MIDWIVES' EXPERIENCES OF PERSONAL PREGNANCY RELATED LOSS

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ABSTRACT

The aim of the study was to explore the experiences of midwives who were having problems with any aspect of reproduction, and relate this to their approach and attitude to their work with pregnant and childbearing women, and to their colleagues.

The study used a grounded theory approach. Data were obtained from written narrative accounts from 40 participants, and from 10 follow up, in-depth, semi-structured interviews. Data were analysed using a constant comparative technique producing categories and the core category of the thesis.

The findings suggested that pregnancy related losses, including infertility, miscarriage, termination of pregnancy, stillbirth and neonatal death, influenced the participants' personal and professional relationships. In common with non-midwives in similar situations, some midwives found it difficult being with pregnant women or babies, although most differentiated between longing for their own baby, and envy of any other baby. Some found difficulty working in particular areas, for example labour ward, although there seemed to be no link between the type of loss, and problematic areas. Most participants spoke of their love for midwifery, and their determination to continue despite difficulties. At work, participants valued practical and emotional support. Some participants suggested that their experiences had increased their practical knowledge and understanding. Some had improved support systems for clients and for colleagues. Many participants mentioned the therapeutic value of involvement in the study.

The implications of the study were that the midwives could not avoid evidence of others' fertility in their work. How they addressed this influenced their approach to work, and some recommendations are made, based on the findings. These relate to potentially supportive management and teaching strategies, and to further research and awareness raising which might help midwives and others in similar occupations following personal experience of pregnancy related loss.

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INTRODUCTION TO THE THESIS

Midwives' experiences of personal pregnancy related loss

I have observed, and it has been my personal experience, that most midwives are asked at some point in their working lives and often many times in one day whether they have children. They may be asked by their client, or by their client's partner, or by another family member. If the midwife has children, the conversation often moves to their ages, their births, their behaviours and other issues associated with childbirth and with bringing up children. For midwives who do not have children, or who may have experienced a pregnancy related loss, I wondered if dealing with the question may be problematic. I also wondered if midwives who have experienced their own pregnancy related loss might have difficulties being around pregnant and childbearing women, and being faced with evidence of others' fertility, and indeed loss, on a daily basis. These personal observations and speculations led ultimately to this study.

The study is arranged over six chapters which document its background, its design, its findings and recommendations. Each chapter is designed so that it can be read alone, to facilitate easy reading of such a long work. However, it will be appreciated that such an approach involves what may seem like repetition, since each chapter gives a resume of what has gone before, an indication of what the current chapter will address, and a summary at the end of what has been covered.

Chapter One describes how my personal interest in the topic of midwives coping with their own pregnancy related losses arose, and provides background information to the study. Definitions of terms used throughout the study are given, and a preliminary overview of literature is given, to set the study in context, and to review what was already known about the topic at the time the research began. The study used a grounded theory approach, and, as is congruent with this study design, the literature review established the need for the study, and gained some preliminary information. The review in preparation for the research took place in the year 2000, and the initial literature review is, therefore, mainly confined to material available at that time. From the literature review, the theoretical framework was derived, the research question determined, and specific objectives set.

Chapter Two describes the research design and explains how the study was formulated. The chapter addresses the complexity and sensitivity of the research topic, and confirms the research question. The staged approach to data collection, first by questionnaires and then by in depth follow up interviews is discussed, as is the method of data analysis. The plans for safeguarding the wellbeing of the participants, others associated with the research, and the researcher are presented. The chapter reviews a selection of approaches in the qualitative research domain, and outlines the reasons for using Sarantokos' (1998) principles of grounded theory to underpin the research methodology. Development of the questionnaire, and its framework to enable the writing of narrative accounts is explained, as is the formulation of questions for the semi-structured interviews. The sampling strategy is presented, together with inclusion and exclusion criteria. The principles underlying data analysis are presented, together with the scheme for ensuring validity of the findings. The implications for personal involvement, and the need for researcher reflexivity are also examined in this chapter. Finally, some strengths, drawbacks and limitations of the research design are highlighted.

Chapter Three introduces the forty participants, and presents the findings from analysis of their narrative accounts in the questionnaires. The emerging categories and the core category for the research are also presented. The findings are summarised, and the chapter shows how they contribute to the design of the schedule for the semi structured interviews.

Chapter Four introduces the ten follow up interviewees, and explains how they were selected from all those who volunteered to take part in the follow up stage. Findings from the interviews are presented alongside those from the questionnaires, and it can be seen how the findings are integrated to produce the categories and core category of the research. At this stage, the categories could not be confirmed, as a further source of data, that is, further literature, needed to be consulted.

Chapter Five explains how the findings from chapters three and four informed a further search and review of the literature. At the beginning of the study, it could not be known what areas the participants might reveal as relevant in their narratives and in their interviews. It was only at this stage that further literature could be consulted against which to discuss the findings. At the end of this chapter, the categories and the core category, which contains the essence of the whole study, are confirmed.

Chapter Six draws together the thesis and advances the theoretical principle arising from the findings. Two illustrative models are offered, the first showing the concept of the midwife who has experienced a personal pregnancy related loss, specifically in relation to the findings from this study, and the second representing the interface between such a midwife and her client. The chapter ends with recommendations drawn from the findings. These recommendations are not meant to be generalised, but to offer areas for consideration in relation to midwives and others in similar occupations who experience pregnancy related loss, and to suggest areas for further exploration and research.

CHAPTER ONE

RATIONALE FOR THE STUDY AND INITIAL REVIEW OF THE LITERATURE

Introduction to Chapter One

This chapter provides background information to the study, and presents the results from the initial review of the literature. First, I describe how my interest in the topic of midwives coping with their own pregnancy related losses arose. Using my observations from work-related and personal perspectives, I highlight the events which initiated my wish to pursue the subject as a research topic. Next, I explain the rationale for my definition of the term "pregnancy related loss" which is used throughout the thesis. I then discuss the place of theory in the epistemology of midwifery, touching on the use of conceptual models to offer a visual representation of abstract, interrelated concepts. Following this, the theoretical framework underpinning this particular study is discussed, although it is not explicated until the end of the chapter, following the initial review of the literature. Congruent with the grounded theory approach to the research, an initial overview of some existing literature is given in this chapter, to set the study in context, and to review what was known about the topic at the time the research began. As will be appreciated, the review in preparation for the research took place in the year 2000, and is, therefore, confined mainly to material available at that time.

Background to the study – some personal observations

The ideas for this study arose from personal experience, and from observations of how midwifery colleagues, who had experienced pregnancy related loss, interacted with childbearing women. Their losses in this context included circumstances relating to fertility, miscarriage, termination of pregnancy, intrauterine death, stillbirth or other baby death. These are the losses I was aware of during my observation of my colleagues, although there were probably many others of which I was ignorant at the time, but which I considered when planning the study. The research explored the midwives' experiences during their everyday contact with women and babies, whilst dealing with their own reproductive circumstances.

My own interest in the subject of how midwives who do not have children, and those who have experienced problems related to fertility or pregnancy, feel about their reproductive circumstances arose for a number of reasons. I observed that many pregnant and labouring women asked their midwives if they had children. I do not have children, and began to wonder how I could respond to the question without particularly entering into any discussion which might divert attention away from the woman and her circumstances. A blunt "no" seemed inappropriate, and I thought might leave the woman feeling uncomfortable, although when I gave my negative response, most people's responses were generally that I had plenty of time, or they wondered whether seeing many women in labour had discouraged me from going through the experience myself. I also noticed that the nature of the question changed as I became older, with the assumption being that I was a mother, and the enquiry more likely to be "How many children have you got?" (Bewley, 2000a).

The interaction seemed to cause a temporary hiatus in the conversation, as the woman reviewed her initial impressions, and then we moved on to other areas to develop our relationship. I then began to notice how other midwives dealt with the question; for those who had children, the answer was "yes" and the conversation centred on how many, how old, and other child orientated issues. However, the question might have posed problems for some of my colleagues, who I knew had experienced problems with pregnancy and other aspects of reproductive life. More than one had a long history of infertility and had undergone numerous investigations and treatments, and desperately wanted a family. Another, after many years of infertility, was overjoyed to become pregnant, yet found that she had an ectopic pregnancy. Yet another had a termination of pregnancy for gross fetal abnormality and another had a baby with a chromosomal abnormality who only lived a few hours. Another had a preterm baby who died at only a few hours old; on one occasion, we were visiting a woman who had given birth to twins, one of whom had died. The midwife was extremely supportive, and at one point in the conversation the woman asked her "Have you got children?". The midwife replied "no", but I wondered how she felt and I realised how difficult she must have found it to respond, and how it must have reminded her of her own child. I wondered about my other colleagues, and thought about how difficult they might find answering the question. I also thought about how they felt, being in a situation where they were confronted with the evidence of other women's fertility on a daily basis. Additionally, I wondered how they related to women in the face of such intense emotion.

My own knowledge of the importance of the death of a baby arose from my mother's experience, which she related to me. Her first child, a boy, was stillborn at term in the late 1940s. She never saw him, but my father confirmed that he was perfect. The cord had been wrapped tightly around his neck, which I assume led to asphyxia. I knew this from a very early age, but gradually, my mother told me other things, which had clearly remained with her over a long period of time, some of which related to her interactions with her midwife. For example, while she was in hospital recovering, she was asked to give an artificial feed to another baby whose mother had died. The midwife said to my mother "you can have another baby, but he can never have another mother". I was my mother's second child, and at the time I was born, the custom was that the baby was taken away immediately for bathing etc, and was only ever returned to the mother for feeding. When I was born, the attending midwife was the same one who had looked after my mother during her first labour, and, she gave me to my mother straight away. My mother even remembered that the midwife had red hair. I also remember, many years later, that my mother phoned me one April evening, and said, "My first baby would have been forty today". The enduring sense of loss and the strength of her memories reinforced for me the significance of pregnancy loss, and the potential the midwife's personal experience of loss might have for influencing the midwife's relationship with her clients. Thus, my personal observations and experiences generated my initial interest in exploring the topic further.

Defining pregnancy related loss

At this point I define the term used throughout the current research to cover the range of losses experienced. I used the term "pregnancy related loss" to cover a wide range of conditions and situations. Specifically, these are miscarriage, termination of pregnancy for any reason, intra uterine death, stillbirth, perinatal, neonatal and infant death. I used the word "related" to include other situations where loss is not that of a specific pregnancy. For example, I included infertility in this definition, because a number of participants in previous studies (Bartlett, 1994; Bewley, 2000b: Macallister and Clarke, 1998; Rowan 2003), described themselves as infertile yet had also experienced one or more of the pregnancy losses described above. Further, infertility constitutes a loss of choice about pregnancy, and the loss of motherhood. I also included those who had reached menopause without having living children, since menopause also removes choices about pregnancy.

Somewhat contentiously, since one could argue that there is no loss involved, whilst I did not actively invite participation from those who described themselves as voluntarily childless (or childfree), I did not exclude them from the study. The rationale for this was that some participants in the studies reviewed later in this chapter, described themselves as childless by choice, yet also described gynaecological or obstetric histories which included infertility and/or pregnancy loss which occurred prior to, and indeed may have contributed to, their decision to remain childfree. The negative views of society in relation to childlessness and the childfree, and the difficulties some women had in "classifying" themselves, led me to seek a wider rather than a narrower range of experience. However, this particular approach may have led to there being no respondents, post menopausal or otherwise, in the current study who described themselves as childfree, or childless by choice.

I also included those who had relinquished a child for adoption, however there were no such participants in the study.

Midwives in same sex relationships may also have experienced pregnancy related losses as described above, therefore the term includes such midwives, although the primary concern of the current study is that of pregnancy related loss, rather than sexuality. The disclosure of same sex relationships was left to the participants. No such disclosures were made.

Midwives who are men are not subject to the socially constructed views of motherhood described later in this chapter, therefore they were excluded from the definition.
Thus the term pregnancy related loss is used to encompass a wide range of experiences, whilst acknowledging that they will be disparate, and that such disparity allows the potential for lack of validity in the sample. Nevertheless, I felt it important to err on the side of inclusivity, with the focus on generating data corresponding with the concept of loss.

Theorising in midwifery

The grounded theory approach to the study sought theory generation, to broaden the epistemological bases of midwifery, particularly in connection with relationships. I therefore examined some existing approaches to establishing theory in midwifery. Bryar (1995) analysed theory development on therapeutic relationships in midwifery. She drew on the work of American nurse theorists to determine concepts, adapting four main concepts of nursing, which they described as, person, health, environment, and nursing, to midwifery. Bryar suggested that the midwifery concepts would be women (and partners, and children), health, environment and midwifery practice. Fleming (1998) challenged these basic concepts, suggesting that they have been imposed upon midwifery rather than being developed from midwifery. She offered a conceptual model of the interdependent relationship between midwives and their clients, but whilst her model was grounded in the concepts revealed by her research, it was confined to the relationship taking little regard of the wider issues suggested by the nursing concepts. Bryar (1995), developed her thoughts on midwifery theory by further suggesting that the midwife's self-knowledge was a fifth vital element or concept, basing her thoughts on the personal knowledge aspect of Carper's (1992) ways of knowing. Bryar (1995) examined some basic midwifery texts, concluding that these reflect the personal philosophy of their writers, implying that they would then influence their readers. She also suggested that midwives' personal philosophy, whether acknowledged or not, is influenced by their many personal and work-related experiences. This philosophy will inform midwives' approaches to relationships with clients.

Self-knowledge seems crucial in interactions between midwives and their clients, and indeed between midwives and their colleagues, including students. This is particularly important, where the midwife is dealing with her own pregnancy related losses. Forrest (1993) suggested that concepts of self in the Western world are based on an individual's perception of how they compare and "fit" with others they come into contact with, and that self-concept has two components, self-image and self-esteem. Midwives, and their clients, will have internalised the dominant, socially constructed (but not necessarily objectively correct), views on motherhood, pregnancy and pregnancy loss prevalent in their communities. Midwives will also have internalised, or rejected, the philosophy of the midwives who have taught them, those with whom they work, and, unless they are working independently, will also be influenced by the management philosophy of the National Health Service. Chapter Five explores in greater depth the use of reflection and other methods to explore some aspects of self-knowledge generated from the findings.

Bryar (1995) emphasised naming concepts, and highlighted naming as a first step to understanding. Concepts can be illustrated by using conceptual maps and models, which provide a visual representation of abstract, interrelated concepts (Grbich, 1999; Burns and Grove, 2001; Polit and Beck, 2004). Bryar, (1995) further suggested that the formulation and testing of theory is crucial to the establishment of a midwifery body of knowledge. Burns and Grove (2001) suggested that compared to concepts, theory is narrower, more defined and testable. It is questionable whether theory derived from qualitative research can be testable, but, as Chapter Six in the current study suggests, there is the possibility of testing a theory generated by qualitative research by using larger, possibly quantitative studies. However, in the interests of gaining new knowledge about aspects of midwives and how they relate to their clients, one of the aims of this thesis is to produce a theory and a conceptual model, or models, to represent the midwife-mother relationship where the midwife has experienced or is experiencing a pregnancy related loss. The next section of the chapter considers the theoretical perspectives which guided the preliminary review of the literature, and contributed to the formation of the theoretical framework.

Establishing the theoretical framework

There is considerable discussion in nursing and health related research literature about what constitutes a theoretical framework (Grbich, 1999; Benton, 2000; Burns and Grove, 2001; Polit and Beck, 2004). Some authors have suggested that the terms theoretical frameworks and conceptual frameworks are interchangeable, whereas others have described in minute detail the steps necessary to extract a framework from series of concepts (Burns and Grove, 2001).

Polit and Beck (2004) offered an evaluative tool for readers of research which specifically asked them to consider whether or not the absence of a theoretical framework, particularly in qualitative research, detracted from the general usefulness of the study. They inferred that lack of a framework is not necessarily detrimental, but that readers should decide for themselves whether this is the case. Benton (2000) further suggested that use of a preconceived framework in grounded theory approaches may result in rejection of important new material which does not fit the framework. However, in my position as a reflexive researcher working from a perspective driven by understandings of loss, a pre existing theoretical framework was not sought, but was developed, as shown in this chapter, to identify the fundamental issues which underpin all aspects of the current study.

Grbich (1999) reviewed four theoretical perspectives, which may inform qualitative research. First, theory/concept driven, which explores and tests existing theory, second, theory/concept generating, which is adopted to explore an area where little is already known. Grbich (1999) then reviewed postmodernism/poststructuralism and finally, the theoretical perspective offered by feminism. Of these four, the theory/concept generating approach, characterised by the interactionist perspectives congruent with grounded theory, is that which underpinned the current study. Grbich (1999) further observed that the place of literature searching in this approach is minimal, or may not even be undertaken at all, in order to avoid overdirection and clouding of the researcher's view. However, the obvious drawback with such an approach is that the researcher will simply reinforce her own unidentified biases. The theory/concept generating approach requires sufficient knowledge of the subject under investigation to "lightly underpin" (Grbich, 1999:30) the research design, and to highlight areas which require consideration. Polit and Beck (2004) concurred with this view, asserting that the chosen research approach should acknowledge its theoretical underpinnings. At the most basic level, Burns and Grove (2001:131) suggested that in qualitative research, the theoretical framework offers the reader a glimpse of the researcher's "world view".

The explication of my own world view in relation to the current study needed to take account of a number of issues. In the spirit of grounded theory, and in light of the discussion around the development of the theoretical framework, I was reluctant to impose too rigid a theoretical perspective from the outset, on the basis that theory should arise from analysis of the data. However, I needed to acknowledge how my own personal interests, together with the dominant discourses on social contexts, social constructions, and social interactions, informed my approach to the work in all its stages. From an ontological perspective, and from a qualitative standpoint I accepted that different (and equally valid) ways of being and views of reality co-exist, and are subjectively perceived. In this context, I sought knowledge deriving from the analysis and interpretation of participants' descriptions of their reality, whilst acknowledging my interactions with them as a researcher (Polit and Beck, 2004). Thus, in this study, the ontological bases were the midwives' personal experiences of pregnancy related loss, and their impact on their midwifery practice. The epistemological object of the research process was to collate these differing views of reality and, to establish valid claims for their translation into knowledge about midwives' experiences of personal pregnancy related loss.

Thus in the current study, the grounded theory approach was chosen because of its philosophical basis in symbolic interactionism. The premise is that social interactions are influenced by personal experiences, and may be consciously modified according to social context, social acceptability, and according to the role adopted by players involved in an interaction. These theoretical perspectives are exemplified in the work of Goffman (1959, 1972), and discussed in greater detail in Chapter Five, page 266.

The theoretical framework which underpinned the current study, therefore, focused on exploration of the participants' personal experiences of pregnancy related loss. The preliminary literature search highlighted key areas which underpinned initial data collection for the study. The major theme is that of loss. This is not only the loss of a particular pregnancy, or a particular baby, but the much wider losses, such as loss of the ability to conceive, and the perceived loss of status consequent on not achieving motherhood. The work context of the midwives forced them to confront their losses on a daily basis, unlike others in similar situations who may have the opportunity to avoid pregnant women and babies. For this reason, the nature of the midwives' interactions with clients and colleagues, and some strategies they adopted in their role as midwives was also examined as part of the initial literature review. The next stage in the epistemological process was to demonstrate how I sought to generate theory through the integration of the philosophical underpinnings of grounded theory, and the findings from the initial literature view. The resulting framework is explicated on page 42, but first, the initial literature review is presented.

Setting the study in context – initial review of the literature

Hart (2003) observed that the literature review is the key to ensuring that everything published and unpublished about a particular topic is explored prior to beginning a further study. However, as Chapter Two (page 56) explains in detail, grounded theory guided the research design for this study, and some issues about searching the literature are explored further within that chapter. A grounded theory approach required the use of existing literature principally to determine the justification for further work on a topic. Only after data collection and analysis has occurred was the literature consulted again, and used as further data against which to discuss the findings (Chapter Five). Since the findings arose from constant comparative analysis, it was impossible to predict at the beginning of the study areas which would require further review of the literature. This chapter, therefore, highlights only the literature relevant to the background of the study, and indicates where certain areas will be explored in much greater depth in Chapter Five.

The initial literature review involved recognised IT searching techniques using the keywords loss, midwives, motherhood, relationships, shared experience, pregnancy loss, perinatal grief and bereavement in various combinations to achieve an overview of what was available. Literature written in English over the past thirty years was searched, using a variety of sites including Midwifery Information and Resource Service (MIDIRS), Cumulative Index to Nursing and Allied Health Literature (CINHAL), National Health Executive Library (NHEL), and Medline. I also searched using the specific phrase "Midwives personal experiences of pregnancy loss", which yielded very little, other than from a search of MIDIRS. The literature review in this chapter also included books and articles recommended by colleagues, and serendipitous finds from browsing relevant sections in specialist libraries such as the Royal College of Midwives, and University College Library, and on the internet. There was a wealth of literature available on perinatal loss in general, from psychological, sociological, midwifery and medical sources, and in websites from bereaved parents. In some cases, I have used the original works of feminist writers such as Oakley, particularly where these are acknowledged as key texts. I returned to all these sources of information following analysis of the questionnaire and interview data from the research participants, and a greater in depth exploration of the literature appears in Chapter Five. Other than my own work, there was little research evidence available on midwives' experiences of personal pregnancy loss, infertility, or being a midwife who does not have children (Bewley, 1995; Bewley 2000a and b). The initial literature review, therefore, drew on this work extensively to inform the current study, whilst acknowledging the limitations of sampling, sample size, and generalisability of the findings inherent in my previous work.

My thoughts and observations about midwives' personal pregnancy losses, and how they might impact on their daily work prompted my first study of the topic in 1994. My thoughts were that the influences of what I termed at that time "adverse reproductive experience" on midwives would be largely negative. The first study therefore, (Bewley, 1995; Bewley 2000a), adopted a phenomenological approach to explore the experiences of six self-selected midwives who did not have children. However, my request for participants generated a somewhat unexpected sample. Recruitment was via a letter sent to 17 midwives from a particular team practice where I could not know in advance their individual reproductive circumstances. I specifically asked for respondents who did not have children, and all but one of the participants were young women, who fully expected to have children in the future, and who had not yet "tested" (Bartlett, 1994) their fertility. Only one respondent knew that she could not have children. Thus although they did not have children, they had not experienced a pregnancy loss, and did not constitute the sample I had expected. Nevertheless, the findings provided new knowledge on the relatively unresearched topic of midwives who do not have children. It revealed that the midwives without children adopted various strategies to convince their clients that they were suitably qualified and experienced as midwives, and that they were caring and empathic, despite their lack of personal experience of pregnancy and childbirth (Bewley 2000a).

Based on the findings of the first small study, I embarked on a larger study in 1998, in an attempt to recruit a group of participants with a wider range of experiences. Participants for the second study (Bewley 2000b) were recruited via an advertisement placed in a monthly midwifery journal sent to all members of the Royal College of Midwives. Participants (n=184) provided data through questionnaires, and by ten follow up, in depth interviews with randomly selected participants from 150 who indicated willingness to contribute to further research.

Their responses indicated a strong inclination to provide answers, which suggested that they were aware of society's expectation that, as women, they would at some point have children. Those who had experienced pregnancy loss, or who had fertility problems sometimes found their choice of response as to whether they had children difficult. They could respond truthfully, or, try to steer the conversation to another subject. Their responses suggested they tried to deal with probing, personal questions, sometimes having to conceal intense emotion, especially when thinking about their own losses. Despite this, many midwives described themselves and their relationships with women in positive terms. Many described a process of resolution, during which they had come to terms with their loss. However, some respondents felt depressed, and some had been diagnosed with depression. Others said they had left midwifery because of their reproductive circumstances (Bewley, 2000b).

Findings from this second study (Bewley, 2000b) suggested that, as in the general female population, some midwives do not want children at the moment, some do not want them at all, and some want children but are unable to have them. Some were in same sex relationships where, at the time of completing the questionnaires, they felt that having children was inappropriate. Some found the question "Have you got children?" from clients conversational, but others felt that a negative response would indicate that they had failed in fulfilling their potential as women. They considered their response a key factor in promoting and maintaining good relationships with childbearing women, and wanted to assure them that their lack of personal experience would not affect their capacity to be caring and compassionate. Those who were involuntarily childless did not necessarily experience more negative feelings, but many spoke of "bad days" when they felt upset and vulnerable. They also identified supportive and non-supportive behaviours by colleagues and managers. A number commented on the therapeutic effects of their participation in the study.

Rowan's (2003) phenomenological study, entitled Midwives Without Children, involved interviews with fifteen midwives who did not have children for a variety of reasons. Her findings are very similar to those from both my previous studies, (Bewley, 1995, Bewley 2000a and b), and indeed have very similarly entitled themes, suggesting that although the studies were relatively small, the midwives taking part had similar experiences. Her study also concluded that personal experience of childbirth did not necessarily improve the quality of care provided for women, although this is difficult to substantiate since she did not speak to clients.

Mander (1996) wrote specifically about voluntarily childless (or childfree) midwives, drawing on her study with experienced midwives, and with women who did not have their babies with them (sic). Her article focused principally on the epidemiological consequences for midwives on the increasing number of women who will choose to remain childfree in the United Kingdom. However, she made some pertinent observations about the type of questions that childfree midwives are likely to encounter, and offered examples of midwives who have had children using their experiences inappropriately. She recognised the negative stereotypes which surround the voluntarily childless, but concluded that women are unlikely to be disadvantaged if their midwife has not had children (Mander, 1996). Whilst interesting, the article was largely speculative and did not explore in depth the sequence of events which may lead to a woman describing herself as childfree.

The work consulted thus far provided information about midwives without children and their work experiences, but was still limited to those who did not have children, whether voluntarily or not, even though some had experienced pregnancy loss. Neither of my own studies, perhaps through flaws in the sampling strategy, had fully explored the experiences of midwives and their own pregnancy related losses, which I had originally intended. In the second study (Bewley, 2000b), I received two responses from midwives who fell outside the sampling parameters, in that they had experienced a pregnancy loss, but had then gone on to have a healthy baby. I realised, that again, by restricting my sample to midwives who did not have children, I omitted a potentially large group of midwives who already had a child and then experienced a loss, or who went on to have a baby after an initial loss, or losses. Thus my experiences with these studies informed my sampling strategy, which was based on the definitions described earlier in this Chapter (page11) and explored further in Chapter Two (page 49).

The societal and work related contexts of midwives' experiences of pregnancy related loss are explored in the next section of this chapter. These include prevailing views on how women as mothers are seen in society, society's view of childless and childfree women, midwives' personal experiences and their potential impact on the midwife-mother relationship, work related aspects of midwives' experiences of pregnancy related loss, sharing experiences, support for midwives, and aspects of loss.

Women, motherhood and society

In many societies, motherhood within a culturally sanctioned, heterosexual partnership, is considered woman's biological destiny, and natural function in life (Ong, 1986: Kirkham 1989). It confers status on the woman, and on her partner, and, as Kirkham (1989) suggested attracts society's maximum approval. There is a dominant view that women who choose not to have children are selfish, whilst those who cannot have children are to be pitied (Woollett, 1991; Pfeffer 1993). In many societies, women are defined by their biological ability to give birth, and those who are unable to have children may be considered useless, and ostracised from their cultural groups (Browner and Sargent, 1990; Priya, 1992). Woollett (1991) suggested that whilst the general view of the Western world is "pronatalist", women who produce large numbers of children by different fathers are viewed with disapproval. Ong, (1985) observed that even though some mothers neglect, or are actively cruel to their children, their status and existence as women is reinforced through their motherhood. These paradigms of maternity, and indeed of reproductive behaviour, are not merely biologically constructed, but reflect the dynamism of social, political and economic processes (Browner and Sargent, 1990). Extensive work by feminist writers such as Kitzinger (1978) and Oakley (1980) has expanded the knowledge of sociocultural dimensions of motherhood, and the writings of both have contributed in shaping contemporary midwifery care, which ultimately aims to restore choice, continuity of care and control to childbearing women (Department of Health, 1993). The next section of this chapter examines some of the literature relating to motherhood and experiences of motherhood, and introduces some aspects of loss as they relate to the current study.

Rogan et al (1996) analysed the early motherhood experiences of 55 first time mothers in Australia. Using specific theories from nursing, midwifery, feminism and sociolology, and with a grounded theory approach, they analysed data generated from three focus groups. The theoretical underpinnings of the study are helpfully described, and centre on maternal role attainment, aspects of transition to motherhood, and the oppression of women, long held to derive from the biological obligations of reproduction. They contrasted the negative views of oppression by using Rich's (1976) work, which sought to emphasise the creative power of birth and motherhood, and encouraged women to talk about their own experiences of motherhood in a society which had previously relied on male descriptors. Their conclusions were that women strove to attain cultural expectations associated with a prescribed social model of motherhood, without a clear understanding of the personal losses (for example of confidence, self esteem and energy), which accompany first time motherhood for some women. Realisation of the losses seemed a key factor in enabling the participants to incorporate their status as mothers into a new personal identity. The study challenged the concepts of attachment, suggesting that post natal assessments of women's adaptation to motherhood is based on external observations of mother/child reactions, as opposed to exploring the women's perceptions of themselves within the relationship. The study did not examine the processes of attachment (see Chapter Five, page 208) which could have offered further insight into the losses they describe, and this may have added another dimension to the findings. However, the work offered a well-structured articulation of the paradoxical discourses on the personal difficulties of motherhood versus its social desirability. Nevertheless, as Symonds and Hunt (1996:101) and Kent, (2000) point out, although many beliefs about motherhood are somewhat illogically predicated on the belief that all "natural" women will want children, however illogical the premise, these beliefs currently inform Western views of motherhood, and as such, influence childbearing women and their midwives.

It seems therefore, that there is a collective expectation that so called normal women have a social and possibly biological imperative to have children. There is a somewhat negative view of women who do not have children whether by choice or through inability, and indeed, those who have experienced a pregnancy related loss are viewed with particular suspicion. Bartlett (1994), interviewed fifty women, whom she described as childfree, inferring that her interviewees had all made a conscious decision not to have children. However, some described themselves as infertile, and some had experienced pregnancy loss, suggesting that the term childfree, with its positive connotations about choice about motherhood is a misnomer in this instance.

Nevertheless, she made some pertinent observations about society's views of women who do not have children, and how these collective views contribute to women's feelings about themselves. She cited the portrayal of such women in films of the last century such as "Fatal Attraction", in which the main female character became mentally unstable and violent following the termination of her pregnancy. She gave a further example of how the main character in "The Hand that Rocks the Cradle" joined a household as a nanny following the death of her own child, and subsequently, through a series of malevolent acts, usurped the rightful mother's position. Brien and Fairbairn (1996:149), writing about their experiences as counsellors in pregnancy and abortion clinics, recounted some of the difficulties some women face after termination of pregnancy. Among these, they documented the potential for thoughts of abducting a baby as a result of envy of women with children. These thoughts occurred to one or two participants in both my previous studies (Bewley 2000a and b); after several miscarriages, one midwife thought fleetingly about abducting a baby, but immediately realised the anguish she would cause to the mother, and the potential damage to her own career. She also recognised, as did other midwives in the studies, that to reveal such emotions and thoughts could lead to a climate in which bereaved midwives were viewed with suspicion by managers (Bewley, 2000a and b). Symonds and Hunt (1996:109) also agreed that psychological profiling in cases of child abduction is flawed, in that it highlights women who have recently lost a child. Based on the findings of an investigative TV documentary (Channel 4, 1995) Symonds and Hunt (1996:109) further pointed out that, abduction is more likely to be carried out by those women seeking to save an insecure relationship rather than who have lost a child. This area is explored further in Chapter Five (page 226) in conjunction with the findings from the current study.

The views of childless women in the United Kingdom and the USA are relatively well-researched (Dowrick and Grundberg, 1980; Bartlett, 1994: Morrel, 1994; McAllister and Clarke, 1998) and revealed how women dealt with probing, personal questions about their reproductive circumstances. Midwives in my previous studies (Bewley 2000a and b) experienced similar feelings, as they responded to questions in ways which affirmed their intention to join the motherhood "club" (Duggan, 1997), or which distanced them from the unacceptability of voluntary or involuntary childlessness.

However, in the United Kingdom, increasing numbers of couples decide on a childfree life. McAllister and Clarke (1998) carried out a qualitative study of 34 voluntarily childless women, and some of their partners in the United Kingdom. They documented a pattern of decision making in the process of "choosing" to be childfree for the couples they studied. Some decided early in the relationship that they did not want children, while others experienced doubts over a period of time, but finally decided to remain childfree. Some postponed the decision, or never really thought about it while others felt the decision was taken for them, in the form of fertility problems for which no treatment was sought, or because of (unspecified) lifestyle preferences.

Further comments in the work of McAllister and Clarke (1998) echoed those of midwives (Bewley 2000b) indicating that they did not necessarily dislike children, but viewed parenthood as a serious commitment which they were not prepared to make. The midwives also made a clear distinction between the physical and emotional experiences of pregnancy, labour and childbirth, and the long term investments required for bringing up a child (Bewley 2000a). Those in McAllister and Clarke's (1998) study also expressed frustration as did some of the midwives, when comments they considered valid, about childcare and aspects of parenting were discounted, due to lack of personal experience. This also mirrors the experience of those midwives who felt their midwifery expertise was challenged because of their lack of personal experience of childbirth and parenting (Bewley, 2000a).

Work consulted so far on midwives, other than my second study (Bewley, 2000b), has dealt only with midwives who do not have children, and has not specifically examined the feelings and experiences of midwives who do not have children, but who have also suffered a pregnancy loss. Neither has there been any specific exploration of the experiences of those who may have at some point experienced a pregnancy related loss, but who also have living children. The next section considers how midwives' personal experiences may affect their perceptions of themselves as women, and may impact on their relationships with their clients.

Midwives' personal experiences and their impact on the midwife-mother relationship

As previously suggested, there is little available literature on the personal reproductive experiences of midwives, adverse or otherwise, and how these contribute to the midwife-mother relationship. The term midwife-mother relationship arises in Kirkham's work (2000), and presupposes that the interactions between midwife and client will constitute a relationship, which I explore further in Chapter Five (page 272). The term also raises some questions about the word "mother", begging the question of whether a pregnant woman who has not yet given birth to her first live child can be called a mother. However, for the purposes of the current study, I have retained the term "midwife-mother relationship" since it appears so frequently in other literature, but discuss in Chapter Five (page 262) some further issues around terminology.

McNabb (1989) observed that those attending a woman in labour may bring with them such powerful negative emotions (albeit not necessarily related to their own reproductive circumstances) that they have a detrimental physiological effect on the labour. This view was echoed by Gaskin, (1994) and Thomas, (1994) who also suggested that midwives' life events, such as those mentioned below, may impact on women in their care, affecting them adversely.

Gaskin (1994) further suggested that midwifery training places insufficient emphasis on the midwife's personal life experiences and their potential effects on the midwife-mother relationship. Thomas (1994:2) also suggested that life circumstances which affect a proportion of women in the general population, such as eating disorders, sexual abuse, depression, domestic abuse, stillbirth and homosexuality, must, by their widespread existence occur in the personal lives of some midwives. She commented that very little work has been done on the psychodynamic nature of the midwife-mother, suggesting that self-exploration is essential to elicit aspects of personal life which may influence practice. Gaskin (1994) further suggested that the intensity of involvement in the birth processes may result in midwives being directly and perhaps unexpectedly, confronted with aspects of their own life experiences. These are speculative yet plausible opinions about the potential for midwives' personal experience to impact on practice. A small, unpublished study of six student midwives in the United Kingdom used semi structured interviews to explore the maternal feelings of the students during their time on the labour ward (Williams,1992). The study suggested that a dominant and recurring theme was that student midwives who had not had children, were distressed on their initial exposure to labouring women. We are not told how many of the students had children, nor of any other themes emerging from the study, which would have helped set the dominant theme in context.

Kitzinger (1992) found that experiencing or witnessing the birth process triggered memories of sexual abuse and rape in some women, and caused some to question, for the first time, their own sexuality. Walton (1994) agreed, speculating that midwives need to recognise their own, and other aspects of sexuality, and to consider the impact this might have on their working and personal lives. All the writers cited above, whether expressing opinions, or as a result of research, called for midwifery education to include exploration of self as a part of the midwifery curriculum to prepare midwives for their possible reactions to being with pregnant and childbearing women.

Those who have written about midwives without children agreed, that all midwives, no matter what their own experiences, need to recognise that each woman's birth experience is unique (Mander, 1996; Rowan, 2003). However, I suggest that midwives may need help in recognising how their personal experiences might affect their ability to relate empathically to women. The next section highlights some of the limited literature, which showed how some midwives reviewed their own experiences and applied them to their practice.

Some midwives have documented their personal experiences of pregnancy loss, and how it affected them as women and as midwives. Shuttleworth, (1995) wrote of her experience of miscarriage, and specifically mentioned the benefits she felt by being cared for by a midwife who disclosed that she also had experienced a pregnancy loss. In another personal account, Brown, (1995) who experienced a stillbirth prior to qualifying as a midwife, recounted her experiences, and the impact of her loss on her feelings as a student, and then later as a practising midwife. Radestad (1999) went further, not only describing the loss of her first child before birth, but drawing together expressions of grief from many bereaved parents. Her work, informed by her personal experience, was aimed primarily at helping health professionals to improve their care for bereaved parents. Spruce (1996) a midwife teacher, also recounted her experiences of returning to work following pregnancy loss, although her account is critical of the attitudes and support she felt from her colleagues. More experiences of grief and loss in pregnancy are further explored in Chapter Five (page 212) and re-examined in light of the findings from the current study.

Other literature relating specifically to midwives who do not have children for any reason, including pregnancy related loss, was limited, and in the main, not based on research, but on personal opinion. However, it reinforced the generally negative views of society of women who are voluntarily or involuntarily childless, as explored in the previous section. Walton (1994) examined concepts of sexuality, particularly in relation to motherhood. She acknowledged that midwives might inappropriately use their personal experiences to inform their midwifery practice, however, her claim in this context is that "women, on the whole, prefer the midwife to be a mother" (Walton, 1999:113). Donnison (1988) reached a similar conclusion, and her history of midwifery shows that in Europe and in many other parts of the world, maternity and maturity were until fairly recently essential qualifications for midwifery. The desire for maternity reflected society's assumption that the personal experiences of pregnancy and birth increased the midwife's knowledge and skills. The desire for maturity related to the midwife's availability, in that she should have borne and brought up children, but still be young enough to carry out her midwifery activities. Despite these comments, there is currently no requirement for maternity or maturity as a qualification for entry to midwifery training in the United Kingdom, and indeed no evidence to indicate that there should be.

In addition to Walton and Donnison's observations, there were some negative statements in the literature relating to midwives who do not have children. Hulse (1997) wrote a scathing letter about the inappropriateness of being attended by midwives who are "spinsters" (sic) and who have no children. She wrote as a mother, and likened the concept of being attended by a midwife with no personal experience of childbirth, to having a life-guard who cannot swim. This further negativity was echoed by Flint (1989) who suggested that some midwives treat women insensitively and that much of this thoughtless treatment arises from the unresolved grief of childless midwives. She also offered this as a reason for the unkind treatment of young midwives by their older, childless colleagues:

> To be unable to have children is a great source of grief and some of the insensitive treatment of parturient women is a result of this unresolved grief within our profession. Some of the unkind treatment of younger midwives may be something to do with this grief and anger from women who will never have children towards those who probably will. (Flint 1989:5/6)

Flint's comments infer that the consequences of this envy are unkindness. Whilst there was certainly evidence in some of the literature on pregnancy related loss about feelings of envy and resentment on the part of those who had been bereaved (see Chapter Five page 220), there was no suggestion that these feelings were translated into unkind behaviours, or that acts of unkindness were the province solely of women or midwives without children. The context of this statement is that midwives should be aware of each other's circumstances and provide a supportive, and indeed, cherishing environment (Flint, 1989). However, such sweeping and unsubstantiated statements as those quoted in this section imply that midwives who do not have children have a serious experiential deficit, which not only compromises their practice, but impacts adversely on their relationships with women and with their colleagues.

Mander's (1996) work on childfree midwives discussed the potential differences between care from a midwife who has children, and one who does not, concluding that there is no difference in the quality of care, based solely on whether or not the midwife has children. However, there is an underlying ad hominem argument suggesting that midwives who do not have children are bound to say that this makes no difference to their practice. Mander (1996) observed that all the midwives in her study valued expertise over experience, as did the midwives in my first study (Bewley, 1995). However, Mander (1996) went on to elicit from the midwives that each felt her own life experiences, whatever they were, equipped her for providing good care. This view is impossible to refute or to disprove, since there can be no simple comparison of practice between a midwife who has children and one who does not. The experience of pregnancy and childbirth varies from woman to woman, and indeed within the same woman from one pregnancy to another. Further the qualities which contribute to being a "good" midwife are far more complex than a simple sharing of experience.

As part of my previous research (Bewley, 2000b) I invited participants to think about the phrase "You can't be a good midwife until you've had your own" a statement often made by midwives who have had children, and who believe that their practice has improved because of this (Bewley 2000b). Some respondents felt alienated and threatened by such remarks, while some recognised that midwives who had children imposed their experiences inappropriately on women in their care. This tendency is, of course, not unique to midwifery. In their work on pregnancy and abortion counselling, Brien and Fairbairn (1996:174) explored the issue of health workers' own reproductive circumstances, and how these impact on their work, and these are explored later in this chapter, on page 34.

Women and midwives highlight the importance of continuity of care and carer (Department of Health, 1993), and the midwives in previous studies (Bewley 2000 a and b) stressed that the better they knew their clients the more open they could be with them. In an ongoing relationship, the woman's trust in the midwife is not founded on, or limited to, their shared experience of pregnancy or childbirth, but is based also on what the midwife reveals about her knowledge, skills and capacity for empathy (Bewley, 2000b).

Changing Childbirth (Department of Health, 1993) placed emphasis on woman centred care and the importance of development and continuity in the midwife-mother relationship. Kirkham (2000) has written extensively about the imbalances, which can undermine the relationship, including issues of power and control, which rest mainly with the midwife, but which can have adverse consequences for the woman. Continuity of carer can enable the building of trust and mutual respect on both sides, and it is important to consider how midwives' past experiences will influence the formation of that relationship. This again is explored in greater detail using findings from the current study in Chapter Five (pages 269 and 272).

I could locate no research evidence linking voluntary or involuntary childlessness with unkindness, which raised questions about how midwives bereaved by pregnancy loss cope with statements challenging their expertise as a midwife, in the absence of personal experience of childbirth. The next section considers the literature in relation to midwives returning to work following pregnancy related loss, and facing such challenges.

Work related aspects of midwives experiencing pregnancy loss

Society's views on motherhood have been explored, and some of the negativity associated with being childless or childfree discussed. Application of this to the midwives' relationship with her clients has also been explored. As previously discussed, being asked if they have children posed problems for some midwives, just as it did for non midwives (Bartlett, 1994) and for some midwives, their personal reproductive experiences impinged on their working lives (Bewley 2000b). For many, simply being asked if they had children raised difficulties in how to phrase their response. The question operated on a number of levels, and, although often asked as a simple conversational opener, was problematic for some midwives.

The question "Have you got children?" whilst seemingly innocuous, is not a simple question, and contains a number of underlying questions. It is also a question which has a different meaning for the woman asking, and for the midwife responding. For example, does it mean:
Have you got children now?
Have you ever had a baby?
Have you ever been pregnant?
and perhaps more significantly:
Is any element of what I am experiencing anything like you have experienced?
It may also carry an inherent challenge to the legitimacy of the midwife's presence at all, if she cannot back her expertise with personal experience. The question cannot always be satisfied by a yes or no answer, with or without a qualifying statement. There will always be a follow up question, either implied or outright, as women and their midwives seek to establish their relationship. Considerable social skills are required to provide an answer which satisfies both parties, but which led to some of the convoluted responses given by participants in my previous studies (Bewley, 2000a and b). These responses sought to confirm their experience as a midwife, or were designed to deter further questions on the subject.

Midwives who experience pregnancy related loss (rather than those who intend to have children at some future date), actually fall into three groups, when considering their answer to the question. The first group comprises those who have never had a child, whether or not they have been pregnant, and who, if answering honestly, will always answer the question "Have you got children?" in the negative. The second group comprises those who, at some point in their reproductive career have had a child who is living at the time the question is asked, who will answer "yes". The third group is those who have had a child who has died, and who have no other living children; their honest answer to the question is "no", but this negative answer may be denying the existence of a much wanted and much loved child.

My own exploration of midwives' responses to the question "Have you got children?" prompted a number of speculations from respondents as to why women ask (Bewley, 2000b). These included thoughts that it was about making conversation, establishing the credibility of the midwife, or seeking some sign that the midwife would be a kind and caring person. Mander (1996) suggested that pregnant women have significantly more on their minds when asking than merely making conversation. She proposed that women are operating their own form of "personality screening" (Mander, 1996:187), and assessing what the midwife knows about the reality of childbearing, as opposed to the theory. She also made the point that unless we know why the woman asks the question, it is difficult to make a considered response.

Some midwives (Bewley 2000a and b) told how they and some of their childless colleagues "invented" a child, so that they could respond positively to the question "Have you got children". Some did so to protect themselves; one felt that women lost confidence, particularly in labour, when the midwife revealed that she had no children. Chapter Five explores this issue in greater detail in conjunction with the findings. Mander (1996) suggested that when midwives create imaginary children for themselves, the whole midwife-mother relationship is based on a lie, and as such becomes less valid as a helping relationship. However, as the section on Sharing Experiences in this chapter suggests, deception to some degree, is a frequently used strategy in many relationships.

There were other work-related areas which midwives disclosed as being problematic. For example, of those who were experiencing infertility, or who had had miscarriages, some found specific groups of women, and particular sets of circumstances difficult to deal with, for example, seeing and holding babies, and hearing babies cry (Bewley, 2000b). Some respondents (Bewley 2000b) became cross with women who smoked or used drugs in pregnancy, or who expressed negative feelings about their baby. One respondent returned to work following the death of her six day old baby and was distraught when a woman who had just given birth rejected her baby, angry that it was a girl and not a boy. The midwife was unable to continue, asked a colleague to take over, and fled to the staff room in tears. Feelings of negativity towards pregnant women and babies, and a striving to avoid them occurs many times in literature on pregnancy loss relating to non midwives (Bartlett, 1994; Brien and Fairbairn, 1996; Kohner and Henley, 1997; Moulder, 2001). The difference for midwives is that they cannot avoid pregnancy and babies in their everyday work.

Further, those midwives who had experienced pregnancy loss did not necessarily want to disclose it for a number of reasons. They did not want to frighten the woman about her own pregnancy, nor did they want to spoil her happiness. Additionally, they did not want to risk becoming upset, and perhaps, therefore, what they termed "unprofessional", by disclosing their own personal circumstances. They also wanted to avoid becoming the cared for rather than the carer (Bewley, 2000a and b). Brien and Fairbairn's (1996) work on abortion counselling involved many health workers including doctors, ultrasonographers, gynaecology nurses and counsellors. They cited the difficulties faced by one of their respondents, a gynaecology nurse who was infertile, and who was continually upset, to the point of tears, when she cared for clients undergoing terminations of healthy fetuses. They made the point that this nurse felt unsupported in her work. However, another respondent, a counsellor, returned to work following a miscarriage and experienced no such qualms, but cited her own therapy, presumably during her counselling training, as being crucial in helping her reconcile her own position in relation to her loss, and her work situation.

Most of the midwives who disclosed negative thoughts (Bewley, 2000b) emphasised how they sought to conceal them from women, and struggled to maintain what they termed their professionalism in the relationship. In this context, they seemed to use the term "professional" to denote that they consciously strove to prevent their own experiences from affecting their relationships with their clients. Hochschild's (1983) work on relationships in the air line industry, identified this as "emotional labour" a process by which personal feelings are suppressed to maintain an outward professional appearance which exerts a positive effect on others, but which is intensely stressful to the professional. Smith (1992) also wrote about the emotional labour of nursing, and this is explored in more detail, and with specific application to midwifery in Chapter Five (page 248). Sandall (1997) also commented on the effects of burnout associated with some aspects of midwifery. Although, neither of these works related this to midwives' own experience of pregnancy loss, the concept of emotional withdrawal and its effects on midwives and women is explored, and will be returned to in Chapter Five.

Many of the work related circumstances which arose related to the potential for shared experience between midwives and pregnant women, and this is explored further in the next section.

Sharing experiences

Although my previous work (Bewley 2000a and b) focussed on the feelings of midwives, so many women ask if the midwife has children, that it may well be important to them. Literature on midwife-mother relationships, showed that midwifery skills, together with knowledge, compassion and empathy (Berg et al, 1996; Kennedy, 1995) are those attributes which are valued by women. Midwives also cited these qualities as important in providing good care (Bewley 2000a and b). Pope et al's, (1998) United Kingdom national study into aspects of maternity care sought the views of midwives, clients, supervisors of midwives and doctors, on what constituted "quality care" with emphasis on what made a "good midwife". The doctors and midwives cited knowledge, clinical competence, good communication skills and empathy as important. The women consulted (n =115) suggested that sharing of personal experience by the midwife was valued. The researchers do not make clear exactly what aspects of personal experience, but mention it in relation to the women's antenatal and intrapartum experiences. Despite the potential for shared experience to exist between mother and midwife, however, the midwife must disclose this, as there is nothing which immediately marks out the mother from the non mother.

Argyle (1990) suggested that self-disclosure is a likeable quality, and important in the formation of relationships, subject to the social acceptability of what is disclosed. As previous discussion in this chapter has suggested, childlessness is not necessarily accepted in society, and, on the whole, the midwives were questioned about their childlessness rather than disclosing it voluntarily. Argyle (1990) and Goffman (1959) studied relationships in which deception was used to avoid censure from other parties for behaviour or views, which are not approved of. As previous sections in this chapter have shown, society's negativity towards childless women makes it unsurprising that midwives' responses to their clients sought to establish common ground with the women they cared for, by affirming their desire to achieve motherhood. The issue of loss also raised the potential for midwives to engage in some form of deception, in their wish to protect themselves from hurt, and their clients from worrying about them, or to prevent clients worrying more about the outcome of their own pregnancy (Bewley, 2000b). The fact that some midwives "invented" children also accords with Goffman's (1959) view that self-presentation may include deception in order to maintain face and status. In my previous studies of midwives (Bewley 2000a and b), the midwives thought their childlessness less important than their midwifery skills. Some made joking responses, such as "No, I've got enough babies to look after here!", which effectively prevented further discussion on childlessness, yet they employed self-disclosure to confirm their professional competence. In this way, the midwives maintained control over topics which could be discussed.

Kirkham (1989) has written widely on the subject of communication in labour, suggesting that midwives use one line non-sequiturs to direct conversations, and to assert their own control of the labour situation. Perhaps the midwives joked to illustrate that they did not have children, but that they were caring and not representative of the popular views on childless women. Also, they were able to send out the message "don't ask me about this any more" in a way which they hoped, would not embarrass the mother (Bewley 2000b). Those who had experienced pregnancy loss felt they needed to avoid answering to protect themselves from further hurt, and to prevent women becoming upset.

Regardless of the intention behind the response, there is no way of knowing how the pregnant woman and her family feel when they hear it, or what their response will be. Given the potential for the interaction to influence the midwife-mother relationship, this is explored in more detail in Chapter Five in conjunction with the findings from the current study.

Supporting midwives

Those who experience pregnancy loss may approach support groups, where they may gain comfort from sharing their personal feelings and experiences. Many of these groups have worked closely with midwives and other health professionals to produce guidelines based on experiences of those affected. However, during my review of support groups prior to beginning this study, none of those contacted provided specific support for midwives, or indeed health visitors, gynaecological nurses, female obstetricians and others in similar work, who will return from pregnancy loss to an environment dominated by the evidence of others' fertility. Of those I contacted, SANDS (Stillbirth and Neonatal Death Society) confirmed that they have a number of "befrienders" who are midwives. This lack of specific support seems ironic since there is emerging evidence to suggest that midwives are at high risk of difficulties with conception, and subsequent miscarriage, possibly related to shift work (particularly night duty) and exposure to nitrous oxide (Boivin, 1997:Ahlborg et al, 1996; Axelsson (1996). Ortalyi et al's (1996) study of pregnant workers included 197 nurses, 184 physicians and 192 bank workers. They found that the nurses and physicians experienced higher incidences of preterm labour and low birth weight babies and, ironically, since they are in the "caring professions" highlighted what they termed negative attitudes to their pregnancies from their employers.

Spruce (1996), a midwife teacher, described how unfeeling her colleagues appeared, when she returned to work after miscarriage. However, as findings from my studies suggest (Bewley 2000a and b), colleagues needed help to find a balance between being sensitive yet not being over sensitive. Participants spoke about how they were unsure whether to talk about their own or other colleagues' pregnancies in case they caused offence. It appears that there is little targeted support for midwives experiencing pregnancy related loss. This was an area highlighted as important in the findings from the current study, and is explored in more detail in Chapter Five (pages 233 – 235).

Loss and Pregnancy loss

The underlying theme throughout the thesis is that of loss. As can be seen from previous sections in this chapter, the losses explored are not confined to loss of a baby, child, or specific pregnancy. As previously suggested, loss, and the processes of grief and mourning also apply to those who lose the potential to become mothers, through age, medical or physical problems, or through a conscious decision not to pursue infertility treatment (Bartlett, 1994). When contemplating motherhood, Bartlett (1994) suggested that there is a process of decision making for women when they consider pregnancy and childbirth, and documented the transitional period in a woman's life when her fertility is untested, and she believes she has a choice about having children. If discovery of infertility, or intervention of the menopause removes that choice, there is grief, not only for the loss of potential motherhood, but also for the loss of choice. Additionally, loss may occur as a result of relinquishing a baby for adoption and as Mander (1994, 1995) points out, the associated grief is as ongoing and prospective as that of any other pregnancy related loss. Further, in the current study, losses associated with fertility and motherhood occurred in a working situation dominated by evidence of others' fertility.

Theories of attachment and loss are explored and analysed in much greater detail in relation to the findings from the current study in Chapter Five (page 208), but at this stage, it is important to acknowledge some of the fundamental beliefs about loss and grief which informed the development of the study. Writers on bereavement and loss have noted a series of emotions which may accompany loss, and which were described by Kubler Ross (1970) in relation to five stages of death and dying. These stages were initially described as disbelief or denial, anger and hostility, bargaining, depression, and finally acceptance or resolution. These responses may not necessarily occur in any particular order, and in some cases may not occur at all. Bowlby (1969) suggested that the emotions associated with loss are felt only when a significant degree of attachment has occurred between the bereaved and the lost person. Parkes' (1998) work with prematurely bereaved widows and widowers described grieving as an ongoing process, consisting of a number of stages, whereas Worden (1991) described a more active approach in a series of tasks of mourning, which needed to "worked through".

Walter (1999) adopted a Durkeheimian sociological perspective to examine twentieth century studies of loss and grief. He expressed concern that the dynamic, explanatory theories of the analysts' search for knowledge about grief and loss, became obscured in what he termed the "clinical lore" adopted by many professionals in their attempts to support the bereaved. Walter (1999) suggested that, in particular, young professionals (sic), such as medical and nursing students, without personal experience of bereavement, adopted a dogmatic, inflexible and simplistic interpretation of the stages of grief and mourning. He further suggested that such professionals attempt to "police" the grieving process, attributing failure to follow the stages to an abnormal or pathological grief reaction. In particular, he cited misinterpretation of resolution as an unhelpful consequence of this translation of explanatory theory into inflexible dogma. For example, Worden's (1991) last task of mourning is cited as a breaking away from the deceased and the reinvestment of emotional energy into a new relationship, and accords with the processes of resolution described by other writers, for example Parkes (1998). Resolution was cited as an essential component of grieving in which the bereaved person acknowledges that the lost loved one will never return, and assimilates the loss into their own lives (Parkes, 1998; Bowlby, 1991). Walter (1999) felt that this was interpreted as a detachment from the loved one, enabling the bereaved person to "let go" and "move on", and suggested that this was the dominant view of the twentieth century. However, he further observed that some who are bereaved have no intention of moving on yet achieve resolution by simultaneously "keeping hold" and "moving on" (Walter, 1999:xiii). On publication of his own views on resolution, he received letters from bereaved people expressing relief that he considered this an acceptable way of dealing with loss. Walter (1999) did not dismiss the concept of resolution but acknowledged that it may present in many different ways. A survivor of the Hillsborough disaster (described in the current study in Chapter Five, page 235) in which she lost friends and relatives was asked at one point if her life was back to normal. Her response was that things would never be back to normal, as her own personal normal was now different to her pre Hillsborough normal (Taylor et al, 1995). This suggests that for her, resolution involved acknowledgement that her experiences of loss had changed her as a person, and that she accepted what she had become as a result of that change. This accords with Walter's view that resolution takes forms other than a relinquishing of all memory and emotion associated with the lost person.

In some cases, such as infertility, the loss is not related to a person, but as the comments from Bartlett (1994) showed earlier in this chapter, to loss of a potential person. Some midwives in my second study (Bewley, 2000b) commented that their feelings and their responses to questioning about children had changed over time, as they came to terms with their circumstances. They experienced a resolution of their particular pregnancy related loss, incorporating their changed circumstances into their view of themselves as women and as midwives.

The emotional responses to loss described above can apply to many life circumstances, such as loss of employment, loss of health, and loss of material possessions, and have also been described in relation to pregnancy related loss . Over the past thirty years, the treatment of bereaved parents, those who experience infertility, miscarriage, and termination of pregnancy has changed considerably, and is explored further in Chapter Five (page 212). In preparation for the current study, the literature on pregnancy loss was consulted but is not reported in this chapter in any great depth. This may seem unusual since the study is about pregnancy related loss, but my concern was that the findings should not be pre-empted by any views, which I might unknowingly assimilate about the new areas I wanted to explore. The primary aim of the initial literature review and search was to establish the need for the study. To this end, the literature on loss was consulted in general terms, and the major works which contribute to helping midwives support bereaved parents such as Kohner and Henley (1997) and Mander (1994) appear briefly in this section, but are consulted, with other important work on the subject of loss, in more depth in Chapter Five (page 212).

Much of the literature on pregnancy loss rightly focuses on providing effective support for bereaved parents, and other family members. There is also emphasis on the need for staff to be supportive of each other and to debrief following instances where there is a loss. Little of the literature on pregnancy loss deals with the impact of personal loss on midwives except to highlight the need for them to support and share parents' sorrow, for example, Rajan, (1994). However, Rajan also found, in a study of 483 bereaved women, that some women perceived midwives as "unhelpful" in supporting them after loss. Mander (1994) examined the difficulties midwives experienced when giving emotional support to bereaved parents, which may contribute to an appearance of being unhelpful. However, none of the work consulted considered whether midwives' own reproductive experiences influenced their ability to relate to parents, in either a positive or negative way.

Self-help groups for those who have experienced pregnancy related loss produce a wide range of literature for parents and for health professionals. There is, however a lack of specific literature for health professionals returning to work following pregnancy loss, and for coping with those groups of clients they may find challenging. Previous studies (Bewley 2000a and b) suggested that some midwives found certain strategies supportive, including referral for counselling outside the workplace and sensitive placement in the clinical area, to enable them to avoid groups of clients or situations they found difficult. Findings from my previous work (Bewley 2000b), also suggested that some midwives considered leaving the profession because of their own reproductive experiences. Whilst no causal link is inferred, this may have implications for retention of midwives. There are currently approximately 90,000 Registered Midwives in the United Kingdom, of whom approximately 30,000 are practising (Nursing Midwifery Council, 2003). Although the recent RCM Survey on Why Midwives Leave (Ball et al, 2001) did not reveal aspects of personal experience as a reason for leaving, it is unclear whether it featured specifically in their research questions. However, other areas they explored are examined further in conjunction with the findings in Chapter Five (page 250).

Summary of literature review

Considerable research documents the life changing experiences related to issues of reproduction and pregnancy whether that experience culminates in loss, or motherhood (Oakley, 1980; Dowrick and Grundberg, 1980; Bartlett, 1994: Rogan et al, 1996; Kent, 2000). Literature from sociological, anthropological and psychological sources suggested that in many societies, motherhood was considered woman's biological destiny, and that women who do not achieve their reproductive potential are viewed with suspicion, pity and negativity (Pfeffer, 1993, Morrell, 1994: Hunt and Symonds, 1995). Conversely, there was little research based literature on the personal reproductive experiences of midwives, and how these may influence practice and relationships with clients (Mander 1996; Duggan 1997). Unsubstantiated statements by Flint (1989) and Walton (1993) inferred that some midwives treated women (and student midwives) unkindly, and that this unkindness was related to the unresolved grief of midwives who do not have children. Research into what women perceived as "good" midwifery care, indicated that they wanted a midwife who was not only clinically skilled, but one who possessed qualities of compassion, empathy and kindness. Women also valued the midwife sharing her own experiences of pregnancy and childbirth (Berg, 1996, Pope et al 1998). There is no intention to suggest that any of the qualities which women valued is more important then any other. However, none of the studies differentiated between midwifery care being good or poor in relation to whether or not the midwife had children (Bewley 2000b).

Studies on loss, and on grief and loss in childbirth suggested that there is considerable support generally available for women who experience pregnancy related loss (Kohner and Henley, 1997: Mander, 1994), or for those who are infertile. However, little or none exists specifically for midwives, (or others in similar occupations), whose needs may be different to those who are not closely involved with pregnancy and childbirth, and who face evidence of others' fertility on a daily basis.

Midwifery theorists (Bryar, 1995) advocated the exploration of self and the use of models to understand and test concepts in midwifery knowledge and practice, and to improve the therapeutic relationship between midwives and childbearing women. My personal observations, my previous work, and the initial review of the literature in this chapter, suggested a number of important concepts which contribute to the theoretical perspectives which guided the current study. These are shown below, under the headings in which they appear in the chapter.

Theorising in midwifery:

> exploration of self, and use of models can advance and test midwifery knowledge and theory, including that of relationships with childbearing women

Women, motherhood and society:

> the dominant discourses on motherhood, whilst dynamic, are socially, politically and culturally predicated on the assumption that motherhood is the appropriate outcome for a woman in a heterosexual relationship

Midwives personal experiences and their impact on the midwife-mother relationship:

> midwives may be affected in their work by personal experience of pregnancy related loss
>
> some midwives who are asked whether they have children feel uncomfortable replying "no" and feel they have to justify their responses
>
> the nature of the midwives' response directs further conversation between midwife and mother and can influence their subsequent relationship

Work related aspects of midwives experiencing pregnancy related loss:

> the reproductive experiences of midwives may impact on and may be impacted upon by the nature of their daily work
>
> midwives are frequently asked if they have children and this can be problematic for some of them
>
> some midwives who have experienced pregnancy related loss sometimes express difficulties in relating to women and to their colleagues in certain circumstances

Sharing experiences:

> midwives' personal experience can be used appropriately or inappropriately to support mothers and other midwives

Supporting midwives:

> midwives may have specific areas of concern in relation to their practice which may not arise for other women experiencing similar pregnancy related losses
>
> there is little available in the way of support specifically aimed at midwives

Loss:

> loss in the context of the proposed study, may relate to the loss of an actual or potential pregnancy, to the loss of a child, to the loss of the potential for motherhood, or for the loss of choice in relation to any of the foregoing

Establishing the research question, aim and objectives

From the review of the literature, the current study was devised to address the research question:

> What are the experiences of midwives who have had a personal pregnancy related loss and how do these impact on their midwifery practice?

The overall aim of the research was, therefore:

> to explore the experiences of midwives who have had a pregnancy related loss, and relate this to their approach and attitude to their work with pregnant and childbearing women, and to their colleagues

Specific objectives from the aim were to describe and analyse experiences; to relate experiences and attitudes to daily practice; to consider how midwives' personal experiences may influence how they approach their work; to consider educational, professional, and other support systems which take account of personal experiences of both midwives and student midwives. From a theoretical perspective, objectives were to examine the relationship between client and midwife, where the midwife has experienced a pregnancy related loss and to produce a theory and conceptual model (or models) to illustrate the midwife/client relationship where the midwife has experienced a pregnancy related loss. The research question, aim, and objectives are revisited and set in the context of the study design in Chapter Two.

Conclusion

In this chapter, I revealed the reasons for my interest in the topic of midwives' personal experience of pregnancy related loss. I set out my intention to contribute to the epistemology of midwifery by using a theory generating qualitative approach to the study. The rationale for using a theoretical framework in a grounded theory approach has been explained, and, following the initial review of the literature, the framework which guided the development of the study was explicated. The framework related to issues of women and motherhood, midwives' personal experiences and their impact on the midwife-mother relationship, some work related aspects of pregnancy related loss for midwives, sharing experiences, supporting midwives, and some aspects of loss. The research question was formulated, and the overall aim and objectives of the study outlined. Chapter Two describes the how the study was designed based on the foregoing, using a grounded theory approach.

CHAPTER TWO

STUDY DESIGN

Introduction and overview of the chapter

Chapter One reviewed the literature and previous work on midwives who have experienced personal pregnancy related losses, concluding that little research based evidence is available on the nature of such experiences and how they may impact on midwifery practice. The research question therefore was:

"What are the experiences of midwives who have had a personal pregnancy related loss, and how do these impact on midwifery practice?"

As discussed in Chapter One, the aim of the research was to explore the experiences of midwives who have had a pregnancy related loss, as defined in Chapter One (page 11), and relate this to their approach and attitude to their work with pregnant and childbearing women, and to their colleagues. The following specific objectives were addressed:

describe and analyse experiences

relate experiences and attitudes to daily practice

consider how midwives' personal experiences may influence how they approach their work

consider educational and professional, and other support systems which take account of personal experiences of both midwives and student midwives

from a theoretical perspective examine the relationship between client and midwife where the midwife has experienced pregnancy related loss

> produce a theory and conceptual model (or models) to illustrate the midwife/client relationship where the midwife is experiencing or has experienced a pregnancy related loss

In association with the above, the theoretical framework, derived from my personal observations, from my own previous work, and from the initial review of the literature informed the research design and is summarised as follows:

> the dominant discourses on motherhood, whilst dynamic, are socially, politically and culturally predicated on the assumption that motherhood is the appropriate outcome for a woman in a heterosexual relationship
>
> midwives may be affected in their work by personal experience of pregnancy related loss
>
> midwives may have specific areas of concern which may not arise for other women in otherwise similar circumstances
>
> experience can be used appropriately or inappropriately to support other midwives and mothers
>
> exploration of self and use of models can advance and test midwifery knowledge and theory, including that of relationships with childbearing women
> (see figure 2:1)

This chapter describes how the study was designed in two phases, discusses the sampling strategy, methodological approaches, data collection and data analysis. Some drawbacks and limitations are highlighted, which led to changes in the sampling strategy.

STUDY DESIGN

Overview

The study design replicated that of my second study (Bewley, 2000b), building on its strengths and adapted to suit the needs of the current study. The current study targeted a different population, using a new questionnaire based on the original findings (Bewley 2000b) and subsequent literature searches. The current study was designed in two phases. The first phase consisted of a self selected, self reporting group, responding to a request for participants which appeared in the Royal College of Midwives Journal (Bewley, 2003a). This group completed questionnaires consisting mainly of open questions, which generated narrative accounts of their experiences. Following qualitative analysis of these data, a second sample was drawn from the first sample, for in-depth follow up interviews, using questions based on the findings from the first phase. Data analysis from both phases informed the findings.

Population

There are currently approximately 86,000 Registered Midwives in the United Kingdom, of whom some 30,000 are practising (NMC, 2003). However, of this number, it was impossible to establish how many have had personal pregnancy related losses. Applying percentages would have been speculative, and perhaps misleading, as research has already indicated that nurses and midwives experience higher levels of miscarriage than the general population. It was also difficult to ascertain how many would wish to be involved in research in such a sensitive area. The Royal College of Midwives (RCM) is the professional organisation to which a large number of midwives belong. All 37,000 members receive a copy of the RCM Journal or its supplement twice monthly. The Journal contains a letters page in which requests for help with projects and studies appear. I decided to recruit via the RCM Journal letters page, thus the population is those midwives and student midwives who fit the inclusion categories, and who are recipients and readers of the RCM Midwives Journal.

Sampling

The study required recruitment of midwives who have experienced personal pregnancy related loss, as defined in Chapter One (page 11).

Using the recruitment technique described above resulted in a self selected, and initially self reporting sample. There are some difficulties inherent in self reporting, including passage of time (in some cases more than 20 years), desire to present socially acceptable views of self (social desirability), all of which may influence the self reporting by respondents (Polit, Beck and Hungler, 2001). Further, the recruitment technique meant that the sample was drawn only from those midwives who read the Royal College of Midwives Journal, and there was no way of judging how representative it was. Despite the foregoing, my previous success with the questionnaire method gave me confidence that rich, qualitative data could be generated using this method (Bewley, 2000b) to shed light on a new and relatively unexplored field. I was also confident that sufficient participants would be interested in taking part in follow up interviews. As the findings show, a total of 40 questionnaires was completed in which all respondents indicated they would be happy to participate in follow up interviews.

Inclusion criteria

The inclusion criteria were, therefore, experience of infertility, with or without treatment; miscarriage, termination of pregnancy for any reason; stillbirth or neonatal death; reaching menopause without having living children; being in a relationship where male partner is unable to have children; giving up a child for adoption and active decision not to have children.

The study excluded those who had not yet tested their fertility prior to the menopause, and male midwives, who do not face the same views of society in terms of biological expectations that they should reproduce. The invitation letter asked for midwives, but the students who responded were not excluded. The rationale for this was that some of the midwives who responded had experienced their losses prior to becoming midwives, and some of their accounts specifically described events that had occurred during their training.

Generation of sample for questionnaires

I published details of the planned study in the Royal College of Midwives Journal, (Bewley, 2003a) inviting colleagues who were interested, to request further details of the study, and a questionnaire.

Within a week of my letter being published, I had received more than 20 requests for questionnaires, and the first completed questionnaires arrived within the week. I received requests by e-mail, telephone and letter. Initially I sent all the questionnaires out by post, with a stamped addressed envelope for return. Subsequently, I sent questionnaires requested by e-mail, out by e-mail. In total, 56 questionnaires were sent out, and 40 returned completed. I was concerned initially about maintaining exactly the same approach to each participant. However, I transcribed each questionnaire, whether handwritten or typed and on reviewing the transcriptions, it was difficult to tell which had been originally handwritten and which had been typed and sent electronically. I concluded therefore that the variation was not detrimental to the data collection and analysis.

Sampling for follow up interviews

Sampling aimed to reach a cross section of respondents within each of the inclusion criteria. In depth interviews with 10 participants explored the topic areas, and gained additional data not disclosed within the questionnaire. Using a constant comparative technique for analysis, after ten interviews, no further new information relevant to the study emerged. The findings from the interviews gave valuable personal insights, into the experiences of the individuals, and provided confirmation of the categories and core category emerging from the analysis of the questionnaires. I felt this was an appropriate sample size to supplement the detailed information already generated from the questionnaires. There were three telephone interviews and seven face to face interviews. Drawbacks of telephone interviews are acknowledged, in that interviewer and participant are denied cues of body language, although conversely, neither may be influenced by the same cues (Barker, 1998a). There are also benefits in the anonymity afforded by the telephone. The reasons for the telephone interviews were that one participant was ill on the original day for face to face interview, and we agreed that we would follow up by telephone, another had moved house to a remote location in Scotland subsequent to completing her questionnaire. The final telephone interview took place with a participant who was also remote to the researcher.

With participants' permission, interviews were tape recorded except in one case, where the machine for recording telephone interviews failed, and in one face to face interview where the machine malfunctioned after one hour. Detailed, handwritten notes were taken in both these cases. All interviews were subsequently transcribed verbatim.

Credibility

Validity refers to the extent to which the research method measures what it purports to measure. Reliability is concerned with consistency of research findings, or the extent to which replication will produce similar results. However, within qualitative research, there is greater emphasis on credibility. Credibility acknowledges that consistency and replication are difficult, but that within the research, there should be a clear mechanism to track the process by which the researcher has reached conclusions. Guba and Lincoln (1989) refer to this as the "decision trail". The decision trail for questionnaire analysis is described in the section on data analysis . In the case of follow up interviews, each transcript is numbered, and each line of each page numbered. The numbered identification means that any quotations can be tracked to its origin. For example, 9/216, means the statement will be found on transcript no 9, line 216.

Parahoo, (1997), and Brink, (1991) suggest that validity may be further confirmed when others read and can identify with the research findings. Findings from the questionnaires and the interviews were presented to a group of peers, who agreed the categories, and were able often to identify similar events in their own practice.

Ethical issues

Ethical approval was obtained from the Middlesex University School of Health and Social Sciences Ethics Sub committee. Full explanation and written consent was obtained from those involved in follow up interviews. Participants had the opportunity to withdraw from the study at any time. Confidentiality was maintained. In such a sensitive area, the research could be considered an intervention in itself, the results of which might never be known to the researcher. As the section in this chapter on feminist research highlights, (page 66) sometimes, participants are left traumatised and unsupported after divulging sensitive information, and not knowing how that information might be used. To minimise adverse effects, names, addresses and telephone numbers of support groups appropriate to the various needs of the participants were provided. Participants also had telephone, e mail or other access to me, in case of specific questions. Some requests for questionnaires were received well after publication of the initial invitation letter, when the data analysis for the first phase was complete. I answered all these letters, and sent details of support organisations. I also undertook to send details of the completed research project to all the respondents, including those who were too late to take part. All respondents have received details of the findings and were invited to comment. After the first phase was complete, I wrote a letter of thanks to the respondents which was printed on the letters page of the RCM Midwives Journal (Bewley, 2003b)

I also took care when seeking assistance for transcription for interviews. I described the nature of the subject material to the transcriber, and ensured that she felt able to deal with it. At various points when I handed over tapes for transcription, and received the completed transcripts, I also checked with her that she was happy to continue. Similarly, when I sought assistance from peers in confirming the categories, I described something of the nature of the work, and ensured that they were aware that it was potentially upsetting, particularly if they had experienced pregnancy related loss themselves. In one case, a colleague had offered her help in confirming categories, but she had recently been bereaved. I explained that the categories included data on bereavement, and she decided she would not participate. These steps to safeguard the emotional well being of those associated with the research, other than direct participants, are also recommended by Mander (2000). I was supported by a counsellor to ensure my own emotional well being, and by my Supervisor of Midwives, should any issues about clinical practice arise.

Other than when it was in transit to and from interviews, or in the course of transcription, data from questionnaires and interviews were kept in a locked filing cabinet.

METHODOLOGY

This section discusses the methodological approaches, which were considered for the research. A qualitative methodology was sought which would allow participants to present their own experiences and thoughts. The chosen method needed to acknowledge that individuals in apparently similar circumstances might have vastly differing perceptions. A number of approaches were considered including phenomenology, case study and biographies, which are alluded to in this section. However, grounded theory forms the major part of the discussions on methodology. From these, the principles underpinning grounded theory were considered most appropriate, and form the basis for data collection and analysis

CHOOSING THE QUALITATIVE APPROACH

Omery (1983) suggested that nurse researchers often find quantitative approaches in the rationalistic paradigm unsatisfactory, since they fail to take account of the human condition, seeking rather to objectify humans and reduce their thoughts, behaviours and feelings to a succession of numbers and graphs. This view was echoed in midwifery by McNabb, (1989) and Oakley (1990) who criticised research which takes one measureable and quantifiable aspect of pregnancy and childbirth, and ignores other factors which may have equal, but less easy to measure influences. The process of childbirth is linked with many factors, including relationships with midwives. These intersubjective factors cannot be counted, measured or ranked. Quantitative methodology in this instance was inappropriate, since the current study sought insight into the experiences of the participants.

Phenomenology, case study and biography

This section of the chapter briefly reviews three research methods which I considered before deciding on a grounded theory approach.

Phenomenology as a research methodology seeks to understand and interpret the lived experiences of individuals at certain points in their lives. It arises from psychology, and allows for the perception of multiple realities (Gribich, 1999). Knaack (1984) identified three areas, which constitute lived experiences and which are appropriate for phenomenological research. These are, the interpretation of a single unique event, the interpretation of a single unique individual and the interpretation of a general or repetitive psychological process. The development of modern phenomenology is complex, with differing schools of thought on approaches to data collection, analysis and interpretation (Koch, 1995; Polit and Beck, 2004). Husserl's original work concentrated on describing the experience of a phenomenon, (eidetic phenomenology), which extracted the essence, or true meaning of the phenomenon under investigation. My view is that currently, description is placed low in a hierarchy which values critical analysis above all else. In order to describe accurately, the researcher must first critically analyse the data to determine what it is about the phenomenon which needs to be described. In order to achieve accuracy of description, Husserl advocated "bracketing out", or identifying and confronting one's own personal beliefs and biases to avoid confusion between these and the data. There is significant discussion about whether or not bracketing is realistic or achievable; research literature offers a proliferation of confounding theory and counter-theory (Burns and Grove, 2001; Polit and Beck, 2004). These lead me to conclude that the most important aspect of researcher intersubjectivity, which bracketing seeks to eliminate, is that researcher, participant, and reader are aware of potential biases, and that these should be incorporated into the research design, as part of the theoretical framework.

Heidegger (1995), a former pupil of Husserl, developed this approach further, in hermeneutic phenomenology, which included interpretation and understanding of the phenomenon, in addition to description. Heidegger explored the etymology of the word phenomenology, tracing it to the Greek words meaning "to step into the light", and "to say". McQuarrie (1977), the existentialist philosopher, who translated Heidegger's major treatise on Being and Time from the original German, suggested that the word can be traced further back to the Indo-European word *pha* which is connected to light and clarity. He identified two levels in Heidegger's work, the first level of showing (eidetic) the second of interpretation and articulation into speech (hermeneutic) (McQuarrie, 1977). Phenomenology should probably be considered a way of philosophising, rather than a philosophy (McQuarrie, 1977), and allows for the acceptance of multiple versions of reality. Critics of phenomenology have pointed out that whilst it is appropriate for small studies on subjects about which little is known, it concentrates on the individual's perception of a particular situation, without necessarily acknowledging the influence of the particular situation itself. Further, it ignores the macro issues of the individual's exposure to educational, social and environmental factors (Cohen and Mannion, 1991).

My first study (Bewley, 1995; 2000a) adopted a phenomenological approach, and obtained new information about the experiences of midwives who do not have children. The sample size was small (6), as is appropriate in phenomenology. However, other than one midwife, who knew she was infertile, the self selected group, was composed of young midwives who had not yet "tested" their fertility. Nevertheless, the analysis and interpretation of the range of experiences informed the later, much larger study (Bewley, 2000b), in which many of the findings from the first study were supported.

Within the current study, a method was sought which not only acknowledged the ontology of the individual perspective, but also from which theory could be generated to inform further information gathering and interpretation. In formulating the research approach, I also briefly considered case study and oral biographical approaches. A purely case study approach could have been used, since this is suited to expanding knowledge, and adding to existing experience, congruent with a humanistic approach (Gomm et al 2000). Case study can also provide illustrations via stories, about differing social contexts and social groups, and can apply to individuals, or groups of individuals.

However, the very definition of what constitutes a "case" can be problematic, with loose definitions leading to misunderstandings (Grbich, 1999).

Grbich (1999) explored other field based methods and described oral biography as a way of collecting written or oral accounts of life events, and how these impact on individual and collective experience. She suggested that the term "life history" may be used to describe a person's account of their whole life (a full life biography) or an event in their lives (partial life biography). Data collection combines qualitative and quantitative methods to collect rich, in depth data, and demographic information. These are combined to produce an overall picture. Aspects of oral biography appear in the current research study, as respondents complete questionnaires giving great details about their life events. However, these accounts are reflective and subjective, and do not place the respondent in a social context. Oral biographical research demands validation of the reflective accounts by comparison with accounts from those who knew the "researched" at the time. This was not considered appropriate or achievable for the current research.

Grounded theory as described in the next section, allowed for the use of case study within the methodology (Sarantakos, 1998), and enabled the incorporation of some aspects of biography, as in the narrative accounts from the questionnaires. As Sarantakos points out, this principle of grounded theory considers every case (midwife, in this instance), as an autonomous structure in its own right, not merely an element of something else, and allowed for the ontological inferences which I valued in the phenomenological approach.

Grounded theory

Grounded theory is a qualitative research methodology developed by Glaser and Strauss (1966). The term "grounded" refered to the fact that theory emerges from empirical data, collected from fieldwork, and related to everyday thinking and behaviour. The researcher's analysis and interpretation of data result in the development of theory. Grbich (1999 p171) suggested that, in part, grounded theory was influenced by the phenomenological concepts of returning to the essence of a particular person's or group of persons' experience of phenomena. Grounded theory is not a philosophy of itself (Polit and Beck, 2004), but its original proponents, Glaser and Strauss (1966) used theoretical principles arising from symbolic interactionism described by Mead in the 1930s (Grbich, 1999). Mead saw the self as a sociological rather than a psychological phenomenon, proposing that interaction between "selves" becomes a series of constructs, in which one person may simultaneously adopt a number of social roles, depending on the context of the interaction. Individuals plan and carry out their own activities based on their interpretation of previous responses and ongoing community behaviours. Further, interactions are complicated by the use of symbols and ritual (Burns and Grove, 2001), which may be evidenced by use of particular words, clothing and behaviours. My previous research (Bewley 2000a and b) clearly indicated a process of active behaviours and attitudes which midwives adopted in response to the context in which the question "have you got children?" was asked. However, the words and their underlying meanings seemed differently constructed between midwife and client. As the findings in the current study showed, there were other incidences of symbolic significance for example in relation to the midwife's uniform and the change it brought about in self-perception (page 179).

Holloway and Wheeler (1996) suggested that grounded theory has been widely adopted by nurses "due to the orderly and systematic way in which the data are collected and analysed. This, after all, is the way in which health professionals do their work". (Holloway and Wheeler, 1996:99). This statement infers, wrongly, I believe, that health professionals are unable to think creatively and laterally about their approach to research, preferring a step by step rigid framework. Glaser and Strauss, (Strauss and Corbin, 1998) developed grounded theory initially as a means of analysing the interactions between doctors and dying patients; their original work spawned a number of books further amplifying and clarifying the techniques of grounded theory. Holloway and Wheeler (1996) charted the progress of clarification, highlighting those which provided a "clear and practical approach". Textbooks on nursing research, for example Burns and Grove (2001) and Polit and Beck (2004), whilst providing an immense wealth of information, also promoted a rather rigid staged approach to data collection and analysis. Hycner (1985) suggested that the emergence of rigidly structured frameworks offering step by step approaches was an attempt to legitimise the use of qualitative methods in areas which have traditionally revered a rationalistic approach to research. Hycner (1985) commented that to place too much emphasis on step by step analysis may lead to reification of the steps to the detriment of the underlying principles of the research methods. Nevertheless, such so called "soft" approaches still call for a degree of academic rigour to ensure that the chosen method is correctly applied. Baker et al (1992) analysed the processes involved in phenomenology and grounded theory, and the potential for researchers to unwittingly blur the two. Their work charted the evolution of phenomenology from the discipline of psychology, and grounded theory from the discipline of sociology. They provided a clear differentiation, yet managed to avoid being rigid or prescriptive. The avoidance of the "mish-mash" described by Baker et al, (1992) is essential in credible academic work, yet whilst it is important to establish rigour, elements of a number of approaches may be appropriate for any particular study. What is important is that the researcher understands from which methodological approach the chosen elements derive, and that any reader can be clear about how data were collected and analysed.

There is a danger that the choice of, and rigid adherence to a research methodology may become detrimental to the aims and objectives of any research project, and my awareness of this is applied to the current study. The very existence of phenomenology and grounded theory as research methodologies arose from their original proponents' rejection of the contemporary approaches to research available to them. The subsequent discourses on the appropriate and inappropriate uses of both methods, and the further in depth examination of the minutiae of the processes are testament to the dynamism of research methodology. Glaser and Strauss went on to differ widely in their view on what and how grounded theory should be. Strauss (Strauss and Corbin, 1998) developed ever more complex approaches to data analysis, whilst Glaser advocated a much less prescriptive method (Grbich, 1999). I sought a methodology in which creativity would not be sacrificed by slavish adherence, either to the methodology, or to the conventions of data collection and analysis. However, the chosen methodology needed to be rigorous enough to withstand investigation.

Thus, for this study, a research method was sought which would be congruent with the heterogeneity of the midwives, acknowledging each one's unique experience and perception, yet able to use each one's experience to generate further knowledge about the whole group (Bewley, 2000a). Case study and oral biography maintained the focus on the individual, whilst the techniques for analysis described later in this chapter, generated further knowledge and theory. The subsequent literature review enabled the findings to be contextualised by examining current social and psychosocial trends.

The literature on grounded theory, therefore, generally described it as an open minded and flexible method, ideally suited to a topic about which little was already known. It provided elements through which the approach sought above could be accomplished. The approach I chose was based on four central criteria (Strauss and Corbin, 1998). Sarantakos (1998) described these, saying, first, that each case is an autonomous unit which must be studied and reconstructed as something worthy of study in itself. Second, that the researcher should approach the reality of the researched in an unbiased and unprejudiced manner. Third, that the approach to the data should be grounded in everyday thinking and finally that as new ideas emerge and are developed, concepts are developed in an ongoing process. Concepts and theories derive from constant comparative analysis, in which an ongoing process of induction, deduction and verification take place (Sarantakos, 1998).

Thus the current study used the principles of grounded theory; first, a questionnaire, based on the theoretical framework, was used to collect qualitative data, then, semi structured in depth interviews with selected participants explored themes generated from analysis of the qualitative data. Data collection and analysis proceeded together with interaction between the two occurring on a continuous basis. However, the rigid, staged processes of data analysis was rejected as being constraining rather than creative and liberating. As the section on data analysis shows, a, simpler, interpretive style was used, following Beck's scheme (1992).

Reflexivity and reflective analysis – the location of self in the research

In academic writing, it has been argued, particularly by feminist writers, that researchers seek to give an impression of impartiality and neutrality to their work by writing in the third person (Webb, 1992). In this study the philosophy of Hall and Stevens (1991) is adopted, in which the author's own previous experiences, exploration of the topics under discussion and thoughts during the research are acknowledged. This is accomplished through field notes and my reflective diary. Reflexivity and reflective analysis are also acknowledged by the use of the first person in some sections of the study.

Ray (1994) highlighted the importance of reflexive analysis, where the researcher's mind is active as it seeks to "know" the world. This mind activity might lead the researcher to new knowledge and insights, or may raise forgotten but important issues from previous experience. The researcher must decide whether to use an approach to questioning which avoids use of personal conceptual or historical issues, or an approach which incorporates them into the study.

More recently, Finlay and Gough (2003) drew together accounts by various researchers, of experiences of the research process, and their analysis of their interactions with participants. As the editors remark in their introduction, there is a danger that reflexivity can degenerate into a self indulgent exercise of limited value, which may obscure the research process and shift the focus onto the researcher rather than on what is being studied. Perhaps the most helpful part of Finlay and Gough's (2003) work is their introductory chapter which examined the processes involved in achieving reflexivity, rather than the subsequent chapters in which researchers examined their own location in their chosen studies.

In this study, I declared my background as a midwife without children. However, reflexivity is not merely about disclosing personal information, rather it is a way of making the researcher more visible in the research process. It should enable the reader to assess the credibility of the research by being able to discern how much the researcher (and her own biases) have influenced the data collection and analysis, particularly those which may influence the responses of the participants and may impact inappropriately on the interpretation of the data. Anderson (1991) concurred with this view, suggesting that participants and researcher inevitably impose their own values onto the giving and receiving of information. Anderson (1991) further suggested understanding is impeded only when the reader of the research becomes unclear as to what is data, and what is has been spuriously imposed on it by the researcher. Grbich (1999) echoed this when she suggested that lack of reflexivity could challenge the validity of research.

Researcher bias may be pre-existing, or may arise during interactions between researcher and participants. The potential for bias on my part as a researcher arose from a strong belief that ability and credibility as a midwife are not contingent on having been pregnant, or having had a child. However, this bias was unlikely to affect my interactions with participants, as they may well have held the same view. Nor was it a view which this study sought to prove or disprove.

I did not particularly want to discuss my own reasons for not having children, and in the questionnaire phase of the research, this was not an issue. However, during interviews, two participants asked me directly, at the end of an interview, if I had children, and when I responded no, they asked me why. I gave an honest, brief, answer, but felt uncomfortable that they had asked. Given the qualitative premise that findings arise from interactions between the researcher and participants (Burns and Grove 2001), my reluctance to disclose my own circumstances is paradoxical, as it was exactly the area I wanted to explore with the participants. In my reflective journal I noted that the model I produced (Figure 6:2) to show the midwife-mother relationship could just as easily have been modified to illustrate the researcher-researched relationship in this study.

Some sources, including Burns and Grove (2001) suggested that the researcher ought to have had the same experience as the researched, but within my field of enquiry, this

would be impossible. I do not have children, but even in that respect, I do not share that experience with all the participants, as some of them now have children, or, indeed, already had children when they experienced the event they wished to share.
My classification of myself as not having children was as complex as that of the participants, but I have not experienced the loss of a pregnancy. However, as the findings showed, many participants made assumptions about my ability to understand them based on what they thought was my background. I have had similar experiences when speaking on the subject of domestic violence, where I demonstrated an understanding which many people mistakenly assumed arose from my own personal experience. This "as if" quality of my own self-presentation engendered a personal feeling of fraudulence, although nothing in the literature given to participants ever suggested that I had experienced any loss which enabled me to have a deeper understanding of their situations. Indeed, as previously stated, one of my premises is that understanding can be achieved in the absence of personal experience.

From my previous work, I have experienced strong feelings, both negative and positive, when reading completed questionnaires, and from conducting interviews. These lead to a protective approach to the participants. This is positive, because it reinforces the ethical stances I have taken, but could also be negative, in discouraging me from presenting their experiences objectively. However, recognition of this possibility led me to review the work of Bergum (1991), who explored the experience of becoming a mother from a phenomenological perspective. She commented on the tension which exists between the inner passion of the researcher and the outward activities of the research process. Her study of women becoming mothers reflected the depth of her emotional involvement with the women whose stories she wrote: Her empathy and affection for the women enhanced her resolve as a researcher to record their experiences faithfully and accurately. I too wished to represent the respondents in my study in a faithful and accurate way, but recognition of my potential wish to "protect" them helped me to continually question whether what I wrote, accurately reflected what they intended to say. This is reflected in my use of many direct quotes in the findings.

There is considerable debate within the qualitative realm on the status of the researcher and the researched. I have already alluded to the issue in phenomenology, of eliciting and "brackets out" bias which might influence respondents, or the analysis of the data. In counselling, this is also used to enable counsellors to identify and set aside feelings about their clients which might impede the counselling process (Egan, 2002). Midwives may adopt similar strategies when dealing with clients whose behaviour they disapprove of, and which they sometimes referred to as maintaining a professional approach. This self awareness, and setting aside of personal beliefs and views which are potentially unhelpful in the research process constitutes part of the reflexive process. Additionally, I believe my experiences gained in counselling, and from my degree in education, which was largely humanistic in approach, enabled me to stand apart to some extent from my own personal experiences. I had some ideas about what I might find, but these arose from my previous research, and informed my questions. I was quite prepared for my ideas to be discounted by subsequent information. The processes of reflexivity and intersubjectivity highlighted the need for me, as a qualitative researcher, to be constantly aware of the potential influences my own experiences, biases, and reactions in specific situations might have on the research process.

In the questionnaire phase, the intersubjectivity, and my contribution to the interaction is evident from the questionnaire, from its layout, its tone and its questions. However, in the initial invitation phase, participants contacted me by letter, by telephone and by e mail, asking for questionnaires. In this phase, my direct interactions fell somewhat outside the research parameters. When participants disclosed something of their circumstances when they were requesting questionnaires, I always acknowledged their losses, whether on the telephone, by letter or by e mail. I gave details of support organisations to all respondents, and suggested that they contact me if an organisation appropriate to their needs was not mentioned.

I was asked at a presentation of the findings if I felt I needed to respond to e mails and letters in a helping way, that is, to respond specially to people when they disclosed information to me. My answer was that I did, on many occasions, want to respond. For example, one participant wrote a very long and tragic account of her baby's death, and at the end said she was writing it on the tenth anniversary of his loss. I found this very moving, and considered sending a card to acknowledge this. However, I decided not to do this to avoid lack of parity in my treatment of participants, but, as mentioned before, I put a general letter of thanks in the Royal College of Midwives Journal (Bewley, 2003b). Although I have a qualification in counselling, I did not feel it was my role to provide direct counselling to the participants. However, it was my role morally and ethically to ensure they were not left unsupported if their participation in the research left them emotionally vulnerable.

The presence of self in the interviews is more complex. The transcripts show that the vast majority of each interview is (rightly) occupied by the interviewee. However, during the interview process, inevitably, thoughts occurred to me which prompted further questioning, or led to insights. An example occurred during Nina's interview, which appears again in Chapter Four. I gained an insight into the difference between the instrinsic sadness of an event, and the sadness the event can generate by triggering memories of a personally experienced sadness during the interview where Nina spoke of relating her own sadness to that of her clients:

> *Nina: I think that it is more really what is happening rather than my own experiences of it. It is more of the fact that losing a baby that you have tried awfully hard for, it is sad situation, rather than my experience of it...*
>
> *Int: .. is your personal situation different to your work situation so you are able to keep the two things separate?*
>
> *Nina: Yes, I think that's what it is. I think I might have found it harder or more difficult or different if I had got pregnant, if I had a later miscarriage, so I think it is almost like another bit, having had treatment, but pregnancy, it is different.*
>
> *Int: I think I understand what you are saying. When you are with a woman who is miscarrying, you didn't have any sadness of your own to relate to, but you could see it was sad in its own right.*
>
> *Nina. Yes.*

The interviews raised other issues from a reflexive perspective. A major personal concern of mine was that participants would become upset, and that I may have increased their distress by reminding them of their losses. One or two participants became tearful during our interviews, and I kept tissues on hand (but not visible, lest I create the expectation that they should be upset) in case of this. One or two told me they thought they might be upset, but that they still wished to participate. I acknowledged their distress, but in all cases they said they wanted to continue. I was afraid that I too would become tearful, but felt it would be unhelpful, and that they might feel guilty that they had made me sad. This was especially the case when they described something touching, yet remained completely composed themselves. It was only after the event that I sometimes found myself near to tears. One example was when Flora told me she had called her dead baby Peter, after Peter Pan, the boy who would never grow up and who would always be her baby. At a meeting with my supervisors, I chose not discuss this, because I knew I would be upset. However, I also reflected that outward expressions of emotion may not be representative of the depth to which it is felt, either in myself, or in the participants. I could not know whether those who appeared completely composed were equally as distressed as those who were tearful. My own coping mechanism in the immediate situation was to take deep breaths, and remember that in the interview situation, my distress must always take second place to the well being of the participant. These were examples of my own wish to appear "professional", and of my own emotional labour in the interview situation (see Chapter Five). My own support for these situations included a counsellor, with whom I spoke regularly.

Bergum, (1991) and other feminist writers acknowledged the importance of the relationships between researcher and researched, and since this study is about women and carried out by a woman, the next section explores some feminist approaches and views on research, and applies them to the current study.

Feminist research

This section does not provide an in depth analysis of feminist research, but acknowledges that researcher and participants are exclusively female, and that participants work predominantly with other women as clients and as colleagues. For this reason, I have highlighted some aspects of feminism which are pertinent to the study.

Feminist researchers of sociological phenomena noted the androcentric nature of scientific research, which has systematically (although perhaps unintentionally) ignored the predominantly oral history of women, women's lives, and perhaps most importantly, women's propositional knowledge. The move from empiricism and reductionism probably began earlier than the advent of the women's movement (Mies, 1993), and heralded a revision of the quantitative approaches to social science research.

Writers such as Oakley (1992), Roberts (1992), and Finch (1993) reviewed techniques of intervewing from a feminist perspective, and provided, at the time, new perspectives of knowledge about women's lives and experiences. Oakley (1992) favoured an informal, unstructured interview which suggested an equality between researcher and researched, avoiding the objectification of women participants. Oakley (1992), Roberts (1992) and Finch (1993) expressed surprise at the willingness with which women talked at interview, even though there was an element of their own "performance" being judged. Roberts (1992) also reviewed questionnaire responses in which participants made specific comments on the usefulness of the research process, having the opportunity to talk (albeit in written form), and having the opportunity to help someone in a similar situation to their own. More recently Burns and Grove (2001) commented that a basic premise of feminist research is that society privileges men and marginalises women, and this view of women as an oppressed group seemed evident in the writing of other feminists (Sigsworth, 1995).

Salmon (1999) used a feminist approach to analyse women's experiences of perineal trauma post delivery. She used a snowball technique to recruit six participants, aged between 25 to 40 years of age, all white British, all of whom had access to further education. The focus of the study was the women's unique and subjective perceptions of themselves in the immediate post partum period in relation to perineal trauma. She highlighted previous studies which suggested that women suffer from insensitive and degrading treatment in male dominated health care provision, which has systematically devalued their knowledge of their own bodies. She further documented the growth of self help initiatives by and for women, to compensate for the lack of support in areas which women deemed important. In her research, Salmon reported insensitive comments and actions by male doctors which made the respondents feel that their complaints of pain and discomfort during suturing, and in the following months were not only inappropriate but wrong. However, whilst the gendered nature of the doctor patient relationship is important, Salmon suggested that the women in the study attributed the trivialisation of their concerns solely to the gender of those who attended them. Nevertheless, she suggested that midwives colluded in the assertions that the appearance of the perineum, and levels of pain the women experienced were quite normal. Salmon does not comment that midwives also can be disempowered in a male dominated organisation which devalues their knowledge and experience just as it does that of women patients. The adoption of a feminist approach can result in polarisation of argument which attributes any action or event solely to gender. Salmon partially addresses this, but the male doctors emerge badly from the study, whilst the female participants are seen as victims of male oppression.

Other research studies have examined aspects of women's experience from a feminist perspective, with particular reference to women's oppression, and its relationship to reproduction, for example, Rogan et al's study of first time mothers which is explored in Chapter One, (page 22) of the current study in the section on motherhood. Layne (2003) specifically examined the relationship between medical intervention and confidence in women's reproductive abilities to ensure positive pregnancy outcomes or what she termed "happy endings". She almost inferred a collusion between biomedical approaches and those promoting natural childbirth; these contribute to culture of meritocracy, which attributes blame to women who experience pregnancy loss. Within the current study, I do not propose that the participants are an oppressed group, although

I accept that their view of their experiences will be to some extent socially and culturally determined by the gendered nature of their experiences as women and as midwives.

I adopted Grbich's (1999:9) more positive approach to feminist research, in which she suggested that, a desirable outcome when dealing with (and perhaps upsetting the equilibrium of) vulnerable participants, is that they are empowered by increasing their knowledge and insight, or by initiating some kind of action. Thus the feminist principles which informed the current study were related to maintaining equality between researcher and researched, and the concept of empowerment. Whether the participants in this particular study are empowered is yet to be seen.

The foregoing has described how a number of research methodologies were considered, and how the principles of grounded theory as exemplified by Sarantakos (1998) were drawn on to form the basis of the study. The next section discusses the strategies for data collection.

DATA COLLECTION

Method

Data were collected in two stages. The first by a self report questionnaire sent out either by post or electronically, the second by semi-structured, in depth interview, using questions derived from the data analysis of the first stage.

Questionnaire design and use

The literature surrounding questionnaires, is mainly directed towards their use in collecting quantitative information, analysed in a quantitative way. However, many researchers describe how qualitative data can be generated by the use of open questions (Barker, 1998b;Burns and Grove, 2001; Polit and Beck, 2004). These data can subsequently be analysed using qualitative methods as described later in this chapter. Questionnaires may be self administered, or may be used as part of a semi structured interview. Literature suggests that response rate, and quality/quantity of responses to open questions is likely to be limited. However, this was not my experience in previous work, (Bewley, 2000b), and I hoped that the principles I had followed then would result in further "rich" data.

QUESTIONNAIRE DESIGN

A questionnaire must be clear about what information it seeks to elicit. In this case based on the research question, I sought information about the personal experiences of the midwives, and how these had impacted on their practice. From previous studies, I knew that the effects of the experience depended on the type of event, the midwife's work circumstances at the time, and the responses of other people close to her (Bewley, 2000a and b).

The questionnaire (Appendix 1), was printed with the university name, address and logo, and contained further information about the study. Five introductory questions asked for demographic information about participant's age, length of time she had been a midwife, which areas of midwifery she worked in, and if she was currently working as a midwife. There was no intention to analyse the quantitative data, other than to give a profile of the age range of the group. The demographic questions provided background information on each individual, and were designed to move the respondent from simple, everyday information to the more complex and sensitive open questions.

Design of open questions

Open questions derived from the theoretical framework and were designed to generate further data. They were linked to the overall aims and objectives of the study as described in Chapter One. Figure 2:1 in the current chapter shows how the questions were formulated and related to the areas identified at the end of Chapter One.

The open questions (Questions 6 – 14), therefore, were designed to provide a framework for the participant to record experiences, thoughts and feelings in narrative form. Figure 2:2 shows the structure. Space was left under each question for the response, and participants were invited to continue over the page or on a separate sheet if space was insufficient.

The questionnaire was not piloted since the overall structure and format were similar to the questionnaire used in my previous study (Bewley, 2000b). The design of the questionnaire and the tone it sets are crucial in determining whether people will invest the time and trouble to complete it. The design of the previous questionnaire had yielded in depth written accounts, and the same principles were used in the current study. The questionnaire is written in a friendly tone, and aims to engender a spirit of caring and empathy. The highest return rates for questionnaires are obtained when they are logically sequenced, and are written in a language which facilitates communication between the researcher. Further influences include ease of return, and colour on which the questionnaire is printed (Barker, 1998b). Yellow has the highest response rate and was chosen in this instance. All questionnaires sent out by post included a self addressed stamped envelope.

Semi -structured interviews

Semi-structured interviews were used to supplement qualitative data obtained from the open questions in the questionnaire (Barker, 1998b). The interview schedule was designed to draw out further information about general themes which had emerged from analysis of the questionnaires. The schedule consisted of open questions (Figure 2:3)

Figure 2:1 Showing how open questions were formulated – See Appendix one for full questionnaire

Areas for exploration arising from discussion in Chapter One from theoretical framework **(Questions 1 – 5 are closed, demographic questions)**	**Question**
that pregnancy and motherhood are life changing experiences (Questions 6 and 7) that issues surrounding fertility and reproduction are important in women's lives (Questions 6 and 7)	6. Please tell me something about the circumstances of your own reproductive loss or problems 7. Was there one or more particular event (such as miscarriage, loss of a baby, diagnosis of infertility, onset of menopause) which were significant to you in your personal and working life
that the reproductive experiences of midwives impact on and are impacted upon by the nature of their daily work (questions 8 – 12) that midwives are personally and professionally affected by their reproductive experiences (Questions 8 – 12) that midwives may have specific areas of concern which may not arise for other women experiencing similar reproductive events (Questions 8 – 12)	8. How did you feel when you first returned to work? 9. Did your work colleagues, managers, family or friends do or say anything which was particularly helpful or unhelpful? 10. Were there any aspects of your working life which were more difficult than others? 11. How did you cope with these difficulties 12. How do you feel now about being a midwife
that experience can be used appropriately or inappropriately in interactions with other midwives and mothers (Questions 12 – 14)	13. What prompted you to respond to my letter in the RCM Midwives Journal? 14. Please tell me anything else about yourself which you think would be helpful

Figure 2:2

Showing how open questions are turned into statements providing a framework for recording narrative accounts
Circumstances of the reproductive or pregnancy loss
Any particular events, such as miscarriage, loss of a baby, diagnosis of infertility, onset of menopause, which were significant in personal or working life
Feelings on return to work after the event
Helpful or unhelpful things said or done by colleagues, friends or family
Any aspects of working life which were particularly difficult
Feelings now about being a midwife
What prompted the participant to respond to my request
The final question (14) asked if there was any other information that the participant would like to give me, which they thought would be helpful

some general, and some specific to that particular respondent. Interviews therefore enabled clarification of some issues, which seemed ambiguous or unclear on the questionnaire responses. The introduction to the interviews explained further the aims and objectives of the study, the aims of this particular interview, why the interviewee was selected and how the information given in both questionnaire and interview would be used (Barker, 1998b). Anonymity was assured, and all the information given verbally by the interviewer was given in written form for the interviewee to keep. A consent form was obtained from each participant, and again, a copy given to the person to keep. The subjects under discussion were emotive and personal to the participants, therefore the utmost sensitivity was required to avoid causing them distress. Participants were given the names and addresses of support groups, and reminded that they could contact the researcher if issues arose for them following the interviews.

Formulating the interview questions

Particular topic areas arose from analysis of the questionnaires, which I wanted to explore in more depth. These areas were support, empathy, self-disclosure, change in practice, practical issues around work and writing accounts of experiences as therapy. These topic areas and my own questions about them are summarised in figure 2:3.

Throughout the interviews, counselling techniques were used to draw out more information, for example, open questions such as “tell me more about.....”, “how did you feel about....”. In addition, reflecting and summarising skills were used to check that understanding of the interviewer was correct.

Figure 2:3 Formulation of questions for semi structured interviews

Topic areas for exploration	Interview Questions
Support What is support? What would be examples of supportive behaviour?	What does the term "support mean to you? How could you have been supported on your return to work?
Empathy Some participants felt that there were people who they thought really understood what they were going through How could participants tell that people understood and cared about their circumstances?	Can you think of anything that other people said or did which made you think they really understood and cared how you were feeling?
Self disclosure Were participants helped by other people in similar circumstances to their own? What would be examples of this? Would participants tell clients about their own particular experiences? Under what circumstances?	How did you feel when people shared their own experiences with you? How do you feel about sharing your experiences with clients?
Change in practice Some people said their practice had changed because of their experiences In what ways did practice change? How would other people know this? How would clients know (without being told directly) that the midwife's experience had influenced her practice? Would anyone, other than the midwife herself know that she had changed? How do participants think other people would know?	How have your experiences affected your work with women and babies? Would you say your practice has changed? If so, how? How might other people say your practice is different?
Practical issues around work Some people mentioned particular clinical areas, or particular groups of people they found it difficult to cope with. Ask for more examples Was there anything that made these circumstances easier (or more difficult) to cope with?	Were there any particular circumstances you found difficult at work? Can you give examples? Was there anything which made these circumstances easier (or more difficult) to cope with?
Writing accounts of experiences as therapy Some people commented that they found completing the questionnaire helpful What does the participant think now Can they remember any of their feelings while writing the questionnaire? How do they feel now that they have written their account?	What are your feelings now about being a midwife? How do you feel now about being a participant in this research?

Further questions were derived from the individual questionnaire responses

Data Analysis

The two phases of the study required different approaches to analysis, but with the same aims. To identify themes, similarities and differences, and to ensure that that the themes and sub themes could be effectively tracked back to their original sources.

The staggered receipt of questionnaires meant I was able to begin the constant comparative analysis of the narrative accounts immediately. Data were recorded and analysed using three formats, Individual Data Template (IDT) constructed from the questionnaire design, a Master Data Template based on the above, and a File on Emerging Themes and sub themes. Each of these is described below.

Individual Data Template (IDT)

An IDT was completed for each participant. Quantitative details from questions 1-5 were recorded. Qualitative data from narrative responses to open questions were typed verbatim onto the template. Within each section, the participant may have described a number of unrelated experiences, and where this occurred, I inserted spaces, and numbered the responses within the question section. For example this is participant 38's own response, typed and returned electronically, exactly as it appears in the questionnaire, to question 9.

9. Did your work colleagues, managers, family or friends do or say anything which was particularly helpful or unhelpful?):

> My work colleagues sent a lovely bouquet of flowers to my home after I was discharged home which marked the event.
>
> My partner(boyfriend) said " it wasnt a baby though was it?" Very hurtful. My mother was wonderful and came to stay for a few days. I think the most unhelpful while I was on the gynae ward was that none of the nurses asked how I

> was emotionally, or how I felt at losing the baby. At a particularly emotional time (I stayed in a week after) one morning after a bullying nurse was trying to make me take analgesia which I didnt want, the midwifery manager came in – she had a kind of knack of being where she was needed! She was a very matronly soul with an authoritative and non nonsense character. She sat down on the bed and gave me a hug and I wept on her ample bosom. I feel tearful when I think about it now. It was not invasive just exactly what I needed and I feel eternally grateful to her for this. I really would not have every (sic) imagined this kind of support from her which somehow made it even more precious. What was not helpful was another midwife to came to see me on the ward and who proceeded to tell me how she had lost a baby – sorry I just wasnt interested at that time! Interestingly, just recently a very close friend who lives in France said how we had never talked about my infertility. This surprised me as I thought we had, meaning that sometimes if the loving intention is there, communication does not have to be in a verbal form! On the other hand I remember feeling resentful with another friend who was besotted with her new baby that she was not not (sic) sensitive to my situation and did not ask how I was feeling.

Clearly within that response there were a number of different issues. I inserted spaces and corrected the typographical and grammatical errors to ensure ease of reading. I also numbered the responses within each question section as shown below:

1. My work colleagues sent a lovely bouquet of flowers to my home after I was discharged home which marked the event.

2. My partner(boyfriend) said " it wasn't a baby though was it?" Very hurtful.

3. My mother was wonderful and came to stay for a few days.

4. I think the most unhelpful while I was on the gynae ward was that none of the nurses asked how I was emotionally, or how I felt at losing the baby.

5. At a particularly emotional time (I stayed in a week after) one morning after a bullying nurse was trying to make me take analgesia which I didn't want, the midwifery manager came in – she had a kind of knack of being where she was needed! She was a very matronly soul with an authoritative and no nonsense character. She sat down on the bed and gave me a hug and I wept on her ample bosom. I feel tearful when I think about it now. It was not invasive just exactly what I needed and I feel eternally grateful to her for this. I really would not have ever imagined this kind of support from her which somehow made it even more precious.

6. What was not helpful was another midwife to came to see me on the ward and who proceeded to tell me how she had lost a baby – sorry I just wasn't interested at that time!

7. Interestingly, just recently a very close friend who lives in France said how we had never talked about my infertility. This surprised me as I thought we had, meaning that sometimes if the loving intention is there, communication does not have to be in a verbal form!

8. On the other hand I remember feeling resentful with another friend who was besotted with her new baby that she was not sensitive to my situation and did not ask how I was feeling.

This format enabled me to anonymise the responses (although non were received anonymously), and to establish a data trail. For example, in the findings, I would be able to quote from the data using the formula 38 (participant number) 6 (Question number) 8 (response number), giving 38/6/8. Although this was my original intention, it produced a somewhat clumsy format for the presentation of findings. After further discussion with my supervisors, I concluded that it would be more appropriate to give the participants (and their babies, where appropriate) pseudonyms, and include the number of their transcript only. These pseudonyms were of my own choosing, with, for no particular reason, the initial letter, corresponding with the initial letter of the participant's real name. In the case of the interviews, I used the names only, as this made for clearer reading of the findings, and gave a more personal view of the participants.

I also recorded on the individual templates some specific questions to be followed up at interview.

Master Data Template (MDT)

Beck (1992) uses the term "significant statements" to describe responses made by participants, which the researcher considers important in the data analysis. I had used this method successfully in analysis of data from in depth interviews (Bewley 2000a and b), and used it in the current work, to establish themes, similarities and differences in participants' responses. The MDT followed the same structure and format as the Individual Data Template, and on it, I recorded what I considered to be significant statements from different participants.

Emerging Issues and Maps

Finally, I maintained a file in which I recorded themes emerging from the analysis, and which I entitled Emerging Issues. In addition, I mapped out models, and consulted existing frameworks, for example the Johari window (Luft and Ingham, 1955), which seemed significant at the time, and was considered for further analysis, but not actually used, when producing the model for midwife-mother relationship (Chapter Six, page 286). This method is congruent with the coding and memoing in grounded theory, in the search for categories and core category (Strauss and Corbin, 1998).

The methods outlined above enabled me to maximise my time, yet achieve "immersion" in the data. The most useful of these was the transcription of each questionnaire on the Individual Data Template, as it afforded close association with the data, and gave a feel for the person writing it. During transcription of each questionnaire, I kept the computer file for Emerging Issues open, so I could note issues as they arose in the transcription. Immediately after each transcription, I recorded the significant statements onto the Master Data Template. I also noted on each transcript the specific follow up questions I wished to address.

Throughout this initial stage of data analysis, nothing which seemed even remotely significant was knowingly dismissed, but recorded on the templates. Analysis of the questionnaires took progressively longer, as with each analysis, more issues emerged, which meant rechecking previous questionnaires, in case anything had been missed. Once the data analysis from the questionnaires was complete, the schedule for selected follow up interviews was drawn up and the respondents selected.

Data Analysis of interviews

Tape recorded interviews were transcribed verbatim. Interviews were analysed by reading and rereading transcripts in conjunction with field notes, again searching for themes, similarities and differences. The technique of identifying significant statements (Beck, 1992; Bewley, 2000b) was once again used. Analysis again used coding and memoing to check emerging themes, sub-themes and categories (Burnard, 1991). At all stages, significant statements could be tracked back to the original interview by a numbering system which numbered pages and lines from each transcript. These were checked back with the findings from the questionnaires, using a constant comparative technique, and the emerging sub categories and categories were continually reviewed in the light of each analysis. Chapter Four shows how the findings from the interviews supported existing categories from the analysis of the questionnaires. This chapter also shows how data from the interviews informed additional sub categories.

Using literature as data

Following complete analysis of the interviews and questionnaires, I returned to the literature, and used this as further data against which to discuss the findings. Chapter Five shows how the findings from the questionnaires and interviews informed the further literature search. Figure 2.4 gives an overview of the stages of the study.

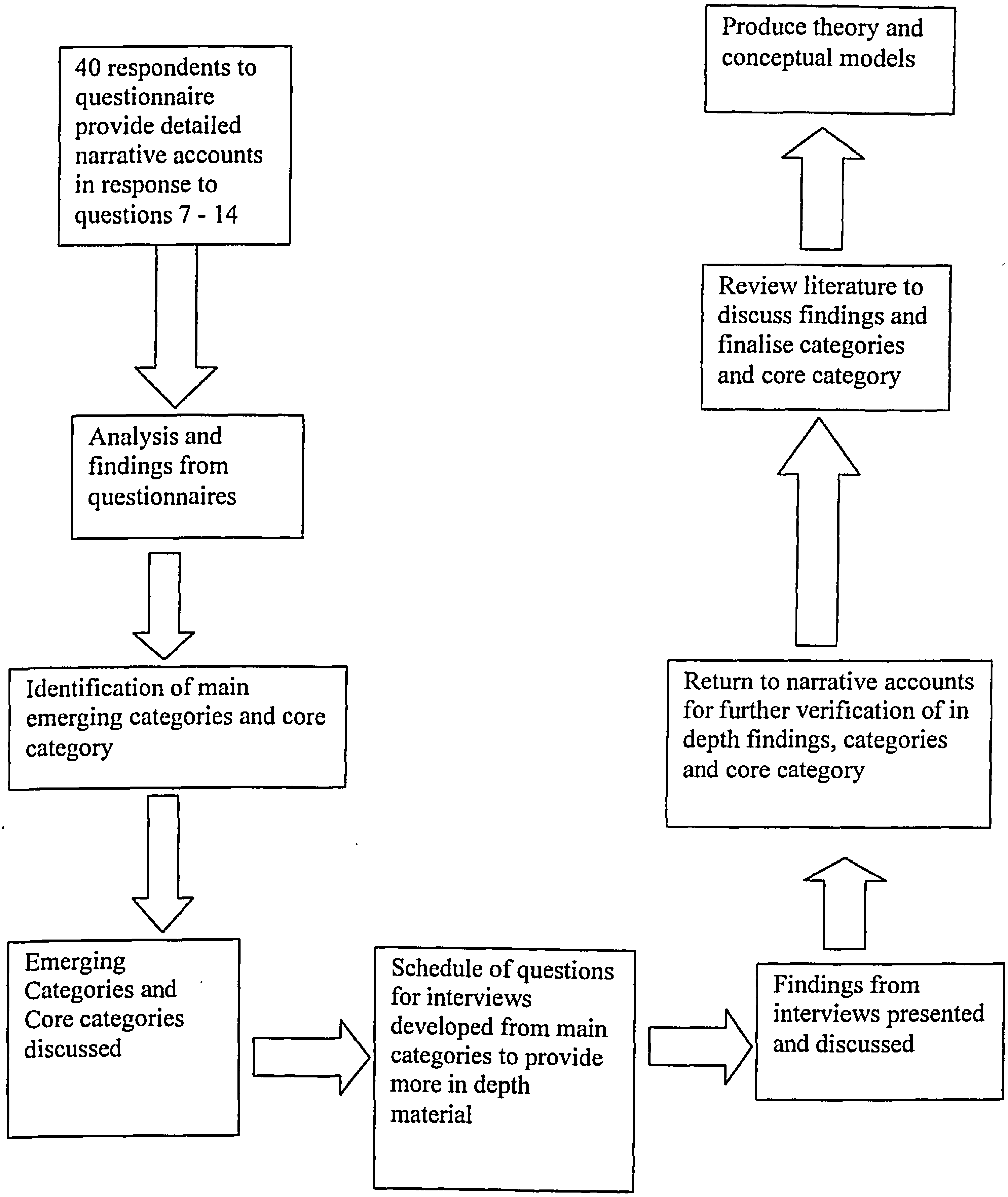
VALIDATING THE FINDINGS

Burnard (1991) comments that within grounded theory, two approaches to validating the findings and establishing credibility can be used singly or together. The participants may see the transcripts of their interviews, together with analysis showing themes, categories and subcategories, and have an opportunity to verify what has emerged. Further, experienced, independent researchers in the field could be asked to scrutinise the findings in conjunction with the data to confirm credibility. In this study, credibility was established in three ways. All participants received a copy of the findings, and were given an opportunity to comment. Two independent practitioners, sensitive to the research issues were asked to scrutinise the findings. As this study forms the basis for the award of M Phil/PhD, and has been supervised by experienced researchers in the field of sociology and qualitative research applied to midwifery, their supervision constitutes the views of experienced researchers.

STRENGTHS, LIMITATIONS AND DRAWBACKS OF THE RESEARCH DESIGN

Stevens (1993:153) observed that criticism of research by its author often comprises "confessional tales" which appear, but are observed from outside the research rather than as an intrinsic component. This section includes empirical observations, but acknowledges the researcher's responsibility, reflexivity and engagement with the

Figure 2.4 An overview of the stages of the study



research process throughout.

Original sampling strategy

The original population for the current study was to be the informants in my second study (Bewley 2000b), of whom 150 indicated that they would like to participate in further research. From these, it was envisaged that up to thirty would be selected for in depth interview. Selection was to be purposive yet pragmatic and congruent with time scales and financial implications such as travel costs. It was also thought that sampling would demonstrate reflexivity on the part of the researcher, in that it would be theoretical, purposive and able to be changed in response to new data. The proposed sampling strategy was problematic, due to the following:

Small number of those who had experienced the conditions I wanted to research
Large geographical spread
Only four responses to my first ten invitation letters

I decided, therefore, that despite the additional work involved, I needed to change the sampling strategy. Following discussion with my supervisor and Director of Studies, I followed a similar route to recruitment from my previous work (Bewley, 2000b). This would involve recruitment of a new cohort, but would also allow for involvement of respondents from the second study. I decided to replicate the second study, targeting a different population, and using a new questionnaire based on the findings and subsequent literature searches. The target group now included midwives who had experienced a pregnancy related loss, even if they now had children, whereas previously, those with children had been excluded.

The new approach generated a sample of 40 participants, with a variety of experiences of pregnancy related loss, as shown in Chapters Three and Four. As previously mentioned, 56 requests for questionnaires were received. Sixteen midwives did not return their questionnaires. Asking for the questionnaire in the first place required an active response, and I was reluctant to place pressure on any of the potential participants by sending reminders. I have no way of knowing why midwives decided not to continue, although some work suggests a high attrition rate in studies on bereavement (Mander, 2000). However, any comments about non return are purely speculative.

The diversity of the sample could be seen as problematic. It is clear that some of the needs of those who described themselves as infertile were different from those who had experienced miscarriage or other pregnancy losses. However, as already explained in Chapter One, I did not want to miss important data because of confusion in participants' own "classification" of themselves. The validity of such a diverse sample seems unproblematic within the spirit of the grounded theory approach the study took, in which each case (midwife in this instance) was considered worthy of study. Whilst the circumstances were different, the central theme of loss, and the comments engendered by this, was common across the groups. All had lost, or were unable to attain, something which they desired, and which they were surrounded by in their daily work. The recommendations in Chapter Six acknowledge that each midwife who experiences a pregnancy related loss will have her own specific needs, and acknowledges that the diversity of experience precludes generaliseability.

Observations on the narrative accounts

Many of the narrative accounts in the questionnaires related to events, which had happened, in some cases, up to thirty years ago. This is significant for a number of reasons. The ability to recall the detail of such events may diminish over passage of time, although the need to recount them, and the detail, which was remembered suggests the importance the events played in the participants' lives.

I made some observations from the questionnaires, about their content, and about how they were completed. For example, as I transcribed, and numbered significant statements, it became obvious that respondents had already engaged in some form of their own analysis. There were few "redundant" phrases or words. Almost every section was completely composed of "significant statements". Many participants used the language of midwifery case note writing to document their obstetric histories, setting them out as if they were taking an antenatal booking of themselves. They used terms like "patient" and "lady" and "antenatals" to describe their clients. I have not altered any of the wording in their accounts, as they are personal to the respondent. Many participants wrote long and reflective accounts, continuing on the back sheets of questionnaires (left blank for that reason) and sometimes continuing on separate sheets. Their accounts were mostly descriptive, occasionally interpretive, often eloquent, and to me, capable of conveying complex emotions

By virtue of their occupation, all respondents must have achieved a reasonable standard of education, and would therefore be able to write coherently. However, many of these accounts went beyond competent report writing, and made me wonder if there is a difference between the information from those who are able to write fluently, and those who are more confident with the spoken word, or if indeed this matters. Writing gives more of an opportunity to reflect before committing thoughts to the researcher. Many of them wrote as though they knew me, and a number mentioned how beneficial it was to "talk" (even though they were writing) to "someone who understood". Further, their comments suggest that the writing enabled them to reach some kind of resolution. These areas are further considered in the findings, in Chapters Three and Four, and in the discussion in Chapter Five.

Observations on the follow up interviews

I aimed to conduct all the follow up interviews face to face, however, as the background information shows, three interviews were conducted over the telephone, due to a number of circumstances. Advantages and disadvantages of telephone rather than face to face interviews have been discussed earlier in this chapter.

Unlike the narrative accounts, the interviews were more representative of typical conversations, in that participants' thoughts were revealed in a less structured way. However, it was evident that some participants had particular things they wanted to tell me, as shown in the findings in Chapter Four. Participants did not have the same anonymity that they did when completing the questionnaires, since I was a visible presence, directly responding to and participating in the experience. I have no way of knowing how, or if this affected participants' responses. However, as far as I was able to ascertain, they responded in an open way. I have recorded the variations in data collection honestly, and explained how these arose, however, in my analysis of the data, I do not believe that these variations invalidated, or negated the findings.

Observations on data analysis

Constant comparative analysis meant continual movement of data between emerging sub categories and categories, and names of categories seemed constantly to be revised. This caused some challenges during the final writing stages of the research. Much could be gained from ensuring the reader could appreciate the research process, and could see the movement between categories. However, there was also the potential for confusion, and lack of continuity between Chapters Three, Four and Five, if every single change were to be documented. I decided, therefore, to show the emerging categories and core category at the end of each of Chapters Three, Four and Five, and to discuss only major changes which had occurred in the names of categories, and the location of data within them. I had rejected Strauss's (Strauss and Corbin, 1998) structures for coding, and therefore, did not use axial coding in the analysis. However, there were occasions when I could see that this might have been beneficial, for example, there were two particular sub categories which could have been located in more than one category. These were "Sharing experience" and "Support". Had I used axial coding, these would have been identified as themes running through the categories. However, I persisted with my chosen approach, and was able to examine both sub categories in detail, showing how they differed in their contributions to the categories in which they were eventually located.

I wanted to retain close contact with the data, so chose a non-electronic method of data analysis. I cannot say whether a package such as NUDIST would have been helpful. I had used SPSS in a previous study, but still needed to carry out manual checks. Also, the computer package did not seem to allow for lateral thinking around the subject areas.

Other observations and comments

Input on psychological aspects of the participants might have provided greater insight into their comments. There are many forms of psychological assessment which, in hindsight might have been helpful, and may be worth considering in a future study.

Some participants requested their questionnaires by e mail, and, some returned them electronically. This raised some ethical questions, since information sent electronically cannot be guaranteed to remain secure and confidential. However, there are many general warnings, which appear periodically to remind those who use the internet about the vulnerability of what they send, and I must trust that the respondents were aware of this.

Observations on the Literature review

Grounded theory allows for literature searching prior to and following data collection and analysis. There are advantages and disadvantages to this, in that data analysis can be relatively free from unconsciously assimilated ideas from the literature. However, in the writing up phase, it was sometimes difficult to prevent ideas from the second search of the literature influencing what was written in Chapter One. Similarly, as discussed in Chapter Five, it required mental discipline to review the literature without being influenced by the findings, and selecting only literature which supported them. Clearly, any comment made now is with knowledge of the participants, the findings, and the further literature search. Retrospectively, I would have concentrated more on the aspects of loss from the outset. This would have contributed differently to the theoretical framework, and provided from the outset a basis for the development of discussions in Chapter five, for example, on attachment, depression and development of empathy.

Observations on terminology

Some terms changed during the study. For example, I began by speaking of the participants as "midwives experiencing reproductive problems". This term seemed inappropriate after discussions with my supervisors and peers, and I rejected it in favour of the term "midwives who have experienced a pregnancy related loss". This term encompassed the totality of their experiences, and set them in the context of grieving and loss.

I reviewed terms used when referring to midwives as opposed to pregnant and childbearing women, and in the section on Being a Woman, Being a Midwife in Chapter Five (page 262) clarify my reasons for this review.

I have used both terms "profession" and "occupation" when referring to midwifery. I am aware of the ongoing debate as to whether midwifery is a profession or an occupation, but have not engaged in that discussion in the study. I use the word "profession" mainly when referring to activities which promote professionalism, for example, establishing a body of knowledge, testing theory, and achieving self regulation. I use "occupation" when dealing with day to day aspects of midwifery encountered by the participants.

Evaluating the study

An evaluation of the completed study was conducted using guidance from Spencer et al's (2003) structured framework for assessing qualitative research evidence, produced by the Government Chief Social Researcher's Office. The results are presented in Appendix Four. Mays and Pope's (2000) guidelines for assessing quality in qualitative research offer a less structured approach, but ask the question "Was the research worth doing?". As a reflexive researcher I have considerable personal investment in the work. However, participants' comments about their involvement in the research (Chapters Three, Four and Five), and its reception with peers confirm to me that the study was worthwhile.

CONCLUSION

This chapter described the complexity and sensitivity of the research topic, and confirmed the research question. The advantages of replicating my previous study (Bewley, 2000b) were discussed, as was the staged approach to data collection and analysis. Plans for safeguarding the wellbeing of the participants, others associated with the research, and the researcher were presented. The chapter reviewed some qualitative research approaches, and outlined Sarantokos' (1998) principles of grounded theory, which underpins the research methodology. Development of the questionnaire, and its framework to enable the writing of narrative accounts was explained, as was the formulation of questions for the semi-structured interviews. The principles underlying data analysis were presented, as was the scheme for ensuring validity of the findings. Finally, some strengths, drawbacks and limitations of the research design were highlighted. Chapters Three and Four present the findings from the questionnaires and from the follow up interviews.

CHAPTER THREE

FINDINGS FROM THE QUESTIONNAIRES

Introduction and overview of the chapter

The previous chapter described how the study was designed in two stages, using a grounded theory approach. The first stage used questionnaires consisting mainly of open questions formulated from results of previous research into midwives' personal experiences of pregnancy related loss (Bewley 2000a and b). The participants were a self selected group of 38 midwives and 2 student midwives, who responded to a letter of invitation placed in a midwifery journal. Their responses to open questions in the questionnaires provided a fund of rich data about their personal experiences, in the form of narrative accounts. These were analysed using a constant comparative technique, searching for themes (emerging categories and sub categories), similarities and differences. From analysis of the questionnaires, an interview schedule was drawn up to explore further areas in more depth, using face to face or telephone interviews with ten of the participants. These were further analysed, again using a constant comparative technique, searching for themes, similarities and differences. Finally, the findings from the interviews were compared with those from the questionnaires, and the emerging categories and core category confirmed.

In this chapter, the findings from the analysis of the questionnaires are presented. This analysis shows how categories and sub categories began to emerge, and how the core category, or essence of the research began to take shape. The chapter draws on the words of the participants to confirm their contributions to the building of categories and sub categories. I have used multiple quotes, and feel this is essential as they provided rich data, which is enhanced by the originality of heard voices. Further, the quotes exemplify the analytical process of identifying significant statements from the questionnaires, and grouping them in a thematic way, as described in Chapter Two. Within the sub categories and categories, significant statements from the data analysis are shown in support of the sub categories and categories to which they contribute.

Within this chapter, the findings are presented, but not discussed. In this, the presentation of the thesis follows the structures outlined by Bell, (1987), Cryer, (1996), and Phillips and Pugh, (1994), where findings and discussion are kept separate. I am aware that in the current study, comment and discussion could have been incorporated within each category. However, my chosen approach avoids confusion between what is data and what is my comment on the data. Furthermore, the chosen approach shows the systematic building of the categories, using analysis of data from questionnaires, interviews and further literature searching. It also illustrates how each stage of data analysis informs the next stage of the research. In the current chapter, the only areas where I comment are in relation to topics for further exploration in the follow up interviews. These are summarised at the end of each category, and again at the end of the chapter. The emerging categories and core category were explored in more detail during the follow up interviews, the findings from which are presented in Chapter Four. The findings from interviews and questionnaires are compared in conjuction with the available literature, and the final categories and core category are confirmed in Chapter Five.

FINDINGS FROM THE QUESTIONNAIRES

As described in the previous chapter, the questionnaires were devised from existing literature. Figure 2:1 in the previous chapter showed how open questions were formulated in relation to the theoretical framework and in line with the aims of the current study.

The open questions provided a framework for the participants to record their experiences. The headings below provide a reminder of the framework within which the participants were invited to write their narrative accounts. These headings also provided the framework for initial analysis and coding:

Particular events and their significance in personal or working life
Returning to work*
Helpful and unhelpful behaviours of colleagues and friends
Difficult aspects of daily working life*

Coping with difficulties*
Feelings about being a midwife
What prompted the person to respond to the research request
Any other information

The findings from the questionnaires were originally grouped under the headings shown above. However, during the further analysis, it became clear that the three headings marked with asterisks above, Returning to Work, Difficult Aspects of Daily Working Life, and Coping With Difficulties, formed a single category, albeit with subcategories. I therefore decided to present the findings relating to these areas under one heading, as will be seen later in the chapter.

In a grounded theory approach, the search is for a core category, which encompasses the whole essence of the research. Figure 3.1 shows the relationship between the areas covered by the questionnaire (blue), the emerging sub categories from the analysis (black), and the emerging categories (red). The emerging categories formed the areas for further exploration during follow up interviews, and also provide the structure for presentation of the findings.

The findings from the questionnaires suggest that the emerging core category is On Being a Midwife Who Has Experienced Pregnancy Related Loss.
Before presenting the findings, the next section introduces the participants.

THE PARTICIPANTS

Fifty six questionnaires were requested and sent out. Requests came via telephone, e-mail, and by letter. Forty questionnaires were completed and returned. Although participants were given the opportunity to complete the questionnaires anonymously, all gave their names and contact details, and indicated they would be willing to be contacted for follow up interviews. Ten in-depth follow up interviews were carried out. The rationale for choosing these, and the findings from their analysis are discussed in chapter four.

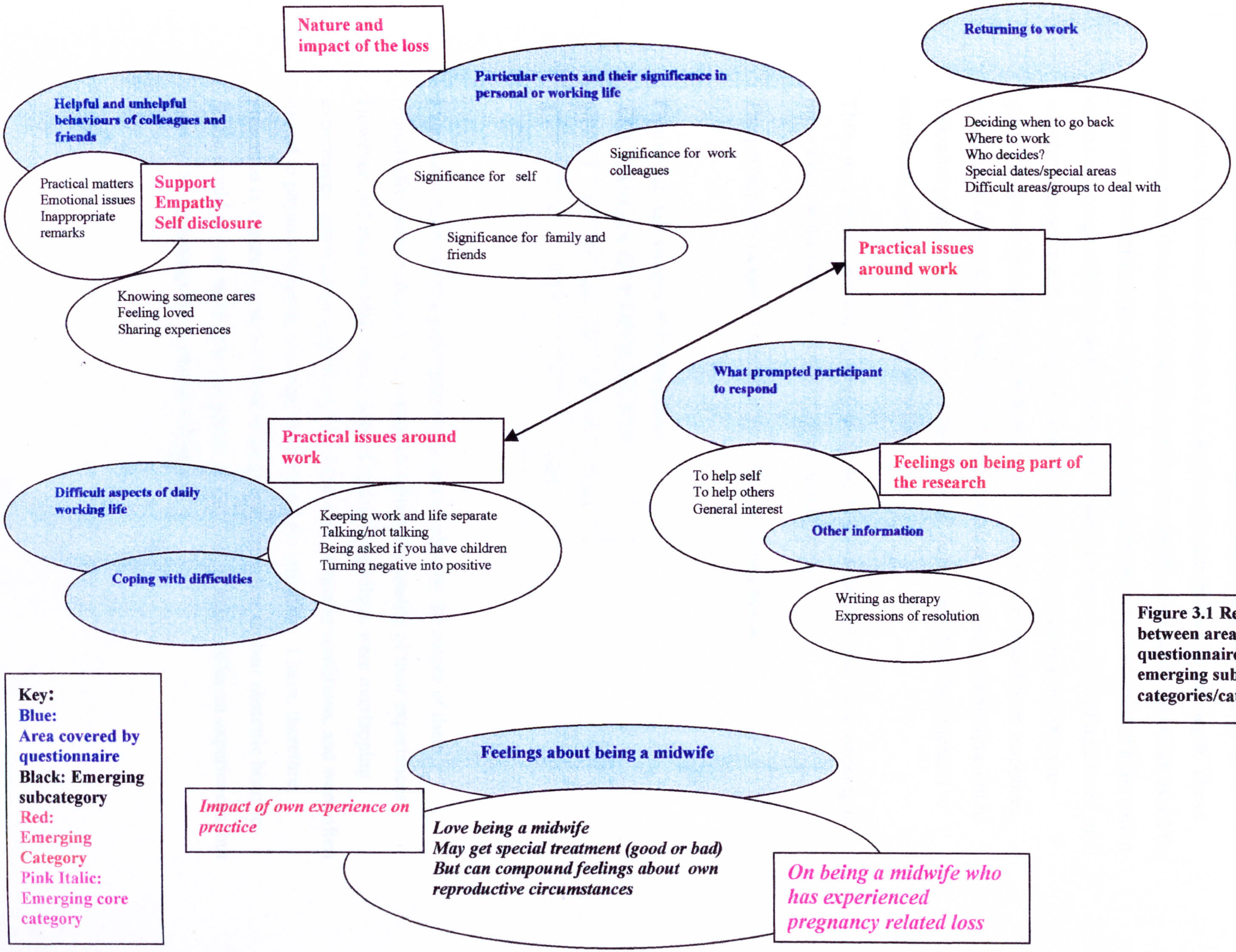


Figure 3.1 Relationship between areas on questionnaires and emerging sub categories/categories

Questions 1 –5 in the questionnaire requested mainly demographic information, although this was not the main point of the questionnaire, and there was never an intention, as discussed in Chapter 2, to analyse this information in any depth. These questions were designed to ease the participants into the open questions which asked for more sensitive information. However these questions provided background information on the age range of participants, whether they were students or qualified midwives, and whether they were still working as midwives. Of the forty respondents, 38 were qualified midwives and 2 were students. It was difficult to ascertain from responses exactly how many participants had left the profession. Some were taking time out to look after young children, some had taken a break from midwifery, but intended to return and some were thinking of leaving.

There were three participants who had definitely left midwifery and were working in other fields at the time of completing their questionnaires.

The participants ranged in age from 20 to 59+, as shown below:

Figure 3.2 Age ranges of Participants

AGE RANGES OF PARTICIPANTS				
20 – 29	30 – 39	40 – 49	50 – 59+	Total
2	15	17	6	40

I was keen to ensure that participants were not labelled by the nature of their reproductive circumstances, as I wanted to capture the totality of their experiences. However, as I analysed the data, I realised that although there were overlapping experiences, some issues applied only to those with particular conditions, and were often linked to physical experiences, such as treatment for infertility. I have, therefore, presented in Figure 3.3 an overview of the group, according to their obstetric histories. Some would fit into more than one group, as they had so many different experiences, but largely, the groupings are as shown in Figure 3.3.

Figure 3.3 an overview of the conditions affecting participants – (figures will not add up to 40 since some participants fall into more than one category)

Infertility (total)	27
Without treatment	2
With treatment	25
With miscarriage	14
Miscarriage	20
Termination of pregnancy (total)	5
Personal reasons	2
Fetal abnormality/other	3
Intrauterine death	2
Stillbirth (unexpected)	1
Perinatal/neonatal death	2
Infant death	1
Other (eg problems with partner's fertility)	2

There were no participants who described themselves as voluntarily childless, or childfree. Appendix 2 gives more details of individual participants' backgrounds.

Use of quotations from the narrative accounts

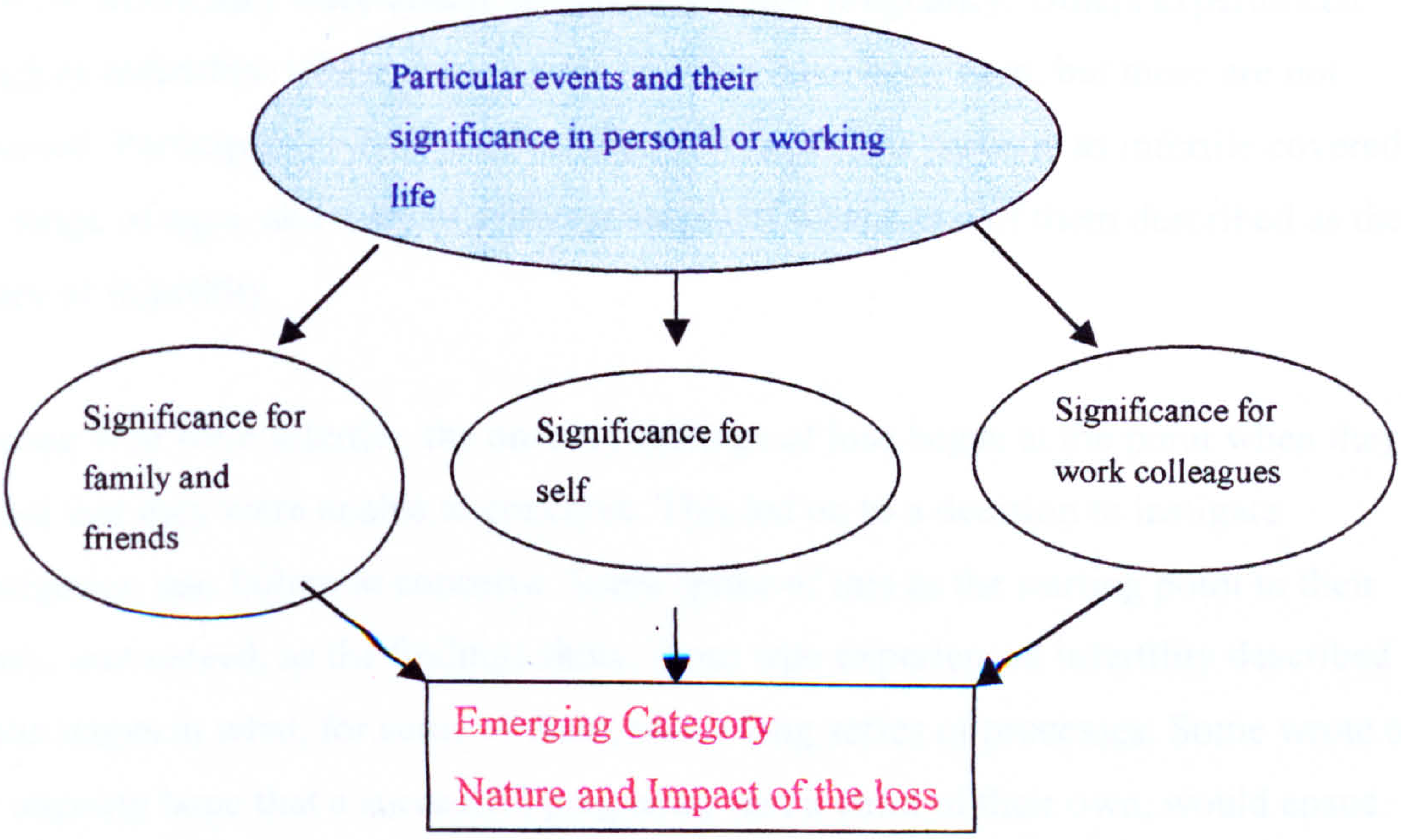
I have used the participants' own words exactly, taken directly from their narrative accounts. I have used ...to indicate where one or two words have been omitted by me. I have occasionally inserted words, which I have put in brackets, where a participant's response was to a direct question in the questionnaire, and which would otherwise not make sense. I have also occasionally inserted an explanation of a midwifery or obstetric term into a quotation, and again, have put this in brackets, with the phrase "my note". On other occasions where some explanation or background information seemed necessary to aid understanding, I have pointed this out, to differentiate this from the findings.

All names have been changed throughout to preserve anonymity. I have chosen the alternative names. All the questionnaires were numbered, and this number appears in brackets after quotations, and after the participant's name, so that all quotes can be directly tracked back to the original source.

The next sections of the chapter present the findings from the analysis of questionnaires by category. Each category has a diagram which shows the relationship of the emerging category to the original question from the questionnaire, and the sub categories which arose from coding. Each section contains examples of significant statements from analysis, grouped to show how they contribute to the sub categories and categories, or highlighted to show differing experiences. At the end of each section, I have summarised the main points.

NATURE AND IMPACT OF THE LOSS

The diagram below shows how the category, Nature and Impact of the Loss, arose from the information given in the questionnaires. The arrows show how the responses to the questionnaires contribute to the sub categories, then to the emerging category:



The findings suggest this category which I have called, Nature and Impact of the Loss. Responses which contribute to this category arose mainly from the questionnaire section headed "Particular events and their significance in personal or working life", although I have also included relevant responses from other sections of the narrative accounts.
I have used the term "loss" in the context of the findings to describe the event, incident, or long term condition relating to reproduction which prompted the participant's response to become involved in the research. It may be the loss of a baby through miscarriage, termination of pregnancy, stillbirth or other baby death. It also refers to the loss of the potential for having a baby, as in infertility, ectopic pregnancy, the onset of menopause, or some condition affecting the male partner. The findings show that the loss had an impact on the participant, and also on friends and family, and on work colleagues. The findings also show that there may be multiple losses, for example for

those women who experience recurrent miscarriage, or failed IVF treatments in infertility.

As can be seen from figure 3.3 the greatest number of respondents were those experiencing infertility (n=27). Within the study, some women described a primary infertility where they were unable to conceive a first pregnancy. Others experienced secondary infertility, where one or more children have been born, but more are not conceived. Participants who described themselves or their partners as infertile covered a wide range of ages, and were at different stages of what some of them described as the journey of infertility.

For some who were infertile, the onset of feelings of loss began at the point when they realised that they were unable to conceive. This led on to a decision to instigate investigation into failure to conceive. Some spoke of this as the starting point to their journey, and indeed, as the findings show, those who experienced infertility described various stages in what, for some of them, was a long series of processes. Some wrote of their ongoing hope that a successful pregnancy and a child of their own, would ensue. Dora had been trying for a family for four years, and made the following comment about her feelings on seeking investigations:

> *Try to laugh think positive as this could be just the beginning of a very long journey (9)*
> *Me and my husband have been trying for a baby now for 4 years. We were referred in November 2002 to a fertility clinic and are at present having the initial tests (9)*

For some, an actual diagnosis of infertility was a relief, as Audrey wrote:

> *The diagnosis of infertility and probable action necessary was actually a relief personally as the "unknown" had been putting a lot of pressure on us both – every month trying to conceive, then disappointment meant making love became a chore we almost came to dread! (4)*

April, in her fifties when she completed her questionnaire told how she was diagnosed with polycystic ovary disease in her late teens. At that time, it was accepted that she would not be able to have children, and when she married, she and her partner accepted this. However, as IVF (in vitro fertilisation) became more successful, the couple's desire to have a child of their own led them to seek treatment:

> *My husband knew and accepted that a family would be unlikely and we had accepted it, although always felt sad about having no family. When IVF became more common we decided to attempt a pregnancy. We had two attempts, the second resulting in a pregnancy. Unfortunately I miscarried at about 12 weeks. The whole process of IVF, the miscarriage, we found too traumatic to make any further attempts, so had to come to terms with having no children again (2)*

Participants described the investigations they underwent, usually involving both partners, but certainly more extensive and more physically invasive for women. For some participants, investigations resulted in a further, and more specific diagnosis of the cause of infertility. Depending on this diagnosis, treatment may or may not be possible, and some participants described the unpleasant side effects of some of the treatments. In some cases there was no explanation for infertility. For many, the need for a child of their own led to various forms of assisted conception, all of which have their own problems. Throughout the whole journey, participants described a cycle of anticipation, which approximated to the woman's menstrual cycle; hope that conception occurred, then the arrival of the menstrual period, which confirmed that it has not.

> *Some days I feel quite down, probably when my period comes round yet* again – *why not me?* (9)

> *.....tears, particularly on starting a period! (13)*

> *After my period started last month, I had an antenatal clinic that morning. The first couple of palpations were really bad for me and I was nearly in tears (19)*

Those who had experienced treatment for infertility wrote about the physical difficulties they encountered. Some experiences had short and long term physical effects. For example, some participants commented that the medication and treatment cycles involved in infertility treatment meant that shift work is more difficult. The treatments also make women feel ill. Lucy wrote:

> *I also didn't appreciate just how IVF treatment can rule your life and how physically demanding the drugs can be (11)*

And Davina commented:

> *The first attempt (at IVF) left me feeling very poorly and emotionally shattered...shiftwork did not help due to the medication I was taking (21)*

Not only was treatment physically demanding, it was expensive:

> *After much deliberation we opted for IVF after cashing in a policy to help with the funding (21)*
>
> *We have spent about 10K on trying to get pregnant (35)*
>
> *My husband and I went through a complicated attempt at IVF which failed and cost almost £4,000. We are just starting another cycle of treatments with many adjustments for the difficulties experienced previously. We intend this to be our last attempt in view of the physical, emotional and financial stresses involved (31)*

Disclosure of the infertility, investigations and treatment was problematic for many participants, because of its significance to them and their work colleagues. Dora (9) faced particular difficulties as she lived in a small rural community where she and her partner were well known. They were being investigated for infertility by GPs and consultants they worked with:

> *It was difficult to decide whether or not to tell colleagues. Myself and my partner were concerned about confidentiality. We had not told anyone we were trying for a baby and we felt quite secretive about the whole process. My husband is an ambulance paramedic we are both well known in the area and the NHS Trust I work for. There have been incidents where we have been pushed into telling people (9)*

For this participant, working in the same place where treatment was being carried out had many drawbacks:

> *There was one incident when I had to go for a salpingogram and there was a nurse there who could not have been more insensitive if she tried – she sort of knew us, but she was not tactful at all (9)*

The extracts above explored the impact of the diagnosis and treatment of infertility, and highlighted some of the difficulties encountered by the midwives in the study. The next parts of this section examine the impact of the loss of an already established pregnancy, in the form of miscarriage, intra uterine death, stillbirth and neonatal death.

For those experiencing miscarriage, the initial impact they described was one of shock. By way of background, miscarriage is the loss of a pregnancy prior to 24 weeks gestation. Within the term miscarriage there are a number of ways in which the loss becomes evident. The woman may experience vaginal bleeding, which can be extremely heavy. She may also have severe abdominal and back pain. She may pass clots vaginally, and, she may pass the fetus and placenta, in a tiny, but often recognisable form. Sometimes, the embryo/fetus dies in the uterus, and it may be unrecognisable as some time may elapse before it is expelled. Sometimes, fragments of embryo/placenta are retained in the uterus, necessitating surgery to remove them. In some instances, the embryo implants in the fallopian tube instead of in the uterus, an ectopic pregnancy. When this occurs, until very recently, not only was there loss of the baby, but also the fallopian tube itself. Ectopic pregnancy is also a life threatening condition for the mother. There are well documented adverse psychological sequalae of miscarriage, which are explored in greater detail in Chapter Five.

The participants described their miscarriages and ectopic pregnancies mainly in terms of their psychological consequences. Sally told how she wept as she held her 11 week fetus in her hand following her miscarriage Anita also described her feelings following her miscarriage:

> *I would sit in the room that was to be our nursery when the house was empty and cry. I would talk to the baby and apologise to it for not managing to keep it (this I did for a few months). My husband wouldn't talk about what happened and I felt very alone at this time. (27)*

Those who recounted the physical experience mostly described "spotting" of blood, which led them to believe they were miscarrying, although Anita commented on how painful the experience was, and how heavy the blood loss.

Martina experienced four miscarriages, and wrote this about her last miscarriage:

> *The last pregnancy in 1999 ended at 17 weeks, I had gone to work on an early shift after experiencing some abdominal pain, but thought nothing of it at the time. On my way to work I started to bleed and one of my work colleagues (and friend) took me to a side ward. I later miscarried but the baby had been dead for about four weeks. I again required an ERPC due*

> *to a retained placenta. I returned to work after four weeks sick leave. (28)*

She also underwent a termination of pregnancy when one of her babies was found to be anencephalic and said:

> *I found the TOP probably the most difficult, having to be induced and labour for no reason. This was my second pregnancy and I thought naively that having passed 12/40 that everything would be ok. I had not taken folic acid with this pregnancy. (28)*

For women undergoing termination of pregnancy, the circumstances and impact of the loss described by the participants seemed to be different, mainly in that there was an element of choice in ending the pregnancy. Pregnancy can be terminated for a number of reasons. In the examples given above, the baby could not have survived outside the uterus even if the pregnancy had reached full term.

By way of background, as well as conditions of fetal abnormality, termination of pregnancy is not illegal if two doctors agree that the continuation of the pregnancy would cause any kind of harm, including psychological harm to the mother. The term "social" reasons is commonly used, somewhat pejoratively, to describe terminations where there is no immediately apparent adverse physical or psychological consequence for mother and/or baby.

Felicity was a student who had undergone a termination of pregnancy for "social" reasons prior to undertaking midwifery. She already had two children, and had divorced her husband, so when she became pregnant, felt the only option for her was to terminate the pregnancy. She had been prompted on many occasions during her training to review her own choice to terminate her pregnancy, and experienced strong feelings of guilt. She found it difficult to discuss the subject with her peers, as they talked unguardedly about their negative feelings about termination of pregnancy. She made the following comments about how she felt, and how she dealt with discussions on the subject:

> *(I feel) guilty. I have never told anyone on my course or at work – and I always think none of them would have done it. As I have never told them, they talk unguardedly about their feelings on TOP. I never contribute much, but always say nobody from the outside will ever understand why*

> *someone chooses to have an abortion. A friend from the course is dead against it, but I always avoid the subject with her. (1)*

The impact of the pregnancy related loss was felt by family as well as the woman, as the following responses show.

Rhona experienced an intra uterine death (death of the baby in the uterus prior to delivery, often abbreviated to IUD). She was not actually a midwife at the time of the IUD, but was working as a children's nurse. She did not say at how many weeks of the pregnancy, but the event took place in 1978. She was, therefore, telling her story some twenty two years later:

> *When I had the IUD in 1978, my husband and I were not getting on well, and he wasn't a bit sorry about our loss. We never spoke about it until 11 years later when I was considering sterilisation and suggested I write to the hospital where I lost the baby. My husband was surprised (that) I didn't know we'd lost a boy and he was perfect. (3)*

Anita also felt unsupported by her husband, although as the following extract shows, he had his own anxieties:

> *My husband was particularly unhelpful. He told me when I got home, and I tried to talk with him, that as far as he was concerned the baby didn't matter as long as I was OK (he thought I was going to die – at one point so did I) (27)*

Julia lost her baby at 24 weeks gestation and experienced a complex range of emotions in relation to her husband:

> *I am married to Derek and already had 2 boys aged 5 and 2 when I became pregnant. We had not intended to have a third child. We had a difficult couple of months as Derek tried to persuade me to have a termination. I was <u>not</u> going down this road – we would cope somehow but it meant I could not discuss being pregnant with anyone, even my parents. I <u>did</u> confide in my best friend who I knew would be on my side whatever happened. At 12/40 I had a <u>tiny</u> bleed but I made a huge issue out of it and it made Derek see that I was determined to have the baby. From then on he was v. supportive, but the scar of that time still lurks on (in) our relationship. Our families know nothing of our torment and sometimes when they are singing Derek's praises I long to tell them, but what good would that do?? (7)*

However, it transpired that, like Anita's husband, Derek had his own needs:

> *Another midwife friend who had looked after me a few days earlier had noticed how little time Derek spent with me when he visited. I said he hated hospitals and she went to talk to him. She took him on one side and found that he thought my life was in danger too, and he was terrified. He wasn't coping well at home, but once he'd had admitted it, he was able to ask his family to help.(7)*

Janet, who cannot have children due to various gynaecological problems, also spoke about her relationship with her partner (now husband):

> *I told my partner that he should go and find someone else who could give him children. I was scared he would leave me for someone else. He said "Children don't seal a relationship. Even if we had children I could leave", and I thought how true that was. (10)*

As well as partners, the responses of other family members impacted on the participants. Maria underwent a termination of pregnancy at 23 weeks, when her baby was diagnosed with spina bifida. She cited the response of her mother as being particularly difficult to deal with and described her mother as not being "up to it". However, in her follow up interview (see Chapter 4), Maria revealed her mother's own loss of a stillborn baby.

Siobhan wrote about her mother's response:

> *My mother also upset me by saying "it was my grandchild". I know that this is inoffensive, but it made me think about how it was affecting our family. (19)*

Kate generally found her family and friends supportive:

> *I coped because I could and did talk to Jim (husband), friends and family*

But Kate said of her mother:

> *My mother found it difficult as I was the only one in the family circle to have problems and she didn't know what to say. (22)*

Linda said this about her husband's family's response to their fertility problems:

> *We didn't tell my husband's family about our fertility treatment because of negative comments they'd made about "people being so impatient these days" and "misuse of NHS money". My husband's family never mentioned the ectopic again after an initial conversation which could be summarised as "Oh never mind". My mother in law was not impressed that following the laparoscopy he had taken a week off work to look after Christine (their daughter), whilst I was recovering as his career is important! (13)*

Deirdre's experience of loss led her to become a midwife:

> *In 1996 I had an IUD at 32 weeks pregnancy. I was induced a day after confirmation by scan. It took 2 days for IOL to work. I gave birth to a stillborn baby girl we called Hayley. A post mortem showed no known cause of death. I got pregnant again within 3 months – out of choice, and was part time training with NCT I took time out of my training. A year later after my son - third child including Hayley stillborn - was born. After a lot of soul searching, I returned to my NCT training and qualified at the end of 1999. I applied for midwifery training in 2000. (8)*

However, she remembered her initial response to her loss:

> *Immediately after my loss, I went to ground, avoided pregnant women and babies, and sought the company of those I felt would be supportive (8)*

Vanda became a midwife because of her experience when her daughter Mary was stillborn at 35 weeks gestation. Vanda already had two children, and had previously had a miscarriage. In each of her pregnancies she had severe hypertension, and in the pregnancy which ended in stillbirth, she also had a placental abruption. Whilst she was in labour, she could hear the deceleration of her baby's heartbeat on the CTG monitor, and a Senior House Officer (SHO) was called to fit a Fetal Scalp Electrode (FSE). This is how she recalled being told that her baby was dead:

> *...they called in the SHO. She tried to fit an FSE but couldn't pick up the heartbeat, so she scanned me, decided the baby was dead, said "I lost a baby last week and now this one's dead" and walked off. I never saw her again.(24)*

It is unclear from the questionnaire whether the SHO was referring to the loss of her own baby, or that she had been involved in a situation similar to Vanda's.
However, this, and other factors that Vanda disclosed, made her decide to become a midwife, as the following extract shows:

> *If I had not had a stillbirth I would not have done my midwifery training...I did my training to get answers as to "why my baby died" and to reassure myself that I was not mad over believing that I was hearing her heartbeat and decelerations. (24)*

As further extracts from Vanda's questionnaire show in other categories, and in her follow up interview, her desire to become a midwife was fraught with obstacles, and she experienced problems in her training and subsequently.

The emotional responses of the participants in relation to their loss was varied. They described feeling devastated, hurt, angry, and having a sense of unfairness that they should be singled out for loss. The feelings of anger disclosed by the participants was mainly related to how they were treated by their colleagues, particularly managers. However, some also adopted positive coping strategies, as Kate did:

> *At first I felt I would eventually become a mother but now I know it is not going to happen. I kept thinking of what I had, husband, family, friends and health and tried to dwell on what I didn't have (22)*

Sally's initial response was "a most all encompassing acute sense of loss and disbelief", but she went on to say:

> *My family were wonderful, it was their grief too. My parents so wanted this baby too, having witnessed our distress with the infertility.(15)*

Other participants expressed the wish that their experiences and sense of loss should be used to ensure that others in the same position would be supported. For example, Flora and a colleague who also experienced miscarriage, set up a support group for women. Chloe became part of a support group for bereaved parents, and led services of remembrance. Vanda became a befriender for the Stillbirth and Neonatal Death Society (SANDS). These three participants all took part in follow up interviews, and more details of how they used their experiences appear in Chapter Four.

A number of participants mentioned that they were depressed, and some received treatment in the form of medication, and/or counselling therapy. Maria described her experience of depression in her questionnaire and in her follow up interview. She underwent a termination of pregnancy at 23 weeks when it was found that her baby, Anna, had spina bifida. It was her colleagues who recognised the feelings and behaviors she was exhibiting as depression. One colleague was able to help by listening, and another was able to help further by pointing her in the direction of counselling, and to her GP. She was diagnosed as having "complicated unresolved grief", and ultimately found Gestalt counselling a great help.

Laura also mentioned how one of her colleagues noticed her depression:

> *...after having my first daughter, I said to someone, I think I was a bit depressed the last few years and she said "a bit depressed" as if - Good God you were dreadful. (30)*

Jilly, whose first baby, Jonathan, had died following severe brain damage at birth, described her experience of depression and support:

> *I had started a new job, Martin (second baby, my note) had started school and we had relocated, all in quite a short space of time. I don't know how much the impact of leaving midwifery (and the problems in the final year of being a midwife in particular) contributed to my problems.*
> *I was fine one minute, and the next I was in floods of tears in Debenhams' café looking at babies.*
> *The next day I drove into a car park and couldn't get out of my car – fortunately I had my mobile phone and was able to talk to someone at SANDS (my note, Stillbirth and Neonatal Death Society) who made me realise that even though it was seven years since Jonathan had died, it was OK to feel the way I did, but it was a very frightening experience.*
> *Again thanks to another great GP I was referred for counselling and started on anti depressants – and talking about midwifery made up a big part of the counselling.*
> *Nearly two years down the line, I am now off the anti depressants and counselling, and the majority of the time I feel that giving up midwifery was the right choice – I just still look at all the job ads and read the journals! (25)*

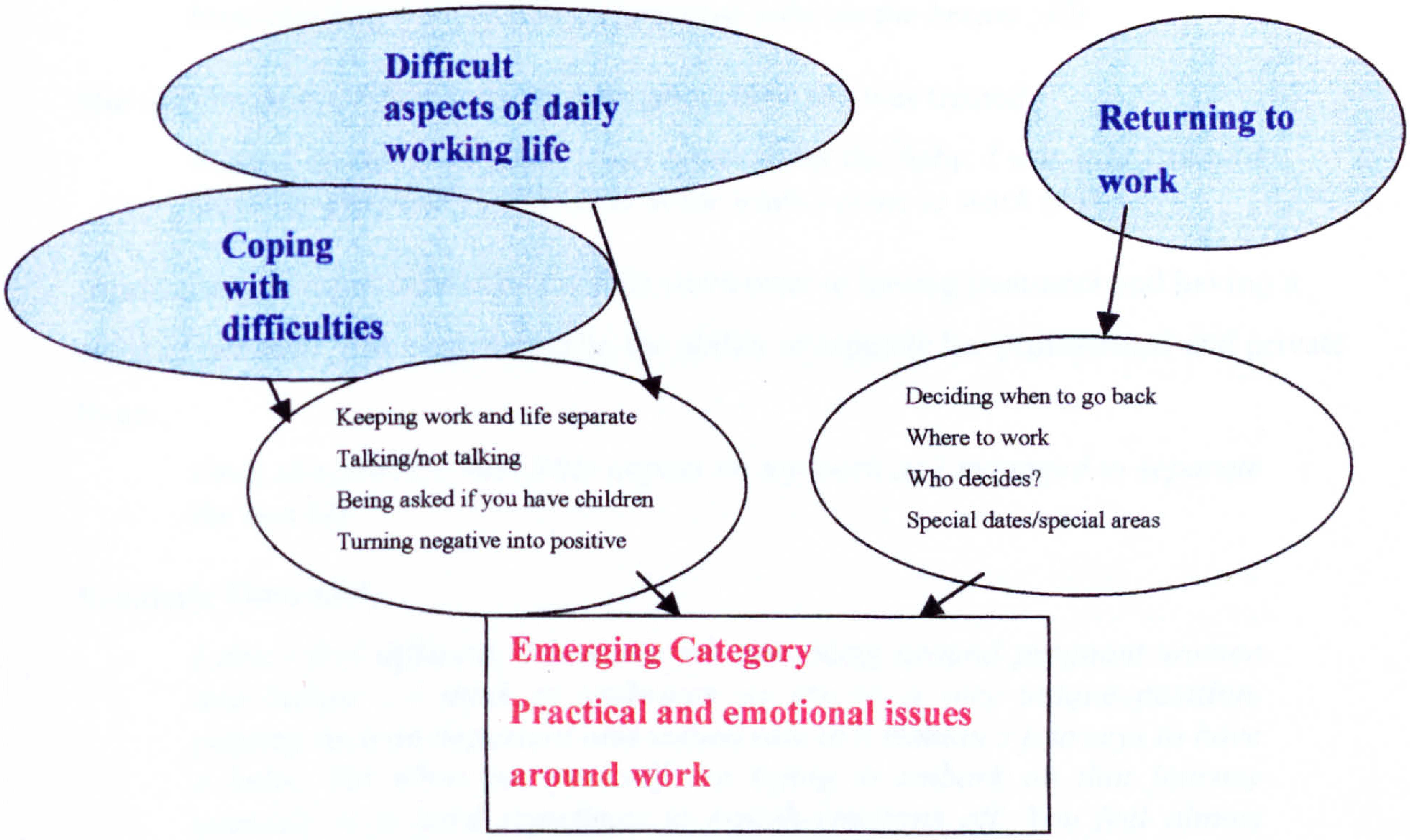
Davina also experienced depression and an eating disorder following fertility problems which spanned a period of 10 years:

> *I became severely depressed which caused me to feel suicidal and was consequently hospitalised for a while. I also developed an eating disorder and could not perform my job adequately. (21)*

As the extracts from the questionnaires have shown, the experience of loss provoked many and varied responses, affecting participant, their friends and their families. There were also consequences on their work, and on their colleagues, which is dealt with in the next category.

PRACTICAL AND EMOTIONAL ISSUES AROUND WORK

The next section on the questionnaire deals with returning to work, however, as previously mentioned, analysis of the data revealed that there was much overlap between this area, the one entitled Difficult aspects of daily working life, and the other of Coping with Difficulties. Accordingly, I have incorporated these subcategories into a larger category, called Practical and Emotional Issues Around Work. The diagram below shows how these interlink, and form the category:



A number of participants commented on the difficulty of returning to work. Martina wrote:

> *I had 5 weeks off following the TOP four weeks sick leave and one week annual leave. The first day back to work was difficult especially as the first delivery I cared for named their baby the same as we'd named ours. The anniversaries have become easier over the years.(28)*

A number of participants commented on the view that the best way to come to terms with things was to meet them head on. However, it seems that they wanted to choose to do this, rather than being forced into it by well meaning colleagues, as this extract by Sophie suggested:

> *Instead of the shift leader asking me how I felt about caring for mothers with problems or pregnancy losses, they would assume that either it would be good for me to come to terms with my loss, and that I could not avoid it forever or limit my involvement to the extent that these mothers would not be discussed in my presence (36)*

Stella had a baby who died from cot death at the age of six weeks. She described her experience on returning to work:

> *I was made to do parent ed (education) classes. When talking about breastfeeding I could still feel my own baby on the breast (40)*

She also made the following comment about how she was treated:

> *When I broke down when I was upset about the baby, I was told I should leave my personal problems at home when I come to work (40)*

Audrey experienced infertility for four years prior to having treatment and having a child of her own. She commented on the ability to separate her professional and private lives:

> *Once diagnosed it had little impact on my work as I managed to separate the two (4).*

Similarly Dora said:

> *I don't feel different, I love my job and being around pregnant women and babies ...I think as midwives we are in a very unique position, playing such an important and valued role in a woman's journeys to have a baby. Yet when you yourself are trying to embark on that journey yourself, it is hard sometimes to switch emotions off. You feel almost robotive (sic) (9)*

However, there were instances, which prompted negative feelings, as the following extracts show:

> *I found the hardest thing was seeing couples together in antenatal clinic, all excited and going for scans sharing a closeness that I felt excluded from (4)*
>
> *And maybe dealing with situations at work – counselling re termination (of pregnancy), child protection, unwanted pregnancies makes me feel sad, but I can't let it affect my work (9)*

> *Every aspect of my job as difficult as you cannot forget pregnancy and childbirth in this job. (21)*

For Lucy, seeing or touching a pregnant abdomen was difficult:

> *I just found it so difficult to even look at a pregnant abdomen which wasn't good as at that time I ran a late pregnancy assessment unit*

Sally found it difficult to deal with women in early pregnancy:

> *I was irritated by women very early gestation, jumping the gun, wanting to be "booked" at the earliest opportunity, simply expecting that because they were pregnant they would have a healthy baby I felt it would be that way for everyone else, but not for me. (15)*

Stella found it difficult when babies resembled her own child, who died from cot death:

> *Occasionally a baby would look like my daughter which always gave me a pang. (40)*

Sylvia highlighted a different area of difficulty:

> *I feel angry that I desperately want a baby and I deal with families everyday that don't want their babies, want to have a TOP are cruel and brutal to their children and feel it is all so unfair (20)*

For Anita, dealing with women and their babies post natally was difficult:

> *I found working in the post natal ward very difficult. If the mums were not quick enough in attending to their babies when crying I would be quite sharp with them. I felt they didn't deserve their baby – that I would have been a better mother than them and it was unfair my baby had been taken away from me. (27)*

However she also said:

> *As far as being sharp with the mums, I had to make a conscious effort to stop myself.(27)*

Janet, who had a hysterectomy following various problems including miscarriage, recounted the following:

> *...Other circumstances I found it difficult were women giving their babies up for adoption. I couldn't empathise with them, it was too raw...(10)*

It was also difficult being asked the question "Have you got children?" Dora made this statement which showed how she felt as a person, and as a midwife, when asked about children:

> *Although sometimes it is difficult when women ask you Why haven't you got children. Sometimes this can happen several times a week it shouldn't affect how good you are as a midwife?? (9)*

Sylvia pointed out:

> *My patients some of which I know very well, some now with a 3rd/4th (sic) baby, are always asking – questioning why I don't have children – new patients ask if I have a family ie children I find it very painful- surgery staff ask "don't I want children?" particularly in view of me being a midwife ...I casually brush it aside by saying things like "Oh give me a chance I've only just got married" or "we do want a family but we want to have some time together first – a few posh holidays etc" (20)*

And Dora wrote:

> *..and also women's reactions to you when you say you have no children. Most are not bothered, but on occasions you feel excluded from their world cause you have never experienced pregnancy, labour, breastfeeding etc (9)*

Sadie experienced fertility problems and miscarriages over a nine year period. She had a son, and left midwifery for a time to look after him, and to try for another baby. However, she describes here her experience on returning to work following her seventh miscarriage:

> *I just felt unable to cope with other peoples' pregnancy loss*
> *On my first shift back following my seventh miscarriage I was told to look after a lady being induced at term with an IUD (my note, Intra Uterine Death). I felt this was so insensitive. It was a nightshift – the ward was quiet and there was enough staff for someone else to care for this lady. I looked after her to the best of my ability but to this day that night haunts me and I have been reluctant to go back to work after my break because I am so scared of having to confront this situation again. (16)*

Flora recalled her shock on the day her baby should have been born:

> *The day of the expected due date of the baby I lost was awful, I was taken completely by surprise with emotion when I wrote the date on a baby's namebands, I had to leave the room weeping – it should have been me in that labour room giving birth (12)*

Sophie said:

> *I still do not work on Andrew's birthday, and have difficulty in entering the delivery room in which he was born (36)*

Vanda's baby was stillborn, and she became a midwife because of this. However, the impact on the decision to allow her to become a midwife raises some issues, which reveal that her motivation to become a midwife was questioned. She was sent for assessment to the Occupational Health Department, because, as her manager put it "we don't want another Beverly Allitt, do we?" She described how she felt constantly watched in case she harmed someone else's child.

As previously mentioned, Janet who had a hysterectomy following various problems and miscarriage, found it difficult to deal with women relinquishing their babies for adoption. She further commented:

> *...I cared for one baby once in the nursery who was awaiting social services collecting him. I fantasised about walking out with him and considered this. Could I get away with it, I even thought about approaching the Mum and asking her if I could have him (I didn't of course) (10)*

Audrey also did not realise the extent of her feelings:

> *Although I felt I was coping well with everything and maintaining an even keel, I'm sure I would have benefited more from understanding more and having chance to discuss the impact on my work etc. Also, I have suffered from mild postnatal depression at around one year after delivery, and I personally think it was the enormity of everything, the investigations, the treatment, the stress of failure of the first attempt, the second attempt, then developing PIH (my note, Pregnancy Induced Hyptertension) and needing EMLSCS (My note, Emergency Lower Segment Caesarian Section) at 34 weeks that eventually hit me (4)*

The wariness which can be associated with women who have lost a child is also associated with depression, which was discussed in the category Nature and Impact of the Loss. Depression, and the possibility for aberrant behaviour are explored further in Chapter Five, discussion of the findings in conjunction with the literature.

Few of those experiencing infertility, with or without treatment, were unduly bothered by working with babies. They were more concerned with having a child of their own, than in jealousy over others' children

> *Dealing with new babies didn't seem to bother me too much*
> *(4)*

> *I have been fine around babies (other people's babies have never cut it for me!)*
> *(15)*

The findings reported above, show how participants described various effects on their work. Despite most of them declaring a love of midwifery, many found it difficult to cope with particular groups of pregnant women. Some developed coping strategies which involved separating their work and personal lives. However, some found it difficult to be faced with pregnancy and birth every day. There were also particular times which raised difficulties, and some areas where certain remarks exacerbated feelings which were already raw.

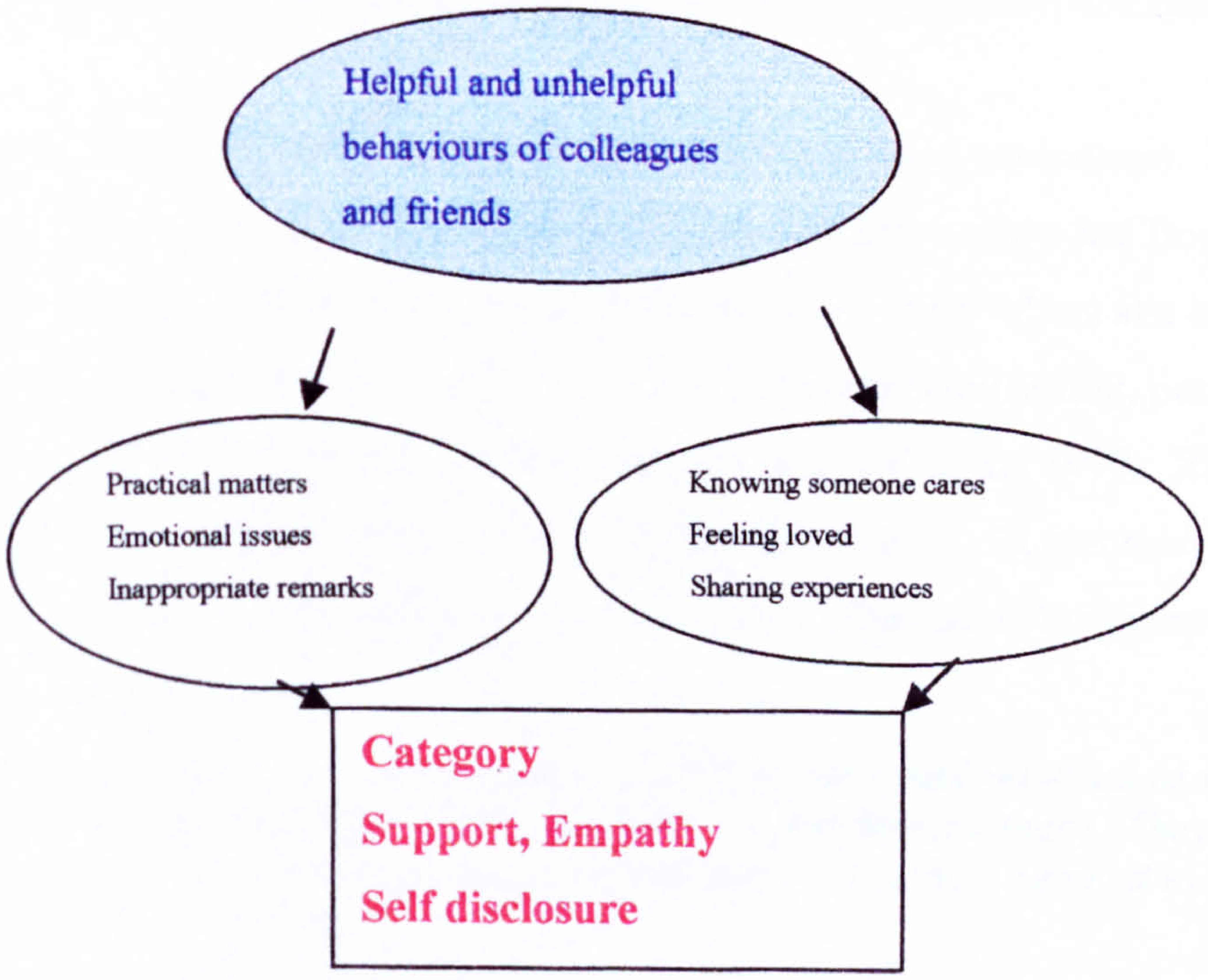
For those who had lost babies or experienced miscarriages, returning to the room where they had received treatment, or where their baby had died was difficult. They also mentioned how hard it was to work on the anniversary of day their baby had died, or on the day the baby should have been born.

Some participants were able to separate their personal and professional lives, although this had both benefits and drawbacks.

It seems therefore, that returning to work, place of work and significant dates played a part in how the midwives coped with their situation. In addition, there were some specific behaviours which midwives commented on in their narrative accounts; some were helpful, some less so. The next section considers these under the category Support, Empathy and Self Disclosure.

SUPPORT, EMPATHY AND SELF DISCLOSURE

The diagram below shows how analysis of the information from the questionnaire section about helpful and unhelpful behaviours from colleagues and friends contributed to the sub categories and emerging category, Support, Empathy and Self-Disclosure.



There were many comments in which participants used the word support, although it was difficult to quantify what constituted support. It appeared to come from many sources including partners, family, friends, work colleagues, managers, counsellors, etc. It included some of the practical issues touched on in the previous category, like consideration of where the returning midwife should be allocated on return to work, and subsequently. The issue of being "allowed" to talk, which also occurred to a lesser extent in the previous category, came up many times, and was classed as a supportive behaviour. I have also included in this section, examples of remarks, which participants classed as unhelpful, and which I have termed "inappropriate remarks". This is a major emerging sub category, and I have devoted a whole section to the nature and effects of chance remarks on the participants.

Analysis of data revealed that there were also, a number of people whose behaviour was considered helpful by the participants, and who were thought to understand what the participant was going through. Also in this category, findings are described which suggest that participants found that sharing experiences with colleagues and friends, and that having others share their experiences could be both beneficial and harmful.

First, participants wrote of their supportive and unsupportive encounters. Rhona's lack of support from her husband was described in the category Nature and Impact of the Loss. At the time of her loss, she was a newcomer to a village where she knew few people, and although she went to church, which she found comforting, people didn't talk to her about the baby, although, as she points out, this was in the 1970s. Rhona's answer to how she coped with difficulties was "I had another baby!". In common with others who had experienced death of their baby, she spoke of him as a "lost baby", and said this about her return to work:

> *Very strange. I remember telling my colleagues I had returned to work to look for my lost baby (I was working in paediatrics then). They didn't know me and I wasn't really aware of their reactions. I seemed to be in a daze for a while. (3)*

Jilly told how her baby, Jonathan, died in 1994, aged 28 days, and how she received excellent support at that time, despite the ensuing medical negligence case:

> *My first baby (Jonathan) was born on 3 May 1994 at 41 weeks gestation I had a ventouse delivery and a 10 minute shoulder dystocia culminating in the birth of a very big baby (9lb 10) beautiful boy with an Apgar of 0. Thanks to some brilliant paediatric doctors and nurses Jonathan was resuscitated and we were fortunate to have 28 days with him. Sadly due to the amount of brain damage he had suffered - due to me being left in labour for too long – successful medical negligence claim - we had to make the decision to withdraw life support and he died peacefully in our arms on May 31st.*
> *(We) conceived Jonathan on clomid and therefore subfertility was also an issue which made the loss of Jonathan even harder to bear (25)*

He was born and cared for in the same unit where Jilly worked, and colleagues knew what had happened. She said this about how she felt on her return to work:

> *Scared stiff!! But had to return to work as I felt that "having taken my baby away from me they won't take my career as well" I remember*

> *saying those words even before Jonathan died to a midwife colleague who was looking after me postnatally. Also had feelings of being glad to be with people who knew what had happened as I had Jonathan in my own unit. (25)*

When Jilly moved away from the area and to a different hospital where staff did not know her history, she felt a loss of the support she had enjoyed.

> *I started a new job in November 2002 and no one knows where I work, so I miss talking about him! (25)*

She also said that support from her husband was "brilliant...has been my lifeline" (25).

Julia went into preterm labour at 23 weeks, after ten days of treatment to try and prevent the labour continuing. She and her husband had to make the decision about whether to resuscitate the baby, and hope that he would survive, or not to resuscitate. They decided that they would not resuscitate:

> *...this was 10 years ago when 24/40 (My Note, babies born at 24 weeks gestation) did not do well. We decided to let nature take its course...and I gave birth to Luke about 3 hours later. He lived for about ½ hour taking the occasional gasp. We have never regretted our decision. (7)*

Julia commended the care she received from the midwives in her unit, some of whom were her friends:

> *the wonderful m/w (midwife) who delivered Luke, - there were just the 2 of us, Derek chose not to be there after the Shirodkar was removed, and I became and still am very close as we shared him while he was alive. She had come in specially to care for me, as labour ward was very busy that night. No one asked me, the late shift organised it without any fuss. (7)*

On her actual return to work, Julia felt mostly very well supported, and as can be seen from the extract below, felt her interaction with her clients, and theirs with her were mutually beneficial:

> *I was very nervous. As a community midwife I get to know my antenatals very well over the weeks. As my pregnancy became evident, a special bond developed with them, especially those who were due around May with me. The coward's way would have been to disappear and not return until after all those who knew me had delivered, but that is not my way. The midwife who covered my leave was brilliant at fielding questions initially, but after I had lost Luke I asked her to answer the women's questions truthfully, if they asked about me.*

> *When I did return to work, the women just as nervous as me, but we dealt with it together. I was honest without forcing a point, and I found myself saying time and time again, "just look after that little one, because he's precious". I was so touched that almost without exception, they were so keen to show me their babies when they came home, and they thrust them at me. Then I knew I had handled it right for both them and me. The healing process for me was very wrapped up in caring for these women.*
> *Most midwives were sensitive to my feelings on my return and offered to take over anything I found difficult. However, this was not needed. A girl who was booked for homebirth at the time Luke would have been due particularly asked for me to continue her care if I felt able to and that was the single most positive boost I had. She had a lovely delivery of a girl. I was relieved it wasn't a boy as I don't know how I would have felt.*

As her account shows, Julia generally experienced good support from her work colleagues. However, she commented on a management issue:

> *The midwife who delivered Luke took some photos, but initially the pictures of him in my head were strong, and so they (the photos) were filed in my managers office with other photos of other babies. However, at about a year, I wanted the photos and asked the midwife, - I didn't get on with the manager, no one did, she was totally disorganised - to retrieve them for me. They were nowhere to be found in the mess in the her filing system.*
> *She (the manager) could not look at me at meetings and scuttled away if we saw each other. Derek wrote to all sorts of people including the Chief Exec. as a result of this these photos are filed totally separately, with much more care. A year later, when the manager was clearing her office when she left, she obviously found them because they came in the post with an NHS compliment slip with her name printed on. No apology, nothing. (7)*

Sophie also experienced mainly kindness and concern from her colleagues. She had two miscarriages and had a stillborn son at 32 weeks. He had Edward's syndrome, a condition incompatible with life. On her return to work, three and a half months later, she commented on how kind and supportive her colleagues were, and acknowledged that it was difficult for them to know what to do or say.

> *I returned three and a half months after the birth. The first week was spent almost on automatic pilot. I tried to be involved in as much as I could, partly to prove to myself that I could and partly to show my colleagues that I could still function.*
> *I was emotionless almost. It was not until 2 or 3 weeks after return that I began to feel that this was not fair. These women were having babies that*

> *cried, mine did not. I found that I related more to the women who were experiencing problems and pregnancy loss, although I was shielded from them by my colleagues.*
> *My friends and colleagues were wonderful. Their support was invaluable for me to achieve a return to work. By the time I was on holiday some 6 weeks later, I was feeling as though I had let my colleagues down, as I felt they were getting fed up of me not dealing well with certain situations. I wrote this in a letter to my manager, as by this time I was considering leaving. I had proved that I could go back, but was unsure if I could cope with the emotions.*
> *However I succeeded in staying with the help of close friends at work. Eventually I was able to care for women suffering pregnancy loss again. In fact on a few occasion other people have let slip that I have had the same experience, in these instances I have felt that my input has helped the parents as I have been able to speak from experience. (36)*

The greatest help for Sophie was from those who let her talk about her experiences:

> *Those colleagues that helped the most were those who asked me how I was and allowed me to talk about my experience to them. They were not always my closest friends, but people who were open to receiving a reply other than I am OK, which I think is what most people wanted to hear. (36)*

Audrey wished she had been able to talk about her experience:

> *I coped with everything bravely at the time "stiff upper lip", but looking back, feel that I really would have benefited from talking to someone about everything (4)*

Laura highlighted some of the difficulties she found :

> *After my first miscarriage many colleagues gave me the opportunity to talk about and were sympathetic, which was helpful. During the time of infertility, I didn't talk about it and no one asked. (30)*

Deirdre described her experiences, and how talking about the loss of her baby, was helpful, both in formal and informal settings (8),

> *The most helpful thing is listening and sharing with the need to go through my story many times with friends and family (and)spiritual support from a yoga teacher, psychotherapist (who ran a counselling course I had attended previously). Also support from SANDS(my note Stillbirth and Neonatal Death Society). It was nice to be asked how I was feeling with direct reference to Hayley, rather than people talking about everything, but I was desperate for her not to be forgotten too quickly.*

> *After my son was born my grandmother died which was quite hard and I felt quite depressed. I had a very good health visitor who suggested CRUSE counselling. This too was helpful. I also had support from SANDS. I feel I grieved very deeply at the time, which has allowed me to move forward now (8)*

From the quotes above, it seemed that some participants found a range of supportive and unsupportive behaviours from their partners, family, friends and work colleagues. One area, which was highlighted in a number of questionnaires was the making of what I have termed "inappropriate" remarks, and the effects these had. They seemed to be cause of annoyance and upset, and were cited by participants as amongst the most unsupportive behaviours they encountered. Many were told, as Deirdre was, "you can have another baby" (8), but as the participants made clear, each baby is a unique being who cannot simply be replaced by another. Deirdre also made the following comments:

> *Unhelfpul – "you can have another baby!" "Are you still upset (two months later)" "Why don't you get some antidepressants" (8)*

Similarly after miscarriage, Sonia remarked:

> *My partner (boyfriend) said "it wasn't a baby though, was it?" Very hurtful (38)*

Jilly said:

> *I had the usual, "it was a blessing", "you can have more" etc, etc, which, although were hurtful, I knew they weren't meant to be. (25)*

Sonia said:

> *I remember feeling resentful with another friend who was besotted with her new baby that she was not sensitive to my situation (miscarriage) and did not ask how I was feeling (38)*

Anita said this about her return following her miscarriage:

> *I really can't remember anyone saying anything that was helpful. Most people were sympathetic to start but always trotted out the supposedly helpful statements eg you're young you can try again, it was for the best etc (27)*

Those experiencing infertility also cited the negative emotions aroused by insensitive remarks:

> *Parents made comments about us living the good life and not wanting*

> *children, but they weren't to know any different (4)*
>
> *Unhelpful comments around misuse of NHS funds for infertility treatment (13)*
>
> *About infertility generally – just relax and it will happen naturally, just forget about it, keep trying, it is such fun trying (5)*

Remarks that were considered hurtful and thoughtless by the participants were made not only by family and friends, but also by colleagues. As the participants observed, the literature on helping couples deal with miscarriage and stillbirth, and widely available to midwives highlights specific remarks, which are hurtful, yet many of these were said to the participants. Jenna made the following comment:

> *The most unhelpful thing people said, and they were usually people I worked with, was go on holiday and you will probably get pregnant. (31)*

Similarly, Nina said:

> *I hope that if one person after reading your results, thinks first and then does not make some glib statement suggesting that all you need is a good holiday (35)*

Siobhan recorded the following:

> *A remark at work following the first miscarriage made me realise how little people with children think about infertility. I knew that I was miscarrying and said I thought I should go home. My colleague remarked "either you are fit to work or not fit. Go home if you don't think you are fit" her manner was frankly hostile (19)*

Despite the generally excellent care she received from her colleagues, Julia recounted the following, which she clearly found upsetting:

> *A few months after returning to work I was on labour ward which was not busy. The senior midwife asked me to admit a lady at 24/40 into the room that I had spent 10/7 in and delivered Luke in. I said I would admit her into another empty room, adding I did not feel ready to confront that particular ghost yet. The retort was "don't be pathetic, you've got to do it sometime". This was a midwife I had previously respected as a caring and sympathetic midwife. Since then I have observed that attitude in her on several occasions, but I felt as if I had been stabbed. 10 years on I still don't like working in that room. Thankfully it's little used except for antenatals , CTGs etc as it's not a proper labour room, and it's right next to the office. Sometimes I just go and stand quietly there. It's often used for breaks at night, but not by me. (7)*

There were other examples of colleagues and friends talking inappropriately about subjects which the participants found distressing, as the following comments show:

> *One midwife was studying for a masters degree in law and ethics and was asking me advice on her assignment. I am sure she did not realise what she was doing but it made me uncomfortable. Her question was about the ethical dilemmas facing staff and parents when they had delivered a baby with Edward's syndrome, should it be offered resuscitation or not. (36)*

The quotation above was from Sophie, whose baby had been stillborn with Edward's syndrome. The following comment was made to Patricia on her return to work following a failed IVF treatment:

> *I'll never forget my first day back, a colleague (most people knew I had failed IVF) said: "She's pregnant and you'll have to get used to that now." I was gobsmacked and horrified (38)*

Patricia also said:

> *I found out "who my friends were". Another colleague showed me her pregnant daughter's "bump" Hurt hurt hurt*
> *Another colleague asked very personal intrusive questions when she knew we weren't really friends. She delighted in making me squirm and I had to be quite direct and (was) probably perceived as rude to mind her own business (38)*

Sometimes, it was not inappropriate remarks which cause hurt, but the circumstances in which friends or family happened to be in at the same time. Audrey made this comment:

> *Other people getting pregnant didn't really upset me as it was my baby I wanted, and whether they were pregnant or not didn't improve my situation. The most distressing thing was during our second treatment. We didn't tell anyone this time, and the day after I had the eggs replaced my best friend gave birth. I found this terribly distressing, (surprisingly so). However, that treatment was successful so I haven't had to dwell on that (4).*

From the above, it seems the participants were often surprised at the remarks and circumstances which caused them distress. As the examples given above show, sometimes those who made the remarks were ignorant of the participant's loss, but there were times when those who made the remarks perceived as hurtful were fully aware of the circumstances.

Participants faced a dilemma when it came to disclosing their loss, and sharing their experiences. As will be seen from the following, some participants felt able to share their experiences, and some were not. Some were also receptive to hearing others' experience, while some found it difficult. Sophie, whose baby was stillborn and had abnormalities made the following remarks about sharing her own experience:

> *I believe that my experience has benefited my understanding of the effects of pregnancy loss, both short term and long term. I have read a vast amount of literature, particularly relating to issues arising in a pregnancy subsequent to a pregnancy loss, mostly stillbirth.*
> *Within my current role I am not as involved in clinical care as I used to be, but I believe I have a valuable contribution to make in the development of services for this group of mothers and actively participate in this. I am also keen to try to complete some research in a related area.*
> *I hope that the involvement that I have had with women and their families following a pregnancy loss has in some small way helped them. Sometimes it feels appropriate to share that I have had the same experience and sometimes it is not. Whenever I have, the relationship I have with the parents changes immediately. It ceases to be on a professional only basis and becomes much more personal and more satisfying as they seem to ask more questions, particularly of a practical nature, such as funeral arrangements.*
> *I am still in contact with some families and have seen them again when they have had a subsequent baby in happier circumstances. The feeling that I have helped in some way is satisfying and for me makes my job worthwhile. (36)*

As she pointed out, Sophie has enhanced her experiential knowledge by reading around the whole subject, so her personal experience formed a basis for, but not the sole information for the support she now gives.

However, there was also a feeling that midwives sharing their experiences might be problematic for women and their families. In a letter appended to her questionnaire, Patricia said:

> *I haven't told any clients of my experience because I haven't wanted to affect their happiness and parenthood. If I had let on, I might have gotten into dodgy ground, like they may feel guilty because they were successful and I wasn't. And the fact that they were successful is probably the best thing that ever happened to them. (38)*

As will be seen later in this section, many participants were asked if they had children. Jilly wrote about the problems this posed for her in relation to disclosing her own experience:

> *My biggest worry was how I would cope when clients asked if I had children, as they invariably did! I didn't want to deny the existence of Jonathan, but neither did I want to get drawn into conversation about him, as I didn't want to be telling a labouring woman about my baby who had died – not fair to them or me! (25)*

However, she also told in her account of the first time she disclosed her circumstances to a couple she cared for:

> *However, I firmly believe that Jonathan's short life was not in vain, and I also believe that God made sure that the circumstances of me first telling someone about Jonathan were right. I was looking after a couple having their first baby. A beautiful baby boy was born – healthy in all respects except he had a cleft lip and palate. Mum was fine, but dad would not look at or hold his baby. I was in the middle of suturing when mum asked me if I had children and I just felt that I had to tell my story about Jonathan. The next thing I saw was dad picking up and cuddling his son! (25)*

Jilly, correctly or not, took the action of the father to be that her disclosure had been well accepted.

Some participants mentioned how other colleagues or friends had talked about their own experiences, and this was received in different ways. For example Sophie said:

> *What was not helpful was another midwife who came to see me on the ward and who proceeded to tell me how she had lost a baby – sorry, I just wasn't interested at that time! (38)*

Sometimes, particular people were highlighted and named, as having been supportive as shown below:

> *Eventually another consultant to whom I will be forever grateful said "Flora, this baby is at risk of 1) extreme prematurity , 2)infection 3)poor limb development 4) poor lung development etc. did I have problems conceiving? (answer not at all!!!). In my opinion continuing this pregnancy is not a sensible option" thank you, thank you James, the sort of straight talking I needed from my own consultant (12)*

Conversely, there were some whose words and actions were remembered negatively over a long period of time, and where the respondents expressed strong negative emotions, to the point of not forgiving that person for whatever they had said or done Laura, related the following:

> *After first miscarriage I came back to work very shocked and raw. On my first morning back, a pregnant midwife came into the office complaining about her pregnancy and making derogatory remarks about her baby. I doubt she knew what had happened to me. I had to leave the room to cry. I felt loathing for that midwife which has continued to this day – very unusual for me! (30)*

However, Audrey made the following comment:

> *They (colleagues) were all very supportive, although one of them did say a few tactless things at times, but only with the of best intentions if you haven't gone through this, it's hard to know what might upset someone. (4)*

And Kate observed:

> *But not all comments were painful, often it was said how close J (husband) and I were, a special bond between us (22)*

As the significant statements quoted in support of this category have shown, the participants recounted many instances of supportive behaviours from their colleagues and friends. They were able to identify particular people and actions which contributed to practical and emotional support. Talking about the loss generally seems to have been beneficial, and those who listened to the experiences, sometimes many times over, were appreciated. It is not clear whether those who were supportive drew on their own experiences, but there seems to be a skill in using experience to be supportive, yet not actually mentioning one's own experience.

Conversely, there were those who made tactless and hurtful remarks, regardless of whether or not they knew the participants' circumstances. Participants acknowledged that this may have been due to thoughtlessness, lack of experience, lack of ability to empathise, and possibly the participants' own heightened sensitivity. What they seemed to find surprising was that they should be treated insensitively by colleagues whose daily work requires them to exhibit caring qualities.

The participants' accounts reveal that some found it preferable to disclose, while some preferred to keep their circumstances private. In some cases this would have been possible, for example, those having infertility treatment, or those who experienced loss in the early stages of pregnancy when perhaps their pregnancy would not have been visible, and therefore not generally known about.

Some participants felt their own experiences had helped them be more supportive to women in similar situations, but, of course, there is no way of knowing how the recipients of their subsequent care felt.

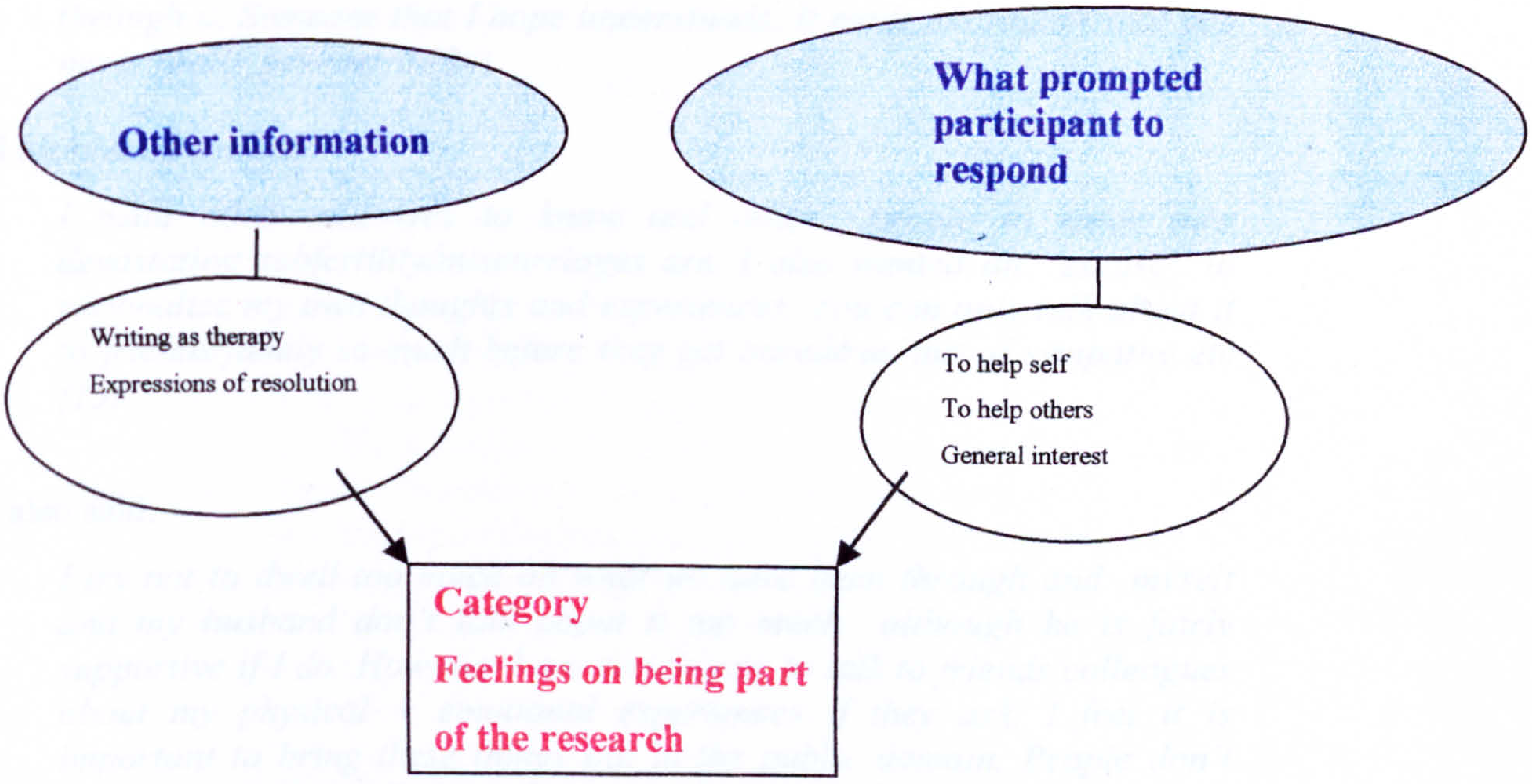
One participant went beyond talking about support, and being cared for, and alluded to feeling loved, and that this feeling was tangible even when unexpressed. Sonia commented:

> *Interestingly, just recently a very close friend who lives in France said how we had never talked about my infertility. This surprised me as I thought we had, meaning that sometimes if the loving intention is there, communication does not have to be in a verbal form! (38)*

I have included this, as it came up again in the findings from the interviews, and appears in the discussion in Chapter Five.

FEELINGS ON BEING PART OF THE RESEARCH

This category was informed by sections of the questionnaire relating to what prompted the participants to respond, and to the section on any other information they wished to give me, as visually represented below:



Some participants felt their experiences would help others in the same situation, for example, Melissa said:

> *I responded because what I have to say may assist with your research (37)*

Sonia felt the area of investigation itself was interesting:

> *I felt it was a little investigated area. Just like midwives attitude to sexuality. Midwives are expected to advise and teach women when they may well be the ones who need the teaching! (38)*

Sophie, whose baby was stillborn wrote this about her motives for responding:

> *Firstly because of my interest in the wider issues surrounding pregnancy loss, I have read other publications by the researcher.*
> *Secondly, in order to improve the care that could be offered to these families short and long term, including returning to work, it is important to gain as much information as possible. Having survived the experience it seemed appropriate to respond. (36)*

Emma's response was complex:

> *The day that I read your letter, I had delivered a term, macerated stillborn infant. It was a very difficult day and it stirred up a lot of suppressed emotions in me. The death of this baby brought back all the pain and grief that I had suffered during my years of infertility and seeing your letter made me want to let someone know how it feels I felt to go through it. Someone that I hope understands. It made me realise that you never really get over it (34)*

And Siobhan's reasons:

> *I want other midwives to know and other people to know how devastating subfertility/miscarriages are. I also wanted an "excuse" to rationalize my own thoughts and experiences. You can only talk about it to friends/family so much before they get bored/run out of sympathy etc (19)*

She also said:

> *I try not to dwell too much on what we have been through and myself and my husband don't talk about it too much although he is fairly supportive if I do. However I am very happy to talk to friends/colleagues about my physical + emotional experiences if they ask. I feel it is important to bring these things out in the public domain. People don't know if you don't tell them. However, the downside is that they tell you all the "remedies" for falling pregnant that they have heard!*
> *On the whole, they think that they are being supportive, but at the end of the day it is me that has to get on with life, job etc, and me that can't fall pregnant/hold onto a baby (19)*

Maria wrote:

> *There is a sense of wanting to help others coping with being a midwife and losing your own baby. The range of reactions is so vast and I am aware that my own was a bit dramatic and so needs to be added to what is known. It has also been useful to write about it after so long and to realise that despite there always being a shadow where Anna should have been I really have moved on considerably. Thank you (29)*

Vanda, whose baby was stillborn, and who had become a midwife because of this, wrote this about why she responded:

> *A desperate wish to get it across to the profession that if someone does not want to offer the full range of services, they can still practise as a midwife with skills in certain areas. For example, a bereavement midwife, or one who offers listening skills in an antenatal clinic to women with*

> *problems would be an ideal job for me, but I am not "experienced" enough as a midwife! (24)*

In our subsequent interview, Vanda told me which areas she did not want to work in and why, and also about her experience as a befriender for SANDS.

Patricia was searching for help in her own situation. She wanted to hear how others in similar situations had coped and found nothing, she therefore wanted to make her contribution for the future:

> *Having to come to terms with involuntary childlessness I started doing a literature search to see how other midwives coped with involuntary childlessness and despite getting a MIDIRS search there was nothing I could find to tell how others had coped. So when I saw your letter I responded as I feel this must be a neglected area of research.*
> *There must be 100s of midwives out there coping somehow, in what I have found to be a very unsupportive management structure.*
> *I found little research regarding management within NHS of this too.*
> *There must be other midwives (like me) who have left because of childlessness, and it would be interesting to hear how they were treated (38)*

Some participants expressed positive feelings about having written about their circumstances, as Melissa said:

> *It gives me the rare opportunity to share in confidence a brief "snapshot" of my life's experiences/heartaches. It has given me a chance to give my experiences an airing! THANK YOU FOR ASKING! (37)*

Patricia also said:

> *The experience of writing it all down, getting it out helps. I realise a lot of my response is grief. (38)*

Some participants had clearly reached some kind of resolution about their situation. For some, it was the end of their quest for a child. Sometimes self imposed, sometimes circumstantial.

For those experiencing infertility, resolution came in a number of ways; menopause may intervene, finance may run out, the couple may accept their childlessness, or the fact that they only have one child, and decide against further investigations or treatment. For some, by chance, or as a result of treatment, a child may be conceived and born. Others may decide to adopt. Linda wrote:

> *but when it's all over and there are children, it all seems minor (13)*

For Sonia (38), the decision about children was taken out of her hands, yet resulted in a resolution:

> *The menopause was a good time however, now it all feels more assimilated into my life (38)*

And for Davina:

> *My depression and eating disorder were completely gone following children (21)*

However, this was not the case for some. On the last page, where I ask for any further information, Melissa wrote:

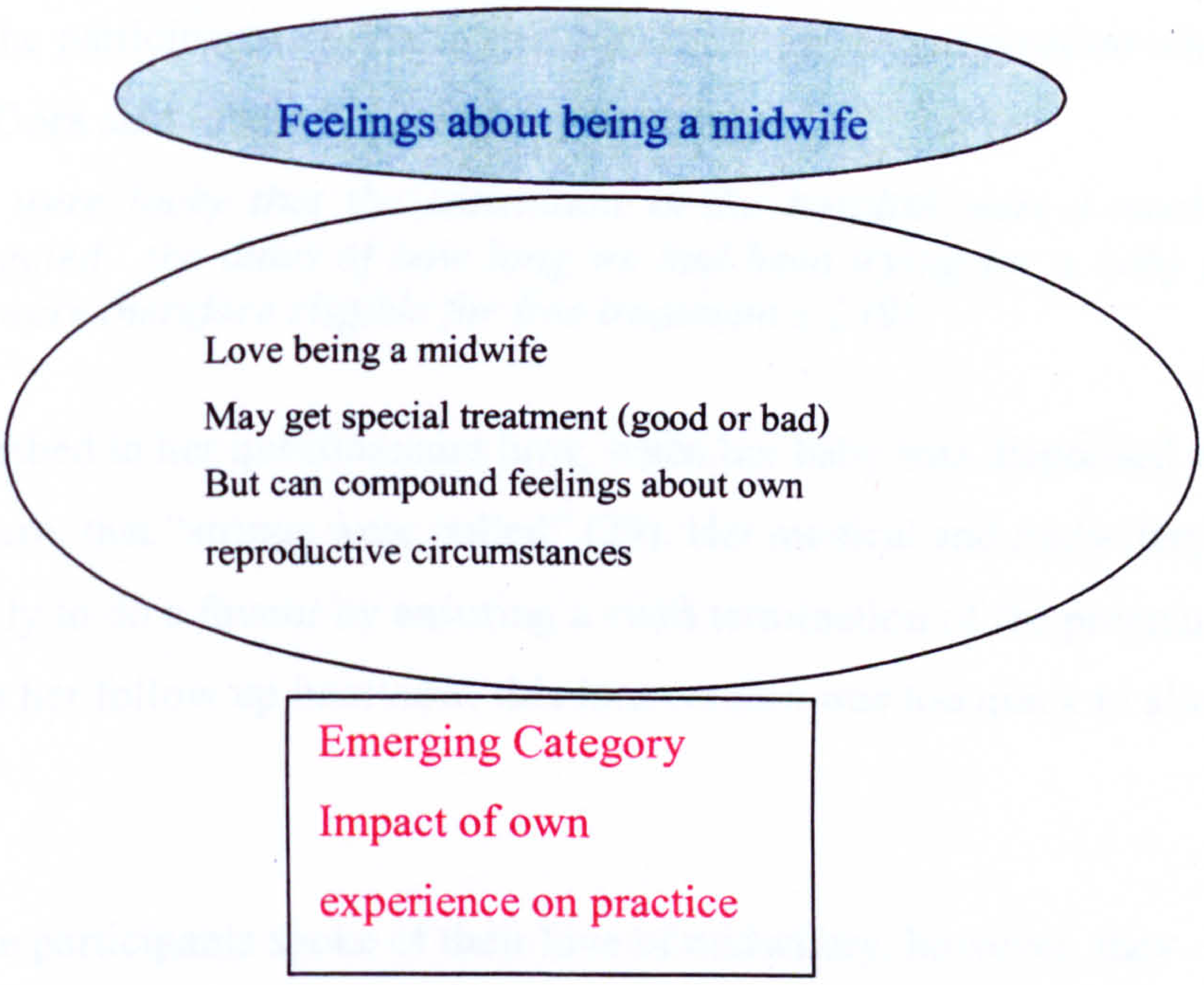
> *I have left this page empty = because this is how I still feel (37)*

FEELINGS ABOUT BEING A MIDWIFE

The previous categories presented the findings relating to how pregnancy and reproductive losses impacted on participants, their family, friends and colleagues, how they felt on their return to work, their relationships with clients and colleagues, and their motives for becoming part of this research. This section presents the findings in relation to how being a midwife influenced and was influenced by the experience of loss. This is the emerging core category of the research, and deals with the participants' perceptions of themselves as women and as midwives. It reveals the findings about how they think their own practice has been changed by their personal experiences of pregnancy or reproductive loss.

The midwives' experiences not only impacted on their work. The fact that they were midwives (or subsequently became, or stopped being midwives) impacted on their own experiences of reproductive loss. Chapter Four will show how the findings from interviews resulted in a major change in this category, to incorporate the participants feelings about being a midwife and the changes in practice resulting from their experiences. However, for the moment, the findings from the narrative accounts are presented in accordance with the original analysis.

The diagram on the next page shows how the section in the questionnaire on Feelings About Being a Midwife generated information which contributed to the category of Impact of Own Experience on Practice. From there, the diagram indicates the major contribution this has made to the emerging core category, which at this stage is entitled On Being a Midwife who has Experienced Pregnancy Related Loss



Feelings about being a midwife

Love being a midwife

May get special treatment (good or bad)

But can compound feelings about own reproductive circumstances

Emerging Category

Impact of own experience on practice

The first part of this category deals with expectations of how much being a midwife contributed to the participants' emotional responses to reproductive problems. Some described how they were expected to know much more than they actually did, and were sometimes expected to cope better.

Flora had an amniocentesis to check for abnormalities in her baby because of her age at the time (she was 35). The amniocentesis caused a premature rupture of the membranes which raised potentially serious problems for the baby if the pregnancy was to continue. She wrote of her experience as an antenatal in-patient:

> *I was desperate for information and shouted out to anyone/everyone that was passing my room to come in and talk to me, I asked them all what their opinion of my situation was. I sent colleagues to the library to try and find out. (12)*

She felt strongly that there should have been a differentiation between herself as a midwife and herself as a woman:

> *I find I get very intense when the whole issue of antenatal screening and diagnosis is discussed as I felt I was not given good information it was assumed that as a midwife I should know. We should treat pregnant mums as pregnant mums not pregnant midwives, or teachers or pregnant doctors etc.(12)*

However, the participants were also in a somewhat privileged position when it came to treatment. Dora said (about her infertility treatment):

> *We were lucky that the consultant in the hospital were I worked had "juggled" the dates of how long we had been trying for a baby for and we were therefore eligible for free treatment x 2 (9)*

Maria described in her questionnaire how, when her baby was diagnosed with spina bifida in utero, that "strings were pulled" (29). Her medical and midwifery colleagues acted quickly to do a favour by ensuring a swift termination of the pregnancy, but, as she said later in her follow up interview, this intervention was too quick to allow her time to think (29).

Many of the participants spoke of their love of midwifery, however, they sometimes had to sublimate their own feelings in order to function in their working capacity. Sylvia wrote about the "face" she had to put on to deal with her everyday life:

> *I feel as though I am acting all day pretending to be pleased and happy about patients "good news", I feel being a midwife at the moment is making me very stressed because it is highlighting every minute of every day that I am not pregnant and I may never be without IVF...there could not be a worse job when trying to conceive - I feel a failure It is in my face all day long but I know I have developed good ways of hiding it. (20)*

She also talked about the need to separate her work self from her personal self:

> *I am a different person at work I have to be to protect myself (20)*

Emma also wrote of the need to put on a brave face and hide her pain:

> *I cried a lot in private.....I built up an emotional protective barrier and laughed off our problems in public.....I still love my job, but it's not such an important part of life... I have become hardened externally, but inside there is still a raw nerve there....(34)*

Maria also wrote about the need for emotional distance in order to provide care:

> *I did not know how to say no to being allocated to care for women having TOP's or with IUD's etc so I got on with it and it really was torture. I also feel I did not give good care overall as in order to get through the shift I had to detach myself emotionally and treat her as a package on a production line. I am surprised none of them complained about me being distant and aloof. In terms of screening I just did not mention it and*

> *answered only the bare minimum that questions from women required. This is how I behaved for a very long time at least for 2 years may have been slightly more. (29)*

Janet described the depth of her feeling about midwifery after she had a miscarriage, then, following a number of health problems, had to have a hysterectomy:

> *Returning to work was one of the hardest things I have ever had to do. Every minute of every day I felt sick, hurt, angry and very very sad. It is a devastating illness (infertility) made a million times worse by working as a midwife. The job you once loved becomes like a slap in the face everyday. I cried so much....on the way to work, at work and on the way home from work (10)*

She also said:

> *I would deliver a baby, go to the changing rooms – have a good cry – sob my heart out, and then go back to the woman with a smile on my face. This happened with every delivery, every day (10)*

And yet:

> *I love midwifery, I love my job, but I sill have the odd bad day ..*
> *No one can understand the devastation of infertility, but if you are a midwife, it is so much harder. Midwives are carers, but they tend to forget to care for each other (10)*

And Siobhan said:

> *Sometimes it is so hard, I just don't want to do it (19)*

Julia however, saw her experience, as something to be cherished, citing her care at the time as a contributory factor to how she feels now:

> *Aside from the grief and longing, I look back at Luke's birth as an experience to be cherished. I was wonderfully cared for by the midwives, at the time, and by 2 or 3 in particular. (7)*

The next extracts from Felicity's questionnaire show how she reviewed her own pregnancy loss as she watched a colleague at work:

> *Once when a young girl came in with a concealed pregnancy. She had a normal delivery and the day staff coming on said straight away "no need for social work involvement, she clearly wants to keep the baby as she had kept the pregnancy a secret, even from herself". I did not want to look after her as I felt, I could have done that too, and kept saying to myself, why didn't I do that? In the end, I did look after her, and she was*

> *such a lovely person and so happy with her baby that it was OK (1)*

In response to the question on women she had found it difficult to care for, she spoke of another young girl having a late termination of pregnancy:

> *Looking after a young girl having a TOP at quite a late stage and later looking at the baby (boy) in a white bucket. The midwife delivering the baby was so gentle and motherly to the girl, completely unjudgemental (1)*

She told how being a midwife was a career choice, which reminded her daily of "what I have lost through my own fault" (1). However, she gave further examples, of how reviewing her own feelings made her more aware of the potential for others to be hurt:

> *...a colleague told me she had felt empty at a breast feeding supporter tutorial. A small group of midwives and health visitors, we had met for a few weeks, and at each meeting, everyone had constantly referred to their children. This person had no children, but none of us noticed how she must have been feeling. She probably won't have a baby ever now, and this is sad for her. (1)*
> *It was after this conversation that I saw your letter, and had e mailed for information. I told her that I had replied, when in another brief chat, she told me she had read your letter. We were interested for completely different reasons (1)*

Nevertheless, she still said

> *But I still love my job, it is not about me after all and*
> *I feel it is the right thing for me to do (1)*

Sadie had mixed feelings:

> *I do love being a midwife – but as time goes on in my secondary infertility saga I'm finding it harder to get back to work as I am worried about dealing with clients experiencing pregnancy loss. Also clients can say some really hurtful things sometimes which niggle away in your head for a long time. Sometimes I wish I wasn't a midwife because I feel I would cope so much better (16)*

Wylva spoke of the support she received during her experience of 3 miscarriages, but again mentioned the disadvantages of being a midwife:

> *I feel support and understanding are really important and helped me to pass through the grieving process, but at times being a midwife made it slower (18)*

For some, the stress of being around pregnancy and babies was too much, and they sought midwifery posts which would remove them from direct contact with them, or even decided to leave midwifery altogether. Maria moved into teaching to avoid clinical midwifery, and others described different reasons for seeking a break from practice. Patricia told about her ongoing struggle to remain in midwifery while coping with the grief and stress of her childlessness. At the time of writing her account, she was working on a postnatal and transitional care ward, as she felt she could cope with that aspect of work. However, whilst her previous manager was accommodating, she is now under pressure to perform the entire role of the midwife, despite her ongoing emotional difficulties:

> *I feel I can't be a midwife any more, I'm training to change direction, into Health Visiting, which I hope I will cope with, as that will still be around families and toddlers. And I still grieve not having a family of my own.*
>
> *In the hospital I work there is pressure to rotate to all depts and because I couldn't cope with pregnant or labouring women I feel I have to leave plus it's clear from management pressures that they will not accommodate my Occupational Health needs for long.*
>
> *I am very resentful that management are unsupportive. I have given my life to NHS, I feel, and worked for 13 years for same employer and feel I am being pushed out. Whereas, ever since my IVF failure, I have wanted to stay in the same environment and not create more stress by moving areas.*
>
> *I feel that management are totally wrong not to support me, and I will look back on my last 18 months at NHS hospital with resentment and animosity.*
>
> *I am very very angry management are being like this and I have having (sic) to call in my union to fight it – more stress that I think is unfair, totally unfair. And they talk about "having loyalty" (38)*

Sallyanne experienced infertility, and decided to have a break from midwifery. However, she clearly had mixed feelings, and cited the treatment she received from her Trust managers as contributing to her decision to leave midwifery:

> *Having had a break away from midwifery, I feel that I have missed it and realised that the problem was not the job, as I felt just as bad, sometimes even worse than I had felt than I felt as a midwife. I felt I had lost a profession and a career as well as the chance of a family. I think more could have been done to make my situation more bearable, such as taking on or becoming involved in a non clinical role for a short time, which may have prevented me from leaving. (23)*

Nevertheless, she was able to distinguish between how she felt about midwifery as against how she felt about her employers:

> *I feel fairly positive because I feel the previous Trust let me down, and not midwifery (23)*

Clearly for these participants, practical and emotional support at work were important influencing factors in their decisions about whether or not to remain in midwifery. They mainly continued their work as midwives whilst experiencing the range of feelings associated with loss. It seems they expected, and in many cases received, sensitive care from their midwifery colleagues, who, they thought, would know how to deal with a woman experiencing a pregnancy related loss. However, they seemed surprised at some of the uncaring behaviours they reported from their colleagues. Whilst this may seem unrelated to loss in the context of the findings, it may be an important factor in the colleague-colleague relationship in midwifery. Rhona (3) also made the following comment, which, as the discussion in Chapter Five shows, reflects something prevalent in the culture of midwifery, and relates to previous comments about midwives being carers but not caring for each other:

> *I feel inadequate when it comes to delivery – my confidence has been knocked out of me by bullying colleagues (3)*

In the findings from the follow up interviews, Chloe revealed her surprise at some of the treatment she received from her colleagues, which links with the comments above. Similarly, Vanda had experienced treatment from midwives as a patient prior to becoming a midwife, as a student, and as a midwife, which left her feeling strongly about the profession:

> *I hate it (being a midwife) and feel ashamed of the profession. The only reason I reregistered...was because I was told that it is easier to renew than to take a break and then try to reregister. (24)*

Her follow up interview explores some of the unkindness she feels she experienced as a student and as a midwife.

Some participants felt their experiences also influenced their thoughts and approach to practice in a positive way, as Audrey pointed out:

> *I didn't take one minute of my pregnancy for granted, and can now fully appreciate how anxious other mums-to-be are (4)*
>
> *And:*
>
> *I just feel a bit more aware of how women with similar problems or even those who have suffered miscarriage or loss must feel (4)*

Dora said:

> *I feel I think if anything, more protective of pregnancies and how precious they are (9)*

Rhona made the following comments:

> *My job is demanding and stressful, (but) I really am able to empathise with women who lose their babies (3)*

Julia wrote this about her practice as a midwife now:

> *I think I was always a fairly rounded m/w, but it has enabled me to look more objectively at things midwives do and say around stillbirths and TOPs for abnormality. Little things that had previously never occurred to me. For example the baby remains warm when tucked up with mum/dad even when dead, but cools very quickly and if then returned to mum <u>feels</u> very dead.*

She also made the following practical point:

> *The power of a black and white photo taken in natural light should be every parent's right. Polaroids/other snaps are awful. (7)*

And again about using her experience to educate others:

> *I often talk to students about my experience when discussing care of women with pregnancy loss. They ask all sorts of questions they probably wouldn't have courage to ask (7)*

Davina, who experienced infertility for ten years, and became depressed, became pregnant, and gave birth to twins. Following the birth, her eating disorder and depression disappeared completely and she observed:

> *Now that I have children, I do not feel the need to avoid any aspect of midwifery I feel totally different now, very grounded, complete and the feeling of being normal.I feel able to be supportive of the women and have greater insight into the way they think and feel (21)*

As previously mentioned, some midwives in the study had a stated intention to make something positive out of their losses, for example, two set up a support group for women who had miscarriages. Another became involved in a support group for bereaved parents, and led meetings and remembrance services.

DISCUSSION ON FINDINGS FROM THE QUESTIONNAIRES

From the findings, it is clear that some of the participants were recalling their experiences from some time ago; advances in medical and surgical technology also mean that some of the events which are recounted would be approached in a different way now, and the outcomes, if the event occurred now may be very different. This applies to diagnosis and treatment for infertility, antenatal screening for abnormality, and for the survival of very preterm infants. There has also been a significant shift in the nature of the mother/midwife/obstetrician relationship, with women adopting a more active approach to their own care. As they recounted their own reproductive circumstances, the participants were often recipients of midwifery/obstetric care so there may have been difficulties for them in casting and being cast in the role of cared for rather than carer. However, those who talked about leaving midwifery because of their experiences are recounting fairly recent histories, which suggests an area which needs to be addressed, given the current shortage of midwives in the United Kingdom.

Some participants stated that their own experiences had improved their ability to deal with women who experienced loss in pregnancy, or made the general comment that their experiences had made them better midwives. However, it was unclear as to how their practice had become better, what defined better practice, and who would know that their practice was different, or better, other than themselves. It seemed that it was not only the intrinsic experience which was significant, but also the way they had been treated themselves.

Participants suggested that people make tactless remarks simply because they know no better, or are not aware of circumstances. The number of times similar remarks were made in connection with miscarriage, infertility and pregnancy loss suggests this is an area for further exploration. The same common phrases appear, and are clearly meant to be helpful, however, those who reported them found them unhelpful and insensitive. Participants who heard these things and who experienced loss knew that they were unacceptable. However, it is not clear if they knew them to be unhelpful only after they had experienced the loss.

The emerging core category suggests that for the participants in this study, experience of reproductive loss in whatever capacity could not be separated from their midwifery profession. Ultimately, it is about being a woman and being a midwife, and how to reconcile the two when aspects of expectation about womanhood and fertility are compromised. There is also a realisation, however, that separation must occur, to maintain the ability to function as a midwife, and to maintain their integrity. Certain factors are enabling in this process, for example, practical and emotional support from management and colleagues, the ability to separate personal and professional self, and the positive use of experience.

In the core category, there is also the sense from the findings that there are some differences in dealing with reproductive loss for midwives as opposed to non midwives (or women not closely involved with childbirth). The participants touched on some areas, for example, about having particular knowledge about subject, having "connections" in hospital or medical settings, and perhaps, therefore, slightly different access to services. Colleagues were often aware that midwives needed protection, not only from potentially upsetting situations, but also from other personnel who were deemed "not suitable" to know the midwife's circumstances. These included those whom the midwife might subsequently have to manage, or those who were students. As the participants pointed out, there is also no way to avoid babies and pregnant women, no matter how upsetting contact with them might be. Clients are likely to ask if the midwife has children, therefore participants were obliged to consider the appropriateness of disclosing their own circumstances and the reaction they may elicit. Client's responses may challenge the midwife's credibility, the midwife may unwillingly present her vulnerability, and may feel she has become the cared for rather than the carer, and perhaps may experience a loss of control (and possibly power) in the midwife-mother relationship. The client may have a positive response, particularly if she already knows the midwife, or may welcome the additional knowledge the midwife's own experience brings to her situation. Conversely the client may become upset, or scared that her own pregnancy may be harmed.

All of the above contribute to how the participants felt about discharging their midwifery responsibilities in light of their reproductive experiences.

AREAS FOR FURTHER EXPLORATION

Analysis of the narrative accounts provided rich data about the areas I had highlighted in the questionnaires. However, as the discussion above, and within each category shows, there were some issues raised which I wanted to explore further. These centred on what exactly constituted support, how participants recognised that someone else empathised and understood them, how their practice had changed, and how anyone other than themselves would know this. If there were difficult circumstances at work, what made it easier to deal with them.

Given that so many participants had commented on the helpful nature of writing about their experiences, and about being involved in the research, I also wanted further information as to what aspects of participation were helpful, and what they hoped might be achieved by their involvement. I wanted to explore this, not only as an area of general interest, but also in case participants revealed specific areas which would be helpful to others in their own situation.

There were, therefore, five main areas approximating to the emerging categories which I wanted to follow up, drawn from analysis of the questionnaires, and these were as follows:

Impact and Nature of the Loss
Support, empathy and self disclosure

Impact on practice
Practical and emotional issues around work
Feelings on being part of the research

The translation of these areas into the basis for semi structured interview is discussed in detail in Chapter 2, Research Design. However for ease of reading, figure 3.4 on the next page shows how the interviews were structured.

Within the emerging categories, I sought particular specific information to add to the data from the questionnaires. The category of Support, Empathy and Self Disclosure suggested a number of topics which required clarification, and in the figure overleaf, (figure 3.4), I have broken it down into its three component parts.

Figure 3.4 Showing how areas for follow up from interviews were formulated

Category – Nature and Impact of the Loss

Review of the participants circumstances

Category – Support, Empathy and Self Disclosure

Support

What is support?

What would be examples of supportive behaviour?

Empathy

Some participants felt that there were people who they thought really Understood what they were going through

How could participants tell that people understood and cared about their circumstances?

Self disclosure

Were participants helped by other people in similar circumstances to their own?

What would be examples of this?

Would participants tell clients about their own particular experiences?

Under what circumstances?

Category - Practical and emotional issues around work

Some people mentioned particular clinical areas, or particular groups of people they found i difficult to cope with.

Ask for more examples

Was there anything that made these circumstances easier (or more difficult) to cope with?

Category - Feelings on being part of the research

Some people commented that they found completing the questionnaire helpful

What does the participant think now

Can they remember any of their feelings while writing the questionnaire?

How do they feel now that they have written their account?

Findings from the interviews are presented in Chapter Four.

CHAPTER FOUR

FINDINGS FROM THE ANALYSIS OF FOLLOW UP INTERVIEWS

Introduction and overview of the chapter

Chapter Three described the findings from the narrative accounts in the questionnaires, and showed the emerging categories and emerging core category. This chapter introduces the participants in the follow up interviews, describes the findings from the analysis of their in-depth, semi structured interviews and compares them with the categories and core category emerging from the analysis of questionnaires. Refinements and changes to the emerging categories are described in light of new data, and the chapter highlights how the core category captures the overall essence of the data given by the midwives in the study.

The interviews

Ten in-depth, semi-structured follow up interviews were carried out. Seven were face to face and three were carried out over the telephone. All but one of the interviews was tape recorded. This was a telephone interview where the recorder was unavailable. In another face to face interview, the tape recorder malfunctioned after 45 minutes, so the remainder of the notes was handwritten. All other interviews were face to face and were tape recorded. Chapter Two has already discussed the advantages and disadvantages of this method of data collection..

As previously discussed, the interviews aimed to confirm the emerging categories, and the structure of the interview was determined by the five emerging categories, as discussed in Chapter Three, which were as follows:

Nature and impact of the loss
Support, empathy and self-disclosure
Practical and emotional issues around work
Feelings on being part of the research
Impact on practice

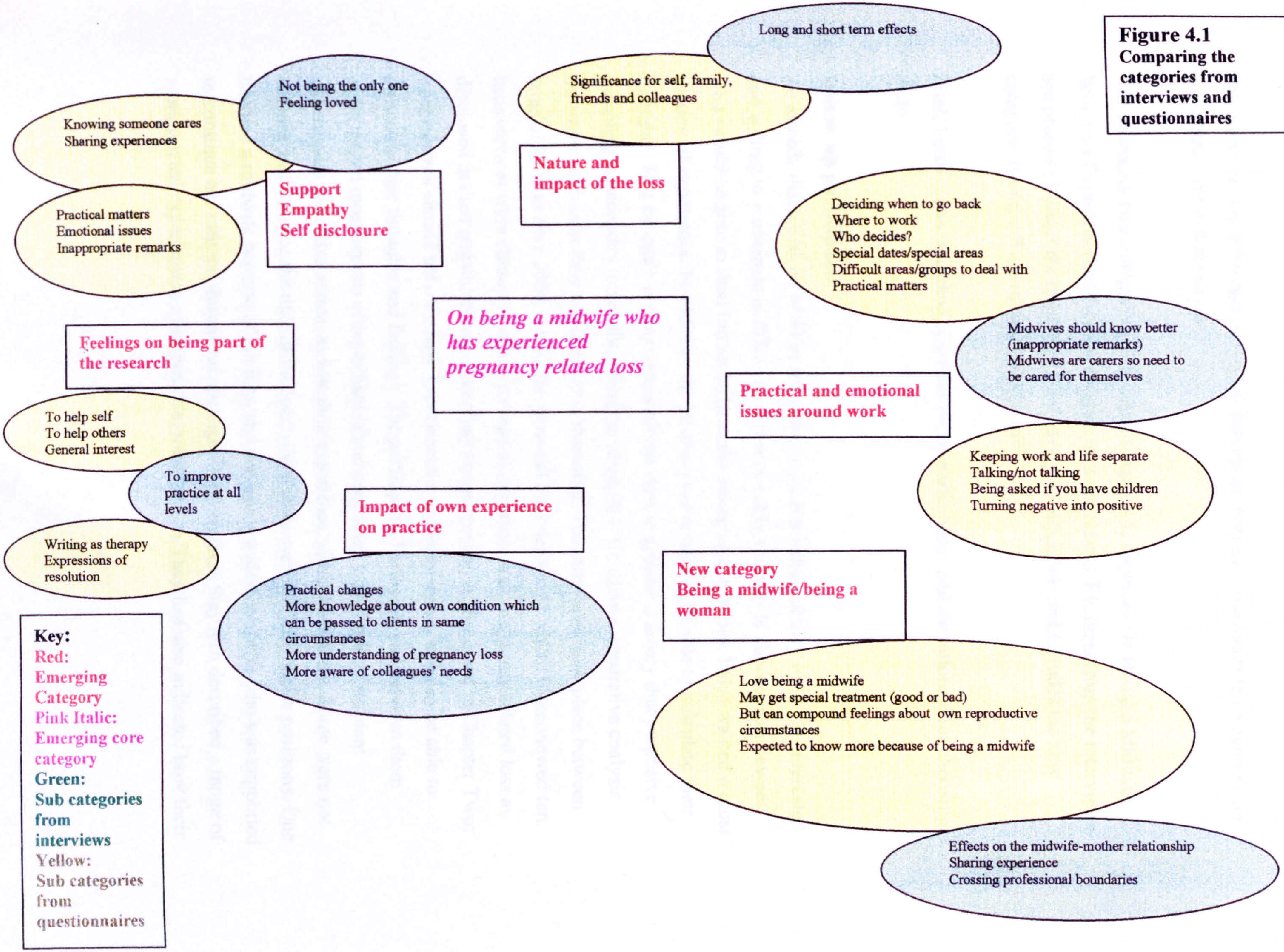
The semi-structured nature of the in-depth interviews allowed for specifically identified areas to be explored further, yet enabled participants to include other areas which they considered important. The analysis of the interviews, which searched for themes, similarities and differences, suggested that some of the emerging categories were supported by data from the interviews, and that there were some areas where new information arose, or shed further light on findings from the questionnaires.

Figure 4.1 shows how findings from the analysis of interviews linked with the findings from the questionnaires. Within each core category, sub categories from questionnaire analysis are shown (yellow areas). New sub categories arising from the interview analysis are also shown (green areas). As can be seen, some subcategories contribute (albeit in slightly different ways) to more than one category, for example, Sharing Experiences appears in Support, Empathy and Self Disclosure, and also in the new category (explained below) of Being a Woman, Being a Midwife.

During analysis of the interviews, it became clear that the category Impact on Practice incorporated elements of how participants felt about being a midwife who had experienced or was experiencing reproductive loss. The sub categories contributing to the category Impact on Practice, described in Chapter 3, and shown in Figure 3.4 remained constant. However, there were some issues relating directly to the area on the questionnaire entitled Feelings About Being a Midwife, and which emerged as important in analysis of interviews. I created a new category, therefore, called Being a Midwife, Being a Woman. This category contributes to Impact on Practice, but contains different elements of the midwives' perceptions of themselves. This major area of change results in an additional category, and section in this chapter, entitled Being a Woman, Being a Midwife. This category also makes a significant contribution to the emerging core category, On Being a Midwife who has Experienced a Personal Pregnancy Related Loss.

Each section of this chapter contains a diagram showing the relationship between the category, the subcategories from analysis of questionnaires, and any additional sub

Figure 4.1
Comparing the categories from interviews and questionnaires



categories arising from analysis of the interviews. Further refinements to categories are discussed later in this chapter.

The emerging core category at this stage of analysis is therefore On Being a Midwife Who Has Experienced a Personal Pregnancy Related Loss. Findings from the interviews are presented under the headings of the emerging categories, and includes the new category, Being a Woman, Being a Midwife.

First, I provide an overview of the follow up participants, and the rationale for choosing them.

Follow up participants

As already discussed, all of 40 of the participants had indicated they would be interested and willing to participate in follow up interviews. My aim was to choose interviewees who would be able to shed further light on the emerging categories. I also wanted a cross section of experience. In addition, the interviewees needed to be able to articulate their thoughts. This rationale is congruent with the view in grounded theory that purposive sampling is necessary to test the emerging categories. Constant comparative analysis informed each interview and interviews thereafter. The interviews took place between August 2003 to May 2004. I selected potential interviewees of whom I interviewed ten. Interviewees were chosen to obtain a range of experiences of pregnancy related loss as disclosed in their questionnaires. Sampling was purposive, as discussed in Chapter Two; interviewees should not only have experienced a particular event, but also be able to articulate their thoughts and feelings. The participants I selected, had between them experienced most aspects of reproductive and pregnancy loss. Their subsequent experiences were also varied, as was their experience within midwifery. Some were not actually midwives at the time of the loss, whilst some were in fairly senior positions. One became a midwife because of her loss, and one was a student midwife who was supported to continue her training despite miscarriage. Between them they also described a range of work related experiences, some positive, some less so. They had also indicated how their own practice had changed, or was influenced by, their experiences. Their questionnaires were written in a way, which suggested they would be able to articulate their thoughts at interview, although this was, of course, an impressionistic view.

Interviews took place at a venue and time of the participant's choice, and I have indicated that choice for each one. The next sections introduce the participants, and give some background information about their circumstances.

As previously mentioned in Chapter Three, no specific questions about ethnicity or cultural background were asked.

Janine

Janine experienced two miscarriages, one in 1985 and one in 1987, both prior to her becoming a midwife. She already had one child at the time of the miscarriages, and went on to have another. She is now in the 40 – 49 age group, and has reached the menopause. At the time of her miscarriages, she was undertaking a family planning course, and in her questionnaire, told how angry she was when she was discontinued from the course against her will. Her tutors at the time felt that as she had had a miscarriage, she would bring her own feelings to bear inappropriately on clients who wanted to discuss termination of pregnancy. Her questionnaire suggested that she felt angry that such an assumption of how she would use her feelings was made, and that she still felt anger against the tutors who had made that decision. She also talked about her feelings that experience of both motherhood and loss helped her to support women, and that she was supported by her family and by her own spiritual beliefs. Janine's interview was conducted face to face, in an office in her workplace, at her own choosing.

Flora

Flora was aged 35, and already had a three year old daughter when she became pregnant in 1993. She was already a qualified and fairly senior midwife at the time. Her obstetric consultant, a fellow colleague, suggested she might want an amniocentesis to rule out abnormality because of her age, and she agreed. However, the amniocentesis caused a premature rupture of the membranes, which meant a potentially extremely premature baby, risk of infection, and risk of limb deformity. After much waiting and deliberation, she decided to terminate the pregnancy. Her questionnaire highlighted the drawbacks of being a midwife in a situation where she was expected to know much more than a "lay" person. She had made numerous comments about helpful and unhelpful members of staff, and about how she coped with being back in practice, significant dates, and making decisions about amniocentesis in her next, and successful pregnancy. She talked about the positive effects on her practice, and how she subsequently organised and led a support group for bereaved parents. Flora chose to be interviewed in an office at her work place.

Chloe

Chloe has been a midwife for fifteen years and has been in a fairly senior position for some time. She is currently in a management type role developing midwifery led care. Just prior to starting her midwifery training, she experienced a pregnancy loss through termination of pregnancy. At that time, she was experiencing a number of life events and felt termination was her only option. She got married in the 18 months prior to completing the questionnaire, and is currently experiencing secondary infertility. Chloe wrote in her questionnaire about the length of time it took for her to come to terms with her loss. She realised she was actually depressed and sought help from her GP, who referred her for counselling, which she found helpful. She also mentioned that her sister had more recently had a termination of pregnancy when her baby was found to have spina bifida. Chloe had stayed with her for this and supported her subsequently. Chloe has also been involved in leading memorial services for bereaved parents. Chloe chose to be interviewed in my office.

Anita

Anita experienced a miscarriage in 1976, when her first pregnancy was at 15 weeks and six days. She was very ill at the time, lost a lot of blood, and needed a blood transfusion. The miscarriage happened the day before she was due to sit her midwifery final examination. She believes she had another miscarriage in between the births of her two children, but this was at about 6 weeks, and she had not confirmed the pregnancy.

Anita went on to complete her midwifery training, with the support of her teachers. She also set up a support group for women experiencing miscarriage, with the help of a colleague who had also experienced miscarriage. Anita made a number of comments about how her experiences affected her work in positive and negative ways. Anita's interview was carried out over the telephone, as she was ill on the day we had set for a face to face interview.

Maria

Maria was a midwife on a mixed ante/post natal ward when she became pregnant with Anna thirteen years ago. A blood test revealed a raised Alpha Feto Protein, suggesting some spine and or brain abnormality, and a scan confirmed that Anna had severe hydrocephaly and meningomyocele. Maria decided to go ahead with a termination of pregnancy at 23 weeks gestation. She subsequently experienced infertility, and whilst contemplating whether to have treatment, she became pregnant with her son, who is now three. Maria wrote in detail about her feelings and interactions with her family, friends and colleagues, and about what was helpful and unhelpful. She also experienced a long period of depression which was subsequently attributed to pathological unresolved grief. She had counselling, which she has found of great benefit. Her experiences have impacted on her practice, and on her career, as she became a midwife teacher to remove herself somewhat from the practice area for a while. Maria chose to be interviewed at her place of work.

Nina

Nina has been a midwife for almost ten years. She and her partner have been together since 1997, and have been trying for family since 1998. They have had various tests which confirm that her partner has antibodies on his sperm which prevent conception. Although they have had a number of attempts at assisted conception, these have not been successful and have been costly. Both she and her partner have been quite open in talking about their difficulties, and she described how helpful this was, although she did make some observations in her questionnaire about people making what she called glib remarks. Nina and her partner have now begun the process of being considered for adoption. Nina's interview took place by telephone, as this was more convenient for her and additionally, she was remote from the researcher.

Laura

Laura had a missed abortion in 1992. She was already a midwife at that time, and has been a midwife for sixteen years. Laura had always viewed pregnancy and labour as normal events, and described herself as "frozen" following her miscarriage. She was diagnosed with secondary infertility, and at that time elected to become a midwife teacher as she did not want to practice clinically if she had no children. She became pregnant following IVI, but at six weeks began to bleed. The pregnancy was discovered to be a twin pregnancy, one twin had died, but the pregnancy proceeded normally, and she had a little girl. She had a further miscarriage in 1998, after which she was very ill. She had further infertility treatment and unsuccessful IVIs, but then conceived naturally, and had another baby in 2001. Laura described in her questionnaire how her experiences impacted on her view of midwifery, and changed the pathway of her career. She also discussed the fact that she became depressed, and that counselling helped. She is currently not practising, as she is bringing up her two pre school children. Laura's interview took place by telephone, as after she completed her questionnaire, she moved house to a place remote from the researcher.

Vanda

Vanda had a miscarriage in 1981 then had two children, a boy and girl. She experienced problems with severe hypertension in both pregnancies. In 1990, Vanda was pregnant for a fourth time, and, following problems with her blood pressure, and some vaginal bleeding, at 35 weeks, she went into labour. During the course of the labour, her baby died, and she gave birth to a stillborn girl, whom she called Mary. Vanda was very unhappy with the circumstances surrounding how she was treated, both physically and emotionally. She developed depression after Mary's birth, and received oral anti depressants. In 1994 she applied to do direct entry midwifery training at her local hospital, the one where her baby had died, and was refused. She reapplied to another hospital, and was successful at interview, but when she disclosed her anti depressant treatment, was told she needed to be free from treatment for a year before she could be accepted. She then became a midwife, but has now left the profession for a number of reasons. Vanda's interview took place in my office.

Sophie

Sophie already had a little girl when she became pregnant with Andrew. She had misgivings about the pregnancy when her first scan found the baby "lying in a heap" as she described it, at the bottom of her uterus. At 32 weeks, she felt excessive movements from the baby, and then felt nothing at all, leading her to think that the baby had died in utero. She did not have this confirmed until a few days later, and did not tell any of her family, including her husband, what had happened. She drove herself to hospital where an ultrasound scan confirmed that the baby had died. Labour was induced, and she gave birth to Andrew, who had Edwards syndrome and multiple abnormalities, and who could not have lived. On her return to work, Sophie set herself a series of "tasks" which she felt she should accomplish, to prove to herself that she could continue as a midwife. As extracts from her interview show, she felt she was very well supported by her colleagues, who tried to shield her from situations they thought would be too traumatic for her. She was also supported informally by her Unit's bereavement counsellor, and she found the SANDS (Stillbirth and Neonatal Death Society) book "When a Baby Dies", a great comfort. Gradually, after a number of surprisingly (for Sophie) emotional encounters, she was able to continue in her midwifery job. In her family life, Sophie wanted to become pregnant and have another baby as soon as possible, and within a year of Andrew's loss, had had two miscarriages. She became pregnant again, with complications due to transverse lie, and went on to have another girl. Sophie kept a journal following Andrew's death, which she kindly copied for me. She found this helpful, as the extracts from her interview show. Her interview was undertaken at her place of work.

Martina

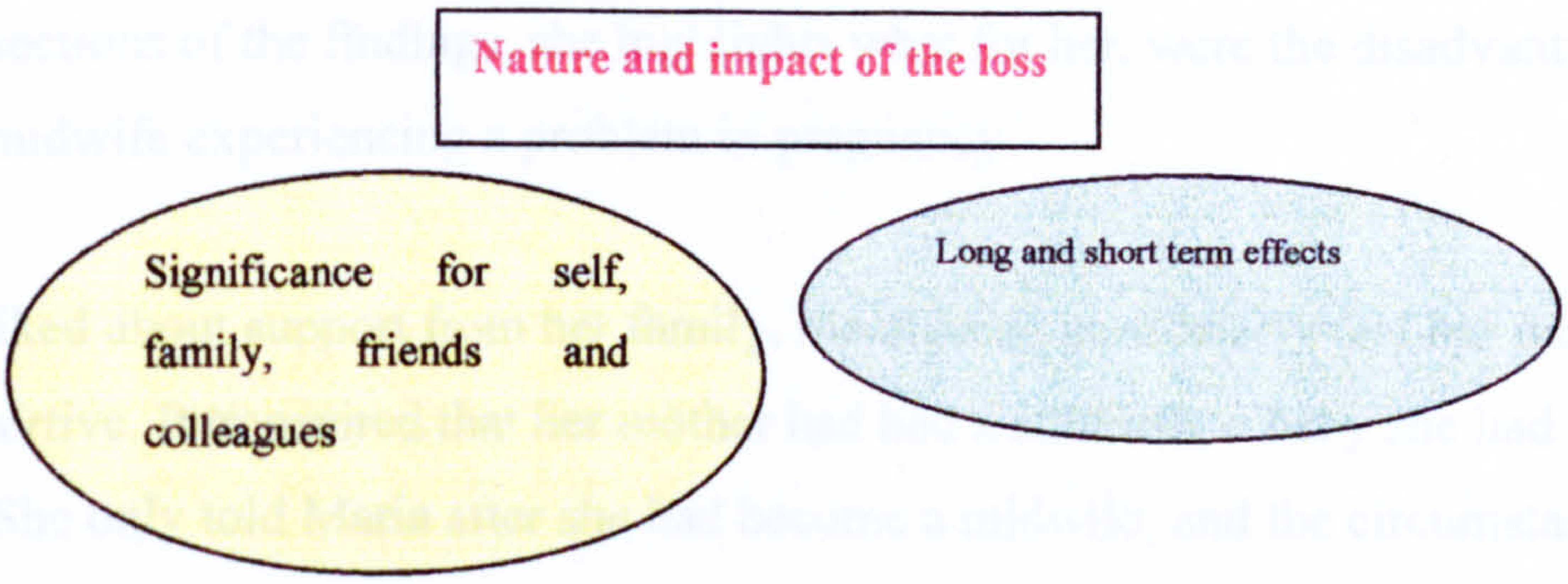
Martina had a miscarriage in 1992, and her next pregnancy in 1993 was terminated when a routine scan showed the baby was anencephalic. She had a daughter in 1994, then went on to have three more miscarriages. Two of her miscarriages and her termination of pregnancy occurred in the month of September, which she has found a difficult month to deal with in the past. Martina spoke of the difficulties she experienced when making her decision to terminate her pregnancy, and of the effects this had on her work as a midwife in relation to advising pregnant women. She also highlighted the supportive work environment she returned to, with colleagues who endeavoured to "protect" her from difficult situations at work. Martina and her husband have now decided not to try for a further baby. Martina's interview was carried out in her own home, at her invitation.

Thus, the participants' collective experiences covered miscarriage, termination of pregnancy for personal and for fetal reasons, infertility treatment resulting in conception, infertility due to problems with partner, resulting in decision to adopt, and stillbirth. The next section of the chapter presents the findings under the headings of the emerging categories, which are shown below:

Nature and impact of the loss
Support, empathy and self disclosure
Practical and emotional issues around work
Feelings on being part of the research
Being a Woman, Being a Midwife
Impact on practice

Each section begins with a diagram showing the category, together with its supporting sub categories from questionnaire findings (yellow) and from interviews (green).

NATURE AND IMPACT OF THE LOSS



As the findings from the questionnaires have already suggested, the loss was felt not only by the participants, but by their families, friends and colleagues. This category was explored further by asking the interviewees how they felt about their loss at the time of the interview. In some of the interviews, the comments about the nature and impact of the loss also related to other categories, and the data was located in these. However, the participants reveal how their losses had long term effects on their perception of themselves as women, and as midwives, and indeed, sometimes affected the course of their midwifery careers.

Maria revealed the long lasting impact of her loss on her and on her career as a midwife, and began the interview by saying how nervous she was. I was conscious that it was the month of August, the month in which her baby had died thirteen years previously. I asked her how she was feeling and she said:

> *It's been very hard to come to terms with and I have done that gradually…from time to time, I deal with a bit of it and then I have to put the lid back on because it's too much…and I think because of the way I was treated. They meant well, but they didn't know how to help me because I was a midwife, and so I spent a lot of years not dealing with it, pretending I was OK because nobody knew how to help me I think. They really didn't.*

For Maria, the loss of her baby was ongoing, and she talked about "processing" her loss:

> *…it's taken a back seat in the last couple of years because my brother was killed and that was extremely tragic, in a road accident. I feel I have buried it a little bit to deal with that…so I find lot of my emotional energies are really wrapped up in that really…I know I have still got lots*

> *of processing to do, but I am doing it.*

Maria clearly felt that being a midwife had affected the way she had coped, and in the various sections of the findings, she highlights what for her, were the disadvantages of being a midwife experiencing a problem in pregnancy.

Maria talked about support from her family, mentioning particularly that her mother was not supportive. It transpired that her mother had had a stillbirth, a baby she had called Gillian. She only told Maria after she had become a midwife, and the circumstances surrounding the birth and burial of the baby had obviously had long lasting effects on Maria's parents.

> *The priest wouldn't bury her and said that because she never breathed she couldn't be buried and that was hard. My dad has not been to church since. It was really hard for my mum. He took her round to the vicarage and the vicar said he would find a plot for her and he left a note saying under whatever tree...*

At that time, if a baby was born without signs of life, it could not be buried in consecrated ground, as it could not have been baptised. Maria's sister also lost a baby, and feels that her mother was jealous about the treatment her sister received in comparison to her own. The sister's baby was buried, and Maria buried a photograph of Anna at the same time, which she says she found cathartic.

The impact of Maria's loss had profound effects. It reawakened memories for her parents, and lead to a long term process of grieving which not only affected Maria, but also her husband. They both grieved deeply but separately for many years until they went together for counselling, which had helped them come to terms with the loss.

Sophie also spoke of how she and her husband grieved in very different ways for the loss of their stillborn son, Andrew:

> *His way of dealing was not to talk about it and just get on with things and that worked for him. I didn't feel that I could keep talking to him because it kept re opening the wound for him and he wanted to close it.*

In this situation, Sophie found the bereavement counsellor in her workplace an excellent resource, as she could to talk to her about her loss.

Chloe had felt unsupported by her family at the time of her termination (1986). She had finished her relationship with her partner, by whom she felt "betrayed" and her mother was "very judgemental" . She was angry and upset at the time, but feels that her experience has increased her capacity for empathy:

> *I was angry and upset initially, but I understand it now. Perhaps that makes me more empathic when I deal with other people, with loss and grief. I don't move away from it. I don't embrace it, but I actually meet (it) if someone is suffering*

The stillbirth of Vanda's daughter, Mary, had long term effects on her and her family, and led to Vanda becoming first a befriender for SANDS, and then to undertake her midwifery training. The loss also had an effect on her existing children, something she was not totally aware of at the time, but which her daughter has been discussing with her recently. Her daughter, who is now studying psychology, is also interested in her mother's participation in the research, and has read all the literature relating to the research. Her son, Jamie, and his partner have recently had a baby, and clearly Jamie's memories of his sister's stillbirth were in his mind. Vanda told me:

> *My son and his young lady had a baby in November and she was delivered at the hospital I applied to that wouldn't take me on, and they had a policy on the labour ward that it is only the pregnant woman, her partner and her mother and nobody else and obviously I turned up because Jamie wanted me to be there in case things started going wrong. But of course he was 8 years old when his sister died. He remembers the devastation that it caused, so he was very much, you are going to be there mum. You are*
> *going to deal with this.*

Vanda's children had always known of their sister, and of the effects it had had on them, and on their mother.

Sophie already had a daughter when her son, Andrew, died in utero. She experienced strong feelings about his loss, and these extended into her next pregnancies:

> *I had two miscarriages after I had Andrew…they were almost*

> *insignificant...but they couldn't possibly cause me as much distress or upset as I had already had. I suppose my focus was on getting pregnant and having a baby, so the miscarriage was just a sort of hiccup*

She experienced complex thoughts around her next baby, particularly in relation to attachment:

> *I felt very detached from the pregnancy and that baby. It was an inner fight I suppose. I wanted to get attached, but wouldn't let myself in case something happened. It was almost a resentment that I had got this baby growing inside me and I didn't want this one, I wanted Andrew.*

Sophie's personal challenge was to have another baby, but once her second daughter was born, she said:

> *I have done it. I have got a baby, it is alive, but I don't want it. But I have proved I can do it now. I don't feel like that now, but that was my initial reaction. That upsets me now, because obviously I don't feel that about her now.*

Sophie had spoken in her questionnaire about how she sought similar experiences to her own in the book "When a Baby Dies" (Kohner and Henley, 1997). She reiterated this at interview, and also told me that one of the most helpful things she did following her loss was to keep a journal, in which she recorded her thoughts in the time following Andrew's death, and following the birth of her daughter. She told me:

> *I have never shown them to anybody. I have still got them. I wrote them down because some of the things I was thinking I needed to tell somebody, or I felt I needed to because it was all too much in my head, all these thoughts and my head wasn't big enough to keep them in.*

Other participants had found comfort in writing their thoughts down in various ways. Flora told me that she had kept her baby's post mortem report, and a letter she wrote to him, saying good bye and explaining why she had made the decision to terminate the pregnancy. I am unable to present Flora's words verbatim, as at this point in her interview the tape recorder malfunctioned. Accordingly, I am reporting her words from my detailed notes taken at the time. At the time we spoke, she was debating whether she should tell her daughter about what had happened; they had been at her mother –in- law's house the weekend before our interview, looking at photograph albums. They came across photographs of flowers which had been sent at the time of the baby's death, and the photographs were dated. Her daughter did not ask about them, but the event made Flora think about how she should tell her in the future, particularly as her own mother had had similar experience. Flora told me how she remembered her baby over the years, but that each year the anticipation of the date of his birth is not so marked, that she doesn't think about it in the weeks approaching, or on the date think "it's today".

Martina had four miscarriages and a termination of pregnancy for fetal abnormality, but has one daughter who is now nine. Although her daughter knows about the lost pregnancies, she still sometimes asks her mother if she will have any more babies, and Martina finds this quite difficult to deal with:

> *She (her daughter) said about not having a brother, and I said, well, it's not as if we haven't tried, but you would have had a baby brother, and she was quite upset about that...she is the only one in her class who is an only child.*

Anita, who had a miscarriage and was very ill herself, made a number of comments about the long term effects this had:

> *...it changed my life. I think it changes you as a person...it can totally destroy your life*

However, she also made this comment on how she feels now about her loss:

> *It was 27 years ago and I do have the occasional day when it comes to my mind for some reason, I can't even say what reason, but no, I am absolutely fine. It's always been my baby...I am fine with that, and it was 27 years ago. I don't think I will ever forget.*

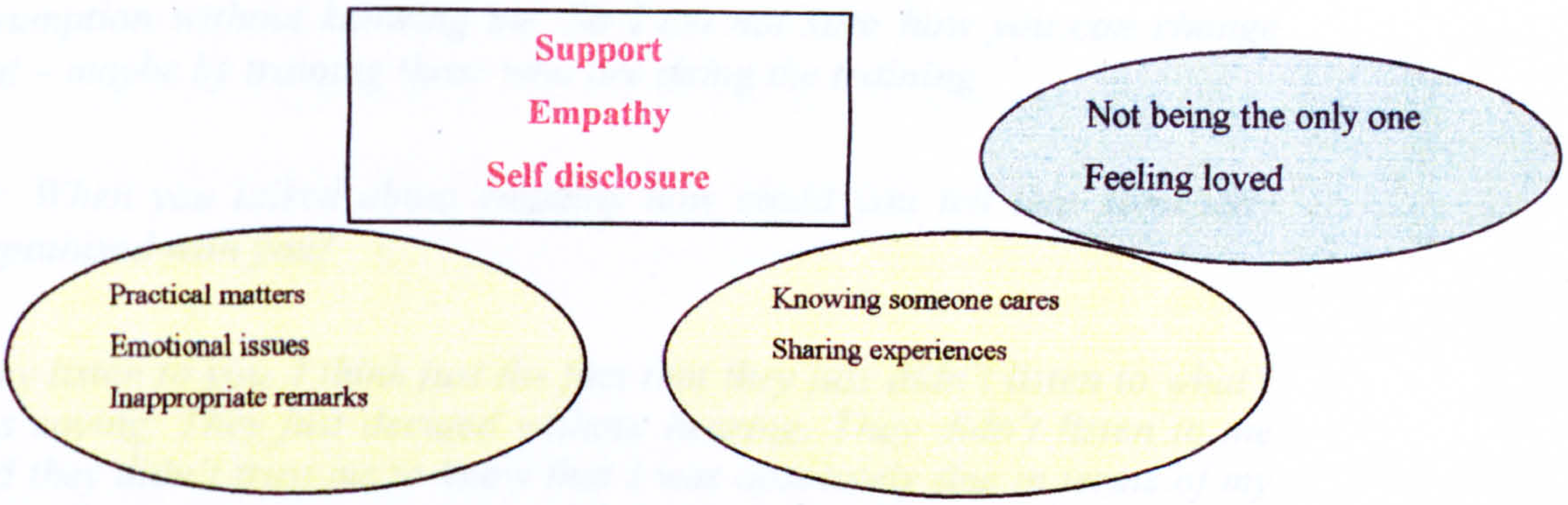
Vanda commented that although she can be a midwife, she can never stop being a bereaved parent. It is a part of her life which she cannot change. An encounter she related about a midwife teacher shows how she views herself as a midwife, and as a bereaved parent:

> *One of the essays we did was about what could go wrong. I did it with the stillbirth, wrote my essay and the comments came back that I had written it as a bereaved parent and not as a student midwife to which I turned round to the tutor and said, I will always be a bereaved parent. I don't ever have to be a student again cos I can walk out the door and I don't ever have to be a midwife. But you will never take away the bereavement. So she was somewhat annoyed and we didn't really see eye to eye thereafter and I didn't see eye to eye with the head either.*

Vanda's comments and those of the other participants, suggest that their losses assumed an important and defining part of their lives, which exerted an influence on them at the time, and for the future.

The next section examines the findings from the interviews which explored the participants experiences in relation to support following their loss.

SUPPORT, EMPATHY AND SELF DISCLOSURE



The data from the questionnaires, as shown in yellow above, frequently mentioned support, although it was unclear exactly what the participants meant by support. There were some elements which were of a practical nature and I have included these in the category on Practical and Emotional Issues Around Work. However, in the current category, there seemed to be some elements of being understood (empathy), and of having the opportunity to talk, which necessitated some degree of self-disclosure. I sought further information in relation to how the interviewees felt about talking or not talking about their experiences, and how they could tell if someone empathised with them. As previously discussed, some sub categories relate to more than one category. By comparing the diagram above with Figure 4.2, it can be seen that Emotional Issues, Inappropriate Remarks, and Sharing Experiences appear in this section, and in the section on Practical and Emotional Issues Around Work. Discussion on the rationale for final data location, and confirmation of the categories appears in Chapter Five

I specifically asked the participants what they thought constituted support. For Janine, it was mainly an emotional issue:

> ... *understanding, or trying to understand or empathise with what the other person is going through*

She had very strong feelings about lack of support surrounding her first miscarriage:

> *Maybe it was just the culture of thinking at the time, it was in the early 80s and maybe things have changed a lot now, but when I went back to the course, (family planning)... I was interviewed in a very sterile manner by two teachers wearing white coats... but you see that wouldn't happen any*

> *more...I hope it wouldn't. To be dealt with by somebody who wasn't judgmental. They decided that I wouldn't be able to deal with women coming to stop the pregnancies or go on to termination. They made that assumption without knowing me. So I am not sure how you can change that – maybe by training those who are doing the training*
>
> *Int: When you talked about empathy how could you tell that somebody empathised with you?*
>
> *They listen to you. I think just the fact that they just didn't listen to what I was saying. They just decided without hearing. They didn't listen to me and they didn't trust me to know that I was absolutely fine in terms of my life and my experience was mine and that I could differentiate between my experience and those of the women who were coming to me for advice or care. ..they had decided that if you had a miscarriage during this course, then there was no way you would have the ability to give rational advice to someone who didn't want to be pregnant, and for me that made absolutely no sense. I couldn't work out where on earth that had come from. So listening, understanding, and not judging somebody.*

Janine had clearly lost more than her pregnancy at that time, she had lost a place on a course that was important to her. She was frustrated with her experience, and remained (possibly remains) frustrated for a long time.

Some interviewees found specific support groups were helpful, Flora and Vanda specifically mention SANDS as being supportive, not only for them, but for their clients in the future. However, Flora had also attended and recommended to some women, a local support group for bereaved parents. She commented that the women running it had been the same ones doing it ten years previously, and she wondered how valid their input was after that length of time. She noted that their letters of introduction described them as bereaved parents, and she speculated as to how long they could describe themselves as such. This raises issues for her about what I have called the "shelf-life" of shared experience, and, after the passage of time, how much of the experience of perinatal loss and the responses to it, remain constant over time. However, as Vanda's comments in the previous section suggested, a bereaved parent is always a bereaved parent and nothing can ever change that.

Laura also felt that emotional support was important for her, and again stressed the importance of "someone who understood and would let me talk". However, for Laura this was sometimes difficult, because she had chosen not to tell many people about her problems, and said she might have had more support had she done this. She felt too upset at the time to talk. She particularly mentioned two senior managers who were receptive to her requests to change work areas, and reduce her hours when she was having infertility treatment:

> *I spoke to different senior midwives and mentioned why I wanted to change. They were both very supportive and also were dealing with their own experiences of loss, otherwise, I rarely discussed my feelings with work colleagues*

She further mentioned how helpful she found it to talk to people who had had the same experience:

> *...someone who understood and would let me talk. Someone who had been through it and had similar experiences. (to be) allowed to do what I wanted and be allowed to talk.*

Laura found a workshop on infertility very helpful, and was advised by the facilitator that she should have counselling. She did this and said of her experiences:

> *It was years down the line, and I ended up bawling my eyes out (I) went for counselling where I would weep for an hour at a time*

Nina, who was experiencing infertility also found talking about her problems helpful:

> *John (her husband) and I were quite open about the treatment, the investigations we were having and in a way, talking about it was kind of helpful and supportive. It was...helpful that people were prepared to listen and you could just talk about it...I have always been very open and chatty about it.*

Maria also highlighted being able to talk about her problem, and found it unsupportive when people expected her not to talk, and to behave like nothing had happened. Anita said that she too felt supported by having people who listened:

> *...certain people, family, colleagues, friends, certain ones were very good. They said they were sorry and they listened to me. In that respect I felt I was getting supported, that they allowed me to talk*
>
> *Int: and did you want to talk?*

> *Anita: yes I did...there was a couple that I felt I was able to talk to at the time...they were mostly colleagues. Her sister had just actually had a still birth so we supported one another at that point, because she was quite traumatised at what had happened to her sister. She was faithful, and (I) would say she was the best person.*

Later in her interview, in response to a question about how she could tell when people understood her situation, she returned to the support she had had from her colleague:

> *She would put her arms around me and say how are you managing. She could see I was struggling at times, she picked up the signs. She's the main person I can remember clearly, other people initially yes, but that died away very quickly. She was the one that persisted*

Flora also found support in being listened to:

> *I talked endlessly about it. Probably to the embarrassment of a lot of people, but that was my way of dealing with it.*

Flora commented on an offer of support which she welcomed, but which was never followed through. Her manager sent a letter of condolence, in which she offered to come and see Flora at home to discuss her return to work. Flora "phoned and phoned and phoned" but was never able to contact her. On her return to work she bumped into the manager, who accused Flora of hiding from her, and then wanted to talk about her experiences. Flora said:

> *I started off having a good day, I was doing very well, but she took me and sat me down wanting to talk, and I ended up having a bad day..she made it into a bad day because she wanted to talk about things that would have been more appropriate to talk about 3 weeks previously...it hurt at the time, you know, she made that offer and didn't follow it through*

Flora also told about the support she had from one particular colleague:

> *She was great you know, just an Irish person, and she always has a lot of insight, and she's a surviving twin, and they are very intuitive. Just saying the right things and she bought me a bottle of iron tonic, just always said the right things. And she would phone me up and ask how're you doing, you know. She's not someone I would see an awful lot outside work..now and then I meet up with her and she is special*

Later in this chapter I include a section of Flora's interview in which she talked about a colleague experiencing infertility, who she believed became "too involved" in client care. Here she pointed out that she thought the way colleagues and clients are treated is, and she implies, perhaps should be different:

> *Int: was she the same one you were saying people thought she got too involved?*
>
> *Flora: Yeah*
>
> *Int: so you would have been a recipient (of that involvement)*
>
> *Flora: absolutely and appreciated, but her involvement with me was a little different because I was a colleague. She's just a really intuitive person and she can pick up what the right thing to say at the time is.*

Sophie spoke very positively about the support she received from her work colleagues, and from the bereavement counsellor at her work place. As well as being able to talk about her loss to them, she told me:

> *They let me be upset...because they were midwives, because they were familiar with the situation of caring for women under that sort of circumstance.*

This is in contrast to what many other participants found, as overall, many expressed surprise that midwives could be so uncaring and insensitive. Sophie also found her colleagues helpful in thinking about what kind of work she was allocated to do:

> *They protected me from things that they thought might not be the right thing to do at the time...they were very protective, but there were things that I had to do. If I didn't do them I would never do them.*

Sophie set herself a series of tasks, which she called "hurdles" relating to elements of work on the labour ward which she felt she had to accomplish. She said:

> *It was a coping mechanism I suppose, I was focussed on the things I had to do.*

However, she felt that by acting in this way, she exerted a great deal of control, which, although helpful for her in one way, put her under a great deal of emotional strain:

> *..it is a very emotionally charged job, and it is not something you do without letting your emotions surface every so often.*

Chloe talked about the issues of support in relation to her management role, and her support of staff in her managerial position. She felt that support involved understanding, and recognising that if a midwife's performance is not good, or if she is "sharp or aggressive or whatever" then the manger should pick this up. She also commented on how, when her staff were involved with bereavement at work, she always saw them, and gave them details of the Trust's confidential counselling service.

She had felt unsupported at the time of her own experience of pregnancy loss (by termination of pregnancy, and prior to becoming a midwife), and says that she felt she couldn't talk about it:

> *...it didn't feel safe actually to say...I found midwifery quite draining, but I had to think about the issues I was involved in, and ...think about my own self because I wasn't given any counselling for my termination at all, they didn't offer anything, they just said right get on with it. It took three years and suddenly I realised I had other alternatives, but I didn't have the support and I think this is what I have learnt... I didn't have the support, and therefore I would want to provide it. I don't want to provide midwives with this sort of comforting support, but it is about directing them, and understanding that they have issues, and (directing them) gently into an area that might help them.*

Chloe spent a number of years having counselling from a consultant psychologist and said:

> *I think it was the best money I spent because I think it helped a huge amount.*

Clearly, Chloe felt she benefited from talking about her experiences during counselling.

Vanda found a very complex set of circumstances surrounding support and the potential for support. As the overview of her experience showed, she made two applications to undertake midwifery training, and her entry onto the course was dependent on her remaining free from anti depressants for a year. She needed to be reinterviewed after the year, and on this occasion, two senior midwives conducted the interview and asked some searching questions about her experience of stillbirth. The following section of her interview shows how probing questions were asked, but never followed up with support:

> *It was very interesting that the interview I had at that time was with the 2 senior heads, one the head of midwifery, one the head of the school, whereas the one the year before had been with one of the midwifery tutors who actually is a lovely lady and we have kept in touch. But it was very interesting to see the difference*
>
> *Int: in what way?*
>
> *Vanda: far more searching questions whereas the first interview I had had been very much more a chat and did I understand what the course was about and how did I feel about it. That sort of general thing that you would ask anybody, whereas the next year it was very much along the lines of how do you feel the stillbirth will impact upon your work. All those sorts of questions. Very searching questions. How did I now feel? What would happen if a baby died on the unit? And how would I feel delivering a dead baby and that sort of thing?*
>
> *Int: so they asked you those questions in the interview. Was there any kind of follow up to see how you were doing?*
>
> *Vanda: no*

Despite the lack of follow up, Vanda felt well supported for the first 18 months of her training:

> *I was with people who knew I had a still birth and were very determined that they would support me, so anything I wanted to know. They were very supportive. The group of midwives I was with were really wonderful and I did all my duties, so I got the pick of the deliveries and it was really good.*

I asked Vanda how people knew she had had a stillbirth:

> *I told them. I felt that it was best to be upfront immediately. When I was introducing myself and saying a bit about myself and they were doing the same, I said, I think you ought to be aware that I have had a stillbirth and gave them the very barebones of what had happened, because I felt it was only fair.*

However, the second part of her course left her feeling unsupported and disillusioned for a number of reasons. She also mentioned being bullied, as the following extract shows:

> *but my second 18 months, the people I was then with were... one was without doubt a total bully, didn't believe in the direct entry midwifery. ...she was very scathing in everything that she wrote, and from then the*

> *attitude with the other tutors changed.*

Vanda also commented on the general lack of support for others on her course, and the fact that her own experiences of stillbirth, and of working with SANDS, were never capitalised upon:

> *They were also quite cross that any of the girls that wanted to know about still births would come and ask me. If they wanted to know, they would come and ask me. One of the students had a fresh stillbirth during training and there was no debriefing.*
>
> *Int: her own baby?*
>
> *Vanda: no she delivered one. There was no support, no debriefing, anything, so it was me she turned to, and obviously this was known on the course cos she mentioned it in her final assessment of the course and again it was, you are here as a student, you are not here as a SANDS member. and I thought well no, this isn't right. I am a SANDS member, I am a bereaved parent and that will go on forever until the charity either folds or I (will) die. But the midwife part is an option if you like.*

Anita had felt supported by colleagues, but had found her husband unsupportive at the time of her miscarriage:

> *I think he was more worried about me at the time. I remember his coming round and saying the baby meant nothing as long as I was OK...looking back you can see where he was coming from, but at the time I was very hurt by that.*

Maria spoke about the difficulties she encountered during her termination of pregnancy. She was cared for by senior staff, as described later in this chapter, and other staff were generally kept away from her. She talked about two nursery nurses who peeped in through the door but who were not allowed in. She could "feel their support…just seeing their look" I asked her what it was that she felt:

> *I can only describe it as a love really. I just felt love from them and I wanted them to come in. Just for them to be with me would have helped me.*

Maria also spoke of how horrified she was because people sent her flowers. Janine had mentioned she had been sent flowers and interpreted it as supportive but Maria said:

> *Everybody sent bloody flowers. I really hated the flowers, I think because of my religious beliefs, I couldn't get beyond the notion that I killed my*

> *child and I was being rewarded with all these flowers...I killed my child and they were giving me flowers.*

As mentioned before, Maria felt unsupported by her mother, and said she wanted a mother figure. I asked her to tell me more about how such a mother figure might be:

> *Someone that accepts you for who you are and encourages you to grow, supports you and doesn't always agree with what you do. There is no way a human being can always totally agree with another...someone who is more mature than you, emotionally more mature, and my mother isn't. I am very much the parent now. My sister too..someone who you always felt that they loved you, no matter what and I have never felt that.*
>
> *Int: With anyone:*
>
> *Maria: oh yes, with my sister, my friend, who is old enough to be my mother, but only just. She is 60 this year...very caring, unconditional love and support and I have been quite lucky to meet quite a few people like that.*

However, Maria also identified something about herself which suggested that she had become more receptive to that kind of support herself, and indeed feels able to give it:

> *..but I think that it happens more as I get older and I am more able to give that to other people.*

She also said:

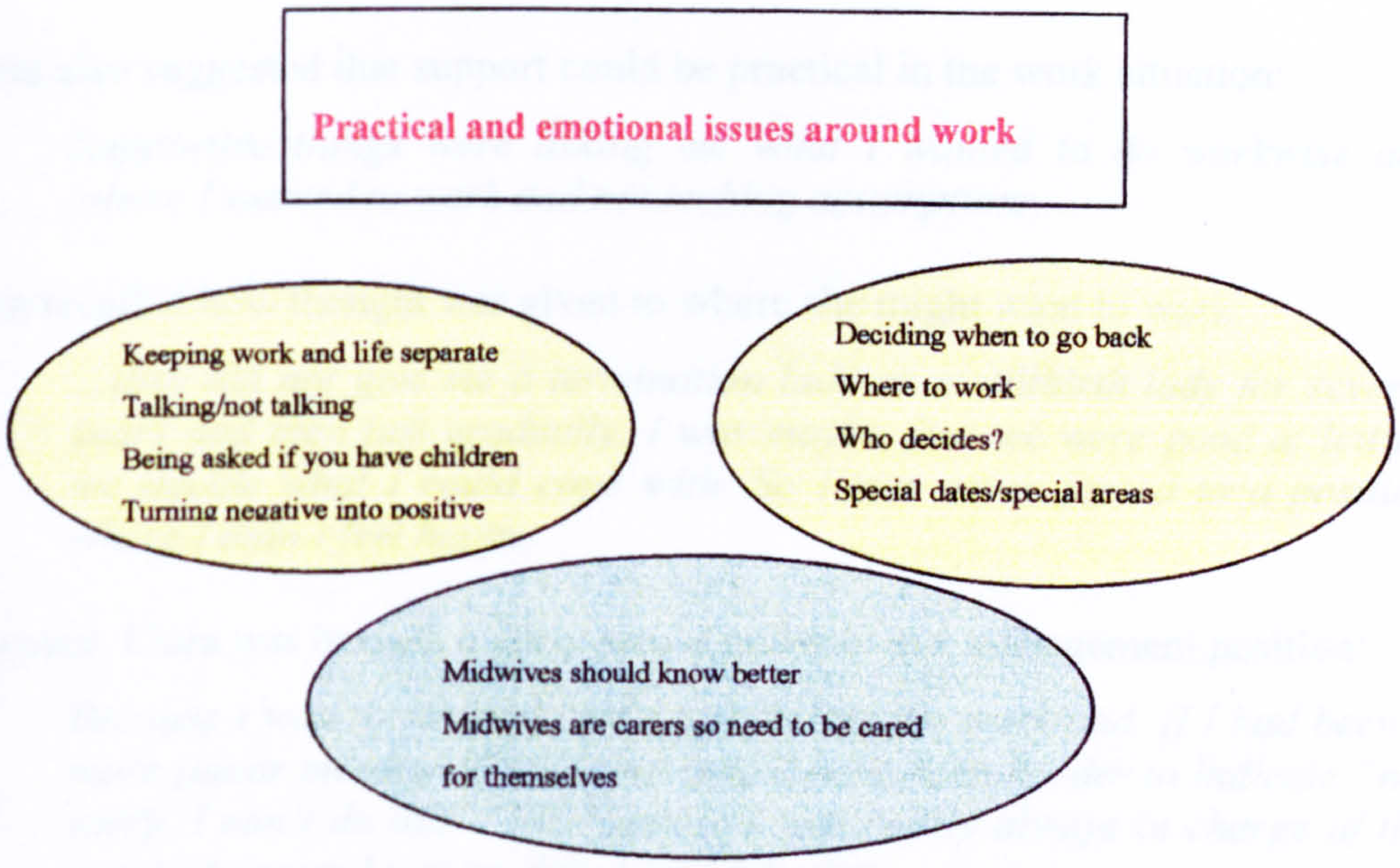
> *I have friends and colleagues who are hovering out there, knowing that I am with you today..looking after me, and they are going to be there when I come out of here because I need it. I don't need to say anything, we will just have coffee and talk about the weather or something. They'll just be there and that will help.*

Clearly for Maria there was a sense of being cared for and being valued which she found supportive.

The findings in this category suggested that the participants valued being listened to and not judged, and that talking about their losses could be helpful. Two areas arose as additional to the previously identified sub categories. The first was related to not feeling alone, that is, an appreciation that what had happened to them had happened to others. This also occurred in the section on Feelings on Being Part of the Research, in that participants sought information about people in their own situation. There is no assumption that personal feelings were identical, or that there was a universal experience for individuals in similar situations, rather that participants looked for evidence that there were others who had shared a similar experience, even though they may have processed it differently. The second additional sub category in this section is what I have called Feeling Loved. Maria described it most eloquently and it seemed like a powerful supportive mechanism, perhaps more spiritual than the sub category Knowing Someone Cares, which contained similar sentiments expressed by the participants.

In the current section, interviewees mostly mentioned their work colleagues and the next section examines some of the emotional and practical issues they encountered in the work situation.

PRACTICAL AND EMOTIONAL ISSUES AROUND WORK



As the questionnaire findings suggested, many participants found returning to work difficult and encountered a number of problems, for example, which areas to avoid on return. The interviewees talked about some of the issues which arose for them around their work situation, and highlighted how their treatment by managers and colleagues impacted on how they felt. As the diagram above shows, two other subcategories (green) emerged from analysis of the interview data, which suggested that interviewees thought their midwifery colleagues should know better than lay people how to treat them, and that midwives are carers, and therefore need to be cared for themselves.

Anita recounted how she was helped in practical ways by her tutors, but the issues of where to practise in midwifery to avoid painful memories arose:

> *Actually, I was going to give up midwifery and she (the tutor) said you can't give it up you need to come back and you need to finish it. One of the tutors was very good. They used to come out to the workplace at the time, and they used to say, are you fine and everything and she'd say, you're not doing that one, I'll give you another assignment cos the assignment maybe was too close to home. They didn't take me to the nursery... but there's nowhere in midwifery that you can go that doesn't hurt.*

Anita also received practical support from a former nurse colleague, who was a staff midwife at the time:

> *She was very good. She did try to keep me away from people that had had miscarriages. It was very hard.*

Maria also suggested that support could be practical in the work situation:

> *Supportive things were asking me what I wanted to do workwise and where I wanted to work and not making assumptions.*

Flora recalled how thought was given to where she might want to work:

> *...they did not give me a termination lady or a stillbirth lady for several years and then just gradually, I was maybe, just we were good at letting me decide what I could cope with. So I was never forced to a position where I didn't feel happy.*

However, Flora was herself, a fairly senior midwife in a management position:

> *Because I was so senior I could just dictate the workload. If I had been a more junior member of staff that would have been harder to indicate "no, sorry, I can't do this". But because I was nearly always in charge of the ward whenever I was on duty I could do that.*

The interviewees also identified groups of women they found it difficult to look after. For some it was those who were experiencing similar losses, or experiences to their own. For example, Flora found it difficult to give advice on screening and amniocentesis:

> *..to give really non biased, factual, research case, evidence based information, and I say to them I am probably not the best person to talk to about this, because I was one of the ones in 200 (who will lose the pregnancy following amniocentesis)...I refer them on because they are not going to get a balanced view (of the risks of amniocentesis).*

Martina also found it difficult to give information and advice about antenatal screening, because of her own experiences. She had thought she would never agree to a termination of pregnancy, yet when a scan revealed her baby had anencephaly, she agreed. She described a difficulty she experienced when talking to a client who had high risk markers for Downs syndrome, but who said she would not have a termination:

> *I thought, well, I could have said that a month ago, but you just never know what is going to face you, do you?*

She also said:

> *...when their opening line is I wouldn't have a termination no matter what is wrong, then I say it is up to you, you have the rest of your pregnancy to prepare yourself. I think that took quite a bit of confidence to say that to*

> *women. They want answers there and then...they want a definite answer that everything is going to be alright... the last five years has certainly changed the way I approach people.*

Martina felt that her experience as a person who initially would have said she would never have a termination, made her more aware that the knowledge that an abnormality exists can profoundly alter long held views which people have about themselves. Further examples of how the interviewees dealt with the areas they found difficult appear in the section on Impact on Practice.

Flora felt that her own experience influenced how she dealt with junior staff who had experienced personal pregnancy loss:

> *...you take the support when you need it, and then you come into the position to be able to give that support*

Chloe's current position is not managerial, but is a relatively new post which involves developing practice and midwifery led care. Her experiences have not so far been good, and although unrelated to her pregnancy loss, provide insight into how midwifery work colleagues' behaviour can influence other midwives, and the women in their care:

> *I have never been involved in a job where people aren't particularly kind or want to see you fail which is really just extraordinary, because I am just not that sort of person. Shockingly it is more midwifery than medical staff...midwives, some of the midwives can be very difficult*

She gave me an example of where she had been looking after a woman in early labour, who she thought needed to mobilise. The midwife in charge of labour ward overruled her (publicly), separated the labouring woman's birth companions from her, and suggested that Chloe's decision to let her labour had been a mistake. The woman subsequently went on to have a Caesarian section. Chloe felt undermined, and also felt that the midwife had disrupted the woman's own birthing process by criticising her, and removing her source of emotional support.

There were other examples she gave of being excluded from important meetings, and of being told that from the start "the doctors did not want me". She said:

> *You feel that people are trying to stab you in the back. I think if they are*

> *treating me like that, how are they treating each other?*

Although this may seem unrelated, I included the above remarks, because they illustrate that Chloe felt hurt at the attitude of people she clearly thought should know better. This links to what participants generally said about expecting midwives to be caring.

As a previous section showed, Vanda had also experienced bullying by a midwife, during the time she was a student. She recounted another experience of uncaring behaviour, at a time prior to her becoming a midwife and just before the birth of her daughter:

> *I was admitted....with high blood pressure and one of the sisters said on the ward that if I didn't stop all this nonsense then my baby would be dead. Fortunately she has been demoted and I am so pleased to see it... you can't be like that with people.*

However, Laura felt strongly that midwives are in a position of caring, and that they cannot take on this nurturing role unless they themselves are nurtured. She gave this as part of her reason for wanting to take part in the research saying:

> *I hope it will get it out to be discussed. Midwives have got lots to deal with, they are therapeutic persons which is difficult if you have difficult stuff.*

She had clearly taken the view that what happens in the life of the midwife impacts on her ability to take care of women, and that midwives need to be nurtured themselves if they are to nurture women and their families.

Martina's difficulties arose largely in relation to her direct work with clients, since she found her colleagues very supportive. She was often asked by clients if she had children, and said that once she had had her daughter, she found it easier because she could give a positive response:

> *The majority of people ask me if I have children or not, and for some reason, I think it is better if you have.*

However, she was often asked if she intended having any more, and this led her into a more guarded response:

> *I usually say to them, I have got one, but that is not the way I wanted it, but that's the way it's worked out...I think that people very often think, she*

> *is a midwife, she tried it once and she doesn't want any more...I think people think that if you are a midwife and you have one child then you didn't like the experience then you will never come back for another one.*

Martina had pitched her response so that it indicated her personal view right from the start. Martina found that for the most part, her midwifery colleagues were supportive, and protected her from situations which they thought might be upsetting. Just as she was quite direct with her clients about her personal situation, she also found it helpful to be direct with her colleagues about her own past situation, often bringing up the subject herself. She told me:

> *I am really quite happy to talk about it, and usually with new girls, we will talk about family and things, I will tell them right from the beginning...they (then) know that I would support them*

However, Nina highlighted an area where she thought midwives should know better in terms of the remarks they made. She pointed out that some people at work responded to her infertility with comments like "you'll be next" (to be come pregnant) which she deemed inappropriate, and about which she said:

> *It was those kind of comments where I learnt not to say that kind of thing to anyone. Although there were people who knew what was going on, there were people who didn't know. They were the ones that made the glib comments, and I thought that wasn't really well thought out. How little you know, sort of thing. And depending on how I felt at the time, I decided what my response was...unthought about comments that in the job that we do, we didn't really expect...just so unhelpful, that kind of throwaway, unthought about line*

Nina's remark confirmed my impression from the questionnaire data that participants expect a greater degree of understanding from their midwifery colleagues than from their friends and family. Her comment also links to the questionnaire findings on making inappropriate remarks, that what people often say instinctively is unacceptable. The findings suggest that those who have had the same experience, or have taken note of what people have said about the experience may be less likely to make inappropriate comments.

The section in the current chapter on the Nature and Impact of the Loss showed how Vanda became a midwife because of her experiences, and how her depression played a great part in the decision to offer her a place for training. Once qualified, Vanda experienced further problems at work in the Special Care Baby Unit, where she felt she was being watched carefully. The greater degree of watchfulness was initiated by the storyline of a popular TV soap at the time:

> *I had already realised on the unit that when anything happened on Eastenders, or any of the soaps, it immediately became a talking point over the incubators that this was what was happening, and obviously this little baby (in the soap) had got group B strep and died, and we actually had got a baby on the unit with group B strep who was doing really well, so I had watched it so that any concerns that she (the mother) brought up, at least I knew what was being said on the program. So happily sat there watching it, totally annoyed with the program that they had allowed this mum to kidnap this baby. When I went on to the unit, the first question I got asked by one of the sisters was, did you ever feel like that? And none of the mums (that she befriends) ever do. If they do, there is something wrong with them that has been there forever. It is not the stillbirth that has done it. We just want our babies back. But I realised that I was being watched, that there were jokes being made about me.*

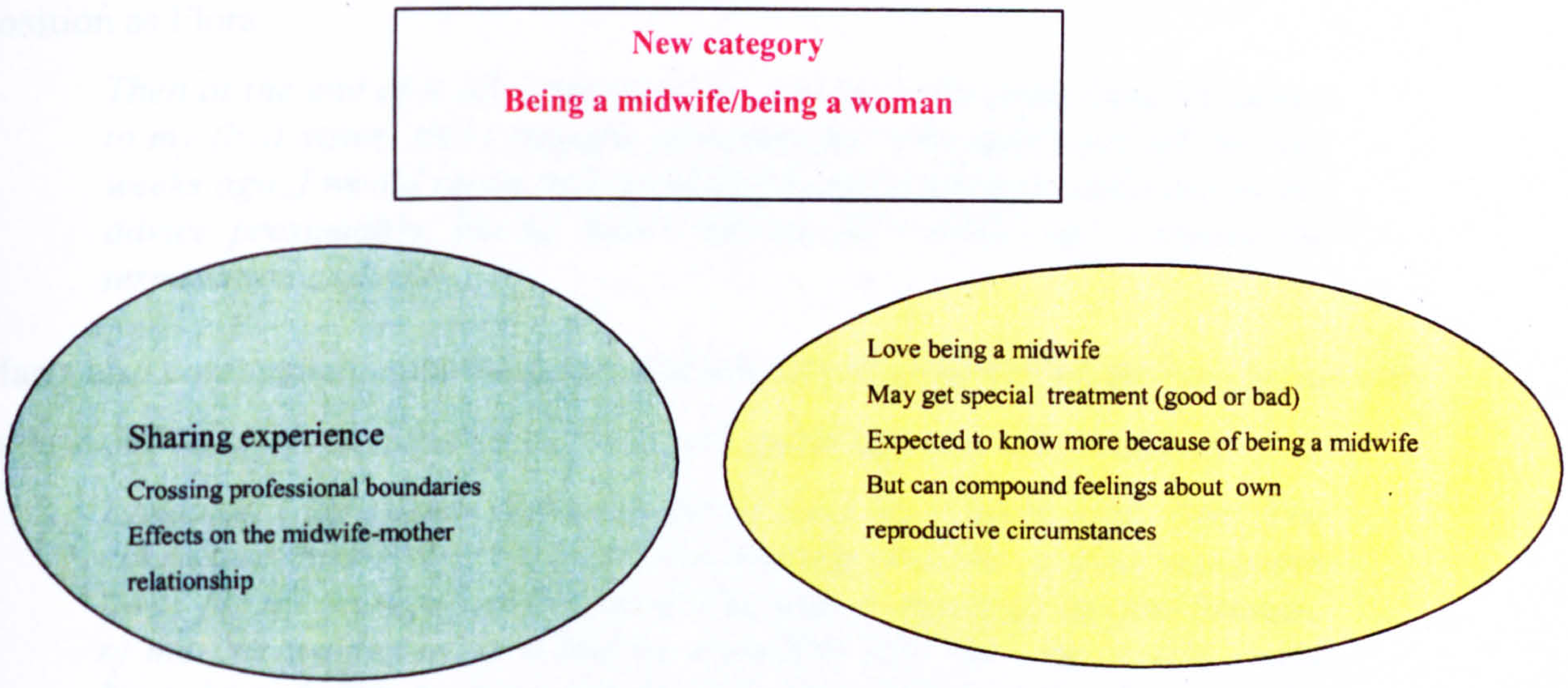
However, Vanda also recognised the popular view of women who have experienced pregnancy loss:

> *But I dismissed them because it is very much the public perception of what is going to happen. It is very much every time that a child or baby goes missing, and a clinical psychologist who says we are looking for a woman who has just lost a baby, and I scream at the screen every time...it was just that particular incident that was sort of taken out of proportion towards me. So I put it down to people's ignorance.*

Although Vanda came to terms about how and why her colleagues behaved as they did, her account reveals the potential problems that women who experience pregnancy loss can encounter, in the face of public opinion about what kind of person would abduct or harm a baby.

The extracts in this section suggested that additional subcategories relating to expectations about midwifery colleagues, and about midwives needing to be nurtured themselves before they can care for others, needed to be added to this category on Practical and Emotional Issues Around Work, as shown in the diagram.

BEING A WOMAN BEING A MIDWIFE



This new category uses the sub categories from the category originally entitled Impact on Practice, as it became evident that there were two distinct areas, albeit closely linked. Elements of the sub category on Sharing Experiences also fit in this category, as well as in the category on Support, Empathy and Self-Disclosure. There is more evidence from the findings from the interviews on how the midwives' own experience also contributes to their encounters with clients. The issues of professional boundaries and their place in the midwife-mother relationship also arises in this section. First, the participants talked about how being a midwife affected their experiences of loss.

Flora talked about the fact that her knowledge as a midwife did not help her make her decision to terminate her pregnancy. She discussed how her own obstetric consultant had adopted a wait and see approach, and in desperation for some direction she approached another consultant renowned for his straight talking. She actually said "he's a bit of a pratt…." but nevertheless, she told me:

> *He was so straight and he said, no, this baby is going nowhere, and this is the sort of thing I wanted my own consultant to say and he waffled around…..eventually I said to him, having talked to this other chap, I just can't do this. I think it's time to call it a day, and the look of relief on his*

> *face because it came from me rather than him.*

However, it transpired that her own consultant's sister had been in exactly the same position as Flora:

> *Then at the end of it all, afterwards he just said, the same thing happened to my (his) sister, and I thought, goodness me, why didn't you tell me this weeks ago..I would really had (sic) liked to know what his sister did on his advice presumably, but he didn't tell me till I think once I signed the termination consent....*

Maria also commented on how being a midwife meant being treated differently, not only in terms of being given information, but in the entire way she was cared for:

> *I shouldn't have been rushed. I should have been given some time. The consultant meant very well, and was looking after me, and he was going away for the weekend and in the end he didn't, he stayed around because of me...he wanted to do it and he wanted to look after me. And it would have been better to have left me till the Monday to let me have the weekend to let me have the idea of saying goodbye really. He made it indecent, shameful..he made it like it was a dirty thing that had to be sorted.*
>
> *Int: can you think what might have made it seem that way?*
>
> *Maria: there were a lot of closed doors...shutting me away...not letting people come in and see me.*

Maria was looked after by the most senior staff, which she understood was felt to be respectful, but she felt that she would like to have been asked who she wanted to look after her, perhaps her friend, who was a community midwife.

Like Flora, Martina did not feel that her consultant gave her enough information about the circumstances surrounding the need for termination, and wondered if this was because she was a midwife, and was expected to know already. She said:

> *I think being (a midwife), he didn't give me all the pros and cons.*

Sophie found some difficulties in reconciling her experiences as a woman with her occupation as a midwife, and she said:

> *(I knew) life was going to be hard. All I knew how to do was be a midwife, and if I didn't go back and do it then what would I have left? ...do I want to lose it altogether or do I push on and struggle and come out the other*

> *end. I pushed on and I am glad I did. I think now I have something a bit more to offer to women in the same sort of circumstance.*

She clearly felt that her experience, and the way she came to terms with it, had helped her as a midwife.

The category on Support, Empathy and Self Disclosure had a sub category "Sharing Experiences". In this context, I used the term to describe situations where people may have had similar experiences, or think they have had similar experiences, and where one or other of them discloses that experience. The disclosure may result in further sharing of knowledge about a particular experience, or, as described in the findings from questionnaires, might be deemed inappropriate. In the interviews, I explored this further, since it seemed possible that it might also contribute to other categories, particularly in relation to practice issues. The following extracts reveal how the interviewees felt about other people sharing experiences with them, and about sharing their own experiences.

Nina found it helpful when people who had had investigations and treatment for infertility gave her and her husband practical information on what to expect:

> *It is helpful if you know a bit, it is helpful. So that was useful, that we had met up with people before who had the investigation.*
>
> *Int: would you ever share your experiences with clients? Would you ever be open with them about what was happening with you?*
>
> *Nina: depends, although, one woman was talking about (infertility treatment) and I must have said something like, it's really hard, that implied to her that I knew what she was talking about. And she said have you had treatment, and I said yes, and left it at that and she asked a couple of questions, and I did tell her that we had been unsuccessful, not in graphic detail, but just that we had been unsuccessful. And another one recently who had miscarried at 22 weeks (after infertility treatment) when I looked after her and again, it was difficult to say something that doesn't imply that you know what you are talking about when you do know what you are talking about*

Nina had not become pregnant after her infertility treatment, and had not had a miscarriage, so in a sense she did not share the woman's experience, but she had clearly communicated a sense of understanding. She further said:

> *In a way there was more connection, more immediate rapport that we had between us because I kind of knew the treatment she had, and I know I didn't miscarry or anything....*

However, Nina also acknowledged the need for discretion when disclosing, saying:

> *They have enough on their plate without worrying about anyone else.*

Janine felt that she might share her experience with others, but only if she thought it was appropriate:

> *I might say to them I experienced a miscarriage and physically I know what it is like, but I always feel that I wasn't devastated by it. It didn't unduly upset me. I accepted it completely. So if somebody was desperate to be pregnant and they miscarried, I wouldn't go into the fact that it didn't bother me.*
>
> *Int. And clients, would you ever tell them?*
>
> *Janine: it would really depend on the situation. You just feel from some people that they need to hear that you understand and I think that experiences are a good teacher...if they ask me direct questions then I would answer them honestly...I wouldn't go into the nitty gritty of it, simply because they are not there to listen to my problems. I would only use it as a tool to show, yes, I know what that feels like, or I know what it could feel like.....*

Laura recounted two instances where she had shared her experience with clients. On one occasion she was with a woman who had just had a Caesarian section, and was feeling "bad". Laura felt that the woman needed to know she was not alone in her feelings, and shared her own experiences:

> *She said she felt better knowing that she was not unique or abnormal in her experience, but (I) felt embarrassed afterwards, and didn't want to be felt sorry for.*

More recently, she was running parent education classes where 5 out of the 8 women attending had had problems with infertility:

> *They were all discussing this, and it was surprising to find so many. (I)*

> *shared my experiences and then started crying, it was a moment of everyone being open, but (I) was not comfortable crying and leading the group, (but) it felt special. It was good to be open.*

Sophie, whose baby had Edwards syndrome and was stillborn recounted the first time she shared her experience with a client who was in a similar situation:

> *It was 12 months after I had been back at work, and a lady tragically lost her baby... they got me in talking to her, and the health care assistant came in and just said to me "all this must bring back memories to you". So immediately the lady picked up on it...so I explained to her what my experience had been, and it actually changed the experience ...she talked to me a lot more about her feelings and so on. It is a like a bond, comradeship...we have been through similar things.*

Martina, who had four miscarriages in addition to a termination of pregnancy when her baby was found to be anencephalic said:

> *I am quite willing to go in and talk to them. I never tell them that it has happened twice (sic) to me, or that I terminated, because I don't want them to think...why should we be any different. So I talk about it as if it was one experience..I tell them it is an awful decision to have to make.*

Anita told me that, on a social occasion, she mentioned to her hostess that she had had a miscarriage, and the hostess said that she too had had one, but had gone on to have a family, and not to give up hope. I asked Anita how she felt:

> *I don't think it made me feel any better, but I didn't feel quite so alone*

The sense of not being the only one has occurred already in the section on Suppport, Empathy and Self Disclosure, and comes up again in other interviews. I asked Anita if she would discuss her experience with a client, and under what circumstances:

> *I would listen to them and be sympathetic, and they would say, you don't understand, and I would say, actually I do understand. And then I would feel that other ones, don't need to know that you have been through it as well, do you know what I mean?*
>
> *Int; I am not sure……*
>
> *Anita: when you're talking to them and you are trying to be sympathetic...that's when I say, I do understand cos I've been through it, but otherwise I don't challenge (sic) it*

Chloe, who had had a termination of pregnancy for personal reasons, talked about sharing experiences, but felt that unless the woman had actually chosen to have a termination, she would not. She also talked about what she called personal and professional boundaries:

> *I ...know that women want to get to know their midwives...but there is a part of me that says, I have to protect myself as well. I think midwives could have a very privileged relationship if we get to know our women, but there is a boundary, and if you cross it...*
>
> *Int: Can you tell me a bit more about crossing the boundary?*
>
> *Chloe: There is an invisible line...for me personally, it's vulnerability. Leaving myself wide open. I think I want women to feel that I am a safe person and I am someone that will protect them or be their advocate. So they need to feel they can trust me, and maybe if I was to show and step across, and show that I am a vulnerable human being – I am making huge assumptions here – but I wonder...would they think, is she going to be alright with this? I don't want them to worry about me. I want them to be themselves...*

Chloe went on to discuss how the notion of the boundary was completely different when she looked after her friends. She spoke about one in particular about one who was a friend and a midwife:

> *We worked quite closely together and it was ok to be her midwife without having to worry about the boundary.*

Maria also talked about protective barriers, and told me about her most recent group of couples in parenting education classes. She had decided for the first time to share with them that she had lost her first child before going on to have another, and I asked her what their response had been:

> *I didn't want them to be hurt, or worried or concerned. But I found that this group is one of the ones I have been closer to than any other...perhaps they got a bit of the real Maria as a real person...it was a barrier and I have let that barrier down*

Martina felt that her uniform contributed to the barrier between her personal and professional selves:

> *I think when you put your uniform on, and you go to work, you hide behind your uniform sometimes. When you have your uniform on, people expect you to be professional, and not an emotional wreck...some days*

> *you think, I am doing my best, I really don't want to be here today, but I am here.*

The notion of the protective barrier, the putting on of a brave face, and the need to separate personal and professional approaches also appeared in the data from the questionnaires, and is important since it has the potential to impact on the midwife-mother relationship.

Maria went on to say that she was choosy about whom she told, and that she tried to determine if they would judge her for having had a termination of pregnancy. She felt this was not rooted in knowing what their beliefs about termination were, just that they were able to value her as a person. I asked how she might know that:

> *The way they talk to you. The way they greet you. The way that they behave towards you, remembering that at the weekend you had something difficult to do, or you are doing something nice...the people who showed a little more interest or care*

Maria described here some of the elements involved in developing friendships, and some of the skills cited for effective management. These are areas which affect midwives, and the women in their care, and highlight the importance in establishing exactly what is the nature of the relationship between client and midwife, and how it may be affected by the midwife's own experiences. It also highlighted some differences between how midwives behave in their relationships with women and with each other, which are discussed further in Chapter Five.

Vanda's experiences as a woman and as a midwife influenced her own approach to clients and to her colleagues. Vanda's account of her labour, which resulted in the stillbirth of her daughter Mary, told how she could hear the decelerations in the baby's heartbeat prior to birth, and that she experienced vaginal bleeding, which was later attributed to placental abruption. During the labour, she tried to alert the midwives and obstetrician caring for her, to the fact that she felt something was radically wrong, and she said:

> *I wasn't listened to when she was being delivered and I think that coloured what I thought about trained midwives, and then for 18 months*

> *when everyone was so supportive I thought it was just that hospital that has the problem. But then come the second 18 months when I wasn't being listened to again, I thought that was just the profession. And I am, very dismissive now of midwives. I don't have a lot of patience. They have to prove that they are doing their job properly. Otherwise I don't want to know.*

Vanda felt that as a labouring woman, her knowledge about her own body and her baby was not valued, and this coloured her view of midwives.

Vanda's experiences also affected how she felt about working on labour ward, and she said she became panicky when she was concerned about the baby's heart rate on the monitor, or when women had what she thought might be excessive bleeding, prior to delivery. She felt that when she raised her concerns, they were not listened to, and she was dismissed as being hysterical because of her own loss. She told me:

> *Any panics that I had, any feelings that I just couldn't rationalise were, well she's already had a stillbirth. Don't worry about her.*

Ultimately, these feelings led to Vanda's being unable to work on labour ward. She felt she could support and care for women whose babies had already died, but she was afraid that complications might arise during otherwise normal births, and that her concerns would not be taken note of:

> *I don't feel that I have enough back up if something goes wrong. I don't feel that I am listened to if I have a worry and I just don't feel safe.*
> *If a baby died in my care I would never be able to forgive myself even if I had done nothing wrong, I still wouldn't be able to forgive myself. I can deliver dead babies easy. It doesn't bother me because it has happened and I cant do anything to make it worse. But no, I don't like delivering live babies at all.*

However, whilst Vanda felt able to work as a midwife in areas other than the Labour Ward, she was not allowed to opt out of the full range of care required from a midwife:

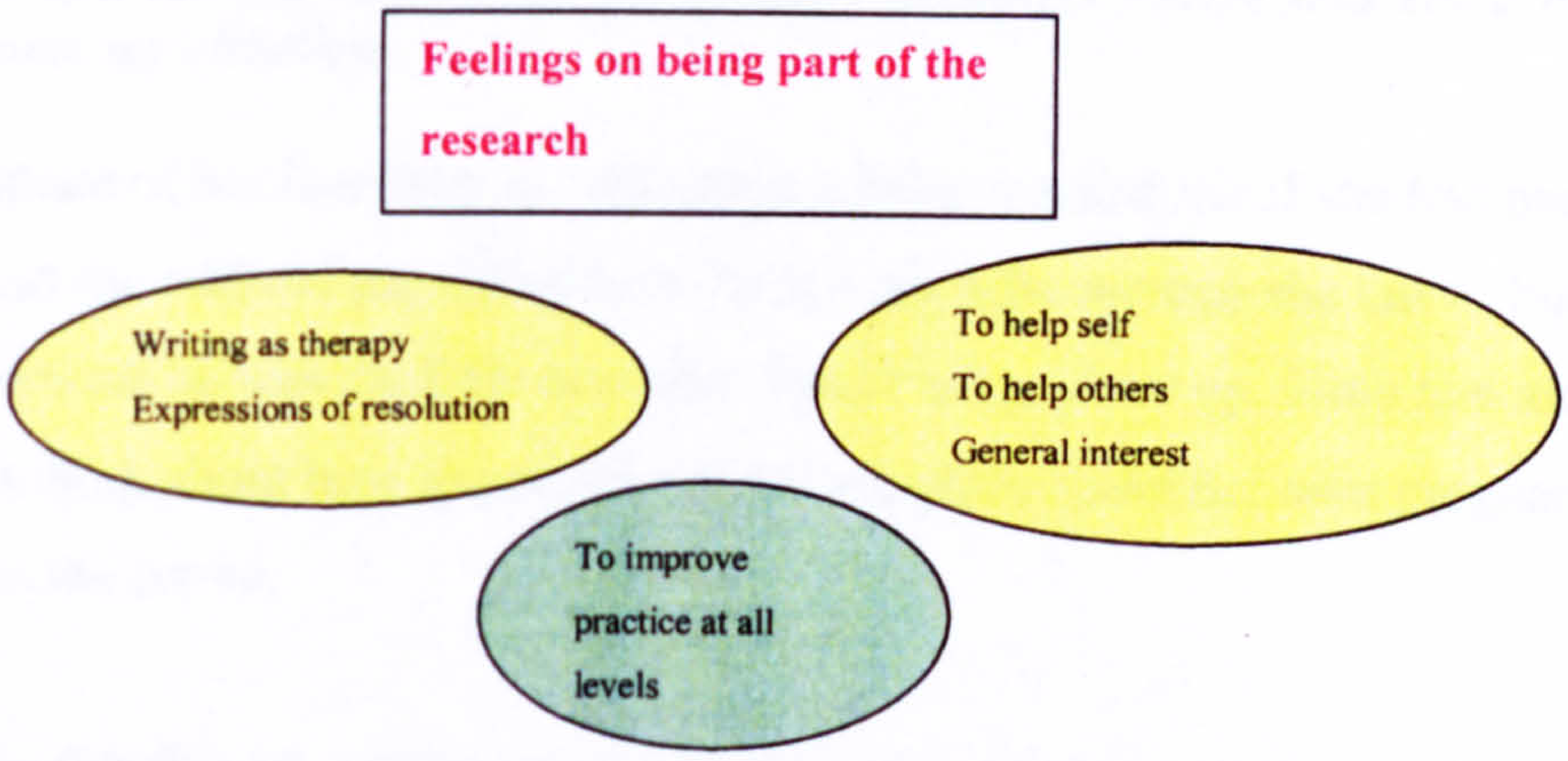
> *I said I would go and do midwifery shifts but, their comment was if you come back into midwifery you have got to offer the full range. So I said I can only do these hours. And they said well what happens if we have got an emergency. And I said that you cannot leave the post natal ward without a midwife so you can send everyone else up (to the labour ward), and I will stay on the post natal ward, not a problem. But to them it was. So I did a few shifts in clinic but it was only a few, and when they started*

> *jumping up and down and saying you've got to do some shifts on the labour ward, I just pulled out. I won't work on the labour ward.*

Ironically the area of supporting bereaved parents, where Vanda's experience as a midwife, as a woman and as a SANDS befriender would have been most helpful did not seem to have been used effectively. Other interviewees seem to have had greater success than Vanda in choosing where they worked, and in being supported in that choice.

This section has presented findings from the interviews which support the category on practical and emotional issues around work. Two additional sub categories arose which suggested that midwives should be expected to exercise greater sensitivity because of the caring nature of their work. However, it was also suggested, that in order to provide support, they, as individuals and as a group, needed to be supported themselves.

FEELINGS ON BEING PART OF THE RESEARCH



The interviewees were invited to say how they now felt about being part of the research, and their responses support the sub categories emerging from the interviews, shown in yellow in the diagram above. They wanted to help others, they were generally interested in the subject, and some had found value for themselves in writing and talking about their experiences. They further identified a wish to use their experiences to improve their own practice, and to disseminate good practice to other midwives. This last sub category, shown in green above, emerged as a result of analysis from the interviews. Further, they sought information about other midwives in the same position as they were in.

Janine returned to the negative effects of the teachers who had discontinued her from her family planning course:

> *I still feel very cross with now, and maybe it (the research) will help me to let go of that because it is just negative and I can't go back and tell them, and I am never going to see them again, and just the fact that I reacted like this shows that it is still there, because it is not about the pregnancy loss, it is about their attitude towards me so it was good to write it all down...it was good to write it down and it was good to be able to put it into something that might have a positive outcome in future, not dealing with people in that stupid way*

Anita felt strongly that miscarriage does not get the recognition that it is life changing and that it could "destroy your life". She had felt slightly upset at thinking about her lost baby again but said:

> *It was 27 years ago, and I do have the occasional day which it comes to my mind for some reason. I can't even say what reason, but no, I am absolutely fine...periodically I will look back and think about that baby. That will always remain my baby, and the babies I have had since have become my children.*

Flora also spoke of her lost baby as remaining a baby. I asked her if she had named her little boy, and she told me she called him Peter – not after anyone she knew, but after Peter Pan because he was the little boy who would never grow up. Flora had also been prompted to think about how she might tell her daughter about her own pregnancy loss at some time in the future.

Nina said she felt fine after taking part, and wanted to know more about what she called the bigger picture:

> *I know my own local people's feelings about it, but that bigger picture...*

When I asked Maria how she felt about being involved in the research, she said emphatically:

> *I know what I think I want to say now. Have I said things that are going to make a difference, that are going to make midwives behave differently out there. I ought to tell you things like midwives said to me like you're young, you will have other babies. One midwife had very long finger nails, and she was doing a VE (vaginal examination) on me with these long talons. She was completely unaware and I told her that it hurt.*
> *They forced an epidural on me for them – they couldn't cope with me screaming out. I wanted to feel the pain, I needed to. It needed to be real, and I needed to feel but they couldn't cope.*

The way Maria told me about what she wanted to make clear, suggested that she had rehearsed these particular items, and wanted to be sure she got them across to me clearly. Maria had also discussed her participation in the research with her husband and he asked her if she would be able to cope. She said:

> *Yes, I think I will be able to, and if I am not, then I can pull out. I felt very in control thinking, I don't have to do this...but...I hoped it would make a difference and all the things that were difficult for me would not be difficult for other midwives in the future. He was very supportive.*

Maria had made contingency plans in case she felt upset by our interview. She knew she would be upset, and said she would go and have a good cry. Her colleague and friend was waiting to take her for coffee, and then she said she was going to have lunch with her husband. All evidence of the coping strategies she used to enable her to take part, do what she thought was right, yet take care of herself as well.

Chloe said this about her participation:

> *I think it has been really interesting talking about it really...I don't often talk about it in relation to my work, so it has been quite good.*

She also commented that she and a colleague who work closely together, had got to know each other better:

> *..we work very closely together, I showed her bits (of the questionnaire). In many ways we have worked so closely together and support each other but she does not know anything about me. I did say I had a miscarriage last year but I didn't say very much about it, and she was very nice about it.*

They had also gone on to have discussions about their respective views on their fertility, and about whether or not to have children. The research had provided them with an opportunity to share more of their personal lives with each other.

Sophie wanted to be part of the research so her experiences might help other people in similar circumstances:

> *Anything that can help people in that situation has got to be (good). It is a female dominated profession, and there are a lot of women in it who are in the same situation that you don't necessarily know about.*

Similarly, Martina wanted to help other people by participating in the research. She said:

> *I feel quite positive in some ways, I think that if I can help by participating in your research, making colleagues think about how people are dealing with it.*

She wanted to emphasise the emotional lability, and difficulty of not being able to forecast her emotional responses at work. She told me:

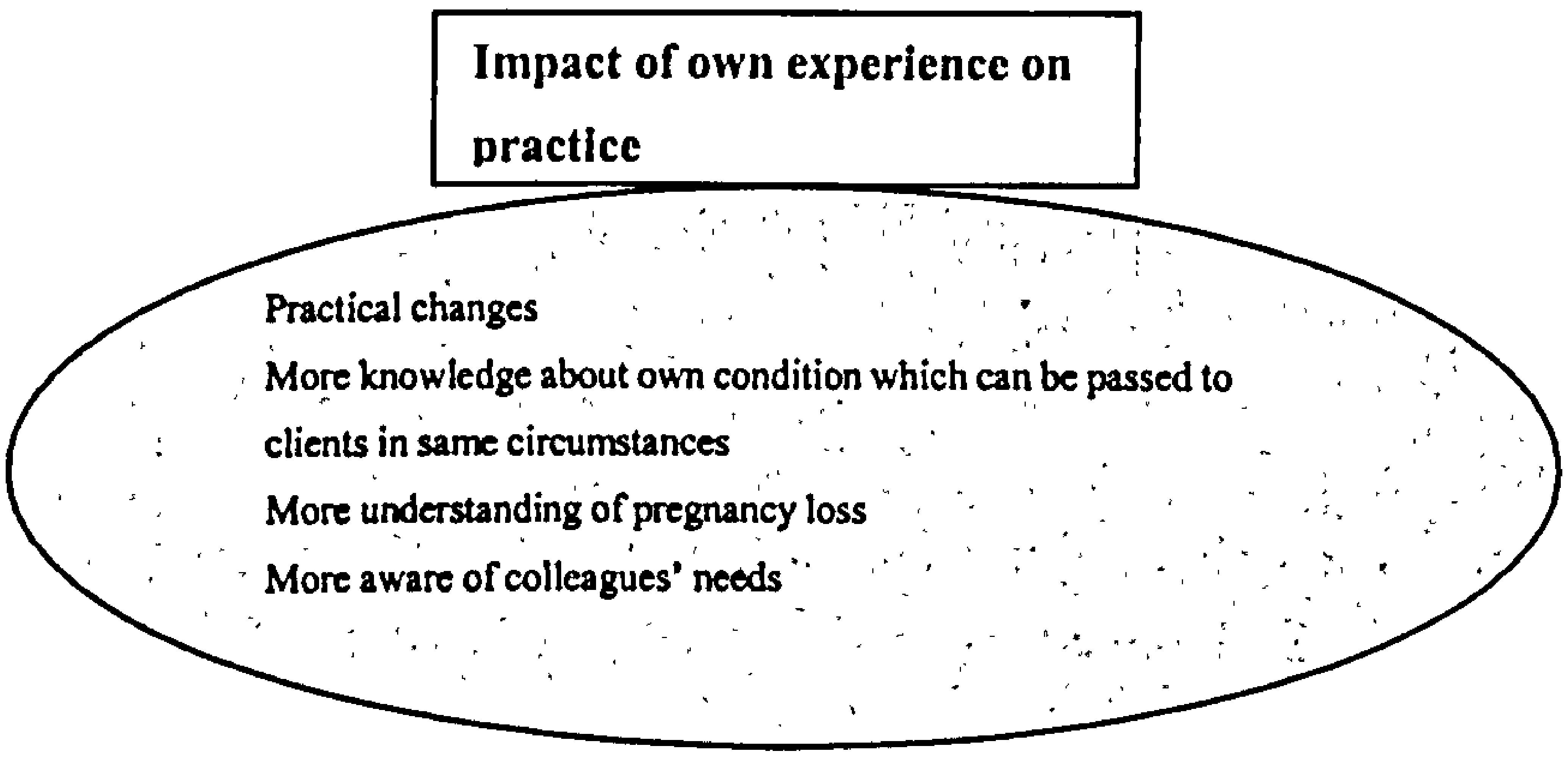
> *They think (colleagues) that because physically you are able to go back to work, you are emotionally able. You will have good days and bad days, and just when you think they are all good, you will have a bad day which is totally unrelated, and a really bad day.*

Laura became upset during the interview, and said that she still felt pain, although now that she has children, she doesn't think about it all the time. As an extract in a previous section shows, she felt strongly that midwives need to be supported in dealing with their own emotional issues to enable them to support others, and she hoped her participation in the research would highlight this. As she previously stated:

> *I hope it will get it out to be discussed. Midwives have got lots to deal with, they are therapeutic persons which is difficult if you have difficult stuff.*

This section has presented findings on the interviewees' feelings about being part of the research and adds their views that they wish to improve practice at all levels, in relation to midwives experiencing a pregnancy related loss. They felt that this might be accomplished via the current study. The next section presents the findings as they relate to the midwives' perceptions of how their experiences affected their own practice as midwives.

IMPACT ON PRACTICE



As discussed earlier in the chapter, many of the sub catgories which originally informed this category have now been relocated to the category of Being a Woman, Being a Midwife. Consequently, the sub categories shown above, have emerged from the analysis of the interview data alone. The categories relate to some of the very practical changes which midwives initiated, to the knowledge they had gained, to changes in their attitudes which impacted on practice, and from a growing awareness of the needs of others in similar situations.

Janine had concentrated primarily on the emotional effects of her treatment after her miscarriage, but made the following comments about how she conducts herself as a person and as a midwife:

> *I am not you and you are not me and our experiences are different and we see things in a different way. They might merge in different areas of life...what has happened to me has a bearing on the way I react to other people...so it's just like knowing that there is separate, there is common ground but there is also separateness.*

Janine's interview revealed how her philosophy of life and her belief in reincarnation had helped her to deal with her miscarriages. She had strong feelings that both her miscarriages were of girl babies, and that she "doesn't carry girls". The night before her miscarriage she dreamt of a little girl who left her and said she had to go with someone else.

She also said this about her beliefs:

> *I knew they were not meant to be (her babies) and maybe that comes from the spiritual sense of knowing. I just knew that they were not meant to be...I just wasn't meant to have a girl. I was meant to have two boys and I believe that very strongly. Both of the boys were meant to be. So I think that helped me not to be grief stricken about them, and I know some women are when they miscarry, but I wasn't.*

It seems that Janine was sustained by her fatalistic beliefs. Yet, she also made the following remarks about how loss is viewed in today's society:

> *Sometimes I feel guilty because I wasn't (grief stricken) because of the way society is at the moment tells you that you are supposed to be and you are supposed to want to have counselling, supposed to join the therapy group. I think there is a lot of pressure to do certain things at different points in life.*

Janine had also experienced a number of tragic losses in her life since her miscarriages, all in the space of four years. Her mother, aunt and father and niece died, and her nephew was murdered. She commented that the enormity of these other losses put the miscarriages in another perspective. She felt that all of her life experiences contributed to her approach to her work as a midwife.

Flora used her experience of pregnancy loss to provide practical support for women. For example, when women had lost babies, she would offer them a lift to the consultant appointment at which they would receive information on how or why their baby died:

> *I just realise how difficult it is to get there, to go to that appointment, and I have several times given a lift, gone in, sat with them and listened and then taken them home again, have tea and talked about things like, what did he mean when he said so and so...I am certain that if I hadn't have been there myself I wouldn't have*

Flora compared her own approach with that of a colleague:

> *Her way of coping with her infertility was getting very very involved with mums, and everybody would say she got too involved. I don't think she would ever acknowledge that that was the way she coped with her infertility... phoning these mums at home, following them up and meeting them years later. I think I provide perhaps the service that they really do need, not need, but do appreciate...I do go home and think about these people in my off duty time, but I am their local midwife and would hope I*

> *am providing them a good standard of care.*

However, as we saw previously, Flora had been an appreciative recipient of that care herself.

Chloe's experience influenced how she dealt with her sister, whose baby had spina bifida. The pregnancy ended at 22 weeks, but I am not clear as to whether it was terminated, or ended spontaneously. However, Chloe was at the birth, held the baby, and showed him to her sister. She says her sister and her sister's husband remained emotionally detached, and she found that difficult to deal with, because she herself felt acutely emotional. Part of Chloe's work included leading a memorial service for bereaved parents, and she said she often thinks about her dead nephew when she holds the services. Her work with the bereavement group arose after she had a two month break from midwifery; she was a community midwife, was very tired from being constantly on call, and was very upset after caring for her sister. However, she made a conscious decision to become more involved in caring for bereaved parents. She said:

> *I remember sitting there the first time and thinking, these lovely people, they were a lovely group, and they all have the same philosophy. They wanted to make it better for women and I thought that it was multi professional and we all got on really well.*

Chloe also drew on her experiences when she dealt with a particular case of parents who had lost their baby due to gross abnormalities, but where there had been a supervisory investigation into the midwife who had conducted the delivery. Chloe had supported the parents and the midwife in this instance and she says about something she read around the case at the time:

> *Midwives don't go out to harm babies, and if they are involved in something like this, it does cause a lot of grief for them and it may bring up other issues.*

As a supervisor of midwives, Chloe also did some proactive practical work with the midwife concerned to help her improve her practice. Laura also remarked that the annual supervisory meeting, which all practising midwives should have with their supervisor, would be an appropriate way of midwives raising personal issues which they thought might be impacting on their work.

Chloe was thinking she and her current partner would like to have a family. She thought she had a miscarriage last year, although had not done a pregnancy test to confirm. She said she has mixed feelings about her fertility, it would be lovely to be pregnant, but at the same time, she would feel comfortable with herself if it did not happen.

Anita told me that ten years after her miscarriage, and after the birth of her children one of her colleagues returned to work after a miscarriage and as they talked, it seemed to Anita that "nothing had ever changed". She described herself as being shocked that nothing had changed in a decade. She found that leaflets which were given out to women who had miscarried were out of date, and contained old information. She and her colleague formed a group to improve support and to update information leaflets. The support continues now, and has been in existence for 10 years. She discussed the effects of the group with those who attended it:

> *It's a support group. It's not counselling that we do...they said they found it very very helpful and they felt because there were new women coming every month they were able to help and basically, hopefully, they'll talk among themselves.*

She spoke about group members who attended over a relatively long period of time, two years in one case, until the woman became pregnant, and still attended the group until she reached 18 weeks of pregnancy. She felt she needed the support of the group to get her through the early weeks.

Although Anita felt unsupported by her husband at the time of her miscarriage, she actually drew on his experiences when setting up the support group, and they were able to discuss how he had felt.

Sophie had reviewed some of the literature around pregnancy loss, as a way of gaining more knowledge for herself, but also so she could help other women in similar situations. She told me:

> *Reading the literature actually helped because it put my experiences into focus.*

She felt this enabled her to help other women in her situation, as her knowledge was personal and theoretical.

Maria felt her experience impacted on her practice in a number of ways:

> *Some people took the view that because it had happened to me, I should help every other woman, so everyone who was having an IUD or termination, I got them all really. But a part of me wants to look after them because you know how bad it is. Not because you think you are any better then anybody else or that you can do it better, but you know what not to do in a way. Or you know what should have been done to you.*

Nina felt that her practice has improved in respect of her knowledge base about infertility treatment, and about some particular areas such as early induction of labour following assisted conception. She felt this was helpful in the type of information she was able to give, not only to women in her care, but to her colleagues. I asked her whether other people would notice a change in her practice:

> *Possibly, yes, they do, because I have explained stuff, with donor egg or donor sperm...it is really just sharing that information with your colleagues as to why it is different, or why things happen differently.*

Nina also talked about her feelings about being a midwife, in connection with going through the adoption process:

> *One thing that was said about adoption, was surely you must find it really hard being surrounded by babies all the time and you haven't got any of your own. I am not sounding like blowing my own trumpet or anything, but it's something I have always done. I have been a midwife for 10 and a half years now, before I realised we had fertility problems. It was something I did, something I enjoyed doing. You know, so much of what I do that, the fertility side of it is just an extra bit...*

Nina also felt it was possible to appreciate the intrinsic sadness of a situation without having experienced it oneself. However, she also thought it was possible that for those who had experienced the same (or similar) circumstances, that the situation may also trigger unexpected personal emotions relating to one's own loss:

> *I think that it is more really what is happening rather than my own experiences of it. It is more of the fact that losing a baby that you have tried awfully hard for, it is sad situation, rather than my experience of it...*
>
> *Int: .. is your personal situation that is different to your work situation so*

> *you are able to keep the two things separate?*
>
> *Nina: Yes, I think that's what it is. I think I might have found it harder or more difficult or different if I had got pregnant, if I had a later miscarriage, so I think it is almost like another bit, having had treatment, but pregnancy, it is different.*
>
> *Int: I think I understand what you are saying. When you are with a woman who is miscarrying, you didn't have any sadness of your own to relate to, but you could see it was sad in its own right.*
>
> *Nina. Yes.*

Flora said something similar in her interview. She was at a memorial service for the children who had been murdered at Dunblane Primary School, and during a two minute silence, she found herself suddenly very upset as she recalled her own dead baby. However, she used her experience, as previously discussed, to support women in similar situations, and to support colleagues.

Laura also spoke about the impact on her practice. At first, she was surprised at how incidents upset her. She described the following:

> *(I) was in delivery suite following return to work after miscarriage. A woman in theatre was having removal of placenta after a normal delivery. The woman said "I have waited years for this" and was crying and (I) started weeping with her. I wondered what the anaesthetist would have thought. (I) was surprised I could be in clients' homes and anything could upset (me), particularly insensitivity of mothers.*

However, she felt her sensitivity to women who had experienced pregnancy loss increased when she cared for them in subsequent pregnancies:

> *(I) would give them the opportunity to talk, maybe half an hour, others might need more. I am much more sensitive to how women are feeling after loss. I am more likely in the next pregnancy to reassure women, for example, listen to the fetal heart more, give extra time.*

Laura commented on a much more radical change in her approach to practice following her miscarriage, and something which was commented on by a student she worked with:

> *This student, who as quite naïve and overfocussed on normal midwifery made a throwaway remark (about Laura's miscarriage), and said "you have really changed, you've become much more negative"*

Laura felt that prior to her miscarriage she had approached midwifery with the view that everything was completely normal, however, now:

> *am more realistic now. (I) was probably like that student at one point, but I would not want continuous CTG, but am more aware of possible outcomes*

As well as appreciating the sadness of certain situations, Nina told me about an area of practice which had been positively influenced by her personal involvement in the adoption process:

> *One thing the social worker did tell us about was often kids that are relinquished (for adoption)...have no experience or knowledge about their background, and one recently...was 20 and she had come over from France to be an au pair, but (was) already pregnant when she got here...didn't tell her employment, didn't tell her parents back in France and put up her child for adoption. I suggested to her to take some pictures of both of them together. Did extra cot cards, extra ankle bands, just so if the baby has something extra of its life history, like where it was born, then at least it was there.*

This is a practical area which would make a difference to the knowledge an adopted child had about its background, and which would provide a memory for the relinquishing mother, in anticipation of the grief which can surround the giving of a baby for adoption. Martina and Sophie both confirmed that they were happy to care for women undergoing termination of pregnancy, or in labour following intra uterine death, since they felt their experience would be supportive. They were both also happy to talk to parents about their own experiences. However, Sophie said she would find it very difficult to be at the birth of a dead baby, and indeed has not done this yet since her own loss of Andrew.

Thus the category on Impact on Practice shows how the midwives' applied their knowledge to women in their care, and to their colleagues. There is also evidence that they do not consider their own experience to be universal, and most were careful about how they used their experiences.

Summary of the findings from the interviews

At this point in the chapter, the findings from the interviews are summarised. Following this, the chapter shows how the findings from both questionnaires and interviews were used to refine the categories. Within the summary, it is acknowledged that the participants presented their own views, which are not necessarily generalisable, but which are of value in themselves.

The findings suggested that the interviewees valued emotional support. Some felt that support manifests itself as being allowed to talk, being listened to and not being judged. The talking might involve telling the story many times over. However, it seems that the person experiencing the loss needs to be the one who initiates and continues any conversation about her loss. Interviewees felt that some people seem to be good at picking up and responding to clues about how the bereaved person is feeling. Some also found that certain midwives were insensitive. The remarks about this related not only to pregnancy loss, but to some general treatment at work. Those who mentioned this felt it was sad, and that midwives should know better. The interviewees felt that some midwives did not necessarily apply the same knowledge and skills in their relationships with colleagues that they did in their relations with clients. However, as one remarked, perhaps some midwives need help with their own emotional needs before they can help others.

Additionally, the participants suggested that some midwives who are pregnant or trying to become pregnant do not necessarily know any better than lay people and are not necessarily more able to make "better" or more informed decisions about their own care or treatment. In the context of the remarks made by the participants about insensitivity, the participants expectation that midwives should know better is somewhat challenged. The interviewees suggested that some of their midwifery colleagues applied their knowledge about dealing with loss to their clients, but not to their colleagues. It seems that the midwives in the study found it difficult to apply their midwifery knowledge to their own situation, yet expressed surprise that their colleagues failed to apply midwifery knowledge to them. This suggests to me that some find it difficult to apply professional knowledge of pregnancy and loss in a situation outside professional parameters.

Experience can improve practice in many ways, for example an increase in knowledge about certain groups, and setting up support systems for clients. There is also evidence of participants being supported by colleagues who were also experiencing, or had experienced pregnancy loss, however, there was a suggestion that there might be a time limit on the usefulness of shared experiences, both personal and in a supportive group. There was an understanding that while they appreciated sharing experiences, they realised that all experience is different. Some participants were able to discuss their own experiences, however, sharing experience with clients had its problems in that it exposed the midwife as a vulnerable person, and may make the client, or indeed the midwife feel uncomfortable. It also caused the midwife to cross what was termed "professional boundaries", the invisible markers which separate personal and professional lives, and this is explored further in Chapter Five. However, as the interviewees suggested, the barrier can be knowingly or unknowingly breached. The midwife can choose to disclose and share her experiences, but she cannot know beforehand the outcome of her disclosure, for example, that she will not be judged for terminating a pregnancy for whatever reason. Neither can she know beforehand whether women might welcome the additional knowledge and experience the midwife has gained from her own loss, or whether the woman will find the knowledge about the midwife's experience frightening or upsetting. Conversely, the barrier can also be breached unexpectedly and without the midwife's choice. A chance remark, a coincidental date, an unexpected encounter with a woman or colleague having a similar experience can penetrate the barrier, and leave the midwife exposed and emotionally vulnerable, yet still expected to function in her professional role. However, the midwife can mostly choose what she keeps hidden behind the professional barrier, which is ironic, since the woman has little opportunity to keep any of her experiences, physical or emotional, from the midwife.

The midwife's aim in her daily work is to provide the best care she can whilst maintaining her own emotional equilibrium. To do this, she herself may need support as she deals with the grief associated with her loss. This is a long and short term position, which has implications for the midwife in her personal and professional life.

As discussed within the various sections, the findings from the interviews largely supported the data from the questionnaires, although some relocation of data and refining of the categories and sub categories was required. Figure 4:2 shows how the sub categories and categories contribute to the core category following analysis and integration of findings from questionnaires and interviews.

From the findings, it seemed that the ability to function as a midwife who has experienced pregnancy loss was covered largely by the emerging categories as follows:

The nature and impact of the loss
Support, empathy and self disclosure
Practical and emotional issues around work
Being a woman, being a midwife
Feelings on being part of the research
Impact of own experience on practice

The emerging core category, at this stage is therefore On Being a Midwife who has Experienced a Personal Pregnancy Related Loss (see Figure 4.2).

In the current chapter, the emerging categories and core category have been refined in light of the data from analysis of the interviews. In Chapter five, the findings from the questionnaires and interviews are examined in relation to the existing literature, using the literature as further data. Some of these areas are already well researched, others, particularly those relating specifically to midwifery, and to the core category, are less so. The next chapter discusses the findings within their categories, in relation to the literature, to further explore the emerging categories and core category.

Figure 4.2

Integrating the categories from interviews and questionnaires

CHAPTER FIVE

DISCUSSION OF THE FINDINGS IN CONJUNCTION WITH LITERATURE

Introduction to the chapter

As Chapters Three and Four have shown, a complex series of interacting themes and sub themes have emerged from the findings thus far, from the questionnaires and the interviews to form the categories and core category. Chapter One explored the literature available at the beginning of the study to support the need for the research, and to determine the research question. This chapter now returns to the literature and considers this with the findings from the questionnaires and from the interviews. The literature is used as further data to explore the categories and core category as they have emerged at this point. The chapter begins with an explanation of how the literature was searched and used in this chapter. A summary of the findings from the questionnaires and interviews is given, followed by an overview of the categories and sub categories. Literature relating to the categories and sub categories is presented and discussed in relation to the findings within each category. Finally, the chapter reviews the categories and core category, and identifies areas for further discussion in Chapter Six.

Using literature as data

As previously discussed in Chapter One, an initial literature search was carried out to determine the need for further work on the research topic. The initial review of what was already known informed development of the questionnaires, and from these, the plan for the semi-structured interviews was formulated, as described in Chapter Two. Using a grounded theory approach, it was not possible to anticipate the areas which would emerge from the data analysis and which would require further searching of the literature. At this point in the study, however, such areas have now emerged and in this chapter, literature is used to give further insight.

As Hart (2003) observed, it is important to retain a critical mind when reviewing the literature, and to avoid reading selectively, choosing only those texts (or portions of text) which will support the findings. Hart (2003) also reminds the researcher that all that is written is not irrefutably correct, and that premises and arguments should be rigourously challenged during reading. At the beginning of the research the aim was to avoid allowing the literature to pre-empt or influence the data collection and analysis. At this point the aim was to avoid allowing the findings to influence the reading of the literature.

The literature used to explore and examine the findings derives from a number of academic and other disciplines. As previously discussed in Chapter One on the background to the study, and the research design, there is little work specifically about midwives' personal experiences of reproductive loss. Further, as Cecil (1996) observes, the study of pregnancy and birth itself, has only relatively recently received research attention which considers anthropological and sociological aspects. Research in the past has more usually arisen from obstetric and psychiatric disciplines.

For the purposes of this chapter, literature from psychological, sociological, anthropological, nursing and midwifery sources was reviewed. There was also reference to religious and philosophical work. As before, (Chapter One, page 17) literature was searched using MIDIRS, CINAHL, NHEL, and Medline, using key words and synonyms arising from the findings. The specialist library at the Royal College of Midwives was consulted, as were the libraries of Middlesex University, and University College London. Literature from the past thirty years was drawn upon. Occasionally, older, key texts have been used, where more up to date literature has not added significantly greater knowledge, or where they have been used as a foundation for later work. Examples are the works of Douglas, Oakley, Sheila Kitzinger and Bowlby. Within this chapter, some areas yielded more available material than others, therefore presentation and discussion of literature in some categories is lengthier than others. Where this occurs, further explanation is given. Also in this chapter, issues which may not have arisen in the findings, but which appear in the literature, are presented. There is no assumption that participants purposefully excluded information, or that I had excluded them in analysis, rather that the literature is an alternatively informed source of data.

The findings from Chapters Three and Four are summarised below within their categories, to set the literature review in context, and indicate those areas of literature which appeared relevant. These areas were searched to elicit further information related to the findings.

Summary of the findings from the questionnaires and interviews

Within the first category, Nature and Impact of the Loss, the findings suggested that for the participants, the implications of their pregnancy related losses were far reaching, affecting their personal and professional lives in a variety of different ways. Their relationships with their immediate families, their friends and their work colleagues were influenced by their losses. External responses to their loss, and their own emotional and physical responses affected their thoughts and behaviours immediately and in the longer term. In the current chapter, some work on rituals surrounding birth and death is described, since some participants mentioned these in relation to their own losses. There is also a review of the modern rituals surrounding pregnancy loss. Some of the literature on attachment and loss is explored to examine how it relates to the issues raised by the participants. Finally, in this category, the literature on depression associated with loss is examined. Suggested links with depression and aberrant behaviours, such as baby abduction, which was mentioned in Chapter One, and again in the findings in Chapters Three and Four, are also examined.

The second category, Support, Empathy and Shared Experience, suggested that emotional support is valued and manifests itself as being allowed to talk, being listened to and not being judged. The talking might involve telling the story many times over. However, the person experiencing the loss needs to have control over initiating or continuing conversations about her circumstances. Some people were said to be good at interpreting and responding to cues, often given out unconsciously, about how the bereaved person was feeling. In this context, literature relating to counselling and counselling skills is examined, as is some work on friendships. Work relating to self help and support groups is also drawn upon, since some participants mentioned using them, and others set up support groups for their clients.

In the third category, Practical and Emotional Issues Around Work, participants spoke of some difficulties of being at work, or returning to work, in relation to their losses. In the work situation, some colleagues were felt to be insensitive, in the remarks they made, and in certain of their approaches to allocating work. Participants considered this surprising, as it was felt that midwives should know better. This area prompted a search of the literature in relation to those experiencing pregnancy related loss outside midwifery, to explore how their experiences compare with those of the midwives. Support systems for midwives were also reviewed. This section also examines the organisation and culture of midwifery work and the effects of bullying and harassment at work, since this arose for some of the participants.

In the fourth category, Being a Woman, Being a Midwife, participants examined the situation of being both "patient" and midwife. There were a number of aspects contributing to this category, including the suggestion that midwives who are pregnant or trying to become pregnant do not necessarily know any better than lay people and are not necessarily more able to make "better" or more informed decisions about their own pregnancies. In the context of the remarks made about insensitivity of colleagues, this raised the question as to whether midwives, in general, should be expected to deal differently with their midwifery colleagues who experience pregnancy loss, than they would deal with their clients. This section also revealed the difficulties midwives encountered when broaching their own reproductive circumstances with their clients. Some participants were able to discuss their own experiences, however, sharing experience with clients was felt to be problematic in that it exposed the midwife as a vulnerable person, and could make the client feel uncomfortable. It also caused the midwife to cross what the participants termed "professional boundaries". Literature relating to professionalism, self-disclosure, and sharing experiences with clients is explored in the category.

In the fifth category, Feelings on Being Part of the Research, the findings suggested that some participants derived benefit from taking part. Some also expressed thoughts about reaching resolution. This prompted a review of the literature on participating in research, on reflection, and on writing as a therapeutic activity. Literature on story telling, autobiographical work and memory work is also explored.

Within the sixth and final category, Impact on Midwifery Practice, participants considered the impact of their experience on their midwifery practice, suggesting that experience can improve practice in many ways. There may be an increase in knowledge about certain groups, which is helpful to couples in that situation. Some participants set up support systems for clients. There was also evidence of participants being supported by colleagues who were also experiencing, or had experienced pregnancy loss. These views are examined using literature concerning the wider context of the midwife-mother relationship.

Finally, the chapter draws together the findings and the literature and examines these in relation to the core category, On Being a Midwife who has Experienced a Personal Pregnancy Related Loss.

In this chapter the literature available is considered under the headings of the categories, highlighting those areas of literature suggested by the findings, as described above. Figure 5.1 outlines how the findings prompted the areas of literature for further exploration.

Figure 5:1 Showing areas for literature search

Category	Sub categories	Area for literature search
Nature and impact of the loss	Significance for self, family, friends and colleagues Long and short term effects Depression	Rituals surrounding birth and death Attachment Grief and loss Depression Abduction of babies/causing harm to babies
Support, empathy and self disclosure	Knowing someone cares Feeling loved Not being the only one Sharing experiences (with colleagues) Inappropriate remarks Talking/not talking	Sharing and shared experiences Self help/support groups Counselling skills
Practical and emotional issues around work	Returning to work Where to work Difficult areas/groups to deal with special dates, special areas Midwives should know better (inappropriate remarks) Midwives are carers so need to be cared for themselves Being asked if you have children Turning negative into positive	Support for midwives Organisation of midwifery care Bullying
Being a midwife, being a woman	Love being a midwife May get special treatment Can compound feelings about own reproductive circumstances Expected to know more because of being a midwife Keeping work and life separate	Role conflict Sharing experiences with clients Setting professional boundaries
Feelings on being part of the research	To help self/to help others General interest Writing as therapy Reaching resolution	Reflection/reflective practice Journal writing Biographical work Memory work
Impact on practice	More knowledge about own condition which can be passed on to clients More understanding of pregnancy loss More aware of colleagues needs	The midwife-mother relationship

The first part of this chapter deals with the category Nature and Impact of the Loss.

NATURE AND IMPACT OF THE LOSS

As the findings from the questionnaires and interviews show, reproductive loss relating to infertility, miscarriage, intra uterine death, termination of pregnancy, stillbirth and neonatal death is felt in different ways, and includes long and short term effects. This section explores the literature in relation to aspects of loss raised by the participants. Reproductive loss is the central feature of the research, and since this can involve both birth and death, there is a brief exploration of some of the rites and rituals surrounding both. There is also a review, in relation to pregnancy loss, of the changes in approach by health professionals over the past thirty years. This section considers the literature on attachment theory during pregnancy, particularly as it is closely connected to grief and loss. There is also an exploration of depression as a consequence of loss, including a reference to the abduction of babies, and causing of harm to babies, and their links with depression. All of these areas are related specifically back to the findings from the midwives in the current study.

The ethnic and cultural backgrounds of the participants have already been mentioned in Chapters Three and Four. The discussion in this section, therefore, is based on a predominantly western, Christian view, although beliefs and traditions from other cultures are drawn on where appropriate.

Rituals surrounding pregnancy, birth and death

In western society, the rites and rituals surrounding pregnancy, birth and death have evolved from the religious Judaeo-Christian teachings and traditions, and reflect the beliefs about personhood and ensoulment within these major religions. However, there are other influencing factors which have their roots in pre-Christian thinking, and which have elements of similarity with beliefs in other cultures, for example taboos about the simultaneously powerful and polluting nature of women, especially in association with menstruation and childbirth (Douglas, 1973). Helman (2000:158) describes ritual as a way of marking physiological life events, and giving them a social meaning which may be symbolically beyond their physiological significance.

This study does not attempt an in depth exploration of the anthropological literature, however, some important anthropological observations are outlined here, to show how societies attempt to ascribe meaning to physiological events. Yearley (2000) reviews anthropological influences in midwifery, observing that in most societies there are complex ritual observances which accompany rites of passage, particularly giving birth and dying. Both constitute liminality, an anthropological term applied to transitional or marginal states, such as between life and death, which give rise to social ambiguity (Yearley, 2000; Helman, 2000). In childbirth, mother and unborn child are in a situation where one or both of them may not survive. Those giving birth and those who are dying are often physically removed from their communities until the transformational period ends, and their status within the community confirmed as living or dead. Helman (2000) illustrates the phases of social transition based on physiological events, using the work of Van Gennep and Leach:

Initial social status → Period of transition → New social status
Separation Marginality Reincorporation

In pregnancy and childbirth, the woman moves from her status as (married) woman to mother, on the birth of her first child. However, she undergoes separation, marginality and reincorporation with every pregnancy thereafter. Childbirth and dying are also linked with beliefs about harm befalling other members of the community if they are closely involved (Douglas, 1973). In some cultures, one aspect of the midwife's role is to accompany the woman through her state of ambiguity, and to protect the community until renewed status (as mother), is confirmed (Yearley, 2000). When the pregnant woman enters her transitional status and the outcome is not as expected, such as in pregnancy loss, both the woman and society must deal with an altered state for reincorporation (Kavanagh, 2002).

The rites and rituals surrounding death and mourning are linked to the formal acknowledgement that a person who was a full member of a community has left that community permanently. The acceptance and departure of such a person is dependent on that person's formal reception into the community in the first place. This is accomplished in various ways, but usually involves a ceremony or series of ceremonies. These often accept that the first months and years of a child's life are precarious, indeed, in many parts of the world, a high proportion of children do not survive the first year of life (Cecil, 1996:7). In western society, these rites and rituals are frequently no longer observed, and even when they are, the underlying spiritual and cultural beliefs may have been forgotten (Kavanagh, 2002). Rituals surrounding childbirth acknowledge the woman's transitional state, in which she remains for a prescribed period. In Judaeo-Christian beliefs, this period is six weeks, which coincides with the cessation of lochia, considered to be unclean. At the end of this time the woman may undergo a ceremony (churching, in Christian belief) which cleanses her from the polluting effects of childbirth, and gives thanks for her reconfirmed status as a full member of the community. Similarly, the child is not accepted into the community until after a naming or other ceremony, and in some cases circumcision. Baptism, is a ceremony, and is essentially a ritual which, in many Christian beliefs, accepts the concept of original sin, and the need for humans to repent and be reborn in a state of grace in order to partake of the benefits of the afterlife. The baptism symbolises the washing away of sin. Newborns obviously cannot meaningfully consent and participate in this ritual, and the undertaking to bring them up to understand the meaning of their baptism is usually assumed by godparents. Cecil's (1996) memory work with elderly Irish women who had experienced pregnancy loss in a rural community discusses the meaning of baptism for the women concerned, its implications in what became of their babies' bodies, and its role in helping some of the women create some meaning for themselves of their experiences. Cecil (1996) comments that one of the areas the bereaved women were encouraged to avoid was that of funerals, or of becoming a godparent. These duties were thought to be too onerous for someone dealing with their own grief. However, the creation of meaning through ritual is important, and the exclusion of the bereaved from those processes may hinder the course of events associated with loss. As the section on changes in approach to pregnancy loss shows, considerable attention is now paid to helping parents to acknowledge and mourn their losses, (Samulssen, 2001; Kavanagh, 2002).

The rituals described above have previously excluded acknowledgement of pregnancy which did not result in a living child. Cecil (1996) comments that within anthropology, pregnancy loss has received relatively little research. She observes that the personal experience of miscarriage recorded by the early female anthropologist, Margaret Mead in the 1960s, may have prompted further exploration of the subject. Certainly within midwifery, the past thirty years has seen the evolution of a set of rituals with the specific intention of creating lasting memories of a lost baby. For example, photographs are taken, foot and hand prints made, and entries may be made in a book of remembrance. Often, a religious or secular service, is held to mark the existence of the lost child, regardless of whether or not it was born alive, and irrespective of whether or not it was baptised. These modern rituals are considered further in the section on grief and loss in this chapter.

These activities are thought to help in giving meaning to pregnancy loss, considering it as another aspect of the processes of birth, and of death. Whether or not the participants in the current study believed or adhered to these ceremonies, some of the difficulties they encountered arose because of them. There are a number of examples in the findings of the current study, of separation, for example, Maria specifically talks about herself as being "shut away" from other people. Maria also highlights the issue of what happened to her stillborn sister Gillian's body, and the effects this had on her parents. Gillian had not breathed at birth, and therefore could not be baptised, and accepted as a full member of the Christian community. As such, she was also denied the right of burial in consecrated ground. Maria did not say what happened to her own baby's body, but says she buried a photograph of her with her sister's baby, who also died. Chloe also describes the somewhat vicarious mourning of her own child through her participation in her nephew's birth and death.

Also in the current study, Vanda, Sophie, Julia, Flora, Jilly and other participants, describe the ceremonial blessing of their babies, and the creation of other memories, which sustained them later as they grieved.

These symbolic acts helped the participants to acknowledge to themselves and to others, the fact that a birth and death had occurred. The literature acknowledges that in order to experience loss, attachment must have occurred in the first place, and this is considered in the next section of the chapter.

Attachment

The processes of attachment between mother and child are well documented. Bowlby's (1991) work on attachment, loss and grief was one of the first texts to analyse the processes of attachment. His work was somewhat discredited, following its misinterpretation and inappropriate application in the period immediately after the Second World War, when it was used to encourage women out of the workplace they had occupied to replace serving soldiers, and back into the home to take care of children (Holden, 1989:122). However, Bowlby (Holden, 1989:122) refutes this misuse of his work, stating quite categorically that it was misinterpreted. Nevertheless, his work is still widely used to test more recent theories of attachment, particularly in association with the development of depression (Simpson et al, 2003), and in the analysis of maternal/ fetal/infant relationships (Doan and Zimmerman, 2003). Klaus and Kennel's original (1976) work on the development of mother infant relationships was similarly misinterpreted, suggesting that there is a once and for all moment immediately after birth when "bonding" between mother and child occurs. Despite this, their work led to many positive changes in the way mothers and babies were treated in maternity units. For example, early skin to skin contact between mother and baby, was promoted, and babies remained at the mothers' bedside instead of remaining in the nursery at all times, other than for feeding. However, this widespread view, posed potential difficulties for some women, for example, those who gave birth by Caesarean section under general anaesthetic, and those whose babies were ill, and needed to be in Neonatal Intensive Care Units. There was the potential for them to believe they had missed the crucial bonding point, when this was clearly not the case. However, Klaus and Kennel's work promoted further research and insight into maternal/child and carer relationships.

Doan and Zimerman (2003) reviewed the literature on prenatal attachment from 1970 to the present day, including their own research studies. They constructed a multi-dimensional view, to conceptualise attachment in relation to maternal emotion as well as behaviour. Their work confirms that understanding the nature of attachment can help promote healthy maternal/child relationships which extend beyond the pregnancy. Importantly, they suggest that pregnancy is not just significant in itself, but that it is part of a developmental sequence of thoughts about pregnancy, which predates pregnancy, and which occurs in never-pregnant as well as pregnant women. They emphasise that the prior ability to form abstract thoughts about pregnancy (even before conception) and to fantasise about the fetus are key factors in determining the degree to which women are able to form attachments. The other area they considered important was that of the women's emotional ability to separate self from the fetus. This ability enabled them to become sensitive and responsive to the needs of the fetus, and subsequently to the baby (Doan and Zimerman, 2003).

There are a number of sequential events during the pregnancy which, it has been suggested (Doan and Zimerman, 2003) contribute to attachment. For example, a pregnancy test can confirm a pregnancy within days of a missed period. Ultrasound scan can confirm the pregnancy very early on, and allow parents to visualise the growing embryo. Printouts from the scan, which many parents ask for, constitute the first "photographs" of the baby. Whilst these events may produce strong emotional responses in parents, they do not necessarily contribute to attachment . However, confirmation of pregnancy, and scan pictures may be kept as signs of the existence and continuance of the pregnancy.

Early visualisation of pregnancy means that women may know much sooner than formerly if their baby has an abnormality, or if a pregnancy has ended prior to term. This can create difficulties for women, as, if an abnormality is detected, they have to make a choice about terminating the pregnancy. If the pregnancy were left to proceed normally, miscarriage may occur anyway. Women often feel guilty that they could have engaged in some activity or behaviour which caused miscarriage (Moulder, 2001). However, when a conscious decision is made to end the pregnancy, there may be related guilt at having been the agent of that choice rather than the sufferer of a "natural" miscarriage. Similarly, if the baby dies during the pregnancy, this can also be confirmed on scan, and again, the woman needs to decide whether to have labour induced, or to await spontaneous delivery. Midwives in this study, such as Flora, Maria and Sophie, described the difficulty of making such choices relating to termination of pregnancy, and to induction of labour following intra uterine death.

Where the pregnancy proceeds, the process of attachment continues with the feeling of fetal movements. Indeed, in former times, the feeling of movement was known as "quickening" which means "alive". Prior to the advent of scanning, and regular antenatal care, fetal movements, feeling fetal parts, and audible fetal heart provided confirmation of a continuing pregnancy, and in Ancient Roman Law constituted the existence of life. These signs are only evident after about 18 – 20 weeks of pregnancy, and of these, fetal movement is considered a potent factor in maternal/fetal attachment (Ritsher and Neugebauer, 2002). Doan and Zimerman (2003) acknowledge quickening as a major factor in pre birth attachment, but observe that some women report high levels of fetal attachment even prior to feeling movement. Ritsher and Neugebauer's (2002) comparison of studies using the Perinatal Grief Scale (discussed further in the section on Depression), cites maternal investment in the child as a powerful factor in attachment. Toedter et al (2001) further suggest that decoration of rooms for the baby, and buying of clothes demonstrates considerable maternal investment in the child's future. Thus, by the end of pregnancy, the woman has experienced a number of events, which promote emotional attachment to the baby. At this stage, as Raphael Leff (1991) comments, the baby is a "fantasy" in the woman's mind. After birth, the baby becomes a reality, and other processes of attachment begin (Doan and Zimerman, 2003). Many mothers want to look at their naked babies, and examine every part of them in great detail. They then begin the more gradual process of attachment, which Bowlby (1991) describes as falling in love, leading to being in love, in the filial sense. However, many women remark on how detached they feel from their new born babies, and the literature suggests that there is a period of mourning for the loss of the pregnant state, and for the loss of the pre birth self

(Raphael Leff 1991). Further, attachment to the fetus is not the same as attachment to the baby. This is important, since if the baby is stillborn, there is no opportunity for any new attachment to be made, and the mother may still retain a primary attachment to the fetus, or fantasy baby. There is also an alteration in the transitional process to becoming a mother; there is loss of a new status, but no way of returning to the prebirth self.

As can be seen, therefore, when pregnancy ends in a situation other than the birth of a live, healthy baby, for example by miscarriage, by termination of pregnancy, by intra uterine death, stillbirth or neonatal death, the process of attachment has already begun for the mother. The magnitude of the loss felt is not conditional on the gestation of the pregnancy, but is related much more to the degree of maternal attachment. The assumption that gestation determines the degree of loss often seems to be the source of what some participants interpreted as inappropriate remarks. Indeed the predictive indicators of pathological grief and resolution suggest that there is essentially no difference in the degree of grief arising from any pregnancy loss. However, Mander (1994) observes that instead of anticipating a degree of grief based on gestational age, we should simply acknowledge and accept any articulation of grief by parents.

Thus it can be seen that attachments are formed throughout the pregnancy, and the woman may invest considerable emotion at a very early stage. However, once the baby is born, there is an end to attachment to the pregnancy, to the fetus, and to the woman's pre birth self. Then follows the formation of a new attachment to the baby. Therefore, there can be a situation of loss, even if the outcome of the pregnancy is a live healthy mother and baby.

Where pregnancy loss occurs, the process of attachment is interrupted, with no possibility of a new attachment being formed. Where the baby is born alive, there is an opportunity, albeit perhaps short, for the new attachment to begin. However, after termination of pregnancy, miscarriage or stillbirth, there is no such opportunity, and the prevailing situation is one of loss. The next section of this chapter considers the effects of grief and loss as they relate to the particular circumstances of reproduction and childbirth.

Grief and loss relating to pregnancy

Literature on grief and loss in pregnancy suggests that typical reactions to loss include numbness, disbelief, guilt, self-blame, anger, social isolation, yearning and searching for the dead individual. These are often classified into three groups, shock and numbness, yearning for and preoccupation with the dead individual, depression and disorganisation, with or without anxiety. The last group is the one which has received most attention, and attempts have been made, as shown later in this chapter, to identify possible predictors of depression (Ritsher and Neugebauer, 2002). The final stage in the process of grieving occurs with resolution, which is also discussed later in this chapter.

Over the past thirty years, the attitude of health professionals and others has changed dramatically in relation to stillbirth and pregnancy loss (Samuelsson et al, 2001; Begley, 2003; Chambers and Chan 2004). Prior to this, it was thought important that mothers forgot their babies as soon as possible, and Bourne (1968), described the "rugby tackle" approach to the birth of a baby already known to be dead. The mother was heavily sedated, the baby delivered, and then removed from the room as quickly as possible (Samuelsson et al, 2001). As previously discussed, in the absence of baptism, in Christian society babies could not be buried in consecrated ground. They were often buried in the coffin of a completely unrelated person, and their graves remained unknown. The bodies of babies born sometime before term were often simply incinerated with hospital waste, and the mother was encouraged to have another baby as soon as possible. This meant that for the parents, there was a denial of their loss, no acknowledgement by society that the child had existed, and no memories of the child to review and reflect upon (Samuelsson et al 2001; Mander, 2002;). Further, the injunction to have another baby often meant that if there were no problems with conception, the next child was likely to be born at around the same time as the one who died. Similar circumstances can arise for women who have miscarried. Because the most common time for miscarriage is around three months gestation, if the woman becomes pregnant within a short time of miscarrying, the next child is likely to be born at around the one year anniversary of the miscarriage. The literature suggests that the timing of the next pregnancy following stillbirth can be problematic, and that post natal depression is more common following an early subsequent pregnancy. Hughes et al (1999) examined the next pregnancies of 60 women who experienced stillbirth after 18 weeks of pregnancy, and matched them with 60 controls. Thirty one of the women conceived less than twelve months after the loss of their babies. None of the women had experienced depression or other psychiatric symptoms after the stillbirth. Assessment of the women's emotional state was carried out on four occasions, once during the third trimester, then at 6 weeks, 26 weeks, and 12 months after the birth. There were four assessment instruments including a general demographic questionnaire, the Edinburgh Post Natal Depression Scale, Beck's Depression Inventory, and Spielberger state-trait inventory. Overall, those who conceived a year or more after their first loss showed fewer symptoms of depression, and were less likely to be depressed at 12 months than those who conceived prior to 12 months. However, the researchers acknowledge that neither group was tested for trait anxiety prior to the study so there is no way of knowing if their choice to become pregnant sooner or later after bereavement was determined by their personality. The researchers also accept that scores indicating anxiety and depression could also arise because participants were still mourning their lost babies. Further, they point out that the majority of women who conceived quickly after stillbirth did not actually experience high levels of depression and anxiety, and that the benefits to them of an early next pregnancy might outweigh the possibility of adverse psychological symptoms. They also suggest that a "common sense" view would be that women who have been bereaved need adequate time to grieve. They do not mention that women might be anxious about the outcome of the subsequent pregnancy, in view of their previous experiences.

Bower, (2003) reviews Mander's (1994) work on pregnancy loss from the perspective of a midwife who gave birth to a stillborn son. Bower comments that Mander seems to support a delay in pregnancy following stillbirth, however, Bower argues that pregnancy and grieving are not mutually exclusive. She contends that, given the uniqueness of the emotions associated with subsequent pregnancy, the decision about when to become pregnant again is purely personal. Her view accords with some of the feelings of the midwives in the current study.

The findings from the questionnaires and interviews in the current study, suggest that for some, an immediate "replacement" pregnancy was exactly what they wanted. Sophie specifically acknowledged that her own personality, and her view of life, was that she had a series of challenges to be faced, which made her determined to become pregnant again very quickly. Flora mentioned her anxiety about a subsequent pregnancy, and commented on the help she found invaluable from her GP in supporting her. Some participants would like to have become pregnant again quickly, but their infertility problems prevented this. Vanda became depressed after her baby Mary was stillborn, but pointed out that she had had a miscarriage prior to the pregnancy she lost, and felt she was still grieving this loss during her pregnancy with Mary.

Over the past thirty years, the approach to pregnancy loss has changed considerably, and, as part of the change, parents (and siblings) are encouraged to see and hold their dead children, often regardless of the gestation. There is also recognition that reactions to grief associated with lost babies features many of the components described for any bereavement. However, the memories of a loved one, which can be sustaining for the bereaved, are not present when a pregnancy is lost, and grief is often prospective, not retrospective. There is a need to create memories, thus, as previously mentioned, locks of hair, footprints, photographs etc are kept, and services of remembrance are held for lost babies. The importance of these tokens of remembrance is emphasised in the literature (Brown, 1995; Samuellsen et al, 2001). Mander and Marshall (2003) make some observations about the historical antecedents for pictorial mementos, based on a selective review of literature on representations of infant death, and on observations of 16th and 17th century paintings of dead babies. They suggest that grief was more open at that time, and that paintings enabled families to acknowledge the existence of the dead baby. They further suggest that the difficulties experienced in the twentieth century in how to treat bereaved parents may be a temporary aberration in society's previously otherwise healthy views of death and remembrance. However, paintings would have been expensive to commission, and one might assume were the province of the wealthy. The process of photography has become more accessible, although Mander and Marshall (2003) make the point that photographs should be taken by someone skilled in photography, and it should not be assumed that midwives will have the ability to take photos which are appropriate. In the current study, Julia makes the point that polaroid photographs fade, and that every parent has a right to what she calls "a good quality black and white photograph" of their dead child. Julia's loss occurred at a time when amateur colour photography could not guarantee a lasting image, and her point, and that of Mander and Marshall, is the importance of assuring a lasting memento.

Other midwives in the current study related how they kept mementos of their lost pregnancies, even when they had lost the pregnancy at a very early stage. For example Polly, who kept her positive pregnancy test result as a tangible remembrance of her only pregnancy, and Flora, who took pictures of the flowers sent to her following her termination of pregnancy, and who also wrote a letter to her dead baby.

Mander (1994) points out, treatment of women who have stillbirths or intrauterine deaths is still not particularly based on sound evidence that what we are doing is "correct" in the long term. Indeed, there is no evidence of an objective correctness for treating women experiencing pregnancy loss. At present, we are acting on a belief that to encourage parents to see, hold, acknowledge and mourn their lost babies will help them to come to terms with their loss. Just as the social construction of motherhood is dynamic, as discussed in Chapter One (page 22), so perhaps, is the treatment of bereaved parents, with no solid evidence that there is an objective correctness.

In an attempt to gauge the effects of current treatment of bereaved parents, Hughes et al (2002) attempted to assess the effects of maternal contact with her stillborn baby. They interviewed 65 women in the pregnancy subsequent to a stillbirth, and matched them with 60 controls. They used three rating scales to assess depression, the Edinburgh Postnatal Depression Scale, Spielberger's state anxiety scale and Beck's Depression Inventory. They also used a Post Traumatic Stress Disorder scale. Within the study, they allowed for variables such as seeing the baby, holding the baby, attending a funeral for the baby, and the keeping of mementos. Their findings suggest that the incidence of depression in the group was higher for those who held their baby than for those who saw their baby. Those who did not see or hold their baby were least likely to be depressed. The researchers acknowledge that their study sample was small, and that controls were not perfectly matched, however they make the point that they were able to establish statistical significance in relation to seeing and holding the baby. Further, they used an assessment scale to measure maternal infant attachment in terms of security, the Strange Situation procedure, concluding that infants of mothers who had held and/or seen their stillborn babies were more likely to display disorganised attachment behaviour with the subsequent infant. It is unclear whether this was related to their depression, or to the fact of holding/seeing their stillborn child. The publication of the study in the Lancet caused a flurry of letters in response (Correspondence, 2002). There were letters from professionals engaged in similar work, and one from Kohner, who has produced a wealth of literature in conjunction with SANDS. There were also letters from bereaved women who had valued the opportunity to hold their stillborn babies, and who felt their relationships with the subsequent children had not been affected. The common theme in the letters, and in the Hughes et al's (2002) research is that the wishes of the parents should be paramount, and that no suggestion should be made to them by staff, that they would regret not seeing or holding their baby.

Walter, (1999), whose work was discussed on Chapter One (page 39) in more general terms, highlighted the tension between the psychological effects of grief on the individual, and the beliefs of society about appropriate grieving in the Western world. He suggested that not all those who are bereaved find comfort in seeing the body of a loved one, or attending the funeral, and that bereaved people should not be forced to conform, or made to feel that their way of dealing with grief is incorrect.

Nevertheless, it seems that treatment of bereaved parents is more acceptable than formerly. Samuelsson et al (2001) positively review changes in the last thirty years from parents' perspective. Chambers and Chan's (2004) systematic review of interventions following perinatal loss is prefaced with the following statement:

> an empathetic caring environment and strategies to enable the mother and family to accept the reality of perinatal death are now part of standard nursing and social support in most of the developed world (Chambers and Chan 2004:1).

suggesting that most parents receive a high degree of positive support and action. Jones (1997) also comments on the beneficial effects felt by women supported by a caring midwife, and Swanson (1997) suggests that interventions by caring health professionals can prevent long term emotional and psychologically adverse outcomes for women experiencing pregnancy loss. These comments suggest that health professionals are acting in accordance with the various recommendations for good practice in this area made over the past thirty years. However, the literature also reports the difficulties this can present for staff, and the types of support they themselves might need in order to provide good care.

Mander's (1994) study of midwives and their difficulties in helping women who have stillbirths highlights some points relevant to the midwives who experienced pregnancy loss in this current study. Mander (1994) found, almost without exception, that the midwives she spoke to had great difficulty knowing what to say to women who had experienced pregnancy loss. Begley (2003) also points out that despite improvements in the care of bereaved women, nursing and midwifery staff still experience difficulty in knowing what to say to bereaved parents. This is significant as some of the midwives in my current study suggested that midwives do not treat each other as they would treat any other client who experienced a pregnancy loss. Burden and Stuart (2002) suggest that there is an assumption by families that health professionals, particularly midwives (2002:14) are trained to cope with issues surrounding death, and to remain able to function when family members may feel unable to cope. Burden and Stuart (2002) further suggest that midwives are likely to have formed a relationship with the woman that means her loss also causes them grief. The midwife may also question her own practice, and feel that some aspect of care has been inadequate (Mander, 1994). Although calling for support for staff, Burden and Stuart (2002) acknowledge the difficulties this can create in a busy and stressful atmosphere. They further point out that midwives have a duty to care for their own emotional well-being, otherwise there is a risk that they will become ill, and transfer their feelings of sadness over one event to other clients in their care (2002:14/15). Indeed, they go as far as to say "Imagine the disruption to the care of a client and the other team members if a grieving colleague were to suddenly become indisposed at a crucial moment when caring for a client" (Burden and Stuart 2002:15). Burden and Stuart are describing responses to another couple's loss, but as the findings from the current study show, there were instances when the participants were so overcome by grief related to their own loss, that they needed to leave the situation. Burden and Stuart (2002) suggest that regular debriefing sessions, which take account of the midwife's own life experiences are essential to prevent excessive stress and burnout. In midwifery, the process of supervision might or might not provide such an opportunity, as discussed later in this Chapter. Mander (2002) suggests that the midwife's own emotional situation should be assessed before such challenging work is allocated. As the findings show, this was indeed the case for some participants, but, as Julia's allocation to the room in which her son died suggest, this was not always the case.

As previously discussed, most literature on grieving suggests there is a pattern which may include anger, denial of the loss, searching for the lost loved one, and dreaming that the loved one is still alive. These are not processes which take place in a fixed order, nor may they all necessarily occur at all. In the current study, Julia just wanted to go and be alone in the room where her baby died, but other participants could not bear to return to the same room. Anita sat in the room in her house which would have been the nursery, just talking to her baby. Other participants tried to achieve "connections" with their babies by writing letters to them. Sophie wrote extensively about her feelings on the death of her baby, Andrew. The writing preserved her memories, and her pain, and was a way of maintaining her connection with her lost child. All these behaviours suggest the yearning that was described earlier in this section.

The descriptions the participants gave of their grief did not seem to follow a linear pattern. As the findings suggest, there were times they would expect to feel sad, and would anticipate that sadness, for example on the anniversary of the loss, or the date when their baby would have been due. However, many spoke of "good days and bad days" unrelated to specific events, or places, and indeed many were surprised by a sudden and overwhelming grief. For example, Sophie thought she was coping well, then suddenly became upset when she heard the cry of a newly born, healthy baby. For many of the participants, the effects seemed to be more pronounced as they internalised the reality of their loss, and their changed circumstances. Stroebe and Schut (1999) reviewed thoughts on the grieving process, and advanced the Dual Process Model. This suggests that during everyday life, the bereaved oscillate between two dimensions, the first is Loss-Orientated, which involves focus on the loss, and the second is Restoration-Oriented, which involves actively moving away from the loss into new roles, identities and relationships. In the early part of grieving, Loss-Orientation dominates, then, more gradually, Restoration-Orientation activities become more dominant. They further suggest that women are more Loss-Orientated, whilst men are more Restoration-Orientated following the death of their child (Stroebe and Schut, 1999). Samuelsson et al (2001) studied the grief responses of 11 Swedish fathers from a phenomenological perspective. These men had all experienced the death of their baby prior to birth. The study confirms that attitudes to the loss were different in the men to those of women in similar situations. The men talked less about the loss to their partners, but recognised and valued the need their partners had to talk to them. In their interviews, they described feelings of severe grief, great disappointment, emptiness, abandonment, guilt and shock. Their prime concern was to protect their partners from further grief, and they tried to take on practical matters to accomplish this. However, they sometimes found their grief so emotionally draining that they found it difficult to take on everything they wanted to do. This study was carried out in Sweden, but Kavanagh's (2002) review of studies on men's grief following stillbirth observes similar responses, suggesting that while women grieve the loss of their child, men also grieve for their partners. All the studies conclude that communication between partners is vital to help them grieve in the way that is most helpful to them.

In the current study, the participants perceived differing attitudes in their partners, sometimes suggesting that they did not care, for example, Anita's husband, Julia's husband, Derek, and Martina's husband. Maria and her husband grieved in parallel, but never discussed their grief until many years later when they both received counselling. Although each participant has a unique experience, there are some areas which many bereaved parents experience in common, as the next section shows.

Kohner and Henley (1997) present the stories of a wide range of parents who have experienced a pregnancy-related loss, using their letters, other written accounts, and interviews. They acknowledge the uniqueness of each loss, yet across the accounts, show how much bereaved parents have in common. The accounts describe feelings of emptiness, isolation, guilt that they might have contributed to their baby's death, failure, and pain. They also describe feelings of jealousy and envy of other women who have successfully had children. The sight of pregnant women and babies in pushchairs often triggered these feelings, and the thought of pregnant women who smoke, drank or abused drugs in pregnancy made many of them feel angry. Moulder (2001) describes similar views in relation to women who have experienced miscarriage. These feelings about other women, their pregnancies and their babies are expressed by at least some of the midwives in this study. The difference for the midwives is that they were not always able to withdraw themselves, at least physically, from such situations. However, as the findings show, there were times when they withdrew emotionally, and this is explored further in the section on Practical and Emotional Issues at Work.

Most work on pregnancy loss and grief suggests that the negative feelings described above are so frequently reported by bereaved parents as to be considered normal. Indeed the premise of Kohner and Henley's (1997) work is that parents worry that their feelings are abnormal or unnatural, and their book provides evidence that others are feeling exactly the same. In the current study, Sophie relied heavily on this book, and read it many times, searching for parallels with her own circumstances to assure her that she was normal. The literature is describing paradoxical situations. Negative thoughts about other women's pregnancies, criticism of their behaviour during pregnancy and their subsequent attitude to their babies, together with a yearning for their own lost pregnancy or baby are simultaneously described as both normal and abnormal. Participants were searching to locate themselves and their own experiences and to relate them to those of others, to assure themselves that they were not "abnormal". The section later in this chapter on Depression explores how research from psychiatry attempts to differentiate between normal and abnormal responses to grief and loss.

Thus far in this category, the discussion has related to loss in general, with some specific applications to stillbirth, intra uterine death and miscarriage. The nature of loss in relation to termination of pregnancy has some slightly different aspects which need to be considered in the context of the current study. The next sections consider some of the issues which arose for those participants in the study who terminated their pregnancies, either for personal reasons, or in relation to fetal abnormality.

Two participants in particular, Chloe and Felicity, underwent terminations of pregnancy for personal reasons prior to becoming midwives. Both described their feelings that their decisions at the time were perhaps not well thought out, and that, given different circumstances they might have kept their babies. Felicity, a student midwife at the time of writing her account, felt her fellow students would judge her if they knew she had had a termination, so felt she was in a situation where she could not be open. The work of Brien and Fairbairn, (1996) already mentioned in Chapter One (page 24), confirms that while many women are relieved following the termination of an untimely or unwanted pregnancy, others experience long lasting feelings of guilt, and may need counselling to enable them to talk through their feelings of loss. Indeed, as Chloe commented in her interview, counselling was the best investment of her money she had ever made.
Maria, who had a termination of pregnancy for fetal abnormality, struggled with the guilt of having "killed her child". She imagined many times over, an alternative ending for her pregnancy, in which she allowed it to go to term, and gave birth, knowing that Anna could not live. Flora's perspective was different in that she felt her decision was the right one for her baby, as did Martina, whose baby had anencephaly. Brien and Fairbairn (1996) comment on the differences between termination of pregnancy for social reasons, and that for fetal abnormality, or serious, life threatening maternal conditions, suggesting that more sympathy and respect is accorded to the latter. They outline the ongoing difficulties which couples may experience together, or individually, for example

apportioning of blame for abnormality, fear that abnormality is a punishment for a previous perceived transgression, such as infidelity or a social termination of pregnancy. They also fear that the same thing might happen in a future pregnancy. It is impossible to do anything other than acknowledge and accept the enormity of emotion which prevails for women making a decision to terminate a pregnancy. In the current study, Flora, Martina and Maria commented that their experiences had influenced the way they gave information about screening tests to women antenatally. They were aware that the outcome of their own tests made them wary about presenting facts and figures to parents, knowing that their own results had been outside the reassuringly low incidence levels which are usually given. The section in the current Chapter on Impact on Practice explores this further.

As discussed in Chapter Three, loss in this context also includes loss of the ability to reproduce, as described by those who experienced infertility. The current chapter considers some aspects of loss which were felt exclusively as a result of infertility, and where the findings do not necessarily extend to other pregnancy loss.

As the preliminary review of the literature in Chapter One (page 22) suggested, having children is viewed by society as a natural and desirable consequence of reaching adulthood. Sidebotham (1997) reviews the potential sequences of events which may result in pregnancy following infertility and assisted conception. Her work includes a number of entries suggesting how the midwife may be "ideally placed" (1997:118) to help women come to terms with a pregnancy which may have seemed tentative (Katz Rothman, 1988). Sidebotham (1997) also remarks that given the relatively recent increase in the number of assisted conceptions there is new knowledge for midwives to gain about how their role can evolve to provide realistic support for such couples. For the midwives experiencing infertility in the current study, this obviously presented a potential problem. The feelings of failure, self blame, rising and then dashed hopes discussed by women experiencing infertility are echoed by many of the midwives in the study. Similarly, their feelings of being coerced into treatment, and the "competition" which some of them felt occurred between them and their peers, is supported by the literature (Harris, 1994;

Marck et al, 1994). As the chapters on findings have shown, some of the midwives experienced difficulties relating to pregnant women, including their pregnant colleagues, and I could locate nothing in the literature searched specifically addressing these issues. Participants in the current study described their experiences of both primary and secondary infertility, as discussed in Chapters Three and Four. Those experiencing infertility faced a series of losses, as their diagnoses were confirmed, and they embarked on investigations and treatment. As the findings show, the participants engaged in their work, perhaps feeling ill from treatment, constantly being in contact with other women's fertility, and often seeing fellow patients from infertility clinics subsequently as their own clients. Harris, (1994) charts the likely sequences of events which surround the diagnosis and progress of those experiencing infertility. Historically, the diagnosis was a once and for all explanation for failure to become pregnant, where the problem lay with one or other partner. Nowadays the choices involved in pursuing investigations and/or treatment into infertility are complex. However, these are no different for midwives than for non-midwives. Just as the participants described, so non-midwives describe the decision making processes of embarking on treatment, and of the multiple losses they feel each time a period starts, or a pregnancy test following embryo implantation is negative, or if their implantation is successful and then miscarriage occurs. Participants also describe their losses as their frozen embryos are used up, or perhaps fail to survive defrosting. What is different for the participants, is that their working lives force them to engage on a daily basis with women who have successfully become pregnant. As the findings from the current study suggest, some of the participants found this more difficult than others. The consequences for them are considered further in the sections on Being a Woman, Being a Midwife, and in the section on Practical and Emotional Issues around Work.

As previously discussed (pages 38 and 212) some literature (Jacobs, 1993; Mander, 2000) suggests that there is a "healthy" process of grieving following bereavement, and that it is a normal response to the loss of a loving and highly valued relationship. The outcome of grief is that a point of resolution and acceptance is eventually reached, although how this occurs and what form that might take is individual to each bereaved person (Walter, 1999). The findings clearly showed that this had happened for some participants, who were able to give meaning to their losses, and often to use them to help care for others in similar circumstances. For others, such as Maria, this point was not reached until many years after the loss. For those who experienced infertility, the process of grieving occurred many times over. Some reached resolution when they were successful in achieving pregnancy and having a baby, as did Linda and Davina, whereas some reached resolution by coming to a point when they accepted their childlessness such as Nina, or like Sonia when the menopause ended their ability to continue. Some in the study had not yet reached resolution, for example, Patricia continued her struggle to come to terms with the loss of fertility, and this process was not helped by close proximity to babies and pregnant women.

This section has examined some aspects of grief and loss related to pregnancy, and explored the literature in conjunction with the findings. As has been seen, in many instances, the experiences of the midwives closely mirrors that of non-midwives, although there is little literature which specifically examines experiences of midwives, or those in similar occupations. Some of the midwives had experienced depression, which they attributed to their loss, and the next section explores depression linked with reproductive or pregnancy loss.

Depression

There are many studies which explore depression and pregnancy (Cooper and Murray, 1998: Wheatley et al 2003). Post natal depression has received considerable attention over the last twenty years, but more recent work suggests that 10 to 20% of women are depressed antenatally (Evans et al, 2001), and that high scores in antenatal depression assessment are predictive of post natal depression (Hughes et al, 1999). Most estimates of prevalence of depression postnatally indicate that around 10% of all new mothers will experience some form of depression (Cooper and Murray, 1999). However, Oakley (1986), reviews what she calls unhappiness after pregnancy, and suggests that a trend arose in the twentieth century leading to what she calls the "medicalisation of unhappiness" (1986:137), which she calls one of the "disasters of the twentieth century" (1986:137). Her view is that although many women undoubtedly are depressed, the sociological factors which contribute to the wretchedness of some women's lives are sublimated in favour of psychological attribution. Studies by Rajan (1994) and other researchers suggest that women who are socially isolated, and those who receive little practical support from their partners are also at risk of experiencing depression. Recent work by Sure Start, a government initiative to promote the well-being of 0 – 4 year olds, which also addresses aspects of parenting, attempts to assess the totality of women's life experiences and their effects on maternal emotional wellbeing (Department for Education and Employment, 1999). The aim is to identify those women who are mildly to moderately depressed during pregnancy (Wheatly et al, 2003), presumably to identify and address areas which may lead to social isolation or deprivation, and which may contribute to post natal depression.

Other researchers have examined the effects of pregnancy loss on women, to determine whether there are any specific factors which can predict the likelihood of depression following pregnancy loss, and whether it is possible to differentiate between depression and grief. Chambers and Chan (2004) suggest that one in five mothers or family members (unspecified) will experience what they term (but without definition) "prolonged psychological abnormality", after perinatal death. This can be manifested by morbid preoccupation with the dead baby or fetus, anger directed towards clinical staff or family, self directed guilt or sense of failure, desperate searches for explanations and negative feelings towards other babies. However, many of the features above appear in accounts by bereaved parents, and in the accounts given by the midwives in the current study, and as mentioned in connection with Kohner and Henley (1997) are so widespread as to be considered normal responses. There is clearly some disagreement, therefore, about what constitutes an appropriate reaction to bereavement.

A Perinatal Bereavement Scale (PBS) was developed by Toedter et al (2001) in an attempt to predict those women who would become clinically depressed following miscarriage or perinatal loss. Toedter et al's (2001) review and their subsequent evaluation of its use in a number of studies leads them to believe that a high score is predictive of future depression. It is an 84 item questionnaire which contains statements about pregnancy, as well as statements about how the woman feels about herself. Literature from psychology and psychiatry proposes a new entity of grief, that of traumatic grief, which differs from normal grief and from post traumatic stress disorder (Ritsher and Neugebauer, 2002). The distinguishing features, which also differentiate traumatic grief from depression, include yearning for the deceased, increased feelings of suicide, and increased risk of heart disease. Ritsher and Neugebauer (2002) specifically attempted to isolate items from the PBS which related to the lost baby, as opposed to those which related to depression, in an attempt to differentiate between depression and grief. They scaled down the PBS to a 15 item questionnaire, which they named the Perinatal Bereavement and Grief Scale. Using this, they interviewed a total of 304 American women of white and Hispanic origin who had experienced miscarriage at varying stages of gestation, up to 27 weeks and 6 days. Participants were interviewed between 1 and 3 times in the first six months after the loss, and as well as the PBGS, completed a recognised questionnaire on depressive thoughts (the Center for Epidemiologic Studies – Depression Scale, Ritsher and Neugebauer, 2002). The PBGS measured only feelings relating to yearning and preoccupation following pregnancy loss, and did not differentiate between loss of the pregnancy or loss of the baby. As the section in this chapter on attachment suggested, work by Ritsher and Neugebauer's (2002) and the review by Doan and Zimerman (2003) suggests that quickening, and thoughts about the baby as a person, increase the bereaved mother's feelings of yearning and missing the baby, and lead to higher scores on the PBGS. Whilst not being predictive, the development of the PBGS opens the possibility for further research on perinatal grief, and its links with depression.

A number of the participants in the current study reported that they had experienced depression, and some said that colleagues recognised their depression before they themselves did. As the previous discussion has suggested, depression can occur post partum, with or without the experience of pregnancy loss, and can be debilitating for the woman and her family. In the context of pregnancy loss, a further area which arose and was significant for Vanda, and for others in the current study, was that of depression linked to aberrant behaviour, specifically, baby abduction or causing harm to babies. This section of the chapter explores these issues in more detail, with particular consideration of mental health issues in relation to nurses and midwives.

Whilst not specifically or consistently linked to a diagnosis of clinical depression, one or more participants in both my previous studies, mentioned their transient, and almost immediately dismissed thoughts of abducting babies (Bewley, 1995, 2000b). As the discussion earlier in this chapter shows, such thoughts were also mentioned by women who told their stories to Kohner and Henley (1997). The subject of baby snatching received high profile coverage in the United Kingdom in 1995, when Julie Kelley abducted the newborn Abbie Humphreys. Two abductions of newborns occurred at around that time, one in Wales and one in Nottingham. Stephenson (1995) writes that since 1990, about (sic) six infants aged between 0 – 6 months were abducted from their natural parents by strangers. Abduction by family members, such an estranged partners, is much more likely for a variety of reasons (Sulaiman, 2004).

Most of the literature around the act of abduction relating to nursing and midwifery dates back to the events of 1995. More up to date literature deals mainly with security arrangement in maternity units to prevent abduction. The National Centre for Missing and Exploited Children in the USA (Rabun, 1995), analysed the abductions of 77 newborn babies, half of them less than a week old, from hospitals in the USA between 1983 and 1992. The abductor was typically female, aged between 14 – 45, had impersonated a nurse, and may have also been involved, in a peripheral way, with health services. She was also likely to have been overweight, may have experienced loss of a baby herself, had recurrent miscarriages, or may have previously faked pregnancies. There was no evidence that abductors had experienced mental health problems, or that they were mentally ill at the time of the abduction. In all cases, the babies were returned unharmed within two weeks. The two abductions in the United Kingdom prompted the implementation of widespread security arrangements in maternity units to prevent abduction of babies. Norman (2004) contends that women who abduct babies are ill, and that they should not be treated as criminals. He writes on behalf of the Portia Trust, which campaigns against injustice directed at women. His piece is unreferenced, and somewhat emotive in tone. He cites the thoughts of the novelist Catherine Cookson, who, after losing four children, and then knowing she could have no more, fantasised about abducting another woman's child. However, her fantasies remained as such, just as the midwives in my studies had reported (Bewley, 1995, 2000a and b).

There is no evidence that a nurse or midwife has been involved in abduction. However, the case of Beverly Allitt, an enrolled nurse who was convicted of murdering four children in her care in 1991, shows that a health care professional was capable of harming patients. Her case prompted a widespread review of recruitment, and the monitoring of the mental health of nurses and midwives, when there was a suggestion that her actions may have been linked to a history of mental illness. The Clothier Report (Clothier, 1994) recommended more stringent attention to occupational health checks, checking previous sickness, including history of eating disorders, attempted suicide, self-harm, and frequent attendance at Accident and Emergency Departments. The recommendations also suggested that no person who had experienced a major personality disorder should be considered for nursing, and a number of articles appeared in the midwifery press, urging vigilance by managers (Tranter, 1994; Wooster, 1994). Another nurse, Amanda Jenkinson, who also had a history of mental illness, which she had failed to disclose to her employers, was convicted of tampering with a patient's life support equipment. The Bullock Report into the Jenkinson case, (Bullock, 1997) endorsed and strengthened the recommendations by Clothier. Whilst these recommendations were necessary to protect the public from harm, there were far reaching consequences for managers and midwives. Dimond (1997) calls for a balanced view which avoids discrimination against staff, and allows those who need counselling, or who need to consult their GPs about depression, to do so without being treated with suspicion.

The consequences of these debates were significant, most obviously for Vanda, whose entry to midwifery, and her subsequent treatment, caused her distress, and which was directly related to the Beverly Allitt case. However, most telling is the behaviour she describes, of those who interviewed her, and of her colleagues on Special Care Baby

Unit, who, she says, viewed her with suspicion and vigilance, in response to a fictional television programme they had seen, featuring baby abduction by a bereaved woman.

As Chapter One (page 24) showed, abberant behaviour by bereaved mothers features in a number of fictional situations, which act as potent factors in determining how such women are viewed in society, and for Vanda, how she was viewed as a potential, and then actual midwife. The real life abductions of newborns, and the actions of Beverly Allit must not be confused with fictional representations. It is difficult to assess what strategies could have been used to support Vanda, or to help those midwives who briefly thought of child abduction. Their view was they should keep quiet, lest their fleeting thoughts were taken seriously. This makes it difficult for any midwives who are depressed to access counselling which may be supportive. It is also difficult for managers to deal with the subject in a sensitive and supportive way, yet acknowledging their duty of care to the public. As the findings showed, the issue of support was very important. Part of support was linked to self-disclosure, but as the discussion above suggests, the circumstances for self-disclosure in connection with work can be problematic. A similar situation was described by a student nurse, who recounted that she became clinically depressed during her training (Brooks, 2000). She documents how students were told by their teachers that if they became depressed or otherwise mentally ill, they would have to leave the course. In the event, this was not the case for her, as she received appropriate psychiatric treatment, and was able to complete her course. However, her situation confirms the attitude, certainly of her teachers, to mental health problems in health workers.

Literature consulted to support the category under discussion, that of Nature and Impact of the Loss, confirms that pregnancy loss has far reaching and possibly long term consequences, not only for the woman, but for her family, her friends and her colleagues. Social aspects of pregnancy loss also impact on the emotional well being of the woman. For midwives, the recommendations of reports made in connection with the mental health of nurses and midwives could have an adverse impact on their treatment at work. The literature consulted, therefore, provides further data to support and confirm the category Nature and Impact of the Loss.

SUPPORT, EMPATHY, AND SELF -DISCLOSURE

This category combines the three areas of support, empathy and self-disclosure, since many of the incidences described by participants involved elements of all three. The participants used the word "support" many times in their narrative accounts, but without defining specifically what they thought constituted support. The findings from the interviews amplified these data, by giving examples of supportive behaviour, which included being available to listen, often many times, to the same story. Other behaviours including accepting and not judging, and understanding what the bereaved person was experiencing. There were also those who were described as being intuitive, and being able to sense when the bereaved person was not feeling well, or was feeling sad. Such people were also capable of anticipating situations which the participants might find upsetting. Many of the descriptors used by participants are also used in connection with counselling terminology, particularly empathy and empathic understanding. Self-disclosure is also included in this category, as is sharing experience, which formed an important part of the category on support, empathy and self-disclosure.

Some of the qualities described as supportive, applied to work colleagues and to managers, and are closely linked to the qualities of friendship outlined in the Friends and Friendships website (www.cyberparent.com/friendship, 2004). They are the qualities which move the relationships between colleagues from merely working together, or being managed by, to a situation where there is mutual concern for the other person's welfare. The website further suggests that friendship constitutes an in-depth relationship, and cite the following as being the qualities of a friendship: equality, loyalty, non-manipulation, praising, showing empathy, sharing feelings, allowing an equal share of talking, and forgiving. It is also suggested that friendships need agreed limits and boundaries, that friendships can be built, they can be maintained, and that they can and do end. The qualities of friendship mentioned here also arose in participants' descriptions of what they considered supportive management behaviours, and are considered further in the category on Practical and Emotional Difficulties at Work. The same qualities of friendship are also discussed in the category on Impact on Midwifery Practice in the section on the midwife-mother relationship.

Mander (2001) explores the nature of support in the midwifery environment, acknowledging the difficulty in defining such a concept in the first place. She draws on a number of studies to identify four major constituents of support. The first is emotional support, which encompasses behaviours and acts which contribute to an individual's feelings of being cared for and belonging to a community or group. The second is instrumental support, which in the current study, I termed "practical support". This involves more tangible benefits, which may include redistribution of workload, provision of time off or breaks. The third component is informational, and comprises the giving of information which may lead to problem solving. Finally, and possibly linked with the first, Mander highlights esteem as a factor in support. She acknowledges that the term psychosocial support can both encompass and yet still fail to adequately describe the complexities of a term which is used so freely and in such an unqualified manner. In the current study, the behaviours described by the participants, and which I analysed as suppport, equate well to the descriptions given by Mander, and help to confirm the category within the study.

Mander's (2001) exploration also considers the behaviours which may be exhibited by either the supporter, or the supported, contending that supportive relationships are reciprocal, and constitute a social exchange. However, in order to attract and receive support, the person in need must exhibit certain characteristics. In the current study, this would equate with the participants' perception that their cues, whether consciously or unconsciously given, were correctly interpreted by those who then acted in a supportive manner. However, there were also those in the study who did not want to talk about their experiences. Mander (2001) observes that sometimes, the stress associated with support seeking behaviour may not make it worthwhile. She makes a further observation that whilst support is generally considered to be a "good thing" (Mander, 2001:16), well-intentioned, but ill informed actions can be unsupportive, and possibly damaging. In the current study, the participants mentioned the well meaning remarks already cited in this Chapter, which were intended to give a positive slant to their losses, but which were hurtful. Similarly, the suggestions that participants would be helped by confronting the situations they dreaded, such as caring for women who were experiencing similar pregnancy loss to their own, or returning to care for a woman in the room where their own baby had died, may have been intended as supportive, but were not perceived as such by the participants. The above has explored some general points about support, and the issue is raised again in connection with the organisation of midwifery care later in this chapter. Thus far, it seems that a degree of self-disclosure is involved in the supportive processes described by the participants in the current study. The next section in this part of the chapter explores self-disclosure in relation to shared and sharing experiences.

Shared experience

The issue of shared experience and sharing experiences (Self-disclosure) was discussed briefly in Chapter One (page 35), where it was suggested that finding commonality through shared experience is a recognised feature in forming relationships. It will be remembered that those who self-disclose are generally well liked, as long as what they disclose is acceptable. The discussion in Chapter One focussed mainly on disclosure by midwives about not having children. In this section, the topic of shared experience is considered from a number of perspectives, and a review of terminology is necessary at this stage. I use the term "shared experience" to denote a situation where two or more people have had the same or similar experiences. The term "sharing experiences" I use to denote a situation where one or more people discloses information about a particular experience, which may or not be shared by those to whom it is disclosed. Thus the term sharing experiences also involves self-disclosure. Without self-disclosure, and its attendant risks of disapproval, there can be neither sharing of, or knowledge of shared experience.

In the current study, sharing experiences occurred in two contexts. The first was that of sharing experiences with, and hearing the experiences of other midwives. Some participants welcomed hearing the experiences of others, as it reassured them that they were not alone in their thoughts and feelings. Sophie commented that she read the book "When a baby dies", seeking a match for her own circumstances. Moulder's (2001) work on miscarriage documents the experiences of women following miscarriage, and notes how many women felt they were misunderstood when sharing their experiences. Then, suddenly one person would acknowledge that they had felt the same, and the women were able to relax and feel that their experiences tallied with those of someone else, and that, therefore, they were "normal". Without entering into the debate of what constitutes normal, it must nevertheless be acknowledged that a feeling or thought cannot be constituted as normal simply because of its mutuality. However, in this context, the mutuality was supportive in confirming the sense of not being alone.

As the discussion in the previous category has already shown, the findings, and the literature suggest that sharing experiences can be beneficial in assuring people that what they are experiencing is similar to those who have been in similar situations. However, there is also the possibility that those who experience something completely different to the reporting by others will assume that their response is abnormal or unusual. It may simply be that, as the discussion on self-disclosure suggested, if people feel that their experience is not socially acceptable, even though there may be many in similar circumstances, they may not feel able to disclose it. As previously discussed, at one time, it was thought bizarre that a woman who had experienced a stillbirth would want to see her dead baby. We have no way of knowing whether those who did want to see their babies were considered abnormal at the time. The trend now is for all family members to see and hold a dead child, but there are occasions when those to whom this is offered find it a macabre suggestion. One of Mander's (2000:34) midwife interviewees commented that she would not like to cuddle a dead baby herself. Some of the fathers in the Swedish study mentioned earlier (Samuelsson et al, 2001) also expressed some reluctance about seeing and holding their dead babies. As with many of the issues raised so far, the social construction of these behaviours is dynamic, and is considered further in the discussion on support groups.

In the current study, the participants discussed how they sometimes wanted to talk about (or share) their experiences, and sometimes did not. There were advantages to disclosure, in that if managers knew what needs the midwife had, they were better able to support their requests, for example for particular shifts or time off, or avoidance of certain areas. However, with the disclosure came the risks previously discussed, of being treated with suspicion. The midwife could also be perceived to be vulnerable. In many cases reported by the participants in the current study, colleagues and managers were sensitive to this, but on other occasions, it was, it seems, purposefully exploited, and this is explored further in this chapter in the section on bullying. A certain amount of disclosure and sharing of experience seemed necessary, otherwise it was difficult for colleagues to be supportive.

Thus far, this section has examined shared experiences as they relate to midwives' work situation with colleagues and managers. However, the sharing of experiences also arose in connection with clients, and this is dealt with separately later in this chapter. The next section moves the discussion about shared experience further, and considers the role of self-help and support groups

Support and self help groups

Shared experience forms the basis for many support groups. This may be a sharing of a similar experience at a similar time, or may be the sharing of participation in the same event, for example, those who have been involved in disasters such as the Hillsborough football stadium incident in which more than 90 Liverpool Football Club supporters were crushed to death (Taylor et al, 1995). The stories related by those who were involved in the Hillsborough tragedy are diverse and individual, however, their commonality, in that they arose from the same event, has provided support for those individuals. Mander (2001) discusses the mutual support available when people have shared the same experience of a particular event in her analysis of midwives' experiences of maternal death. Mander (2001) conducted a qualitative analysis of the experience of maternal death on 36 midwives, 32 of whom had been involved in a maternal death. Semi-structured interviews were conducted, mainly by telephone. Comments from the midwives suggested that they felt more supported by those colleagues who had been on duty at the time of the woman's death, or had been closely involved with her in the few days prior to the death. Whilst they acknowledged the support offered by other colleagues, mutuality of experience was considered to provide more informed support (Mander, 2001:151). The midwives in Mander's study sought informal support, however literature suggests that more organised forms of support exist in the form of self help groups.

Befrienders at SANDS (Stillbirth and Neonatal Death Society) are parents who themselves have experienced a pregnancy loss, and then receive training before they go on to support those in similar circumstances. However, as Vanda suggests in her interview, shared experience does not assume a universality of experience, rather it allows for and acknowledges individuality of response to loss.

When searching for information for this chapter, I looked at the internet for information on support groups for those experiencing pregnancy loss. There were numerous pages of entries, particularly in relation to lost babies, with stories of parents' hopes and dreams dashed with the death of a much wanted child. One of such groups, which I chose as an example, was called Angelchild, and from the many stories appearing there, I highlight that of Myrna Willick (Willick 2001) who writes about her son Jacob. Jacob had a genetic condition, incompatible with life, and he was stillborn. His mother's creation of memories, and her subsequent desire to make something positive of his short life, closely mirror the sentiments expressed by the participants in this study, and in other literature, who had lost a child. Willick went on to study perinatal loss as part of a degree in clinical psychology, in an attempt to reach understanding and to help others. Willick wrote a poem based on her reading of other bereaved parents' stories, and, despite my personal reservations about its oversentimentality, I was struck by the resemblance of the points she makes in the poem, to the situations described by participants, and by the actions which were prompted by their losses. The poem speaks of parents feeling that their loss has made them better people, that they have experienced an increase in their capacity for compassion, they have taken on new causes, founded support groups, or offered their support to other bereaved parents. They have developed a sense of perspective on what is important in their lives, and have made a conscious attempt to turn the negativity of their loss into something positive. Willick ends by commenting on how the positive thoughts of other bereaved parents sustained her when she found it difficult to cope.

Writing in the Guardian, Fink (2002) has a different view, but speaks of the secret community she discovered when she typed in the word "stillbirth" to a search engine in her computer. She made links with women in circumstances similar to her own, and described the bonds she formed with them as they shared their experiences of loss. However, she acknowledged the ephemeral nature of the connections she made, and knew that although she was spending hours each day communicating with them through a chat room, their circumstances would change again, and they would be drawn back into the reality of their own lives. Nevertheless, Fink found solace, at least temporarily in writing about her loss and communicating with others in a similar position.

There is little evaluative research on the benefits or otherwise of self-help and support groups. However, Egan (2002:207) suggests that the shared experience of attenders at Alcoholics Anonymous contributes to its success in helping members with their addiction. He comments that former addicts can act as role models, disclosing their problems, and revealing how they coped with them. They also have "inside experience" of the difficulties which recovering addicts face.

A wide variety of other support groups now exist, in many different forms. Some are part of large, charitable organisations with knowledgeable and well-respected board members. They often fund research and sometimes fund provision of care, and may exert pressure for improvements in their area of concern. An example relevant to the current study is that of SANDS. There is, however, a myriad of groups and many completely unregulated web pages providing support and information for a range of diverse needs. It is not known whether their effects are wholly, or indeed in any way beneficial, since there is a lack of evaluation of self help groups in general. They may in fact have a self-fulfilling potential for a sharing of doom and gloom, with no positive outcome. I could find little research in this area, but noted that SANDS were particularly commended by participants in my own study. However, Flora expressed some concern about the organisers of her local bereavement group, who, after ten years continued to write the same letters describing their experiences to new members of the local group. This led me to reflect on what the participants had said about sharing experience, and their rejection of proffered similar experiences if they did not provide the desired match. Changes in maternity care mean that similar situations occurring ten or more years apart might not result in a similar outcome or experience. Participants who were diagnosed as infertile thirty years ago, would not have the same experience if they were diagnosed now. Julia's preterm baby, had he been born now, may have survived. It is impossible to comment on the intentions of those who run support groups, but presumably, their wish to help arises from their own experience, as it did for the participants in the current study. However, one would hope that their emotional needs are identified, and help offered with resolution, as they are with befrienders from SANDS. This would address the potential that the continuance of their involvement reflects an unresolved issue in their own lives, as suggested by Flora.

The section on loss earlier in this chapter discussed the issues of Loss-Orientation and Restoration-Orientation in grieving, and, in connection with the above, raises questions about how those who have experienced loss see themselves. Without being diagnostic, and in the absence of first hand knowledge of the individuals described by Flora, there is a possiblity that they remain Loss-Orientated, and that this might be potentiated by their work with SANDS. There may be the formation of what could be termed a "fixed tragic identity", in which the person becomes forever defined in terms of a previous life experience such as their loss, rather than in any other of their life capacities or achievements, or indeed any future life events. Whilst this remains a speculative view, I raise it because the current study is exploring and seeking to raise awareness of midwives who have experienced personal loss. It is important within this context, therefore, that the participants are neither defined nor limited by their reproductive experiences.

Another of the intentions of the current research is to elicit what the needs of midwives experiencing pregnancy related loss might be. Inherent within this intention is to consider the nature of support in relation to those needs. It could be said, therefore, that the wish to provide support forms one of the bases for this research. Many participants related their reasons for wanting to take part in the current study as wanting to help others in similar situations, and wanting to know about what was available for people like themselves. Patricia searched the internet in vain, to find out what help might be available for midwives such as herself, experiencing infertility. There are clearly some aspects of shared experienced and its application to self help and support groups which are difficult to address. What is clear, is that the needs of the midwives in the current study were not always met, and that they sometimes sought external support which they felt was not available from others in similar situations.

The previous sections have shown how participants valued being able to talk, to share their experiences, be listened to and not judged. Empathy was a much-valued quality in colleagues, and created the climate in which participants could self-disclose and share their experiences. The next section considers how the skills involved in counselling link to the supportive behaviours described by participants.

Counselling and counselling skills

As shown above, participants valued those work colleagues and managers who were able to allow them to talk about their experiences in an empathetic and non-judgmental atmosphere. The literature consulted on counselling and counselling skills, highlights many of the qualities identified by the participants, and summed up by Rogers as unconditional positive regard, empathic understanding and genuineness (Rogers, 1990). Whilst unconditional positive regard may seem alien to management strategies, some participants described how, within the management role, there were elements of the ability to see the midwife as a person as well as an employee. Those participants who talked about their experiences of formal counselling said they found it beneficial, although only Maria mentioned the specific type of counselling she received, which was Gestalt counselling. Some participants had considered and rejected the idea of counselling, whilst others would like to have accessed it but for whatever reasons were not able to. One of my previous studies suggested that some participants had found counselling outside the workplace beneficial in helping them to come to terms with their feelings of loss (Bewley, 2000b), and clearly, there were perceived benefits for some of the participants in the current study.

People they described as most supportive were those who seemed actively to use counselling skills. However, some who were described as acting in a supportive way exhibited an intangible quality which some participants attributed to intuition. They described this as knowing the right thing to say, knowing when to speak and when to touch, picking up the signals and responding accordingly. I explored some of the counselling literature to gain further insight into what the participants had said.
The term empathy is commonly used in counselling to describe a situation of understanding, and there are a number of definitions. Rogers gives one definition:

> To sense the client's private world as it if were your own, but without ever losing the "as if" quality. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger fear and confusion getting bound up in it..."
> Rogers 1990:226

Rogers (1990) further asserts that empathy is an unappreciated quality, and that few people learn to listen with intensity and selflessness.

Some counselling literature contains complex discussions about levels of empathic understanding, (Nelson Jones, 1988:45). Egan (2002:48) acknowledges this complexity describing empathy in a number of ways. First, as a disposition, or personality trait, present naturally, and conferring the ability for greater empathy on some than on others. From a situational perspective, empathy can be contextually bound, when it is necessary to imagine another's perspective. Empathy may also be a process, building in stages to sense another person's feelings, and to communicate an understanding of them. Egan (2002) suggests that empathy is part of a repertoire of interpersonal communication skills which can be learned. He emphasises, however, that learning to understand another person's situation requires "working hard" on behalf of the person seeking to understand (Egan 2002:48).

In the current research, I asked the follow up interviewees specifically how they knew if someone understood them, but it was difficult to attribute anything tangible to their responses. Ickes (1997) describes empathic accuracy, which accords with what the participants in the current study said about the intuitive qualities of those they found helpful. He said:

> Empathically accurate perceivers are those who are consistently good at "reading" other people's thoughts and feelings (1997:2)

Counselling literature emphasises the importance of understanding, but also of communicating such understanding. Without this communication, no matter how well the listener understands, such understanding remains hidden, and might as well not be there at all. Communication of understanding is much more complex. Nelson-Jones (1988) and Egan (2002) offer practical techniques to develop and communicate understanding. These include active listening, and checking back with the speaker that what has been said has been understood. Two techniques which commonly appear in counselling literature, in connection with communicating understanding are paraphrasing and restatement, are rejected by Egan (2002:97) as being mechanical, and lacking any human component. Rogers (1990) and Egan stress that elements of self are closely involved in developing and communicating empathy.

Self involvement, as discussed above, is also referred to as indirect self-disclosure, where the characteristics of the listener are communicated back to the speaker by looks, responses and body language (Egan 2002:207). Direct self-disclosure was touched on earlier in this chapter, in connection with colleagues disclosing, or participants in the current study disclosing their circumstances. Participants also described how they had sometimes disclosed their circumstances to clients. In the current study, there is no way of knowing how clients felt when participants disclosed their situations or implied that they understood how the client might be feeling. We have only the participants' view of how the disclosures were received. We also have an insight into those occasions where the participants withheld their experiences in what they considered were the client's best interests. However, there were other occasions where participants recorded that their clients sensed an understanding of their situation, which they assumed derived from personal experience. My interpretation of their accounts, is that they were experiencing empathic understanding from some of their colleagues, who they felt understood them, and that they were communicating empathic understanding to some of their clients. There were also occasions where it seemed that clients were communicating an empathic understanding of their midwives. It would seem therefore, that empathic understanding can be achieved with or without experiencing the particular event under discussion.

Empathy as a concept also appears in other literature. For example, Dalmiya and Alcoff (1993) explore empathy from an epistemological perspective. They assert that there is a gender specific experiential knowledge about childbirth which is only accessible to female midwives. They suggest that ultimately, only person A can know the reality of person A's experience. Person B can attempt to enter Person A's frame of reference, but one person can never truly know what it is like to be another person. Dalmiya and Alcoff further suggest that, however, even person A may not truly understand their own situation. Their first person knowledge may actually exclude some aspects of their experience. However, by use of imagination, one person may gain insight into the experience of another, and by voicing the imagining, help the other to clarify their own experience. Norberg (1994) explores the use of essential imagination in carers working with elderly people who have dementia and who seek to develop their understanding of their clients.

Karniol (2003) reviews her own, and other's work on the location of self in social prediction. She presents the theories on how self is used in making predictions about the thoughts and feelings of others, and via these discussions, makes some links with the development of empathy.

Karniol's (2003) work draws on theories already alluded to in the section of this chapter on attachment. These centre on the ability to see the self as distinct from others, often referred to as the Self As Distinct (SAD) theory. In the SAD model, individuals engage in complex processes of comparing themselves to others, finding themselves either similar, or dissimilar. However, Karniol also suggests that when comparing others with self, individuals will find more similarities than when comparing self with others. People are more likely to predict that, when making choices, the majority of others facing the same decision making processes will make the same choices as they themselves. Karniol offers two perspectives from which people might exercise empathy. The first involves imagining the self in a particular situation, and, by extension of self, and by use of self-knowledge, gauging what a known other person might think or feel. The second involves the conscious suppression of self-knowledge and the use of knowledge of the other person, to assess how that person might think or feel. The first is an egocentric view, with the self at the centre of the process, and the second is procentric with self and self-knowledge removed from the process. Where the person is unknown to the individual, the individual will call on prior knowledge to create a generic representation, or prototype. The ability to use imagination to generate such a prototype can be an indicator of the potential to develop empathy

Karniol further suggests that individuals who see themselves as more distinct than others, and who see those who are known to them as more distinct than prototypes, will have a higher degree of empathic perception (Karniol, 2003:575). In midwifery, this imaginative capacity would enable midwives to identify groups of clients they might have difficulty dealing with, for example those who abuse drugs. It might also enable them to identify the attachment processes discussed earlier in this chapter, and to empathise with maternal feelings in relation to pregnancy and pregnancy loss. From a theoretical perspective, Karniol's work provides an insight into the analysis and development of empathic understanding, however, this cannot be tested in the current study, since those deemed to be understanding cannot be interviewed or tested. However, it is clear that they displayed some ability to understand how the participants were thinking and feeling, and to modify their own responses accordingly, in a humanistic way.

Humanistic, and Rogerian thinking not only apply to counselling, but also to teaching, and underpins the philosophy of many nurse and midwifery teachers. Hunt (Hunt and Symonds, 1995:50) owns it as her philosophy of midwifery, and the qualities already mentioned of unconditional positive regard, genuineness and empathic understanding are evident, although perhaps not explicit in the writing of many midwives (Kirkham, 2000;

Leap, 2000; Flint, 1989), although as Schon (1987) observed there may be a dissonance between espoused theory and theory in use. Bryar (1995) notes that students are influenced by the tone of what they read, and perhaps assimilate the attitudes from their reading into their own practice, and into their dealings with their colleagues. Just as the participants were able to identify those who "should know better", so they were also able to identify and prize the cherishing behaviours extended to them by those who supported them emotionally. These are necessarily my own interpretations, since I have not interviewed those who were described as supportive.

Participants mentioned how, at times, they felt that someone cared about them. Maria, and Sonia used the term "feeling loved". Their words conveyed a complex, and somewhat spiritual view of what they experienced, and for which I turned to the writing of the Apostle St Paul. He describes the Christian virtues of faith, hope, and love (1 Corinthians, 13:vv 4 – 8). In the Authorised Version of the Bible, the word love is translated as charity, deriving from the Greek word for altruistic love, caritas. For example, St Paul highlights the positive components of love as patience, kindness and truth. He comments on its lack of envy, conceit, selfishness and gloating, and keeping score of wrongs, and commends its endurance over time. Carl Rogers essential qualities also contain some parallels with St Paul's descriptors. These qualities are also similar to those of friendship discussed earlier, perhaps the one significant exception in the concept of caritas is the absence of reciprocity.

Flint (1989) uses the word "cherish" to describe the atmosphere of self-care she would like to see midwives create for one another. Again, this word relates to the Latin caritas, deriving from the associated word "carus", meaning dear, and entering the English language via the French "chere".

Fink, who was mentioned earlier in connection with her encounters with other bereaved parents on an internet site, also writes about her midwife, Tessa. Tessa was her friend as well as her midwife, and was with her at the birth of her stillborn child. She also returned to the baby's grave with her a year later. Fink sought consolation from her Rabbi when her baby died, and he told her that the only answer to radical loss is radical love. Fink says:

> ..and there I think of Tessa. I stop, stilled by the thought of her grace and beauty. I can still feel her gentle midwife's hands pressing my abdomen, still see her dear face as she brought my son out of me. Out of love, from friendship, Tessa made the worst day of my life the most miraculous thing. (Fink, 2002:17)

Whilst Tessa's characteristics of grace and beauty may not be attainable by all midwives, the qualities which motivated her to express such support for her friend may be learned by cultivating the essential imagination for empathy.

This has been a difficult category to explore with its multiple and largely unmeasureable contributory factors. The literature consulted and presented in this section confirms the importance, the complexity, and the intangible nature of support. Elements of support include empathy and self-disclosure, and may include shared experience. Again, the literature consulted confirms that these are important qualities in ensuring that people feel understood, and cared for. The difficulties of appropriate self-disclosure, as described by the participants in the current study are echoed in some of the counselling literature. The literature consulted provided additional data to confirm that the category of Support, Empathy and Self-disclosure is appropriate, and that the data located in this category is correctly situated. However, as the discussion has shown, there are two areas which, with slightly different connotations, also appear in other categories. The first is sharing experiences, which is discussed further in the section on Being a Woman, Being a Midwife. The second, is that of support, which, as literature has suggested, may be personal, or organisational. The practical and organsational applications are considered in the next category.

The next category to be considered in this chapter is Practical and Emotional Issues Around Work, which is discussed in the next section.

PRACTICAL AND EMOTIONAL ISSUES AROUND WORK

The findings suggested that there were some specific areas around work which were problematic for midwives who had experienced pregnancy related losses. Some of these have been discussed earlier in this chapter in the section on Nature and Impact of the Loss. These related to the antipathy that the participants sometimes felt towards parents, and, as the findings in Chapter Three suggested, there were groups of clients the participants found particularly difficult to deal with. These included, for example, those who expressed negativity about their pregnancy, who abused drugs, or who had other children who were in care. However, some participants also found it difficult to share the joy of couples who were pleased with their pregnancy. Participants also discussed difficulties around returning to places where they had been treated as patients, or the room in which their baby had died. All of these presented practical and emotional difficulties.

Additionally, the wide spread of participants meant that there were some who were already midwives at the time of their loss, and some who became midwives subsequently. This part of the chapter examines literature relating to the midwifery workplace and the organisation of midwifery care to gain insight into the working environment and midwifery culture, with which the participants came into contact. The last category considered how the midwives used the term support in their accounts, and discussed the intangible qualities of some behaviours described as supportive. The support in that context related primarily to personal and emotional support. The first section in the current category reviews some literature relating to support in the working environment, and examines existing support systems in midwifery.

Support systems in midwifery

Midwives in the current study commented on how they were treated in the work environment, and the first part of this section further explores their observations on remarks made to them by their colleagues. It seems from other sources, and from the advice produced by support groups, that the making of what I termed inappropriate remarks was widespread at the time the study was undertaken. The Miscarriage

Association produces leaflets for couples who have experienced miscarriage, and those who might come in contact with them. The latter gives a list of remarks which should be avoided on the grounds that they might be hurtful to the bereaved person. These include comments about how the baby was probably deformed, that the woman is young enough to have another baby, that they should be glad it wasn't later in the pregnancy, that they already have one child (Miscarriage Association, 1998). All these remarks appear in some form in various narratives and interviews from the participants in the study. As mentioned previously, it was felt ironic by participants that such remarks are often made by midwifery colleagues, who by virtue of initial and ongoing education must have become aware of the need for sensitivity.

What concerned participants in this study, was their belief that midwives should be more sensitive. They were not alone in their expectations. Hadikin and O'Driscoll's work on bullying, which is also discussed later in this chapter, (2002:55) presents the case study of a midwife whose mother was dying of cancer. The midwife's expectation was that her colleagues would be caring, understanding and supportive, but felt ultimately that her treatment was lacking in compassion, cold hearted and thoughtless. During the time her mother was terminally ill, she was reprimanded for the only personal telephone call that she received during that time; this was from her father who was worried about her mother's condition. She was on night duty at the time and was refused permission to leave early, even though it was a quiet night, and she had offered to make time up. When her mother died, she was phoned on the day of the funeral, just as the hearse arrived, to ask when she was coming back on duty. Hadikin and O'Driscoll (2002) describe her treatment as bullying, and I will return to this issue later in this section.

In the current study, similar remarks about insensitivity related not only to pregnancy loss, but to some general treatment at work. Those who mentioned this felt it was sad, and that midwives should know better. The interviewees felt that some midwives do not necessarily apply the same knowledge and skills in their relationships with colleagues that they do in their relations with clients. However, as one remarked, perhaps midwives need help with their own emotional needs before they can help others.

Cohen (2003) describes day to day life as a psychotherapist with responsibility for supporting parents, staff and babies in a busy inner city Neonatal Intensive Care Unit (NICU). Among other things, she describes her attempts to set up support groups for staff, and at one point includes her account of how she tried to involve midwives working outside of, but closely with the NICU. Cohen's account emphasises the need for staff support, but does not specifically mention how nurses, doctors or midwives cope in NICU when they are dealing with their own pregnancy related issues. However, she does consider how life experiences can impact on work events, and recounts an episode where a member of staff became upset at having to perform a procedure on a baby, and thinking of how she would feel if it were her own child. As Nina observed in the current study, there were many situations in the work environment which were intrinsically sad. However, there was also the potential for bereaved staff to superimpose onto these their own memories and experiences of loss.

The issue of staff support for those who work in emotionally charged situations is well documented in nursing and other literature. Emotion work has already been alluded to briefly in chapter one (page 35), and this section expands the concept. A number of authors in midwifery cite staff support as being crucial in generally maintaining an emotionally manageable working atmosphere. Hochschild's (1983) work with air stewardesses provided the starting point for considering "emotional labour", when she examined how they maintain a calm and assuring atmosphere by using techniques similar to acting. She proposed that some of their techniques distanced them from the emotional reality of their work, whilst others were deeply internalised and actually became a part of their reality. In nursing, Smith (1992) further examined the strategies nurses use to deal with their emotions, and proposed that nurses' emotional labour increased as a consequence of changes brought about by the introduction of the nursing process, which moved care away from task to patient orientation. Menzies (1981) wrote about task orientation as a method of nurses' avoiding personal involvement with patients, thereby decreasing stress. Davies and Atkinson (1991) documented student midwives' retreat into the safe territory of routine observations, which obviated their need to interact at a deeper level with pregnant and childbearing women.

Hunter (2001) has used the same approach to review what she terms “emotion work” in general and to apply it to midwifery. Hunter (2001) proposes that the changes in midwifery care introduced in line with Changing Childbirth (DoH, 1993) emphasise the nature of the midwife-mother relationship, and may represent an increase in the emotional content of the midwife’s work, and the situations encountered by students during training (Hunter 2001:437). She also points out that this may be positive or negative.

Hunter (2001) goes on to describe some situations which, anecdotally, involve midwives’ emotion work, and which, if used positively, have beneficial effects for mothers and midwives. Conversely, there are many descriptions of women’s encounters with their midwives that have negative connotations (Edwards, 2004), and which adversely influence not only the mother’s perceptions of herself in the interaction, but which also may exert physiological consequences, particularly in labour, as discussed in Chapter One (page 26). Hunter (2001) further suggests that there are four areas of particular significance when considering midwives’ emotion work. These are (in the order she presents them), changes in organisation of midwifery care, with greater emphasis on continuity, working in situations of high levels of expressed emotion, intimate work which involves aspects of sexuality, and working with women who are experiencing intense pain. Begley (2003) observes that Hunter has not specifically included in this consideration, the intense emotions involved in pregnancy loss. Whilst one could say they would feature under high levels of expressed emotion, the findings from the current study suggest that much of the emotion related to pregnancy loss experienced by the participants remained suppressed.

However, Smith (1992) and other researchers in nursing and midwifery, observed that, when faced with extreme stress, nurses withdraw emotionally from their patients. In nursing, such stress seems to arise from the type of nursing engaged in, for example, oncology, paediatrics, and trauma nursing, where nurses are constantly faced with the distress of patient death (Begley, 2003). However, as shown in the following discussion, studies which document stress and burnout in midwifery relate this almost entirely to the structure in which care is provided, rather than the actual practice of midwifery. The next section examines the organisation of midwifery care in connection with support for midwives.

Organisation of midwifery care

Kirkham and Stapleton (2000) investigated the support needs of midwives following the introduction of Changing Childbirth (DoH, 1993) using a grounded theory approach to gain data from five different National Health Service (NHS) sites, and one site with midwives working outside the NHS. One hundred and sixty eight midwives were involved, using in-depth ethnographic type interviews. The findings present a dismal catalogue of low esteem, worthlessness, feelings of lack of support, lack of role models, failure to stand up for one another, and failure of management to provide support. The emphasis seemed to be that midwives worked in an atmosphere pervaded by their own sense of self sacrifice, and that any discussion of how they might help themselves was thought to be selfish. The midwives considered themselves powerless, and spent much time "covering their backs" and practising defensively, and to the detriment of childbearing women. Kirkham and Stapleton (2000) suggest that in a climate where midwives feel powerless themselves, they are likely to disempower their clients. Just as the midwives in my current study, those in Kirkham and Stapleton's (2000) wanted and valued support. In Kirkham and Stapleton's (2000) work, the supervisor was considered an appropriate person to provide support, a person who would listen and not blame, who would foster autonomy, and who would represent the midwives at management levels. However, support was only considered an option in the presence of trust, which seemed to be absent in the climate of "horizontal violence" described by Kirkham and Stapleton (2000). The term horizontal violence denotes a situation in which, the behaviour exhibited would be classed as unacceptable if directed towards patients. Their study describes a little of the differing experiences of the one site outside the NHS, remarking that the midwives in that working environment developed their own support structures.

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Conversely, those strategies which contributed to high levels of work satisfaction were assertiveness in negotiating working practices, not only with colleagues, but with clients, and in the home. Other strategies included ensuring support at work and in the home, and having what were described as "meaningful" relationships with women. They also had clearly defined time away from work, and interests outside work. Sandall (1997) also observes that continuity of care is as important for the midwife as it is for the woman. Some of the participants in the current study worked in this atmosphere which not only changed the philosophy and organisation of care, but also how individual midwives worked within that system, as the next section shows.

The other issue which Changing Childbirth (DoH, 1993), and to a lesser extent clinical grading in the late 1980s, brought about was that of ensuring that all midwives provided all aspects of midwifery care. This meant that midwives who had worked in one area for many years, for example, antenatal clinic, postnatal area, or community, were required "cajolled, or forced" (Hunt, 1997:167) to extend their work to all areas, including labour ward (Hunt, 1997). Anecdotal and observational evidence suggests that not all midwives were able to accomplish this without great stress (Hunt, 1997). It can be seen, therefore, that many of the participants were required to radically reorganise their working practices perhaps around the time when their losses occurred.

Some participants in the current study commented on how difficult they found it to work in certain areas, often directly related to their pregnancy loss, and how "management" made this even worse by the insistence that they provided the whole spectrum of midwifery care. For example, Stella, who was made to take classes on breastfeeding when she still could feel her own dead child at her breast, and Patricia, coming to terms with infertility, with an inflexible management approach about where she worked, and having the added difficulty of an unsupportive partner.

In light of the studies on support at work, I reviewed the findings from questionnaires and interviews, and noted that some participants had specifically mentioned team midwifery as a source of stress, and that some had used the word burnout. These were cited as contributory factors in their difficulties at work. The current study did not specifically address work conditions in relation to the midwives' pregnancy related losses, so it is impossible to substantiate any possible connection, however, the situations some of them describe in relation to their treatment mirror the findings of the studies of midwifery provision in this section. Some participants used the word "bullying" to describe their experiences, and this is considered in the next section.

Bullying in midwifery

Where insensitivity is concerned, the findings show, and previous discussion in this chapter has suggested, there are midwives, and other health professionals, who treat their clients and colleagues unkindly. As a teacher, I hear much from student midwives about how they are treated. As a student midwife myself, my recollection is not only of excellent role models, but also of unkindness, and in some cases sheer rudeness. The issue of bullying in midwifery is currently receiving widespread interest and is cited as a contributory factor to midwives leaving the profession (Ball et al, 2002). In the current study, Rhona, Chloe and Vanda had experienced what they perceived as unkind and bullying treatment from their colleagues, in connection with their pregnancy losses and as part of their general working lives. Vanda also experienced unkindness as a client prior to becoming a midwife, she experienced it as a student, and now as a qualified midwife.

Leivers (2004) studied workplace harassment in an NHS hospital, providing care for 2,500 pregnant women per year. Thirty-two midwives returned semi-structured, self-complete questionnaires, comprising of open and closed questions. Twenty-eight respondents said they had personally experienced harassment within the unit, and the same number had witnessed harassment of their colleagues. The term harassment is used in this context, rather than bullying, since it is suggested that bullying carries connotations of physical aggression whereas harassment manifests as intimidation, humiliation, and excessive criticism. Other writers on harassment in the NHS and in midwifery suggest that the strict hierarchical and authoritarian structures within which midwifery care has been arranged promote a culture of harassment and bullying. Hadikin and O'Driscoll (2000) imply that the organisation of the NHS and of midwifery provides an environment which, until recently, has condoned and perhaps even encouraged bullying as a management strategy. These views support the criticisms of a culture of horizontal violence as discussed earlier. The participants from the current study mention bullying only marginally in connection with their pregnancy related loss. However, the lack of parity between the unkind treatment they received, and the treatment their clients were likely to receive is cited in work on bullying (Hadikin and O'Driscoll, 2000), and in Mander's (2001) work on support in midwifery. As previously explained, "horizontal violence" is the term used for behaviour towards colleagues which would be inappropriate if directed at clients. For example, it is difficult to imagine a situation where a woman would be forced to return to the same room in which her baby died, with the intention of making her come to terms with her loss, as happened with Julia, a participant in the current study. This again, suggests that midwives do not behave to each other in the same way they behave towards their clients.

Other work related issues

Many participants mentioned the length of time they stayed away from work. This ranged from weeks to months, and seemed unrelated to the type of loss which occurred. Moulder (2001) documents the feelings of women on their return to work after miscarriage, and describes how they encounter mixed responses from colleagues as did the midwives in this study.

Aside from sensitivity their psychological needs, many participants in the current study would have had physical needs, differing according to their circumstances, and needing to be addressed on an individual basis. What emerged from the findings was the participants' desire to be seen as a person, not just a name on the off duty, whose work needed to be covered during absence. The participants cited those managers who telephoned or wrote to them to enquire about their health and their feelings as making a positive contribution to their recovery. Those who enquired merely to find out when they were coming back to work were deemed insensitive. This equates with findings from my previous study (Bewley, 2000b), in which participants valued management approaches which treated them with courtesy and sensitivity.

Some participants mentioned the difficulties they had in performing the full role of the midwife, and spoke of certain areas and certain groups of clients they felt uncomfortable with. The issue of placement under these circumstances has arisen in the section on Organisation of Midwifery Care.

Those coming to terms with infertility, and those having treatment for infertility experienced problems connected with physical reactions to their treatment, which made it difficult to do shift work. They also needed time off to attend appointments. There are now strict employment guidelines relating to the treatment of those who are disabled (Every, 2004). Employers are required by law to make "reasonable adjustments" to enable employees to carry out their work. The issue of infertility as a disability is unclear, and requires assessment on an individual basis. Some aspects would relate to the mental health of midwives, who felt they would be able to work more easily in some areas of midwifery than others, for example, Patricia, who specified that she found work on labour ward difficult while coming to terms with her infertility. Other aspects relate to the physical problems encountered by some participants undergoing infertility treatment and who could use the Disability Discrimination Act (1995) to support their requests for particular placements and shifts. They could also approach their Occupational Health Departments to ask for assessment under the European Working Time Directive (1993). This situation is usually reviewed six monthly, but could ensure that midwives avoided being placed on night duty. However, as Every (2004) implies, some sensitivity by managers in the first place, would ensure that midwives received appropriate work allocations to support them, and encourage them to remain in midwifery.

Despite the difficulties experienced the midwives emphasised how they behaved in ways that enabled them to carry out their midwifery work, even though some acknowledge, as did Maria, that their practice may have seemed lacking in emotion, cold or aloof. This area is explored further in the section Being a Woman, Being a Midwife.

This part of the current chapter has explored the category of Practical and Emotional Issues Around Work, drawing on literature relating to the organisation of midwifery, and support in general for midwives in the working environment. Some areas, such as bullying, which arose for some participants, have also been examined. The findings and and the literature consulted suggest that there are re-integration processes which would be beneficial to midwives coping with pregnancy loss. These may also help them to improve their outlook, and thereby their practice. Thus the findings and literature confirm the category Practical and Emotional Issues Around Work.

The next section of the chapter explores the participants' Feelings on Being Part of the Research.

FEELINGS ON BEING PART OF THE RESEARCH

Writing as therapy

As the findings show, many of the participants in the current study said they derived benefit from thinking and writing about their experiences. One participant, Jill had already taken her writing to a different level, and had an article published in a national women's magazine on her experience of being a midwife who could not have children. I initially thought it would be difficult to find literature on women's written accounts of experience, but work by Layne (1996) made me realise that such accounts are available on an everyday basis in women's magazines, in the letters pages of professional journals, in newsletters from support groups, and on the internet. Browne, (2003) also documents the powerful information which can be exchanged within groups engaged in memory work about their experiences. Chapter Two has examined some of the methodological issues arising for the researcher when considering written narrative accounts, and the current chapter has already examined some aspects of mutual remembrance in the section on self-help and support groups. However, empirically, the sharing and writing of life experiences can help to ascribe meaning, for those who write the accounts, and for those who read them. This chapter has already alluded to those who sought a "match" for their own experiences, looking through stories of others in similar situations to assure themselves that what they were thinking and feeling was normal, and this is reflected in this current category.

There is a growing trend for discussion and memory work to be acknowledged as a valid source of evidence about events and experiences, and a number of midwifery and birth orientated publications now use the medium of story telling, for example the quarterly publication for midwives, MIDIRS Midwifery Digest (MIDIRS). In its March 2004 issue, MIDIRS features extracts from the diary of a newly qualified midwife (Mottram, 2004). It also contains an account called "Disappearing Babies", written by a former midwife (Worth, 2004) and comprising a mix of personal recollections, opinions and anecdotes related to babies who disappeared under dubious circumstances at the beginning of the twentieth century. An editorial comment follows the article, in which its inclusion is justified despite its being "a great deal more speculation and imagination than secure knowledge" (Marchant 2004:30). This comment is indicative of the qualitative/quantitative debate, and the relatively recent obsession with evidence-based practice. Sources of evidence on which to base practice can legitimately include autobiographical work, as important studies in social sciences have revealed (eg Finch, 1993).

Bolton (2000) describes her work, including practical workshops, on creative writing and explores the role of committing thoughts to paper as therapy. She advocates any form of writing including keeping a journal, writing letters (which may remain unsent) and writing poetry, and considers these may be beneficial, not only in times of emotional difficulties, but as a regular activity. In her comments on writing letters, she gives the example of a man who wrote letters to his dead father, saying the things he wished he had said in life. She particularly recommends the recording of dreams, and documents the dream of a pregnant woman who dreamt she was attacked by dogs, who bit her until she bled, and who woke to next morning to find she was having a miscarriage. In the current study, two of the midwives, Sophie and Janine dreamt of their respective stillbirth and miscarriage in the days before it happened, and wrote down their dreams.

Reflection and reflective models have emerged in the last twenty years, and have been embraced by educationalists, including myself (Cooke and Bewley, 1995) as an essential component of the theory practice continuum. They can help practitioners to examine their experiences and ascribe some meaning to events which may be puzzling or traumatic. However, these reflective activities usually require some academic discipline in the form of a reflective model, or, in the case of oral group work, some skilled facilitation to transform and give meaning to a described event. Leamon (2004) suggests that in oral storytelling work, particularly in an educational setting, strict ground rules should prevail to prevent inappropriate personal disclosure, and that stories which "sensationalise" childbirth should be discouraged. Those who feel that personal experiences may impinge on their midwifery practice are encouraged to reflect on them privately, and, if necessary, consult their personal tutor or midwifery supervisor on a one to one basis for further guidance (Leaman, 2004). None of the above negates the writing or reflection which participants in the current study engaged in, rather it illustrates that their memories provide the raw data for theorising (Browne, 2003), rather than being theory of themselves.

As mentioned in Chapter Two, many participants had already engaged in some form of analysis prior to writing, and in most cases their thoughts were already well structured. Earlier in this chapter, I used the work of Karniol (2003) in the discussion on empathy, and referred to her thoughts on generic representations. She also suggests the foundations of memory are largely composed of generic representations of experience, upon which more memorable, specific events are superimposed for example, taking a walk in the park might be a generic experience, whereas taking a walk in the park and witnessing a shooting would be a specific experience (Karniol, 2003:569). Events which are emotionally charged, or unique, are those which are likely to be remembered for their distinctiveness. Where individuals are unable to attribute specific, differentiated memories to an event, they are likely to depend on their generic memory. Karniol observes that a preponderance of generic over specific autobiographic memory is associated with depression and post traumatic stress disorder. The ability to recall particular events would seem essential in the attribution of meaning.

Layne (1996) also describes some of the ways in which people seek to ascribe meaning to important life events. She carried out a textual analysis of newsletters from support groups dealing with bereaved parents and other family members following pregnancy loss. Bereaved parents, other relatives and sometimes nurses mostly wrote the texts. The groups involved were self-help groups comprising mainly white, middle class families of Christian or Jewish backgrounds. Her study reveals that the dominant view of pregnancy is predicated on the belief that biomedical technology has improved pregnancy outcomes. She found that women viewed their losses as life changing experiences, and events which punctuated their lives from there onwards, and after which they would never be the same person. This accords with the views presented earlier in this chapter about the transitional status of some life events. They talked about their lives in relation to the incident, and recalled events as being either before or after the pregnancy loss. She likens the narratives to the writings of soldiers during the Great War (First World War), whose war time experiences changed their lives irrevocably, and against which they dated and rated all other life events.

However, there are many other events which punctuate life histories and about which one can say things were never the same again (Parkes 1998). Work with survivors of disasters such as the incident at the Sheffield Football Stadium at Hillsborough also documents the life changing effects of those directly involved, even when they have survived (Taylor et al, 1995). Similarly, those who lived during the Second World War often regard it as the defining moment of their lives. The differences between the recollections and significance of these events is that those relating to personal loss largely remain private and defining purely in the lives of those affected, whereas events such as wars and disaster become part of the collective memory of a community (Walker et al, 2003). There also seems to be a differential value placed on the experiences of women and those of men. Cecil (1996) suggests that the women in her study had never considered their experiences of pregnancy loss worthy of telling. Many of the women involved had never discussed what happened to them.

Memory and recall feature in all narrative accounts, whether written or spoken. Cecil (1996) comments that in some cases, there is recall of one or two significant occurrences, which stand out, and which may assume greater importance for the narrator. Some phrases may have been rehearsed, and performed during the storytelling, many times over, and so may seem to be more significant. Walker et al (2003) analyse the emotions which accompany autobiographical memories, suggesting that negative experiences generate negative emotions, which will fade over time. They observe that sharing autobiographical details triggers effects in others, so that when positive experiences are shared, positive feedback occurs, which boosts the positive feelings originally engendered by the event. Conversely, sharing a negative experience often generates expressions of sympathy and support, which can help to minimise or "dampen" the negative experience. However, Walker et al (2003) observe that in cases where individuals are mildly depressed, or dysphoric, they may already have negative thoughts about themselves which render them less able to share autobiographical memories. Additionally, they may not have the personal support systems which facilitate the sharing of experiences. Walker et al (2003) also comment that the negative physical sensations associated with a traumatic incident fade less quickly in those who are depressed. This raises the issue of whether recalling traumatic incidences simply reinforces their horror, for some individuals, and that for some people, the best way of dealing with their grief is in manageable chunks, which they attend to in their own time, or maybe not at all. Stroebe and Schutt (1999), and Lupton (1998), challenge the thinking that encourages engagement with negative thoughts in a calculated attempt to turn them into something positive. Whilst Egan (2002) promotes the principles of positive psychology, he too warns against the "Pollyanna" approach which can seem to trivialise traumatic life events offering an overly simplistic message that negative is bad and positive is good.

The processes involved in dealing with traumatic life events incidents via written or oral discussion seemed helpful to many of the participants in the current study. Sophie kept a diary for many months after her son Andrew was stillborn, and many participants wrote or spoke of the benefits they gained from writing or speaking about their experiences. They also said they hoped their experiences might help someone else in the same situation. Literature consulted suggests that memory work can form part of a process of attributing meaning to a life event, and incorporating it into the individual's self concept. Areas from the literature concerning psychological aspects of memory work are speculatively applied to the findings, since the current study did not make any assessment of the participants' emotional state. However, the findings from the literature consulted suggest support and confirmation for the category.

BEING A WOMAN, BEING A MIDWIFE

This section begins with a brief personal observation on terminology which, I believe, is important in the establishment of this category. When I began writing this study, I used the word "woman" to refer to the pregnant or childbearing woman, as opposed to the midwife. However, part way through the work, it occurred to me that, for the most part, and certainly in this research, all the midwives were also women. I began to think of them as clients and midwives, or I used the term "pregnant and childbearing women" to denote which group I was referring to. Within the current category, Being a Woman, Being a Midwife, it is acknowledged that midwives may experience the same or similar physical, psychological and emotional effects as many other women. The integration of personal knowledge and experience into professional work may subsequently influence their practice as a midwife, as the next category Impact on Practice will show. However, for the current category, the emphasis is on the issue of Being a Woman and Being a Midwife, and how those two roles may undergo dynamic processes of separation and/or integration, as the midwife struggles to reconcile different aspects of her self.

The initial review of the literature in Chapter One suggested that many midwives are likely to have experienced the same life events as many other women. For example, they may have experienced eating disorders, been depressed, been subject to domestic violence, or have questioned their sexuality (for example, Thompson, 1994). In addition to their pregnancy related losses some participants in the current study disclosed that they also had experienced depression, eating disorders, and in one case, domestic violence.

As has already been said, the midwife brings elements of her own life experience and personal qualities to her work, and her contribution to the birth experience should not be underestimated. McCrea et al (1998) studied the personal qualities of midwives in relation to their approach to pain relief in labouring women. Using a non-participant observation method, they examined the interactions of 11 midwives and 15 clients (therefore more than one client per midwife at some times) during labour, specifically in relation to pain relief. They described three types of approach by the midwives, using two extremes and an ideal. The first was the "cold professional" who gave information in an impersonal way, but remained distant and detached, removed emotionally from the labouring woman and her pain. The other extreme was described as the "disorganised carer" who offered haphazard snippets of information, and spent considerable time in social chat as opposed to listening and observing the labouring woman. The third, and ideal approach, was that of the "warm professional" who combined the giving of helpful information with comments and gestures indicating that she was there for the exclusive benefit of the labouring woman, and cared what happened to her. The researchers are careful to point out that the midwives they observed exhibited elements of all three approaches, and did not exclusively fall into the categories. The researchers give some demographic information about the midwives, indicating that of the 11, 8 had one or more children. They also make the specific comment that "Most of the midwives had children, and, therefore, they had personal experience of labour pain" (McCrea 1998:179). However they do not give any details about the midwives' own birth experiences, and seem to assume that all would have experienced labour rather than, for example, having an elective Caesarean section. This is a missed opportunity to gain insight into how the midwives' own experiences of pregnancy and birth (or lack of them in the 3 who did not have children) may have influenced their approach to pain relief in labour.

Some literature suggests that even outside the sphere of pregnancy loss, midwives have difficulty reconciling certain aspects of their personal lives with their professional responsibilities, for example, midwives who smoke, or who have given up smoking find it difficult to advise pregnant women about giving up (Bishop et al, 1999). Those who have never smoked sometimes find it difficult to comprehend the power of addiction (Allen, 2000). The potential for cognitive dissonance in such situations, and in the case of the midwives in the current study gives rise to an area of significant emotion work for the midwife.

The work of Hunter (2001) on emotion work in midwifery has already been discussed, and she remarks on the dearth of material available which documents the midwife's experience of emotion work. Of the available literature, Mander (1995) has recorded midwives' feelings around caring for women who do not have their babies with them, and more recently, she examined the feelings of midwives involved in cases of maternal death. In the latter work, Mander (2001:154) specifically comments on what she terms the "vulnerable" midwife, citing the experience of a midwife who was coping with the death of her own mother, whilst dealing with an emotionally charged working environment. Hadikin and O'Driscoll (2000) also document midwives' feelings in relation to their work environment, and to the demands of their home lives. However, none of these works specifically examines the feelings of the midwife who faces daily direct confrontation of her own pregnancy related loss.

The literature consulted about non-midwives who experience thoughts of antipathy towards pregnant women, and to their babies, suggests that they seek to remove themselves from such situations (Moulder, 2001; Kohner and Henley, 1997), but often midwives are unable to do this. The findings from the current study suggested that some participants felt that being a midwife hindered their grieving process associated with loss. However, the findings also revealed that many participants find their midwifery work a source of great joy, and derived enormous satisfaction from working with mothers and babies. Many expressed the desire to use their experiences positively to help others, and were able to identify the processes both internal and external, which helped them to incorporate their losses into their own sense of self. Some spoke of an ability to separate their personal and professional lives, and I explore this further below.

Separating personal and professional lives

A number of participants in the current study commented on the importance to them of being able to separate their personal and professional lives. As previous discussion in this chapter has suggested, support mechanisms outside the midwives' professional sphere were considered important in promoting emotional wellbeing (Kirkham and Stapleton, 2000; Sandall, 1997). Sandall (1998) considers the difficulties some midwives experience when they become mothers, and discusses the gendered nature of midwifery work. She concludes that midwives with family commitments are required to balance their midwifery work and their domestic arrangements in an organisational regime which fails to acknowledge their dual responsibilities. She calls this the "double shift" of motherhood and midwifery.

Hunter (2001) also discusses the gendered nature of midwifery when she considers the emotion work involved in providing intimate, continuing care for pregnant and childbearing women. Although she and other writers on emotion work touch on the difficulties of dealing with emotion in the work environment, there seems little on the difficulties of working with one's own emotion, when there is such dissonance between the joy expressed by pregnant and childbearing women, and the sorrow of the midwives in the current study.

Some of the emotional aspects of the midwives' experience in the current study related to expectations of how their colleagues treated them as women and as midwives.
The discussion in previous sections of this chapter considered the climate in which the accusations of insensitivity may have arisen, and I now return to the discussion to the question of inappropriate remarks made by midwives. As the literature earlier in this chapter suggests, inappropriate remarks about pregnancy loss are widespread. They centre on assumptions that the less the gestation the less significant the loss, that it is better for a fetus or baby with an abnormality to die than to live, that if the woman is young she can have another baby, and that one baby can be easily replaced by another. Another assumption seems to be that the loss of a pregnancy or a baby is much less significant than the loss of a child or adult. As those who have been bereaved confirm, their experience of the loss is generally, although not always, more significant to them, than the thoughts underlying the general assumptions. However, as the literature on perinatal loss has shown, a new range of norms has arisen, to which bereaved parents are encouraged to subscribe. It seems that only those who already know, through personal experience, or through education (although this is not always the case), the kind of behaviour and remarks which are appropriate have any chance of avoiding giving offence at such a sensitive time. What surprised the participants however, is that midwives have been exposed to a wide range of educational materials around the support of women

following pregnancy loss, which must include input on the kind of remarks which are well meant but hurtful. There was an expectation by participants, therefore, that being midwives, their colleagues would not make those remarks. However, there was another expectation about midwives and the knowledge their work gave them. Some participants suggested that midwives who are pregnant or trying to become pregnant do not necessarily know any better than lay people and are not necessarily more able to make "better" or more informed decisions about their own care or treatment. In the context of the remarks made by the participants about insensitivity, the participants' expectation that midwives should know better is somewhat challenged. The interviewees suggested that their midwifery colleagues apply their knowledge about dealing with loss to their clients, but not to their colleagues. It seems that the midwives in the study found it difficult to apply their midwifery knowledge tò their own situation, yet expressed surprise that their colleagues failed to apply midwifery knowledge to them. It is difficult to know whether it is the issue of bereavement which raises problems for the midwives in relating to their colleagues, or whether there is something about applying professional knowledge in a situation outside the midwife-mother relationship. This suggested to me that certain behaviours occur within a fixed view of what a person's role should be at a particular time.

This is a complex area around which I could locate little specific literature, although sources drawn on earlier in this chapter confirm that expectations of consistent caring behaviour from midwives to either their clients or their colleagues are often misplaced. I reviewed some literature from psychology and counselling sources on self, sense of self and self presentation in an attempt to gain insight into how the participants might deal with the events in their lives as women, and their professional role as midwives.

The role of the midwife

Within the findings from the questionnaires and the interviews, many participants used terms about their professional lives which were borrowed from acting and the stage. For example, they talked about being on stage, putting on a brave face, or being behind the scenes. This acting terminology, and the stage as metaphor is widely used in many spheres including sociology, psychology and counselling (Goffman, 1959, Hochschild, 1983, Lupton 1998), although Goffman (1959) warns against taking the metaphor too literally, with a reminder that acting is not real. As previous discussion in this chapter has suggested, however, those whose true emotional state must be concealed for the benefit of their clients (Hochschild, 1983, Lupton 1998) may indeed be acting, and this was true from the descriptions given by many participants in the current study.

To continue the stage metaphor, ethnographers in midwifery have commented on the "scripts" that midwives use in particular situations, for example, in the antenatal booking interview (Methven, 1989). These scripts and stage directions are also evident in other situations, such as prior to vaginal examinations (Bergstrom, 1994). However, only the midwives know the rules, the patter and the moves. Clients, and students do not. In order to work as a midwife, the midwife must be "in role". The adherence to the script ensures her performance is consistent, even though it may be repetitive and not necessarily helpful to the client, and it can act as a prop, particularly under difficult circumstances (Kirkham, 1989). When she is required to step outside role, for example, when her own emotions conflict with her work requirements, or to address a situation for which there is no prepared script, there is a challenge. McCrea's et al's (1998) study also reinforces the notion that even within the best practice, there may be elements of a scripted performance.

The stage metaphor includes behind the scenes, or backstage areas (Goffman, 1959) and for those in the current study these were places such as the staff rest room, the sluice, or the privacy of their own cars when working in the community. Hunt and Symonds (1995) also allude to the backstage areas where midwives prepare themselves for their forthcoming shifts, and where they may be "themselves". In these areas, they may reveal their true emotions, as opposed to those they assume whilst they are working with clients. In my study of midwives who do not have children (Bewley, 2000b), participants commented that when talking about their experiences to colleagues, they were much more likely to reveal what they really felt, than when they were with clients. However, given the previous discussion on the management of emotions, I sought further information from literature.

Lupton (1998) examines the nature of emotion in connection with concepts of self, and proposes two main perspectives. The first is that emotion is socially constructed and dynamic. There are societal expectations of particular sets of emotions which are appropriate for different occasions, and individuals are expected to confirm to these. The expression of emotion is the indicator that the person is indeed experiencing the correct response. Conversely, there are certain emotions which are not commonly acceptable, and the expression of these, such as anger, may be considered inappropriate. Hochschild's (1983) work on those who have to structure their emotions to suit their clients' needs sits within this structuralist view. She also suggests this social construction encourages individuals to analyse and work on undesirable, negative emotions to render them more positive.

In contrast to the structuralist view, Lupton (1998) describes the phenomenological approach. This suggests that what we call emotion, is the naming of a set of physiological responses which occur in an individual, and which are mediated by their environmental and interpersonal contexts.

In both views, structuralist and phenomenological, the ability to discern emotional responses in the self and in others is considered a personal quality, often referred to as Emotional Intelligence. However, Lupton (1998) acknowledges that within the theoretical perspectives the search for the "authentic self" is difficult.

Phenomenology, as a philosophy rather than a research methodology, acknowledges the multiple realities of life, and accepts that a person's description of themselves at a particular time is their reality at that time (Hospers, 1990). Over a lifetime, any midwife may be a number of different people, as her life events influence her perceptions and behaviours. Even at any one time, she may be a number of different people to others in her life. There will be times when the midwife's experiences as a woman, enable her to integrate her multiple selves, but there may be other circumstances when her roles are in conflict. This might explain why the pregnant midwives in the current study found it difficult to apply their midwifery knowledge to their own circumstances, and why midwives did not apply their knowledge of appropriate treatment for bereaved parents to their colleagues.

Some literature which could be applied to this category has also arisen in other categories, for example, Hadikin and O'Driscoll's (2000) work on bullying suggests that there is an expectation that those who care for others will also care for each other, as does Mander's (2001) work.

Clearly, there may have been issues around role conflict of being a woman, and being a midwife. However, many felt that the experiences they had as women, went on to inform, and enhance their midwifery practice. Whilst some of this is explored in the next category on Impact on Practice, I include in the current category the issue of women sharing their personal experiences with their clients.

Sharing experiences with clients – maintaining and crossing professional boundaries
As women, the participants had experiences which impinged on their knowledge and attitudes to midwifery, and which may have affected their practice, and their interactions with their clients. As the findings show there were mixed feelings about participants sharing their own experiences with clients. One or two had done so, but some had been unhappy with the outcome, and in some cases, their clients had also not been happy. As Maria noted, when she disclosed her experience of the loss of her daughter, her clients then saw more of the real Maria, rather than the professional. Laura felt similarly about disclosing her losses to her clients. Chloe talked about maintaining and crossing professional boundaries, and, therefore, the literature was searched to determine what material was available which dealt with establishing and maintaining professional relationships, with specific emphasis on sharing experience. Some aspects of this are explored later in this chapter under the heading of the midwife-mother relationship, however, within the current section, the aim of the literature review is to examine the

integration of experience as a woman into the occupation of being a midwife, and how this relates to clients.

Guidelines from the Nurses' Registration Board of New South Wales, Australia, specifically explore the overlap between nurses' professional and personal relationships. They make it clear that the issue of self-disclosure can be difficult, acknowledging that some self-disclosure can be helpful to patients, but that disclosure used to deal with a nurse's own unresolved issues is inappropriate and harmful to the patient. Their principles of safe practice state:

> Self-disclosure should be limited to revealing information that has therapeutic value to the client
> Self-disclosure should only occur within an established therapeutic relationship
> Nurses need to carefully consider their motives for disclosing personal information (Nurses Registration Board of New South Wales, 2004)

The guidelines give examples of appropriate and inappropriate self-disclosure, two of which relate to pregnancy. The first concerned a woman who presented at the Accident and Emergency Unit with miscarriage. The attending nurse was also pregnant, but disclosed that she did not want the pregnancy, and wished she had had it terminated. The patient was very distressed at the disclosure. The second example, which is rather confusingly presented, concerned a couple who lost a pregnancy at 22 weeks gestation, but who did not want any extended (sic) contact with their baby. The attending nurse had a similar experience, but had felt guilt at not having contact with her baby. The family decided to have contact with the baby, and found the initial disclosure therapeutic, however, the nurse maintained contact with the family, who subsequently felt the nurse's involvement was then carried to extremes, and they had to ask the hospital administrative staff to intervene. My interpretation of this, is that the couple saw their dead baby, and were happy with that, but the attending nurse, because of her own experience, encouraged further contact with the dead child which then became troublesome for the couple. The accounts above convey the difficulties experienced by nursing staff in deciding to make disclosures. Although one could argue that the nurse-patient, midwife-mother relationship is different, they remain, at the moment, bound by similar professional codes of practice. Whilst the United Kingdom's various guidelines for professional behaviour from the Nursing and Midwifery Council do not include such specific advice on self-disclosure, they promote the safeguarding of all aspects of the patient's interests, including emotional well-being.

The examples quoted above relate mainly to negative experiences, however, as the literature for the initial review in Chapter One suggested, clients who were specifically asked, valued hearing about their midwife's own childbirth experience. As also previously discussed, there is little literature on the appropriate disclosure of personal experience, be it positive or negative.

For the midwives in the current study, the issues of self-disclosure to parents was sometimes problematic, and some, for example, Maria and Laura, had clearly rehearsed how they might broach the subject. There is no evidence in the current study from clients as to how the disclosures were received, so it is difficult to assess from their perspective.

This section has considered how the midwives' experiences as women impacted and was impacted on their occupation. There is less specific literature to draw on to use as data to confirm this category, however, the findings from the questionnaires and interviews have revealed new information about how pregnancy loss affects midwives as women.
The literature consulted confirms that in other areas of midwifery, personal experience may impact on practice. Some literature also highlights the difficulties of working in an environment where one's emotional state must be guarded for the protection of clients. Further, the issues of sharing experiences with clients has confirmed that the difficulties reported by participants in the current study is shared by those in similar situations. To a lesser extent, literature suggests that there may be an element of role playing within an occupation such as midwifery, particularly when personal circumstances cause emotions which conflict with those desirable in the workplace. I consider therefore, that in this study, the category which I have entitled Being a Woman, Being a Midwife is confirmed as appropriate from the literature consulted.

IMPACT ON PRACTICE

Many participants in the current study suggested that their own experiences influenced their practice beneficially. The literature examined in previous sections has indicated how the desire to improve an outcome for others informed the behaviours of many bereaved parents, such as the formation of support groups, fund raising and other positive activities. Similarly, participants in the current study, formed support groups, updated literature for particular groups, and acquired specific knowledge around certain conditions. This section now considers the midwife's direct relationship with pregnant and childbearing women, and begins with a further exploration of the midwife-mother relationship.

The midwife mother relationship

Kirkham draws together a number of studies written mostly by midwives which focus on the midwife mother relationship. The general view is that the relationship contains elements of friendship, that it should be equal, that it should be a partnership, that it is time limited, and that the longer the two are involved with each other, the more close that relationship will become (Kirkham, 2000). However, the writers generally concur that there are professional elements, and that women and midwives will approach the same relationship with different expectations, and different perceptions. Wilkins (2000:36) suggests that for both, elements of personal, emotional and biographical experience influence the development of the relationship. Earlier work by Flint (1989) also emphasises the empathic qualities of shared personal and emotional experiences in the formation of the relationship.

Pairman (2000) actively compares friendship and partnership, drawing on her study of six New Zealand midwives and their clients. She suggests that in the midwife-mother relationship, the intimacy of the relationship derives solely from its association with pregnancy and birth. However, she acknowledges that within the time limited relationship, qualities which equate to those exhibited in friendships, may be evident. She uses the term "professional friendship" to describe the relationship between midwife and client. She gives an example from her research of how a client, who felt the midwife was her friend, sought to buy her a gift. However, she suddenly realised that in trying to choose the gift, she knew less about the midwife's personal taste and likings than she expected (Pairman 2000). Her perception of the midwife as a friend was predicated on their mutuality in the woman's birth experiences, but did not extend outside the boundaries of the professional relationship. Pairman draws on the work of Caroline (1993), who used concept analysis to examine the construct of close adult friendships. As the previous discussion in this chapter showed, friendship involves, amongst other things, long-term commitment to sustaining the relationship. Pairman suggests that, using Caroline's definitions, the midwife-mother relationship constitutes a borderline case, in that it shares some of the characteristics of the construct, such as intensity, mutuality, and meaningfulness, but lacks the qualities of affection and commitment.

Features of friendship are its voluntary nature, its endurance over time, its occupation of a primary place in the friends' life, its intimacy and love. Friendship also needs proximity, investment of time and emotion, and, importantly, the personal capacity to develop friendship. Caroline also outlines the consequences of friendship for both parties, suggesting that feeling loved, empowered, and experiencing enhanced self esteem are some of the benefits of friendship. Her analysis of the constructs includes other relationships which may be time limited, and may lack the intensity of the emotional involvement in friendship. Caroline's and Pairman's work provides an insight into how two people in a relationship may misperceive its nature. Wilkins (2000) explores this further in her study of the midwife-mother relationship. She conducted a longitudinal study of 43 women and their midwives using in depth interviews, with a further sub study of 7 of those 43. She was puzzled initially by what she called the mismatch between what the midwives and women told her about their relationships and by what the literature on midwives and their relationships with women suggested. She suggests that prevailing views are based on a professional paradigm, which locates midwives and their clients in completely separate social dimensions. Wilkins comments that such a view splits the personal and professional components of the midwife's personality, and prevents her from drawing on her biographical and experiential knowledge. She further asserts that this view splits midwives from women, and midwives from themselves. This accords somewhat with my view presented earlier about the potential role conflict which midwives might experience as they struggle to maintain their professionalism. This façade divorces them from their own personal experiences, but may make it easier for them to deal with their everyday working lives.

Walsh (1992) also documents women's feelings of partnership and friendship with their midwives, and the sense of grief they felt when their relationship with their midwife came to an end. Hunter (2001), commenting on Walsh's work, suggests that midwives may also feel a sense of loss when their relationship with particular women comes to an end, and that this creates further emotion work for them. However, Leap (2000) emphasises the need for midwives to see the temporary nature of their relationship with women pointing out that once the baby is born, the woman has a new and more important relationship to concentrate on.

Current organisation of maternity care means there are two ways in which clients and midwives may meet and form relationships. First, especially in the hospital situation, the midwife may encounter a number of different women, and not see any of them more than once, as they attend for antenatal care, and when they are in labour. In these short encounters, as Kirkham (2000:245) suggests in her commentary on one of my previous studies, there is little motivation for the midwife to move beyond the most superficial greetings before proceeding to the business in hand. In these circumstances, the midwife may feel it is not worth the emotional distress involved in self disclosure if she is unlikely to see the woman again. However, when women's questions about whether or not the midwife has children are brushed aside with humour or one line responses, the woman will seek other signs that she will be cared for, and that she can trust the midwife. As mentioned in Chapter One (page 32), we cannot know why the woman is asking the question in the first place, so it is difficult formulate an appropriate answer. In the absence of knowledge about her midwife in the sometimes impersonal hospital setting, women may respond in a way which the midwife, in an emotionally compromised state, finds hurtful. This is damaging to both parties. The woman is already disadvantaged, as she is experiencing physical and emotional changes in relation to her pregnancy, her hospital visit occurs solely because of her pregnancy, and she is likely to feel vulnerable, and that events are already out of her control. Women's responses to this type of situation are well-documented, (Edwards, 2004). They are afraid of alienating their caregivers afraid that information will be withheld if they are not compliant, afraid that if they assert their wishes the exact opposite of what they want will happen (Green et al, 1998). Furthermore, the physiological consequences are that the woman may stop labouring if she feels unsafe. If the woman were in her own environment, or were in her own job situation, she would probably act in a different way. She would be exhibiting the emotional temperance and control the midwives in this study spoke of when they steeled themselves to deal with pregnancy and birth in the face of their own losses. Edwards (2004) suggests that the most powerful element of the midwife-mother relationship is trust. However, the women Edwards quotes felt they were unable to establish any relationship with their midwives, let alone a trusting one. The issue of trust has arisen before in this chapter, in connection with horizontal violence, and the need for midwives to have a trusting relationship with their supervisors. However, trust must be built, and perhaps midwives are not always able to convey that they are to be trusted. The issue of self presentation, and of deception as a poor basis for a relationship arose in Chapter One (page 33), and I quote below an example of the reasons a midwife in one of my studies Bewley, 2000b) gave for engaging in deceptive behaviour.

The midwife said that she had once lied and told a woman she had children when she had not. The timing was significant, in that it occurred when the woman was in labour in the crucial transition between first and second stage. This is a time when, however well a woman has coped previously, she may become acutely distressed, and will beg for analgesia, ask for a Caesarean Section, and seem totally unable to cope. Once transition is accomplished, the woman moves into the more focussed second stage, and seems to recover her sense of control. Mander (2002) reviews the transitional stage of labour, and refers to the woman's "frank and honest articulation of her likes and dislikes at this time...which can be interpreted as rudeness" (Mander, 2002:10). In the case I highlighted, the midwife who had been untruthful did so because she felt that the woman wanted assurance that someone with her had shared and could identify with her pain. In a similar situation, in another of my studies (Bewley 2000a) Rosie, a midwife who was experiencing infertility, was asked by the labouring woman's partner if she had children, and when she replied no received the angry response from the woman:

> Then how the ****can she look after me? (Bewley, 2000a:p 175)

The midwife who had misrepresented her status as a mother was in the process of changing jobs to move to an area where one to one midwifery care was in operation. She envisaged a longer process of getting to know her clients, where the issue of her childlessness would be broached early in the relationship. Her skills and experience as a midwife who had supported many mothers would transcend her lack of experiential knowledge (Bewley, 2000b). The second midwife was also providing care in the type of environment which precluded the woman knowing her midwife prior to being in labour. Her honest answer left her feeling devalued; we have no way of knowing how the woman felt, but her response sounds as though she felt angry or cheated at what she perceived was a lack of personal experience, and as a consequence, an inability to understand her pain.

The types of relationships between midwives and their clients which are promoted in one to one schemes and similar organisations of care, facilitate disclosure and encourage the personal investment of the midwife. Julia, in the current study, spoke of the benefits which accrued from her close relationships with the women she had been seeing for antenatal care, and their responses when they knew she had lost her baby.

However, there is a tendency for an idealisation of the midwife-mother relationship, and for certain aspects of continuity of carer to be overlooked. For example, if the midwife fails to engage the woman's trust from the outset, as Edwards (2004) suggests, then there can be little satisfaction for the woman in the relationship. Although the traditional, NHS dominated organisation of maternity care has been cited as detrimental to women, and to midwives, there are other factors involved. Hunt (1997) cites four vital areas in organisational structures, one of which is the staff. As previous discussion in this chapter suggests, some staff are unkind to women and to each other (Hadikin and O'Driscoll, 2000). However, there are also accounts by women, and by midwifery students, of the positive contributions made by certain midwives to their care and education (Anderson, 2000). The midwifery profession does not comprise a homogenous group of people, all exhibiting the same or similar behaviours. It is notoriously difficult to discern what life experiences contribute to personality, as the discussion on self in the previous section of this chapter showed.

For the midwives in the current study, therefore, the ability to contribute to the formation of the relationship may be compromised by the impact of their own reproductive experiences. Like any other grieving person, they needed to work through the processes of grieving to reach a stage where they could use their experience to enrich the midwife mother relationship. Within the relationship, the mother must remain the central focus. She is the client, her pregnancy and labour are the sole reason for her engagement with the midwife. However, in order for midwives to support and nurture their clients, perhaps they need to be supported and nurtured themselves. Perhaps there is also merit in further study, exploring the midwife-midwife relationship.

There were other tangible benefits, which the participants documented, such as formation of support groups and increase in knowledge in particular areas, which they used to inform and improve their practice. Literature already used to support the category Nature and Impact of the Loss, confirms that many people who experience personal loss use this to improve the situation for others in similar positions. Other examples are those of Anne Diamond, the journalist whose son Sebastian, died from Sudden Death Syndrome, and who became an influential campaigner for the Government's Back to Sleep programme. Some literature from nursing sources documents the personal experiences of nurses as being influential both in their decision to become nurses, and in their choice of specialism (Hicks, 2000; O'Neill, 2000).

The category Impact on Practice has examined literature available to support the category, and has found similar examples of using personal experience to improve the situation for others. The consequences for the midwife-mother relationship have also been examined, since the experiences of participants in the current study influenced how they practised as midwives. The available literature, which is used as data, has reinforced what the participants said about the nature of their relationships with clients, and has confirmed the category, whilst suggesting that further work needs to be carried out on midwives' views of the midwife-mother relationship.

ESTABLISHING THE CORE CATEGORY

This chapter has drawn together the findings and the available literature as they seem to be related. In the majority of cases, it is evident that in many ways, the experiences of the midwives closely mirror that of non-midwives. The areas which are significantly different are those which relate specifically to being a midwife who has experienced a pregnancy related loss. These areas have been extrapolated from the categories to illustrate the core category, and are summarised in the next section.

AREAS WHICH CONTRIBUTE TO THE CORE CATEGORY

It has been established that the experience of pregnancy loss affects all aspects of women's lives. Within the core category, those elements from all the contributing categories, which specifically affect midwives, have been extrapolated. This is an illustrative rather than a reductionist approach. This approach acknowledges the totality of experience, whilst highlighting particular important and relevant areas which contribute to knowledge about midwives' experience of personal pregnancy loss. I accept that many of the issues cited as exclusive to midwives may also apply to other health professionals, but since the current research is about midwives, I can at this stage only relate it to them.

The findings show that some pregnancy related losses described by the participants occurred prior to their becoming midwives. The experience may have been the reason for becoming a midwife, or becoming a midwife may have triggered memories of a pregnancy related loss, sometimes unexpectedly. Also in the current study, some participants experienced their losses after being midwives for many years. In all cases the experience influenced them as midwives, and the fact of being a midwife influenced their perceptions of the loss.

It was sometimes expected that their midwifery knowledge would make it easier for them to make decisions about their own pregnancies, but this was not always the case. That they were midwives sometimes meant they had "special" treatment, for example, easier access to services, being assigned to the most senior person when they needed care, and action being taken quickly. However, for some, being a midwife made the whole experience of pregnancy loss more difficult, and being faced with other women's pregnancies every day was felt to have hindered the grieving process.

Those who experience pregnancy-related loss may have difficulty being with pregnant women or those with new babies. They may feel jealousy and resentment towards other couples and their pregnancies, and to their babies, particularly in cases where they judge the parents to undeserving of the baby. Conversely, they may be unable to deal with the joy of couples about their pregnancies. Midwives who experience pregnancy related loss may encounter such situations in their day to day work. Some participants had left clinical practice for management or teaching to avoid direct clinical work with mothers and babies. A small number had left midwifery altogether. However, most participants agreed that it was their own baby they wanted, and they were not overly distressed by other babies. One or two may have had fleeting thoughts about baby abduction, but these remained fantasies. Nevertheless there was an awareness of the postulated associations between pregnancy loss, depression and baby abduction. This may have made participants reluctant to seek help for depression, particularly in light of government reports about high profile baby abductions and child murders.

Many participants reported being protected from potentially difficult situations by vigilant colleagues. However, they were also sometimes unable to avoid the rooms where they had received treatment, or where their baby had died. Anniversaries such as the expected date of delivery, and anniversary of the death were particularly difficult for participants to deal with. However, there were other, often unexpected triggers for grief, which they encountered in their work, such as dealing with women in similar situations.

Those experiencing infertility found it difficult to cope with shift work and night duty, especially when they needed time off for hospital appointments, or when they were having treatment cycles for their infertility. They appreciated management consideration for their condition, and the support of managers in arrangement of off duty.

Sensitive placement in the work area can help with the above, however, the midwifery environment was not always conducive to such placement, and there was an emphasis for some participants on fulfilling the entire role of the midwife. This again led to some participants wishing to leave midwifery.

The organisation of midwifery care can be supportive in promoting midwife-mother relationships based on continuity. Those participants who reported close relationships with their clients found them supportive and mutually beneficial. However, the way midwifery care is organised to provide continuity is crucial in promoting the emotional well being of midwives. Those experiencing pregnancy loss, may simultaneously be working in a stressful and demanding work environment. Bullying was mentioned by some participants and from the literature consulted seemed to be an influence on some midwives leaving the profession.

Trust is an essential part of relationships within midwifery and with pregnant and childbearing women and their families, however, midwives experiencing pregnancy related loss sometimes found it difficult to answer questions about their own circumstances completely honestly. They also found themselves having to express feelings of happiness for pregnant and newly delivered couples, when their own emotions were those of sadness and grief. Some seemed to have reached a personal resolution about their circumstances, and this integration of the loss into their lives enabled them to be supportive to women in similar circumstances.

Many participants spoke of their love for midwifery and, despite their difficulties, continued to practise. They used their experiences to inform their practice, and to provide tangible forms of support such as information based on an increase in knowledge consequent on their pregnancy related loss. They formed support groups, and made sure up to date literature was available for their clients. However, they were often unsure when it came to sharing their experiences with clients. Where they thought it would be helpful they did so, and sometimes received what they felt was positive feedback. On other occasions they deliberately withheld their own views, where they felt they might be upsetting or frightening. Occasionally, they told women outright that their personal experiences made them unable to give unbiased information, particularly about antenatal screening tests.

There was an expectation that midwifery colleagues would be supportive and sensitive, and there were many positive reports of kindness from colleagues and managers who listened without judgement, and who expressed genuine interest in participants as people, not just as a pair of hands. However, there were also many expressions of surprise at some of the seemingly callous treatment they experienced in the form of insensitive remarks, and insensitive allocation of work. There was also a view that midwives, as carers need to be cared for themselves.

The Core Category for the study contains the essence of what has been revealed by the findings from the initial literature review, the questionnaires, the follow up interviews and the subsequent literature review, particularly as they relate to midwives. The Core Category, encapsulates the totality of the experiences reported by the participants. It is touched by and touches every other category. The core Category and the basis for the title of the research derives from the findings which pertain to midwives' experiences of their own pregnancy related losses, and is, therefore:

> ON BEING A MIDWIFE WHO HAS EXPERIENCED A PERSONAL PREGNANCY RELATED LOSS

The core category also forms the basis for the models and the theory presented in Chapter Six.

Conclusion

This chapter has drawn on available literature to confirm the final categories, and to show how being a midwife influences and is influenced by personal experience of a pregnancy related loss. The next chapter draws together the thesis, the final categories and core category, and presents the theory and conceptual models arising therefrom.

CHAPTER SIX

CONCLUDING THE STUDY

Introduction to the Chapter

The study has explored the experiences of midwives who have their own pregnancy related losses. Chapter One outlined existing literature on the topic to confirm the need for the study, and to determine the research question. Chapter Two described the research design, and Chapters Three and Four presented the findings from questionnaires and from interviews. Chapter Five returned to the literature, and, using the literature as further data, examined the findings in greater depth. Chapters Three, Four and Five showed the process of development in determining the categories and core category of the research. The current chapter presents the theoretical principle arising from the research. It also offers two models, which offer visual representations of two aspects of the study. The first to show how the categories and core category were built to represent the midwife who has experienced a pregnancy related loss, and the second to show the interface between the midwife and her client, where the midwife has experienced a personal pregnancy related loss. The current chapter makes some tentative recommendations for further research, for management and for education. First, the categories are confirmed.

Confirming the categories and core categories

The previous chapters have shown how the sub categories contributed to the categories, and how data were relocated during the constant comparative analysis between data from questionnaires (Chapter Three), interviews (Chapter Four) and literature (Chapter Five). The discussions in Chapter Five led to the final categorisation as follows:

Category One: Nature and Impact of the Loss
Category Two: Support, Self-disclosure and Empathy
Category Three: Practical and Emotional Issues Surrounding Work
Category Four: Being a woman, being a midwife
Category Five: Being part of the research
Category Six: Impact on own midwifery practice
Core category: On being a midwife who has experienced a personal pregnancy related loss

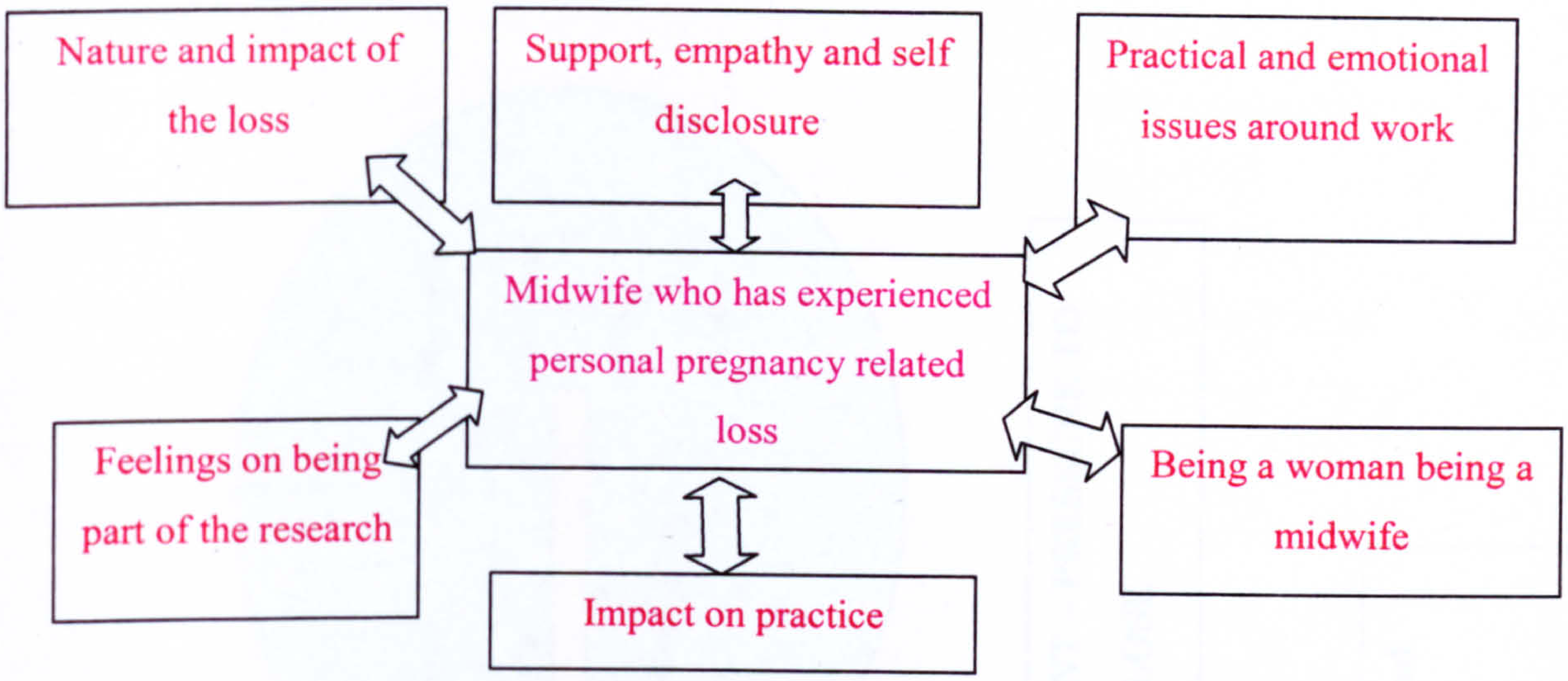
Following the first of Sarantakos' (1998) four principles, originally outlined in Chapter Two, each of those midwives acts as a case study, and her experiences are valid in their own right. Each midwife's account has added to the body of knowledge about how the midwife's personal experience of pregnancy related loss affects her as a woman and as a midwife. Within the limitations of the study already highlighted in Chapter Two, and in Appendix Four, I have sufficient confidence in the findings from the study to offer an emergent theoretical principle.

Presenting the conceptual models and the theoretical principle

One of the aims of the study, as stated in Chapter Two (page 46) was to examine, from a theoretical perspective, the relationship between client and midwife where the midwife is experiencing or has experienced a pregnancy related loss. The intention was to produce a model or models to provide a visual representation illustrating the abstract concepts involved in establishing and maintaining a professional relationship where the midwife has experienced a personal pregnancy related loss. In strict theoretical terms, given the wide debates amongst nursing theorists about what constitutes a model (Meleis 1997), and the frameworks used for testing models as presented by Fitzpatrick and Whall, (2005), there could be some semantic discussion about whether what follows can be termed models. As Meleis (1997) suggests, some models indicate relationships, though not necessarily causal relationships, between systems, or in this case, categories, which share similar properties. Meleis (1997) comments that models can be used to simplify and illustrate more complex descriptions of reality, and to underpin theory. This was the intention behind the formulation of models in this study. The further intention was to establish a theory relating to the midwife who has experienced pregnancy related loss. First, the two models, are presented.

Model one (figure 6.1) represents the midwife who has experienced her own pregnancy related loss. The model shows how all the categories impact on and are impacted on by the midwife's own loss. This model may be helpful in providing a visual focus which shows all the categories and the core category simultaneously.

Figure 6:1 Model to represent the concept of the midwife experiencing her own pregnancy related loss



A second conceptual model is proposed from the research, and provides a visual representation of how the midwife experiencing pregnancy loss operates in the midwife-mother relationship. It draws on what the midwives revealed about how they decided what they could disclose about themselves, both to protect themselves, and to protect women from knowledge they thought might worry them. They spoke about how they operated within what they termed "professional boundaries", how they could feel hurt by particular remarks, and how they put on a brave face in order to continue their midwifery work. The midwife may choose to keep her personal information behind her public persona. In contrast, the pregnant woman's most personal details are almost always known in great detail, and she has little option but to disclose everything, including her own pregnancy losses. The model shows how the midwife balances her personal and professional personae, as two halves of the sphere, yet reveals the imbalance in the midwife-mother relationship. The midwife has a professional responsibility to provide non judgmental care for women regardless of their circumstances. The woman, whilst sensitive to the fact that her behaviour might be judged, has no such responsibilities to the midwife, and is under no professional obligation to keep her opinions hidden.

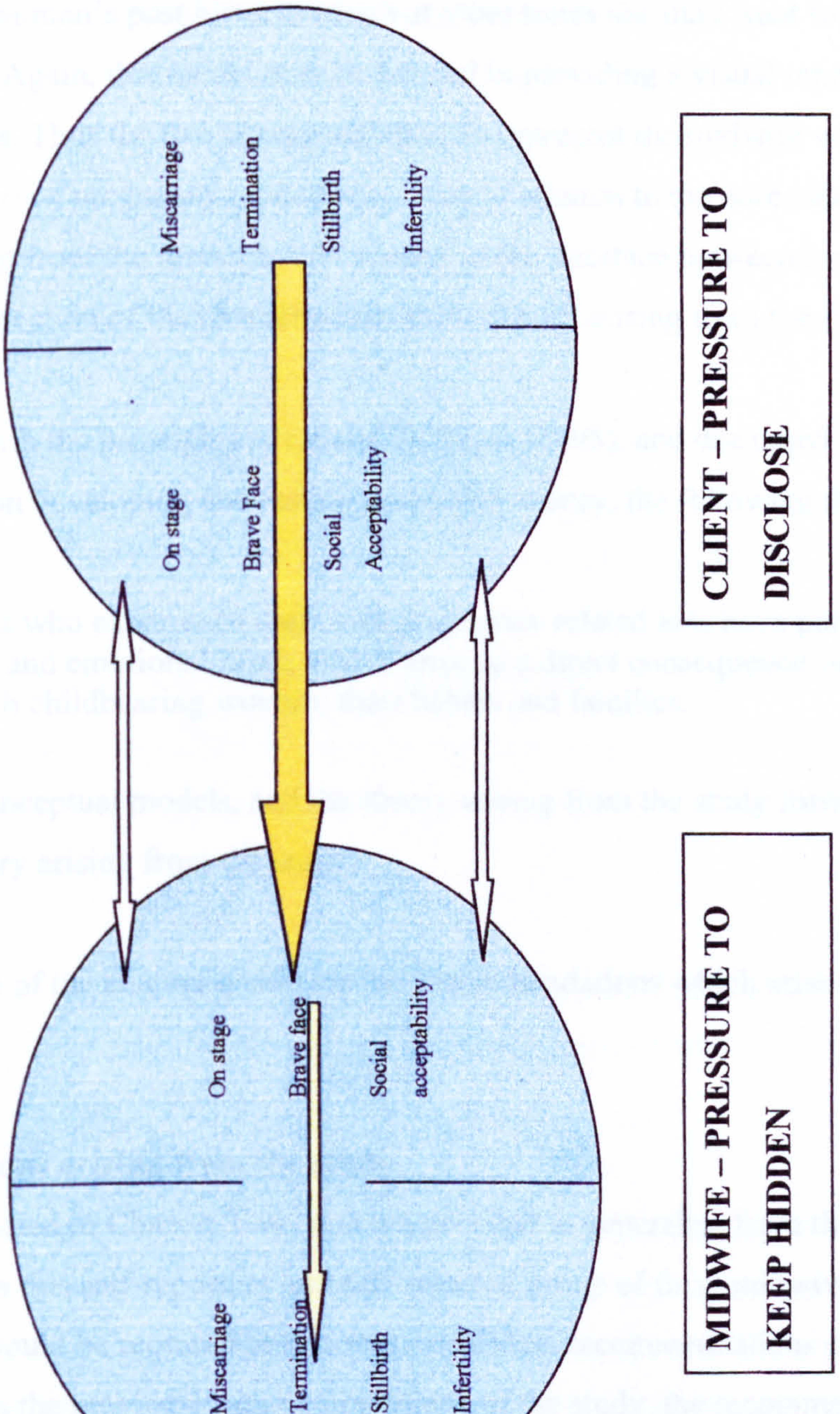


Figure 6:2 Model to show the interface between midwife and client where the midwife has experienced a pregnancy loss

The stage as metaphor informed some of the discussion in Chapter Five on Being a Woman, Being a Midwife. The midwife and the mother are "on stage". Both have to consider the social acceptability of what they disclose to each other. The midwife keeps her losses behind the central line, although there may be times and circumstances when her relationship with her client allow "leakage" between the public and private personae. In contrast, the woman's past history, which at other times she may want to keep hidden, is open to view. Again, this model may be helpful in providing a visual representation of abstract concepts. Thus the two conceptual models represent the midwife who has experienced her own pregnancy related loss. First in relation to the core categories and categories arising from the research, and second in the interface between herself and her client. The next section of the chapter presents the theory arising from the research.

In accordance with the principles advanced by Bryar (1995), and discussed in Chapter One (page 13), on developing and testing midwifery theory, the following theory arises from the thesis:

> midwives who experience their own pregnancy related loss have particular practical and emotional needs which arise as a direct consequence of their work with childbearing women, their babies and families.

Together, the conceptual models, and the theory arising from the study form the substantive theory arising from the study.

The next section of the chapter addresses the recommendations which arise from the study.

Recommendations arising from the study

As previously stated in Chapter Two, it is not possible to generalise from the findings, which arise from this self-reporting and self-selected group of forty midwives. Further, larger studies, would be required before more confident recommendations could be made. However, within the previously stated limitations of the study, the recommendations arise directly from the findings, and some may be useful for further studies. More importantly, it is acknowledged that the diversity of experience around pregnancy loss means that recommendations may not apply in every case. There is no intention to suggest that responses to loss are universal. The most important consideration is, if in any doubt, to ask the person concerned how they feel, and what they would like to happen. As the findings from the study, and the literature suggested the climate in some organisations indicates an absence of trust, and that bullying and harassment affect a number of midwives, whether or not they have experienced pregnancy loss. Literature has also highlighted that lack of support for midwives, and general feelings of low self esteem, contribute to the high number of midwives leaving the profession (Ball et al, 2002). This is not to suggest a causal link between midwives' personal experience of pregnancy related loss and attrition, rather to acknowledge this as a potential contributory factor where organisational support may already be lacking.

Midwifery requires considerable emotional investment, and emotion work. Findings suggest that a supportive working environment, a degree of personal control over work, together with a supportive home life, are beneficial in promoting midwives' general feelings of well being, and helping to deal with emotion work. Team building activities were shown to be beneficial in establishing support systems in organisations. These might include reference to individual's own experiences and how these might impact on practice. That these were in place was not always evident, either in the findings from the participants, or in the literature consulted.

Continuity of care and of carer can benefit both midwives and women. It leads to early establishment of the relationship and may allow for an openness which can be enriching for the woman and the midwife.

Despite the difficulties raised by the participants, there were many positive comments in the study relating to the personal qualities of individual colleagues and managers who exhibited care and concern, and who were emotionally and practically supportive in many ways. These positive aspects are drawn on to produce realistic recommendations directly related to the findings. It is acknowledged that the study is small, the sample diverse in experience, and that the findings need to be verified by further studies.

However the recommendations are offered as potentially helpful in the light of what has emerged. Each recommendation is preceded by a brief review of the findings on which it is based.

The first recommendation concerns the midwife's return to work following pregnancy related loss. There is little literature on specific support on return to work, however, some preparatory information on how they might feel in certain situations may be helpful. They might need to consider how they will deal with significant dates, anniversaries etc, and how to arrange their work to take this into account. Participants commented on how valuable it was to have their wishes about where they wanted to work taken notice of, and how they appreciated being able to change locations according to their feelings. Anticipation of difficult dates and locations on behalf of participants by caring colleagues and managers was greatly valued. The findings clearly identified groups of clients and situations which participants found it difficult to deal with. Midwives in the current study suggested that in some cases they were able to identify people, times or geographical areas which directly and adversely influenced their practice, and that these might have been avoided.

Midwives might need to think about how they will answer questions from clients about whether they have children, and to consider a response which they are comfortable with. This may need some practice, and might be accomplished in a counselling situation, within, or outside the work setting. Midwives are likely to encounter thoughtless and inappropriate remarks, and might need to consider how they will deal with these.

Midwives returning after pregnancy loss, or after diagnosis and/or treatment of infertility may need to concentrate their midwifery input to those places where they feel they can function effectively, even if by doing so they cannot fulfil the full role of the midwife. Their sensitive treatment at this time may enable them to remain in the profession, and, at some time in the future, resume the full role.

Recommendation: Midwives returning to work after pregnancy related loss may find a preparatory meeting with managers helpful to address their needs in relation to the potentially difficult areas highlighted above. Such a meeting could be supportive for the midwife, but is also important from a managerial and supervisory perspective. Guidelines addressing issues such as potentially difficult areas of work, forthcoming significant dates, and how to deal with seemingly insensitive remarks may be helpful for use at such a meeting.

Participants who accessed counselling spoke positively of their experiences, some were unable to access counselling, and some were happy that they did not want counselling.
Recommendation: Midwives experiencing pregnancy related loss could find it helpful to be offered counselling. The offer should be made more than once, and counselling should preferably be outside the workplace. The cost of such counselling may be an issue. However, many NHS Trusts already have facilities for staff counselling. There is also access to counselling via professional bodies such as the Royal College of Midwives. Information about access and costs should be provided at periodic intervals.

Midwives in the study who were being investigated or having treatment for infertility highlighted specific needs for example, avoiding night duty and being able to have time off to attend appointments.
Recommendation: Some midwives have specific needs associated with treatment or investigations for infertility. For example, they might want to avoid night duty and be able to have time off to attend appointments. Making their needs known to management can provide an opportunity to negotiate these issues. If necessary occupational health departments could also negotiate special duties under the terms of the European Working Time Directive (1993).

Midwives experiencing pregnancy related loss may also become clinically depressed, and it can be difficult to differentiate between grief associated with loss, and depression. The organisational approach, whilst maintaining the first principle of duty of care to clients, is ideally one which facilitates disclosure of depression without fear of censure.

Recommendation: Clear guidelines for staff and managers about dealing with depression, and about implementing the recommendations of the Clothier and other reports with sensitivity, would be helpful.

Annual and other supervisory meetings may provide a venue for midwives to talk about personal experiences which are affecting their performance. However, literature consulted in connection with this study concludes that the supervisory relationship is not necessarily supportive in this respect.

Recommendation: Research is needed to determine what support systems, other than supervision, could benefit midwives who are experiencing pregnancy related loss, or other life problems which have the potential to impact on their work.

Support organisations can provide valuable help for people in a number of situations. Midwives, and others in similar health related professions may need specific advice and support to enable them to function in the work environment.

Recommendation: that the findings from the study are disseminated to the support groups originally involved in the study, so that they can consider incorporating relevant advice into their literature.

Whilst the findings apply to midwives in the first instance, there is a strong possibility that women in other occupations who have close interactions with pregnant and childbearing women may have similar experiences. This could include nurses working in gynaecology, infertility clinics, family planning centres, and paediatrics. Health visitors, social workers, and female doctors may also be affected.

Recommendation: that the findings from the study are disseminated to as wide an audience as possible via presentations at conferences and study days, and by publication in book form, and in articles appropriate for a wide range of journals. Professional organisations such as the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners, Health Visitors Association and Royal College of Nursing could also benefit from having the results.

Participants seemed to have little opportunity during their educational programmes to consider how their life experiences, whether pregnancy related or not, might affect their interactions with clients.

Recommendation: initial and ongoing midwifery education should consider students' and midwives' past life experiences in connection with pregnancy to raise issues of self awareness. This may enable them to see how their experiences may impact on them as midwives, and how midwifery could cause them to review past experiences. However, educational sessions should not encourage disclosure of personal experiences in an open setting. It is preferable to discuss the general principles of how personal experience can impact on midwifery. Ideally, they should be conducted by a skilled facilitator who can advise and guide on appropriate disclosure and discussion in a safe environment. In the university setting, student midwives and midwives undertaking post qualifying study can be directed to the university counselling service. In a NHS Trust, staff counselling services may be used.

Participants were surprised at the insensitivity of remarks made to them by their colleagues, who they felt should know the kind of remarks which would be upsetting. Clearly this is an area where practitioners may need reminding about the need for sensitivity.

Recommendation: initial and ongoing input can help remind practitioners of the need for sensitivity in dealing with clients, and colleagues. This may be individually in supervisory sessions, by case conference or case analysis, or by team building activities such as awaydays, examining aspects of client/colleague relationships.

Little of the literature consulted considered the impact of midwives' own life experience on their practice, and in research and opinion papers some assumptions were made about midwives who have children.

Recommendation: future research into midwife-mother relationships could consider the potential influences of midwives' own pregnancy and childbirth experiences on attitudes and practice.

All the recommendations derived directly from the findings, are realistic and, within the limitations already discussed, able to be put into practice.

CONCLUSION

The study has now reached its end. It arose from my personal observations about my colleagues, and, though slightly less so, from my own experiences as a midwife who does not have children. It has drawn extensively on the accounts of a group of midwives who have all experienced a pregnancy related loss. Many shared their stories with the express intention of improving the experiences of others who might find themselves in the same situation in the future. Others said they found resolution for themselves in writing about their experiences. There have been examples from their stories and from literature consulted, about unnecessarily harsh and unkind treatment from other midwives. However, throughout, there are examples of warmth and kindness from which lessons in how to support grieving colleagues can be learned, and from these examples, are drawn the recommendations for the future.

It is difficult to bring a study such as this to a close; the experiences of the participants do not end with the completion of the research. For many of them their losses are ongoing as perhaps they continue with treatment for infertility, they await the allocation of a child for adoption, or the anniversary of their baby's death comes around again. However, the writing must end, and so I close with thanks to all those who shared their experiences, and an expression of hope that I have increased awareness and understanding of midwives' personal experiences of pregnancy related loss.

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APPENDIX ONE - QUESTIONNAIRE

MIDWIVES' EXPERIENCES OF REPRODUCTIVE OR PREGNANCY LOSS

LEAD RESEARCHER - CHRIS BEWLEY
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Dear Colleague

Thank you for participating in this project. I am grateful for your interest, and for your time. The following questions are designed to help gain a picture of you and how you feel. Please continue on a separate sheet if there is not enough space on the form. I am interested in you and your experiences, so please write whatever you feel you would like to write.

With thanks

Chris Bewley

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1. What is your age group? (please circle)

20 – 29 30 – 39 40 – 49 50 – 59 60 – 69 Over 70

2. How long have you been a midwife? (or student midwife)?

3. Which areas do you mainly work in? (eg Teams, Labour Ward, Clinic)

4. Are you working as a midwife at the moment?

5. If you are not working as a midwife, please let me know what you are currently doing.

> **The following section asks some questions about your reproductive or pregnancy loss. The questions are only intended to guide you. Please don't leave anything out, which is important to you. It may not be mentioned in the questions simply because I haven't thought about it. If it is important to you, it is important to me.**

6. Please tell me something about the circumstances of your own reproductive loss, or problems (please continue on a separate sheet if necessary)

7. Was there one or more particular events (such as miscarriage, loss of a baby, diagnosis of infertility, onset of menopause), which were significant to you in your personal and working life?

8. How did you feel when you first returned to work?

9. Did your work colleagues, managers, family or friends do or say anything, which was particularly helpful or unhelpful?

10. Were there any aspects of your daily working life which were more difficult than others?

11. How did you cope with any difficulties?

12. How do you feel now about being a midwife?

13. What prompted you to respond to my letter in the RCM Midwives Journal?

14. Please tell me anything else about yourself which you think would be helpful (please continue on a separate sheet if necessary)

Thank you for taking the time to complete this questionnaire. Your reply will be treated in confidence and may be completed anonymously. However, if you are happy for me to contact you for further information, or a follow up interview, please complete the next section:

Name...

Address...

..

Post

code..

Telephone: Home....................Work (if appropriate) ....

APPENDIX TWO – DETAILS OF PARTICIPANTS

	Name (Pseudonym)	Background
1.	Felicity	Felicity had a "social" termination of pregnancy following divorce from her husband, and one year prior to starting midwifery. She has two sons
2.	April	April had treatment for infertility due to polycystic ovary, and also had a miscarriage. She has now reached the menopause, and does not have any children.
3.	Rhona	Rhona has four children, all girls, but after her second daughter, she was pregnant with a son who died in utero, she does not say at how many weeks.
4.	Audrey	Audrey and her husband had treatment for infertility, including to attempts at IVF. The second was successful, and Audrey had a baby, although she had a difficult pregnancy due to pre eclampsia, and had an emergency Caesarian Section.
5.	Moira	Moira has had treatment for infertility problems, and had IVF. She became pregnant spontaneously, but subsequently miscarried her baby. Moira also took part in one of my previous studies.
6.	Janine	Janine experienced two miscarriages. She took part in a follow up interview.
7.	Julia	Julia had two children when she became pregnant with Raymond. She had a number of problems in the pregnancy, and went into preterm labour at 24 weeks. She and her husband decided not to opt for resuscitation due to the prematurity, and Raymond died. Julia wrote her account ten years to the day of his death.

8.	Deirdre	Deirdre's baby Hayley died in utero at 32 weeks, with no known cause. She was not a midwife at the time, but was teaching with NCT (National Childbirth Trust). She now has two children and is currently a student midwife.
9.	Dora	Dora and her husband have not been able to conceive after 4 years, and are having initial tests into infertility
10.	Janet	Janet had a miscarriage, and had a number of gynaecological problems which caused infertility. She was awaiting IVF when her health deteriorated and she needed a hysterectomy. Janet wrote an article for a women's magazine about being a midwife and being infertile.
11.	Lucy	Lucy is having treatment for infertility, including IVF, non of which has been successful to date.
12.	Flora	Flora had a termination of pregnancy following problems with an amniocentesis. Flora took part in a follow up interview.
13.	Linda	Linda had problems with infertility, and had an ectopic pregnancy. She went on to have two girls, both conceived following fertility Treatment
14.	Caroline	Caroline's husband had cancer of the testicle, and had chemotherapy. They saved some of his sperm, and Caroline had 3 attempts at IVI, which were unsuccessful. She had 3 IVFs of which two were successful, but she miscarried at 8 weeks. She and her husband have two frozen embryos left, and she was due to have another IVF at the time of completing the Questionnaire
15.	Sally	Sally had her first child after infertility treatment. Her second pregnancy ended in miscarriage after 11 weeks, and she is now unsure how she feels about attempting another pregnancy.
16.	Sadie	Sadie has had seven miscarriages over a period of 9 years. She has one son. She has had various Gynaecological problems, and at the time of completing her questionnaire was awaiting IVF.
17.	Chloe	Chloe had a termination of pregnancy for personal reasons, is now

		married, and experiencing infertility. Chloe took part in a follow up interview.
18.	Wylva	Wylva has three children, but also had three miscarriages, at a time when there was less support for women having miscarriage than there is now. She set up a support group and made a bereavement package to help women in her hospital.
19.	Siobhan	Siobhan and her husband have had a full range of fertility tests which reveal nothing abnormal for either of them. They have had 8 IVI/IVF attempts. Three ended in miscarriage, and the others did not work. She had just had her last failed IVI at the time of writing her Questionnaire
20.	Sylvia	Sylvia has been married for 14 months and has been trying for a baby during that time. She has endometriosis, and thinks she might not become pregnant without IVF.
21.	Davina	Davina and her husband had infertility problems for ten years. During that time, she was very depressed, and at one point became suicidal and had to be hospitalised. She also had an eating disorder. She then had IVF, one embryo did not take, but the other split and they had twins. Diane had a difficult pregnancy, but her twins were healthy, and were 22 months old at the time of completing her questionnaire. All her mental health problems have now disappeared.
22.	Kate	Kate had two ectopic pregnancies, one following a natural conception, and one after her fourth attempt at IVF. Her last ectopic left her sterilised which she found difficult to cope with. At the moment, she and her partner do not want to consider adoption.
23.	Sallyanne	Sallyanne and her husband had infertility problems and tests revealed a premature menopause. She has had 7 unsuccessful cycles of IVF treatment, which has been successful to date. She left midwifery for 3 months, as she found it too difficult to continue, however, she missed it and has returned. She is going to continue with IVF.

24.	Vanda	Vanda had a stillborn baby and her story suggests a degree of negligence in her care, which she has followed up. She became a midwife after this, but experienced some problems convincing managers that her mental health was satisfactory. Vanda took part in a follow up interview
25.	Jilly	Jilly's baby Jonathan was conceived after fertility treatment. He was a large baby, and suffered brain damage following shoulder dystocia at delivery. There was also negligence in Jilly's care during delivery. Jonathan lived for 28 days before Jilly and her partner decided to allow his life support to be switched off. Jilly now has another son, Martin, who was also conceived following fertility treatment. Jilly experienced depression seven years after (but related to) Jonathan's death. She has now left midwifery and works in a completely unrelated job.
26.	Polly	Polly had infertility treatment in the 1970s, and became pregnant, only to experience a.miscarriage. She continued infertility treatment until she was 40, then was told she could not carry on because of her age. She went on to adopt two sons, but has still kept the results of her pregnancy test as a reminder of her only pregnancy.
27.	Anita	Anita had a miscarriage prior to having her children. She took part in a follow up interview.
28.	Martina	Martina had four miscarriages. She also had a termination of pregnancy when her baby was found to have anencephaly. She has one child, a daughter. Two of her miscarriages, and her TOP occurred in the month of September, which still remains a difficult month for her. Martina took part in a follow up interview.
29.	Maria	Maria's first baby, Anna, was shown to have abnormalities on scan, and Maria agreed to a termination of the pregnancy. She then went on to have her son. However she experienced depression for some time after her termination and found midwifery very difficult. She took part in a follow up interview.

30.	Laura	Laura had a missed abortion in 1992, when she was already a midwife. She became a midwife teacher to avoid direct practice. She became pregnant with twins, one of whom she miscarried, following IVF. She then had unsuccessful IVI treatment, and had another baby by natural conception. She became depressed after her pregnancies, and found counselling helpful. She took part in a follow up interview.
31.	Jenna	Jenna and her husband were having treatment for infertility when she became naturally pregnant with their daughter. Following this, she had a miscarriage, then a failed (and expensive) IVF. She and her husband are awaiting another cycle of treatment, but have decided this will be their last.
32.	Linda	Linda had a baby girl, and then experienced four consecutive miscarriages. One was due to chromosomal abnormalities, although on testing, Linda and her partner were both without problems. Her last pregnancy was successful, and she had another daughter. She writes of the excellent support she had from her work colleagues throughout her experiences.
33.	Charlotte	Charlotte was unable to conceive and has had three unsuccessful attempts at IVF. She had always wanted children, but was not in a relationship where this was possible until she was aged 40. She is finding it very difficult being without children.
34.	Emma	Emma and her husband had infertility treatment including IVF for ten years. There was no discernible problem for either of them. Her second IVF treatment was successful, and she has a daughter. She had six IUI treatments at her own hospital, which she found difficult.
35.	Nina	Nina's husband has antibodies on his sperm which are preventing conception. Following many tests and attempts at assisted conception, they have embarked on the adoption process. Nina took part in a follow up interview.
36.	Sophie	Sophie's first baby was a girl. Her second baby, Andrew , died in utero at 32 weeks. He was subsequently found to have Edwards Syndrome, a

		condition incompatible with life. She then had two miscarriages before having another baby. Sophie took part in a follow up interview.
37.	Melissa	Melissa experienced many gynaecological problems including a miscarriage and ectopic pregnancy. These problems led to a hysterectomy when she was 38. She also describes a number of very troubled and violent relationships with male partners. She became a midwife to be around babies, but has never had a child of her own. She describes herself as proud to be a midwife, but is currently working as a nursing project manager.
38.	Sonia	Sonia experienced infertility and had one pregnancy which was ectopic. Although Sonia is sad not to have experienced birth, she never wanted IVF or considered adoption. She is currently working as an antenatal and yoga teacher to pregnant women.
39.	Patricia	Patricia married at 44 years old, having previously had two terminations of pregnancy. She experienced infertility, and she and her partner had treatment. Her husband did not agree with IVF, so they only had one cycle of treatment which was not successful. Patricia describes various work incidents and her feelings about childlessness which have persuaded her to leave midwifery and take up health visiting.
40.	Stella	Stella's daughter died at 6 weeks of age, the cause being attributed to cot death although Stella says it was pneumonia. She was "made" to work in clinic and do parent education classes, although she had always worked on labour ward. When she became upset at work, she was told to leave her personal problems at home. She mentions her family but does not write specifically about any other children

APPENDIX THREE – INTERVIEW SCHEDULE

MIDWIVES EXPERIENCES OF ADVERSE REPRODUCTIVE OR PREGNANCY LOSS LEAD RESEARCHER – CHRIS BEWLEY

Some people have mentioned support or lack of support at work; what does the term "support" mean to you?

How could you have been supported on your return to work?

What did people at work do which was helpful?

What did they do which was unhelpful?

How have your experiences affected your work with women and babies?

Would you say your practice has changed, and if so how?

How might other people say your practice was different?

How do you feel about sharing your experiences with your clients?

What are your feelings now about being a midwife?

How do you feel now about being a participant in this research?

Questions specific to this respondent:

Is there anything else you would like to tell me?

APPENDIX FOUR – RESULTS OF EVALUATION OF THE STUDY

The evaluation is presented using the headings suggested by Spencer et al (2003) and discussed in Chapter Two.

How credible are the findings?

The "building blocks" of the findings are evident throughout, showing how the initial literature review informed the development of the questionnaires, findings from the questionnaires informed the development of the interview schedule (Chapter Two), and findings from the interviews and questionnaires informed the return to the literature (Chapter Five). There is little other literature or expert opinion to corroborate the findings, however, peer comment suggests that they are resonant with other knowledge and experience.

How has knowledge/understanding been extended by the research?

Key issues have been identified as relevant, mainly due to lack of existing information about how midwives' personal experience of pregnancy related loss and its related effects. The study is set within the context of changing approaches in provision of maternity care, and acknowledges the potential concurrent effects of these on the participants. Recommendations made are logical, and congruent with findings. Findings also offer alternative or additional perspectives for other researchers when considering other aspects of maternity care which may be affected by the midwife's own personal experiences. Areas which remain to be clarified, for example the impact of participants' personality traits, and the views of clients, have been clearly identified.

How does the evaluation address its original aims and purpose?

The study was broken down into an overall aim with specific objectives, which were tracked back in the conclusion. The limitations in meeting the aims and objectives are those imposed by the sampling strategy, in that it cannot be known if the sample is representative. It also seems a small sample, yet without knowing the actual numbers of midwives who have experienced a personal pregnancy related loss, it is impossible to confirm that it is small.

How well is the scope for drawing wider inference explained?

There was no intention to generalise from the findings, although Chapter Six explains how the theory could be tested. There is also discussion in Chapter Six on how the theory, models and recommendations could be modified to apply to other occupations in which those who experienced a pregnancy related loss may work in close contact with pregnant and childbearing couples.

How defensible is the research design?

There is clear discussion in Chapter Two about how the research design was chosen to address the aim of the study. The limitations of the research design are discussed in Chapter Two and include a discussion on the merits and drawbacks of the position of literature searching in grounded theory. The discussion also acknowledges the difficulties of constant comparative analysis, particularly in the presentation of the findings, where the movement of data between categories is an important process, but where its reporting can obscure the smooth flow of reading.

How well defended is the sample design/target selection of cases/documents?

Chapter Two details the way in which the sample was recruited, the criteria for inclusion, and the limitations of a self selected and self reporting group.

How clear is the basis of the evaluative appraisal?

This section includes a question on reasons for non-participation of the sample approached. The self-select sampling strategy generated 56 requests for questionnaires, of which 40 were returned. It is impossible to speculate why those who did not return their questionnaires chose not to do so. However, Chapter Two notes the difficulties in response and the drop out rates for respondents in studies on perinatal loss and bereavement.

How well was the data collection carried out?

Chapter Two includes full details on the researcher who collected the data, on the procedures for collecting and recording data and on how interviews were conducted and recorded. The Chapter also includes information on how differences in interview recording (that is some by telephone and some face to face) may have influenced findings. There is also information on the setting for the interviews, and how this may have influenced data collection. The study is described in great detail so that replication would be possible.

How well has the approach to and formulation of the analysis been conveyed?
The structure of both questionnaire and interview schedule informed the subsequent data analysis and this is explained in Chapter Two. Examples are given of data analysis of questionnaires and interviews, together with details on how significant and emerging issues were recorded. The constant comparative analysis of all emerging findings is also explained and tracked throughout the study from questionnaires, interviews, and literature as data. The depth and richness of data is portrayed by use of direct quotes from participants from questionnaires (Chapter Three) and from interviews (Chapter Four). The use of a statistical package, or a computerised data analysis package was discussed in Chapter Two, and rejected in favour of manual analysis, and submission to experienced researchers and peers for checking.

Contexts of data sources – how well are they retained and portrayed?
There is an explanation and brief history of all participants. Further details of their experiences are given in the findings to explain direct quotes drawn from their questionnaires or interviews. The historical context of their experiences, and the current context of the provision of maternity care are included where this seems relevant. Throughout the presentation of the findings, the comments of the researcher are identified as such, so there is no confusion as to what constitutes explanation as opposed to findings.

How well has diversity of perspective and content been explored?
As explained in Chapter Two, the sample does not claim to be representative. It is not diverse in its social, cultural or ethnic representation. It is also exclusively female. Within the context of pregnancy related loss, however, the sample is reasonably diverse, although numbers of each type of loss are avoided, since some participants fell into more than one group. This is explained in Chapter Three. In some instances, only one participant had mentioned a particular circumstance, for example, that of the potential for

a woman to contemplate baby abduction following pregnancy loss. However, the constant comparative analysis, and use of literature as data suggested this was an important area.

How well has detail, depth and complexity of the data been conveyed?

Throughout the study, terms used by the researcher have been explained, for example, the use of the term "shared experience" is explained in detail (Chapter Five). Use of terms "midwife" and "woman" are explained in Chapter Five to denote the nuance of meanings which often divorce the midwife from her identity as a woman. Where participants use similar but difficult to define terms, such as "support" these are also explored in more detail with appropriate literature.

How well can the route to conclusions be seen?

In all cases the conclusions and recommendations can be tracked directly back to the findings, and this is explained in Chapter Six. The analysis from description of the data is evident in the theoretical principle and the conceptual models presented in Chapter Six.

How clear and coherent is the reporting?

The structure of the study, is such that at the beginning and end of each chapter there is a review of what has gone before, and an indication of what will be presented next. Although this may seem repetitive, it is a long work which requires the reader to be directed through the narrative. Each stage of the work proceeds logically from what has been identified earlier. Key points are summarised throughout.

How clear are the assumptions/theoretical perspectives that have shaped the form and output of the evaluation?

The study includes a discussion on the theoretical literature predating the research, but makes no attempt to theorise at the outset. This is left until the end of the study, following completion of the constant comparative analysis of data (Chapter Six). Researcher bias and observations on reflexivity which may influence the theorising processes are discussed in Chapter Two.