https://doi.org/10.1177/160940691201100102*

Smythe, E., Payne, D., Wilson, S., & Wynyard, S. (2013). The dwelling space of postnatal care. *Women and Birth,* 26(2), 110–113*. https://doi.org/10.1016/j.wombi.2012.05.001*

Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies,* 45(9), 1389–1397. *https://doi.org/doi:10.1016/j.ijnurstu.2007.09.005*

Smythe, E., Payne, D., Wilson, S., Paddy, A., & Heard, K. (2014). Revealing Tact Within Postnatal Care. *Qualitative Health Research,* 24(2), 163–171. *https://doi.org/10.1177/1049732313519704*

Sneller, R. (PhD). (2017). *Wholeness, Health Awareness & Health Assessment.* [Health 21]. *Retrieved from Wellness website: http://health21magazine.com/article/wholeness-health-awareness-health-assessment/*

Söderquist, J., Wijma, K., & Wijma, B. (2006). The longitudinal course of post-traumatic stress after childbirth. *Journal of Psychosomatic Obstetrics and Gynecology,* 27, 113–119. *https://doi.org/10.1111/j.1471-0528.2008.02083.x*

Soet, J., Brack, G., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth,* 30(1), 36–46. *https://doi.org/10.1046/j.1523-536X.2003.00215.x/*

Sorenson, D.S., & Tschetter, L. (2010). Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum women. *Perspect Psychiatr Care,* 46(1), 14–25. *https://doi.org/10.1111/j.1744-6163.2009.00234.x*

Spiegelberg, E. (Ed.). (1994). *The Phenomenological Movement: A Historical Introduction.* Kluwer Academic Publishers.

Spinelli, E. (2000). Creation and being: Existential-phenomenological challenges to psycho-analytic theories of artistic creativity. *Journal of the Society for Existential Analysis,* 11(1), 2–20.

Stambaugh, L. (1996). Special Learners with Special Abilities. *Music Educators Journal, 83*(3), 19–23. https://doi.org/10.2307/3398973

Staricoff, R. L., & Loppert, S. (2003). Integrating the arts into health care: Can we affect clinical outcomes. In D. Kirklin & R. Richardson (Ed.), *The healing environment: Without and within.* (pp. 63–79). London: Royal College of Physicians.

Statistics NZ (Online). (2014). *2013 Census QuickStats about culture and identity. Retrieved from http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/languages.aspx*

Steel, M. (2015). Daring to Play: Art, Life and Therapy, From Heidegger to Gadamer, By Way of Barthes' Punctum and the Paintings of Paul Klee. *Existential Analysis: Journal of the Society for Existential Analysis,* 26(2), 208–224.

Steele A, Beadle M. (2003). A survey of postnatal debriefing. *Journal of Advanced Nursing,* 43(2), 130–136. *https://doi.org/10.1046/j.1365-2648.2003.02687.x*

Steinhaur, S. (2015). Decision making in midwifery: Rationality and intuition. *Pract Midwife,* 18(4), 14–18.

Stern, D., Bruschweiler-Stern, N., & Freeland, A. (1998). *The Birth of a Mother. Retrieved from https://www.basicbooks.com/titles/daniel-n-stern/the-birth-of-a-mother/9780465015672/*

Stuckey, H. L., & Nobel, J. (2010). The Connection Between Art, Healing, and Public Health: A Review of Current Literature. *American Journal of Public Health, 100(2), 254–263. http://psycnet.apa.org/doi/10.2105/AJPH.2008.156497*

Svendsen, A. (2012). *The Professionalization of Intelligence Cooperation: Fashioning Method out ...* (1st Ed.). Great Britain: Palgrave Macmillan.

Tallon, A. (1978). Intentionality, Intersubjectivity, and the Between Buber and Levinas on Affectivity and the Dialogical Principle. *Thought: Fordham University Quaterly,* 53(3), 292–309. *https://doi.org/10.5840/thought197853346*

Taminiaux, J. (2004). *Metamorphosis of phenomenological reduction.* Milwaukee: Marquette University Press.

Taylor, J. R., & Van Every, E. J. (2000). *LEA's communication series. The emergent organization: Communication as its site and surface.* Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Teutsch, C. (2003). Patient-doctor communication. *Med Clin North Am.,* 87(5), 115–145. *https://doi.org/10.1016/S0025-7125(03)00066-X ·*

The American Heritage Dictionary of the English Language. (2016). Boston: Houghton Mifflin Harcourt.

Thomson, G., & Downe, S. (2010). Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology,* 28(1), 102–112. *https://doi.org/10.1080/02646830903295000*

Thomson, G. & Downe, S. (2016). Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in North-West England. *Midwifery,* 40, 32–39. *https://doi.org/10.1016/j.midw.2016.06.010*

Thorne, J. O. & Collocott, T. C. (1974). *Chambers biographical dictionary. Retrieved from https://trove.nla.gov.au/version/21742664*

Tymieniecka, M. T. (2003). Introduction: Phenomenology as the inspirational force of our times. In M. T. Tymieniecka, M. T. (Ed.), *Phenomenology world-wide. Foundations-expanding dynamicslife- engagements. A guide for research and study* (pp. 1–10). London: Kluwer `Academic.

Underwood, L., Waldie, K. E., Peterson, E,. D'Souza, S., Verbiest, M., McDaid, F., & Morton, S. (2017). Paternal Depression Symptoms During Pregnancy and After Childbirth Among Participants in the Growing Up in New Zealand Study. *JAMA Psychiatry,* 74(4), 1–10. *http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2601411*

Valle, R. S. & King, M. (1978). *Existential-Phenomenological Alternatives for Psychology.* Oxford, England: Oxford University Press.

van Manen, M. (1990). *Researching Lived Experience.* Ontario: Althouse Place.

van Manen, M. (1991). *The tact of teaching: The meaning of pedagogical thoughtfulness.* London, Ontario, Canada: Althouse Press.

van Manen, M. (1995). On the epistemology of reflective practice. *Teachers and Teaching: Theory and Practice,* 1, 33–50. *https://doi.org/10.1080/1354060950010104*

van Manen, M. (1997). *Researching the lived experience: Human science for an action sensitive pedagogy* (2nd ed). Ontario, Canada: Althouse Press.

van Manen, M. (2001). *Writing in the dark: Phenomenological studies in interpretive inquiry.* London, ON: Routledge.

van Manen, M. (2007). Phenomenology of practice. *Phenomenology & Practice,* 1(1), 11–30.

van Manen, M. & Adams, C. (Eds.). (2011). *Textorium. Phenomenology Online: A Resource for Phenomenological Inquiry*. Retrieved from http://www.phenomenologyonline.com/sources/textorium/

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing.* London, ON: Routledge.

van Manen, M. (2015). *Pedagogical Tact: Knowing What to Do When You Don't Know What to Do.* Oxon: Left Coast Press Inc.

van Manen, M. (2016). A conversation with Max van Manen on phenomenology in its original sense. *Nursing & Health Sciences,* 18(1), 4–7. *https://doi.org/10.1111/nhs.12274*

van Warmerdam, G. V. (2015). *Not Feeling Heard*. Retrieved from Pathway to Happiness website: https://www.pathwaytohappiness.com/happiness/2015/06/10/not-feeling-heard/

Vessey, D. (2009). Gadamer and the fusion of horizons. *International Journal of Philosophical Studies,* 17(4), 531–542. *https://doi.org/10.1080/09672550903164459*

Viguera, A. C., Tondo, L., Koukopoulos, A. E., Reginaldi, D., Lepri, B., & Baldessarini, R. J.. (2011). Episodes of mood disorders in 2,252 pregnancies and postpartum periods. *Am J Psychiatry,* 168(11), 1179–1185. *https://doi.org/10.1176/appi.ajp.2011.11010148.*

Waldenström, U., Borg, I. M., Ollson, B., Sköld, M., & Wall, S. (1996). The childbirth experience: A study of 295 new mothers. *Birth,* 23(3), 144–153. *https://doi.org/10.1111/j.1523-536X.1996.tb00475.x*

Waldenström, U., Rudman, A., & Hildingsson, I. (2006). Intrapartum and postpartum care in Sweden: Women's opinions and risk factors for not being satisfied. *Acta Obstet Gynecol Scand.*, *85*(5), 551–560. https://doi.org/10.1080/00016340500345378

Walker, W. (2011). Hermeneutic inquiry: Insights into the process of interviewing. *Nurse Researcher*, *18*(2), 19–27.

Walsh, D., & Steen, M. (2007). The role of the midwife: Time for a review. *RCM,* 10(7), 320–323.

Walsh, K. (1996). Philosophical hermeneutics and the project of Hans Georg Gadamer: Implications for nursing research. *Nursing Inquiry,* 3, 231–237. *https://doi.org/10.1111/j.1440-1800.1996.tb00046.x*

Walsh, S. (2007). Midwifery in New Zealand. *RCM, Midwives Magazine. Retrieved from https://www.rcm.org.uk/news-views-and-analysis/analysis/midwifery-in-new-zealand*

Walters, A. J. (1994). Phenomenology as a way of understanding in nursing. *Contemporary Nurse,* 3(3), 134–141*. https://doi.org/0.5172/conu.3.3.134*

Warfield, B. (2016). Dialogical Dasein: Heidegger on "Being-with,""Dis-course," and "Solicitude". *Janus Head,* 15(1), 63–85.

Warner. C. T. (2001). *Bonds that make us free: Healing our relationships, coming to ourselves.* Salt Lake City, UT: Shadow Mountai*n.*

Warnke, G. (1987)*. Gadamer: Hermeneutics, Tradition, and Reason.* Stanford University Press.

Water, T. (2008). *The meaning of being in dilemma in paediatric practice: A phenomenological study.* (Doctor of Philosophy, Auckland University of Technology). *Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/405/WaterT.pdf?sequence=1&isAllowed=y*

Webb, D. A., Bloch, J. R., Coyne, J. C., Chung, E. K., Bennett, I. M., & Culhane, J. F. (2008). Postpartum Physical Symptoms in New Mothers: Their Relationship to Functional Limitations and Emotional Well-being*. Birth,* 35(3), 179–187. *https://doi.org/doi:10.1111/j.1523-536X.2008.00238.x*

Weick, K. E. (2005). The experience of theorizing: Sensemaking as topic and resource. In K. G. Smith, & M. A. Hitt, (Eds.), *Great minds in management: The process of theory development* (pp. 394-416).). New York: Oxford University Press*.*

Weimers, L., Svensson, K., Dumas, L., Navér, L., & Wahlberg, V. (2006). Hands-on approach during breastfeeding support in a neonatal intensive care unit: A qualitative study of Swedish mothers' experiences. *International Breastfeeding Journal,* 1(2), 20. *https://doi.org/10.1186/1746-4358-1-20*

Weisberg, J. (2016). We Are Hopelessly Hooked. *The New Yorker Review*. Retrieved from http://www.nybooks.com/articles/2016/02/25/we-are-hopelessly-hooked/

Wendt, E. K., Marklund, B. R., Lidell, E. A., Hildingh, C. I., & Westerståhl, A. K. (2011). Possibilities for dialogue on sexuality and sexual abuse—Midwives' and clinicians' experiences. *Midwifery,* 27(4), 539–546. *https://doi.org/10.1016/j.midw.2010.05.001.*

Wenzel, A., Haugen, E. N., Jackson, L. C., & Brendle, J. R. (2005). Anxiety symptoms and disorders at eight weeks postpartum. *J Anxiety Disord,* 19(3), 295–311*. https://doi.org/10.1016/j.janxdis.2004.04.001*

Wessely, S., Rose, S., & Bisson, J. (1999). A systematic review of brief psychological interventions (‘“debriefing”’) for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder. *In: The Cochrane Library.* Oxford: Update Software.

West, A. (2018). *Being with and saying goodbye: Cultivating therapeutic attitude in professional practice.* (2nd (Edn).). New York, NY: Routledge.

Westerhof, G. J., van Vuuren, B., Brummans, B. H., & Custers, A. F. (2014). A Buberian Approach to the Co-construction of Relationships Between Professional Caregivers and Residents in Nursing Homes. *The Gerontologist,* 54(3), 354–362. *https://doi.org/10.1093/geront/gnt064*

White, T., Matthey, S., Boyd, K, & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology,* 24(2), 107–120. *https://doi.org/10.1080/02646830600643874*

Wheeler, M. (2011). *Martin Heidegger.* In Stanford Encyclopedia of Philosophy (Oct 12). *Retrieved from https://plato.stanford.edu/entries/heidegger/*

Wiklund, I., Wiklund, J., Pettersson, V., & Boström, A-M., & Boström, A. M. (2018). New parents’ experience of information and sense of security related to postnatal care: A systematic review. *Sexual & Reproductive Healthcare,* 17, 35–42. *https://doi.org/10.1016/j.srhc.2018.06.001*

Wilberforce, N., Wilberforce, K., & Aubrey-Bassler, F.K. (2010). Post-traumatic stress disorder in physicians from an underserviced area. *Family Practice,* 27(3), 339–343. *https://doi.org/10.1093/fampra/cmq002*

Williams , L. E., & Bargh, J. A. (2008). Experiencing Physical Warmth Promotes Interpersonal Warmth. *Science,* 322(5901), 60–607. *https://doi.org/doi:10.1126/science.1162548.*

Wilson, E. (Ed.). (2017). *School-based Research: A Guide for Education Students.* (3rd Ed.). London: Sage.

Wisnewski, J. (2013). *Heidegger: An Introduction.* Plymouth, UK: Rowman & Littlefield.

Wittgenstein, L. (1922/1960). *Tractatus Logico Philosophicus.* London: Routledge & Kegan Paul.

Wojnar, D. M. & Swanson, K. M. (2007). Phenomenology: An exploration. *J Holist Nurs,* 25(3), 172–180. *https://doi.org/10.1177/0898010106295172*

Wolff, R. (2011). *Original Wisdom: Stories of an Ancient Way of Knowing.* Inner Traditions/Bear.

Wolin, R. (1993). The Heidegger Controversy. Cambridge: MIT Press.

Woodruff Smith, D. (2003). *Phenomenology.* Stanford Encyclopedia of Philosophy, (Winter*). Retrieved from http://plato. stanford. edu/entries/phenomenology*

World Health Organisation (WHO). (2010). *WHO Technical Consultation on Postpartum and Postnatal Care. (p. 65). Retrieved from World Health Organisation website: https://www.who.int/maternal_child_adolescent/documents/WHO_MPS_10_03/en/*

World Health Organization. (2013). *WHO recommendations on postnatal care of the mother and newborn. Retrieved from https://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/*

World Health Organisation (WHO). (2017). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors.* (2nd (Ed.). Geneva: WHO.

World Health Organisation (WHO). (2018). *WHO recommendation on effective communication between maternity care providers and women in labour (. Retrieved from https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/who-recommendation-effective-communication-between-maternity-care-providers-and-women-labour*

World Health Organisation (WHO). (2018a). *WHO recommendations: Intrapartum care for a positive childbirth experience. Retrieved from https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/*

Yelland, A. (Dr). (2013). 'Midwifery is about communication, communication, communication….' *MIDIRS Midwifery Digest. Retrieved from https://www.midirs.org/midwifery-is-about-communication-communication-communication/*

Young, C. M. (2011). *The experience of burnout in case loading midwives An interpretive phenomenological study.* (Auckland University of Technology). *Retrieved from https://openrepository.aut.ac.nz/bitstream/handle/10292/2447/YoungC.pdf?sequence=3&isAllowed=y*

Young, J. (1997). *Heidegger, philosophy, Nazism.* Cambridge, UK: Cambridge University Press.

Zeldin, T. (2000). *Conversation—How Talk Can Change Your Life.* United States: HiddenSpring.

Appendices

Appendix A: Ethics Approval

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

A U T E C
S E C R E T A R I A T

29 October 2013

Liz Smythe
Faculty of Health and Environmental Sciences

Dear Liz
Re Ethics Application: **13/301 Post-birth reflective conversations: How does this impact on those involved.**
Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC).
Your ethics application has been approved for three years until 29 October 2016.
As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online throughhttp://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 29 October 2016;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 29 October 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.
AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.
To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.
All the very best with your research,

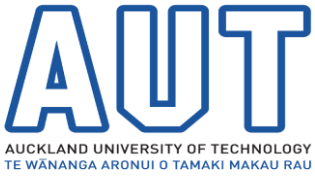
Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Nimisha Waller

Appendix B: Safety Protocol

Safety Protocol for Research involving one to one interviews to be conducted by a researcher in private homes in Auckland.

- The research involves interviews in private homes with women who have had live birth and midwives. The researcher will be conducting interviews alone. However the supervisor considers that the safeguards provided in this safety protocol are sufficient to manage the safety risks.
- Risk management strategies have been discussed between the researcher and the supervisor, and both parties are clear as to procedure. The researcher will discuss interview safety and perform practice interviews with the supervisor.
- The time and location of the interviews will be communicated to a third party. The researcher will communicate with the third party prior to commencing the interview and after the interview is completed.
- The researcher will take steps to ensure that she is able to leave at any time.This includes only entering ‘public’ areas of the house where possible (such as lounge or kitchen), ensuring that the exit route is clearly known, and watching to ensure that the door is not locked after entering.
- Should anything untoward happen, or the researcher becomes uneasy for any reason, the interview will be terminated immediately and the interviewer will leave. The supervisor will be contacted as soon as practically possible.
- Where possible, interviews will be conducted in daylight hours or in the early evening. Transport to and from the interview will be by car owned by the researcher.
- This safety protocol has been agreed and accepted by the researcher and the supervisor.

Appendix C: Participant Information Sheet



Participants Information Sheet

Title of the Project: Post-birth reflective conversations: How does this impact on those involved?

Kia Ora

My name is Nimisha Waller. I am a Doctor in Health Science (DHSc) student at The Auckland University of Technology (AUT) in the School of Heath Care Practice, Faculty of Health & Environmental Sciences.

You are invited to participate in my research on post-birth reflective conversations and the impact this has had on you and on the person you had the conversation with.

Your participation in the study is voluntary (your choice).

What is the purpose of the study?

The purpose of the study is to explore, uncover and thereby promote understanding of reflective post-birth conversations and the impact this has on those involved. This study will contribute to completion of Doctor of Health Science degree. I would value hearing your experience of post-birth reflective conversations

Am I eligible to be part of the study?

You can participate in the study if:

- you have had your first or subsequent baby that was born alive in the last 24 months.
- you are midwives who have been involved in midwifery care for more than one year.
- you are able to converse easily in English.
- you are living in the Auckland area of New Zealand.
- you have not had the researcher as your LMC midwife
- you have not been diagnosed for postnatal distress or are being treated for postnatal distress

What happens in the study?

If you agree to participate in the study you will need to sign a consent form. You can change your mind at a later time and ask to withdraw from the study. This can be done by sending a letteror email or by phoning Nimisha Waller. The contact details are at the end of this information sheet.

The study will involve you being interviewed by me, which will take about sixty to ninety minutes. The interview will occur at the time and place mutually convenient to us. I will request a follow up telephone conversation only if I need to clarify anything you have said. After the interview the tapes will be transcribed. You will be posted the copy of the transcript of your interview, unless you choose not to receive one. You will have 2 weeks (or longer if extra time is requested) in which to make changes to the transcript (e.g. edit out anything you do not wish to remain in the data).

You are free to withdraw or decline to answer any specific questions during theinterview and up to the time of the writing of the thesis or the report. You withdrawal will have no effect on any health care you may be receiving at present or in the future.

What are the discomforts and risks?

Talking about your experience can sometimes bring up upsetting issues. The possibility of this will be minimized as much as possible by the style of interviewing. However should you feel in any way distressed by remembering or speaking about your experiences one to one support will be available if required and you will be given an option of accessing a counselor or other services as appropriate.

What are the benefits?

Being a participant in the research will provide you with an opportunity to describe your perceptions of post-birth reflective conversations. The information I gain from t he study will help health professionals to better understand the impact of such conversations on those involved and hopefully help to develop effective care or women following birth of their baby.

How will my privacy be protected?

I believe privacy and confidentiality are important. I will keep all study information confidential and no one apart from my supervisors Liz Smythe and Deb Spence will be told about your participation in the study. Any information you provide will be treated as confidential.

All audiotapes will be destroyed once the study id completed and the final report is written unless you have requested a return of the audio-tape on the consent form. The transcriber if employed will sign a Confidentiality Agreement form and will only have access to data gathered as a part of his study. The transcripts will be kept in the locked filing cabinet in my office for 10 years. You will not be identified in the transcripts. No material that will personally identify you will be used in any reports or presentations from this study.

How do I join the study?

If you would like more information or want to be part of this study please contact Nimisha Waller on 09 921 9999 ext 7210 or email nimisha.waller@aut.ac.nz. If I am not available please leave a message with your name and phone number so I can phone you back.

What are the costs of participating in the project (including time)?

The interview will be held at the venue and time that is convenient to you. The interview will take about 60-90 minutes of your time. Follow up time to clarify issues may be half an hour and can be done on the phone. You may need some time to read through your transcripts and make any changes. This may take approximately another half an hour toan hour.

Do I have opportunity to receive feedback on results of research?

After analysis of the data a report will be written. A copy of the report can be sent to you if you wish. If you would like a copy of the report please indicate this on the consent form.

What if I have concerns?

Please feel free to contact the principal investigator if you have any questions about this study:

Nimisha Waller, telephone 09 921 9999 ext 7210 or email nimisha.waller@aut.ac.nz

My supervisor is: Dr Liz Smythe, Associate Professor, School of Health Care Practice, AUT. Tel: 09 921 9999 ext 7196 or email liz.smythe@aut.ac.nz

If you have any queries or concerns regarding your rights as a participants in this study you may wish to contact a Health & Disability Advocate, telephone 0800 555 050 .

Statement of Approval

The study has received ethical approval from the Auckland Regional Ethics Committee.

Thank you very much for you time and help in making this study possible.

Appendix D: Consent Form

Consent Form

Title of the Project: Post-birth reflective conversations: How does this impact on those involved?

Researcher: Nimisha Waller

I have read and understood the information sheet dated……..for participants taking part in this research project. I have had an opportunity to ask questions and have them answered and I am satisfied with the answers and that I understand the research.

I understand that:

- Taking part in this research is voluntary (my choice) and that I can withdraw at anytime up to the writing of the thesis and that this will in no way affect my ongoing or future health care.

- All information I provide in an interview is confidential and my name and identifying details will not be used when the result of the interview are written up or in any material that results from the study.

- I understand that the interview will be audio-taped and transcribed.

- The interview will be stopped at anytime if I request it.

- I can bring a friend or a support person with me to the interview.

- If I withdraw, I understand that all relevant tapes and transcripts, or part thereof, will be destroyed.

- I agree to take part in this research. YES/NO
- I wish to receive a copy of the report from the research. YES/NO
- I wish to have my audio tape returned to me at the end of the study. YES/NO

Participants signature: ……

Participants name: ……...

Participant Conatct Details (If appropriate):

……

……

Date: ……

Appendix E: Indicative Interview Questions

Indicative Questions for Interview

Interviews will follow a semi-structured format. The initial interview question will be:

For women: "Tell me about your experience of a conversation with your midwife about labour and birth following the birth of your baby". During the interview the researcher may pose further questions such as: "Who initiated the conversation?" "How did it go?" "What did you talk about?"

For midwives: "Tell me about the last woman you had a conversation with about her labour and birth experience". Further questions posed may include "tell me about the time when this kind of conversation felt like it made a difference?" "Tell me about the time that it did not work so well?" "Tell me about a woman who seemed not to want to talk?"

Appendix F: Crafting of a Story

Initial story at the time of the interview

At home when the midwife visited – I think Zara may have been about 10 days to 2 weeks old I decided to discuss the bleeding at the time of birth (as I was informed by the doctor on the ward that it was a litre) and having a fit and how scary it was for us — the midwife said that she could not stay long but it was normal to have blood loss at the time of birth as my labour required use of hormone and was long, women didn't die in childbirth these days. Over the four weeks we did try to talk to our midwife about how we felt about the bleeding (we knew there would be blood but we never discussed the amount when making a plan) but we met her silence. She suddenly said at four weeks her care was coming to completion. Our midwife may have wanted us not to be anxious or scared about the experience but we wanted to talk with her about it so we would know why it happened and how to prepare for next time. Our experience of attempts at these conversations was that our concerns were being brushed off.

When we got pregnant again we decided to have another midwife as our LMC. The first meeting was about getting to know each other and seeing if we wanted to have her as our midwife. Nath and I were totally comfortable with her from the time we first met her. After introducing herself and talking about her practice she asked “now tell me about your first birth experience – what was it like for you both?” We were just so taken back by her inclusion of “both” and we talked at length about our experience of pregnancy, labour and birth. We were concerned about bleeding happening again. We were with her for 1 hour and 15 minutes and felt for the first time being listened to. The midwife hardly said anything but listened to our experience and how we felt. She said that if we decided to share the experience of the second birth together it would be good to get the copy of the notes (we did not even know that we could have copy of the notes from Bradley’s birth) so we could see what was written in them regarding the blood loss and fit or shaking and encouraged me to contact the midwife involved in Zara’s birth for copy of the notes.

Once we got the notes – I think it took about a month to get all the records we planned an appointment that was longer than the other appointments to discuss what was written in the notes. I had lost just over a litre of blood –and that my shaking was likely to be related to sitting up and blood pressure dropping as well as from the effects of the epidural. The bleeding may

have resulted from the uterus that may have been tired due to long labour and hormone not working efficiently anymore. We were able to make a plan with the midwife regarding birthing again in hospital, having fluids and not getting up from bed following the birth too quickly.

We were on our way to the hospital following phone call to our midwife but the waters broke on the way and I had strong urge to push. Nath called the midwife and said what had happened and plan was changed to go to the birthing facility nearby. I was anxious that it was not the hospital but when I arrived there was a midwife and a second midwife from the birthing facility was there to help. I gave birth within 15 minutes of arriving at birthing facility. I was offered skin to skin with the baby for over an hour and not asked to go to shower till she was about 3 hours old. The midwife was with me and we were fine. I asked if I could stay for few more hours to ensure there was no heavy bleeding before going home and our midwife organized this with the birthing facility staff. The birthing staff cared for us until we were ready to go home.

My midwife visited us the next day and said “well how do you both feel with the birth in a birthing facility?” We just had beaming smiles for her – we were made to feel even with change in place of birth that we were expected in that facility, we felt safe and protected in presence of both the midwives at the birth and with other staff who cared for us. The blood loss this time was less – 500mls. Our midwife discussed this while I was having skin to skin as she was weighing the pads to get an idea of the blood loss. My plan to get up slowly after the birth when I felt comfortable was supported – there was no indication of hurry by anyone that was involved in our care. The place may have been busy but we were not made aware of this.

Two stories were crafted from the above transcript.

The first story highlights the need for space to be created for conversation and willingness of both to enter the space.

> *I tried with my midwife to have conversations about the bleeding and fainting that occurred following birth of my first baby. After the initial response, every time I tried to raise the topic I was met with silence. In the end it became frustrating and she decided that care could be completed at four weeks after Zara’s birth.*
>
> *I made sure that when I was pregnant the second time I contacted a midwife who would be open to have a conversations. I didn’t feel I could move without talking about the previous experience. So my post-birth conversation happened at the beginning of my second pregnancy. I met the midwife and she listened to my experience. It was the first time I felt heard. We planned to*

meet again once full information of the past event was available. Once we got the notes – I think it took about a month to get all the records, we planned an appointment that was longer than the other appointments to discuss what was written in the notes.

The bleeding may have resulted from the uterus that may have been tired due to long labour and hormone not working efficiently anymore. We were able to make a plan with the midwife regarding birthing again in hospital, having fluids and not getting up from bed following the birth too quickly.

The second story crafted highlights birth being a celebration as there was openness between Jane and the midwife from their first contact.

My midwife visited us the next day and said 'well how do you both feel with the birth in a primary birthing facility?' We just had beaming smiles for her – we were made to feel even with change in place of birth (when Jane was in second stage and wanted to push, the decision was made to go to the nearest birthing centre) *that we were expected in that facility, we felt safe and protected by the midwife and the other staff who cared for us for a few more hours after our midwife had left. The blood loss this time was less – 500mls. Our midwife discussed this while I was having skin to skin with my baby as she was weighing the pads to get an idea of the blood loss. My plan to get up slowly after the birth when I felt comfortable was supported – there was no indication of hurry by anyone that was involved in our care. The place may have been busy but we were not made aware of this.*