

**MIDWIVES' EXPERIENCES OF
WORKING WITH WOMEN IN
LABOUR: INTERPRETING THE
MEANING OF PAIN**

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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 nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

P. Vajpe

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Abstract

A key midwifery activity is the support of a woman in labour. Pain in labour has been extensively researched from the woman's perspective, but less has been explored in relation to the midwife and her approach to pain. The way in which the midwife works with a woman and her pain in labour is the focus of this qualitative study, using Heideggerian hermeneutic phenomenology. This philosophical approach seeks to uncover or illuminate aspects of the midwife's practice which are frequently taken for granted in their everydayness.

Seven midwives, including both independent practitioners and hospital-employed, were interviewed. Their narratives were analysed to uncover the meaning of the way in which midwives work with women and their pain in labour.

The findings of this thesis suggest that midwives work by interpreting the woman's pain. Before the pain begins, they 'leap ahead' to help them anticipate the pain and how they will confront it. During labour, midwives give pain meaning by translating its purpose in that context. They 'leap in' when required, sometimes using 'self as an intervention.

Midwives interpret women's pain through their understanding of lived time. They know how the perception of time passing changes depending on the setting for labour or the amount of anxiety and pain the woman is experiencing. Midwives use time in their work. They break it down to help a woman focus on a single contraction rather than looking too far ahead toward the unknown. Time can be a midwife's friend when the arrival of the baby replaces the urgent need for pain relief. It can also be her enemy if her interpretation of a woman's pain differs from the woman's perception. The memory of pain may persist for the woman, after labour has finished, with a backlash for the midwife.

Some midwives believe in the process of birth and the woman's ability to labour with such conviction that they gain a woman's complete trust. At her most vulnerable time, they encourage the woman to call upon inner reserves and be truly empowered by her experience.

Chapter One

Orientation to the Study

Introduction

This study explores the meaning of the experience of midwives working with women and their pain during labour. It offers an interpretation of the narratives of seven midwives who provide intrapartum care. Using hermeneutic phenomenology as my methodology I explored the way in which midwives support women to make decisions about pain and its management during labour. I searched for meaning within their experiences and can reveal something of the nature of their work.

What is labour pain?

For most women, labour involves pain. Often the pain of contractions is the most severe pain that a woman ever has to face and she can approach labour with considerable trepidation about what lies in store. She may have endeavoured to prepare herself by reading about what labour is like or by talking with friends and family who have had children already. She may have attended antenatal education classes to learn about labour or she may have had discussions with a midwife or doctor in the course of her antenatal care. In the end though, a woman's labour is a unique experience. It is a private and totally subjective experience because it is her labour and only she can feel her contractions.

Lauris Edmonds, a New Zealand poet, writes in her autobiography about her first experience of labour:

What actually happened the night of my baby's arrival I didn't tell Fanny (her mother), or anyone. I couldn't have explained what kept me silent — it was as though some racial memory, a lesson I had learned countless generations before, instructed me: it was an instinct, I obeyed it. My labour had in fact shocked and horrified me all the time it was going on: it was an interminable nightmare, with myself at the centre roaring and shrieking to an array of busy yet impassive spectres who acted upon me as though I was a joint of meat, to be turned this way and that and carved to the bone. The puerile idea that if I

relaxed all would be well lasted no time at all. Once the pains became strong and frequent, I could do nothing. I would try and relax as each began, but quite soon it would grow larger, deeper, more gripping, more savage and mountainous, until I lost all vestiges of sense or control and yelled and yelled. I'd never done such a thing before, or ever imagined doing it, but equally odd, the nurses seemed not at all surprised – as far as I could think about them, which wasn't much.

(Edmonds, 1991, p.40)

This paragraph describes a labour in the 1950s. Lauris Edmonds seems to have felt alone and unsupported despite the dim presence of 'spectres' who seemed to her remote, in a physical and emotional sense. This is a typical account of the childbirth experience for New Zealand women fifty years ago. No partner in support and a woman facing a fearful ordeal about which she knows little in advance.

Although each labour is unique, there are general patterns which tend to characterise labour. Labour usually begins with mild uterine contractions which are noticed by the woman as tightenings, often accompanied by a period-type pain in her lower abdomen and/or lower backache. The contractions usually become more frequent, longer in duration and stronger as labour becomes established. Generally women are able to employ strategies such as walking around, breathing techniques and distraction to cope with the pain. Towards the end of the first stage of labour, a period known as transition, the contractions become even stronger and more frequent. This is the time when many women encounter their greatest challenge. The woman can become irritable, she may feel very frightened and have a sense that her body is out of control. She may vomit, she may start to shake uncontrollably. At this point some women say that they just can't go on any longer, that they want it all to stop. They may appeal to the midwife for help and request pain relief such as pethidine or an epidural to take the pain away.

What is 'working with' pain?

In working with a woman in pain, the midwife occupies a privileged position. She is sharing a momentous occasion in the life of this woman and her family. Simkin (1991) has described women's ability to recall their labour and birth experience with great clarity, even decades after the event. The origin of the word 'midwife' is, in Old English, 'mid wif' (Macdonald, 1972). Literally, this means 'with woman' and aptly describes the essence of the midwife's role. In the context of advanced labour, her role in 'being with' the woman is to help her to cope with her pain. She has many tools at

her disposal. These include supportive measures such as sharing information, words of encouragement, support or diversion; physical measures like touch, water and changes of position; and analgesia in its many forms ranging from nitrous oxide to pethidine to epidural.

The midwife must have confidence in her midwifery skills in assessing and supporting the labouring woman if she is to truly 'be with' her. In response to a request for pain relief, the midwife can help the woman to arrive at a decision about the most appropriate intervention based on the context of the situation. Particularly if a woman is experiencing labour for the first time, it can be very difficult to plan pain management strategies in advance. The unknown dimension of labour pain means that hard and fast opinions may prove inappropriate for the context of a given labour. If the midwife has been able to discuss options for pain relief with the woman antenatally, she is likely to have some knowledge of her preferences. These may have been documented in a birth plan and that may form the basis of a discussion before the woman makes a decision.

If, on the other hand, the midwife is working as a hospital employee and providing fragmented care, she may not have any prior knowledge of a woman's wishes. The midst of labour is not an ideal time to be attempting to discuss options for pain relief. The midwife also has the challenge of determining how effectively she has formed a rapport with the woman and whether that is sufficient to have built a sense of trust to aid the decision-making process. A feeling of security and trust is very important in this situation because the midwife may wish to invite the woman to delay a pharmacological intervention in favour of more active midwifery and partner support. Experience may tell her that the progress of labour is such that analgesia could be better employed later on, or maybe not at all. Clearly if such a course of action is agreed to, the woman has to have confidence in her ability to cope with the support of the midwife. That confidence is born of a sense of trust in the midwife which results from the relationship that has formed.

What is the nature of the relationship?

Most midwives understand the importance of the rapport which needs to be established with a woman in order to foster in her a sense of security and trust. Communication is of vital importance in forming a relationship (Ralston, 1998). Depending on the woman's choice of lead maternity carer, the midwife could be someone she has become

acquainted with throughout her antenatal period, or she could be a total stranger whom she is meeting for the first time. Many midwives are skilled communicators and can share information in appropriate ways with ease. Midwives also know how important their very presence is to a woman in labour. There have been a large number of studies which reinforce the premise that continuous midwifery support, especially in active labour, has a positive effect on a range of outcomes. These include less likelihood of medication for pain relief, a shorter duration of labour, less likelihood of an operative delivery and, perhaps most significantly, a more positive birth experience for the woman (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Hodnett, Gates, Hofmeyr, & Sakala, 2003; Lavender, Walkinshaw, & Walton, 1999; Lundgren & Dahlberg, 1998). In addition to a constant presence, women in labour value the chance to be involved in making decisions regarding their care. Taking an active role in decision making adds to the woman's sense of control over her labour and her surroundings (Halldorsdottir & Karlsdottir, 1996). This is of particular significance in the area of pain relief. Women need to feel that their needs are being acknowledged and met. Woman-centred midwifery care is based on the notion of partnership between the woman and the midwife and a collaborative style of decision making is implicit in this philosophy.

The partnership model of midwifery practice

The Partnership Model was first articulated by Guilliland and Pairman as an attempt to define a relationship which holds the woman paramount. The focus is on the woman who defines her needs based on her knowledge of herself and her family, her life experience, intuition and wisdom (Guilliland & Pairman, 1994). The midwife contributes her knowledge of midwifery – scientific, intuitive and experiential. In addition, the partnership model seeks to promote a sense of feeling equal between the woman and the midwife (Pairman, 1999). This involves the notion of reciprocity wherein there is openness, shared information, mutual respect and the goal of sharing power and control. Continuity of carer is another fundamental element within the partnership model as it allows time for the two parties to form a professional friendship upon which to base decisions and trust in each other throughout the childbirth experience (Pairman, 1998).

Research Question

The research question asks: "What is the experience of midwives working with women and their pain in labour?" My questioning of the participants concerned their practice

when working with women in pain during labour. Through their words, I sought to draw meaning from the experience and explore aspects of the way that midwives make decisions with women regarding pain and its management in labour.

Methodology

The philosophical underpinning for this research study is Heideggerian phenomenology. Heidegger [1899-1976] was a German philosopher who was concerned with understanding Being. In order to achieve this he called for a focus on the everyday existence of people in order to explore the nature or meaning of a phenomenon (Heidegger, 1962). Phenomenology seeks to explicate the essence of a phenomenon as experienced by human beings when they interact with the world. The phenomenon this study set out to understand more clearly concerns an area of midwifery practice which seems commonplace. Pain and its management are everyday occurrences for midwives caring for women in labour. This world of practice may appear to be clearly understood. Yet phenomena are frequently concealed or partially obscured from our view by our very familiarity with them. We make assumptions about our world which can contribute to our inability to see aspects of it clearly (van Manen, 1990). This methodology offered me a means of looking beyond the taken-for-granted everyday practices through the participants' stories. These stories reflect their practice reality and make possible the opportunity for me to derive meaning from their lived experience. Van Manen (1990) argues that phenomenology "begins in lived experience and eventually turns back to it" (p.35). This is because the purpose of any phenomenological research is "to construct a possible interpretation of the nature of a certain human experience" (van Manen, 1990, p.41). It is accepted that my interpretation is only one way of glimpsing the phenomenon through story. This methodology does not attempt to generalise findings. It is concerned with developing understandings which stay rooted in the incomparable diversity of human beings.

Why phenomenology?

The methodology of phenomenology allows for my questioning to try to get as close as possible to the actual experience of working with women and their pain. By striving to relive the experience, the midwives' descriptions may allow an uncovering of that which is not normally recognised or talked about. Phenomenology encourages me to keep myself open to possibilities in order to grasp meaning from the narratives of the midwives. My research question fits well with this methodology, concerned as it is with

articulating meaning from a world of practice where midwives' knowing in relation to pain management is taken-for-granted or hidden from view.

The Impetus for my Study

The role of supporting women in pain during labour is one that I am familiar with from my years in practice. Aspects of the way in which I worked with women in fulfilling that role came to intrigue me and so led me to question practice and to undertake this study.

A story from practice

A few years ago I was caring for a primigravid woman in labour. This woman had read extensively in preparation for labour and had a detailed birth plan to promote her aspirations for the birth of her baby. Once labour was established she and her husband employed the techniques they had practised before labour and they worked well as a unit. Suddenly the picture changed. The nature of the contractions, and the woman's ability to cope with them, was different. She began to lose control. I stepped in to help the couple regain their equilibrium. I explained that this was transition and that things often seemed really tough at this stage, but that everything was progressing well. This was the last phase before the exciting bit where pushing started. The woman requested an epidural. In her birth plan she had been adamant that she did not wish to have an epidural and she had reiterated this desire to me earlier in labour. My sense was that this woman could be supported to cope with the end of the first stage if she would trust me and her husband to provide that support. We discussed the situation and I urged her to give it an hour or so before reviewing progress. I hoped that she would be almost fully dilated by this time and would avoid the need for epidural anaesthesia. At the end of the hour, during which she worked hard and coped well, the cervix was 7cms dilated. The woman was demoralised and the husband was angry at the suffering he felt his wife had endured unnecessarily. An epidural was inserted and the labour progressed smoothly to a vaginal delivery four hours later. I saw the woman the next day and apologised for suggesting that she forgo the epidural when she had requested it. She replied that she felt that she had somehow failed because she had an epidural. She wished she had been able to trust my faith in her and to 'soldier on'. For her, the birth experience had been blighted by her lack of courage.

This experience caused me to question my practice. Although I had been in similar situations before, this was the first time that I was aware that I had 'got it wrong'. Previously, I had successfully supported women through a difficult patch at the end of labour and basked in the gratitude expressed once the baby was born. On other occasions, I had concurred with the woman's assessment of her pain and her inability to cope. In these situations I gave the pain relief as requested and felt that this course of action was for the best.

So what happened on this occasion? Why had I influenced the woman to delay epidural anaesthesia? She had demanded it even though she had been previously so opposed to the idea. This was, after all, her labour and her pain. Surely she knew when she had had enough? It seemed that I knew better. My experience of working with women in labour told me that if she had an epidural anaesthetic, the chances of labour slowing down were greater than if she did not have an epidural. A scenario can then unfold which has been termed a cascade of intervention (Inch, 1985). In order to augment better uterine contractions, a Syntocinon infusion may be started which increases the risk of fetal distress and increases the likelihood of a slower second stage of labour through a decreased desire to push. This in turn can lead to an instrumental delivery which necessitates the woman being placed in a lithotomy position and probably requiring an episiotomy (Enkin et al., 2000). I felt that I possessed the necessary midwifery skills to support this woman through the rest of her labour and I wanted to help her uphold the intentions of her birth plan. Maybe it also represented a challenge professionally. Working with someone in pain is certainly harder work than acquiescing to comprehensive pain relief such as an epidural provides.

But after the event, the woman felt that she was to blame for not adhering to the birth plan. A sense of failure was her enduring memory of the birth of her first child. Most midwives can relate similar stories about the decisions women make with regard to pain during labour. Some will capture the triumph that a woman feels when she works with her pain throughout labour and wonders at the strength she taps into. Other stories will concern women whom midwives perceive as having unrealistic or inflexible ideas prior to labour, who adapt their thinking to the reality of labour and accept this when the pain engulfs them.

A colleague's story

A conversation with a very experienced midwifery colleague raised further questions for me. We were discussing the situation where a woman demands an epidural late in labour and the midwife may have reservations about the need for it. My colleague described situations when she has been faced with this kind of request. She admitted that she will imply that she is organising an epidural when, in fact, she is procrastinating in the expectation that the woman can be supported until she reaches second stage. She felt considerable guilt about the deceit involved and stated that she would never admit this subterfuge to the woman, even once the baby was born.

This midwife seems to be articulating a common dilemma faced by those working with women in labour. Why then the reluctance to discuss the prevarication with women? Why the guilty feelings about a judgement call? So many of the factors involved in the decision making are hidden and I wonder if the midwife is even aware of the process by which she arrives at her choice of management in a specific instance.

The questions which my story from practice, and this midwife's account raised, led me to the literature. I could find few references within midwifery journals or books to decision making by midwives in relation to pain management. The questions from practice and the paucity of research therefore helped to shape my research question and methodology.

Context of the Study

In order to situate this study I need to describe the New Zealand context within which the midwife functions. I will discuss pain management in childbirth from an historical perspective, in its present framework and as it pertains to my own context.

The midwife

In New Zealand, a practising midwife can provide care for a woman in labour in differing capacities. Firstly, as an independent practitioner working in a self-employed role (independent midwife) as the primary caregiver or lead maternity carer (LMC). The LMC takes "responsibility for the care provided to the woman throughout her pregnancy and postpartum period, including the management of labour and birth" (Ministry of Health, 2002, p.11). Secondly, as a member of a team scheme or Know Your Midwife (KYM) team who is employed by a hospital but provides continuity of

care for a caseload of women. Thirdly, as a hospital-employed midwife working rostered shifts and thus providing fragmented care for women in labour whom they may never have met. The participants in my study are drawn from both independent and hospital-employed midwives.

History of pain relief in childbirth in New Zealand

At the beginning of the twentieth century most New Zealand women birthed at home. Pregnant women engaged the services of mainly lay midwives (also known as handywomen) to provide support, caring and assistance (Donley, 1998). Birth was a physiological process and pain relief in labour was basic – keeping mobile and upright during first stage, with medical assistance being called only in an emergency. The midwives were highly competent and dedicated women who worked long hours for poor pay. Their livelihoods came under threat with the passing of the Midwives Registration Act in 1904 and they were gradually replaced over the next twenty years. The Act created a register of midwives and established a group of state-run training hospitals for midwives – the St Helens hospitals (Jowitt, 2000). These hospitals offered either domiciliary or hospital care for a small fee and midwives provided full care for normal labours. Only doctors were permitted to administer sedation during childbirth. This consisted of a whiff of chloroform from a Murphy inhaler for the women using St Helens hospitals who required instrumental assistance to deliver (Donley, 1998).

In 1902, a German professor called Gauss developed an obstetric cocktail of morphine and scopolamine which produced sedation and amnesia. Middle class women, who could afford it, increasingly moved from the home to private hospitals to birth in order to sample the painless childbirth which 'twilight sleep' promised (Jowitt, 2000). The demand for sedation resulted in normal labours becoming medicalised as specialist supervision was required in a hospital and forceps deliveries became prevalent. Midwives were no longer able to perform their traditional support role on unconscious women and saw their midwifery skills undervalued in the new environment. The transition to the function of an obstetric nurse had begun (Jowitt, 2000).

A most disturbing result of the high rates of sedation and intervention was reflected in the dramatic rise in maternal deaths from puerperal sepsis. Paradoxically, public concern over these statistics, coupled with the growing strength of the medical discourse of birth as inherently pathological, resulted in ever-increasing numbers of women

turning to hospitals for childbirth. Pain relief remained the primary concern. Women demanded universal access to twilight sleep and, because this option was too expensive to fund publically, midwives were belatedly trained in the use of the Murphy inhaler to give chloroform in second stage. The clamour for all women to be afforded the opportunity to experience complete pain relief continued though and a Committee of Inquiry into Maternity Services was convened in 1937 to consider this issue, amongst others. Dr Salmond, in his evidence, described his practice thus: "chloral hydrate and bromide, then morphia and Nembutal, then gas and oxygen and then I finish them off with chloroform at the end" (cited in Committee of Inquiry into Maternity Services, 1938). Following the Committee's recommendations, the Social Security Act was passed in 1938 which provided for pain relief to be administered free of charge by the doctor of the woman's choice. This Act heralded the arrival of the era of drugs and medical dominance.

By 1951, 95% of deliveries in New Zealand were attended by doctors in hospitals (Donley, 1998) and the majority of midwives were doctor's assistants. They were still the primary caregivers in labour though, so inevitably they were increasingly responsible for dispensing the sedatives, narcotics and analgesic gases that were part of the repertoire of routine maternity care (Jowitt, 2000). Rumblings of discontent were beginning to make themselves heard, albeit faintly. The Natural Childbirth Association formed in 1952 to dispute rigid practices such as routine analgesia in mainstream maternity services (Dobbie, 1990). It soon changed its name to the less threatening Parents Centre and was effective in setting up antenatal education classes teaching relaxation breathing techniques based on the work of Grantly Dick Read, an outspoken obstetrician from England who sought ways to alleviate fear in childbearing women without the use of drugs (Read, 1958).

Over the next twenty years, the women's health movement and childbirth education classes promoted women's awareness of their right to information, choices and self-determination. A few brave and committed midwives practised as domiciliary midwives providing labour care in the home without analgesia (Donley, 1998). They offered a range of alternative pain relieving techniques – distraction, massage, conversation, acupuncture, homeopathy, warm baths, a familiar environment and caring support people. Some women were able to reclaim childbirth as a physiological process. The Home Birth Association was formed in 1978 and the women and the midwives in

the association challenged the medical establishment to justify their practices, particularly regarding analgesia and anaesthesia (Donley, 1998). Not only on the home front was the medicalisation of childbirth being confronted. Internationally, convincing evidence was emerging from obstetricians like Michel Odent who supported non-intervention in normal childbirth. Odent (1984) contended that women should be encouraged to trust in their own bodies and the strength of their inner resources to successfully birth without the need for drugs. He advocated mobility during labour and an atmosphere conducive to privacy and intimacy for the couple.

The small but vocal minority of women who defied the status quo to give birth in their homes without analgesia were the cornerstone of the opposition to the medical model of birth. Midwives joined forces with women and pressed hard for changes to the existing maternity services (Donley, 1998). In 1990, the Amendment to the Nurses Act gave midwives the right to practise autonomously. Women were now able to choose the health professional they wished to engage for their birth and the place of birth. These choices also affected the type of labour support and pain relief available in the various settings.

Current forms of pain relief

Midwifery care for labouring women in New Zealand today commonly involves some form of pharmacological pain relief. As the majority of births occur in a hospital setting, the availability of nitrous oxide, pethidine and epidural anaesthesia is widespread. Nitrous oxide is frequently used in advanced labour in a 50:50 concentration with oxygen. It is also available at homebirths.

Pethidine is generally used in smaller doses than were commonplace in the 1980s. One or two intramuscular injections of 100mgs pethidine are nowadays more likely to be replaced by divided intravenous doses of up to 50mgs of pethidine.

Epidural anaesthetics are popular with many women and their use appears to be increasing. While there are undeniable advantages in having this form of analgesia available in some situations, an epidural is never a single intervention. Choosing an epidural guarantees the initiation of intravenous fluids and usually, confinement to bed, restriction of oral intake of food and fluids, continuous electronic fetal monitoring and oxytocin to stimulate contractions (Mann & Albers, 1997). In addition, the flow-on

effects to mother and baby in terms of a longer labour, increased incidence of instrumental birth and morbidity outcomes are well recognised by health professionals (Dickinson, Paech, McDonald, & Evans, 2002; Enkin et al., 2000; Howell, 2003). Many women, however, are unaware of the potential sequelae following an epidural which are sometimes referred to as a cascade of intervention (Inch, 1985). The promise of something to mask the pain of contractions is very seductive to many women. As this form of pain relief continues to gain in popularity, women's faith in their body's ability to birth successfully is being eroded.

Midwives embrace the philosophy that their care should enhance and protect the normal course of childbirth wherever possible. Indeed, in the New Zealand College of Midwives' Handbook for Practice (2002), under the scope of practice is the statement "the midwife promotes and supports the normal childbirth process" (p.4). Midwives can play an important role in providing women with the information necessary to make an informed choice about measures such as epidurals. They also have a duty to advocate for women when intervention such as induction of labour or Syntocinon augmentation is being considered, as this may result in a more painful or lengthy labour and thus increase the likelihood of an epidural being required.

A national overview

In New Zealand, whether a birth takes place in the home, in a birthing centre or a hospital environment, a midwife is the health professional who provides all or most of the care and support. In 2001, 54,288 live babies were born in New Zealand (New Zealand Government, 2003). Over 90% of these babies were born in a hospital or birthing centre, with the remainder born at home. A midwife was the woman's chosen LMC 66% of the time. Although women have embraced the opportunity to have a midwife as primary caregiver since 1990, few women are choosing home birth. While this may reflect a view among some women that hospital is a safer option, I believe that the availability of epidurals is a significant factor. The prevailing view among some sections of society that pain is undesirable in childbirth has gained momentum with its endorsement by high-profile 'personalities' who enthusiastically endorse epidurals from the beginning of labour. This message that pain can, and should, be eradicated has proved to have a pervasive influence on women contemplating birth. Their partners, mothers and other friends and family are not immune to the weight of media coverage either. A growing unease about the safety of childbirth has arisen and inevitably

women, and in some cases, midwives are reflecting that concern by favouring more interventionist practices. Surtees' recent research (2003) recognises this influence on practice. In her study of the discourses surrounding midwifery practice in New Zealand, she explores the effects of the tensions for midwives as they respond to choices for hospitalised births.

A normal vaginal delivery was achieved by 68% of the total number of women who birthed in hospital in 2001 (New Zealand Government, 2003). Operative deliveries were experienced by 10% of the women. These were defined as vaginal births which included a vaginal breech delivery, forceps or vacuum extractions. The total caesarean section rate was 22%.

Regional statistics

In the Auckland region's hospitals, where this study is set, 18,856 women gave birth in 2001 — a figure which represents 36.7% of the total number of women in New Zealand who gave birth that year. Of that group of women in the Auckland region, 32% had an operative delivery and 62 women out of every 100 had an epidural in situ at delivery. The figures citing the incidence of epidural also include emergency caesarean sections (New Zealand Government, 2003). The statistics show that European and Asian women have almost double the epidural usage of Maori and Pacific women. The data represent obstetric practice two years ago and there is no evidence to suggest that epidural anaesthesia and the incidence of operative deliveries has slowed.

National Women's Hospital is New Zealand's largest women's health service provider and furnishes services ranging from primary to tertiary care. The hospital works closely with the University of Auckland's School of Medicine in teaching and research roles. I will present the most recent figures from this hospital to provide a snapshot of labour outcomes from the Auckland region, although there are a number of other hospitals used by women giving birth in the province. In the year 2000, 7827 babies were born to women at National Women's Hospital with operative deliveries (i.e births excluding Caesarean sections) making up almost 14% of the total number. Epidurals were used by 52% of the women who gave birth that year, with 31% of them using an epidural following the onset of spontaneous labour which culminated in a normal vaginal delivery. Pethidine was used by 38% of all women and nitrous oxide by 18% (Stone & Knight, 2001).

Personal Context

It is against this background that my practice has occurred. I worked in the delivery unit of an urban hospital when I first registered as a midwife twenty-five years ago. It was not uncommon to admit women in very early labour, put them to bed and suggest that the partner go away for a while because "it's still early days". The woman was frequently left alone except for an hourly check of the fetal heart. If fear and loneliness exacerbated the pain of the contractions, she might start moaning. Noise wasn't welcomed in delivery unit and we were quick to inject pethidine intramuscularly. This probably disorientated and sedated the woman for a couple of hours. We would often repeat the pethidine before moving on to an epidural anaesthetic. Sometimes women were transferred to our unit from a smaller birthing centre or from home when complications necessitated such a move. These women represented the face of the minority who had agitated for change to the medicalised system prevalent at that time. They began to open my eyes to the possibilities of practising in a way that supported women in labour in a midwifery sense.

Throughout the 1980s I worked at this hospital and witnessed the change in hospital practices as women increasingly exercised their right to choice. Although pethidine and epidurals were still used for pain relief frequently, there was a growing awareness of the alternative methods of coping with pain. These included measures to keep women more mobile during labour, the use of heat and massage, and variations in labour and birth positions. I further developed my skills at being with the woman in a supportive and encouraging way.

Following several years away from midwifery practice, while my children were young, I returned to work in a similar type of urban hospital in the mid 1990s. In a labour setting, I learned new strategies to offer women. Baths, birthing pools, hot/cold packs for back or perineum, aromatherapy oils and homeopathy were increasingly used. Women were encouraged to participate in decisions regarding pain management and many embraced the opportunity to view their labour in a more positive light and try to avoid traditional forms of medication. But not all of these women were clamouring for less drugs and intervention.

The era of post-autonomy practice as I observed it seemed to incorporate women from three mindsets with regard to pain relief. One group was passionate about coping with the pain of labour without resorting to pain relief if possible. The other group was more willing to use pain relief if they required it. This group appeared to be the largest in number and that was probably fortunate. A significant number of women in the unit where I worked, many of whom had labour induced and augmented with Syntocinon, required an epidural in labour. They almost always needed an epidural to cope with the intensity of augmented contractions. The third group of women represented a new phenomenon in my experience. These women wanted an epidural in labour and as early as possible. They feared the pain of labour greatly and wished to take advantage of the available technology to have a painless labour and birth. I was saddened to talk with these women and hear how frightening the spectre of labour was for them without the merciful action of bupivacaine. Whilst autonomy for midwives has brought increased choice for women as to where they birth and who they use as LMC, there remains much to do in rekindling in women the knowing that their bodies are designed to cope with labour and normal birth in most cases.

My Pre-assumptions

In keeping with my chosen methodology, I need to examine my own history – as a midwife, as a mother, as a daughter. My place in the world, my being-there, is inextricably linked to my research activities. I bring all my life experiences, biases, beliefs and assumptions with me to any situation. I need to make explicit these attitudes and assumptions that colour my being-in-the-world in order to recognise them and perhaps in doing so, come to see the phenomenon being studied through fresh eyes. Merleau-Ponty suggests that in examining the phenomenon of lived experience we re-learn looking at the world "by re-awakening the basic experience of the world" (cited in van Manen, 1990, p.31). My pre-assumptions accompany me in everything I do. To acknowledge and articulate them allows the reader to discern influences on my interpretations.

I recall my mother relating the story of my birth in graphic detail. I am the first child and was lying in a posterior position during labour which resulted in a very long and very painful time for my mother. Epidural anaesthesia was not yet available and my mother clearly recollects the excruciating backache that my head caused her to suffer because of my position. A very difficult forceps delivery was required to induce me to

turn my head sufficiently to exit and the ensuing extension to the episiotomy made for a most uncomfortable postpartum period. My labour, thirty years later, was strikingly similar on most counts. The main difference was the availability of epidural anaesthesia which I accepted with alacrity. Memories of birth stories such as my mother related and seven years of midwifery practice in a delivery setting, meant that I 'knew' the debilitating nature of the backache associated with posteriorly positioned babies and an induction of labour.

But how have these experiences influenced the way in which I decide about aspects of pain relief in other women? I believe that I have a fairly flexible approach to pain in labouring women. I am aware that I make judgements based on factors such as the number of babies a woman has had, her general demeanour, her ethnicity, the support she has in attendance and whether or not I get a sense that I can, or have, developed a rapport with her. I don't feel compelled to 'save' a woman from pain. I really enjoy actively supporting her to 'ride' each contraction and stay focussed in the 'now' rather than looking too far ahead. But I don't feel any less engaged with a woman who requests pain relief and has it. Trying to apply a one-size-fits-all approach to issues such as the stereotypical picture of a particular ethnicity and how 'they' cope with labour is fraught with difficulty. The longer I have practised, the more comfortable I have become with taking a very pragmatic approach to each labouring woman and her situation at that time.

Summary

In this introductory chapter I have attempted to describe something of the labouring woman's perception of pain and the midwife's role in relation to this. I have introduced the research question and how it pertains to my chosen methodology. I have described the context for this study, within a New Zealand setting, and within the context of my professional and personal history. To achieve this I have summarised the maternity service in New Zealand over the past one hundred years with an emphasis on the area of pain in childbirth. I have attempted to reveal my pre-assumptions in this area in order to help the reader see how they have coloured my interpretation in later chapters of this thesis.

Chapter Two

Literature Review

Introduction

The literature review will help to situate this study within a context of existing writing which has relevance to the study's focus. The writings within the field of pain are numerous and complex. I begin with an overview of pain and some of the theories of pain. Next I explore physical, psychological and cultural aspects of pain in labour and seek to show areas within the literature which seem to pertain to aspects of the relationship between the midwife and the woman in a labour setting. I have found writing about the midwifery relationship in the professional literature and have also searched for it in a more general domain. Specific characteristics which may enable midwives to work effectively with women and their pain have also been presented using a variety of literature. Most of the writing emanates from overseas although I have highlighted New Zealand literature when possible. Research and other writing from disciplines outside midwifery have been presented to help a reader place this study in a wider context. In so doing, I have become aware of areas within the body of knowledge relating to this area of labour about which little is written. An examination of the literature will highlight the present context in New Zealand and help set the scene for an exploration of my research question for this study.

The language of pain

"Pain... is stark and unyielding to decoration, pain fills the world to the hilt, bursting its edges in an unseemly way; pain doesn't admit anything else — it usurps all the space available."

(Kassabova, 1999, p. 52)

Pain is an embodied experience that stamps its existence on a particular part of the body with an intensity that only the sufferer can feel. Pain is a sensation that is unable to be shared (Scarry, 1985). The pain in the passage above is the pain expressed by a young woman who has had to leave her homeland and flee far across the world to a place of

and verbal coaching for some women. If a labouring woman is feeling relaxed and confident, the descending inhibition is high so less pain is perceived (Coad & Dunstall, 2001).

The language of labour pain

Pain belongs in a unique way to the woman, who is utterly alone with it. She cannot share it. She has no doubt about the reality of the pain experience, but she cannot really tell anybody what she is experiencing (Illich, 1976).

I withdrew into a private world. Sometimes it was dark and quiet. Sometimes it whitened like hot steel and there was a thin, high sound above the whitening. My own body was the steel, thrust into a furnace. The whiteness would dim to red, and to black again, and the thin sound would stop, and for a while there would be silence and peace.

(Banks, 1960, p.258)

Pain "ensures unsharability through its resistance to language... it actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned" (Scarry, 1985, p.4). All of our other internal moods, such as fear, love and hunger, are feelings *for* or *of* something. Pain is different. "It is not *of* or *for* anything. It is precisely because it takes no object that it ... resists objectification in language" (Scarry, 1985, p.5). In fact, pain mutes words by rendering them unreachable as this account of a woman in labour captures:

The pain in my back returned deafeningly. I closed my eyes but that shut me into a dark roaring world of pain... I opened my eyes ...I tried to call out...For a second I knew what it might feel like to be alone in the world

(Banks, 1960, p.2.57)

For the midwife who works with a woman in pain there is clearly a challenge to penetrate the inarticulate and lonely world she inhabits. Mander (1998) suggests that there is a reluctance on the part of health professionals to be convinced of the veracity of women's accounts of their pain. Illich describes it thus: "Others have 'their' pains, even though I cannot perceive what they mean when they describe them" (Illich, 1976, p.140). The midwife cannot enter into the experience of pain, but relies on her perception of pain as expressed by the woman.

In addition, there is evidence to suggest that midwives regularly underestimate the severity of labour pain in women for whom they are caring, when this pain is compared with the women's perception of it (Bradley, Brewin, & Duncan, 1983; Rajan, 1993; Sheiner et al., 2000). A recent Australian study examined the perceptions of labour pain by women and their attending midwives using the short form McGill Pain Questionnaire. The survey showed that pain scores by women and midwives were similar at mild to moderate pain levels, but midwives significantly underestimated pain intensity at levels that women described as severe (Baker, Ferguson, Roach, & Dawson, 2001).

This fictional account of an interaction between a labouring woman and the 'nurse' echoes these findings:

She went rigid to another labour pain, deeper, more savage; this time her breath caught hard and the nurse turned at her gasp, nodding as if to give due recognition to pain, otherwise unimpressed, except to note the time.

(Hobson, 1971, p. 219)

It has been postulated that midwives' behaviour with regard to estimating the severity of pain may be an unconscious coping strategy adopted by the midwife to dilute her impression of the degree of pain being suffered (Mander, 1998). I argue that this could also be attributed to the difficulty in interpreting the embodied experience of the woman.

Rajan (1993) recounts that the use of pethidine in labour was one area where perceptions of its effectiveness differed widely between women and health professionals. There were frequent instances of women complaining that their pain was not helped by the drug whilst the professional believed that it was. Women reported that not only did pethidine take away their sense of control and not provide pain relief, but also it was often deleterious to the establishment of breastfeeding. Rajan suggests that this divergence of views can result in the woman continuing to experience pain and also a sense of powerlessness at the perception by staff that they have addressed the pain relief and need do nothing further to help.

Studies in Canada (Melzack, Taenzer, Feldman, & Kinch, 1981) and Scotland (Niven & Gijsbers, 1984) demonstrate remarkable congruence in the perception of labour pain,

which women rated as very intense. Niven & Gijbers (1996) point out in a later publication, though, that most of the numerous studies which attempted to quantify the intensity of labour pain have been carried out in developed countries where childbirth is a medicalised event occurring in a hospital environment. Furthermore, the timing of labour pain assessment is likely to be crucial given that the pain usually increases from early labour to late in the first stage. In addition, some studies used retrospective pain assessment which introduces the possibility of confounding effects such as memory and mood.

Critics of medicalised settings for normal birth, such as Sheila Kitzinger, have challenged these findings, arguing that births which take place in familiar, non-medicalised settings are often less painful (1984). The methodology of such studies is questioned by those more accustomed to a positivist approach and randomised controlled trials. Prominent critics of the ascendancy of modern diagnostic and therapeutic medicine such as Ivan Illich (1976) and Ian Kennedy (1981) suggest that medicine has produced more harm than good in that being healthy is not always synonymous with not being ill. Their views appear to find recognition within the groups who critique accepted obstetric practices, favouring a less interventionist approach to a normal physiological event.

Physiological Aspects of Pain in Labour

The physiological stress of labour and hypoxia associated with pain causes maternal catecholamine levels to rise, along with adrenaline secretion. High maternal levels of catecholamines can affect placental blood flow and the fetus in labour. Adrenaline secretion causes vasoconstriction and a reduction in uterine blood flow and uterine activity (Mander, 1998).

Endogenous opiates, which include beta-endorphins, enkephalins and dynorphin, block pain transmission and are therefore of particular importance in labour. Beta endorphin levels increase during pregnancy, are further stimulated by the stress of labour and peak at delivery (Coad & Dunstall, 2001). They are powerful relievers of pain given optimal environmental conditions such as privacy, calm, intimacy, freedom to labour in any position and the helpful presence of a midwife (Odent, 1984).

This woman's description of her labour at home conveys a clear picture of the way she sought her own space and her own pace as the endorphins kicked in:

I was in my own world – the contractions were pretty strong, and I wasn't focused in on what anybody else was doing. It was like tunnel vision; I was only into myself and my body. I remember that I wanted to be in a dark corner, like a cat having her kittens. I crawled between the bed and wall ...I just kind of laid there, curled up in a fetal position – off like a wounded animal.

(Greene, 2000, p. 125)

Psychological Aspects of Pain in Labour

The perception of pain varies among individuals even though the stimuli for pain may be similar (Sherr, 1995). One of the most significant predictors of all components of pain in labour is confidence in the ability to handle labour. Anticipation of labour pain causes intense anxiety for many women (Lowe, 1989; Shearer, 1995). Negative feelings surrounding pain in labour are often associated with anxiety during pregnancy (Coombes & Schonveld, 1992). The more pain and anxiety associated with latent labour that a woman experiences, the more likely she is to have slower labour, more fetal distress and greater incidence of instrumental delivery (Wuitchik, Bakal, & Lipshitz, 1989). Women who are more anxious tend to have less positive expectations of childbirth and experience less satisfaction with birth (Booth & Meltzoff, 1984; Green, 1993; Green, Coupland, & Kitzinger, 1990).

Providing information which is accurate and realistic is recognised as an important part of the preparation for birth. Grantly Dick-Read, in his book "Childbirth Without Fear" (1958) first articulated the link between fear, tension and pain which he viewed as a vicious cycle, having the potential to slow cervical dilatation. He advocated relaxation classes antenatally and education to forearm women with knowledge of the mechanisms of labour. Antenatal class attendance is more likely to comprise women who are older and of higher socio-economic class (Jones & Dougherty, 1984; Niven, 1994). Although these studies were conducted in England some years ago, there is little reason to doubt that antenatal classes in New Zealand are composed of a similar demographic stratum. As the midwife is more likely to see a wide cross-section of women, she therefore has a crucial role in providing all women with information during pregnancy, and indeed labour, to encourage them to feel more confident about their pain. Slade et al (1990) and Byrne-Lynch (1990) both found the best kind of preparation for childbirth appears to be

the generation of positive but realistic expectations which encourage the woman to feel optimistic about her ability to cope with labour. There is research, however, which suggests that skills acquired through childbirth education to moderate pain and distress can be superceded by the shift from latent to active labour if women continue to harbour anxieties (Wuitchik, Hesson, & Bakal, 1990).

The midwife also needs to recognise the power imbalance which may exist in her relationship with a woman because she holds much 'expert' knowledge. While this may be true, the woman may have acquired a great deal of her own knowledge, through books, family, friends and the internet. In addition, she possesses specific knowledge of her own body and what is happening to it (Weaver, 1998).

Enabling women to make informed choices and decisions and to feel in control during labour are important factors which make women feel confident and satisfied with the childbirth experience. McCrea and Wright (1999) sampled 100 postnatal women in Northern Ireland using a questionnaire to examine the influence of personal control on their satisfaction with pain relief in labour. The hospital they gave birth at practises a policy of active management of labour. Despite this environment which limited their movement during labour owing to intravenous augmentation of contractions, continuous fetal heart monitoring and two hourly vaginal examinations, the most important finding to emerge related to the significant correlation between personal control variables and satisfaction with pain relief.

The concept of control is an idea which is still not well understood as it applies to women in labour (Weaver, 1998). McCrea and Wright (1999) also comment on the complex nature of women's definition of personal control. For some women control involves some participation in the decisions which are made about the management of labour and birth (Berg et al., 1996; Bluff & Holloway, 1994; Green et al., 1990; Halldorsdottir & Karlsdottir, 1996; Hundley, Ryan, & Graham, 2001; Lavender et al., 1999; Niven, 1994). A prerequisite for decision making is having full access to information (Lovell, 1996). But, as Green et al (1990) found, choice can prove threatening for a woman because she is being asked to assume responsibility for decisions or because she is overwhelmed by a plethora of options. Bluff & Holloway's (1994) important study coined the phrase "they know best" wherein women and their partners believed that the midwife knew what care was best, even when their own

specific wishes were disregarded. This study clearly demonstrated a need for midwives to acknowledge the inequality of the relationship and not abuse the trust so obviously invested in their professional judgement.

The psychological effects of control over what happened to women and over decisions about their care in childbirth can be very long-lasting (Simkin, 1991). Long-term satisfaction over the whole experience, even twenty years later, can be expressed by women as having achieved something highly significant. Similarly, when Githens, Glass, Sloan & Entman (1993) compared women's memories of their birth to their hospital records, women recalled this information accurately for a minimum of 4 to 6 years.

For other women, control is associated with feeling in control of emotions and behaviour in labour (Green et al., 1990; Niven, 1994). This passage portrays a woman carefully watching for each contraction as she struggles to encounter them in just the right way:

It is time. I am out at sea heaving between the waves of pain, waiting, angling to face the next. Each wave must be cleft with the smooth deep V of my breastbone at the right angle, my head calm and still. A little to the left and a little to the right is turmoil and I'll go under.

(Sallis, 2000, p.117)

Feelings of self-control are closely linked to information giving and the encouraging and supportive role of the midwife (Gibbins & Thompson, 2001). A study by Levy (1999) concluded that midwives continue to act as gatekeepers of information, often guided by benevolent intentions, but that these sometimes appear to serve the interests of the midwife or the institution in which she works. Midwives must be prepared to share their knowledge, viewing it as an opportunity to help women achieve the type of childbirth experience they desire, rather than a threat to their professional authority (Cooper, 2001).

Some commentators argue that sharing of knowledge should entail presenting a realistic picture of birth to women, for to protect her from the concept of pain is to leave her without preparation for coping (Peterson, 1984). Oakley & Houd (1990) advance the idea of birth as a therapeutic process during which women may confront and address various repressed painful experiences. The authors see one of the midwife's tasks as

facilitating the expression of the range of possible emotions which the experience may provoke.

Cultural Aspects of Pain

New Zealand is a multicultural society and, as such, the midwife is likely to be involved in the care of women from a range of Maori, Polynesian, Asian, Middle Eastern, African and European backgrounds. Cultural perception and expression of pain varies widely. This is reflected in the vocalisation of pain by some women while other cultures appear to value stoicism.

Some of the cultural meanings attached to childbirth for Maori are captured in this poem which speaks from a mother as she labours and awaits the birth of her baby.

Te Ha

Breathe
even as I squat I am myself.

Breathe
my body a heavy weight, you so rough inside the bony seam.

Breathe
the waka surges forward.

Breathe
in all my efforts I am locked in the embrace of Hineteiwaiwa.

Breathe
an unsullied moon wraps itself around us.

Breathe
help me as the next generation carves a pathway from my body.

Breathe
in the space between worlds I link my life and yours.

Breathe
each physical exertion pushes you to towards my arms.

Breathe
in vigour and action.

Breathe
time is painful slow and quickened.

Breathe
the rhythm fastens.

Breathe
each action brings you closer.

Breathe
you slip through the last gateway.

Breathe
my deep-throated calls carry you forward.

Breathe

*and out and out and out
into this gasping world of rich-scented earth.*

Breathe

your first breath, one taste of life.

Breathe

*the men drum softly, the sound of Tane as he moves amongst trees,
quiet thunder and rain, open-mouthed glory.*

(Potiki, 1999, p.5.5)

This poem speaks of the power of birth. The woman sees herself within the continuum of her lineage. She views the impending birth as important to continue the whakapapa or bloodline of her heritage. The hard work that is labour is accepted with pride because it is she who carries and gives birth to the next generation or mokopuna, regarded as taonga (irreplaceable treasure) within the family group. The pain acquires meaning as each contraction brings the baby closer to her waiting arms. The refrain 'breathe' sounds like a constant reminder to steady herself as she labours. It also suggests the efforts of second stage when she begins to push her baby out from its dark world into the world of light. The goddess Hineteiwaiwa is associated with birth and enfolds mother and child in her arms as the baby takes a first breath (Potiki, 1999).

I could find no New Zealand publications about care of women from a midwifery perspective. 'Ukaipo' (1998) is the result of research by Maori about Maori women's experiences of pregnancy and birth. Its focus is on the women's accounts of their interaction with the health system with the aim of helping to educate health professionals about the specific needs of Maori women (Rimene, Hassan, & Broughton, 1998). A preference for Maori midwives to provide labour care was expressed by some women who appreciated care that felt more culturally safe. Communication with midwives was an area where possible misunderstandings could arise. One woman pointed to the fact that nodding the head after receiving information from a midwife does not necessarily indicate understanding. Sometimes, it is merely an effort to try to please or just to acknowledge that the information has been heard. This has implications for all midwives, particularly when working with women from a different culture.

Holroyd, Yin-king, Pui-yuk, Kwok-hong & Shuk-lin's (1997) study of Hong Kong Chinese women's perception of support during labour from midwives describes how the cultural reluctance of women to express emotions meant that the midwives found it very difficult to interpret non-verbal expressions of pain, even though they were from the same ethnic background. Similarly, in a study of Hong Kong Chinese women's

experiences of vaginal examinations in labour, some women reported that their examination had caused pain but that they were reluctant to comment on it or display signs of the pain (Lai & Levy, 2002). The study's authors describe how women are expected to tolerate pain in childbirth and crying out is viewed as shameful according to Chinese culture.

The cultural and spiritual meanings of childbirth were explored in a North American study by Callister, Semenic & Foster (1999) which found that religious beliefs help women define meaning in childbirth and may provide coping mechanisms for labour. Bowler (1993) has shown how midwives are in danger of stereotyping women according to their cultural background. In her study, she demonstrated how midwives dismissed Asian women in pain as "making a fuss about nothing" because they are perceived to have a low pain threshold. This assumption led to the women having pain relief withheld and to different treatment to that received by other women.

Leap (1996), in her study of a midwifery perspective of pain in labour, states of her participants:

Midwives were all aware of different cultural expressions of pain in labour but were anxious to avoid ethnic stereotyping when talking about their experience of working with women from other cultures... (p.55)

Clearly, midwives need to be mindful of the potential pitfalls associated with attributing certain behaviour in labour to pre-conceived assumptions of its meaning

The Midwifery Relationship

The relationship between a midwife and a woman is central to the midwife's work. There have been several studies published which explore the relationship from the woman's perspective (Berg et al., 1996; Kennedy, 1995; Tarrka & Paunonen, 1996; Tinkler & Quinney, 1998; Walsh, 1999). Despite this research being conducted in different countries – Sweden, United States, Finland and England – women expressed satisfaction with the midwifery care they received when the midwife was 'present' in offering support and information. Women also valued feeling respected and commented on the sense of trust which evolved, even though they had not met the midwives prior to labour in three of the four studies.

A systematic review of studies concerned with women's satisfaction with childbirth and the roles of pain and pain relief found that four factors – personal expectations, the

amount of support from caregivers, the quality of the caregiver-patient relationship and involvement in decision making – appear to be so important that they override the influences of age, socio-economic status, ethnicity, childbirth preparation, the physical birth environment, pain, immobility, medical interventions and continuity of care when women evaluate their childbirth experience (Hodnett, 2002).

Halldorsdottir and Karlsdottir (1996) studied labour using the metaphor of a journey. Midwives were categorised by women as either an 'indispensable companion' or an 'unfortunate hindrance'. There appeared to be no middle ground in their eyes. Of crucial importance was the ability of the midwife to make herself emotionally available to address fear and anxiety. This involved being fully 'present' to the woman.

Continuous, one-to-one support, by women, for women during labour has been found in a recent Cochrane Review to reduce the likelihood of analgesia and operative birth and increase the level of satisfaction with their childbirth experience (Hodnett et al., 2003). This support may or may not come from a midwife, as nurses, doulas and other lay female companions were also found to make significant contributions during labour. Common elements of this care include emotional support, information about labour progress and advice regarding coping techniques, comfort measures and advocacy. Recently continuous support has been viewed as a form of pain relief, specifically as an alternative to epidural analgesia (Dickinson et al., 2002) because of concerns about the deleterious effects of epidural analgesia on labour progress (Howell, 2003).

Lundgren and Dahlberg's study specifically looked at the woman's experience of pain during childbirth, using a phenomenological approach to interview four primigravid and five multiparous women shortly after giving birth in a Swedish birthing centre (1998). The women found the pain hard to describe and had contradictory feelings about its meaning. They also described handling the pain by trusting their bodies to do the work and needing to have trust in their partner and midwife. In the absence of studies in other countries, it is difficult to determine if a major finding such as the women expressing the need to trust themselves and their bodies in labour is linked to any cultural factors. The choice of birth setting is more likely to reflect a less medicalised approach to labour care and different expectations for pain management from women and midwives alike. Research which examines the relationship from a midwifery perspective is less common. McCrea and Crute (1991) explored midwives' understanding of the factors

which affected the development of a therapeutic relationship with women. An emotional involvement with women, honesty and a sense of trust appear to be important components of such a relationship.

There are few studies that address the issue of the midwife's approach to pain relief in labour. Leap's (1996) study articulates an emphasis on 'working with pain' in normal labour amongst her participants rather than the more traditional emphasis on 'pain relief'. These midwives, with extensive homebirth experience, view the pain associated with normal labour as pain which can be borne by most women because it represents a normal physiological process. This philosophy possibly indicates a mindset in relation to labour pain which is more likely to be found in women who choose to birth outside the hospital environment. It also is more likely to occur with women who are receiving continuity of care as the antenatal period is a crucial time for information gathering and preparation for labour. The midwife plays a significant part in conveying a positive and supportive attitude.

Midwives in a Northern Ireland hospital were observed interacting with women during labour (McCrea, Wright, & Murphy-Black, 1998). Three types of midwives' approach to pain relief were identified. An uncaring, emotionally aloof carer who may have met the physical needs of the woman, but not the psychosocial needs was termed a 'cold professional'. A 'disorganised carer' who exhibited little professional competence or good communication skills was also identified. The 'warm professional', by contrast, provided care in a holistic way and treated the woman as 'special'. Furthermore, she promoted an attitude of partnership and a positive portrayal of labour pain. These qualities had a positive influence on the women's experience of pain. Given that the birth environment is likely to be a medicalised setting with strict obstetric management through protocols to actively manage labour, one feels encouraged by this indication that a midwifery heart still beats in a less sympathetic setting.

Seibold, Miller and Hall (1999) observed some labours in an Australian hospital and retrospectively interviewed women and midwives who had cared for them. Initial chart audits revealed that midwife and partner support in labour was hidden because it was not documented and was therefore less likely to be valued as it went unrecognised. Staff shortages meant that midwives were sometimes more likely to administer pethidine if they were unable to maintain ongoing contact with a woman in labour. Lack of

opportunity to spend more time with women and the layout of rooms limited women's options for other strategies such as change of position or shower. Despite the difficulties of such a hostile environment it was clear that midwives can make a difference at times. Some midwives gave good support when the pain was intense. Presence, voice, calm and assured demeanour, focus on the woman, non-verbal communication and touch were all observed to have a beneficial effect.

The only New Zealand study I found which explores the midwife-woman relationship deliberately chose participants who were engaged in continuity of care and independent midwifery practice and their clients. The nature of this form of relationship with the woman is unique to midwifery because of the way in which the midwife is engaged to be alongside a woman "throughout a life event" (Leap, 2000, p.4). Guilliland & Pairman (1994) first articulated the nature of the partnership which underpins the midwifery philosophy and forms a model for practice in New Zealand. Pairman (1998) wrote further about the midwife-woman relationship which she characterised as a "professional friendship"(p.8). This term seeks to encompass the "intense and meaningful shared relationship involving emotional and physical presence, concern, warmth and trust" (1998, p.9). In addition the participants are involved equally in a reciprocal relationship which forms for a specific reason and ends when its purpose is achieved.

Lundgren and Dahlberg (2002) describe the midwives' experience of the encounter with women and their pain during childbirth in Sweden. They conclude that the midwife should strive to be an 'anchored companion'. As a companion, this entails a physical, psychological and emotional presence and a relationship built on mutual trust and confidence. Being a companion also means to be available to the woman by listening to the woman, acknowledging her pain and following her through labour. To be a companion, midwives need to share responsibility with the woman. The definition of anchored incorporates the way that midwives watch the woman's ability to deal with her pain carefully and are prepared to "seize the woman" if necessary. This refers to a more assertive verbal approach to help the woman maintain control. The word anchored also captures the recognition that midwives need to be aware of their own professional limitations if labour moves away from the normal.

Emotional labour

Emotional labour is labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions (Smith & Gray, 2000). It is a concept initially conceived of during research by Hochschild with airline attendants which concluded they are trained to suppress their real feelings in order to perform their jobs (cited in Smith & Gray, 2000). Dealing with their emotions in working with the flying public was termed emotional labour. It was seen as having the potential to cause exhaustion and possible burnout.

The concept of emotional labour has been embraced by health care researchers who suggest that it is largely invisible and unacknowledged in the field of nursing where management tends to focus more on physical aspects of care (James, 1989). The gendered nature of emotion work results in its invisibility and undervaluing within the workplace (Smith & Gray, 2000). The area of palliative care is one domain where pain plays a major part in caregiving and emotional labour is an everyday occurrence. Cicely Saunders worked as a doctor in an early hospice in England where she coined the term "total pain" to capture its multiple dimensions – physical and emotional, biological and cultural, spiritual and existential – in relation to cancer patients. Saunders was concerned not only to *understand* the world of pain, but also to *change* it for patients (Clark, 1999). She wrote that "pain becomes invested with value for what it can tell us of the suffering person, whose narrative is told both *about* and also *through* the body" (Saunders, cited in Clark, 1999, p.730). In other words, total pain helped to provide meaning for pain.

Mander (2002) has drawn parallels between the concept of total pain in this context and that of the transitional stage of labour. She suggests that this is a time of very painful contractions which severely test the woman's resources, both physical as well as psychological, emotional and spiritual. The support of the midwife is more necessary than ever and if she has elements of over-exposure to pain in the form of burn-out, her ability to offer support may be very limited. In this case, the midwife is likely to rely on pharmacological pain relief to achieve a 'quick fix'.

Very little midwifery literature appears to deal explicitly with the emotional aspects of midwifery work. Hunter (2001), in her review of current knowledge of this topic found that the evidence is more readily available through the consumers' perspective where

numerous studies attest to the quality of midwifery emotional support impacting on women's childbirth experiences, for example, Hallsdorsdottir & Karlsdottir, 1993; Niven, 1994; Tarrka & Paunonen, 1996.

Midwives' perceptions of their work in the area of emotional labour are not numerous. Lovell (1996) calls for 'emotion-work' during labour and birth which is highly valued by women, to be more fully acknowledged as "real work" (p.271). Kirkham and Stapleton published results from their study which suggests that midwives' experiences are strongly influenced, often negatively, by the culture of midwifery within the English health system (2000). Midwives working within the hospital system strive to provide woman-centred care whilst their own needs remain unacknowledged. Managing such contradictions is likely to create emotional work, Hunter (2001) suggests.

The implications for the midwife's personal life of providing continuity of care are that this may result in increased emotional labour as well. Walsh (1999) provides rich accounts from women about the emotional closeness that resulted from partnership caseload midwifery care. The women spoke of their midwives as 'friends' and experienced a sense of grief and loss when the relationship ended. There are no accounts from the midwives' perspective and we can only speculate about the possibility of a similar emotional investment for the midwife. There are high levels of expressed emotion involving the woman and her partner during labour, which require emotion work by the midwife. There is also the issue of pain which may create emotion for the midwife (Hunter, 2001). Being with a woman in pain is an experience shared by all midwives and this may be a source of discomfort to her (Leap, 1997). As suggested by the observational research of McCrea et al (1998), the 'warm professional' was able to provide most positive support for labouring women. It would appear that these midwives were able to effectively manage emotions with therapeutic effect, perhaps because they were able to find a meaning for the pain.

The meaning of pain

If the pain of labour can be understood to have a purpose, it may help women to cope with it. Bergum's study was one of the first to explore a new understanding of the meaning of birthing pain. It began with an examination of the assumptions about labour pain which suggested that pain should be denied, must be relieved, is only negative and can be explained (1985). The study uncovered different interpretations of pain from

women's accounts and paved the way for more work in the area. Leap's study 'A midwifery perspective on pain in labour' (1996) also looked at a new meaning for labour pain. She summarises its purpose beyond the physiological mechanism for expelling a baby from the uterus. "Pain" she writes, "marks an important transition, musters support, develops altruistic behaviour in mothers, triggers beneficial neuro-hormonal cascades, and empowers women through an ensuing sense of achievement" (Leap, 1996, p.67). Ng & Sinclair (2002) use the term 'mastery' over labour pain to explain the sense of achievement women feel at the end of their home birth experience (p.59).

This sense of achievement is celebrated in the words of Barbara Katz Rothman:

"Birth is not only about making babies. Birth also is about making mothers — strong, competent, capable mothers, who trust themselves and know their inner strength"

(1996, p. 254).

These sentiments are echoed by Beatrijs Smulder, a Dutch midwife, who is proud of Holland's strong tradition of home birth and the emphasis on keeping birth normal. She promotes a message which encourages women to see pain in a positive way without denying that labour hurts. She emphasises that labour pain is never in vain. It keeps birth safe. Focus on the pain, she urges, and welcome it. The more pain, the stronger the contractions and the sooner the baby is out (2002).

Niven and Murphy-Black (2000) conducted a literature review to establish if labour pain is forgotten and if recall is accurate. Methodological inconsistencies made interpretation and comparison of many of the studies impossible. A considerable number of the studies had been conducted retrospectively and asked women to recall and assess pain that they experienced at different stages of labour. Also, very few studies record pain during childbirth so recalled pain is compared with a recollection, not with the pain experience. These are possible confounding elements in the research.

Further evidence of the embodied nature of pain, specifically our memory for pain is related in this piece of fictional literature:

But who can remember pain, once it's over? All that remains of it is a shadow, not in the mind ever, in the flesh. Pain marks you, but too deep to see. Out of sight, out of mind.

(Atwood, 1987, p.13.5)

Niven and Murphy-Black's review also found that many women's later recall of labour pain indicated that they had mostly positive feelings about their ability to cope with the severe pain. Penny Simkin, a widely respected childbirth educator, commenting on the review surmised that this may indicate that the severity of labour pain in itself is less important to some women than the meaning of that pain (2001). Simkin advances the opinion that if labour pain is accompanied by feelings of emotional wellbeing, of being in control, and being nurtured and respected by their loved ones and caregivers, a woman's memory will later focus more on her sense of achievement in having dealt with the pain successfully and place less emphasis on the severity of the pain (2001).

Presencing

Once again, women have identified the qualities that are important to them in a midwife. Feeling supported, feeling a sense of control and feeling special are a recurring set of themes throughout the literature as it relates to labouring women. How do midwives enable women to feel this way?

Within the nursing literature, Benner & Wrubel (1989) describe expert practice by a nurse who prepared women for mastectomy by teaching them about what to expect and exploring after-care with them. A patient asked the nurse at the end of a session if she had had a mastectomy herself. The nurse had not, but regarded this as a compliment to her teaching. In seeking to convey a sense of caring which extends beyond physical presence and reflects a sense of being 'in tune' with a person, Benner & Wrubel borrow a phrase from Heidegger to capture the complexity of this notion. He talks of "presencing oneself" (cited in Benner & Wrubel, 1989, p.13) to describe the way in which a person makes her/himself available to understand and to be with someone.

In the world of occupational therapy, Wright-St Clair explores the idea that caring forms the essence of the client-therapist relationship, stating that it is characterised by

receptiveness and reflectiveness (2000). She views caring as being about connectedness and attunement, saying "When attuned to a client you feel it in the heart, not just the head. You are drawn to caring" (Wright-St Clair, 2000, p.'7).

Kirkham (2000) rues the fact that presence is not highly valued in midwifery, a culture she describes as regarding action and measurable skill more highly. Several studies support the view that the attuned presence of a midwife is beneficial to women (Halldorsdottir & Karlsdottir, 1996; McCrea & Crute, 1991; Tarrka & Paunonen, 1996).

This poem stands as a tribute to a midwife attending a homebirth whose presence is palpable, not only to the woman, but to the poet who is there in a support role:

Midwife

*'It's time' one of us
breathes into the phone –
but she knows, she's already
here putting down
her bag of mysteries
(oxygen mask? forceps?)*

*and the chief performer,
first violin, the star,
takes her position;
as for the rest of us,
well, we know a maestro
when we see one –*

*she's the one with the
supple wrist; easy,
precise, she coaxes us
into our parts,
we'd follow her anywhere
- when she's ready*

*for us to move forward,
aside, we know
by a particular intentness
of fingers and face
that draws us in to the
whole resonant magic:*

*and then we're there – all,
even the extras,
have come to a brilliant
finale. She steps down,*

*congratulating the lead
(there are two of them now),*

*us too – and yes thank you
she will have a glass
of champagne – as though
she's done nothing
special. Now that's skill.
That's style.*

(Edmonds, 1990)

The midwife in this poem stamps her presence on the labour and birth. Her role is likened to a conductor's as she orchestrates the functions that those others present are responsible for. Her empathetic presence is uncovered by the words of the poem. In the area of counselling, recent moves by therapists to use their 'self' in order to more genuinely relate to clients has been hailed for its potential to enhance their personal growth (Edwards & Bess, 1998). Although this is an area which does not feature in midwifery literature a great deal, there has been some discussion of the benefit of promoting a therapeutic relationship in midwifery (Ralston, 1998; Siddiqui, 1999).

The attuned presence of a midwife sometimes involves an embodied response to a woman in pain. The midwife responds to the 'other' because she is touched by the vulnerability she sees. Her response may be to use her 'self' as a means of providing support. This is a presence which seems to rely more heavily on the personality of the midwife to impose her presence physically and emotionally on the woman. Levinas describes this encounter by the 'self with 'other' as a face-to-face relationship which can occur at any time when 'self' is moved by an image, is hurt or touched in some way in a bodily response which occurs before any cognitive decision is reached (1999). In a midwifery situation, this could mean that the midwife is called to answer a moral responsibility to bypass her own needs and completely respond to those of the woman in pain. The image of the woman in labour touches the midwife to a depth she has not comprehended even before she consciously realises that it has stirred the surface of her being (M. van Manen, personal communication, 9 October, 2003).

While the ability to presence oneself and to demonstrate caring for a woman are of great importance to a midwifery relationship, there are additional qualities that some midwives use to work with a woman and her pain. Central to these qualities seem to be the use of intuition and a sense of believing.

Intuition

Benner and Tanner (1987) define intuition as "understanding without a rationale" (p.23). They argue that intuitive judgement is what distinguishes expert human judgement from decisions which might be made by beginners or machines. They are clearly asserting that intuitive decision making is a direct result of experience.

Other commentators suggest that intuition may be more an innate than a learned ability. Davis-Floyd and Davis (1997) interviewed direct-entry midwives in North America and Certified Nurse-Midwives (CNM) about intuition to determine if it has any validity or authority in practice. The data suggests that intuition may be present in midwives regardless of their level of experience, but it is the way that they engage with it that varies according to their orientation. "The CNMs seem to begin by regarding intuition with mistrust, then move into trust through lived experience, whereas the empirically trained midwives seem to begin by trusting intuition and move into confirmation of that trust through lived experience" (Davis-Floyd & Davis, 1997, p.327).

Midwives who predominantly practise homebirths in North America placed great value on "connection" with women. They used this term to describe not only a physical but also emotional, intellectual and psychic links with women (Davis-Floyd & Davis, 1997). This connection with a woman enabled intuitive knowing on occasions when they were providing labour support.

Levi, in her address to the International Confederation of Midwives' Conference in 1993, describes the use of intuition as an aspect of subjective knowing, a trusting of an inner voice. She suggests that, in addition to its use by midwives during labour, a woman may develop greater confidence in her own intuition if she can place her trust in her body to give birth.

Pelvin (1996) presented a paper to the New Zealand College of Midwives' conference, entitled "On the Edge: Midwifery and the Art of Knowing". She emphasises the "unpredictability of the when, what and how of childbirth" (p.15). She acknowledges the 'feelings' that midwives often get about women they are caring for, but suggests that it is only after the specific event occurs, that the basis for the feeling becomes clear. She

cautions against a state of practice where a midwife believes she 'knows' what is going to happen, preferring to be in a state of 'not knowing' and ready for any eventuality.

Leap (2000) describes the ability to embrace uncertainty with the woman as one of the essential elements of midwifery care. She argues that this is as much to do with addressing the power dynamics within the relationship as enabling the woman to develop confidence in her ability to cope with whatever happens.

Sheila Kitzinger describes how helpers at a birth in many traditional cultures in the Third World and Europe go round opening boxes, uncorking bottles and untying knots to enable the woman to relax and give birth (Kitzinger, 1987). She received the following poem from a woman who had attended her lecture about this custom and shortly thereafter gave birth to her first child. The image of the knots had stayed with her and helped her during her own labour (Muller, cited in Kitzinger, 1987, p.75-76):

*A woman's feet curl, mouth
tight as a locked cervix.
She worries that her hands,
claw-like, mean the child is trapped
inside, will never ease through her
to light, to your cupped hands
waiting for the warm, waxy head.*

*She hears sobbing, the child
drowning in her fearful grip.*

*Stand near her. Begin to untie
knots, a long length of them.
Let the rope slide in wide loops
to the floor. Open the door,
raise windows. Fill the room
with the damp smell of rain,
with spaces she can fall through.*

*Stroke both her legs, thigh
to foot. Her eyes close.
Soon, she will release the child
to her own cupped hands.*

This poem could be revealing how the presence of a midwife loosens knots in a woman's body, and perhaps in her mind, which enables the baby to be born. By her touch and her demeanour, the midwife helps the curled feet and tight mouth to

unclench. Just as the knots unfurl and the loops of rope cascade in soft spools, so the cervix opens and the baby comes closer to the waiting hands.

Believing

During the pain of labour, the woman may look to the midwife for confirmation that the labour is progressing normally and that she is coping. The midwife's belief in the process of birth and in the ability of the woman to handle labour is vital. Her words, her touch, her whole way of being with the woman should convey her unswerving belief that the woman can do this (Leap, 1996). Such belief can be hard to cling to at times.

It takes courage to hold fast against whispers of doubt and to persevere with the woman towards the uncertain future. Some midwives seem to have a sense of self-belief as well as a belief in the woman's ability to birth normally. I have been unable to find any articles discussing this phenomenon in the midwifery literature, but there are remarkable life stories which attest to the existence of a sense of pragmatic optimism which appears to underlie some midwifery practice.

Accounts by former prisoners-of-war chronicle the emotional and spiritual qualities which seem to be an essential ingredient in the battle to survive extraordinary hardship and uncertainty about one's future (Frankl, 1985; Collins, 2001). Viktor Frankl was a Viennese psychiatrist interned in a series of concentration camps during World War II. He endured many privations over several years of hard physical labour, starvation and physical abuse. Frankl remained interested in the effect of the emotional abuse that he and his fellow camp inmates faced on a daily basis. He observed that it is "possible to practice the art of living even in a concentration camp, although suffering is omnipresent" (1985, p.64). Frankl determined that the 'size' of human suffering is absolutely relative because, whether great or small, it completely fills the human soul and conscious mind.

In addition he discovered that if a prisoner lost faith in his future, he also lost his spiritual hold and quickly his physical and mental reserves deserted him, leading to death. So, man is ultimately self-determining for it is he who decides whether he gives in to conditions or stands up to them (Frankl, 1985).

Forty years later, during the Vietnam war, Jim Stockdale found himself a prisoner-of-war. He also endured great hardship, including repeated torture. He not only survived, but discovered that his unshakable resolve to prevail against all the odds was the key to his continued existence (Collins, 2001). Again, the concept of the individual holding the power to determine how he copes with challenges is apparent.

The woman requires courage to confront issues such as pain and uncertainty and Finfgeld's (1999) meta-analysis of six studies of courage suggests that hope is vital to promote and maintain resolve. Although this review looked at courage predominantly in the face of chronic or life-threatening illness, uncertainty along with powerlessness, lack of control and pain were identified as significant threats. Finfgeld mentions the presence of others, their willingness to communicate openly and to serve as an advocate as elements which may enhance courage. These are all components of the midwifery relationship.

These are times when the nature of the relationship with the midwife assumes real importance, in helping the woman to work towards the birth of her baby.

Mothers and midwives mirror one another. I know that I get all of my courage from the mother. And I bounce it back to her, and she gets her courage from me ...It's a dance – the woman has to trust her midwife, and the midwife has to trust her woman for that bouncing back
(Maggie, midwife in Davis-Floyd & Davis, 1997, p. 33)

Summary

In this review of the literature I have shown some aspects of pain and associated theories in a general way. The pain of childbirth has been extensively researched, and written about, from the woman's perspective. Studies evaluating the degree of satisfaction women report based on antenatal education, pain relief requirements and midwifery support are numerous. Less apparent in the literature I examined is information from the midwife's perspective, particularly her approach to pain in labouring women. In the three studies discussed in this chapter (Leap, 1996; Lundgren & Dahlberg, 2002; McCrea et al., 1998), qualities such as warmth, trust, physical and emotional presence emerged as desirable traits in a midwife. These attributes are echoed

in the findings of other researchers who reported women's insights concerning sensitive midwifery care.

The area of emotional labour is another where there is a dearth of writing from a midwifery angle. In spite of several studies attesting to the quality of midwifery emotional support from the point of view of the consumer, this remains a relatively invisible part of midwifery work.

I chose to highlight three specific features of skilled midwifery care which are also not widely acknowledged in midwifery literature. These are presencing, use of intuition and believing. It seems that these areas of midwifery care may be beginning to attract the attention I believe they deserve.

Midwives are generally not visible within the fiction and autobiographical literature that I sampled. Accounts of women's experience of the pain of labour abound and provide wonderfully rich descriptions of the nature of pain and the meaning it has for some. Mention is occasionally made of the midwife in attendance, but I was unable to find any literature that presented a first-hand account of midwifery practice.

It seems appropriate that this study focuses on the midwife's experience of working with women and their pain in labour because, as this literature review demonstrates, it is an area which deserves further exploration.

Chapter Three

Methodology

Introduction

The philosophical underpinnings that have informed my approach to this phenomenological study are articulated in this chapter. I will describe how my research question and the method used are congruent with Heideggerian hermeneutic phenomenology. Notions from Heidegger and van Manen will be introduced to set the scene for interpretation of data. Aspects of the method, such as recruitment of participants, interviewing and ethical considerations will be discussed. The issue of trustworthiness will be addressed in relation to the method used in the study.

Philosophical Underpinnings

Heideggerian hermeneutic phenomenology has directed my journey throughout this study. The research question asks: "What is the experience of midwives working with women and their pain in labour?" By posing the question in this way I sought the opportunity to better understand everyday lived events through the words of the participants. Phenomenology is a philosophical methodology that allows for the chance to explore the nature and meaning of human experience (van Manen, 1990). Phenomenological inquiry is concerned with interpreting experience in the context of a person's lifeworld. Therefore the midwives I interviewed describe working with pain from their own personal context as well as the context of the environment and the women with whom they are interacting. Phenomenology challenges us to look beyond the taken-for-granted nature of our lived world, to see afresh phenomena that are frequently hidden from view or partly obscured by their everydayness (Heidegger, 1962). Munhall (1994) describes it as "...sailing-through-life without reflection, the dazed going-through-the motions..." She continues: "Phenomenology ... takes us from this dazed perspective to a gazed perspective where we give, reflect, and attempt to understand the whatness' of everyday life" (p. 4).

Where phenomenology is primarily concerned with the study of meaning, hermeneutics is more focussed on language or text as a form of interpretation. Assumptions and meanings within texts can be uncovered during hermeneutic inquiry of which the authors themselves are sometimes unaware (Crotty, 1998).

Narratives have been fashioned from the participants' stories to allow me to seek further understanding of the phenomenon through interpreting and writing. Van Manen (1990) calls this writing activity "a bringing to speech of something" (p.32). He sees writing as a means of rendering thought visible. "The essence or nature of an experience has been adequately described in language if the description ... shows us the lived quality or significance of the experience in a fuller or deeper manner" (van Manen, 1990, p.10).

Van Manen's existentials

Van Manen's writing about how to research lived experience proved a valuable beginning point for me in terms of method and methodology. His clear and seemingly effortless prose helped me to grasp more fully the nature of the process I was to follow. The sections concerning how to write were particularly helpful as I strove to 'show' what was being said "*in and through* the words" (van Manen, 1990, pp.130-131). But it was van Manen's lifeworld existentials' that have been most useful during the data analysis and discussion (1990, p.101). These consist of four fundamental themes that suffuse the lifeworlds of all human beings and thus provide a framework on which to 'hang' interpretation. 'Lived body' reflects the idea that we are always bodily in the world. We can never free ourselves from this embodiment. So "the human being does not 'have' a body, but 'is' the body" (Dahlberg, Drew, & Nystrom, 2001, p.51). In this study midwives observe embodied knowledge as cues when working with women in labour. 'Lived space' manifests itself in the way that different birth environments affect the way that midwives 'feel' space. 'Lived other' is present in the study in the way in which midwives and women relate to one another. 'Lived time', as subjective time and as dimensions of a temporal landscape, is a strong thread throughout the study and led me on to deeper exploration through Heidegger's notions.

Heidegger

The central tenet of Heidegger's philosophy is concerned with 'being', or more specifically, with the meaning of 'being'. But being, for humans, is always being-in-the-world. Heidegger seeks to make clear what lies beneath the myriad ways of being in the world, including our consciousness of being. Being is "familiar to everyone but only indeterminately" (Mitchell, 2001, p.122). Heidegger calls our being-in-the-world 'Dasein'. It is a form of everyday being and reflects our embeddedness in the world. Heidegger argues that our ordinary actions in the world demonstrate how we understand the world we inhabit. The way we 'do' in the world presumes our presence in it and it is this 'doing' which is the Dasein (Mitchell, 2001). The purpose of this research study is to attempt to get closer to the Dasein of the midwife participants by gathering data about their lived experience of working with pain. By engaging with the data, thinking, writing, thinking again, writing again, I sought to 'bring to the light of day' aspects of their experience which might allow a glimpse of the phenomenon which is their work. Further ideas of Heidegger, such as notions relating to time, relationships and language will be incorporated into my analysis of participant's narratives within the three findings chapters.

The hermeneutic circle

"To understand the whole through grasping its parts, and comprehend the meaning of parts through divining the whole" is the way that Crotty (1998) defines the hermeneutic circle (p.92). The term is used to describe the way that the researcher moves to and fro between a general interpretation of the text and significant parts of the text. The two are inextricably linked and one can only 'see' the whole in the context of its parts, and vice versa. In my search for emerging themes as I engaged in the process of analysis, I found that the parts steered me towards a new understanding of the whole. It was in coming to see the nature of the whole, that I gained further insights which added to my grasp of those themes.

The 'fit' with my research question

As discussed in the first chapter, I chose an interpretive approach to the area of midwifery practice that interested me, because it offered the opportunity to bring out the meaning of the experience. In order to uncover such meaning I sought a methodology that allowed me to explore a common practice such as working with women and their pain in a comprehensive manner that also kept me open to possibilities. This was

necessary because, as Heidegger tells us, in our everyday world we take much for granted and as a result, often the things that we are closest to are the things that are most hidden from us (Dahlberg et al., 2001). Hermeneutic phenomenology, therefore, with its orientation towards a search for meaning within lived experience, connected well with my research question. In my attempts to describe and interpret these meanings to a level of depth and richness, I was afforded the chance to involve myself in "the attentive practice of thoughtfulness" (van Manen, 1990, p.12). By dwelling with the participants' stories, I was able to gradually express my interpretation of their experiences and offer a view of working with women and their pain which may provide some insight into their relationships.

Phenomenology and midwifery

Phenomenological studies in the field of midwifery are a small, but important contribution to the body of knowledge upon which the profession reflects and learns about its practice. There are two distinct, yet similar, philosophical approaches to phenomenological research. One approach, informed by Heidegger, adopts the view that the researcher brings to the research question, and to the interview process, some prior understanding. Van Manen suggests that frequently it is not "that we know too little about the phenomenon we wish to investigate, but that we know too much" (1990, p.47). The challenge lies in recognising our beliefs, assumptions and biases in order to use them as a kind of reflector when faced with a view of the phenomenon. By taking these biases to the data and by showing them to the reader, the researcher acknowledges the impossibility of peeling off our understandings because they go ahead of us into each new situation (Smythe, 2000).

Husserl, who was Heidegger's teacher, had a different approach. He was of the view that the researcher is obliged to "bracket" any prior knowledge or understanding of the phenomenon under scrutiny. He argues that it is possible to identify pre-understandings and then temporarily suspend them, to retain an element of objectivity so that they will not influence any interpretation of the data.

Many of the phenomenological studies published in British and American midwifery journals use a Husserlian approach involving bracketing. An example is an exploration of women's expectations and experiences of childbirth conducted in the north of England by Gibbins and Thomson (2001). Not all researchers specifically align

themselves with a philosophical underpinning for their methodology. Rather bracketing is discussed as part of the method for some phenomenological research. Examples of such published studies are Lundgren and Dahlberg's (1998) description of women's experience of pain during childbirth and an exploration of women's experience of planned home birth in Northern Ireland by Ng and Sinclair (2002).

One Swedish study interpreted midwives' narrated experiences of being supportive to prospective mothers/parents during pregnancy using "a phenomenological hermeneutic method inspired by Ricoeur" (Hildingsson & Haggstrom, 1999). Ricoeur was concerned with meaning derived from analysis of the language in narratives.

Phenomenological studies which cite a Heideggerian approach in the international journals are much less frequently encountered. Lendahls, Ohman, Liljestrang and Hakansson (2002) based their study of women's experiences of smoking during, and after, pregnancy on Heideggerian notions. They were guided in their analysis by van Manen's framework. Although the number of New Zealand midwifery researchers is relatively small, there are a few who have used Heidegger to underpin their studies. Smythe (1998), in her doctoral thesis, used Heideggerian hermeneutic phenomenology to explore the meaning of 'being safe' in childbirth through the narratives of women and practitioners. Hunter (2000) also used hermeneutic phenomenology in her study comparing the experience of midwives providing intrapartum care in a small maternity unit and a large obstetric hospital.

I am aware from my reading that Heidegger's international standing as a philosopher has been tainted by his links to the Nazi regime during Hitler's time as Chancellor of Germany (Cooper, 1996). Scholars have critiqued his work on the basis of his apparent sympathy with the prevailing dogma of the time. From my perspective, the man's political leanings may mean that I would not have warmed to him on a personal level, but his writing has provided me with a glimpse of innovative and challenging notions about ways of being in the world. It is with these notions that I have engaged during the course of this research and they hold no political or doctrinal weight in my opinion.

Study Design

Ethical approval

The Auckland University of Technology Ethics Committee granted ethical approval in May 2002 (see Appendix A). I heeded my obligation to protect the participants in my study throughout the process.

Recruitment of participants

I used four criteria to select possible participants for this study. Firstly, as the research was to be conducted in the Auckland area, participants needed to be currently practising midwifery in the region. In keeping with my chosen methodology, I used purposive sampling to approach midwives whom I determined would have sufficient clinical experience to converse knowledgably about their experience of working with labouring women in pain (Polit & Hungler, 1997). I also elected to approach midwives whom I perceived to be articulate and reflective practitioners in order to enhance the opportunity for an account of the lived experience to be expressed as fully as possible. This necessitated that their command of English was good. Finally, I decided to recruit a spread of participants who had practised in a variety of settings, again in order to capture experiences of working with women and their pain in as comprehensive a manner as possible.

Initially I sent an information sheet with covering letter to six midwives inviting their participation in the study (Appendix B). I also included a consent form which I invited the midwives to sign and return if they were interested in being a participant (Appendix C). Five replies were received indicating agreement to be interviewed. One midwife declined due to work commitments, expressing regret.

After the first three interviews, it was clear that antenatal preparation for labour was seen as important to the participants and one of my supervisors suggested approaching a midwife who was involved in antenatal education classes. I made use of my midwifery networks to find a midwife who was teaching antenatal classes and practising. I followed the same procedure in seeking her involvement as a participant and she agreed to take part.

Similarly, I recruited the seventh participant in response to the emerging data which suggested that the views of a midwife who had been practising for only two or three years might provide an added dimension to the views of other participants with more years' experience.

By the end of the seventh, and final, interview, I was certain that I had obtained sufficient data to proceed further with analysis and interpretation. Kvale (1996) suggests that a determining factor to the number of participants is that you have found out what you need to know. Phenomenological research does not aim to sample large numbers of participants. The emphasis lies in learning about others' experiences by interviewing a relatively small number of people who can provide detailed descriptions of the phenomenon. This method does not seek to generalise meanings to a larger population in the way of quantitative studies. The study set out to derive new understandings of the lived experience of these midwives as they worked with women and their pain in labour. I anticipated that between five and nine participants would be sufficient to provide enough data for analysis, and seven were interviewed for this study.

Study Participants

Six of the seven midwives interviewed were of European descent and one was of Pacific Island origin. All the participants were female. In order to place their data in context, I will provide a brief description of their midwifery experience using the pseudonyms I chose for them and listing them in the order in which they were interviewed:

Amanda	an independent midwife with 5-10 years experience
Barbara	a hospital employed midwife with 20-30 years experience
Catherine	an independent midwife, with 20-30 years experience
Diane	an independent midwife, formerly hospital employed, with 20-30 years experience
Evelyn	a hospital employed midwife, formerly independent, with 4-5 years experience

Frances	an independent midwife, formerly hospital employed, with 20-30 years experience
Gemma	a hospital employed midwife with 2-3 years experience

Protection of participants

The midwifery community in New Zealand is small and I was always mindful of my obligation to the participants with regard to issues of anonymity and confidentiality. Consequently, I offered to meet participants for interviews at a venue of their choosing to lessen the chance of their involvement in the study being revealed.

Confidentiality has been further maintained by not revealing the identity of any of the participants. As mentioned above, all participants were given a pseudonym to protect their anonymity. I have removed or altered details, in transcripts, of locations, identifying details of practice and some clinical details which may have compromised a participant's anonymity or that of her client. The first two interviews were transcribed by a typist who signed a confidentiality agreement (Appendix D) and the remaining transcription was done by myself. Storage of data has also preserved confidentiality. Audiotapes and transcripts from interviews are securely held in a locked cabinet.

The nature of the stories that the participants in my study shared during our interviews was not generally a source of distress. In fact, the participants appeared to enjoy the opportunity to reflect on aspects of pain management. There was an exception. One participant told me of an incident which had greatly upset her at the time. She shared the story with me in quite a lot of detail because she knew that it was precisely the type of experience I was interested in hearing about. Some time had elapsed since the occasion being described and the participant was not unduly distressed by the re-telling of the tale. She was, however, concerned about how recognisable the account might be if included in the thesis. I altered several parts of the sequence of events, which didn't detract from the overall story and showed this version to my supervisors for their comments. I returned it to the participant in the context of a draft chapter of analysis for her to consider. She generously agreed to the new format and its inclusion in the data chapters, but asked that the story not be highlighted during any oral presentation of this study in the Auckland region. I am happy to abide by this request.

Interviewing

The aim of the interview in a phenomenological study is to enable the participant to reflect on the phenomenon (Dahlberg et al., 2001). It was therefore my role as interviewer to encourage this process by asking questions that allowed the participants to describe their experience of working with women and their pain by staying as close to the lived experience as possible. The goal was to elicit detailed accounts of aspects of midwifery practice and participants' feelings. There were two factors that I needed to constantly remind myself of during the interview process. Van Manen (1990) cautions of the need to keep the research question to the forefront of our mind as the focus for all our probing. On some occasions, my initial question was sufficient to unleash a succession of fascinating anecdotes. Sometimes these stories took us far from the specifics of the research question and I needed to wait for a pause in the conversation before trying to lead us back to the issue at hand. I was more successful in limiting these diversions as the number of interviews mounted, but at times I realised that seemingly irrelevant details about practice contained wonderful insights that were pertinent. So, I learned to listen more fully and concentrate on hearing about the incident in as much detail as possible, rather than trying to steer the conversation too often.

The second issue became painfully obvious when I first listened to my initial interview. I was appalled to hear my voice intruding frequently with small comments during the participant's attempts to answer a question. I called this to mind on every successive interview and made a determined effort to limit my speaking to questions or prompts only when necessary.

Interview venue

Most of the interviews took place at the participant's home. This was the venue of their choosing and began with a cup of coffee and a general chat. To demonstrate my appreciation of their participation, I took a contribution of food. One participant elected to meet with me at a neutral location and another came to my home. I found the time spent before the interview started gave us both time to focus on the issue we planned to discuss. We had time to put other things to one side for the space of the interview. This was a good time to set my tape recorders going so that we could move into the interview without needing to pause. Starting the taping session appeared to be off-putting at first to several participants, so this play allowed them to relax before the interview began.

Interview format

The interview format was of an unstructured nature and lasted between one hour and one and a half hours. To begin, I showed each participant the consent form she had originally signed and restated its contents. I then captured her verbal consent again on tape and reiterated the research question. I began each interview by asking the midwife to summarise how long she had been practising midwifery and in what settings she had provided labour care. A question I frequently asked to begin the interview, because many of the participants had experience of caring for women in labour in a home setting and in a hospital, was *"Is there a difference in the way you work with women depending on where they choose to birth?"* I strove to keep my questions as open as possible and to let the participant lead the way in terms of what they described. At times, they spoke in a very general way about women and I would attempt to bring them back to the time when they were *in* the experience with a question such as *"Can you tell me about a time when... "*

I took to each interview a list of questions addressing areas of practice that I was interested in hearing about. I relied on these prompts at some interviews when the talking stopped. I used questions such as *"Have you ever been reluctant to give a woman the pain relief she is certain she needs?"* or *"Tell me about a time when you wrestled with a decision about pain relief?"* I also learned to wait when a story seemed to have finished, or at the end of an interview. Sometimes, from these pauses, came an unexpected insight or a detail which took the conversation in another direction.

Transcribing

I chose to conduct only one interview because all participants intimated that they had told me all that they could by its completion. After one particular interview, I was uncertain of the chronology of one story and contacted the participant by telephone to establish the correct sequence of events. There were no other problems in understanding stories within transcripts. Following each interview, there was a pause while it was transcribed and the initial analysis begun. I transcribed five of the seven interviews myself because I found that it took a considerable amount of time to edit and fill in gaps from the earlier transcribed interviews when they were returned to me. I therefore decided that it was simpler to do it all myself. In fact, I am pleased that I made this decision because I became familiar with each of the participant's narratives very quickly

by being so immersed in them from the beginning. I began to see similarities between the stories and also the contrasting accounts of midwives' practice.

Returning stories

Over a period of eight months, I interviewed seven participants and transcribed their narratives, listened to the audiotapes and made tentative notes about the 'themes' I thought I saw coming from them. I worked with each participant's transcript to pull out stories which captured an aspect of the phenomenon contained within my research question. Between six and eighteen stories were separated out from each transcript. Both the stories and the full transcript were returned to the participants for their comment. They were invited to clarify, alter or delete any part of their story that they wished. Several participants altered grammar and one deleted a small section of her transcript.

Analysis

The process of coming to understand and draw meaning from the participants' narratives has been both fascinating and painful for me. Fascinating because I have been privileged to talk at length with midwives about an important area of practice and have come to appreciate anew the complexities of the midwifery relationship. Painful because the journey towards understanding has been fraught with struggles to unearth hidden meanings, bring them to the surface and then name them. Van Manen summarises this journey's goal as "effecting a more direct contact with the experience as lived" (1990, p.78). He stresses the leap of faith a researcher makes in a phenomenological study by allowing the thematic understanding to come rather than following a pre-determined set of rules to effect that end. Nonetheless, he does explicate a framework from which to reflect and interpret and I was guided by this.

My analysis began by reading each transcript as a whole several times. I looked within the transcript for passages which related directly to my research question. Sometimes these passages were a discrete entity and at other times they were threaded through several pages of a larger anecdote. I pulled these stories from the transcript to examine more closely. These parts of the transcript now became separate 'wholes' and I re-read them in their new form. I asked myself *what is this story about? what does it mean in relation to pain? how is that significant? what is it showing about pain?* I tried to pick out metaphors or phrases from these stories to base my initial interpretation around.

When I had finished initial analysis **of** one transcript, I moved on to interview the next participant and repeat the process with her transcript. In this way, **I** began to accumulate several piles of stories with similar themes and some with contrasting data. The contents of any one pile changed from time to time as the name for the theme altered and **I** continued my engagement with the data by re-reading and then re-writing my interpretation. **I** played with the possible meanings contained within words and phrases as **I** sought to take my level of understanding deeper and to show a reader an opportunity to see the phenomenon in a new or different way.

Bringing my prejudices to the data

As **I** grappled with the stories **I** was aware that **I** approached them with my own prejudices. It was likely that my pre-assumptions had lent weight to the very stories **I** had initially selected. A little later, **I** returned to the original transcripts and recognised a story which **I** had previously overlooked. Although it was subsequently omitted from the data chapters, it served as a solemn reminder that my prejudices are inextricably enmeshed with my interpretive lens. When participants talked to me about instances when a form of pain management either worked well or did not, **I** found myself remembering similar occasions when just such a scenario had involved **me**. This inevitably affected the way **I** first approached these stories as **I** identified with the midwife's reaction. **I** could sometimes see both sides **of** a situation and didn't wish my interpretation to be seen as judging the actions of the midwife. Batchelor & Briggs (cited in Caelli, 2001) point out that researchers are often surprised by "conflict of loyalties" they may encounter (p.280). **I** found it helpful to journal these tensions and articulate them to my supervisors. In time, **I** was able to take a wider perspective and look for other possibilities of meaning.

Turning to the literature

As **I** reflected on the data over a period of almost a year, it became very familiar to me. There seemed to be such a wealth of detail within the narratives that **I** felt overwhelmed at the thought of paring it down to essential themes and thus to the thesis of my thesis. **I** was encouraged to look at the 'bigger picture' concerning each story in an effort to capture a tentative 'handle' or theme. **I** turned to the literature to assist me. **I** read other research studies and examples of phenomenological accounts (Bergum, 1985; Paddy, 2000). **I** dipped my toes into the impenetrable depths of Heidegger to further explore specific notions which seemed to suggest further clarity for **me**. **I** also relied on other

authors to render Heidegger more understandable (Gelven, 1970; King, 1964; Leonard, 1989; Mitchell, 2001; Smythe, 2000; Steiner, 1989). And I read fiction and autobiography for pleasure, but found that even in the most unlikely of genres, I would be offered a snippet occasionally which was added to the mix that fermented on the back boiler.

Parts and whole

I came to see the stories, with their interpretations, as parts of a larger whole again. The nature of the whole seemed too big and too complex to easily describe. As I continued to reflect and re-write deeper interpretation of the individual stories, they fell into a number of sub-themes. Gradually, the themes became apparent to me. There are stories about 'before the pain' – the antenatal period and pre-assumptions that midwife and woman bring to labour; 'working with the pain' – the 'how' of the midwife's work; and 'after the pain' – the period when the birth is over, but the pain may not be. DeSantis & Ugarriza defined a theme as something which "captures and unifies the nature or basis of the experience into a meaningful whole" (2000, p.360). The whole consists of many parts and all relate to each other and to the whole.

The three data chapters each contain stories from the participants illustrating the themes and accompanying interpretation and discussion. Each chapter builds on the other to reveal the phenomenon of working with pain. Through the new meanings uncovered by writing and reflecting on participants' stories, I came to better understand my involvement within the hermeneutic circle. As I moved between new understandings of the phenomenon from the parts, to an overall interpretation and then back with enhanced appreciation of those details, my writing had a sense of purpose as the meanings became clearer.

Trustworthiness

A critical factor for any reader of phenomenological research is the issue of how trustworthy the study is. Issues concerning rigour and trustworthiness have been the subject of much debate within research circles. At the heart of the discussion is a move to reject empirical criteria for evaluating rigour because it is seen as inappropriate in an interpretive paradigm (Koch & Harrington, 1998). These authors add their voice to the debate with a suggestion that illustration of rigour be shown in a reflexive way which allows readers to decide for themselves if the result is credible. It is my task, therefore, to take the reader through the methods used in this study in order to demonstrate the "red thread" which should be apparent throughout (Dahlberg et al., 2001, p.231).

Reflexivity

Koch and Harrington (1998) discuss the importance of context in relation to interpretive research. My personal and professional background has been described in the introductory chapter, and in this chapter, in order to make plain how I am situated within this study. I have shown that I am a part of the research process and therefore that my prejudices are brought to the interview process and to the interpretation. Before I began interviewing participants, one of my supervisors interviewed me to encourage me to reflect on my pre-assumptions regarding labouring women and their pain. This opportunity to articulate attitudes to practice allowed some of my pre-assumptions to surface so that I could acknowledge and engage with them. I have described how I brought my prejudices to the interviews. I also brought them to my analysis and would remind myself of their possible influence by asking *'what else am I missing? "is there another way of looking at this?'* At all times though, I was aware that any interpretation is only ever one way of describing a phenomenon. There is always the possibility of other description which may be richer or deeper (van Manen, 1990).

In addition to my personal context, the research study is shown to be situated in a social context. The introductory chapter and literature review chronicle the historical and political setting for midwifery practice in New Zealand since the early 1900s. The rise in epidural anaesthesia and its effect on instrumental or operative deliveries is also described. The voices of the participants are to be heard from this context, for this is their life-world.

Koch and Harrington (1998) suggest that the reader of a study such as this should be able to discern the presence of voices other than mine within the discussion. Although the bulk of the writing and interpretation is my work, there are undoubtedly other voices to be heard. The participants, my supervisors, midwifery colleagues, fellow postgraduate students and many authors of journal articles and books can be seen to have influenced my thinking or verified my work. Supervision occurred in a small group comprising three to six postgraduate midwife students and supervisors. Our shared clinical specialty and similarities of progress through our research allowed for stimulating and useful discussions. The feedback from early attempts at analysis urged me to look further for meaning and to be creative in my interpretation. The questions encouraged me to read and reflect. Gradually, through my thinking and my writing, understanding grew.

Credibility

In a phenomenological study, there is an underlying notion that there are multiple meanings or 'truths' associated with a phenomenon. In order to demonstrate congruence with such a belief, I was aware of the need to seek other's verification of possible meaning within the data. Firstly, I returned each participant's transcript, and the stories which I had pulled from the transcript, to them for comment. By giving each participant the opportunity to alter, delete or further explain sections of their stories, I was acknowledging that their understanding of what was said may differ from mine. The alterations requested, and complied with, were either grammatical changes or, in one case, deletion of several words which the participant felt might appear critical of a colleague. Streubert and Carpenter (1999) advise researchers to incorporate any additions or deletions into the interpretation as a measure of credibility.

In addition, my supervisors read and provided comment on my interpretation throughout the writing process. Their phenomenological nods became increasingly apparent as my analysis deepened the meaning I drew from the stories. As the themes emerged, I sensed that they concurred with my interpretation. The midwives who comprise the students and supervisors in my supervision group have heard some of the participants' stories and the accompanying interpretation. They agreed with my analysis of those stories and recognised aspects of particular stories from their own practice. This seemed to indicate a universality within the data. In a teaching session with undergraduate midwifery students I shared several stories and my interpretation. This

provoked a lively discussion about similar experiences they had observed or experienced and I took this to be further corroboration of a credible set of findings.

Internal consistency

It is important that a research study can show the relevance of its question to the overarching philosophy. I have addressed this point earlier in the chapter where I explain how the wording of my question signals the quest for meaning through experience. Just as the research question must be congruent with a hermeneutic phenomenological approach, so must the methods employed in interviewing participants and interpreting their narratives. Earlier in this chapter I have detailed the way in which I interviewed participants in an unstructured and conversational manner which fits within a phenomenological methodology. So to the interpretation of data guided by van Manen's existential life-worlds and Heidegger's writings. Notions relating to caring and time have been used to uncover ways in which midwives work with women in pain which seek to deepen understanding of their practice. The discussion of the findings also demonstrates a consistency of approach to a phenomenological philosophy by explicating common themes from within the stories which reaches for a new understanding. Finally, in keeping with the metaphor of the hermeneutic circle, all of the parts must be able to be viewed as a whole, and its relevance to the guiding philosophy made apparent. I have endeavoured to show this throughout the study.

Engaging the reader

Koch and Harrington (1998) challenge researchers to write eloquently in an effort to enhance the connection that the reader makes with a research study. This study contains a wealth of moving accounts of the way in which midwives practice when caring for women in labour. The narratives also capture the admiration that midwives have for women and their struggles with pain. I have tried to include many stories so that the reader is drawn in as closely as possible to the participants' lived experiences. In my own writing, I strove to make my interpretations evocative and to render discussions of a philosophical nature as readable and informative as I could. The general presentation of the work should move the reader from one section to the next in a logical and measured manner. The centrepiece of the work lies in the voices of the participants and in their lived experience. My interpretation aims to reveal dimensions of their

experience that may not be immediately apparent, in a writing style which engages the reader. Whether or not I achieve this goal will be up to you, the reader, to decide.

Summary

In this chapter, I have described my philosophical approach and how it directed the research question and methods used to carry out the research. I have described details of the method from gaining ethical approval, to recruiting participants and interviewing them. Ethical considerations towards participants were outlined and the area of analysis explored. This section was necessarily vague, as the process is one of gradual dawning of understanding amidst the re-reading and re-writing that characterises phenomenological research. Trustworthiness of the study was demonstrated by using Koch and Harrington's (1998) conceptualisation of rigour as a framework.

The following three chapters contain verbatim narrative excerpts from the participants and my interpretation of their stories which reveal how midwives work with women and their pain in labour.

Chapter Four

Before the Pain

When a woman is pregnant and contemplates what lies ahead of her, it is likely that the pain of labour is a compelling feature of her reflections. Similarly, when a midwife thinks ahead to being with a woman in labour, she is likely to dwell on the challenge of supporting her through the pain. The pain itself is known as the challenge of labour. What is not so well known are the attitudes and strategies that midwives embody as they work with the woman and her pain. The data shows that much of the 'work' takes place before labour begins. This chapter reveals the nature of that work.

Mustering Resources

Choosing where to birth

The choice of where to give birth probably provides one of the first clues for a midwife as to the woman's beliefs about herself and about birth. This is primarily because the types of pain relief available are more limited in a home environment than a hospital setting. This midwife describes the importance of thinking ahead about the ramifications of pain relief resources:

If they're opting to have their babies at home ... they have made it very clear what their perception of managing pain is and that's enormously helpful. They have made a statement about where they are coming from and also indicated that they are resourceful and prepared to rise to the challenge in a way that often women who choose to have their babies in hospital don't. So you have to talk to them about this time when they may say 'it's too much'. You have to explain that the consequences of me meeting your needs [for transfer] at that time are going to be fairly enormous.... But if you're prepared to work quite hard with me, and me with you and your support people, we will probably get through and there are various things that we can do that will help you. I think

that women who do get through without having pain relief even though you may have had a bit of a battle with them at the time and have to work really hard and get their support people to work hard, do feel fantastically satisfied at the end of it.

[Amanda, Pl/a]

Amanda recognises that by choosing to birth at home, women are demonstrating that they are capable of 'rising to the challenge' by calling upon resources both within themselves and around them. In her choice of the word 'battle' to describe her midwifery support she conjures images of a contest between a woman and her pain. The word 'battle' can also imply success or victory. Perhaps women who make these choices about places of birth are illustrating that confidence is a major ingredient. They are deliberately engaging with the pain of labour in defiance of the current norm which sees increasing numbers of epidural anaesthetics being used.

Maybe the importance of the potential gains, and losses, of contemplating birth in a low-key environment is also reflected in Amanda's use of 'big' words. Words like 'extremely', 'enormously', 'really hard' and 'fantastically'. The perceived reward or spoils of victory following this battle are seen as the tremendous satisfaction women may feel after giving birth without recourse to pharmacological pain relief. The satisfaction derives from the knowledge that they tapped their own inner resources, and those of their midwife, to realise their dream for childbirth.

Amanda also encourages the woman to contemplate the possibility that there may come a time when she is overwhelmed by pain and feels that 'it's too much'. By asking the woman to look towards her future, Amanda seeks to prepare her for such an eventuality and, in so doing, to render the situation familiar. If the woman reaches this point in her labour, the memory of the conversation may help her recognise it and spur her on to work with Amanda.

Heidegger's notion of being-in-time is called temporality. It incorporates past, present and future in a seamless whole that is always in a setting of doing. Time can only be seen "within the context of the having-beenness and being-expectant, or its past and future, by which it is constituted" (Leonard, 1989, p.74). In this story the midwife's having-beenness might include her recall of other labours where pain has caused women to waver in their resolve to birth at home. She might remember the difficulty of supporting them through the remainder of their labour if they came close to losing

being-expectant could incorporate the knowledge that talking about how the woman might feel at that point in her own labour may help her to know it and to place her trust in the midwife.

Heidegger terms this kind of being-with-one-another "leaping ahead" (1962). It relates to a desire to enable someone to deal with a situation in the future by preceding the other into that situation. The purpose of going ahead of the other is to reveal the future in order for it to be recognisable, and thus understandable, by that person when they reach it. So when Amanda suggests that the pain might become 'too much' during labour, she could be leaping ahead to prepare the woman for such an eventuality. By discussing the possibilities and the strategies that might be experimented with, the woman is given the opportunity to make her own decisions at a later stage.

Another midwife, Catherine, describes how she gives women information about pain relief to help them make decisions:

In going through a birth plan I go through all the pain relief options that are there and say these are the things I know you don't want to know about, but I'm telling you now because you'll understand them more if you're having a complicated labour. So I run through all those things and say they're there, but I also say all these things have a price tag. If you're having a difficult birth, that price tag can be totally acceptable and worth paying. If you're not having a difficult birth and it's just that you're tired and fed up, then it's better to be supported getting through that phase than to resort to pain relief that has a price tag that you don't need. So it's giving them a message all the way through that this is a normal event but also saying to them that if you're having a terrible time and it really hasn't worked out, I'm going to be totally supportive of us looking at what we need to do to get you comfortable, if it's become unmanageable.

[Catherine, P3/f]

This story also shows a midwife leaping ahead in the way she works with women antenatally. Catherine helps women to look towards a future that may contain elements that lie unseen at this point. By giving women information about all of their options for pain relief, she invites them to consider the possibility that their labour may take a different course than they expect. Heidegger calls this possibility for the unexpected to occur at any time in our daily lives, "thrownness" (1962). The taken-for-granted nature of aspects of our lives, in their everydayness, render them invisible, unnoticed. It is only when Dasein, our Being-in-the-world, is thrown by an unforeseen possibility, that we are jolted into a new interpretation or understanding of a situation. In this case, Catherine

hopes to cushion the effect of a woman being thrown by a labour being more painful or more protracted than she anticipates by shining some light on a potential scenario.

Catherine also uses a metaphor about 'price' to enable women to consider the cost of electing to use pain relief. They are told there is a 'price tag' attached and that there are circumstances when that price will be worth paying. If the course of labour strays from its normal bounds, the pain is severe and the woman has exhausted her stores of energy and resolve, despite Catherine's efforts to provide support, effective pain relief will be welcomed and considered good value for money. On the other hand, if the woman is 'just tired and fed up' with the relentless pace of contractions in the course of a normal labour, she is asked to consider that midwifery support is a better option. The inference is that her money should stay in her wallet and be reserved for a time when she really needs to spend it. Again, Catherine is preparing women for their future by challenging them, in the present, to anticipate a time when they will need to call upon their resources to help them through a testing time. Perhaps in reliving their past at that time, and recalling the words of their midwife, they will look at the price tag and weigh up whether or not the price is right.

Some women who wish to birth in a hospital setting express strong opinions about avoiding pain relief Amanda describes how she broaches the subject:

I say to women beforehand "If you are really keen not to have medication in terms of pain relief you need to know that I'm not going to bring it up. I'm just not going to mention it. It's got to be you that initiates that wish," because I think once you start to talk about it, it's undermining and women think "Well, she thinks I need it, so I must".

[Amanda, Pl/e]

This midwife seems to be acknowledging the degree of influence she could wield during labour if she suggested pain relief or even enquired how a woman was coping. Leap (1996) found in her study that the midwife's attitude to pain and the messages she gives to women can affect her response to pain. Amanda's silence on the matter appears to reflect the sense of mutual trust that builds during the antenatal period.

Keeping silent may, paradoxically, be a way of communicating for Amanda. Mueller-Vollmer (2002) interprets Heidegger's writing about keeping silent: "As a mode of

discoursing, reticence articulates the intelligibility of Dasein in so primordial a manner that it gives rise to a potentiality-for-hearing which is genuine, and to a Being-with-one-another which is transparent" (p.238). Amanda is showing by her silence that she is comfortable 'being with pain' and not afraid to work with the woman if she wishes not to use pain relief. This stance demonstrates her confidence in the woman's ability to determine how she manages her pain and appears to place the decision making, and the control, in the woman's hands. The midwife is a willing assistant, responding as directed and when required.

Facing fears

The preparation for labour often begins with antenatal classes. In this setting, women and their partners combine information-gathering with the opportunity for discussion of their feelings and concerns. For women who receive antenatal care at a hospital clinic, this may be of great value as they approach labour because they are less likely to have the opportunity for a relationship with staff midwives who may only see them once or twice during pregnancy due to the nature of fragmented care. This midwife participates in antenatal education at a hospital and talks of the benefit of this form of preparation for women who would probably be receiving antenatal care at a hospital clinic:

One of the things we look at in antenatal class is a video that explores facing the fears and challenges of childbirth and where some of those fears have come from with the medicalisation of childbirth. That introduces some issues where they can start to open and talk about how they're feeling at the moment. So a lot of issues come out beforehand for us to discuss. We talk about the physiology of labour so that they can understand the process that's happening inside them, especially with the latent phase which is often the most misunderstood part of the labour process. The latent phase where they can still be at home, still do the things that they want to do, they don't have to panic, there 's no rush because that's often when they come into hospital, with that first twinge of pain and panic sets in. The physiology of labour is really important, I feel. That they know that they can trust their bodies to do this. They watch a homebirth video and we look at the things that the woman used to help herself in labour and therefore what they could use also.

[Evelyn, P5/b]

There is a feeling behind this midwife's words that she believes that fear of labour and a lack of knowledge about their bodies and how labour works, are regarded as a major obstacle to an acceptance of the normality of labour by some women. Evelyn emphasizes the importance of a good understanding of the physiology involved with the start of labour. The latent phase of labour is recognized as a time when women should

be encouraged to stay at home and maintain the routines, so avoiding a precipitate admission to hospital and possible intervention. This intention to give women information about labour and its pain in advance could be seen as another example of Heidegger's leaping ahead.

Grantly Dick-Read, a British obstetrician, hypothesized a vicious cycle involving anxiety and fear of the unknown with muscular tension and heightened perception of pain. He argued that by arming women with knowledge about childbirth and teaching them distraction techniques to help them relax, they would be better equipped to meet the demands of labour (1958). Antenatal classes of today are a direct result of Dick-Read's work and offer a diverse range of preparation for labour.

This midwife offers an interesting variation on this theme where she describes her experience of two very different approaches to labour which appear to refute the common understanding upon which Dick-Read's philosophy is based:

If they've got high expectations and they've read too many books and done too many birth plans and are very rigid in their thinking about what will happen, that sets up an anxiety and a tension. Whereas a Polynesian woman...wouldn't have a clue what a birth plan was. She just comes along and cruises and has her baby. It's an acceptance of a way of thinking or not thinking about it, you know? Think about it too much, it creates anxiety; just chill and you're not so anxious.
[Diane, P4/a]

Diane describes a stereotype where a woman has read widely and formed somewhat uncompromising attitudes concerning the nature of labour and birth. The midwife links this type of woman with someone who engages with labour in a state of anxiety. The implicit meaning behind these words appears to suggest that such a woman will find the pain of labour more difficult to cope with.

Dick-Read (1958) championed the provision of knowledge for women approaching labour as a means of reducing anxiety and fear. Ironically, Diane appears to be citing the example of a woman with an abundance of information unleavened by the reality of experience, who approaches labour in a tense and anxious mood. Perhaps the provision of knowledge in isolation from contextual information leads a woman to adopt unrealistic and rigid notions of how her labour will be.

By contrast, Diane talks of the different expectations she has observed among other ethnic groups. For many of these women it seems that having a baby is a part of life and they accept their part in the process of birth without the need to acquaint themselves with every detail it may involve. It appears that, to this midwife, many Pasifika women are less anxious and more relaxed about labour precisely because they choose not to analyse the events associated with childbirth.

Selecting support

As women prepare for labour, they frequently seek the help of support people. For some women, support will be present in the form of husband or partner. He is often a vital source of comfort and encouragement to a labouring woman and can add to the midwife's supportive role. So, the woman's choice of a support seems to be important. Amanda sounds a note of caution about expectations that men will always be capable of supporting a woman without back-up:

I think that men sometimes can be difficult. I often get quite anxious when women are just going to have their partners for support even though I might have met them several times beforehand. Sometimes I think men have their needs and they override what their role is in terms of being there for that woman. Sometimes you are giving the epidural for the partner who's really unhappy and uncomfortable and feels very anxious about their loved one. I'm not talking about all men because obviously they are very variable and some men are just absolutely fantastic at being brilliant support and as effective as a strong form of pain relief But I think men often do need to have support and that helps them put things in perspective a bit because the responsibility is not 100% theirs. I think that's where they crumble often and they see what women are doing in labour as a reflection on them as opposed to it just being a normal process. They find it very hard to pull out all the stops in terms of the warm fuzzies and the affirmations.

[Amanda, P11f]

This story illustrates how a woman relates to, and draws meaning from those with whom she interacts in her world. Heidegger tells us that "being-in-the-world" ... "is a being-with" (1962, p.26). The self "is never alone in its experience of Dasein (Being-in-the-world)" (Steiner, 1989, p.91). So the world is always experienced with 'Others'. Heidegger (1962) characterises the Others as "those from whom, for the most part, one does *not* distinguish oneself – those among whom one is too" (p.154). In this story, the woman has a relationship with her partner. In the context of her life, this man is a part of her way of being-with the world and someone on whom she intends to rely for support and encouragement.

It may be that she will base her understanding of how well she is coping with pain in labour through the response of her partner. Amanda knows from past experience that some men 'crumble' at the sight of a woman they love in pain. Feelings of powerlessness may lead to anxiety and anger. The woman in turn may crumble at the sight of such naked distress from a familiar and normally reassuring source. The meaning of how effectively she is managing her pain may be altered by the reflected image she 'sees' in her partner's behaviour. Concern for her partner may also undermine her efforts to manage the contractions and so affect the progress of her labour and decisions about pain relief. Just as the woman musters her resources in preparation for the pain of labour, so the midwife adjusts her practice according to the environment.

Adapting to the Context

The context in which the midwife works has an effect on the way in which she works with women and their pain in labour. The emotional environment is an important factor. Women will react to labour and its pain according to a variety of circumstances. Factors such as previous birth experiences, the attitude of family and friends to labour and cultural considerations can all influence a woman's perception of pain and her ability to cope with it.

Emotional environment

Many of the participants in this study talked about the impact that emotional and psychological elements in their clients could have on their labour and their pain. This midwife relates a positive example:

A young woman brought her mother along and she started telling me about her 4 hour labour. I said to her " I think you're going to be fine because your mum has had really good experiences and you're very like your mum." She turned up fully dilated at the hospital. Three hour labour. Her mother expected it, she expected it and that's what happened. So it's very much influenced by who we are, where we live, all the experiences of our lives, and our mothers' lives, our culture. We think we're individual, and we are, but we're part of a culture that behaves in a certain way around labour.

[Diane, P4/j]

This story offers another example of a midwife being-with Other in her midwifery work. By having a confident expectation as to the possibilities that lay ahead in the

woman's birth experience, Diane employed a form of 'solicitude'. This is a term used by Heidegger to describe a "way of care appropriate to being-with other existences in a mutually shared world" (King, 1964, p.80). Solicitude can be expressed in both positive and negative modes. One of the positive modes, Heidegger called leaping ahead. As described earlier, it carries implications of going in front of the woman in order to give her care back to her. In so doing, the woman is empowered to make her own decisions. This story appears to indicate that the woman anticipated her labour would be similar to that of her mother and spent her labour at home, only presenting to the hospital when she was ready to give birth.

She is also likely to have been influenced by her mother's view of the labour she was yet to experience. Her relationship with her mother seems to have been a close one and a similar positive attitude to birth will have been communicated. Her view of self as giving birth may have been interpreted through the view of other – in this case, her mother.

There is research to support the view that the experiences and beliefs of close family and friends are a major factor in colouring a woman's view of the pain of labour (Shearer, 1995). In this story the midwife recognises the vulnerability of some women during labour:

I do think that emotional attitude goes a long way towards getting it into perspective in dealing with pain. And the woman needs to receive that from the people around her. If she's got a mother present who's saying "Oh, you poor dear!" and "This is terrible!" I'll go (beckons) "Let's just pop out and have a cup of tea." And then I'll say to her "She doesn't need this. She needs to actually be supported that she's strong enough to deal with this process and not made to feel that she's having a really rough time and she's a victim of the process." I think that needs to come through from everybody really.

[Catherine, P3/c]

Anxiety or doubts about labour and the woman's ability to cope with it may undermine the midwifery partnership. A constructive attitude to pain in labour is shaped by Catherine's belief in the normality of the birth process. This expectation of a successful labour and birth also needs to emanate from the support people in order to bolster the woman's resolve. The understanding that the woman derives from the people around her of how she is managing her pain is likely to be coloured by their behaviour. The

mother often appears to be an important point of reference for the woman and her over-solicitous behaviour requires prompt action from the midwife lest it erode her daughter's purpose. If the daughter senses doubt or fear in her mother it might set in place a chain reaction of misgivings and uncertainties which result in feelings of panic and a loss of control. This sort of situation is clearly one that Catherine tries to avoid by acting as a catalyst for a concerted message of positive expectation.

Sometimes the midwife suspects a history of sexual abuse. This information may not have been disclosed to her, but something in the behaviour suggests the presence of another facet to the pain:

I think sexual abuse is a major factor in pain, particularly coming into second stage. The physical feelings for a youngster who has been abused are probably mirrored in second stage of labour. So there are dynamics there when you can sense that something's not quite right. Sometimes I don't think it's to do with physical pain, I think it's to do with psychological pain.

[Catherine, P3/q]

The midwife 'senses' that the 'dynamics' are not right. Van Manen (1990) tells us that while "we are always bodily in the world" (p.103) and will reveal some things about ourselves, we will always disguise parts of our physical self, either by accident or design. The woman may not say anything to indicate a shift in her perception of pain but the midwife may hear a different note in the sounds of the labour. She may see a change in the woman's demeanour. She may become more withdrawn and uncommunicative, shunning touch and reluctant to push. By contrast, she may become more needy of the midwife's attention and seemingly more distressed by the contractions. Catherine believes that the change in behaviour reflects flashbacks to body memories from an episode of abuse. The woman's mind is flooded with frightening responses to those memories as her body seems to relive sexual abuse in this example of 'lived body' (van Manen, 1990).

Physical environment

The physical environment can also be a factor influencing a midwife's practice. Midwives appear to work differently in the home in comparison to a hospital setting.

All the participants who have practised in both a hospital and a home setting commented on differences in the way they work with women and their pain in labour according to the environment.

This midwife expresses her preference for practising at home. She feels a sense of freedom to practise away from many of the constraints imposed by a hospital environment:

There's less time pressure. People are not watching the clock and giving you the impression as a midwife that maybe it's time you started Syntocinon, so I guess it makes you feel more relaxed as a midwife. It's a two-way thing isn't it, if you're feeling confident and relaxed, then you work better with the woman and are more able to help her feel confident and relaxed. So home is very different, but I think the main difference is the type of women who choose to give birth at home. They generally have a different attitude. Like Dutch women, they have a no-nonsense approach to giving birth and they don't expect to be rescued from the pain, they just expect to work with it.

[Frances, P6/c]

Frances identifies two factors that alter the way she practises in the home environment. Firstly, the women have an expectation that they will labour at home with minimal intervention and recourse to chemical pain relief. Frances talks of their approach to working with the pain of labour rather than expecting to be 'rescued' from it. The word 'rescue' conjures images of being freed, liberated or salvaged from a situation. It is this very notion that labour pain is such that a woman might need another person to take over and save her from it, that is consciously rejected by such women. This philosophy enables Frances to concentrate her energy on midwifery support of a normal physiological event and she brings confidence and a relaxed manner to her role. This feeling communicates itself to the woman and the partnership solidifies further as they work towards a mutual goal.

The second influence on Frances' practice is the different dimension time has in a home situation. Time as measured by the clock seems to have less meaning in the home. Labour takes its course and the woman, and all those who are sharing the journey with her, adapt to its pace. The midwife adjusts her thinking and her actions to the rhythms of this labour. She does not have the jarring reminders of 'time' that she encounters in a hospital. There is no expectation that vaginal examinations should be done every four hours and that cervical dilatation should be proceeding at 1 cm an hour. Consequently there are not the whispers of doubt about adequate progress to deal with constantly. The result is a more relaxed midwife who can celebrate the progress of a normal experience and project that confidence onto those around her.

The notion of lived time altering according to the situation is identified in this story too. Diane graphically describes the accommodations she had to make to her practice, and her thinking, with a change of working environment:

When I went to home births [after working in a hospital for 12 years], I realised how much I had to unlearn. In that first year, those women taught me so much because I had to trust that they knew what they were doing. You see, I was used to having the backup even if I didn't use it much. I was still used to having pethidine, epidurals and doctors there, whereas at home it's just trusting the process really and sitting and watching and waiting. That took a lot of learning. When I was in hospital I was complying with the hospital rules and when I was in the home I was watching what the woman wanted. I was working with the woman, not the hospital. In the hospital you've always got these deadlines, like "She was 4cms at 2 o'clock, why isn't she fully now?" At home you haven't got that so much. You go and have a sleep or say "let's go out and feed the chooks." Or "I'll go home, you have a sleep and I'll come back later." You don't have that in a hospital environment because of the pressure on the facility and on people to move the women through there.
[Diane, P4/b]

In this story the midwife talks of 'unlearning' much of her midwifery practice because it was based around the 'hospital rules' and the 'backup' to which she is accustomed. In attending women in their homes, Diane began to live time in a different way. No longer was she working within the constraints of a busy delivery unit where a steady throughput of delivered women was essential in order to free up beds for new admissions. No longer was Diane constantly called on to justify why a labour was apparently progressing more slowly than it should have. No longer was she able to take for granted the presence of the on-call medical staff and the pain relief options such as pethidine and epidurals. And no longer was she 'working with the hospital'. In the home situation, the midwife learned to work with the woman. She was taught how to trust the woman. This meant that Diane learned how to 'sit and watch and wait'. By discovering how to let the process of labour unfold at its own pace, she also discovered how to match the woman's pace. She learned how to watch labour with her eyes and her hands and to listen to labour through the sounds that the woman made. She learned that to sit and wait was difficult after many years of busily attending to a labouring woman, the equipment required to monitor her and the policies that the hospital environment required adherence to.

Noise can also be a factor to contend with as this midwife describes:

If you're looking after a client in hospital, there's the expectation that you're a good midwife if you keep her quiet and have control. If a woman is making a lot of noise there's a perception that you're not being a good midwife if you are not taking that pain away and helping her to be nice and quiet and appearing to be managing the labour. Whereas, with my own clients, I talk to them about the fact that it's OK to make some noise, so they know that that's alright and that gives me the courage to allow that more in hospital even though there might be the perception that people outside the door might be thinking, Gosh, she's not managing too well in there with that woman. I know that's OK because the woman has been given permission antenatally by me and herself to make some noise to get rid of the tension or to help her cope with the pain.

[Frances, P6/b]

A 'good' midwife is apparently one who keeps a labouring woman quiet so that she 'appears' to be coping. Whether or not she is coping doesn't seem to be as important as the impression that she is. This midwife counters the pressure to conform by enlisting the participation of her clients. They present a united front to the world outside their room and from this the midwife draws strength to work with the woman and to ignore the possible negative comments. Heidegger (1962) writes of the huge influence the 'They' have on us all. In our everyday lives, we are part of the 'They' who shape our opinions, our behaviours and our activities. He refers to them as a "dictatorship" in that 'They' exercise so much control in such an insidious and largely unseen manner that we often fail to see the pressures that 'They' exert, even though we are all part of the 'They'. This midwife could be describing her perception of the collective weight of opinion that the 'They' wield in this delivery unit setting. By recruiting the assistance of the women, perhaps she is attempting to assert her wish to 'be with' the woman in a singular way.

The midwife adjusts her practice according to factors such as the birth setting and aspects of the physical environment. She is also influenced by the social, cultural and personal backgrounds of women in pain for whom she cares. In addition, her own life experiences will affect her attitudes and her practice.

Being with Pain: The Midwife's Context

The way in which the midwife works with women and their pain is shaped by her own attitudes and life experiences. Her relationship with the woman will be set against a backdrop of personal, cultural and social factors which inform her way of being-in-the-world. These aspects of her self will affect the way she regards pain in labour and the way she talks about it to women. The way in which this midwife sees labour and birth in the context of a normal life event is evident in her words:

I think that there is a very fed up phase in late pregnancy so when women start having labour they go "Whoopee!" instead of "Oh, shit!" That euphoria of being in labour gets them through the first part of the labour which I think is often the most difficult part because they're very intellectually 'there'. They are having to mastermind and intellectualise the process and cope with it on that level. Once they get further up the track in their labour, then they go into 'dozy land' when the endorphins are released and I think it's an easier phase. They capitulate to the process, whereas at the beginning they are often intellectually trying to mastermind it. Once they capitulate and allow the process to go, then I think they usually deal with it a lot better. I often say "You are not alone. There will be hundreds of women out in the world doing exactly what you're doing right now. This is a really big journey in your life but it is a journey women have made since time began.

[Catherine P3/e]

Catherine talks of women being 'very intellectually there' in the early stages of the journey that is their labour. This phrase describes the way that women are frequently monitoring their body for every twinge, counting the contractions or reflecting on tasks not yet accomplished. When labour becomes more established, Catherine describes how the woman turns inward on her body, becomes more docile under the effect of the body's endorphins and gives herself up to the process, or capitulates. There is a sense that lived time assumes an altered dimension when the woman tunes in to her body in this way. Objective time, as measured by the clock, no longer holds the same meaning for her as she allows herself to be swept along by the rhythm of her contractions. Time is experienced on a separate plane and is part of a world filled with sensations. As the woman withdraws from the amount of interaction with her surroundings that characterised the earlier part of labour, she perceives her body differently. The cognitive functions that may earlier have been concerned with questions like 'how much longer?' and 'will the pain get worse?' are faded out, like the dimmer switch on a light, to be replaced by an enhanced awareness of her body. Now the woman is borne towards the end of first stage by a seemingly endless number of contractions that demand her single-minded attention to stay aloft.

The meaning of pain

Addressing the issue of pain is an important part of the preparation for labour. Here are two examples of the way in which participants talked with their clients about the meaning of labour pain:

I talk to them about it being a muscle stretching. I say it's not like a pathological pain which you'd have if you had cut yourself or broken a bone, or if you were ill. That's a warning that something is wrong, whereas the pain of labour is a good thing. It's actually birthing the baby. It's functional. There's nothing bad about it. Occasionally I've used words that I've heard Sheila Kitzinger use like 'welcoming the pain' because it's bringing their baby. So I try and always use positive words without making it sound like it's easy. I've sometimes used words like 'think of your cervix as being soft and opening through the contraction'. Just using the right sort of language helps, I think
[Frances, P6/d]

Pain - it's part of the birth, isn't it? It's normal. It's pain with a purpose. We're going somewhere with it, we're in labour, the pregnancy is going to be over soon, we're going to have a baby - that's what it signals. Women who birth with no pain get quite shocked. They end up quite stunned and take some time to adjust. It's there because it's doing a function and it's not something that's to be feared. You relax into it, you go with it, all those sort of words. Just go down to meet the pain, don't run from the pain, go to it, accept it.
[Diane, P4/i]

Pain has negative connotations for most people. They associate pain with trauma or illness. These midwives seek to redefine pain as it is experienced in labour. They know that pain 'brings the baby', it has a 'purpose' and should be welcomed. The midwives recognise the power of language in helping women to derive new meaning from the word 'pain'. Heidegger talks of the way in which our world is partly constituted by speech and language in our everyday being-together (King, 1964). The words that these midwives use to describe the pain of labour is a reflection of their Dasein or being-in-the-world. Their understanding of the meaning of labour pain is expressed in the words they choose and the way in which they communicate them to women. Heidegger says "speech lets us see what is being talked about" (1962, p.134). By giving voice to the positive imagery about yielding their bodies to the pain of labour, the midwives are attempting to permit a new understanding or interpretation of labour and its pain to women.

One advantage of knowing a woman before she comes into labour is the opportunity for a rapport to develop which enables a midwife to mould her practice according to the

prior discussions about labour and its pain. This scenario rarely occurs for hospital employed midwives who often need to support a woman in labour whom they have never met. Barbara describes her attitude to working with pain and how her use of language has been shaped by past experience:

It is hard being with a woman in pain. When a woman is coping with her contractions with or without my help, that is easy. I can cope with that as well. But if she's distressed and hyperventilating, and I still haven't managed to instil in her a degree of control over her own pain, I find that difficult. It's really not very nice to see people in pain even when you know it's the right thing to be happening. It's sort of a pain that's doing something positive and somehow we should get them to think about it in a different way. In one place I worked, we weren't allowed to use the word 'pain'. "How's the pain now?" We weren't allowed to say that. We used the word contraction instead. All the labours involving low risk women were midwifery run until they proved themselves to be otherwise. If there was something abnormal we would invite the medical staff in. I don't remember the word 'pain' being banned for them, but certainly among the midwifery staff there was a culture of not mentioning or not referring to it as pain. I still don't use the word

[Barbara, P2/e]

Heidegger tells us that in the thrownness of our Dasein, or the way in which we come to be-in-the-world, our Dasein always has a "mood" or an "attunement" (1962, p.128). Attunement always has its understanding and understanding is an essential feature of the being of Dasein. "Understanding", Heidegger asserts, "harbours in itself the possibility of interpretation, that is, the appropriation of what is understood" (1962, p.151). Barbara describes a work place where the word 'pain' was forbidden, to be replaced by the word 'contraction'. The underlying rationale seems to have been a realisation that the meaning attached to the word 'pain' for labouring women carries with it negative connotations. Women hearing the word 'pain' used to describe their contractions were therefore likely to interpret them in the light of all that the word 'pain' conjured up from their past experiences. Their being-in-labour may have been perceived differently if they were instead encouraged to work with their contractions. Perhaps the women were able to experience their labour in a less fearful way. The fact that Barbara still does not incorporate the word 'pain' into her dialogue with women suggests that she has seen the benefit of this approach.

A midwife's attitude to women's pain in labour will often accompany her to a practice situation and affect the way she works. This midwife articulates her approach to pain:

I'm not scared of women having pain. I feel very safe and comfortable working with them. I think there are midwives that are quite anxious about how women behave when they are in pain. I don't have any anxiety about women being in pain, if I feel really confident that it is the normal physiological pain of labour.
[Amanda, P1/b]

Amanda shows the strength of her feelings with the boldness of her opening statement. She is not frightened by a woman's expression of pain during labour as long as she believes that the labour is progressing normally. Heidegger (1962) tells us that fear is a reflection of our engagement with the world through Dasein. Amanda, when she works with women who are in pain, feels 'very safe and comfortable'. Her way of being-in-the-world when offering labour support contains no threat. Gelven interprets Heidegger's writing on the phenomenon of fear by describing it as a state-of-mind which originates primarily from within our lifeworld. "Fear is not learned; it is discovered" he states (Gelven, 1970, p.59). Midwives who are afraid of women in pain may therefore be revealing a mode of Dasein which demonstrates that they feel threatened from within their world of practice by something which has always been there – namely a fear of women's behaviour when they are in pain. Perhaps, as a consequence, these midwives are more likely to be offering women pain relief for their own distress rather than any real need of the woman.

Colliding roles

Just as past experience of a working environment can affect the way a midwife works with women and their pain in labour, so can personal events in her history impact on her practice. This midwife relates her story:

Yeah, it can be hard seeing the woman in pain, especially for the mothers. I've been there too. It's your baby, your child and you don't want her to be suffering that pain. You want to have that pain, not her. I remember towards the end, my daughter cried and said it's just so sore and I said to the midwife she needs something for the pain (laughs). She had an independent midwife who I knew of but didn't know closely, which was really good because the two of us weren't in a personal relationship. She was the midwife and I was the mother. So, when my daughter cried, I lost it and my big mouth – I told her she needed something. But she had a baby instead. I think the midwife must have known that she was coming up to transition and would have the baby soon. I felt really stupid afterwards for saying that she needed to have pain relief (laughs). Obviously the mother overtook the midwife in me. It's lovely to have had those experiences,

both as a birthing mother and a support person. It helps me to reflect on the family dynamics, the support that's happening in the room. You're aware that there are people there just to support her and you need to support them so they can support her.

[Evelyn, P5/g]

Evelyn recognizes that she brings to her role as a midwife, all her past experiences. This includes her own birth experiences and that of support person for her own daughter's birth. She acknowledges that she is likely to have a better understanding of how best to support and encourage close female relatives at a labour because of her previous experience. She knows what it is like to stand helplessly by when your own child is distressed and in pain. She knows how her professional gaze was blurred when her daughter burst into tears and she was unable to maintain a dispassionate view of the situation. She also sees the advantage of the independent midwife caring for her daughter being an acquaintance rather than someone more intimately involved. This midwife was able to cast a more objective eye and judge for herself whether pain relief was a timely option, unencumbered by a sense of obligation towards a friend. Her relationship was first and foremost with the woman. The midwife/mother felt foolish after the baby was born. With the benefit of hindsight, and in the absence of pain for her daughter, Evelyn was able to replay the events of late labour and place the pain and the behaviour in context. She describes how the mothering role assumed a much greater emphasis over her midwife's role, with the result being an entirely understandable need to see her daughter's distress eased.

The experience of another midwife whose professional and private worlds overlapped lends further weight to the notion that midwives are always a representation of all the pieces of their lives, as this story shows:

I looked after a former girlfriend of my son. She had been part of our family over a period of several years and she was very close to me. When she was close to transition, she implored me to transfer to a base hospital for an epidural. I went to the office to arrange the transfer and I was in tears. I just couldn't cope with seeing her in pain. Another midwife was left in the room with her and she came out to me and said "Put the phone down, she's alright. She's decided she doesn't need to transfer now". My closeness to her really clouded my judgement

there. With another primp I might have said "You are fine" and suggested a shower or a bath but because she was pleading with me and because I had an emotional relationship with her, I couldn't stand it. She went on and became pushy very shortly after that so I knew she was going to deliver soon, but that's one of the hardest times.

[Frances, P6/f]

Frances' judgement of how the woman was coping was 'clouded' by the closeness of her personal relationship with her. It was physically distressing to see her in pain and the midwife was unable to view the scene with the same dispassionate manner that she might normally employ. It was her colleague who more accurately assessed the woman's frame of mind in her advanced stage of labour and who stepped in to prevent an unnecessary transfer. Hannah Arendt, writing about thinking and doing, posits the opinion that in order to derive meaning from a situation, one needs to withdraw from involvement in it and thus gain an overview of the whole (Arendt, 1978). "The spectator, not the actor, holds the clue to the meaning of human affairs", she states (p.105). It seems that Frances was unable to detach herself sufficiently from this situation to assume a spectator role and think through the implications of meeting the woman's request for an epidural. As with the previous story, it appears that the presence of an added personal connection to the midwifery relationship made it difficult for a professional view to be maintained.

Summary

Before the pain of labour begins the midwife has an important role to play in preparing the woman for the challenge of that pain. She can be instrumental in helping her to imagine how her labour might be. In the thrownness that is labour, the woman may be overwhelmed by anxiety and fear in the midst of painful contractions. The midwife seeks to reveal the possibilities of a labour by leaping ahead to help the woman recognise them and be confident to be-with the midwife. The midwife's interpretation of pain is a key factor in working with a woman before labour. The nature and function of the pain is different to pain caused by disease or trauma. The pain of labour is a safe pain that heralds the birth of the baby.

The physical setting for birth can alter the way that the midwife works with women and their pain. Lived time assumes a different shape in a home situation as the woman determines the pace of labour. The midwife takes her cues from the woman rather than

being dictated to by the unseen, but powerful 'They' influences which are more apparent in a hospital setting. The midwife's practice is always situated within her life world. Past professional events will travel with her to any labour, and so will personal memories of her own birth experiences. These will colour her practice because they are part of her Dasein. Being-a-midwife for close friends or family can be difficult because the spectator role is hard to maintain in the presence of the personal relationship. The relationship which builds between the woman and the midwife is examined more closely in Chapter Five : Being with Pain – The Doing.

Chapter Five

Being with Pain – The Doing

When a woman is in labour she will almost certainly feel pain. The time for preparation is past. Now the pain is here and she is likely to need the support and encouragement of a midwife during her journey through childbirth. Ways in which midwives work with a woman and her pain during labour are shown in this chapter.

Breaking Down Time

Midwives understand that the uncharted waters of a labour can be very frightening to women. In particular, the length of any labour is an unknown factor and women will often turn to their midwife for certainty and succour when they are in pain.

This midwife articulates her approach to such a situation:

Well, I think it is quite a good strategy to contract with them. To say "OK, well let's just not worry too much about what's going to be happening in three hours time". They want to know "how much longer am I going to be at this point?" and I don't know and they don't know, so I think you have to contract and say, "well, let's do a, b, c and d and then review the situation in half an hour, forty minutes time". You have to wrack your brains sometimes because by then you may well have run out of quite a lot of things – the water, maybe nitrous oxide, massage and acupressure and the TENS machine. So it may be doing something very specific like breathing eye to eye with her through each contraction, giving her a bit of security and that sort of thing. I think then if you get through that forty minutes, maybe you re-contract with her for another period. I think you can say to women that pain relief is not out of the question and it's still an option but let's just see because of the keenness that they originally expressed about managing pain [without pethidine or epidural]. This gives them the opportunity to feel that they really have made a decision that's good for them.

[Amanda, P1/d]

This story captures the nature of 'lived time' during a labour (van Manen, 1990). Amanda knows that, because she is in pain, the woman's perception of time is likely to be different to her own. Lived time slows for the woman as labour becomes more intense. She suggests that it's important that 'we' focus in on small chunks of time

rather than trying to look too far ahead. The woman is probably acutely aware of the minutes creeping slowly by as she contemplates an unknowable number of hours stretching ahead of her, filled with increasing pain. Amanda tries to move the woman's gaze from the distant horizon of her 'future' to a finite section of 'future' in the forty-minute segment. So Amanda works with the woman in the 'now' and encourages her to focus on her embodied responses to pain. Sometimes there is a need to impose her presence more overtly during a contraction in order to reinforce feelings of security and control in the woman's mind. Getting close to the woman and maintaining eye contact while patterning steady breathing throughout a contraction is an example of her intensive midwifery support. Amanda wants to maintain a sense of hope within the woman that labour is progressing well and that she can cope with the pain. However she is careful to be honest about the fact that pain relief is available if required. It is 'not out of the question' if she needs it. Ultimately, the decision rests with the woman.

Heidegger uses the term 'temporality' to describe his understanding of time as a continuum. Rather than "a linear succession of nows" (Leonard, 1989, p.23), he describes time as consisting of past, present and future dimensions which are intertwined with being-in-the-world. We live constantly in the future and in the past, in the unknown and the suspected. The woman's anxiety as she imagines her future and the pain ahead is constituted also by the way she feels right now about the pain and maybe other factors such as how supportive her partner is. Her being-in-labour will also be affected by the past – how long she has been in labour, her previous experience of pain, stories she may have heard from others about labour.

Time can be condensed into smaller portions when midwives work with women, but it can also be viewed from a wider perspective. Barbara describes the way she works with a woman during labour:

It's really quite a difficult time isn't it, those last few contractions? I think that's where you need your midwifery skills. I take it contraction by contraction, just one at a time. I talk her through one and then remind her when it has gone off, ask her how she feels. I say it will last a minute and then it will be gone. I tell her how much the cervix has dilated up, reiterate how much each contraction might have pulled the cervix open. I try to be a bit descriptive to help her, using a bit of anatomy and physiology to explain what each contraction is doing and hope that she understands that each contraction is literally one less to have. I use the analogy of climbing the stairs or up a hill, where each contraction is

higher up the hill, to try and turn it into a positive thing. Just really jolly her through, one at a time, one contraction at a time, not looking too far ahead. I tell her not to be overwhelmed by it because very soon it's going to be over and in the past.

[Barbara, P2/f]

Barbara focuses all her attention on the woman during this testing time at the end of labour. She asks the woman to divide time up into the space of a single contraction and talks to her throughout each one, offering her physical presence and emotional support. She reminds the woman when each contraction has passed to emphasize the absence of pain now – a space to be savoured before the onset of the next. In doing so, the midwife shows her that time is passing and progress is being made even though, for the woman, time may appear to be almost at a standstill. By keeping the woman's experience of lived time very definitely in the 'now', Barbara endeavours to limit the potentially destabilising effect of looking too far ahead and possibly being overwhelmed by pain. Paradoxically, she also invites the woman to look towards her future when the labour has finished and the pain will be a memory, relegated to her past. Through her words, the temporal dimensions of the woman's past, present and future are revealed as ever-present and constant in our being-in-the-world (van Manen, 1990).

Judging Coping

There are times when women find the pain of labour too demanding to cope with and they request pain relief. Occasions such as these represent a challenge to many midwives as they endeavour to judge the best management in the circumstances. This midwife describes how she assesses such a situation:

In picking up where women are starting to tip past dealing without pain relief they get stressed; they get panicky; they start to get het up before the contractions come in and peak; there's lots thrashing around; there's lots of vocalisation "I can't do it, this is too tough". When you check in with them and anchor them, then you get a sense of whether they're anchorable and able to come back on top of it and deal with it again or whether it's tipped to a point where it's beyond them. It's very interesting to watch how people go from being manageable, to becoming a little bit unmanageable, to making the decision to have pain relief and completely spitting the dummy until pain relief comes in. It's like it's a mental process and once you've given up, there's no way you're going to apply yourself to dealing with one more contraction.

[Catherine, P3/o]

Catherine describes the physical behaviours which reveal the psychological turmoil experienced by a woman who is losing control during labour. She paints a picture of the increasingly agitated body movements and the verbal pleading from a woman who has reached a stage where she feels she can't go on without pain relief. The midwife 'checks in' to ascertain how panicked and frightened the woman feels. Her calm and certain expressions of encouragement and faith in the woman's capacity to persevere may no longer be effective. Catherine assesses whether the woman is 'anchorable'. Is it possible for her to communicate a feeling of security amidst the panic? Can the woman clutch something in what Catherine says or does which will hold her fast, anchor her as she is buffeted by waves of fear?

Leap (2000) describes the transitional stage of labour as the time when the woman experiences strong and painful contractions. This can be a difficult time for the midwife to interpret as well. The woman's behaviour may appear to be consistent with the more severe and pathological pain of abnormal labour. Psychologically, the woman may feel very vulnerable (Mander, 2002). For many women, it seems that the effort of maintaining composure when contractions are strong and painful becomes very difficult to uphold once self-doubt begins to creep in. Just as a jumper will unravel when one strand of wool comes loose, so a woman's self control can fray with alarming speed when she mentally gives way to pain. There are times when the midwife needs to clarify exactly what the woman wants:

Sometimes I think pain relief is totally appropriate. You know, the woman has been an absolute heroine and pain relief is totally appropriate. When they're saying "Oh, this is terrible, I can't do it!" I will ask, "Are you just trying to tell me that this is really, really tough and hard or do you actually feel that you can't manage it?" Because I think sometimes that vocalisation around pain relief is because they actually want acknowledgement that it's a tough job and they're really working very hard. Often when you do ask them, they'll say "Yeah, it is hard, but I'll be alright".

[Catherine, P3/p]

Past experience tells this midwife that some women need acknowledgement of their strenuous efforts during labour rather than the pain relief that they might request. In saying "Are you just trying to tell me...", Catherine implies that it's quite OK for the woman to verbalise how hard she is working. Jordan (1993) suggests that in societies where decisions regarding pain relief are made by health professionals, the women face the task of convincing them when they need it. To do this, they need to demonstrate the

amount of pain they are feeling and this causes anxiety before pain even reaches severe levels. By stating the fact that she can see the woman's effort, Catherine tries to reassure her and put the labour into a larger perspective. She could be saying "this is the behaviour that I have witnessed many times before in labouring women and, in recognising it, I am confirming for you that all is well, everything is progressing normally and I'm not concerned." In so doing, the woman is able to interpret 'being in pain' through the possibilities Catherine offers. Catherine conveys a new meaning for the pain through the language she uses. Heidegger (1962) suggests that bringing our being-in-the-world into words helps us to 'see' our world more clearly.

But the woman might be feeling that she really 'can't do it'. She may have reached the limits of her ability to cope. So Catherine adds the second part to her inquiry which allows the woman to consider which description best fits her perception and to differentiate between working hard and managing, or working hard and not managing. It seems that the opportunity to voice her feelings, and have them recognised, will sometimes give the woman the additional strength to continue without pain relief. Maybe Catherine is like a mirror reflecting the woman's courage and stamina back to her as she works with her.

Part of the midwife's assessment of a labour where pain is becoming intolerable for a woman is to look for unseen factors that may lend meaning to the context. Frances teases out the elements that may indicate to her why a woman is no longer coping with contractions:

I suppose it's different for different people but it might be that even between contractions they're still distressed. It might be that the other support people, maybe the partner, are saying to me, she's had enough. It might just be a feeling that I have inside, kind of a gut feeling that this is enough, but usually it's associated with something within the labour that is no longer normal. It's often a prolonged labour or a malposition as well and so I know she's had enough and it's not just because it's a normal labour, it's because there is another factor as well. There are not that many cases, I find, with women who have planned to have an unmedicated birth and are having a normal labour with reasonable progress, where I feel that she's gone past that point of being able to cope. Usually we can work together and manage the pain. There is her physical condition. If she's getting very tired and that's affecting her ability to be positive about coping with the pain, that might alert me to the fact that she needs me to decide she's had enough and not able to be objective any more.

[Frances, P6/g]

The midwife can recognise when the woman has 'had enough'. Frances responds to many different cues. Often these will emanate from the woman and they may be verbal or non-verbal. Sometimes there will be additional triggers to help her put the woman's behaviour into a wider context. These may come from support people or they may gel in the midwife's inner review of a labour as she 'sees' the effect of great tiredness or a baby in an occipito-posterior position. Frances talks of 'knowing' when this point has been reached. She knows in an embodied way. She has 'kind of a gut feeling' based on her attunement to this woman and her pattern of behaviour during the contractions of the past several hours. Perhaps she also brings to this knowing previous labours she has observed where a similar set of circumstances caused a woman to reach the end of her tether.

Heidegger (1962) describes a concept of caring-for or solicitude in relation to the way in which we interact with others in our everyday lives. He tells us that there are positive and negative modes of solicitude. In the positive modes there are two extreme possibilities. One positive mode he calls 'leaping ahead'. Care leaps ahead in order to "give it back to him" and help him "to become free for it" (Heidegger, 1962, p.159). This could be viewed as an act which aims to empower someone, such as a woman in labour when a midwife works with her.

The other extreme form of a positive mode of care Heidegger calls 'leaping in'. He tells us that this is a much more common way of being with one another. It can "take away 'care' from the Other" by doing things for him (Heidegger, 1962, p.158). By dominating in this manner, such care can cause someone to become dependent without them being aware.

Frances might assume the responsibility for 'deciding she's had enough' when the woman in this story acts in certain ways. Her decision may cause her to 'leap in' and suggest pain relief. She may become more assertive in her suggestions for strategies to cope following a decision to leap in. In many cases these actions will be fully justified by the woman's physical and psychological state. The midwife who is truly working in partnership with a woman will remain alert for the time when the degree of care necessitated by leaping in is no longer necessary. She will then begin to move along the continuum of solicitude in the direction of the leaping ahead mode once more.

Learning by Doing

Much of a midwife's expertise in translating a woman's pain and supporting her in coping with it, comes as a result of experience. Gaining this experience can involve learning from situations when it might be necessary to 'leap in'.

This midwife tells of one such time:

Sometimes you think primigravidas are going to do really well. You just get it into your mind that they're doing great, but then there 's a time when they do lose it. I recall a primip. I really thought that she was going to get through. She was in established labour and she was doing good, doing good, then all of a sudden, exploded She didn't ask for pain relief She couldn't. She was just completely screaming and wanting to jump off the bed with contractions. They were getting so strong that she was just not relaxing in between at all. I think that was the closest I've come to wanting to run away and hide because it was when I first started and it was like "Oh, what do I do?" I stepped in finally and said "I think you need pethidine." She had 25mgs of pethidine IV which helped but probably not enough. I can't actually remember if I talked about it after the baby was born, but I'm sure I did because I usually say "How did you feel about it, did things go OK for you?" and even if things have been, you might think, completely crappy for them, often they'll say "No, it's OK" and they're looking at their beautiful baby and everything seems OK They were just lost in that world and now it's all gone.

[Gemma, P7/fil

The incident in this story occurred when Gemma had not been practising for long and may reflect something of her relative inexperience. She describes adopting a 'mind-set' about how well the woman is coping with labour. She firmly believed that the woman was going to cope with the rest of labour. Then, suddenly she 'exploded'. Gemma was caught completely unawares when the pain overwhelmed this woman and her previous behaviours were overtaken by panic and fear as she 'screamed and wanted to jump off the bed with contractions'. Maybe the change in the nature of the labour signalled itself but went unrecognised by a midwife who was comparatively green. Heidegger talks of things in our lifeworld as being "ready-to-hand" (1962, p.99). By this he means items, such as implements or tools which we use and he also means "entities with which we concern ourselves" (1962, p.102). In this story the events in the woman's labour, while they were progressing 'normally' in Gemma's eyes, were ready-to-hand. They were predictable and expected. They were so ready-to-hand that they were more or less taken-for-granted in their familiarity. When the woman's behaviour changed dramatically, Gemma was taken by surprise and her being-with the woman in labour was now "un-ready-to-hand" (1962, p.103). The labour had assumed a different shape

and was unlike the ready-to-hand labour of moments ago. Events had moved with such speed that the woman 'couldn't ask for pain relief. In the world she now inhabited, there was no room for words. There was just pain - ever present and with no promise of an end. Gemma describes 'stepping in' to suggest pethidine. The words imply that she has taken a decision to be more assertive and prescriptive about her attempts to wrest control back for the woman. Gemma's move to assume a more dominant role by providing pain relief and standing alongside the woman could be an illustration of what Heidegger calls "leaping in". She takes over the decision making and tries to pre-empt any further panic by anticipating what the woman is feeling and by explaining what is happening every step of the way. In a sense, she is trying to show the woman a way through her pain and return once more to a mode of being which is ready-to-hand.

Holding back

Just as every woman is different, so is every labour different. Some women will not ask for pain relief during labour even when the midwife suspects that it might be beneficial. There are occasions when the midwife must assume a more passive role. This midwife describes such a time:

I think it's about understanding the birth process. Pain doesn't bother me... well, I must admit, sometimes it does (laughs). Sometimes it does bother me. But I remember what it was like for me when I had my children. I cried and I guess some people feel uncomfortable with women crying. Most of the time it's OK, but there are times when I feel that the woman does need something. But I've got to hold back and not say anything because I don't want her to distrust what she's going through and distrust herself Obviously her not saying that she needs something, means that she's trusting her body and I've just got to allow myself to be quiet. And it's amazing, they do do it. There are times when I've got to realise that this woman is doing OK and I must not say anything that's going to affect her dealing with it. So if she cries, she cries and she'll let me know.
[Evelyn, P5/e]

Evelyn talks of the tensions she feels concerning women in pain during labour. She describes the effort sometimes to 'hold back' and not try to save a woman who is crying with pain. She interprets the woman's silence as an indication that she is managing and relies on the woman to tell her if she needs more input. Evelyn is generally able to support the woman by sitting quietly, by 'allowing' herself to be still. It seems that giving oneself permission to bide one's time and wait can be hard. The temptation is to 'do' something...anything, as a means of suppressing tension and maybe even guilt at the inability to 'help' the pain. Heidegger tells us that "listening to ... is the existential

being-open of Dasein as being-with for the other" (1962, p.153). Evelyn is relating an example of making herself available to listen in a meaningful way as she engages in being-with a woman. "Only he who already understands is able to listen," Heidegger reminds us (1962, p.154). Listening is a form of discourse, as is keeping silent. 'To be able to keep silent', Mueller-Vollmer states, "Dasein must have something to say...In that case, one's reticence makes something manifest and does away with 'idle talk' (2002, p.238). By maintaining a watchful presence, Evelyn is conveying confidence in the woman's ability to determine her need for more direct midwifery support when, and if, she requires it. She is also making room for the woman to be-in-labour by respecting her need for quiet.

Believing

Even experienced midwives can lose their conviction about the way that they work with women and their pain. It seems that circumstances can conspire to undermine a midwife's self-belief and her belief in women to give birth. At such times, the midwife needs to regather her resolve, as Diane recalls:

I'd been out of [independent] practice for about five years. I'd been doing some births at [a small maternity unit] but I hadn't done continuity. With the first few women, I had more epidurals than I normally would have. When they started saying they couldn't do it, my confidence had gone a bit because I hadn't done it as much. So I would start to be persuaded that perhaps they're not going to make it, perhaps they do need an epidural. I started to doubt myself doubt the process, I think I ended up doing a few more epidurals and then about midway through this year, I thought "This is ridiculous! What the hell am I doing? No, I'm not doing that any more. I'm not having epidurals every five minutes and taking blood pressures and all this nonsense. I'm not an intensive care nurse and I don't want to be one. I'm a midwife and that's what I'm going to do." So as soon as I started getting that little bleat "I need an epidural..." No way. Not unless there was an obstruction, a delay or a position that was difficult to rotate or there was a real indication for one. But for pain relief "Nah, come on, let's move. Let's get you moving, have a shower, let's do some other things. Let's see if we can not do this this way." My epidural rate just dropped. I still had a couple though, I'm not saying I didn't give them.

[Diane, P4/e]

Diane describes how losing her belief in women being able to labour and birth normally, affects her confidence in using her midwifery skills to support women in pain. The realisation that she is acquiescing to women's requests for epidural too readily results in her reviewing her function. Heidegger describes phenomena as concealing. According to one commentator, he argues that this is it not so much what else may be in the way to obscure a view, but more about where we are standing, the kind of questions

we are asking in relation to them (Mitchell, 2001). He suggests that when our attention is directed to the experience and we ask questions, the form of the experience is laid bare. Then we are able to re-interpret commonplace experiences in a fresh light (Mitchell, 2001). It appears that Diane may have been called to re-examine the phenomenon of uncomplicated labour and re-evaluate her approach to it. She decides to resume a midwifery role and begins to suggest alternatives to epidural when it is next requested for pain relief. Success in supporting one woman in this way reinforces her resolve and the number of epidurals drop. It seems that the confidence to rely on midwifery support and avoid interventions such as epidurals for pain relief can be lost if the culture of practice where a midwife works embraces such practice without reflecting on its implications. Diane appears to have become part of such a culture until she resumed continuity of care for women. The practice she now describes demonstrates how important is the determination of the midwife to preserve the normality of labour and birth where possible. In the presence of a midwife who is strong in her beliefs about childbirth and strong in her supportive role, it seems that the woman is able to labour with confidence in the process.

The following story by the same midwife is a telling example of the power of the midwife's conviction communicating itself to the woman:

I remember going to a woman who wanted a homebirth because she 'd had an epidural [and instrumental birth with her first baby]. She said to me 'I don't think I can cope. I think I need to go to hospital to have an epidural'. I said "No, you are only saying that because you're right at the place where you had the epidural last time and you haven't got any experience of what happens from here on in without an epidural, but this is what you wanted. You wanted a normal birth, you wanted a home birth and that's what you're having. So, I want you to say this 'I'm having a normal delivery and I can do this. ' So she just went round and round the couch saying that. "I can do this. I'm going to have a normal birth. I can do this". She kept walking and saying it and then she started (involuntary pushing noise) and I said "There you go. Come on. " I mean, it hurt. I'm not saying it didn't hurt but she was just fantastic, she was totally rapt. The woman just changes instantly from being this frightened person to being this "Oh, I can do it".

[Diane, P4/d]

This story captures the way that Diane empowered the woman to take a huge leap of faith. When the woman begins to doubt her ability to cope without an epidural like last time, Diane doesn't hesitate. The nature of the relationship between the two women is

evident as Diane leaps in with strategies to keep the woman at home. As a method of reinforcing the woman's desire to have a normal birth, Diane instructs her to walk around the room repeating a mantra that is short but very specific. By asking the woman to verbalise a positive and hopeful message which can be heard not only by the woman, but by any other people present in a supportive role, Diane is seeking to hand care back to the woman. She encourages her to dispel any doubt and await the birth.

The darkness that is the future holds unknown experiences, but Diane is prepared to accept that she cannot see, or yet understand, what lies ahead. Her message to the woman is that together they will face the darkness and look for signs of light which might allow for more understanding. The birth provokes elation and self-congratulation in the woman who has truly worked to realise this goal. In Diane's words we can also hear her admiration for that hard work. Behind it all, though, is Diane's unswerving belief in the woman which never wavered and which propelled her through self-doubt to an exciting and satisfying birth experience.

Tuning In

There is a reciprocity involved in the relationship between the midwife and the woman which appears to be vital to its wellbeing. This involves an endless circle of midwife, woman, midwife and woman where each part is inextricably bound to and reliant on the other for its survival. A product of such a close bond could be the sense of attunement to a woman and her needs during labour which several participants in this study describe. This midwife provides an example:

I've just completed care for a woman who had a more difficult birth and pain relief for her first labour, a Caesarean section for the second one for a breech. I picked her up for the third time round and we had a normal birth. Now she's a very quiet, not very disclosing sort of woman and I looked after her with a student, which was good experience for the student too. In labour she was completely composed and didn't seem to need much input, but I was doing my usual talking her through and when I sensed she was getting stretched, just anchoring her again and talking her through. But after she had her baby she was a different woman. She was just this effervescent, outgoing, bubbly person that we hadn't seen through the whole pregnancy. She started it off. She said, "I wanted to say to you that when you were saying the things you were saying to me in labour, even though I wasn't responding to you because I couldn't - it was too intense, that was really important to me. You kept me going and if I had had

midwives who had said the same things to me with my first labour, I think I would have got through without needing all those other things that I had." It made a really big change to her and it was great for the student to see.
[Catherine, P3/j]

This story depicts the way in which Catherine expresses "solicitude" in her Being-with-the-woman. Heidegger (1962) uses this term to capture a way of caring, or not caring, for others in the world we share. Two positive forms of solicitude are seen in leaping ahead to enable the woman to direct her care and leaping in, if necessary, to take that care away from her. Catherine's midwifery support seems to have been hovering somewhere between the two extremes during this labour. There is a sense, however, from her words that she was poised to leap in at any stage should that have proved necessary. She describes how she 'senses' when the woman is 'getting stretched'. Small cues within the woman's body language are sufficient for Catherine to respond with more intense praise and encouragement. This serves to 'anchor' the woman again, to provide the steady and dependable message that helps to maintain her sense of control. Although the woman gives little sign of needing, or heeding the midwife's words, she recounts later that they were extremely necessary to keep her going. So effective were Catherine's words that the woman even wonders whether the outcome of her first labour might have been different if she had had this kind of support. One can only guess at the psychological legacy of that first birth experience, but the transformation in her demeanour following this birth suggests that she had endured severe emotional trauma. The student was privy to a wonderful learning experience at the hands of an expert practitioner who demonstrated warm and intuitive support to a seemingly self-contained woman. In so doing, Catherine also worked a healing of deeply hidden hurts and disappointments that appears to have unlocked a happier and more confident self in that woman.

The same midwife allows a more revealing glimpse of her midwifery practice in the following story:

I'm very, very tuned in to the woman. As the labour goes on further and further, and gets more intense, I creep closer and closer. But I'm all the time listening to what's happening and if I feel ... some midwives say, "That's alright, scream if you want to", but I'm not happy with that because I think that women spin out of control really quickly. If I find a woman is starting to get a bit screamy, and you sense there's a panic there, I'll immediately go in and I'll anchor her. Sometimes I'll put my hand on her chest and just say, "Slow yourself down and just come back into yourself Don't spin out, you're alright, slow yourself

down". Then I'll get her in touch with what's happening "You're doing a really big job and birth's overwhelming. You're doing great." If I feel that she's losing it, I'll say to her "What's happening for you?" so that I can connect with where she's at and then it may be that she's beginning to feel the transitional phase. When I get the feedback from her, then I'll interpret what's going on for her. So there's that tuning in to her all the time and as soon as I sense any panic in her, I'm in there immediately and re-anchoring her back in the process and reassuring her that's it's alright

[Catherine, P3/k]

Catherine's focus is totally on the woman as labour progresses. Although she may keep to the background during labour, as it gets more advanced, she 'creeps closer and closer'. Gradually, but inexorably, her presence is more and more necessary. She listens carefully to the woman. Heidegger reminds us that "the being of disclosedness is constituted in attunement, understanding and discourse" (1962, p.168). By giving her full attention to the woman, Catherine invites her to describe the feelings and sensations that she is experiencing. She 'tunes in' to the woman's words and to her body's voice as she seeks to understand what might be happening. With this information, Catherine is able to interpret what is happening for the woman and put it into the context of her labour. By enabling the woman to link the pain, and the feelings that it brings with it, to the bigger picture of a 'really big job' which is 'overwhelming' Catherine strives to acknowledge and commend her efforts.

In her experience women can lose control very fast and she is quick to act on any sense of panic that she notes. She calls it 'anchoring' a woman. She needs to get close and remind the woman of her physical presence. She may touch the woman's chest and draw attention to her breathing. She speaks to her in a calm, slow voice and asks her to re-engage her mind with her body. She reminds her that everything is alright. Perhaps Catherine is the anchor, the steadfast and constant presence who prevents the woman being dashed against the jagged rocks of fear. Maybe she deliberately places herself as an intervention to combat pain and anxiety during labour.

Another midwife describes a situation where her presence seems to have made a real difference:

I recently had a woman being induced for her second baby. I went in [to the hospital] and the woman was distressed. She had been sexually abused by her father, a really bad history, sexually and socially. Very, very anxious, a lot of depression and her husband was really nervous. I'd spent a huge amount of time with her antenatally and she was absolutely terrified. I looked at her and thought I'm sure she's dilating, so I did a VE and she was nearly fully. I don't

know if she'd gone very rapidly with the PGs. I think it could have been that sort of a labour, really fast and she needed quite a lot of calming. I put a lot of hot water on her back, a lot of pressure, a lot of rocking, a lot of holding, a lot of coaxing, a lot of stroking, my voice in her ear. Later she said that's all she heard, was me saying 'You're alright, just calm down, it's OK, don't be frightened' and then get the gas and the water going, and then she delivered. She was absolutely ecstatic but it could have been the complete opposite, if she'd gone in and didn't know anybody. She would have ended up with an epidural —guaranteed and she would have taken another six or eight hours and she may not have had a normal delivery. So you as a person, using yourself are very instrumental in what happens in the end. Even though you may not think you are, you are very, very influential in what happens for a woman.
[Diane, P4/k]

This story illustrates the value of continuity of care for this woman. Diane arrives to find a distressed woman. She is convinced by simply looking at her that she is in advanced labour and a vaginal examination confirms this. Would a midwife who had never before met this woman have been able to assess the stage of labour with such accuracy? Or was there something in the rapport which had developed between this midwife and the woman which enabled her to 'read' her body's reaction to contractions? This seems to be an example of Diane's ability to attune herself to the labour in its context and know that this was the time to leap in for the remainder of the labour.

Now Diane describes how she takes on the role of supporting the woman through each contraction from this moment. She gets physically very close to this woman by holding and stroking and rocking her. She uses hot water and pressure to her back to ease the pain. Kitzinger (1997) describes emotionally supportive touch like Diane is using as 'authoritative touch' (p.229). She suggests that it conveys strong messages to the woman and has a positive effect on the physiological outcome of labour, making it a more satisfying and safer experience.

She keeps up a steady stream of encouragement and reassurance that everything is alright. She repeats the phrases that tell this woman that she can rely on her presence to see her through these contractions. Diane constantly reminds the woman to relax, to submit to the pain, to trust her confidence in the process. She is like an interpreter. She translates each contraction and deciphers the foreign language that is labour, with all the frightening feelings that it conjures up, into plain English. The woman focuses on the familiar words housed in simple phrases and clings to the message they contain. The

meaning behind the words is what the woman recalls after the birth because this was more important than the content. Diane has conveyed a sense of deep understanding of the woman's pain by her words and her instinctive leaping in to enfold her with support.

Scarry comments on the way that pain can silence: "Because the person in pain is ordinarily so bereft of the resources of speech it is not surprising that the language for pain should sometimes be brought into being by those who are not themselves in pain but who speak on behalf of those who are" (1985, p.6). Diane brings to words the woman's pain and acts to support her with wonderful midwifery skills.

So, who the midwife is, can make a difference. She talks of 'using' herself, of making herself emotionally available, in addition to her physical presence, during labour. The therapeutic use of self in counselling work has been found to be conducive to that relationship (Edwards & Bess, 1998). This story uncovers the powerful effect the midwife herself had on this woman's experience. In effect, the midwife is the instrument in this labour.

Promoting Trust

The nature of the relationship between a midwife and a woman can profoundly affect the way in which a labour unfolds. This story captures the way that one midwife works with women:

The primps I've delivered at home have been phenomenally resourceful and quite determined to be at home, but you do have to be very positive and very encouraging and give them lots of feedback about what's happening. You have to take a few risks in saying things like 'you are getting there' and 'you will be fine' and 'you are going to have a baby soon'. Or explaining to them maybe why things are taking a bit longer. That the baby just needs to turn a bit more or come down a bit more. A lot of it is calm reinforcement that's reassuring and then from a practical point of view, you do have responsibilities as a midwife like keeping them well hydrated and getting them to empty their bladders and to be upright and to move around. We provide birthing pools in our practice and that can be very effective and we do simple homeopathy which seems to have some magical effects really. I would really like to think that women do have a trust in you and do have a sense of security and belief around the fact that you will support them through thick and thin. You have built up such a good relationship with women, it just makes such a big difference and I think there 's a lot of really subtle stuff that goes on between a midwife and a woman that it is really very hard to analyse. It's sort of unspoken and it's just a kind of sense that she trusts you and you know her and that helps a lot.

[Amanda, Plig]

This story is about trust. Firstly, Amanda displays her trust in the process by her forceful reassurance to the primigravida that everything is progressing well and normally. She acknowledges that she cannot be certain of the outcome, but is comfortable working towards a future which lies hidden at this point because her expectations are that all is well. With her admission that she is unable to see what will happen, it seems that Amanda's message of confidence and hope could not only offer encouragement to the woman, but also reassure herself in the face of a dark unknown. In addition to orchestrating moral support, there is a need to balance the important role of attending to physical considerations and monitoring the progress of both mother and baby. Whilst Amanda expects labour to proceed without complications, she is mindful of her midwifery responsibilities.

Secondly, the woman trusts her to facilitate her birth at home because of the relationship they have built together during the antenatal period. Much of the trust is tacit, burgeoning from the relationship forged between midwife and woman, but not articulated. Perhaps no words are necessary, just the belief that each can be depended upon, when labour begins, to play their part.

Trust is a cornerstone of the relationship depicted by this midwife too:

Recently, I had a lady who'd had a very bad experience with her first birth — very, very frightened. She had had the monitor put on her at the first birth — routine. She was very, very frightened because she'd had this trace which had dipped and dived in her first labour. She told me that she hadn't wanted the monitor on and the midwife had said to her "Do you want your baby to die?" So she was terrified and I spent a lot of time antenatally talking through that and I got her notes from [the base hospital] and went right back through the whole trace with her. I showed her all the dips and dives and said things like "You were probably on your back there. The variability is really good, although there were dips, probably the cord was round the neck or something, I don't know." When she arrived in labour this time, someone put the monitor on much to my disappointment, because by the time I got there, the baby was having some dips and she was frightened again. Just little quick ones, zip down and up again. Her husband was absolutely anxious, you could just see it pouring out of him, so I took the monitor off and said "Because of those dips, how about I do an internal and we'll see how far you are on, and then if your membranes are intact and you're moving along, let 's rupture them and see what colour the liquor is. If the liquor is clear we won't put the monitor back on, we'll just listen to the baby and we'll get you up and moving and into the shower." So we did that — the liquor was clear. She got up, she got in the shower, we moved her around and she was still frightened. I said "No, you're alright, you're progressing fine". She started to say that she needed an epidural. I said "No, you're just saying that because

that's where you were last time when you had the epidural. You don't need one. Just trust me. You're fine. Your body is doing it, you're just great. Don't fret, just relax." And about an hour later, she delivered. She was totally rapt. Totally rapt. It's so exciting to see women do that.

[Diane, P4/c]

This story celebrates the courage of both the woman and the midwife. The woman is faced with a second labour which seems to echo her first, very frightening, experience. Diane has attempted to prepare the woman for a more positive experience in this labour. In the event, however, the woman finds herself revisiting a past encounter with labour instead. She is put on the monitor on arrival in delivery unit whilst she awaits her midwife. Memories of her previous labour are likely to have flooded back, crowding out any thoughts of the anticipated event for which Diane has prepared her.

The midwife arrives to find a frightened woman and a husband who has anxiety 'pouring out of him'. Such a description conjures an image of a man exuding fear and incapable of offering his wife any help. Now Diane has two people to calm and reassure in the presence of decelerations in the fetal heart rate. Her reaction is to take the monitor off and to assess the baby's wellbeing by viewing the colour of the liquor. As the liquor is clear, Diane makes the assumption that the baby is not distressed by labour and elects to listen intermittently to the fetal heart instead. Although this labour holds the potential for fetal distress to occur, Diane acts on the strength of her conviction that this baby is fine. Smythe (1998) asserts in her doctoral thesis about the meaning of being safe in childbirth that "[t]he Being of safe/unsafe is already there, whether it can or cannot be seen and predicted" (p.129). Diane has considered the possibility that the dipping heartbeat on the monitor was revealing a baby in distress. She is reassured by clear liquor and good progress in labour. She determines that the baby is safe and that her next priority lies with reassuring the woman and her partner. She wants to facilitate a less fearful and more relaxed labour this time. She is prepared to project less concern than she may actually feel onto the couple in order to convey her belief in the woman. As Smythe asks, "Is the happening of safe perhaps an interplay between the 'Being of safe/unsafe and the decisions and actions of the practitioner?" (1998, p.131).

The next hurdle for the woman is that of pain. Diane calls upon the woman to believe her when she tells her that everything is going well and she can do this without an epidural. The force of Diane's belief and her confidence that the woman can do it resonates through this story. These feelings were clearly just as strongly felt by the

woman because, despite her fears, she is able to place her trust in Diane and her skilled support. The resulting birth is a positive and joyous celebration for both the couple and the midwife. Trust plays a vital role in this story. Diane trusts her knowledge of the woman and her instinctive knowing that the labour is progressing normally to provide care that brings the woman back from the brink of panic. The woman, eventually, trusts her body to do it and her midwife to help her head to do it.

Summary

When the midwife works with a woman and her pain in labour, she interprets the pain to make it visible, with the aim of helping her to engage with it rather than flee it. Interpretation has many faces. It judges how she is coping by checking in with her to hear how it feels. It acknowledges the woman's perception of her pain and articulates that to the woman so that she can 'see' it more clearly. To judge coping, the midwife reads the messages from the woman's body and from those of others, such as support people. She also listens to her own embodied response to the pain for she sometimes 'knows' when a labour is progressing normally. She may elect to hold back and continue to listen and watch. The woman's pain may be interpreted as safe by the midwife through the demonstration of her belief in the progress of labour and in the woman to do it. The midwife shows a willingness to believe in the darkness and trust that the light will illuminate the accuracy of her judgement. At other times, the midwife may decide she needs to leap in to provide closer support to a woman. She talks to the woman, explaining what is happening to her and constantly reassures her of her presence. She attempts to anchor the woman with physical and emotional support, sometimes using herself as an intervention. She tunes in to the woman's needs and continues to translate the events of labour as the woman describes her feelings. The goal is to return the woman's being-in-labour to the point where her world is once again ready-to-hand, where she has regained feelings of control and can place her trust in the midwife.

The woman's perception of her pain, and the midwife's interpretation of it, are not necessarily always similar. Chapter Six: Pain in Hindsight contains midwives' accounts of reflecting on decisions. They show examples of occasions where the midwife's management of pain has proved unsatisfactory for the woman. Being with a woman in pain does not always ensure that the interpretation of her pain will be congruent with what she is experiencing.

Chapter Six

Pain in Hindsight

Ask any midwife to relate a story about assessing the need for, and the timing of, pain relief and you will elicit examples that reflect the uncertainty which surrounds this area of practice. Although midwives spend a considerable amount of time working with women and their pain, there is no universal means of effectively dealing with it.

The decision making process can be a difficult one for the midwife. Does the woman really want to change her birth plan now that she is in established labour? Should the midwife accede to a request for pain relief despite her misgivings about its appropriateness in this situation?

The participants in this study all recalled incidents from their practice which have stayed fresh in their memories, even though some occurred many years ago. It seems that some decisions about pain and its management have been the subject of much reflection as midwives seek to learn from their experiences of meeting women's needs during labour.

Getting it 'Right'

There are times when the midwife and the woman combine forces to work through the pain of labour and the outcome is satisfying for all concerned. Barbara recalls one such occasion:

She said right from the beginning that she didn't want anything for pain relief and my heart usually sinks when people say that with their first baby, but she did get on surprisingly quickly and within four or five hours she was fully dilated from about 2cm. I think she was 9cm dilated and she began to lose it a bit and was determined she wanted an epidural at that stage. The head when I examined her was really well down, the cervix had almost gone and she was demanding an epidural. I intimated that the anaesthetist wasn't far away. She went on and had

the baby within 20 minutes, I think. I mean, even if the anaesthetist was on his way and had appeared, she wouldn't have got her epidural. She was really pleased, thrilled afterwards. That's the time when your skills come into their own really and that's the time where you can use a bit of instinct as to whether it's going to happen or not. Someone who is 8cm dilated with an oedematous cervix is very different from somebody who is 9cm dilated with a very thin cervix and the head right down, so to a certain extent you can use your instinct to the good. After it was all over, she thanked me for not arranging an epidural promptly but even if I had done, it wouldn't have been prompt enough.

[Barbara, P2/c]

The midwife in this story used her clinical expertise to assess that the woman was so close to the beginning of second stage that she did not need an epidural anaesthetic. Barbara describes how she assessed the state of the cervix and the descent of the baby's head and went with her 'instinct' that this was a normally progressing labour with very favourable conditions for a quick birth. The woman had expressed a wish to forgo pain relief but changed her mind in the intensity of advanced labour. The chance for a conversation of any length to discuss the options for managing the pain would have been limited by frequent contractions and increasing anxiety. For Barbara, there was little opportunity to remind the woman of her earlier decision not to have pain relief. She was faced with a dilemma. Should she call for the anaesthetist and arrange the siting of an epidural? This was an option Barbara chose not to pursue in the light of her clinical assessment as she knew that it was not necessary. Some midwives would have complied with the woman's request. Perhaps they lack the practice wisdom to gauge the circumstances in context. Maybe they don't have the confidence to provide the intensive backing the woman is likely to need at this time. Should Barbara therefore heed the woman's earlier statement and refuse the request, leaning in with close support to see the labour through? Perhaps some midwives might have taken this approach. They may have relied on the force of their personality and the degree of trust built up to work hard with the woman in pursuit of a birth experience which she had expressed a determination to achieve. Barbara, however, chose a middle path. She gave the impression that the epidural was being arranged, which probably helped the woman to take heart amidst her growing panic. Then Barbara stepped in closer to the woman with encouragement and support. The baby was born very quickly. Once safely on the other side of birth, the woman is delighted with the strategy of procrastination and elated that she didn't use pain relief.

Arendt (1978) writes of the difference between doing and understanding. She suggests that, in order to judge and to derive meaning from a situation, a person must withdraw from direct involvement in it. In order to cast a dispassionate eye over something, and more importantly, to see it in its entirety, the actor must become the spectator. It seems that midwives need to adopt a spectator role at times in order to see the bigger picture. When Barbara was faced with the decision making over pain management, she looked at it through spectator's eyes. She elected not to comply with the woman's wishes. She opted instead to allow the woman to *think* an epidural was imminent because Barbara's summation was that *birth* was imminent.

When a birth plan needs to change during the course of labour, the midwife may be required to advocate for an alteration in thinking. A woman can be very determined to follow a certain course and sometimes it is the midwife who helps her to realise that circumstances have changed. Catherine describes a situation such as this which demanded skilled handling:

I looked after a wonderful young woman who really wanted an uninterfered-with birth and it became an absolute marathon that went on and on and on and on and on. She was just incredibly noble and great about it and for the first time ever (and this was maybe within the last three months) I really felt she needed an epidural and some pain relief. I could see she was exhausted and that she really needed to rest so that her body could recover and she had a chance of birthing her baby normally and she had a real struggle about the need to take pain relief on board. Even though she was beside herself and exhausted, for her it was a major thing of having to give up her autonomy and to take on pain relief that she hadn't wanted to use. So it was the pot calling the kettle black in a way (laughs) and I had to support her and persuade her that there was actually a place for pain relief in her labour. Once she had the pain relief she could reflect and see that, yes, she really had reached the limits of her coping, but I think that she had got past the point of recognising that. So that was sort of a reversal of pain relief The labour continued to be extremely difficult and she needed an assisted birth at the end of that time and I think that because she was rested she achieved a vaginal birth which she may not have done. So, of course she regretted that she hadn't had the easy birth we 'd have all loved for her, but she didn't regret the decision to take on pain relief because she could see that she had needed it at that point in time.

[Catherine, P3/h]

The concept of lived time resonates through this story (van Manen, 1990). Heidegger uses the term 'temporality' to refer to Dasein's existence (1962). Gelven (1970) summarises his thinking on the link between our Being-in-the-world and time saying,

"To be is to be in time" (p.225). Heidegger argues that Dasein (Being-in-the-world) is only possible with the dimensions of time to provide meaning for its very existence. We need the elements of future, present and past to make sense of our dealings with the world in the mode of ready-to-hand (Gelven, 1970).

Catherine finds herself in the unfamiliar position of advocating pain relief for a young woman who has bravely endured a long and arduous labour. In the face of a slowly progressing labour, Catherine sees that the woman has reached a point where she is too tired and too stressed to continue. While the woman's preoccupation lies very much in the present as she confronts her contractions, part of her mind remains focussed on the past. It is in this dimension of time that she determined her intention to forgo intervention for her birth. In spite of the length of her labour, her resolve is rock solid. She wants to tough it out.

Catherine is in a quandary. She admires the woman's stance and wishes that outcome for her, but also knows that the time has come for a change of plan. In addition to the present lived time, she is orientated towards the future - that is, the hours of labour still to come and the birth itself. She knows that the opportunity to rest which an epidural is likely to bring is important if the woman is to achieve a vaginal birth. She is also aware of the irony inherent in this scenario as she quietly sets about helping the woman to see her situation through new eyes and to accept the need for the relaxation and pain relief. In retrospect, the woman could acknowledge the necessity for the epidural and perhaps this intervention helped to avoid a larger one – Caesarean section.

On some occasions, the midwife makes more unilateral decisions regarding pain management. She recognises a need to 'leap in' with some women, as this story illustrates:

A primip, just a tiny little girl and when I did the examination she was 4 cms and the head was well down and she had SROMed. I gave her some pethidine and she slept for about 3 hours and woke up fully. For her, having that rest was really important because she was able to push the baby out. The times when I went into the room to check on baby, she was sleeping but when she got the contraction her breathing changed. It was really good and I didn't want to disturb her too much. She had no antenatal education or anything either so she didn't know what to expect.

[Evelyn, P5/h]

This story seems to demonstrate how a midwife has made a decision to manage a young woman's labour in order to best serve that woman's interests. Evelyn describes a young and physically small woman who has not attended antenatal classes and the inference seems to be that she may be frightened and ignorant of what lies ahead. Following a vaginal examination which indicates that the labour is progressing well and the baby is in a very favourable position, Evelyn administers pethidine. For a woman of her stature, the usual dose of pethidine would have a marked sedative effect and this woman dozed for the remainder of her labour. Evelyn was pleased with the effect of the pethidine in giving the woman a rest and strove to disturb her as little as possible.

The woman's voice, however, is not present in this story. How did she feel when the pethidine was working? Did she feel rested as the effects began to wear off? Would she opt for pethidine in a future labour? Did her baby have any problems with good latching if she chose to breastfeed? Would she have called this a 'right' decision?

Getting it 'Wrong'

There are occasions when the midwife decides on a course of action in response to pain in labour which disappoints the woman. Gemma relates an example of a challenging situation that has caused her to reflect:

I recall a woman who had previously had a baby in America with an epidural. She came in [to Delivery Unit] and she said that she wanted the epidural now. I said "Well, there's a few things we need to go through; we'll just do a CTG trace, and an assessment and see how you're progressing" and she was 7 or 8 cms. And she was "I want the epidural, I want the epidural, I want the epidural" and I said, yeah OK I actually did call the anaesthetist but when he called back, I said don't bother because she was just about ready to deliver. Afterwards, I was bit concerned about it, because she was still quite angry that she didn't get her epidural and she said that she didn't like not being in control of the situation. She didn't like the way that she spoke to her partner and to everybody and she didn't like not being in control. But, you know, on the other side, two hours later she went to one of the outlying units. She wouldn't have been able to do that. I talked to her about that afterwards and I would hope that on reflection she would be happy with the outcome, but I'm not sure about that. I thought, I wonder if she'll actually complain about that, because she didn't get what she wanted. But there was really no time — the time had gone too quickly.
[Gemma, P7/b]

In a sense, both Gemma and the woman were beaten by time in this story. Gemma feels that she was unlikely to have been able to arrange for the epidural to be sited before the

woman was in second stage. Events moved too fast by the time she had completed her assessments. The woman seems to have had insufficient time to adequately convey the urgency with which she wanted something done to quell the loss of control she felt. She may have experienced echoes of that feeling from her first labour and have remembered how the epidural helped her to regain her equilibrium. The absence of an epidural in this labour may have been more keenly felt as pain and fear spiralled within her and she strove to maintain a sense of control. Niven (1994) reported that control is closely associated with feeling in control of emotions and behaviour in labour. However, she was in advanced labour on admission, and perhaps unable to do more than repeatedly demand an epidural in the short periods between contractions. It could be that her body language concealed the panicked feelings from Gemma, who only heard the spoken requests. The woman that Gemma saw in front of her was, in her assessment, progressing rapidly towards a normal birth and any signs of distress were congruent with someone who was coping adequately.

So the woman's pain was being interpreted by Gemma as manageable, whilst the woman's sense was that she was losing control and was afraid. Munhall (1994) describes how the perception of an experience is "what matters, not what in reality may appear to be contrary or more 'truthful' (p.16). The interpretation of an experience from the individual's unique perspective is critical. For this woman, the perception of labour may not be of the pain so much as a perception of loss of control which she could have discerned as being far worse than feeling pain. Gemma's interpretation of the woman's pain and the woman's interpretation were different.

Would another midwife have 'seen' the same picture? Would she have 'heard' panic behind the words that the woman used? Was there a 'right' decision in regard to pain management for this woman?

An absence of pain relief may not, however, be the only source of disappointment for a woman in labour. As this story illustrates, a midwife may be castigated by a woman because she complies with her request for pain relief:

I had a woman who was a multip and she had had a normal delivery with her first baby. She was very far advanced in labour with her second baby and she got quite aggressive. She wanted an epidural and she was kind of absolutely grippingly saying I want an epidural now. She was obviously anxious that I was going to try to persuade her to delay this decision and she got quite cross. I put a drip up and she thought I was procrastinating and then I had to go and call the anaesthetist who had to come in because they're not on site in the middle of the night. As the epidural was going in, she had a strong urge to push and the baby was born. She then asked me afterwards why didn't I examine her, because if I had, then she wouldn't have had an epidural. But it wasn't actually possible to examine her because she was so agitated and intent on the epidural that I felt that if I had even offered her an examination, she would have felt it was tantamount to an assault or another delaying strategy. So that was a dilemma because it would be my normal response especially with a multip to say "Look, let's just examine you and we will probably find that you are 8 or 9 centimetres and, sure this is going to be the tough bit, but we will get through it. Maybe even one contraction later and you'll be ready to push. "

She was really upset about that and probably the only woman who has felt that I hadn't handled the pain management well enough. I think it was a situation where I was damned if I did and damned if I didn't. It was such a shame because she had a beautiful delivery on her hands and knees. But she couldn't let it go afterwards. There is this conflict because when they're in pain they want to get rid of it but also they can get disappointed afterwards that they weren't actually able to cope better and I suppose maybe that is our skill as a midwife to pick it up. But it's very, very hard because women have got the right to change their minds in labour and they have got the right to have their pain needs addressed and who are we to deprive them if they are in a hospital?

[Amanda, Pl/c]

Amanda describes the woman 'aggressively' and 'grippingly' demanding an epidural in advanced labour. As a result, Amanda complies with a haste that isn't typical of her practice. Then the woman blames her for the poor timing of the pain relief because birth was imminent. Could the woman's lingering sense of disappointment be related to the loss of control she seems to have felt late in labour? Her interpretation of her situation is sufficiently grave for her to cry out for an epidural and Amanda feels compelled to comply despite her own interpretation of events suggesting a different approach to pain management could be more appropriate. The woman's pain belongs uniquely to her. She is utterly alone with it on one level and cannot share it. The pain is only felt by her and she cannot really convey to anybody what she is experiencing (Illich, 1976). In the

presence of pain, Illich (1976) asserts that questions are always raised by the person enduring it. These are queries such as "How much longer?" or "Why must I suffer?"

This woman seems to have been unable to look beyond her pain 'now' and recognise that the labour is nearly over. Amanda feels compelled to acquiesce to her request. But it appears that Amanda's decision 'now' has implications for 'later'. Her compliance with the woman's request for an epidural was the right decision at the time in the woman's eyes. Time held no relevance when pain was consuming her rational thoughts during labour. Now she has time on her hands. Time has assumed an elongated shape like a loop. She can review the final scenes from her labour at a safe distance and see possible alternatives to her management. These scenes play over and over in her mind.

Subsequently, that correct decision seems to have become a wrong one. Over time, the wisdom of a course of management can be judged and found wanting. The disparity in the interpretations of both the woman and Amanda is apparent. In the 'darkness', when the woman didn't know how long it would be until the baby was born, the decision appeared to be the correct one. In the 'light' following the birth though, she could look back and 'see' that the epidural wasn't needed. This results in a sense of disappointment for the woman that she 'couldn't let go afterwards'.

The decision to do a complete about-face on an important issue such as chemical pain relief is one that any midwife reaches with considerable trepidation. How close to the edge of coping is the woman? Does she really want pain relief? Will she still feel that way when the baby is born? How easy is it to look into the future when determining how pain will feel? Is it OK to change your mind in the light of the pain now? How does the midwife know which is the right option – the fruit of the antenatal discussions contained in the birth plan, or the plea in labour now? Frances describes a dilemma regarding pain relief where her response was not appropriate in the woman's eyes. She clearly thinks that Frances made the wrong decision:

This woman was a midwife and she was having her first baby. She had chosen me because she was considering a home birth but in the end she opted for [a hospital without epidural facilities]. She told me about her philosophy, particularly with primps. I remember her saying that she'd be quite tough with them and really push them to achieve a normal birth, rather than going to [the base hospital] for an epidural. So I really believed that her philosophy was to

encourage the woman to use all her resources to get through the birth and to feel good about it if she 's achieved the birth without any drugs.

The birth plan changed a little bit because she SRMed and didn't go into labour.

When we started the Syntocinon she was already 4 cms dilated and fully effaced.

So we just used a little bit of Syntocinon. I can't remember what we got up to,

but it was a very minimal dose and she progressed quite fast. She got to about 6

or 7 cms and was feeling a bit distressed, so I said "what about a shower?" She

was quite happy to try a shower and progressed quite fast in there. She asked for

pain relief again, when she was obviously in transition and I felt a little bit

worried that maybe I was pushing her a bit hard. She felt like she wasn't coping

but to look at her she was coping as well as any primip ever does (laughs) in

transition. I guess it was a case of me knowing her a bit better and feeling more

emotionally involved and I went out to the charge midwife and checked out

25mgs of IV pethidine. The charge midwife said to me "Look, don't give it. I

can't believe you're giving that because [this person] would probably feel better

if she didn't have it in the end and people come to you because they don't want

the drugs." So I went back in with the thought that maybe I should withhold it.

The woman was getting quite distressed but she was almost fully dilated. I said

"Let's wait". I think at that stage I made the wrong decision because she did

wait but a little bit later she got more distressed and I gave her the pethidine. By

then she was obviously fully dilated but I felt that she needed that little bit of

help. It was interesting then that, although she was obviously getting a lot of

expulsive contractions, she wouldn't push. She stood up and was walking

around the bed but she was holding on to that baby really tight. Eventually, she

gave birth really well, had a normal delivery, bounced up afterwards, got into

the shower and did the midwife's thing of almost doing her own postnatal and

baby care (laughs).

So things went well for the first few days and then she had a lot of trouble with

postnatal depression. It was during the talking when she was depressed that she

told me that she felt really angry about not being given an epidural and the

feeling of being out of control which she hated. She really wished that I'd

listened to her and had done what she asked because she remembered the

experience as very traumatic. She even used the awful words "I feel like I've

been raped at birth". And yet, to look at what happened (and there was another

midwife colleague there), you would have thought it was a really lovely primip

birth. We know now that there is a lot of history which we knew nothing about at

the time. When she said that she felt like the birth was a rape I felt so cruel, like

I'd really violated her. It knocked my confidence for a while with primips

because I thought if that's what I'm doing by pushing them to do it without

drugs, I'd rather use more epidurals. It still is very hard to feel that I had

allowed her to experience something so traumatic when I could have made it so

different by going along with the epidural. But looking back, I don't really know

how I could have acted differently because it's certainly not normal practice to

get an epidural when someone 's nearly fully and progressing well.

[Frances, P6/h]

This story highlights the tenuous ground that a midwife sometimes traverses when supporting someone through labour. The woman was a midwife with very clear ideas about the kind of birth experience she wanted and she sought a partnership with a midwife who practised in a philosophical paradigm which she endorsed.

Frances' assessment of the woman following her request for pain relief was congruent with a primigravida in advanced labour who was coping 'as well as any primip ever does'. What the woman was feeling seems to have been a different story. She felt out of control and she hated that feeling. She wanted pain relief. Why was an experienced midwife unable to differentiate between a woman who was coping, albeit working hard, and a woman who was no longer coping and needed pain relief? Perhaps the woman's exterior demeanour was at odds with her inner turmoil.

Heidegger defines the word 'phenomenon' as "that which shows itself in itself" (1962, p.51). However he goes on to point out that a phenomenon or 'entity' can sometimes "show itself as something which in itself it is *not*" (p.51). This form of entity he terms a "semblance" (p.51). In other words, something may seem to be one thing, but, in fact, only bear a resemblance to it. When Frances saw the woman in labour, it looked as though she was coping, but this may have been merely a semblance of coping, for she was feeling panicky and out of control. The semblance of coping hid the alternative picture from her. Frances therefore based her decisions and her actions on the reality she perceived - that is, a woman coping well in advanced labour, with whom she shared an understanding that she wished to avoid pain relief if at all possible. Perhaps the woman was so overwhelmed by the strong contractions that she was unable to articulate sufficiently forcefully just how she really felt. Maybe she thought she conveyed her views with conviction, when, in fact, the impression gained by the midwives present told a different tale.

Munhall (1994) states that "meaning is found in the transaction between an individual and a situation so that the individual both constitutes and is constituted by the situation" (p.16). The woman in this story is in labour. She brings to it all her knowledge of labour from her work as a midwife. She also brings her own expectations of what labour will be like for her and the memory of her discussions with Frances which may have helped to shape them. The word 'labour' also holds meaning for her as a cultural and social event in this society. The woman expected pain to be a part of her labour. She also expected to be able to cope with the pain sufficiently well to avoid pharmacological pain relief. At some point in her labour, things changed and she understood that she was no longer able to keep to that plan. Gelven (1970), writing of Heidegger's teachings, explores the link between understanding and interpretation, saying "Understanding functions through the projection of possibilities. In interpretation, understanding *works*

out this projection. So the chief function of interpretation is to make explicit what is already within the range of human awareness" (p. 92). By this I understand him to mean that the woman could see the possible paths her labour might take depending on whether or not she elected to have pain relief. After reviewing the options, she worked out her preference and it was chosen from a known set of options. Gelven (1970) goes on to say "...one first has meaning, and then expresses that meaning verbally" (p.97). So, deriving an understanding of her situation, and then interpreting it to mean a change of birth plan occurred first. Next the woman spoke to Frances of her feelings of loss of control and asked for pain relief. Frances' interpretation of the woman's words and of the embodied response to the contractions was different to the woman's. The lack of congruence between what she was saying and how she appeared to Frances added to Frances' dilemma. There is a suggestion in the story that information which surfaced after the baby's birth may have affected the way that the woman felt about labour and, indeed, this knowledge could have altered Frances' response to her request for pain relief.

However, the result is a woman who seems to have been pleased with her baby and buoyant about her experience. Over time, though, she has reflected more on her labour and now feels violated and angry. Perhaps her need to use pain relief is now a cause for guilt. In a sense, the pain of labour hasn't gone because she is reliving it constantly and harbours a hurt which time hasn't alleviated.

The hurt also lingers for Frances who is left with the feeling that she has failed the woman. The meaning that she drew from the woman's behaviour during labour was, it seems, a very different interpretation of what the woman was truly feeling.

Summary

The woman experiencing pain in labour does so in a primordial sense. She *lives* the experience. The way she exhibits evidence of that pain, through her facial expression, her moaning is an interpretation of it. So too, is any attempt to render the pain understandable through description. This interpretation of pain is then further interpreted by an onlooker, such as the midwife. She watches the interpretation of the original experience or listens to the words used to depict the pain and draws her own meaning from this. Sometimes there is sufficient congruence between the woman's

interpretation of her pain and the midwife's interpretation of that perception for there to be 'right' decisions made during labour.

At other times, the midwife's interpretation of the woman's pain is too different and the potential exists for the decision about pain management to be 'wrong'. Maybe there is a disparity between the woman's body language and the words she uses which confuses the midwife. Maybe the woman, alone with her pain, is unable to adequately convey the meaning of her pain. Sometimes the midwife is misled by a semblance of coping behaviour when the woman actually feels alarmingly close to losing control.

For some women, a 'right' decision now can be 'wrong' later. Her own interpretation of pain can alter with the benefit of hindsight and she may regret a decision that she willingly embraced when the pain was present. And for some women, it seems that the pain doesn't go when labour finishes. A sense of hurt lives on in their disappointment and the hurt can also live on with the midwife who tries to make sense of getting it so wrong.

Chapter Seven

Discussion

In the three preceding chapters, I have presented data from the participants and offered my interpretation of their narratives. The data 'fell' into three distinct areas for analysis — before, during and after the pain. From these many parts of the phenomenon of midwives' experiences of working with women and their pain, three themes emerged. They interweave throughout the data chapters and help to draw the parts towards a central finding — the essence of the phenomenon. The themes are 'leaping ahead/leaping in', 'working with time' and 'believing'.

The hermeneutic circle is the term used to describe the way that the parts and the whole are inseparable and inform new understandings of each other in a never-ending cycle of further comprehension (Crotty, 1998). As I engage with the hermeneutic circle during this chapter, I will show how these themes have revealed themselves and how they enabled me to reach an understanding of the central finding of this study. This is the essence which derives from the Greek *ousia*, meaning the "true being of a thing" (van Manen, 1990, p.177). In the course of this discussion, I will address the implications for practice, research and education which suggest themselves from the findings of this study.

'Leaping Ahead' and 'Leaping In'

The provision of information to prepare women for their pain during labour appears to be one of the main tasks performed by midwives in this study. Several participants talk of how they try to help a woman perceive what the pain might feel like in the expectation that prior knowledge will assist her coping skills.

The nature of the way in which midwives work with women and their pain in labour revolves around the relationship between the two. Central to the interaction by midwives is the concept of 'showing concern for' that Heidegger calls solicitude (1962).

Much of the everyday nature of solicitude consists of deficient or indifferent modes of care, he tells us. One extreme form of solicitude, in its positive mode, he terms 'leaping ahead'. By this he means that care 'leaps ahead' of the 'other' to help them see themselves in their care and then to give it back to them.

Amanda suggests that there may come a time during labour for a woman contemplating a home birth when she will say *that it's too much*. She is anxious to avoid a situation where transfer to a hospital with epidural facilities is required. She talks with the woman about the difficulties involved in such a step and concentrates on helping her to think about what labour might be like and how she and the woman can employ various strategies to combat pain. By 'leaping ahead' to show the woman what the future might contain, Amanda hopes to make such a course of events recognisable for the woman so that she is prepared for them and can engage in decisions about her pain management if they arise. Gunn identified the provision of "anticipatory information" as a key midwifery activity with its goal of fostering calmness and confidence in women about their bodies and about childbirth (2001, p.125).

'Leaping ahead' is generally described by midwives in this study as part of their antenatal preparation of women for pain. 'Leaping ahead' can be seen as a ploy adopted by midwives to empower women during labour. Another example of 'leaping ahead' can be glimpsed in the concern Amanda expresses about men providing support for women without their own back-up. She talks of men who *crumble* at the sight of their partner in pain. Her experience is that they *often do need to have support and that helps them put things in perspective a bit because the responsibility is not 100% theirs*. Amanda knows that a 'crumbly' man may result in a 'crumbly' woman who is unsettled by the loss of a reassuring presence. By highlighting the need for adequate support to the woman, she may ensure an effective support team is in place before labour begins. Raphael-Leff (1991) suggests that men in our culture are often ill-prepared for the transition to fatherhood which involves feelings of powerlessness associated with observing women in pain.

'Leaping ahead' is also apparent in accounts by midwives during labour when they try to anticipate what a woman might be feeling and explain it to her. Catherine says: *'What's happening for you?' ...When I get the feedback from her, then I'll interpret what's going on for her*. Although this example of 'leaping ahead' will be acted upon

almost immediately, there is still the intention to illuminate an area of darkness and unknowing to allay fears and enable more active participation by the woman in her childbirth experience. Gibbins and Thomson (2001) found that feelings of self-control are closely linked to information conveyed by an encouraging and supportive midwife.

'Leaping in', by contrast, is a way of executing care which is much more directive. It conveys a sense of taking over, doing things for the 'other' in a situation of more urgency. Midwives in this study related times when it was necessary to 'leap in' during labour. Gemma describes such a time: *She was just completely screaming and wanting to jump off the bed with contractions ...I stepped in finally and said "I think you need pethidine."* Gemma has taken over the decision making in the presence of a woman who has lost control due to pain. Such an action may be totally justified under the circumstances as the woman is unable to converse, let alone discuss options for pain management.

'Leaping in' may sometimes involve the midwife using her physical presence to work with a woman in pain. Catherine says: *If I find a woman is starting to get a bit screamy, and you sense there's a panic there, I'll immediately go in and I'll anchor her. Sometimes I'll put my hand on her chest and just say, "Slow yourself down and just come back into yourself Don't spin out, you're alright, slow yourself down.* Catherine is trying to transmit a sense of calm and a reminder to the woman of her supportive presence by her touch and her words. She wants the woman to realise that she is not alone in her pain and her fear. Halldorsdottir and Karlsdottir found that the ability of the midwife to make herself emotionally available to a woman in labour was of crucial importance (1996).

These words from Diane also illustrate how 'leaping in' with 'self can be a powerful intervention for a woman in pain. *I put a lot of hot water on her back, a lot of pressure, a lot of rocking, a lot of holding, a lot of coaxing, a lot of stroking, my voice in her ear.* This midwife is physically and emotionally present in this woman's pain. She describes all the practical measures she employed and also the constant explanations and reassurance for the woman. Continuous support has been categorised as a form of pain relief by some researchers (Dickinson et al., 2002) and an account such as this shows how this could be so.

There are also times when not 'leaping in' is required. The midwife may make a conscious decision to hold back, to bide her time. Evelyn describes her conflicting thoughts as she watches a woman in distress: *There are times when I feel that the woman does need something. But I've got to hold back and not say anything because I don't want her to distrust herself... I must not say anything that's going to affect her dealing with it. So if she cries, she cries and she'll let me know.* It can be hard to sit and watch when one's instinct may be to 'leap in', but one way of working with a woman and her pain seems to involve trusting her to determine when she needs more midwifery input.

Working with Time

The notion of lived time threads its way through many of the narratives in this study. The context of time is always present in the way that midwives help women to interpret their pain in labour. It is more apparent on some occasions than others.

There is a sense that time is somehow different for the midwife who practises in a home setting compared to a hospital: *There's less time pressure. People are not watching the clock...so I guess it makes you feel more relaxed as a midwife. It's a two-way thing isn't it, if you're feeling confident and relaxed, then you work better with the woman and are more able to help her feel confident and relaxed.* Frances is able to relax in an environment which doesn't make demands on her to practise in a certain way because of the passage of time. Diane speaks of a similar feeling: *In the hospital you've always got these deadlines, like "She was 4cms at 2 o'clock, why isn't she fully now?" At home...you go and have a sleep or say "let's go out and feed the chooks."* Time seems to progress in a more leisurely way at home in the expectation that labour is progressing normally and does not need to be measured against the time constraints that often dictate progress in a hospital setting. One of the findings from Hunter's (2000) study comparing intrapartum midwifery care in small maternity units with large obstetric settings was that midwives were conscious of "being bound to a timeframe" in an obstetric hospital (p.129).

Midwives in this study understand how a woman's experience of lived time alters when the pain of labour starts. Catherine tells us why she thinks the first part of labour is often the most difficult for women *because they're very intellectually 'there'... Once they get further up the track in their labour, then they go into 'dozy land' when the endorphins*

are released. Women progress from a state of heightened awareness of each contraction and how often they are coming in early labour, to a stage where lived time assumes an altered dimension. Time as measured by the clock no longer holds the same meaning as the rhythm of contractions take over. Midwives in this study relate examples of working with time as they support women in pain. Amanda breaks time down into small segments when she is faced with a woman who is beginning to doubt her ability to continue without pain relief. *They want to know "how much longer am I going to be at this point?" and I don't know and they don't know, so I think you have to contract with them and say "well, let's do a, b, c and d and then review the situation in ...forty minutes time.* Lived time has slowed for the woman in pain and Amanda tries to adjust her outlook from the distant horizon of her future to a closer future, forty minutes away.

Paradoxically, some midwives invite women to see their pain in terms of small units of time while, at the same time, helping them to take a larger overview of their labour. Barbara says: *Just really jolly her through, one at a time, one contraction at a time, not looking too far ahead. I tell her not to be overwhelmed by it because very soon it's going to be over and in the past.* Barbara is describing how she marks the passing of each contraction to show the woman that time is passing as she realises that, for the woman, time may appear to be almost at a standstill. However, she is also encouraging her to widen her perception of time in the 'now' to encompass her future when the pain will have gone. The ever-present temporal dimension to our being-in-the-world is the continuum of past, present and future which we all occupy (van Manen, 1990).

Lived time can work in the midwife's favour at times. On occasion, a woman will request pain relief at an advanced stage of labour. Sometimes, if her request is met, the woman will regret this measure when the pain is over and harbour lingering guilt or anger. The midwife can be in a difficult position when faced with such a request. Barbara *intimated that the anaesthetist wasn't far away* when she was sure that delivery was imminent. The woman gave birth and afterwards *she thanked me for not arranging an epidural promptly enough but even if I had done, it wouldn't have been prompt enough.* Events happened too fast for the woman to get her epidural and Barbara's gamble in not requesting one paid off as the woman was delighted with the outcome. On this occasion, her interpretation of the woman's pain was congruent with her own.

This is not always the case though. Another midwife in a very similar situation, can make the decision to send the anaesthetist away because the woman is about to deliver. Gemma was worried afterwards though *because she was still quite angry that she didn't get her epidural and she said she didn't like not being in control of the situation...But there was really not time — the time had gone too quickly.* This woman's reaction after the birth is the opposite to Barbara's woman. She is angry and it seems that her displeasure relates more to her distress at feeling out of control; a distress that Gemma appears not to have been aware of. There was sufficient time, in her eyes, for an epidural to be sited. Gemma's perception of time is different. She sees beyond the present to the impending. It seems that the interpretation of pain differs according to their perception of lived time.

The perception of time is one that can remain with women following labour. A decision about management of pain during labour which seemed correct at the time can come to be viewed less favourably in hindsight. Amanda describes a woman who demanded, and got, an epidural just before birth and was later disappointed in herself and her midwife. *She couldn't let go of it afterwards...I think it was a situation where I was damned if I did and damned if I didn't.* With time to reflect, the implications of the woman's decision seem to have changed her perception of it from being right to being wrong. Time, and the absence of pain now, allow her to 'see' in the 'light' following the birth that the epidural was unnecessary.

When the midwife's interpretation of the woman's pain is not congruent with the woman's, there may be times when the pain does not leave although labour is over. In the story Frances tells, the woman feels like *I'd really violated her.* The woman is constantly reliving her pain and anguish because time has looped back upon itself. The hurt she feels is also shared by Frances who carries this experience to every labour with her now.

Time is a constant companion of the midwife as she works with women and their pain in labour. It may be apparent in the hands of the clock on a hospital wall or merely glimpsed in the lengthening of the sun's shadows at home. Time may crawl by for the midwife who is *sitting and watching and waiting* or it may fly past unnoticed as she is *very positive and very encouraging and giving them lots of feedback about what's happening.* Time is used by the midwife in its temporal dimension as past, present and

future. Time can be a midwife's friend when the arrival of a baby replaces the urgent need for pain relief. Time can also be a midwife's enemy when her interpretation of a woman's pain differs from the woman's interpretation of it and the pain persists after labour has finished.

I am very surprised to find almost no reference to these notions of time within the midwifery studies I have read in the course of this study. In two instances, I found short comments from women which directly mentioned time. Two participants mentioned the overall length of their labour being shorter than they had expected (Gibbins & Thompson, 2001). Halldorsdottir and Karlsdottir's (1996) study contained a reference by one participant that labour seemed never-ending. In neither report did the authors discuss time as a part of the midwife's daily practice. Given the numerous examples of how midwives work with time presented in this study, the apparent absence of references to time in other work is startling. This may highlight an example of the everydayness of this aspect of practice being passed over, almost unnoticed because of its very familiarity. It is precisely this uncovering which a phenomenological approach aims to achieve.

Believing

Another theme to emerge from the participants' stories in this study is the sense of belief that midwives employ when working with women and their pain. There seems to be an inner conviction within some midwives which communicates itself to women and incites them to call upon something inside themselves when they are at their most vulnerable.

The accounts of prisoners-of-war mentioned in the Literature Review chapter have a particular resonance in the context of some of the narratives in this study which seem to describe a sense of belief by some midwives in the woman's ability to cope with labour. Frankl (1985) recalled a prisoner who had dreamed that their camp was liberated at war's end on 30 March, 1945. The prisoner confided the content of his dream to Frankl in late February as he excitedly awaited the end of March. Two days before March 30th, news filtered into camp that appeared to dash all hopes of the allies liberating their camp within 48 hours. On the following day, the prisoner suddenly developed a high temperature. On March 30th, the day his suffering was supposed to end, he became

delirious and lost consciousness. He died the next day, to all intents and purposes, from typhus.

Frankl survived the war and returned to his former profession, psychiatry, where he developed a revolutionary approach to psychotherapy known as logotherapy. He was heavily influenced by the suffering that he had witnessed and attributed his own survival to the recognition that the individual holds the key to the manner in which he faces up to conditions or gives in to them (Frankl, 1985).

A similar tale of triumph over atrocious adversity being adapted for life under more normal circumstances is to be found in reading about the Stockdale paradox. The paradox is described in a book examining why some companies make the transition from doing quite well to becoming very successful, while other companies struggle with mediocrity and ultimately fail (Collins, 2001). From this unlikely source comes the remarkable tale of Jim Stockdale, an American prisoner-of-war in Vietnam who was tortured repeatedly over his eight-year imprisonment. Stockdale was the highest ranking US officer in captivity during this time and he proved to be an inspiration to other prisoners by his courage and obstinate refusal to be cowed by his captors. He never doubted that he would survive his imprisonment but, when asked who didn't make it, he replied "...the optimists. They were the ones who said, 'We're going to be out by Christmas.' And Christmas would come and Christmas would go. Then they'd say, 'We're going to be out by Easter.' And Easter would come and Easter would go. And then Thanksgiving, and then it would be Christmas again. And they died of a broken heart" (Collins, 2001, p.85). Stockdale believes that what separates people is not the presence or absence of difficulty, but how they cope with the inevitable challenges of life. He found that he had to retain faith that he would prevail in the end and at the same time confront the brutal facts of his reality. This apparent paradox was the key to survival for him, and it is now applied to companies to assess whether or not they will flourish.

It seems that some midwives adopt a similar approach to labour support. They have the utter conviction that the labour is normal and that the woman can cope. They also realise that the woman has fears or doubts and they need to convey their confidence and certainty to the woman. They demonstrate belief in the process and in the woman, and often it gives the woman courage to endure. This could be another manifestation of how

midwives interpret pain for women. Diane says to a woman at home in labour whose resolve is faltering: *You wanted a normal birth, you wanted a home birth and that's what you're having. So I want you to say this 'I'm having a normal delivery and I can do this'.* And she did, of course. The forcefulness of the reassurance and the explicit faith expressed in the woman, results in a lovely home birth and a woman who *just changes instantly from being this frightened person to being this 'Oh, I can do it!'*

Leap (1996, 1998, 2000) has written extensively about the concept of 'normal pain' to characterise normal labour. Her study highlighted the participants' attitude towards pain in labour as something almost always manageable by women if it was a normal labour. This supreme confidence in the woman's ability to cope and the midwives' certainty that they could provide necessary support appears to be echoed in some of the narratives in this study.

Sometimes midwives impart their belief in the woman in the apparent absence of any need. Catherine tells of a seemingly self-contained woman who *was completely composed in labour and didn't seem to need much input, but I was doing my usual talking her through and when I sensed her getting stretched, just anchoring her again.* After the baby was born though, the woman became much more animated. *When you were saying the things you were saying to me in labour, even though I wasn't responding to you because I couldn't – it was too intense, that was really important to me.* Midwives seem to know when to offer intense support even if they are unaware of a conscious need for it. Through their interpretation of a woman's pain they can boost her ability to cope.

A midwife's belief in a woman's capability to give birth can erode if she allows doubt to creep in. This doubt can extend to her own confidence to work with women and their pain. Diane recalls: *I had more epidurals than I normally would have... my confidence had gone a bit...perhaps they do need an epidural. I started to doubt myself, doubt the process.* The midwife's ability to interpret a woman's pain could be affected by the infectious nature of misgivings creeping in.

Many of the participants in this study articulate the importance of believing, in oneself and in the woman. Trust is likely to result from a platform of belief. A sense of trust is essential to any successful midwifery partnership. Amanda talks about working with

primigravid women at home in labour and the expression of believing they need: *You have to take a few risks in saying things like 'you are getting there' and 'you will be fine and you are going to have a baby soon.* The midwife's message of confidence and hope is offered to the woman, but maybe it also gives the midwife heart to hear the words. The midwife's ability to express fearless optimism, tempered by constant vigilance, seems to be encapsulated by Diane in her story about the woman in her second labour who was terrified about possible fetal distress again. *She was still frightened... She started to say that she needed an epidural. I said 'No, you're just saying that because that's where you were last time when you had the epidural. You don't need it.* This display of belief in the woman carries her through labour and *she was totally rapt... It's so exciting to see women do that.* It is also very exciting to recognise the impact that a sense of belief can have. This aspect of a midwife's work with women and their pain is not always apparent.

What Really Matters?

As I seek to draw the parts of the data together towards a whole, I have tried to isolate the insights which have emerged from the data. What are the significant findings from this study?

Heidegger's notions of 'leaping ahead' and 'leaping in' encapsulate the gamut of midwifery support engaged in by this study's participants when working with women and their pain in labour. 'Leaping ahead' has an anticipatory purpose and is often employed before the pain begins by a midwife working in partnership. A desirable outcome would be for the woman to recognise and make sense of her pain as a result of the knowledge acquired before labour. 'Leaping in' describes the action of taking over for a woman, usually in pain, to re-assert a degree of control. This can be achieved by both the physical and emotional presence of the midwife. Both 'leaping ahead' and 'leaping in' are examples of how midwives help women to interpret their pain.

Working with time is revealed by the participants in this study in a variety of ways. Midwives experience time differently according to the setting for birth and this also affects the way that women encounter their pain. The hospital environment is one where surveillance, actual or imagined, impinges on the midwife's way of practising. There seems to be a different perception of time when labour occurs at home. Midwives use time when they work with women's pain. They break time down into smaller parts to

encourage women to focus on the present and not look too far towards the future. It seems that the interpretation of a woman's pain by the midwife is enhanced by the use of time. The woman can be helped to draw meaning from her pain and maybe to view it as safe and endurable.

On occasion, the midwife can be beaten by time. The rapid progress of a labour can overtake any chance of meeting a request for pain relief. This can result in a woman being delighted with the management of her pain during labour, or disappointed and angered when her needs for pain relief aren't met.

Midwives also help women to interpret their pain through their attitude to it. A sense of belief in the normality of an uncomplicated labour and the meaning of its pain is an important concept which may communicate itself to a woman. The midwife conveys an unfaltering conviction that the woman can cope and the woman believes it because trust is present in the relationship.

The Essence

So, the findings from this study seem to indicate that midwives work with women and their pain in labour by interpreting the meaning of their pain. Interpretation always occurs in the context of the world as we are in it. It occurs in the way that midwives are with a woman and how they can 'be' with her – what Heidegger called 'Dasein' (1962). To do this, midwives 'leap ahead' to prepare the woman to recognise her pain and 'leap in', where necessary, to help maintain control by interpreting that pain as it occurs. Midwives know how to work with time, to work with pain in women. Furthermore, midwives who truly believe in the meaning of pain appear to be able to represent it to a woman in a manner which can empower her to work with her pain.

Barbara Katz Rothman, an American sociologist, speaks on behalf of all mothers, regardless of their birth experience, when she entreats: *"When my daughter is in labour... I want a midwife who knows she can do it and has the resources, the patience, the wit and the strength to teach her how"*

(Katz Rothman, 1996, p.254)

The role that the midwife plays is so important. It holds such possibilities to nurture, to empower, to witness a joyous and life-changing event.

Implications for Practice

It is apparent from the lack of explicit discussion of the notion of time in midwifery literature that this is an area which deserves more attention. Much of the practice described by participants in this study is familiar to midwives working with women in labour. Nevertheless, the ways in which time is manipulated by midwives to help women with their pain is important to acknowledge, and to celebrate. The concept of breaking time down into smaller chunks to help women concentrate on the 'now' is recognised by many midwives but may not be acknowledged by them as a valuable strategy. Similarly, the way that time as measured by the clock can prove to be a tyranny for some midwives working in a hospital setting who wish to avoid the constraints of an institution's timekeeping practices. Midwives know that women labour in different ways and blanket adoption of policies for assessing progress can have a detrimental effect on the way that midwives work with women and their pain. Perhaps the views expressed in this study lend weight to the opportunity for a review of hospital policies in this regard to consider less rigid expectations of normal labour situations.

Much of the midwife's work with women and their pain in labour passes unseen by other midwives. This may be because the woman is labouring at home and will only require the presence of another midwife at the time of delivery. If the woman is in a hospital setting, the door to her room may be closed for privacy and peace. Only the support people gathered with her will witness the way in which the midwife works with a woman's pain. So, the opportunity to learn aspects of expert midwifery practice, such as the way some midwives inspire women through the strength of their belief, is limited. It is imperative, therefore, that avenues be created to 'show' this important aspect of practice. This could be achieved by establishing a forum for the sharing of stories from practice in places of work and at professional gatherings such as seminars, conferences or New Zealand College of Midwives' meetings. In this way, practice wisdom can be acknowledged and disseminated to other midwives.

Finally, the findings from this study suggest that midwives need to understand the subjective nature of their decision-making in the area of pain management. They rely on their interpretation of the woman's perception of pain to formulate their midwifery care. The data in this study suggest that the closer the congruence between the midwife's and the woman's interpretation of her pain, the more likely there is to be satisfaction about

the management of her pain once labour is finished. This has significance for all midwives working with women and their pain in labour. A dissatisfied, or worse, angry woman is likely to harbour ongoing hurt which may have ramifications for her transition to motherhood or even delay decisions about future pregnancy. The decisions a midwife arrives at with women in regard to their pain have the potential to cause lingering anguish, but it is difficult to predict which situations have the most risk. In the end, the midwife makes a judgement based on the context of the moment and hopes that the relationship has a strong enough platform of trust to guide her to an action with which the woman will concur.

Implications for Education

All of the points discussed above warrant inclusion in any undergraduate midwifery programme. Labour care is a very important part of any preparation for midwifery practice and less tangible and less visible aspects of support need to be addressed just as much as the more conventional parts of practice. The physical, psychological, cultural and social aspects of pain warrant more emphasis in an undergraduate curriculum. The topic is large and complex. Strategies for 'working with pain' in the development of skills to avoid over-reliance on pharmacological pain relief are subtle and best learned in the clinical environment. In addition, there is an opportunity for student midwives to observe elements of midwifery practice such as the use of time or the way a woman is urged to believe when they work alongside experienced midwives. The value of gaining clinical experience in a variety of settings and with a variety of practitioners is likely to be realised by a greater exposure to a diverse range of midwifery practices. If a student midwife has been exposed to the possibilities raised in this study's findings of working with women and their pain, they may challenge practice which seems to limit choice. For example, where 'leaping in' dominates a midwife's practice in response to a woman's pain, a student midwife may encourage a change by offering an alternative approach.

Midwives, and others, involved in childbirth education already know the value of preparation for the pain of labour. Whilst the concept of 'leaping ahead' may be new to them, the importance of anticipatory information is emphasised in the participants' narratives. Similarly, a different appreciation of lived time may be incorporated into their sessions to further add to women's knowledge before labour.

Postgraduate midwifery education could also incorporate an examination of the concepts of practice contained in the themes from this study. Heightened awareness of different ways to support a woman in pain could result in a critique of practice by experienced midwives.

Implications for Further Research

This study has given rise to many further questions. The area of working with women in pain has attracted some research, but the emotional ramifications of midwives coping with this experience are poorly understood. One study looked at midwives' varying approaches to the support of women in pain (McCrea et al., 1998) but it is not known why they adopt different styles. Emotional aspects of practice require further research.

The midwife-woman relationship has been the subject of quite a body of research overseas, but I am aware of only one study set in New Zealand which examines the relationship (Pairman, 1998). This is an area which requires further research, particularly in the light of the unique context of midwifery in this country.

The participants in this study all practise in one city in New Zealand. Would there be any difference in the study's findings if it had been conducted in another part of the country, or indeed in another country?

I could find no studies which specifically examine the experience of women from other cultures in a New Zealand setting. It is important that the voices of these women are heard. They may have something different to tell us. It may reinforce the notion that pain and childbirth are a universal activity. In the absence of any research, we simply don't know.

There are questions still about the best way to prepare a woman for the pain of labour. How much do you tell a primigravid woman about what might lie ahead? What kind of information will provide her with positive but realistic expectations? The concept of control for a woman in pain has been shown to have great importance, not only to her coping abilities, but also to the midwife working with her. How much does the information the midwife provides, antenatally and intrapartum, contribute to her control? How much is her sense of control derived from the presence of the midwife when she is in pain?

Other areas which I believe are calling for further research pertain to some of the qualities identified by this study's participants when they are working with women and their pain. Increasing our understanding of the way that midwives presence themselves to women, how they use intuition in their practice and the notion of conveying belief are significant gaps in our knowledge at present.

Limitations of the Study

Findings from phenomenological research are, by definition, tentative and highly subjective. They are also the product of the context in which they are situated. This study is set in Auckland and its findings may not be echoed in other areas of New Zealand. One reason for this could be that the Auckland area has the largest concentration of population in the country, so a more diverse ethnic mix exists. Similarly, the midwifery setting in New Zealand is specific to this country's social, political and cultural identity and incorporates scopes of practice which are not so widely available in other countries. The intention of a study such as this, however, is to gain a deeper understanding of the midwife's experience of working with women and their pain in labour. It does not seek to generalise findings to other situations.

Time constraints and limitations on length of the thesis for a piece of research at Masters level, have caused some areas of the study to be under-developed. Nonetheless, every effort has been made to conduct a credible study with thorough attention given to the methodology and the method.

Seven participants were interviewed for the study. Although this number is not large, in the context of a phenomenological methodology, it is appropriate. Furthermore, the data and consequent findings suggest a satisfactory amount of rich description was obtained.

Conclusion

This study sought to understand midwives' experiences of working with women and their pain in labour. Their stories provided a wealth of practice knowing and wisdom which helped me to uncover some of the complexities inherent in the relationship. By engaging with the parts of this phenomenon, I have come to see the whole and thus have

been able to return to the parts with new understanding as I progress around the hermeneutic circle.

Midwives work with women and their pain by interpreting it for them. Before the pain begins, they 'leap ahead' to encourage them to anticipate what the pain will be like and how they will confront it. Midwives give pain meaning for women by naming it and defining its purpose in bringing a baby. When labour begins, midwives help women to translate their embodied pain in its context. They 'leap in' when required, sometimes using self as an intervention. When midwives interpret women's pain, they risk misjudging a physical pain they can't feel, thereby causing mental pain they can't always salve. On many occasions though, midwives can convey belief to women with such conviction that they will trust in their pain to keep them safe. Midwives help to unlock the mystery of labour pain and accompany women on the profoundly moving and humbling journey that is the miracle of childbirth.

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Appendix A

MEMORANDUM

The logo for AUT (Auckland University of Technology) is displayed in white capital letters on a black rectangular background.

Academic Registry - Academic Services

To: Liz Smythe
From: Madeline Banda
Date: 1 May 2002
Subject: 02/17 What is the experience of midwives working with women and their pain in labour?

Dear Liz

Thank you for providing clarification and/or amendment to your ethics application.

Your application is approved for a period of two years until May 2004.

You are required to submit the following to AUTEK:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Madeline Banda'.

Madeline Banda
Executive Secretary
AUTEK

Appendix B

Information regarding research project to be undertaken by Stephanie Vague at AUT for her Masters Thesis.

Information sheet for potential participants

Title of study: What is the experience of midwives working with women and their pain in labour?

You are invited to take part in a study looking at the way midwives work with women and their pain in labour.

Who am I?

My name is Stephanie Vague. I am a midwife teacher at Auckland University of Technology (AUT). I am also involved in part-time study at AUT towards a Masters degree.

The aim of the study.

The study is intended to explore the ways in which midwives work with labouring women and their pain. It hopes to gain insight into the decision-making process employed and to uncover meaning through listening to the stories of experience.

Who can be participants in the study?

The participants will be midwives as it is midwifery practice which is being studied. There will be between 5 and 9 midwives in the study.

If you decide to participate, what will it involve?

There will be an interview lasting approximately one hour. The interview will be conducted at a place which is private and convenient and mutually acceptable.

During our conversation, we will explore your experience of working with women and their pain in labour. You will be asked to tell me about specific instances of providing care in labour and how you made decisions relating to supporting a woman in pain during labour.

The interview will be audiotaped and later transcribed. I will return a copy of the transcript to you in order for you to change or clarify any parts of the interview. You may wish to add further comments or to delete parts of the interview which you do not wish to have included in the analysis.

The audiotapes and transcripts remain confidential to the typist, my research supervisors and myself. A pseudonym or false name will be used on all tapes, transcripts and reports to protect your identity.

At the end of the study, your audiotape will be returned to you or wiped, whichever you prefer.

What will be the risks and benefits to you of participating in this study?
I do not anticipate any risks to you from participation in this study. Sometimes interviews in which you share your experiences of practice and your ideas and thoughts can be unsettling. If you should experience unresolved distress resulting from the interview I am able to support you in seeking counselling. As to benefits, I hope that you will gain some satisfaction from taking part in a study which aims to hear your practice wisdom and knowing in order to add to the body of knowledge concerning the care of women and their pain in labour.

What will happen to the results of this study?

The final research will be published as a Masters thesis which will be available in the Auckland University of Technology library. Short articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will be protected in all of these contexts.

Your participation in the study is entirely voluntary. You do not have to take part in the study. If you do agree to participate, you are free to withdraw from the study, including withdrawal of any information provided, until data collection is complete. After that time, it may be impossible to separate data from individuals. If you choose to withdraw, you do not have to give a reason. This study has received ethical approval from the Auckland University of Technology's Ethics Committee. Any concerns regarding the nature of this project should be made, in the first instance, to the Principal Supervisor, Liz Smythe. Concerns regarding the conduct of the research should be directed to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz or Ph 917 9999 Ext 8044.

Thank you for taking the time to read this information. If you have any further questions about the study, please feel free to contact me. If you would like to participate, please complete the attached consent form.

Researcher
Stephanie Vague
stephanie.vague@aut.ac.nz
Ph 917 9999 ext 7225

Research Supervisor
Liz Smythe
Auckland University of Technology
liz.smythe@aut.ac.nz
Ph 917 9999 ext 7196

Appendix C



Consent to Participation in Research

Title of Project: **What is the experience of midwives working with women and their pain in labour?**

Project Supervisor: Liz Smythe

Researcher: Stephanie Vague

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed
- I agree to take part in this research.

Participant signature:

Participant name:

Date:

Contact details (Phone number &/or e-mail address)

.....

Project Supervisor Contact Details:
Liz Smythe
Auckland University of Technology
liz.smythe@aut.ac.nz
Ph 917 9999 ext 7196

Appendix D

Confidentiality Agreement

I, Debbie Crompton, understand that the transcribing of interviews with participants in Stephanie Vague's research study involves issues of confidentiality. I undertake to respect the privacy of these individuals by not divulging any of the content within the audiotapes. I will store the audiotapes and any hard copies awaiting collection in a secure environment, namely a locked filing cabinet.

Signed

Date