Changing Practice: Changing Lives.

An Action Research Project to Implement Skin-to-skin Contact at Birth and Improve Breastfeeding Practice in a North West United Kingdom Hospital Maternity Unit

Mary R. Price

Institute for Health and Social Care Research

Salford Centre for Nursing, Midwifery and Collaborative Research

University of Salford, UK

A Thesis presented in fulfilment of the requirements for the Degree of Doctor of Philosophy

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Birth - April 2002

In April 2005 I watched this child blow out 3 candles and that evening he and his mother shared their last breastfeed
Abstract

Changing Practice: Changing Lives. An action research project to implement skin-to-skin contact at birth and improve breastfeeding practice in a North West United Kingdom hospital maternity unit

Breastfeeding has health benefits for mothers and babies. An action research project was undertaken to improve knowledge of breastfeeding and implement evidence based practice, that of uninterrupted skin-to-skin contact between mother and baby at birth. The beliefs underpinning the project were informed by critical inquiry, dialectics and feminist theory. Data was collected by means of field notes, participant observation, focus groups and semi-structured interviews. Analysis during the project using critical reflection was ongoing and collaborative, feeding back into the action research cycles, so guiding the changes.

Before successful change in practice can occur, practitioners need to be convinced of its value, involved in the change process and facilitated to incorporate it into practice. Hospitals tend to reinforce the power of professionals by their adherence to historical routines and institutionalised practices which lead to compliance thus hindering change. The strategic use of power by midwives was apparent, constructing people's world view, thus reinforcing the power structure.

Empowerment of women and midwives was necessary to the success of the project by education, support, role modelling, strategies for remembering and the active participation of midwives. Theories of change were used to illuminate challenging issues from the project.

Early contact between mother and baby at birth is an area generating a large volume of literature. Skin-to-skin contact was disrupted by technology, time limits and the social norm of separation. Interviews with women and midwives allowed a deeper insight into the experience of skin-to-skin contact, giving more value to the change. Further issues to emerge were the implications of separation, the social construction of time, embodied praxis and love.

Recommendations are made for the more effective action research approach to implementing change, and personal empowerment as the basis for improving the experience of birth.
Chapter 1  

Background Knowledge

Introduction

This chapter explores my professional experiences of breastfeeding in order to establish my background in relation to the project. I will explore cultural influences on birth and breastfeeding world wide and highlight some of the complex reasons for lost breastfeeding expertise in the United Kingdom, such as medicalization. I will also explore the encouraging international and national trends which place breastfeeding more explicitly in the public health agenda.

My Story

I was a practising midwife for 12 years before becoming a full time teacher in 1989. Although I always had an interest in breastfeeding, my clinical expertise preceded the discovery (or re-discovery) of the current knowledge base. I have no memory of ever seeing a baby being breastfed until just before I began my midwifery career and my midwifery training contained little input on breastfeeding skills, with experience in the clinical area being medicalised. I remember purchasing a book which my tutor recommended, by Mavis Gunther (1973) in a desperate attempt to acquire the skills to help women, but with limited success. On reviewing the book now, whilst some of the breastfeeding positioning descriptions are good, I must question some of its advice. The cover picture seems to show a baby with its bottom lip curled inwards, a sure sign of poor attachment. My practice memories make me want to weep for the women that I could have helped. I feel as much a victim as the women were, as I was full of good intentions but not a little puzzlement. After a few years specialising on Central
Delivery Unit (CDU) as recommended by the government of the day, I returned reluctantly to postnatal ward, sent by my manager who had overheard me saying 'someone should sort out the breastfeeding on postnatal'. I was armed with my bible, alias 'The Womanly Art of Breastfeeding' (La Leche League, 1981) but little else except good intentions. Most colleagues assumed that babies needed bottles of artificial milk at first, especially if over 8lbs in weight. I would often be found poring over my bible to try to find the answers to breastfeeding problems, a fact which did not go unnoticed by my more amused and sceptical colleagues. The answers were elusive as my literature searching skills were limited and user-friendly evidence-based guidelines such as Renfrew et al (2000) were non existent. After 18 months, where at least the atmosphere on the ward was encouraging, I was returned to CDU and the breastfeeding culture reverted to a formula manufacturer's haven. I determinedly stayed away from anything concerning breastfeeding for years afterwards, because of the trauma.

I was catapulted back into the area in 1999 by being 'volunteered' to teach the newly written Lactation and Breastfeeding module for qualified midwives. Initially I was facilitated by a colleague from the University of Central Lancashire and since then have developed the content, revised it in line with UNICEF BFI (2005) educational standards and undertaken almost all the breastfeeding teaching for student midwives in a University Directorate of Midwifery. When I began this action research project I had a lot of theoretical knowledge of breastfeeding in general and skin-to-skin contact in particular, but more limited current practical experience. This experience was from midwifery help given to three women since 1999 for whom I had provided continuity of care during the childbearing
continuum and one postnatally. I had read widely about breastfeeding because of my teaching subjects, had seen the breastfeeding videos ad infinitum, discussed it a lot, and was personally convinced of its value. I believe that the following poem extract by T.S. Eliot says a lot about destiny, and the fact that sometimes you cannot escape it.

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

From ‘Four Quartets 4: Little Gidding’, by T.S. Eliot

Culture, Birth and Breastfeeding

In Chapter 3 I examine the social constructionist underpinning of the choice of research methodology, but here I will examine some of the cultural influences on the issues of birth and breastfeeding which impinge on my midwifery career as well as the subsequent action research project. Through our human history, breastfeeding has been a link between mother and baby, yet in the early part of this century, breastfeeding began to decline (Stuart-Macadam & Dettwyler, 1995). Van Esterik (1989) asserted that lactation began to be seen as part of a doctor’s role with the availability of commercialised alternative infant food. The associated dangers of formula milk to infant health then increased the need for doctors and treatment. Medicalization of infant feeding practices meant that routines and rules were imposed on a natural physiological process so that the normal pattern of breastfeeding became altered with consequent damage to its success. Redefining infant feeding took away the mother’s own power to decide what was best for her baby, whilst the medical community created a market for its services, thereby removing human problems from their social context. Midwives were also influenced by this and many lost their skills in supporting women. Van Esterik
(1989:80) emphasised that 'modernisation' throughout the world does not necessarily benefit women.

Medicalization has impacted widely on the experiences and decisions made by childbearing women, their families and the midwives who provide care for them, however there are other cultural factors which must be taken into account in order to understand their impact on birth and breastfeeding. Helman (2001:2) described culture as:

'an inherited lens through which the individual perceives and understands the world that (s)he inhabits and learns how to live within .. .'

Culture often has implicit guidelines which enable its values to be passed on to the next generations, with actions or rituals which regulate its members and show how the natural and supernatural worlds are to be viewed. Because culture is influenced by others, it is not static and so must always be contextual (Berger & Luckmann, 1966). Douglas (1996) interpreted the work of the French writer, Mauss (1936) who believed that there could be no natural behaviour, because all actions carried the imprint of learning, from such everyday actions as feeding, washing, movement and rest. Douglas (1996) argued however that there were common characteristics across many cultures, which suggested that some of these tendencies might be natural, whilst still being influenced by local history and culture. Mammals are known to seek a quiet, secluded place when labour begins, with many being reluctant to give birth if observed (Sosa et al, 1978, Nowak, 1996, Insel, 2003). Kahn (1995) maintained that whilst the actions of a newborn baby were made up of universal human traits, what use was made of these depended on the social structures of the world it entered. Davis-Floyd (1994) suggested that the real issue was not necessarily what was best for the baby, but
what was being taught to society’s newest members. Jordan (1986) observed that decision-making was connected to the idea of who ‘owned’ the birth territory and that the birth location itself influenced events. If in an unspecialised place like a home, the mother and baby would be kept together, with everyone involved in decision-making. In Holland, where most births were at home she observed midwives making few decisions, except letting nature take its course, assuming that the woman knew what her body wanted. The place of birth could also affect women’s ability to be in control of events as Machin & Scamell (1997) found in an ethnographic study of 40 women. The onset of labour and admission to hospital saw previously assertive women becoming vulnerable, more passive and accepting of the dominant medicalised values.

Jordan, (1997) pointed out that there could be more than one knowledge system in any culture, yet some carried more weight in decision making than others. What happened depended on whose values within a culture might be thought of as authoritative. She observed wide variations in birth practices in different parts of the world, each making sense to that particular group who saw their actions as right and were resistant to any change, even regarding such change as dangerous or unethical. Helman (2001) argued that in every society, childbirth was perceived to be dangerous, with particular rituals being performed to protect mother and baby, or in the case described by Semenic et al (2004), the orthodox Jewish fathers who were prohibited from touching their wives in labour in case they became ritually unclean. In Tibet, Farwell & Maiden (1992) described birth as a sacred moment with practices to enhance this. Adams et al (2005) interviewed village women in the Tibet, who believed that they needed to placate the gods by
offerings and mediations to protect themselves and more especially the newborn baby, from harmful spirits. Mueke (1976) investigated birth practices in Thailand at a time of increasing Western influence, finding that ‘traditional’ practices valued close family involvement and significant social rituals which served to increase spiritual or karmic status. These rituals were meant to ensure survival of both mother and baby by ensuring good karmic status which would provide a bodily home for the ‘life principle’ to be born into. Conversely Mueke (1976) found that in the cities these practices were being replaced by more Western practices based on separation with the women enduring social isolation for the perceived benefit of increased safety. It could be argued that the way that a society regarded birth would be a strong influence on what happened during it and Douglas (1996) hypothesised that the more people valued social constraints, the more emphasis they would put on symbols of bodily control.

Helman (2001) described Western medicalised birth culture as being based on the conceptual separation of mother and baby at birth. The baby, having been ‘properly enculturated’ or ‘baptised’ into the world of technology, by being weighed, washed, checked for normality and labelled, would then be handed back to its mother before being placed alone in a cot separated from its mother. Widström (1987) described a harrowing ritual of the routine insertion of a gastric tube into a newly born baby’s stomach to aspirate gastric contents. The supposed benefit was safety from the perceived risk of aspiration of acid stomach contents but the babies were distressed. Wagner (2001: S26) argued that we ignored our biology at our peril and yet those who only knew technology could not imagine life without it, just as fish cannot see the water in which they swim. Davis-Floyd
(1994) found that some women thought that technology was better than nature and birth a mechanical process making life more controllable. Many women in the Western world will have experienced a birth heavily influenced by this authoritative cultural knowledge, whilst Walsh (2002) observed that Western culture was unusual in not having spiritual rituals around it.

So many rituals have been imposed on birth that the question could be asked, ‘On what evidence?’, as birth practices world-wide are not necessarily beneficial. Kennel & McGrath (2001) commented that it would be impossible to perform studies about normal birth in America, as there were so few women who experienced it. In Canada, Halpern et al (1999) found that only 23% of women were judged to have natural births. Figures for a totally natural birth in the United Kingdom are low with an estimated 47% of women in England giving birth without intervention (BirthChoice UK, 2006). Maternal sedation in labour using either pethidine analgesia, or epidural anaesthesia was found to be common and to affect maternal and newborn behaviour, especially if given too close to the birth (Righard & Alade, 1990, Rajan, 1994, Ransjo-Arvidson, 2001). In Chapter 2, I will examine many research studies and literature which describe birth practices based on separation and control of birth to the detriment of the mother and baby yet finding benefits of uninterrupted skin-to-skin contact for well-being and breastfeeding success. Davis-Floyd (1994) described America as a nation founded on the principles of separation. Through recent decades, researchers have found mother and baby separated for periods of time from a few hours to three days (DeChateau & Wiberg, 1977, Ali & Lowry, 1981, Shiau, 1997, Bystrova, 2003). In the UK often the first thing many new parents ask about the baby is ‘How
much does it weigh?’ implying that separation would be beneficial. Most women will have expectations of their birth which have been passed down from their mothers or the media (Gibbins & Thomson, 2001), which usually shows a baby crying ‘lustily’ and wrapped up to keep warm, exposing only the baby’s face. It seemed almost ‘normal’ to see a baby crying whilst the parents look relieved and smiling (Kahn, 1995), now that the birth was over, with its distress being interpreted as a way to aerate its lungs.

Birth and breastfeeding have been bound up with cultural influences for a long time and the current evidence base explored in chapter 2 has not been in the general domain for very long in cultural terms. What the studies have not done to date is to use a standardised criterion which would enable reliable comparison and the accolade of a ‘gold standard’ for those who value quantitative proof. Those who seek to help women during the childbearing process need to know about the evidence base, rather than what seems right to those in power at the time. Baumslag & Michels (1995) emphasised that breastfeeding was an art, with most problems resulting from lack of information or the ignorance of health care workers and family rather than having a medical cause. The answer was rarely to bottle feed they argued, but to access effective help. They believed that women experienced breastfeeding problems because they did it in a cultural vacuum, as their family or peers could not provide support because their skills were in artificial feeding (Maher 1992). Women’s experiences of breastfeeding from the 1920’s to 1990’s were sought in research by Carter (1995). She found that many women had been castigated as lazy or selfish for not breastfeeding, but argued that lack of support made bottle feeding seem the only way to survive in a patriarchal
society. Whilst artificial feeding gave some women a degree of social control, it was not necessarily the best answer, as it did not address the causes of their oppression. The breast and breastfeeding, observed Van Esterik (1989) were missing from such classic feminist works as ‘The Woman in the Body’ (Martin, 1992). Women also had to cope with poor medical advice which assumed that breastfeeding was only for nutrition, rather than having psychological and social benefits for their child. Vincent (1999:91) discussed how initially she fed her first baby as if it was just a physical process then continued:

‘only later did I feel that giving my baby food was also as an experience of love and communication.’

One of the commonly cited reasons for discontinuing breastfeeding was and is insufficient milk (Foster et al 1997, Hamlyn et al 2002), which occurs mainly because of poor breastfeeding practices, with the rarest cause being that there really is no milk (Van Esterik, 1989, Mohrbacher & Stock, 2003). Maher (1992) reported that there have been times in our history when artificial feeding has been seen as improving on nature. Parents might choose second best believing the differences to be trivial, yet the artificial product has not been tested over generations, as factory made products have only been available since the 1960’s (Renfrew 1998). Minchin (1998) emphatically stated that artificial feeding is the largest uncontrolled in vivo experiment, and this experiment continues today, because the product is ever changing. Breastfeeding might be presented to women as just another feeding option, which is only marginally better than formula feeding. However, as Baumslag & Michels (1995:pxviii) highlighted:

‘Lack of accurate information about breastfeeding makes it hard for women to understand how their right to breastfeed is manipulated by those who profit when they choose not to.’
Increasingly aggressive marketing of breast milk substitutes and the rise of a consumer society were reported by Van Esterik (1989). Minchin (1998) remarked that research sponsorship by formula companies might not alter data but they could influence what questions were asked and what conclusions drawn. Minchin cited researchers who gathered data only to find that the report writers interpreted them with a different slant. A relationship between marketing practices and medical systems, could also be seen, which could lead to widespread misinformation about breastfeeding, including research reports in credible medical journals (Leeson et al, 2001). Van Esterik (1995) pointed out that environmental issues had been under-recognised with breastfeeding never damaging the environment, whilst artificial feeding demanded non-renewable resources and produced waste. The media have been quick to shout about contamination or pollution in breast milk but not about the many hazards of formula (Minchin, 1998). The health benefits of breastfeeding are significant and well documented, with more research being undertaken (Howie et al 1990, Baumslag & Michels, 1995, Cunningham, 1995, Wilson et al, 1998, DoH, 2003a, UNICEF Baby Friendly Initiative, 2004). Cardiac disease, hypertension and obesity are part of the reasons for the current government emphasis on raising breastfeeding rates, as the incidence is higher with adults who were formula fed as babies (Howie et al, 1990, Wilson et al, 1998, DoH, 2003a). Minchin (1998:286) argued that there were two mutually exclusive viewpoints that should be communicated to society, either:

'breastfeeding is often impossible in society as we have it .. so we must not make too much of it or we upset those women who truly cannot breastfeed.'

or we could say:
breastfeeding is often impossible in society, as we have it, and breastfeeding is so important ... that it is society which MUST be changed to make it possible.'

Minchin (1998) felt that to talk about breastfeeding as just one of two options rather than the safest or the norm, might make some women think that it was something to be aimed for but not necessarily very important.

The United Kingdom Story

Minchin (1998:302) pointed out that it was unhelpful to promote 'breast is best' without giving women the resources to achieve it, as this would only result in a group of bitter women who had 'failed'. The following events are the UK attempts to achieve this support. In 1975, the Department of Health became concerned by the low UK breastfeeding rates and began monitoring them every 5 years. Following promotion of more physiological advice such as demand feeding rather than feeding at set times, there was an initial rise, however this trend levelled out in the 1980’s. World-wide protest in the 1970’s against the marketing of infant formula resulted in the World Health Organization’s (WHO) production of the International Code of Marketing of Breast-milk Substitutes, (World Health Organization, 1981). The Code was voted for by 118 of the world delegates. One delegate (United States) voted against, having had direct orders from the Reagan White House just before the meeting, following which he resigned. This lack of total consensus meant that the Code could only be a voluntary one, rather than legislation, a concession to the huge financial interests of the infant formula industry (Van Esterik, 1995). Following the Code, formula companies 'publicly' complied with it, but Nestlé and others diverted marketing budgets from public areas to providing low cost milk in maternity units and other more subtle promotions. The International Baby Food Action Network (IBFAN) works to
promote breastfeeding worldwide and monitors Code violations, with Baby Milk Action the UK branch. Violations of the WHO Code continue to this day, with each report citing fresh examples, which undermine health education messages (Baby Milk Action, 2004).

WHO/UNICEF (1989) launched the document ‘Protecting, promoting and supporting breastfeeding: the special role of maternity services’, which was the start of the world-wide campaign to introduce the ‘Baby Friendly best practice standards’ for breastfeeding. The Innocenti Declaration was compiled by WHO/UNICEF (1990) policymakers, to reinforce the importance of breastfeeding for health. They stressed that women should be enabled to practice exclusive breastfeeding by reinforcing a breastfeeding culture and removing subtle influences which might constrain this. They advocated that all organisations should implement the 10 Steps to Successful Breastfeeding (Table 1). In the UK the Baby Friendly Hospital Initiative (BFHI) was launched in 1992 with the 10 steps, which would meet the Innocenti aims. The most current guidance incorporates 7 community standards (UNICEF UK 2001), so the initiative removed the word ‘hospital’ from its title. Compliance with the BFI Steps has been found to raise breastfeeding rates (Broadfoot et al, 2005), but not all health care facilities follow these. Breastfeeding initiation has improved but not as much as hoped, and discontinuation rates are high. The World Health Organisation (2002) recommendation is for exclusive breastfeeding for six months and then continuing as part of weaning for up to 2 yrs or more. The latest UK feeding report, (Hamlyn et al, 2002) showed an initiation of 69%, which is an improvement, but possibly due to demographic factors of the sample.
Breastfeeding continuation fell to 42% at six weeks, with 90% of women saying they would have liked to have breastfeed for longer.

**Today and the Future?**

There is an increasing trend by government to value breastfeeding, as part of promoting short and long term health gains. The NHS Plan (DoH, 2000) values breastfeeding as part of the strategy to improve nutrition, thus narrowing the health gap between socio-economic groups in childhood and throughout life. Following a systematic review by Fairbank et al (2000) of interventions to promote the initiation of breastfeeding, recommendations included valuing peer support, interactive, small group antenatal education and promotion of changes in maternity ward practices. Future research recommendations by the review do not mention action research but imply it by their use of words like interactive, small groups, evaluation and changes in hospital practice such as implementing the Baby Friendly Initiative 10 Steps.

A Maternity Care Working Party (2001) recommended that all facilities work towards achieving the BFI standards and placed value on promotion of breastfeeding by recognising its enhancement of health in both mother and child. A major boost for breastfeeding was the government target (DoH, 2003a:20) to:

> ‘deliver an increase of 2 percent points per year in breastfeeding initiation, focusing especially on women from disadvantaged groups.’

The document ‘Tackling Health Inequalities’ (DoH, 2003b:1) pointed out that standards need to be set, but encouraged local freedom to meet them, stressing there should be no more ‘one size fits all’. This is echoed in the funding allocated by the Department of Health to the 79 innovative projects (Dykes, 2003), which
were intended to empower socially disadvantaged women to breastfeed. The majority of the projects were developmental and capacity building rather than empirical research, focusing on changing practice and emphasising sustainability. Action research was seen as a useful methodology (citing this project) and in line with government policy to capability build and empower communities.

Van Esterik (1995:145) stated that sometimes rhetoric does not match reality and that:

'extraordinary changes in the way power is allocated in the world would be necessary for breastfeeding to flourish in this world.'

A hospital breastfeeding policy might be overtly supportive, but artificial feeding subtly promoted by a trolley full of formula milk on public display (personal communication with students in 2005). The trend to enable more women to breastfeed for as long as they would like to, seems encouraging, but change is not easy and local projects to facilitate the implementation of evidence based practice seem to be the way forward.

**Conclusion**

In this chapter I have established the background to the need for a project such as the one detailed in this thesis. Birth and breastfeeding has been influenced through generations past, by cultural practices, not least of which are medical and political practices which undermine its success. It could be argued that women would benefit from an awareness of these influences in order to comprehend their impact on their attempts to breastfeed successfully. The future, whilst looking more optimistic, needs strong drivers in order to recover breastfeeding as the norm for
all babies, for the health of our present and future generations of women and their children.

**Table 1** Baby Friendly Initiative Best Practice Standards
The 10 Steps to Successful Breastfeeding

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have a written policy that is routinely communicated to all health care staff.</td>
</tr>
<tr>
<td>2</td>
<td>Train all health care staff in skills necessary to implement the policy.</td>
</tr>
<tr>
<td>3</td>
<td>Inform all pregnant women about the benefits and management of breastfeeding.</td>
</tr>
<tr>
<td>4</td>
<td>Help mothers initiate breastfeeding soon after birth.</td>
</tr>
<tr>
<td>5</td>
<td>Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.</td>
</tr>
<tr>
<td>6</td>
<td>Give newborn infants no food or drink other than breast milk, unless medically indicated.</td>
</tr>
<tr>
<td>7</td>
<td>Practise rooming-in – allow mothers and infants to stay together 24 hours a day.</td>
</tr>
<tr>
<td>8</td>
<td>Encourage breastfeeding on demand.</td>
</tr>
<tr>
<td>9</td>
<td>Give no artificial teats or dummies to breastfeeding infants.</td>
</tr>
<tr>
<td>10</td>
<td>Foster the establishment of breastfeeding support groups and refer women to them on discharge from hospital.</td>
</tr>
</tbody>
</table>

(WHO/UNICEF, 1989)
Chapter 2 Skin-to-Skin Contact: A Review of the Literature

Introduction

In view of the main emphasis arising from the action research project, in this chapter I include a detailed review of literature covering physical, psychological and social benefits of early contact of baby and mother at birth. Physiological benefits of calming, warmth, enabling of early breastfeeding can be disrupted by a medicalised approach to birth, including maternal sedation. Psychological and social benefits such as attachment and bonding are discussed, including the influences of complex birth hormones on the mutual attraction of mother and baby, with possible long term benefits for breastfeeding and health. A brief overview can be accessed in Appendix 1.

This review is intended to make some of the published work more accessible and also to overcome the exclusion of some research by highly selective criteria. Over the last 30 years much research had been conducted on the mammalian mother and newborn baby, including the human mammal as well as sheep, goats, pigs and rats. No work has ever found a detriment to uninterrupted skin-to-skin contact, and it seems beyond doubt that most human mothers like the experience and babies derive some benefit (Klaus & Klaus, 1985, Kristeva, 1986, Lagercrantz & Slotkin, 1986, Finigan & Davies, 2004, Price & Johnson, 2005). However, two recent literature reviews, published in weighty sources have cast doubt on the ‘proof’ of the benefits as compared to the perceived ‘gold standard’ of randomised controlled trials (RCT). Carfoot et al (2003) performed a systematic review of RCT’s evaluating the benefits of skin-to-skin contact, finding seven, which they judged to be of poor quality, meaning that no firm conclusions could be drawn.
They highlight the need for further primary research to assess the effects of skin-to-skin contact on the breastfeeding experience. Anderson et al (2003) in a Cochrane review, included 17 studies, but argued that many were not rigorous enough and more were needed, using similar criteria for comparison. They comment, however, that separation of mother and baby is a modern practice that is unusual in both human history and in mammals. Timing was also judged to be important, because after 2 hours babies often became sleepy and hard to rouse for some hours, making breastfeeding more challenging. However, no detriment was found to skin contact, even though more evidence was needed to ‘prove’ the benefits. Despite this, there was evidence that breastfeeding outcomes were better with skin-to-skin contact, with mothers twice as likely to be still breastfeeding 1-3 months later, effective sucking probably being a critical component of this. Taylor et al (1986) also found this, but provided that as well as skin-to-skin contact, the baby also breastfed. Carfoot et al (2005) performed an RCT in 2002 to examine the effects of early skin-to-skin contact on the initiation and duration of breastfeeding. They found that there was no significant effect beyond the fact that mothers liked it and would repeat the experience next time. Two groups of 102 women, who expressed a wish to breastfeed, were given either uninterrupted skin-to-skin contact or the baby was wrapped and held. There was a small increase in the success of the first breastfeed with skin-to-skin contact but this was not seen at 4 months. The authors acknowledge the limitation that there could have been many influences beyond the initial skin-to-skin contact which could have affected this. This RCT was carried out in a unit where skin-to-skin contact was not practised, nor apparently did the women know about it, as only four requested it. The authors do not mention the extent of the midwives knowledge of it, nor their
skills relating to the atmosphere needed to enhance its success. If the women were given little information about skin-to-skin contact, they would have no motivation to wait until the first breastfeed before interrupting it, as almost 20% did. All women had high rates (around 45%) of either Pethidine or regional anaesthesia use in labour. Both these factors could have significantly affected the success rate of the skin-to-skin group by decreasing the chance of a successful first feed. This RCT could have been affected by the culture of both mothers and midwives, where skin-to-skin contact was not expected or experienced before, which might have had a subtle influence on events.

**Do Not Disturb the Birth**

As Discussed in Chapter 1, culture can affect what happens at birth. Research by Fikree et al (2005) in Pakistan found that some ‘common’ practices are not necessarily helpful for infant well-being and persisted despite health care promotion, for example, some mothers giving their babies a honey mixture or herbal paste soon after birth or buffalo milk for the first three days. In an RCT in Taiwan, Shiau (1997), found that skin-to-skin contact was delayed for hours because of hospital policies. In animals, separation of mother and young can have disastrous consequences for the baby as the mother may reject it (Pederson, 1992b). Humans may be able to mask this long enough to grow to love the baby if the feelings are slow to appear. The human body is immensely complex and despite our advanced scientific knowledge, we still do not know everything. It is more than a set of body parts to keep healthy with an appropriate lifestyle. It is made up of parts we do not consciously control, yet our actions and thoughts influence it nevertheless. Panksepp (1992) reported on experimental research on
the behavioural effects of oxytocin which may act as an influence in the brain on systems that coordinate responses to major life-challenging circumstances, in other words, to promote survival needs. Sanders (2006) reviewed experimental research (including her own) from the 1970’s to the present day, using animals and humans, which demonstrated the complex linking of the sympathetic nervous system, the regulation of antibody response and thereby immunity. Cohen (2006) outlined experimental research showing that the brain could even condition changes to the immune system. Odent (1986, 2001b) believed that even stroking a baby’s skin would have important implications on the primal brain, thereby proposing a link between experiences, well-being and health. Buckley (2003:263) discussed the wisdom of the body, which by experiencing an undisturbed birth had ‘the evolutionary stamp of approval’. This means that it would be safe for the majority and allow women to begin motherhood in the best way. Buckley (2003) suggested that it sounded deceptively simple to say ‘do not disturb birth’ but it was something that was tampered with to our detriment.

Kennel & McGrath (2001) concluded that there was value in examining biological and behavioural data together. Activities described by Matthiesen et al (2001) that seemed at first to be unnecessary time wasting, such as the baby touching, stroking and licking the breast before feeding, were revealed to be essential for the mother to produce colostrum, before the oxytocin milk ejection reflex had become conditioned and to stimulate uterine contractions to separate and expel the placenta and prevent uterine bleeding. The disturbed behaviour reported in America by Ransjo-Arvidson et al (2001), of those babies who were still influenced by maternal analgesia administered during labour, not only explained

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why starting breastfeeding was so difficult for many mothers there, but why many of them became discouraged by their inability to breastfeed. Kennel & McGrath (2001) stated that studies looking at the broader picture were vital, because especially in America, it was apparently almost impossible to find enough women to study who gave birth naturally, without analgesia, interventions or epidurals. Uvnäs-Moberg (1996) believed that it was becoming clearer that neuroendocrine mechanisms were involved in mother-child interactions both by preparation in utero and adaptation after birth. Under stress conditions, adults need adrenaline and noradrenaline secretions which are hormones of fight or flight, to escape from danger, whilst the most important need of a newborn is to survive oxygen deprivation. Lagercrantz & Slotkin (1986) explained that during birth, the fetus produces unusually high levels of adrenaline and noradrenaline, which are not harmful to them, but give protection from adverse conditions such as hypoxia. The surge prepares the infant to survive birth by clearing the lungs of lung fluid so promoting normal breathing and increasing the metabolic rate to mobilise stored glucose reserves and to ensure a rich blood supply to heart and brain. Babies born without labour pains i.e. epidural anaesthesia or elective caesarean section will not have a catecholamine surge at birth and consequently, adaptation may be more difficult.

Calming for Babies

When a baby is born, it enters a different environment, where life will usually be brighter, louder, have new odours and be more tactile than in-utero, so once the birth transition has been completed safely, the baby’s next need is to settle safely with its mother. DeChateau & Wiberg (1977) discovered that babies experiencing
extra contact with their mothers cried less, whilst Widstrom et al (1990) in a study of 57 babies, found that those who had early contact with their mothers had lower gastrin levels, a sign of reduced stress. Anderson et al (2003) commented that reduced crying when babies are in skin-to-skin contact, can be important as vigorous crying in the early days can re-establish fetal circulation, where deoxygenated blood in the heart is forced back through the as yet unfibrosed foramen ovale, causing cyanosis. A randomised trial by Christensson et al (1995) observed the effects of skin-to-skin contact on babies after normal birth with no analgesia. 44 Babies were randomly allocated to uninterrupted skin-to-skin contact, alone in a cot or placed in a cot for 45 minutes then given skin-to-skin contact. After the first few minutes, crying was almost non-existent with babies in skin-to-skin contact. When babies in cots were placed in skin-to-skin contact, their crying ceased almost immediately. Christensson et al (1995) explained that many infant mammals with poor heat regulation give signals when separated from their mothers, known as the ‘separation distress call’. They observed that this started immediately at separation, appeared in short pulses and was kept up for a long time. It ceased immediately when returned to the mother, known as the ‘comfort response’. They concluded that this was a survival strategy, drawing the mother to the baby. Christensson et al (1995:472) suggested that:

‘If this behaviour is pre-programmed in the baby’s brain, its prevention may cause distress. Whatever the evolutionary foundations of this crying it seems to signal that care in a cot, which keeps the baby well within the accepted normal temperature zone, does not satisfy the needs of the newborn baby.’

Opiod systems may also be involved, since morphine diminishes this response in rat pups, with similar effects from intra-cerebral injection of oxytocin. Panksepp (1992) concluded that oxytocin alleviates separation distress, probably from a innate system associated with survival. He hypothesised that brain oxytocin may
cause warm positive feelings in both mother and baby during breastfeeding. Buckley (2003) explained that beta-endorphins are secreted from the maternal pituitary gland in response to pain and stress, as a natural form of analgesia and euphoria. The baby also secretes these, with peak levels occurring around 20 minutes after birth. Beta-endorphins are also in the breast milk, perhaps ensuring a mutually calming experience. She described the effects of epidural use which inhibits this beta-endorphin peak as well as that of oxytocin. A study of 28 women by Zandardo et al (2001), found that after vaginal birth, colostrum contained higher beta-endorphin levels, double that of plasma, as compared to those who had elective caesarean section. They concluded that the pain experience is central to labour, perhaps playing a role in stimulating maternal hormonal, vascular and physiological systems which contributed to fetal adaptation. They suggested that colostrum was probably fundamental in overcoming the baby’s painful birth experience. It is known that suckling, milk, sweet or fat substances are analgesic for babies, probably having an opiod involvement. Gray et al (2000:3) videoed 30 newborns having blood samples taken by a heel lance, comparing babies in skin-to-skin contact to those swaddled in a cot. Those in skin-contact were given 15 minutes to settle before the test was done. They had markedly reduced crying and the:

‘explosive rise in heart rate that normally accompanies heel lance,’

was not seen. This benefit extended into the three minute recovery period. Holding alone was not effective, despite beliefs of others i.e. parents. Gray et al (2000) commented that now it was known that skin-to-skin contact, sucking and taste were analgesic and calming in humans, each using a different neural and neurotransmitter pathway. Breastfeeding was discovered to be analgesic by
Carbajal et al (2003) during venepuncture in term neonates. Babies were tested in a variety of conditions, including being breastfed, being held by the mother and having a pacifier with glucose. In the breastfeeding group, many showed no reaction to venepuncture. They concluded that breastfeeding is at least equal to glucose in these difficult circumstances. This evidence suggests that skin-to-skin contact is more than just a nice thing to do.

**Warmth**

After a birth with uninterrupted skin-to-skin contact, it is usual for the baby to be quickly and gently dried, then laid facing onto the mother’s chest and covered with a warm blanket. Some species have a mature or precocial ability to control body temperature after birth, which enables them to function independently of their mothers at birth. Mammals however, have immature or altricial perinatal heat generation (Christensson et al, 1992), so it is usual for mothers to arrange a ‘nest’ by providing their own body as a source of heat. Uvnäs-Moberg (1998) observed that because oxytocin causes an increased blood supply, the temperature of the breasts increase during suckling, which would help to warm the baby. Nissen et al (1995) discovered a spontaneous peak of oxytocin at 15 minutes after birth, which would initiate this prior to the effects of suckling and milk let down. An experiment was performed by Christensson et al (1992) to compare temperature control and metabolic adaptation in 50 full term babies kept in the ‘maternal nest’ created by the chest and breasts for 90 minutes post partum, compared with those put in a cot. At birth, all babies were prone on the abdomen first, under two thick terry towels. The control group were then cared for ‘as usual’ i.e. separated. Temperatures were taken every 15 minutes ensuring that all
room temperatures were comparable. At 90 minutes all babies were taken to an examination table to check heart rate, respirations, colour and capillary blood, which was analysed for gases and glucose. 18 babies in each group were observed for crying, finding that cot babies cried more and longer, perhaps wanting to return to the nest. Skin contact babies did better in all tests despite being separated from their mother to have them taken and their blood glucose was higher. The researchers concluded that skin-to-skin contact meant that babies had higher body temperatures and more rapid metabolic adaptation, as well as preservation of glycogen stores, by not needing to burn glucose to make heat. Temperature increased rapidly from the time a baby was put in skin contact.

A randomised study by Christensson et al (1998) reported that skin-to-skin contact was better than an incubator for warming babies. The babies gained heat when cold and lost it to their mother when warm (above 37C). They described other benefits, such as promotion of stable cardiac and respiratory function, keeping unnecessary movement to a minimum, improved behavioural state and facilitation of mother-infant interactions. The importance of the 'warm chain' was described by the World Health Organisation (1997) involving skin-to-skin contact at birth, during transfer to postnatal ward and for the first hours after birth. They also recommended it if the atmosphere was cold or to re-warm a cold baby, and weighing the baby at birth was seen as a risk for hypothermia. Bystrova et al (2003) conducted a randomised trial of 176 mothers and babies, to compare skin-to-skin contact with babies being separated from their mothers. I had wondered how they obtained ethical approval for this in such recent times, but it was done in Russia, where separation of mother and baby and swaddling of infants was still the norm. The recent RCT by Carfoot et al (2005) raises similar ethical concerns.
Bystrova et al's (2003) sample were from normal births all of which had 'routine care', being dried, wrapped and placed on a table under a radiant heater whilst the third stage of labour was completed. The baby was then checked, weighed and subjected to the other routines before starting on the trial, taking about 20 minutes. Babies experienced either skin contact with their mothers or removal to a nursery, and they were in a combination of being naked, clothed or swaddled. Basal temperatures were taken at 30 minutes from axilla, interscapular area, thigh and foot. The largest temperature rise was in the skin contact group, especially in the feet, and this was mostly during first 30 minutes. It is likely that peripheral vasoconstriction was initially caused by catecholamines at birth making the feet cold. The heat rise with skin contact had previously been attributed to heat transference but the fact that it occurred so quickly suggested a reduction in sympathetic activity with consequent vasodilation. Bystrova et al (2003:326) concluded that this was perhaps nature's way of antagonising the "stress of being born" once the need for adrenaline was past.

Breastfeeding

Once the newborn baby is safe and warm, the next survival need is for food. Seminal research by Widstrom et al (1987) discovered the well known pattern of behaviour with skin-to-skin contact in the first hour after birth. 21 babies were observed in the days when gastric suction was the norm for 'preventing' aspiration of stomach contents. All babies met criteria for normality and the mothers were unsedated. One group were left in skin-to-skin contact with their mothers, whilst the other received gastric suction after about 5-10 minutes then returned to their mothers, being quite distressed by the suction. After about 15
minutes of inactivity, unsedated babies in undisturbed skin-to-skin contact were observed exhibiting innate behaviours where they progressed from a time of resting, to a 'classic' cry; 'crawling' from abdomen to breast; co-ordinated hand-mouth activity; active searching for the nipple while the mouth gaped and then attaching to the breast. The unfortunate suction group had a delayed and disrupted pattern probably due to vagal stimulation. Matthieson et al (2001) in a follow up from the Widstrom et al (1987) study added to this, the apparently aimless hand movements not previously recorded, in 10 newborn babies in skin-to-skin contact. These movements are seen in other mammals where massage of the udder or teats facilitates the milk let down reflex. In the study, maternal serum oxytocin levels were measured every 15 minutes. Unsedated babies were observed by Matthieson et al (2001) to cry for an average of ½ -7 minutes and then they relaxed. Their eyes opened at about 6 minutes; hand movements began at 11 minutes and hand to mouth movements were observed at 12 minutes. At 15 minutes mothers touched and examined their baby then 'nestling in' occurred. At 25 minutes, there were hand to nipple movements and licking, with suckling at around 80 minutes. The baby’s hands explored and stimulated the breast which was followed by a rise in maternal oxytocin. They concluded that the hand movements played an important role because during suckling, the massage stopped. This may be important in early lactation before the oxytocin reflex becomes conditioned. Klaus & Klaus (1985) elaborated on this by describing the benefits of being undisturbed. They observed that if the atmosphere was quiet, lighting subdued and handling diminished, the newborn began to adapt to its surroundings by being alert, its hands touching skin and eyes open wide, looking at its mother. They felt that this was an innate ability to communicate and a preparation for becoming attached to other humans.
Disruption and Sedation

Righard & Alade (1990) observed 72 babies after a normal birth until the first breastfeed, comparing sedated and unsedated babies and those in skin-to-skin contact with those separated from their mothers. The research showed that babies who were removed from the mother after 20 minutes for ‘routine procedures’ were less likely to breastfeed successfully, showing an uncoordinated sucking pattern when returned to their mother. Those separated as well as being influenced by pethidine did not feed. Research by Widstrom et al (1990) of 57 babies with early or delayed contact, observed that pethidine reduced the incidence of suckling. A survey of the effect of labour analgesia on breastfeeding success, was conducted by Rajan (1994), using 1,064 women. She found that overall, the fewer interventions, the better the breastfeeding rate, whilst pethidine was associated with a reduction in breastfeeding success and the closer it was given to the time of birth, the worse the effect. Ransjo-Arvidson et al (2001) videoed 28 babies after a normal birth, comparing those affected by analgesia to those who were not. The analgesia used was systemic, local or epidural. Perhaps it is debatable whether a birth could be classed as ‘normal’ with such analgesia, however fewer massage like hand movements were observed after analgesia and the babies were also found to cry more and have raised temperatures. Ransjo-Arvidson et al (2001) hypothesized that the crying could have been due to the frustration at not being able to suckle, and the temperature due to more crying. However, maternal epidurals are associated with raised temperatures, possibly due to an imbalance between heat producing and dissipating mechanisms, so a raised maternal temperature could be the same for a baby in skin contact. They concluded that
maternal analgesia during labour might disturb and delay important aspects of the newborn's interactive behaviour. An interesting possible benefit for those babies born following difficult labours was Ingram et al's (2002) findings. In a study of 80 babies, it was found that those having prolonged skin-to-skin contact were less mucousy. They hypothesised that early ingestion of colostrum, which speeds gut transit time could help to eliminate swallowed mucus more quickly enabling the baby to settle and feed normally.

A review of current knowledge by Buckley (2003), explained that synthetic oxytocin used for induction or acceleration of labour, is continuous not pulsatile, reducing natural oxytocin without giving the natural 'brain' effects. Epidurals can inhibit beta-endorphin and oxytocin peaks at birth and drugs enter the circulation, affecting the fetus more than mother. Epidural anaesthesia, with the ½ life of bupivacaine being 2.7 hours in the adult and 8 hours in the neonate, would inhibit both the beta-endorphin and oxytocin peak at birth. There would be reduced catecholamines for both mother and baby, with the consequent impact on adaptation to life. Caesarean section, without labour, would have similar effects. A Canadian prospective study of 189 women (Halpern et al, 1999) looked at the effects of analgesia on breastfeeding success. It was fascinating to note that only 23% of women had natural births and these were never mentioned in the report. The study could not demonstrate any association between analgesia use and breastfeeding success, although 36% had initiation problems in hospital. At phone contact at 6 wks, 72% of women were fully breastfeeding. Whilst this might be reassuring for women, it could depend on their having access to the same level of care in a reportedly very strongly supportive breastfeeding culture, where they had
50 lactation consultants. The study concluded by recommending that other institutions examine their post-delivery breastfeeding policies, to provide the same support, but do not mention a reduction in analgesia rate which would be my first priority.

**Attachment and Bonding**

If babies are helped to survive birth and thrive by experiencing skin-to-skin contact, it could be valuable to explore neuroendocrine studies and other research which might illuminate this. Psychoanalytic theory is an attempt to explain the functioning of personality in both its healthy and pathological aspects. In 1956, Bowlby (1982) began studying how children responded to the temporary loss of their mother, resulting in his classic work on ‘Attachment and Loss’. He observed that most psychoanalysts started from an end point and worked backwards whilst he attempted the opposite, by observing very young children and going forwards, looking for regular patterns. Human attachment is a complex phenomenon and Bowlby (1979) examined the work of ethologists, the study of animal behaviour such as imprinting as well as psychoanalytic theories, to see if any parallels could be drawn. Although some disputed instinctive behaviour in man, Bowlby believed that a child’s behaviour typically follows a predictable pattern in almost all cases, it being not a simple response to a single stimulus but a sequence of behaviour.

Bowlby’s hypothesis of attachment behaviour (put forward in 1958) suggested activities that have proximity to the mother as a predictable outcome. He believed that it was the activation of a behavioural system, to maintain homeostasis, admitting that this was controversial amongst developmental psychologists and clinicians. Fonagy (2001:4) explained that there was much controversy
surrounding Bowlby’s work from psychoanalysts, and his ideas did not lead to a new psychoanalytic school, but:

‘rather, they led to a line of empirical investigation that served to distance attachment theory further and further from psychoanalysis.’

This interest tended to separate him from psychoanalysts for the last half of his life, and Fonagy (2001) commented that most psychoanalysts were worried by his simplistic ideas. Bowlby argued that it was taken for granted that the animal mother stayed with her young, being able to distinguish them and behave parentally only towards them and that the young were also able to distinguish their own parents and behave specially with them. Bowlby made no attempt to directly apply bird behaviour to mammals, but he did see links between other mammals, especially primates. In some human societies, mother and baby are never separated, as is more common in ‘developed’ countries.

Bowlby (1982) looked at the value of different methods of child care, with its effects on the developing capacity to regulate the love-hate conflict and a healthy experience of anxiety and guilt. He believed that it was not what was done, but the way it was done, giving the example of demand feeding by an anxious, ambivalent mother, which might cause more problems than a clock routine by a relaxed happy mother. His first findings were that the infant should have warmth and an intimate, continuous relationship with the mother, in which both found enjoyment. Fonagy (2001) stated that Bowlby’s observations were among the first to recognise that babies are born with a tendency to interact with others. Bowlby (1982) described infant attachment behaviours such as crying and calling which drew caregivers and other activities which could influence maternal behaviour, such as eye tracking and crying which ceased with contact. Some interactions
strengthen relationships, such as face to face interaction which elicits a response from babies. If the baby pays attention, then the mother is more likely to interact, so increasing the bond. In attachment theory, Bowlby (1982:377) implied bonding, explaining that ‘attachment behaviour’ is not applicable to the mother. The mother’s actions could be attachment care-giving, whereby both could be ‘said to have bonded’. Bowlby (1982) believed that his theory was a variant of that put forward by Freud, namely that causes of mental health problems always centre on trauma, with the first six months of life being the most vulnerable. Bowlby observed that a child’s common reaction to separation from its mother was protest followed by despair and then detachment. He believed that detachment was often seen as a sign of recovery, but if repeated, the child may demonstrate superficial sociability but be unable to form deep relationships. Bowlby (1979:129) described attachment theory as:

‘a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others.’

The outcome of which would provide a secure base from which to explore.

**Complexity of the Bonding Theory**

Klaus & Kennell (1983) believed that we cannot be too literal about how bonding works, not being an instantaneous action, like glue, but a complex process. They called the time immediately after birth a ‘sensitive’ period where small disruptions can cause the evidence to evaporate. They made the point that lower primate babies cling to their mothers, but higher order primates such as the gorilla and human cannot. This means that they are dependant on the mother carrying them, making it more important that the attachment to the baby is strong because survival depends on it. The dilemma of whether to stress the value of early
contact, is discussed by Klaus & Kennell (1983) who felt that most humans are adaptable enough to bond later, but wonder about those who might be on the ‘limits of adaptability’ such as unsupported, single mothers in poor socio-economic circumstances. Contact in privacy was seen as important, in the first hour as well as in the first days, yet whilst either time may be more important to some mothers, the baby is more alert in first hour. Not too long ago many mothers had enforced and prolonged separation from babies, yet still have been good parents, suggesting that human survival is not usually reliant on just one mechanism, but keeping mother and baby close soon after birth is more likely to enhance the bond.

Sluckin et al (1983) commented that some people used Bowlby’s theories, often misquoting them, and applying them also to the mother’s attachment to her baby i.e. bonding. They argued that the implication of bonding is that it would lead to unconditional love and self sacrifice. This unbalanced viewpoint had been given in seminars and talks rather than scientific papers, the implication being that if bonding was not experienced, it might blight motherly love for ever. Bowlby does mention the idea of bonding, but not in such a forceful way. Whilst research was being done, notably by Klaus & Kennell, according to Sluckin et al (1983), some people spread the message that unless a mother and baby ‘bonded’ at birth, then there could be problems with parenting later. Early protagonists suggested, on tenuous evidence, that there could be links to autism or even potential child abuse. Some mothers might have felt pressurised to ‘bond’ with their babies and experienced guilt if it did not happen. Parents, who were separated from their babies whilst in neonatal units, might possibly be afraid for their child’s well-
being. Sluckin et al (1983:18) felt that humans were much more adaptable than that, saying:

'Liberating ideas can become oppressive when elevated into prescriptive dogmas.'

They maintained that some of the behaviours recorded by researchers were also those displayed by strangers and that most women have a tendency to smile and touch other people’s children without any question of bonding with them. Whilst there are similarities in animal and human behaviour, this does not make maternal bonding into an exact science. What it does seem to suggest is that mothers, given the chance, might actually enjoy and want proximity with their newborn baby.

Sluckin et al (1983) concluded that it was good to keep mother and baby together, but not a disaster if it could not occur and the relationship would start later. They believed that the bonding doctrine had some good effects, such as keeping mother and baby together in hospital and enabling access to pre-term babies, but it was bad for others, by harassing those mothers who did not want early contact.

**Hormonal Influences on Behaviour**

Since these early theories, more research has been conducted discovering hormonal influences on the behaviours observed. The hypothesis was proposed by Lagercrantz & Slotkin (1986) that the catecholamine surge at birth facilitated attachment between mother and child. The implication being that being aroused and ready to interact at birth was more adaptive than being sluggish and unaware.

The concentrations seen normally in a neonate during the first hours of life would cause an adult to be alert and aroused and even at times to have a sense of well-being. Buckley (2003) argued that under the influence of birth hormones such as endorphins, adrenaline, noradrenaline and prolactin, which she believed were
hormones of love and transcendence, a woman might meet her newborn baby predisposed to form a relationship. Skin contact and eye contact would optimise oxytocin release and beta-endorphins which peak at birth are also present in the colostrum for the baby. Uvnäs-Moberg (1996) concluded that as more research was done, it was clear that neuroendocrine mechanisms were involved in mother-child interactions both in utero and after birth. Carter et al (1992, Carter, 1998, Carter, 2003) reviewing the literature also found that there was increasing recognition that oxytocin could alter behaviour, although McCarthy & Altemus (1997) pointed out that oxytocin in humans is harder to investigate than in animals because of the powerful influence of human cultural expectations. Nissen et al (1995) performed research with 18 healthy women after a normal pregnancy and birth at term and having skin-to-skin contact with their babies. They took blood samples approximately 7 and 15 minutes before delivery and then every 15 minutes for 2 hours. Whilst the median suckling time was at 86 minutes, they discovered a significant and spontaneous peak of oxytocin at the first test i.e. before the first breastfeed. In most cases, there were several peaks up to an hour post partum then returning to pre-labour levels. Nissen et al’s (1995) findings seem to show that maternal oxytocin may be important in the bonding of mother and newborn.

Possible effects of intra-cerebral oxytocin on the human mother during the sensitive time around birthing might be to enhance the mother-baby bond and help with both parenting and breastfeeding success. In a review of research in psychoneuroendocrinology, Carter (1998) pointed out that oxytocin was implicated in memory and sensory processing. Oxytocin and vasopressin (anti-
diuretic hormone) are both from the posterior pituitary gland and can bind to each other's receptors. Vasopressin, as well as having cardiovascular effects and conservation of water, is implicated in memory and attention or learning so might enhance a mother's interactions. A review of literature by Insel (2003:351) concluded that:

‘Nursing, vocalization and play all share a common motivation for social interaction and under appropriate circumstances may lead to social attachment.’

Just before birth, rats nest build, show intense interest in pups and have a decrease in fearfulness. An experiment was performed by Insel (2003) where a reward of cocaine or access to pups was offered to new mother rats. On day 8 the preferred reward was pups, obviously perceived as better than a potently rewarding psycho-stimulant. Dopamine is implicated in the formation of pair bonds and maternal behaviour, so it is possible that hormones facilitate the link to the brain. Insel (2003) believed that oxytocin and vasopressin might be important for linking social signals to reinforcement pathways, as both are released in labour. Both hormones are known to influence social memory, where the mothers accepted strangers more readily. He suggested that illegal opiate use could be a substitute for the rewards of social attachments. Oxytocin in both mother and baby would produce a sense of relaxation and promote attraction between caregivers and receivers. This idea was reinforced by research in Russia (Lvoff et al, 2000) which found that the introduction of practices such as early mother-baby contact and rooming-in was associated with a reduction in infant abandonment.

Fleming et al (1997a) followed 667 women pre-conceptually until three months after birth, finding a strong correlation between postpartum cortisol and the intensity of mother's behaviour whilst interacting with the baby on day three. This
effect was enhanced if they had positive attitudes in pregnancy. Those with a smaller decline in the ratio of estradiol to progesterone, or estradiol levels from pregnancy to early postpartum period reported highest attachment feelings. They felt that hormonal effects may enhance feelings of nurturance by influencing the mother’s feelings of well-being. Seifritz et al (2003) suggested that because survival is important in evolution it is likely that specific brain mechanisms have developed to enable this. Animal studies showed that the mammalian forebrain is important for reproductive physiology and behaviour. In humans, imaging studies demonstrated that mothers of young children showed neural activation in the limbic forebrain in response to a baby crying, but more information was felt to be needed. Research was performed by Seifritz et al (2003) using four groups of ten (mother/father of young children and women/men with no children), using magnetic resonance imaging. Cries of infant distress and laughing (not own child) were used with a control (an average of spectral frequency of vocalisation). Infant vocalisations produced neural activity, which were different in men and women. In women there was also a significant decrease in the activity of one area of the brain. Seifritz et al (2003:1371) felt that this suggested:

‘a gating process suppressing less-relevant sensory information to optimize the cognitive and emotional resource recruitment for goal directed behaviours or anticipated emotional states.’

The response changed dramatically with parents, showing greater activation with crying and the findings compared with non human mammals.

**Extra Contact is Valuable**

Carter (1998) pointed out that because of the difficulty in investigating ‘love’, usually behaviour was studied instead. Attachment is considered to be a part of
love, as it provides security and reduces stress. Staying close and voluntary
contact are common behaviours to use for tests as well as visual tracking. Early
experimental research was performed by De Chateau & Wiberg (1977) with 22
primigravid women having 15 minutes extra skin-to-skin contact at birth and
suckling with their baby. 20 other mothers and babies were separated for three
days, as were the extra contact mothers after their initial contact. The behaviour of
the extra contact mothers was significantly different as they held and cuddled their
baby more, whilst the unfortunate separated babies cried more. Ali & Lowry
(1981) undertook a controlled study where routine care meant nine hours
separation of mother and baby. All women had normal births with no analgesia.
One group of mother baby pairs were allowed 45 minutes extra contact at birth.
This group had more exclusive breastfeeding, fewer had left the baby with others
and there was more gaze and vocal contact during feeding at 12 wks. In a study by
Widström et al (1990) mothers were randomly assigned to routine care or extra
contact. The mothers who had skin contact and earlier suckling with their babies
were more interactive with their babies and left them for less time in the nursery.
Feldman et al (2003) observed the care of 146 pre-term babies when skin-to-skin
contact (also known as kangaroo care) was used. Family interactions after skin
contact were improved and mothers were more sensitive to their baby’s needs and
performed less intrusive interactions. The babies were also calmer and had better
interaction. Feldman et al (2003) found that mothers of pre-term babies often
seemed to over-compensate in the early days, by their way of talking, giving toys
or handling the baby which was not necessarily adapted to the child’s needs. Skin
contact seemed to address this, with the mothers gradually learning their own
baby’s cues.
Nelson & Panksepp (1998) discussed Bowlby’s theory about social attachment, saying that several similarities had been found across species which suggested a common neural system. The neural circuits for social engagement such as maternal behaviour however, though not well understood, seemed different from that for separation distress. Sosa et al (1978) observed that sheep had a ‘time limited’ sensitive period and if separated, the sheep usually refused the lamb. Their early research in humans developed this idea, by observing 60 women to explore whether a sensitive period might be demonstrated. 20 women had skin-to-skin contact with their babies for 20 minutes at birth, 20 had skin-to-skin contact for 45 minutes, but 12 hrs after birth and 20 were separated. Later observation found more affectionate behaviour between mother and baby in early skin contact group. Nowak (1996) described the actions of sheep and lambs at birth. The merino ewe was apparently not known as a good mother in difficult situations, but observations during the lambing period showed that what happened at birth was crucial. If mother and young stayed together for a minimum of six hours and suckling occurred, the mothering was more successful. The usual behaviour of ewes changed after birth, where they separated from the flock, stayed in one place, were less afraid of others such as men and dogs and became attached to their newborn. All these actions were the exact opposite of what was normal for sheep. Pederson et al (1992b: 62) reported that in experiments on rats, raised oestrogen and reduced progesterone just before birth were critical to activation of maternal behaviour, and when injected with oxytocin intra-cerebrally, 42% of virgin rats developed nurturing behaviours in less than one hour.
Carter (1998) concluded that oxytocin may increase tolerance, so enhancing maternal behaviour. The basal level of oxytocin is associated with calmness, whereas pulsatile oxytocin stimulates the desire to please and interact socially. Uvnäs-Moberg (1998) stated that breastfeeding women have a smaller cortisol rise in response to stress, tending to make them calmer, more interactive and social compared to non-pregnant and artificially feeding women. She pointed out that the personality profile of breastfeeding women showed increased social competence and calmness. How much the baby is held, touched and breastfed may influence the hormonal interaction and so the physiology and behaviour of the baby. An RCT by Tessier et al (1998) involving 488 babies, found that mothers caring for their babies with Kangaroo care (skin-to-skin contact) were more competent and had a ‘resilience effect’, in that maternal stress levels were lower. Experimental research using intra-cerebral oxytocin demonstrated strong anti-depressant effects using rats, leading McCarthy et al (1992) to speculate about the significance of intra-cerebral oxytocin in maternal behaviour. As well as the complexity of hormonal influences on mother and baby, concerning touch, smell and sound, there is the fact that oxytocin is a hormone from the posterior pituitary gland, which because of its direct link to the brain, is able to become a conditioned reflex. This would mean that it would only need the proximity of the person, or the surroundings to facilitate release with consequent benefits.

**Hormones Influence Odour Preference**

Both mother and baby seem to be influenced by each other’s odour. A common midwifery practice when mother and baby are separated is to ask the mother to smell a garment worn by her baby, whilst she is expressing milk as this helps with
the oxytocin response and so the milk let-down. High cortisol levels on day 2-3 correlated with positive maternal behaviour and attitudes and positive responses to odour from the baby (Carter, 1998). Fleming et al (1997b) compared salivary cortisol levels, the mother's behaviour with her baby and her response to its odour, finding that cortisol was associated with the mother’s ability to recognise their infants by their smell. Fleming et al (1997b) could not explain why cortisol, which is a stress hormone, would be involved in this but concluded that it may have a different meaning post partum. Cortisol, which is easy to measure, may be only a marker for other chemicals which are not.

Animal studies have found that oxytocin can help nipple attachment, so oxytocin may act on the mother to change her ‘smell’, which would aid the newborn response to her. Romeyer et al (1994) discovered that baby goats found the teat by smell, which is similar in sheep and pigs. Human babies were discovered to have a preference for the mother’s unwashed breast when 30 unsedated mother and baby couples were observed (Varendi et al, 1994). One breast was washed immediately after birth and the baby put into skin contact with 22 babies selecting the unwashed breast. Mizuno et al (2004) reported that infant serum noradrenaline levels in the first hour after birth were 20-30 times higher than later. They reviewed literature which found that noradrenaline neurones in the brain sent signals to the olfactory bulbs and promoted olfactory learning. 60 healthy full term babies were randomly assigned to extensive skin contact (50 minutes or more plus suckling) or no skin contact. After this, all babies were in the nursery for 24 hrs as was the norm in Japan and were bottle fed. This meant that the separation group did not meet their mother for 24 hours. Babies were studied at 1
and 4 days, approximately one hour after a feed, when lying in the cot quietly alert. Odours were offered to the babies in random order; either their own mothers milk; another mother’s milk; formula; orange or distilled water. The frequency of mouthing movements increased significantly when breast milk was presented (at 1 and 4 days). At the four day test, there were more mouthing movements for the baby’s own mother’s milk.

Touching, Eye Contact and Vocal Communication

Experimental work has demonstrated complex links between the brain and behaviour, showing subtle ways of bodily communication. Reviews of the literature on psychoneuroendocrinology (Carter et al, 1992, Carter, 1998) demonstrated with animals the links between hormones, the brain and behaviour related to attachment at birth and to breastfeeding in mammals. In psychoneuroimmunology (Cohen, 2006), links were found between the brain and immune responses, in both animals and humans, showing the effects of stress on the body. Klaus et al (1970) wanted to assess the effects of prolonged separation of mother and baby following pre-term birth. They observed women during their first contacts with their baby; nine were pre-term and twelve full term. All had normal births and the babies were well. Actions followed a predictable pattern for the full term mothers, with initial hesitant fingertip contact to extremities. At 4-5 minutes they started to caress the trunk with their palms then progressively made more encompassing movements. The mothers wanted their babies to open their eyes and when it happened they said they felt closer to them. Pre-term mothers showed an attenuated sequence but in the same pattern as the full term mothers. Klaus et al (1970) concluded that there was strong evidence for species specific
behaviour at first contact. They commented that previous observations were done with dressed babies and probably a heavily sedated mother and baby. This would mean a limp, unresponsive baby with closed eyes which would not provide the same stimulus. Klaus & Klaus (1985:104) observed that in the first hour after birth, there was an extended period of quiet alertness, where eye contact was very special. Mothers reporting feeling:

'warmly close to their infants after the infant has looked at them, acknowledging the importance of relating to the baby through eye contact.'

Early work by Robson (1967:13) observed that the baby’s first behaviours facilitated maternal care-taking responses and observed eye-to-eye contact, which was:

'an interchange that mediates a substantial part of the non-verbal transactions between human beings.'

He concluded that when people do not communicate visually, it was usually a sign that something was wrong, describing early researchers who found that the most effective stimulus was when the eyes met and faces were in the same plane, 'en face'. Robson spent 'many hours' watching mother and baby interactions. Women in Robson’s study described first feeling love when the baby met their eyes, when the baby first became 'a person'. He explained the problems of communication with a baby who is blind, and described the troubled feelings of new mothers before the baby met their eyes, which resolved when this had happened. Mothers reported that during feeding, eye contact could disrupt the sucking, by dominating it, as the baby was totally distracted by the gaze. When a baby was spoken to, he tended to look at the eyes, not the mouth. Maternal caretaking tended to occur with the mother’s face at a 45 degree orientation relative to that of the infant, whereas social interaction was at 0 degrees. A mother who is the perfect caretaker, but does not look at her baby face to face may deprive her baby of this 'face tie'.
Robson suggested that if the face tie is not established, the baby would experience varying degrees of interference in forming his earliest and probably future relationships.

Klaus & Klaus (1985) found in experiments, that babies preferred their mother’s voice and at first did not respond as much to father’s voice. They speculated that this was because in fetal life, the male deep voice does not penetrate the uterus as easily. Spence & Freeman (1996) explained how extra-uterine sounds are detectable in utero, with the body tissue acting as a ‘low-pass’ filter. Higher frequencies were not heard as easily and the mother’s voice was more amplified than others. As the fetal ear develops, it hears low sounds first. Experiments on 16 babies by Spence & Freeman (1996) compared responses to the mother’s voice or another female voice. These were low-pass filtered, which removed linguistic content as these are mainly high frequency. Overall quality and timbre is mostly in low frequencies. In a quiet, dim room, tapes were played via headphones, with the baby being given a dummy connected to pressure transducer. A whispered voice was not like intra-uterine sounds and was not responded to. Newborns responded to their own mother’s voice, but not if she whispered, even though other parts of the experiment showed that they could hear the whispered voice. They did not prefer the father’s voice. Dwyer et al (1998) found that sheep have a specific, low frequency vocalisation or ‘rumble’ specific towards newborn lambs. Breeds that are normally silent begin to vocalise more frequently after birth. In humans, vocal communication may indicate maternal responsiveness. A vocalisation of low amplitude and frequency by the mother to her young has been reported in a wide variety of mammalian species and may be for reassurance and
to keep them quiet. This is a sound for proximity and is not meant to travel far, possibly because of the danger of predators and plays an important part in early attachment in sheep and probably humans.

**Possible Long Term Benefits of Skin-to-Skin Contact**

Apart from the acknowledged long term health benefits of breastfeeding for both mother and baby (UNICEF UK Baby Friendly Initiative, 2004), there are other possible benefits to well-being. As discussed previously, Bowlby’s (1982) observations of a child’s reaction to maternal separation were commonly cries of protest followed by despair and then detachment, a quietness which might be mistaken for recovery. From these observations, Bowlby believed that the ability to make relationships in later life could be affected. Further research studies seem to give weight to this argument. Weller & Feldman (2003) reported that the development of emotion regulation by early mother-baby contact seemed important for future coping skills and the ability to handle stress. They performed experiments using pre-term babies, finding that skin-to-skin contact (kangaroo care) helped these babies to cope with stressful situations. A literature review by White-Traut (2004) concluded that early experiences could affect the pituitary-adrenal response to stress, reporting that skin-to-skin contact (kangaroo care) and massage for pre-term babies reduced their stress response. Another literature review by Yellot (2001) found that pre-term babies progressed faster with skin-to-skin contact (kangaroo care) and they grew more quickly, which meant that they were discharged home earlier. A study of 201 College students by Fukunishi et al (1999) examined the role of early mother-infant relationships in developing emotion regulation. Difficulties in describing feelings and higher sympathetic
activity during rest periods of the testing phase were associated with lower levels of maternal care. Similar findings were reported by Ingram et al (2001), who reviewed literature suggesting that healthy bonding was essential for effective behaviour and lack of it was linked to depression and anxiety. This was followed by a survey of 300 University students, to examine the association between perception of parental bonding and lack of care or overprotection. They found that reported poor parental care was associated with more dysfunctional thinking and lack of maternal warmth was associated with more negative self statements.

Conclusion
Birth practices world wide are heavily influenced by cultural rituals which are not necessarily beneficial and could disrupt the specific and complex behaviours in mother and baby which enhance infant survival and successful mothering. Research over the last 30 years has been examined in this chapter providing evidence that uninterrupted skin-to-skin contact calms babies after the stress of birth, ensures their heat regulation and enhances breastfeeding success. Disturbing the process by separation of mother and baby or subduing the behaviour with sedation can remove these benefits. Attachment of the infant to the mother and bonding of the mother to the infant is complex and can also be disrupted. Neurohormonal and other findings suggest that touch; eye contact and smell are also important factors. Skin-to-skin contact may have longer term consequences beyond breastfeeding success, perhaps influencing the ability to cope with stressful events. After a detailed examination of the literature, whilst acknowledging the previously described work of Carfoot et al (2003, 2005) and Anderson et al (2003), I have difficulty in coming to any other conclusion except
that encouraging undisturbed skin-to-skin contact between a mother and her newborn baby should be offered as the gold standard for care at every birth.
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<th><strong>Table 2</strong></th>
<th><strong>Overview of Methodology</strong></th>
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<tr>
<td><strong>Epistemology</strong></td>
<td>Informs theoretical perspective. A way of understanding and explaining how we know what we know.</td>
</tr>
<tr>
<td><strong>Constructionism</strong></td>
<td>Reality is constructed by interactions between human beings. Objectivity and subjectivity need to be brought together and held together indissolubly (Crotty, 1998). Social Constructionism Culture was there before we were born - people make sense of their world, but it is set in a social perspective (Berger &amp; Luckmann, 1966, Shotton, 1993).</td>
</tr>
<tr>
<td><strong>Theoretical perspective</strong></td>
<td>Philosophical stance informing methodology. Providing context. A basis for the logic and criteria of the methodology.</td>
</tr>
<tr>
<td><strong>Critical Theory</strong></td>
<td>Attempts to find historical reasons which have caused subjective meaning to become distorted. Seeks not just to understand but to challenge and seek change.</td>
</tr>
<tr>
<td><strong>Critical social science</strong></td>
<td>Enlightenment, empowerment, emancipation (Fay, 1987) The ideal communication would be free from systematic distortion, allowing self-presentation by participants, characterised by mutuality of expressions rather than one-sided norms. Unconstrained consensus emerges, whereby the idea of truth can be analysed (Carr &amp; Kemmis, 1986).</td>
</tr>
<tr>
<td><strong>Communicative Action</strong></td>
<td>Communicative competence. Lifeworld and system (Habermas, 1973, 1987). Objective, social and subjective worlds used to interpret ideas of validity of statements Cultural reproduction (joins to existing practices); social integration (does not affect the identity of the group) and socialization (ensures new occurrences are consistent with group norms). Uncoupling of the system and lifeworld – people can define themselves and their aspirations in system terms.</td>
</tr>
<tr>
<td><strong>Critical Feminist theory</strong></td>
<td>Looking at how subordinate groups conform to the dominant one. Uses this knowledge for the emancipation and empowerment of women (Harding, 1986, Hartsock, 1998).</td>
</tr>
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<td><strong>Postmodern feminism</strong></td>
<td>Not just changing something within a horizon, but of changing the horizon itself (Irigaray, 1986, Tong 1998).</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Governs the choice of methods. Design.</td>
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<td><strong>Method</strong></td>
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<td><strong>Focus groups. Participant Observation. Interviews.</strong></td>
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Chapter 3 Methodology

Introduction
In this chapter I will explore action research methodology and the epistemology, ontology and theoretical perspectives underpinning it with reference to why other perspectives were not appropriate. These philosophical beliefs determine how the inquirer should try to find out about knowledge (Guba, 1990). Social constructionism is the epistemology which most closely matches the type of action research which was undertaken, whilst critical theory and more specifically critical social science following Habermas and some emancipatory aspects of feminism are the theoretical perspectives underpinning the project. I have drawn heavily on the work of Foucault (1970, 1977, 1980) in Chapter 5 and whilst he was not known as a critical theorist, his work along with others, does have some congruence with it, and has helped me to address the complex issues of power within childbearing. Freire (1993), a critical theorist also addresses power, but from the perspective of oppressed groups with a view to their freedom from domination, so fulfilling the aim of critical theory which is empowerment. This is dealt with more fully in Chapter 5. Postmodern feminist literature has been used to explore some issues arising during the work, especially in Chapter 7, but the main focus remains on critical perspectives. Whilst not engaging with psychoanalysis as such, some insights from this literature have helped me to clarify issues raised, especially in respect of the experience of skin-to-skin contact and its meaning for mothers. I will demonstrate congruence and contradictions in the
work of key theorists upon which I draw, illustrating their relevance for my study despite their tensions.

**Preparation for Research**

In order to judge the value of any research, the basic beliefs of the researcher must be made overt, as our actions are influenced by them. According to Crotty (1998), this would make research outcomes and conclusions more convincing. Crotty argued that researchers typically start off with a real life issue needing to be addressed, rather than by exploring their philosophical beliefs, which, sounds like we create the research ourselves, but Crotty (1998) supported this, because he believed that every piece of research was unique. However, despite this he believed that looking at recognised research designs and their theoretical underpinnings was formative by enabling other research possibilities to be seen from what had gone before. Ultimately however, he believed that research outcomes were required that merited respect so that others would recognise the findings as sound. For this reason, Crotty believed that we must make our thought processes open to scrutiny, which leads to explanations of epistemology and theoretical perspectives. Having done this, the chosen methodology becomes clearer in the way it meets the purposes of the research.

In my undergraduate dissertation, I completed an ethnographic study using participant observation and semi-structured interviews (Price, 1995). This would be helpful in some aspects of the project; however I had never been involved with action research,
although the possibilities excited me. I had attended a three day research conference
the previous year, where action research was a topic of one of the workshops and its
possibilities for enabling change in practice became clearer. Following this, I gained
funding to carry out this project, which helped to clarify my thoughts about the
direction to be taken. When I considered which approach to take, I wanted very much
to influence practice within the area of my growing interest, which was breastfeeding
practice. As previously discussed in Chapter 1, I had been frustrated in my attempts
to influence practice in the past and believed that an action research approach might
be effective, because I could work with midwives and women and we could try to
facilitate change together. A different approach might have been by trying to
influence or impose my own views on others, because ‘I knew it was right’. The
danger here would be of entering the field like an evangelist and possibly coercing
those present or perhaps carrying them along with my enthusiasm. From past
experience, I knew that this could have a very short term effect and revert as soon as I
had left, or be sabotaged before any change could occur.

As I reflected on the type of person I had become and the skills I had gained, it was
clear that many life events and learning experiences had shaped me. As a teacher, I
had always wanted to encourage students to find knowledge and solve their own
problems. Initially, this was to some extent prevented by the more didactic style of
teaching which was common but on the verge of changing as I entered the profession
in 1989. As the educational environment began to change, in 1996 our Department of
Midwifery began to embrace a problem-based learning approach to curriculum
delivery. In 1999 I took my first group of students using this method and together we embraced this way of teaching and learning. Whilst the setting of the ‘problem’ to be solved required much ingenuity if it was to progress to its intended outcomes, I had to learn to work with uncertainty, to almost sit on my hands and try not to speak too much, whilst students worked out their own problems, with myself as a safety net. I believe that this ongoing experience has enhanced my facilitation skills and the ‘fine line’ between ‘giving’ knowledge and encouraging participants towards self discovery.

This has parallels with the work of Paolo Freire (1993, 1998), whose work I discuss in more detail later in Chapter 5. Freire was a critical theorist (Aronowitz, 1998) who originally worked in Brazil with oppressed peasants, but who was forced into exile by a political coup. His teaching methods were to raise critical consciousness (or conscientization), which helps in understanding how our present and its received wisdom might have been influenced by the past in complex ways (Aronowitz, 1998). This is similar to problem based learning rather than the ‘banking type’ of traditional approaches which tend to encourage dependence. Freire (1998:17) believed that we should try to expose the elements of a dominant culture ‘without fixing moral blame’. Macedo (1998:pxxix) pointed out that we needed to understand our unique position when trying to help others, so that we do not:

‘on the one hand, turn help into a type of missionary paternalism and, on the other hand, limit the possibilities for the creation of structures that lead to real empowerment.’

I believe that this concept tempered the possibility of dominance or coercion on my part as a researcher as well as having a healthy amount of humility regarding my
clinical practice. Despite providing continuity of care for three women during 1999, I still had a lack of current clinical experience in September 2001. Before the start of the project, I read Winter & Munn-Giddens (2001) which is a handbook for novice action researchers. Central to this book were several case studies of successful action research projects using different approaches in varied healthcare settings. I was guided by an instinctive feel for what might work in the setting where my project was to be conducted and this thinking and planning set the project in motion until the collaborative process began.

**Philosophical Beliefs**

The following exploration of my beliefs which underpin the conduct of research gives an insight into what is thought to be the nature of reality and therefore on what basis any claims to truth are laid. Guba (1990:17) defined a paradigm as:

> 'a basic set of beliefs that guide action.'

Whilst Guba suggested that all paradigms were human constructions, and therefore subject to the possibility of error, he believed that broadly they would be distinguished by the way they answered three philosophical questions regarding epistemology, ontology and methodology. Epistemology explains 'what it means to know' and gives philosophical grounds for deciding what kinds of knowledge are possible and how we try to explain our claims to knowledge. It asks about the relationship between the inquirer and what is known (Guba, 1990). According to Crotty (1998) meaning exists in our engagement with world reality, so ontology asks about our understanding of the nature of reality. A theoretical perspective is our view of the world and social life and helps others to see our assumptions about reality,
establishing a basis for the logic and criteria of the methodology chosen (Crotty, 1998). Because of issues arising later regarding critical theory and the work of Habermas regarding knowledge-constitutive interests, I will briefly address the major paradigms followed by a more detailed examination of those congruent with the action research project. Crotty (1998) described three epistemological grounds for deciding what kinds of knowledge were possible, objectivism, subjectivism and constructionism. These would be congruent with either a realist or relativist ontology. An objectivist epistemology would be based in realist ontology and have a theoretical perspective of positivism or postpositivism. The positivist viewpoint would be that:

'objects in the world have meaning prior to, and independently of, any consciousness of them' (Crotty, 1998:27).

It would be a way to gain knowledge grounded in direct experience, not speculation, with no statement being meaningful unless it was capable of being verified and science would 'discover' meaning already inherent in the object it considered (Crotty, 1998:27). Positivist beliefs are about raising people to 'a level of true consciousness' (Guba, 1990:19) and values would be excluded from the inquiry using methodologies of experimentation and control. Crotty observed that this confidence in science came from a conviction that it was accurate, and beyond question. However he argued (Crotty, 1998) that whilst it might be acceptable to speak of scientific knowledge, to claim that it was objective, absolutely certain and accurate was another matter.

A later development of this view was post-positivism, which without entirely rejecting the objectivity of positivism, made more modest claims, by speaking of probability rather than certainty and challenging the ideas that the observer and the
observed could be independent. It would seek to approximate the truth rather than grasping its totality (Crotty, 1998). Postpositivist beliefs modified positivism by taking a critical realist ontological stance, believing that whilst objectivity could never be attained because of human weaknesses, it should at least be a goal. This methodology would use as many sources as possible, to try to remove distortions from any findings. Harman (1996:31) argued that the accepted epistemology of Western science which suggested a world within which everything obeys inviolable “scientific laws”, may be good for manipulative technologies, but does not provide a worldview to guide someone’s decision making. The belief that everything could be explained by laws would rule out the mind or spirit of human beings to contribute to reality. Realism stated Crotty (1998:10) was often taken to imply objectivism, but:

‘the existence of a world without a mind is conceivable. Meaning without a mind is not.’

The interpretivist viewpoint would have a subjectivist epistemology based in relativist ontology. Relativist beliefs are where there is thought to be no single universal truth and knowledge is said to be always incomplete, or not yet refuted (Winter & Munn-Giddings, 2001). The theoretical perspective of interpretivism was developed as a distinction from positivism to help explain the complexity of human life (Crotty, 1998:67), looking for:

‘culturally derived and historically situated interpretations of the social life-world,’ and included amongst other approaches, aspects of phenomenology, seeing a world:

‘teeming with potential meaning.’

Carr & Kemmis (1986) argued that a weakness of the interpretive model could be its failure to acknowledge how understandings might be shaped by beliefs formed by
social structures, rather than as a conscious choice. Crotty (1998:159) observed that interpretivists might hear in their descriptions:

‘the voice of an inherited tradition and prevailing culture.’

A constructionist epistemology would be based on an ontology which viewed reality as socially formed therefore meaning would not be discovered but created.

Sense is made of the world, but within a social perspective:

‘our culture brings things into view for us and endows them with meaning and, by the same token, leads us to ignore other things’ (Crotty, 1998:54).

Constructionism emphasises the hold our culture has on us and gives us a quite definite view of the world and because it also must be questioned it fosters a critical spirit. Crotty (1998:60) suggested that there could be two branches within constructionist social science, leading to either interpretivism or critical theory, which he argued ‘reflects its tortuous history’. Constructionism and constructivism are words used interchangeably by some, but Crotty (1998) offers a useful definition of their differences. Constructivism would be used in the interpretivist sense, meaning the way that individuals make sense of the objects in their world. Contrary to this, constructionist beliefs are that we are introduced to meaning through culture and subcultures into which we are born which give life meaning and shape our thoughts and behaviours. This links to a theoretical perspective within the critical theory tradition, rather than in interpretivist one, because it is more congruent with the nature of potential change in clinical practice. Professional life is based on the assumption that we can discriminate between what are good or bad actions so a relativist stance does not always address the problems of those who must make practical decisions (Winter & Munn-Giddings, 2001). If truth is wholly relative, we might never be able to judge
what is best to do and the nature of practice should be to try to determine what outcomes might be possible. Crotty (1998:118) believed that we could never see reality as being linear or events being ‘causally related to each other’ as reality was multifaceted. Winter & Munn-Giddings (2001) suggested that literature could only say what had been found elsewhere, to help us decide but it could not tell us what to do in a particular situation in our own practice area with that particular client. This dilemma reflects the social constructionist links to both relativist and realist ontology.

I will now explore these issues in more detail.

**Social Constructionism**

Crotty (1998:42) believed constructionism to have elements of both realist and relativist beliefs, being:

> ‘the view that all knowledge, and therefore, all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.’

Harré (1993:vii) discussed a discursively constructed world, which is the:

> ‘.. joint conversational activity of multitudes of people.’

Meaning cannot simply be described as objective or subjective, but Crotty (1998:42) explained that objectivity and subjectivity needed to be brought together, which is what constructionism tries to achieve. Shotter (1993) suggested that the beliefs of social constructionism and realism could seem to be in opposition. However, if it is true that the world is socially constructed then Shotter proposed that acceptable standards in our conduct must be observed which would include a realist stance, or risk the credibility of our actions. Guba (1990) believed that no theory could ever be
fully tested, even if most agree, some may not, as there could be many constructions. This means that knowledge is never ultimately true but always changing. Burr (1995) suggested that constructionism, would challenge the conventional view that knowledge was unbiased and objective and have an impact on what is regarded as truth, i.e. that it is socially constructed and not always a direct perception of reality. Our culture teaches us how to see things and they may have invisible meanings because they are a part of the background, so we should try to discover the multiple, taken-for-granted human realities (Berger & Luckmann, 1966). Crotty (1998:57) suggested that people might try to:

'"set aside' much of the baggage they bring with them in order to be 'scientific', but their starting point is inevitably that of the everyday understanding in their culture.'

We make and remake our own social worlds, but Shotter (1993) suggested that we can also be made and remade by them in the process. A person therefore cannot be understood as comprehensively if separated from the social context which shaped them (Berger & Luckmann, 1966). Freire (1998) pointed out that our awareness of the world was a sign that we were involved in our construction of that awareness, arguing that although we were conditioned by our selves and our culture, we were not pre-determined, implying that change is possible. Shotter (1993:3) proposed that not only was there practical and theoretical knowledge but 'knowing of a third kind' a constructive one that is developed socially and depending on the judgements of others within that context. Social constructionist beliefs help us to understand that change in practice needs involvement and participation, such as in action research, in order to understand how to address change within a particular culture in a particular place and time.
All activities, observed Berger & Luckmann (1966:70), are prone to habitualization, making life easier by removing the need for constant decision-making and providing a form of stability and that:

‘Institutionalization is incipient in every social situation that continues in time.’

Everyone assumes responsibility for keeping standards which serve as controls, so culture, although written by humans, can become reified making actions seem as if objectified and so unquestioned. This implies that our culture should be questioned, so fostering a critical spirit. Theories can be made to underpin an already existing social order, but social order can also be changed to fit the current prevailing theory. This gives it the power to sustain what is constituted as ‘normal’ and is sustained by people’s own actions. Berger & Luckmann (1966) believed that people were capable of producing a reality which denied them as individuals. Lincoln and Guba (2000) stated that they were social constructionists, their beliefs reflecting those embedded in critical theorist perspectives. Their criteria for judging what is ‘real’ and useful come from community agreement and have meaning for the actions to be taken. Both constructionists and critical theorists believe that ‘conventional’ research tends to justify the position of the powerful, so action is important to give a more equitable voice in decision-making to participants. Constructionism is concerned with practical and theoretical knowledge that is developed socially and depends on the judgements of others within that context. This fits an action research methodology which values experiential knowledge gained during the collaboration process. It provides understanding of why some change projects fail due to habitualization and reification
Critical Theory

Marx, in the 19th Century, was one of the principal moulders of modern thought and both inspired and laid the foundations of today's critical inquiry (Crotty, 1998). Marx was concerned not with interpreting the world, but changing it, with ideas grounded in social reality. He believed that the interactions of the powerful and powerless were interlinked and both of them influenced who held power and who was dominated by it. Marx saw oppression touching the whole of a worker's existence, shaping their thoughts and forming a false consciousness by influencing their belief systems. This was not necessarily a true belief, but what was represented to them as reality. Marx believed that emancipation must come from those who were oppressed. The Institute for Social Research, founded in the 1920's to continue the work of Marx, was the beginning of what came to be widely known as the Frankfurt School. The term critical theory, originating from these philosophers in the 1950's was not a unified approach and their thinking differed in many ways from Marx's ideas, but Crotty (1998) argued that what did unite them was a critical approach to society. They believed that a traditional theory would reflect a current situation, whereas a critical theory would seek to change it (Crotty, 1998). Carr & Kemmis (1986:138) pointed out that critical theory was not simply critical - i.e. disapproving, but attempted to find the historical reasons which had caused subjective meaning to become distorted, focusing on things that:

'deny satisfactory and interesting lives to some whilst serving the interests of others'

Critical theory then, looked at hierarchical power structures, it sought not just to understand but to challenge and seek change, looking at conflict and oppression in the social order and institutions, not just individuals (Crotty, 1998). Kincheloe &
McLaren (2000) highlighted that critical traditions drew inspiration from such theorists as Foucault, Habermas, Freire, Irigaray and Kristeva, whose work I draw on later.

Beliefs underpinning critical theory however:

‘converge in rejecting the claim of value freedom made by positivists’ (Guba, 1990:23).

Critical theorists disagreed that forms of reasoning appropriate for the inanimate world were being applied to social worlds. They wanted to challenge the power within the dominant scientific discourse of Western society, which was trying to gain control over nature and make it predictable and:

‘which reduces all social relations to the level of objectified and commodified administration systems’ (Crotty, 1998:141).

Carr & Kemmis (1986) proposed that critical theory generated the idea of a critical social science that was very different from positivist or interpretivist social science. Because those who upheld a belief in technical rationality had become complacent about its role in society, their ideas had become doctrinaire, supposing that they had solved the essential problems of what truth consisted of. Critical theorists saw a real danger in this of critical thinking replaced by rules and conformity. Scientific advances were not necessarily bad, argued Carr & Kemmis (1986), but the dilemma for critical theory was to combine praxis with modern science. Kincheloe & McLaren (2000:281) believed that a map for critical theory in any situation would be to discover how power operated and expose the things that prevented people from being autonomous. They argued that instrumental or technical rationality was one of the most oppressive features of contemporary society, being an obsession with means
rather than ends, being concerned with technique, procedure and correctness and
forgetting the humanistic side of research, which loses the understanding that value
choices would always be involved in the production of ‘facts’. Critical theorists
would be empowered to dig more deeply in the workings of the human psyche to help
discern unconscious processes that created resistance to change. Critical theorists
believed that nature was seen through a value window, so that the problem selected
for study, the methods, analysis and interpretation used, were a political act. The
methodology would be a dialogical one (Guba, 1990:24) that:

'...seeks to eliminate false consciousness and rally participants around a common
(true)?) point of view.'

The result of such effective action would be transformation.

**Critical Social Science**

Fay (1987) proposed that a critical social science could go further than critical theory
because it saw that people suffered and assumed that they wished it were otherwise. It
saw people as having the ability to transform their lives, and if they had different
perceptions, they could form an effective group to alter their society and so reduce
their suffering. Fay (1987) explained that the crucial part of critical social science was
to give people the means to see themselves differently. It offered them a theory
explaining that if they stayed the same, nothing would change; then offered them an
alternative, looking at what might be. He argued that enlightenment was not enough;
the group must come to understand itself in a new way and become empowered to
act.
‘The practical intent of critical social science is thus achieved only when all three phases of the tripartite process on enlightenment, empowerment and emancipation are completed’ (Fay, 1987:29).

False consciousness was seen as responsible for the state of things and why it persisted. Fay (1987:31) believed that a critical theory:

‘would have to offer a critique of the self-understanding of the members of its audience; an explanation of why these self-understandings, although in some false sense, continue to be employed by these members; an account of why these understandings can now be undermined and how this can be done in present circumstances …’

i.e. it would offer alternatives, show how the present situation was in crisis and identify what needed to change. Fay argued that there were four components to a fully developed critical theory and only when all four elements (Table 3) were present and related to each other consistently, could a theory of social life be called critical. This is congruent with the principles of action research and links with the cycles used during an action research process and the consciousness-raising work of Freire as previously discussed and expanded in Chapter 5.

Table 3 Four Components of a Critical Theory (Fay, 1987)

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Theory of false consciousness</td>
<td>Demonstrate why it is, why it came to be and how it is maintained. Contrast with alternative.</td>
</tr>
<tr>
<td>2 Theory of crisis</td>
<td>Show how the society is in crisis – show dissatisfaction.</td>
</tr>
<tr>
<td>3 Theory of education</td>
<td>Offer conditions needed for enlightenment and how these can be satisfied in the current social situation.</td>
</tr>
<tr>
<td>4 Theory of transformative action</td>
<td>Isolate aspects which must change if the ‘crisis’ (my commas) is to be resolved and dissatisfaction lessened. A plan of action giving a general idea of how it might be achieved.</td>
</tr>
</tbody>
</table>

I will explore some of the work of Habermas, to illuminate how he tried to develop critical social science to lead to emancipation. Habermas, who joined the Frankfurt School in the mid 1950’s, was a second generation Frankfurt theorist who believed
that words and speech were the social intercourse that counted. Hammersley (1995) stated that because of historical events since Marx’s time, critical theory tended to be more pessimistic about social transformation. The earlier critical theorists might be forgiven for this around the years of World War 2, whilst trying to remember their aims and:

‘locating residues of possible emancipation amongst the wreckage of history’ (Ray, 1993:ix).

Habermas tried to move on from Marx and criticised his focus on labour as being related to the values of technical reason (Hammersley, 1995). Ray (1993:pviii) pointed out that Habermas had taken critical theory some way from its origins, moving it from general to local social action and had brought it closer to mainstream sociology. By looking at the importance of language, he tried to achieve what he saw earlier critical theory failing to do (Crotty, 1998). Habermas thought that these theorists were more concerned with work than interaction (Scambler, 2001), so reducing communicative action to instrumental action and the further theme of domination.

Habermas tried to show how science:

‘offered only one kind of knowledge among others’ (Carr & Kemmis, 1986:134), believing that knowledge was never detached from everyday concerns and trying to help people see how ideological illusions might be helping to preserve the current social order. Habermas believed that sciences could not be understood without referring to the knowledge constitutive interests which governed them (Table 4).
Table 4  Knowledge-Constitutive Interests (Carr & Kemmis, 1986)

<table>
<thead>
<tr>
<th>Interest</th>
<th>Knowledge</th>
<th>Medium</th>
<th>Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>Instrumental (causal explanation)</td>
<td>Work</td>
<td>Empirical-analytical or natural sciences</td>
</tr>
<tr>
<td>Practical</td>
<td>Practical (understanding)</td>
<td>Language</td>
<td>Interpretive sciences</td>
</tr>
<tr>
<td>Emancipatory</td>
<td>Emancipatory (reflection)</td>
<td>Power</td>
<td>Critical sciences</td>
</tr>
</tbody>
</table>

His thesis of knowledge-constitutive interests explained that those favouring the empirical sciences i.e. positivists, would be led by technical interests around predicting and controlling, and would favour instrumental action. The human sciences, guided by a practical interest to achieve inter-subjective, interpretivist understanding, would be led by practical action. The critical sciences on the other hand would want freedom from domination, leading to the examination of language and the quest for emancipation. Different forms of science should not be a struggle between them, but acknowledge a difference in their constitutive interests, with the first two (Table 4) reflecting the traditional division and the third being new. The knowledge-constitutive interest of critical social science is in language and:

‘dialogue, as the true realisation of the linguistic ability of human beings, represents the concretion of the partners’ mutual recognition of each other as subjects with equal rights’ (Bubner, 1982:48).

A persistent criticism of Habermas was the lack of an epistemological basis for critical social science (Carr & Kemmis, 1986), so he developed the theory of communicative action (Table 7). This was the foundation for his critical social theory (Crotty, 1998). Habermas believed that it was necessary to distinguish between three functions in theory and practice, which were the way that theory was developed and
tested, the processes for organisation of enlightenment and the processes for the organisation of action (Kemmis, 2001).

**Systems and Lifeworld**

Habermas' (1987) theory about the systems perspective and the lifeworld, sought to understand how communicative action might be enhanced or disrupted. The systems perspective is seen particularly in political settings and concerns the rational working of organizational structures, comprising of rules, people’s roles and how these all contribute to attaining goals. It involves setting criteria, targets and monitoring progress towards meeting them. Habermas’ (1987) concept of the lifeworld looked at how communicative action was constantly changing yet could be limited by the system of organised society. Communicative action relies on a cooperative process of interpretation in which participants relate simultaneously to something in the objective, the social and the subjective worlds, even when they:

‘thematically stress only one of the three components in their utterances’ (Habermas, 1987:120).

Those who speak or hear use the reference system of the three worlds as they interpret and devise their common ideas of the validity of the statement. Consensus would not happen if the hearer doubted the sincerity of the speaker. The lifeworld contains a lot of cooperatively understood taken-for-granted interpretations, which guide common understanding and help in completing actions and much can depend on the stock of knowledge available from former experience.
Kemmis (2001, See Table 5) explained that the structure of the lifeworld involved three interacting processes by which people test for themselves the comprehensibility, truthfulness and rightness of the process for them. Cultural reproduction meant that if something new happened, it could be joined to existing practices, the resulting consensus then seeing it as valid knowledge. Social integration meant that actions would not affect the identity of a group and socialization would ensure that new occurrences were consistent with group norms, ensuring conformity.

Table 5 – Three Interacting Processes of the Lifeworld

<table>
<thead>
<tr>
<th>Cultural reproduction</th>
<th>New things can be joined to existing practice to aim to achieve consensus.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Integration</td>
<td>Actions would not affect group identity.</td>
</tr>
<tr>
<td>Socialization</td>
<td>Ensure new events are consistent with group norms.</td>
</tr>
</tbody>
</table>

Unquestioned actions could cause problems, so in the theory of uncoupling of the system and lifeworlds, Habermas (1987) explained how this might have come about. If the lifeworld had been overtaken by the system, then people might perceive political systems to be reified, increasingly defining themselves in system terms and replacing the internal communication which is essential to the formation and reproduction of the lifeworld. In its place would be an external framework of understandings, values and norms based on systems and their functions. This would reshape the individual and collective self-understanding and relationships and practices, possibly leading to domination and demotivation. Scambler (2003) observed that there had been a fundamental uncoupling between the system and public/private spheres of the lifeworld which had become increasingly state-
administered and commercialised. This is resonant with the way mothers experienced birth in the action research project, with the separation of mother and baby being commonplace. The way that the midwives worked reinforced this, by being blind to the fact that it might possibly be detrimental or could be changed and because of the routines which were adhered to by long-standing custom. Habermas’ theory was that communicative action would offer a vision to change this. Critical social science would allow an exploration of the lifeworlds and the settings in which their practices are affected on a daily basis. Ray, (1993:79) observed that:

‘The task of critical theory is to identify those social potentials which resist colonization, and attempt to reclaim the lost integrity of the lifeworld from bureaucracies, technocracies, elitist expert cultures and market forces.’

This has congruence with Foucault’s theories regarding power (explored in detail in Chapter 5), where the impact of institutions and their routines may appear to be reified.

Within communicative action, Habermas’ (1973) theory of communicative competence involved decision making guided by the rationality of arguments rather than power and proposed that truth claims could be tested within a discourse. This emancipatory interest in knowledge would encourage a connection between theoretical and practical knowledge and by reflexivity encourage an awareness of how communication could be enhanced. Habermas (1973) suggested that learning required active participation and that statements should be able to be examined in the light of evidence involving free discussion without being exposed to unnecessary risks. The process for enlightenment should be by reflection in groups of those involved, to test knowledge claims. This would mean that insights would be authentic
for that particular group, providing that all were involved and all contributions were equal, which would involve testing their ideas with self-reflective discussions.

Habermas tried to establish critique within communication, what he called ‘universal pragmatics’, involving implicit norms which:

‘require people to try to ensure that their communications are truthful, comprehensible, sincere and justifiable’ (Hammersley, 1995:32).

These four validity claims within speech (Table 6), would be tested in discourse. Any consensus within this framework could be regarded as a true one i.e. the ideal speech situation. Hammersley (1995) pointed out that problems could occur if there was a belief that all communications were guided by these values, yet if not always possible, it should at least an aim.

Table 6 Four Validity Claims of Communicative Competence
(Habermas, 1973)

<table>
<thead>
<tr>
<th>Is it true?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it comprehensible?</td>
</tr>
<tr>
<td>Is it sincere?</td>
</tr>
<tr>
<td>Is it right for the speaker to be speaking?</td>
</tr>
</tbody>
</table>
Kemmis (2001:93) felt that the concept of communicative action was a major
contribution to our understanding of the relationships between objective and
subjective perspectives; individual and social realities and theory and practice. It
provided:

‘a new way of looking at many of the problems critical action research worked on,
involving participants when personal, social and cultural processes that sustain the
setting as a lifeworld collide with processes which characterise the setting as a
system.’

Hammersley (1995:30) believed that traditional researchers tended not to look at their
own social function, whereas:

‘critical research reflexively accounts for itself and is directed thereby towards
emancipatory goals.’

I explore these in more detail in Chapter 5 when looking at theories of power by
Foucault (1972; 1977, 1980; 1988b) amongst others and Chapter 6 concerning the
change process. These theories, which are congruent with a social constructionist
epistemology have much to offer to the action researcher, who must interact with
others to try to find the best way to understand a particular social situation and seek to
enlighten and empower those involved to undertake transformative action.

Crotty (1998) pointed out that critical inquiry looked at power relations within
society, exposing injustice, so the work of Foucault, although not named as critical
theory, according to Jones (2003) complements it. Cheek (2000) described Foucault
as both a postmodernist and poststructuralist, although acknowledging that he resisted
these labels. Cheek (2000) argued that definitions of postmodernism and
poststructuralism were both highly contestable, being ways of thinking about the
world rather than a set of ideas with a single authority or method. Postmodernism
emphasised the existence of multiple voices, views and realities and could challenge universal claims to truth and the way that taken-for-granted ideas had been constructed as reality. Poststructuralism, which developed in the 1960’s from the work of Foucault amongst others (Besley & Edwards, 2005), believed that social and historical forces governed behaviour in the present and had a renewed interest in history and analysis of power. Despite its commonalities with postmodernism, it had a clearer focus on the analysis of texts and the way that language affected the understanding of reality (Cheek, 2000, Arslanian-Engoren, 2002).

Kincheloe & McLaren (2000) list the work of Foucault as a ‘critical’ school of thought, and elements of his beliefs about social reality and the production of the docile body (Foucault, 1977) and analysis of texts (Foucault, 1972) can be seen to as congruent with both views. Foucault (1988a:328) argued strongly about the benefits of an age of curiosity, where no information would be stifled, allowing the possibility of movement backwards and forwards, highlighting that:

‘people must be constantly able to plug into culture in as many ways as possible.’

Foucault (1980) saw power as a basic factor in the production of truth. Ray (1993) observed that if this was true, and since all sites of power were also possible sites of resistance the question, ‘what kinds of resistance or under what conditions’ might not be asked. Jones (2003) illustrated this by pointing out that Habermas was critical of Foucault’s work, observing that if critique equalled a form of power, then how could power be used to criticize itself. Jones (2003:164) suggested however, that Foucault and Habermas had more in agreement than disagreement and that sociologists had used both to expose attempts by health workers to try to neutralize political issues by
trying to hide them in apparently ‘value free’ technocratic procedures. Jones (2003) gave as an example, the way that power was everywhere in society enabled it to become normalised and in this way, doctors could observe and experiment on subjects by power relations that produced more knowledge. Jones (2003) explained that Foucault seemed to suggest that we should be more concerned with discovering and challenging the rules which said what truth was, rather than discovering truth itself. This is in contrast to Habermas, who distinguished three forms of truth; objective facts, shared inter-subjective communication and the individual subjective world of experience or meaning. Jones (2003:168) commented that:

‘Foucault seems to see demons in discursive acts whilst Habermas places the communicative process on a philosophical pedestal.’

It could also be argued that concentrating on Foucault might miss the way people interact with power structures, which is why Freire’s theories of empowerment are more optimistic and helpful enabling the ideas of Foucault to contribute to the progress towards change rather than just illuminating oppression and domination. Paolo Freire (1993, 1998) as previously discussed, worked to awaken or increase conscientization with oppressed groups to transform their world. These ideas based in critical theory, as highlighted by Fay (1987) would enable people who were subjected to power to see themselves differently and help in formulating a transformative plan of action.
Table 7  Communicative Action  (Habermas 1987)

<table>
<thead>
<tr>
<th>Communicative competence</th>
<th>Decision making guided by the rationality of argument.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emancipatory knowledge</td>
<td>Testing truth claims.</td>
</tr>
<tr>
<td>constitutive interests</td>
<td>Connecting theory and practice by reflexivity.</td>
</tr>
<tr>
<td></td>
<td>Awareness of how communication could be enhanced.</td>
</tr>
<tr>
<td></td>
<td>Active participation in groups.</td>
</tr>
<tr>
<td></td>
<td>Statements examined in the light of evidence.</td>
</tr>
<tr>
<td></td>
<td>Free discussion without risk to individuals.</td>
</tr>
<tr>
<td></td>
<td>Reflection in groups by those involved.</td>
</tr>
<tr>
<td></td>
<td>Insights authentic for that group.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systems perspective</th>
<th>Consisting of organisational structures, rules, criteria, targets.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitoring progress in meeting targets.</td>
</tr>
</tbody>
</table>

| Lifeworld                | Cooperative processes of interpretation and taken-for-granted meanings. |
|                          | Meanings relating simultaneously to the objective, social and subjective world. |
|                          | Cultural reproduction where new practices joined to existing ones, so resulting consensus sees it as valid knowledge. |
|                          | Social integration which ensures actions do not affect group identity. |
|                          | Socialization which ensures new occurrences are consistent with group norms. |

<table>
<thead>
<tr>
<th>Uncoupling of the systems and lifeworld</th>
<th>Perceive political systems to be reified.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Define self in system terms, replacing internal communication which forms the lifeworld.</td>
</tr>
<tr>
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<td>Leading to domination and demotivation.</td>
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Feminist Theory

Because my story is embedded in women’s experiences and their struggles in society, I must explore feminist theory in order to understand their situatedness and link this to the critical nature of this thesis. The main underpinnings of my beliefs are found in feminist theory linking to the critical tradition however I also make use of postmodern feminist ideas to provide illumination of some aspects of the thesis, especially in Chapter 7 with women’s experiences of skin-to-skin contact.

In the mid 1970’s, feminism was evolving from:

‘a reformist to a revolutionary position’ (Harding, 1986:9), aiming not just to improve science but to transform its foundations. Feminists began to question whether they could use sciences which were too closely involved with Western, masculine projects which minimised the importance of women’s personal and private experiences (Letherby, 2003). It was not surprising then, argued Letherby (2003) that feminists focused on these by challenging the way women’s lives were organised and their lack of voice. She observed that earlier feminism wanted to discover the causes of oppression within social structures – i.e. those raised by patriarchy and capitalism and stressed women’s ‘otherness’ as a positive identity. Yet it tried to homogenise, saying that differences between women were less important than similarities i.e. that men were the enemy.

Harding (1986) proposed three contrasting classifications of feminist beliefs, empiricism, standpoint and postmodern traditions. Letherby (2003) described feminist empiricism as accepting the norms of science but critiquing the way it was
practised, which could make it a ‘bad science’, such as men interviewing men about both men and women’s beliefs. An improved feminist scientific inquiry would aim to remove the things that obscured knowledge yet, argued Harding (1986), it appeared to leave the existing methodological norms of science untouched. Because empiricism is allied to the positivist tradition, I will explore feminist standpoint and postmodernism in more detail, as they both informed my feminist position.

**Feminist Standpoint Theory**

Hartsock (1998:107) explained that a standpoint:

‘carries with it the contention that there are some perspectives on society from which, however well-intentioned one may be, the real relations with each other and with the natural world are not visible.’

Feminist standpoint theory argued Anderson (2004), saw one social situation as being privileged, such as in social location. Letherby (2003) pointed out that this would mean that experience would be the starting point for knowledge production, so that the social world would be investigated from the perspective of women and unlike a masculine approach, would value the personal. It was believed that because women were oppressed, they would be able to see their oppression and oppressors more clearly. A dominant group would set limits on how people understood themselves, so marginalised groups would be a better starting point, generating more critical questions about the status quo. They based a distinctive feminist science in:


Anderson (2004) compared feminist standpoint theory to critical theory, examining how subordinate groups conformed to the dominant one, and critical feminist theory also benefits from Foucault’s (1977) idea of the insidious and internalised nature of
power relating this to how women had learned oppressed behaviour. Arslanian-Engoren (2002) argued that feminism adapted Foucault's work to challenge the view that power had a fixed meaning in society which gave women the means to challenge patriarchy, social institutions and power relationships which might oppress them. Anderson (2004) pointed out that women had direct experience of oppression, and critical theory aimed to empower them to improve their situation by enabling them to see it, understand it and then to improve it.

Feminist inquiry was defined by Stanley & Wise (1990:21) as having:

'a focus on women, in research carried out by women, for other women',

a research which is committed to changing women's lives. Reinharz (1992) used examples of work from women who identified themselves as doing 'feminist research' rather than one using feminist research methods. She said that the purpose of feminist research must be to attempt to change things for the better, with some believing that research is only feminist if it is linked to action. Maguire (2001:66) believed that feminism and action research could be powerful allies in the struggle against oppression and domination, therefore:

'we must make visible the conditions of knowledge practice, lest we create more alienating knowledge.'

Thompson (1996:328) declared that:

'feminism is in no danger of "mastery" for the foreseeable future.'

She argued that it could not drop out of the 'grand theory' stakes because it had never been in them. The purpose of feminist inquiry would be to attempt to set this right. Letherby (2003) highlighted the danger that standpoint feminism could become a
defensive stance and not recognise any similarities between women and men’s lives and if women were then said to be ‘different’ then this could imply that male was the norm. The underpinning of these critical feminist understandings could add strength to the attempt of action research to empower both midwives and mothers during childbearing.

**Feminist Postmodernism**

Letherby (2003:51) argued that feminist postmodernism, a term first used the 1950’s should not be mistakenly described as a third stage, or merger following on from feminist empiricism or standpoint. It was more radical, starting from a different place and going in other directions. This was a relativist perspective which would provide no overarching truths, no answers and no single objective form of reality. Nicholson (1999) felt that postmodern beliefs would recognise the diversity of women’s needs and experiences, with no single solution being adequate or as:

‘a celebration of multiplicity’ (Tong, 1998:210),

with no one formula for being a ‘good feminist’ (Tong, 1998:193). Shildrick (1997:4) believed that it was the only approach which could provide feminism with enough argument to radically disrupt the masculine philosophy to make a place for a ‘reconceived feminine’. She argued that it was no good taking over the male stance, whilst leaving the fundamental power structure intact. Shildrick (1997) pointed out that what was missing from the analysis was the explanation of how the dominant male could take subjectivity as though it was neutral, but then construct it in his own image. Luce Irigaray (1985) used the analogy of a speculum, a concave polished mirror which is used to examine women vaginally. In an interview (Hirch & Olson,
1998), Irigaray explained her meaning of speculum, which was an allusion to the classic work of 17th century theologian, John Swan, as being a mirror representing the face of the world, showing its beginning and end and dealing with contemporary conflicts. Irigaray's (1985) argument was that this speculum would not be a mirror in which your own reflection was visible, but that the 'subject' or male could look through it and because it reflected itself, had nothing else to alter the presented image. This mirror would concentrate the light, analyse the object from all angles yet strangely leave it unchanged. The implication here was that despite intense inquiry, nothing had been learned about the true representation of woman, or the 'Other', because the dominant male view was always seen.

Hartsock (1998) suggested that this new perspective must be struggled for and required science to see beneath the surface of society and the education needed, which could come from this knowledge. Anderson (2004) argued that feminist postmodernists had criticised many of the other feminist theories and patriarchy as essentialist, which meant that male and female bodies were believed to have essentially different characters, existing independently of culture's influence. This would exclude any who did not conform to the class of 'true woman' or be seen as inferior. Shildrick (1997) critiqued the moves of sameness and difference, giving precedence to Irigaray's thoughts which anticipated a distinction between women and men and looked at the feminine beyond just the gender difference. Whereas some would define femininity only in contrast to masculinity with the contrast always being hierarchical, Irigaray (1996) wanted to define woman by looking at woman, not
comparing her to man. This would entail a revised ontology where women would shape their own culture with a dynamics of its own. According to Stone (2004), Irigaray concluded that sexual difference was natural and real, not as biological determinism but by giving expression through a wide range of cultural forms. Cultural transformation would be needed urgently if women’s bodies were to gain an expression and spirituality equivalent to men. This could be as basic as examining the way that work was organised around male time which does not fit the lives of women. When considering the events of the time around birth, these ideas might be helpful in seeking to change long-standing medicalization of an experience which can only belong to women.

Tong (1998:195) asked why women would be understood as the ‘other’, i.e. the second sex and believed to be earthbound whilst man was related to transcendence and freedom. Postmodern feminists however, would claim advantages to being earthbound and this otherness could enable women to stand back and critique patriarchy and the values which it sought to impose. Otherness was:

‘a way of being, thinking, and speaking allowing for openness, plurality, diversity, and difference’ Tong (1998:195).

Postmodern feminists argued that language use in the Western world was biased, with no ‘truth’ relationship in it, as meanings in language and reality were variable and shifting (Tong, 1998). This was illustrated by Spender’s (1980) work on ‘man made’ language. Language refuses to be pinned down or limited by reality and the dualist way of seeing the world – such as reason/emotion; mind/body; self/other – was flawed. Nicholson (1999) believed that postmodernism could question such
dichotomous thinking and if replaced, it would be easier for women to construct meanings from social events such as childbirth that are different from the narrow medical definitions. Kahn (1995:6) saw herself as belonging to those who were trying to describe a new language of birth, drawing on lived experience, making:

‘the intact maternal body visible in words on paper and describing the knowledge derived from it – writing the body.’

Kristeva (1986) observed that a new generation of feminists wanted to give a language to women’s experiences left mute by culture in the past. Belenky et al (1986) investigated women’s ways of knowing, finding that some women were silenced by being dependant on others for a voice, whereas when encouraged to develop, some women demonstrated higher degrees of knowledge capability, which restored their voice.

Although not a feminist, Lacan influenced postmodernist beliefs with his work on the symbolic order (Crotty, 1998). Tong (1998) explained that a child must internalise the symbolic order through language, submitting to the linguistic rules of society which are inscribed on the unconscious. Symbolic order regulated society as long as its language was used i.e. internalizing gender and class rules. The concept of an Imaginary is a difficult one to grasp, but Lempiainen (1997:108) pointed out that when a person begins to notice the difference between the self and the other that:

‘the other exists inside oneself as an imaginary space which produces the subject.’

Lacan believed that a male child leaves the Imaginary and enters the symbolic order after the Oedipal stage. Girls remained in the Imaginary because they never completed the Oedipal phase. Minsky (1996) pointed out that Irigaray’s main concern
was to find the female Imaginary which she believed was buried by the male Imaginary. She wanted to work towards incorporating it into language as a way to understand the shared world inhabited by both women and men. Irigaray viewed this as full of untapped possibilities.

At present, anything we know about the female Imaginary is from a male point of view i.e. the ‘masculine feminine’ (Tong, 1998:202). Crotty (1998) drew on Irigaray who believed that there were many possibilities for women within this, attacking the need for ‘sameness’ which could lead people to understand woman in the light of what they held about man. It may be difficult to challenge the symbolic order however, when all the available words came from it. Kahn (1995:331) recounted her experiences of teaching childbirth classes for some years before her own experience, saying that she taught from literature, but deep down, doubted its truth until her first birth when she discovered that:

‘..there is a difference between knowing and really knowing.’

A female language and sexuality is needed and because patriarchy is the social manifestation of masculine it will remain so until the ‘female feminine’ is set free (Tong, 1998).

**Converging Ideas**

Helpfully, for informing my own position, Anderson (2004) suggested that trends in feminist thought in the last ten years have blurred their distinctions, as Harding (1986) herself predicted and encouraged. Letherby (2003) argued that because many perspectives had developed about feminism, any emphasis on one approach could
risk division. This was especially important she argued, because many feminists had sympathies with more than one approach. In the search for the one true standpoint, we could be aiming for a power position, which feminism seems to criticise. The postmodernist emphasis on showing that truth claims were contestable and must be situated in context are thought to be critical and liberating (Anderson, 2004), opening up space for imagining alternatives which could be hidden by dominant ideas. Yet there can be no one theory that captures the whole truth and even the selection of a particular theory is perhaps an exercise of power. Shildrick (1997:153) asked whether it was dichotomous thinking to say we must be either modernist or postmodernist. Perhaps better to:

‘expose the slippages in their supposedly foundational status.’

Tong (1998) said that English feminists initially referred to postmodern thought as ‘French feminism’ citing writers such as Irigaray and Kristeva. Delphy (1996:384) stated that ‘French feminism’ was a label given by Anglo-Americans, naming the ‘Holy Trinity’ of Helene Cixous, Julia Kristeva and Luce Irigaray. They even ‘lump together’ with these, Foucault and Lacan, perhaps because they were French, but these could never have been considered feminists. Delphy (1996) argued that Cixous and Kristeva were not known as feminists in France and had even denounced feminism. She pointed out that this would apply blame to the French for aspects of ourselves that we did not like but also did not want to take responsibility for. The term French feminists she argued could be equated with ‘women writers’.

Nicholson (1999) observed that some believed that postmodern feminism denied history any reality because all that existed was the moment, with research being
unable to find anything worthwhile. Waters (1996:281) thought that postmodernism could be viewed as a natural progression or a treacherous diversion away from feminist ideas and sometimes it had taken over from other feminisms:

'posing as the smarter, more intellectual younger sister who will carry forward the baton.'

Waters (1996:293) suggested that the postmodern contribution was style:

'The beauty of their prose seduces me, and I long (yearn) to be post-modern.'

Yet Thompson (1996:326) argued, it might be liberating to realise that oppression could be recognised as such, rather than a 'personal, idiosyncratic failing'. It also required the ability to recognise the extent to which a person contributed to circumstances, the limits of personal responsibility and the extent to which it was possible to do something about it. The postmodern argument could be that seeking one standpoint might deny the many other voices. Shildrick (1997:1) stated that:

'postmodern scepticism is both weighty and playful, and the feminism I endorse is finally a celebratory one.'

Shildrick (1997) felt that feminist thinking was characterised by acknowledging its ongoing nature and biases and that ways of knowing should be dynamic. Many feminists argued Letherby (2003), had sympathies with more than one approach and could learn from each other. Anderson (2004) suggested that standpoint feminism had abandoned the search for a single feminist standpoint which was superior to all others, with a shift towards other feminist beliefs. Conversely, feminist postmodernism had become wary of divisions, leading some to seek a more middle ground that others can share. Nicholson (1999:100) argued that a combination could

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initially be a ‘trading of criticisms’ but each could learn from the other, producing a stronger perspective. Nicholson (1999:111) argued that since the 1980’s:

‘many feminist scholars have abandoned the project of grand social theory.’

She said that they are not looking for the causes, but consider their work to be more like a puzzle, with pieces filled in by many different people, which she believed was a more mature approach. Delphy (1993:1) proposed that if we wanted to improve our understanding and to enable change, we must:

‘be prepared to abandon our certainties and to accept the (temporary) pain of an increased uncertainty about the world.’

This discussion is helpful in seeing that feminist thought can be complex and an eclectic mixture of ideas could further the enlightenment and empowerment of women as illustrated in this thesis. It is entirely within a social constructionist epistemology to make use of both objectivity and subjectivity if it is useful for informing social change.

**Action Research**

I will now examine the nature of action research to make clear how it is entirely congruent with both critical social science and critical feminist perspectives, with a strong drive towards empowerment and emancipation. Through its processes of working collaboratively to generate situated knowledge of immediate practical use it is also congruent with a social constructionist epistemology. In a seminal text, Susman & Evered (1978) made an important contribution to the turn away from positivism by stating that action research based its legitimacy as a science in a different philosophical tradition, saying that some scholarly journals were remote
from the real world. Susman & Evered (1978:582) argued that positivist science was inappropriate to study organisations whereas action research was 'ideally placed' and needed different criteria to judge its worth. Rapoport (1970:499) pointed out that:

'Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework.'

Susman & Evered (1978) added to this a third, which was to develop self help competencies. Peters & Robinson (1984) presented a consensus view of experienced action researchers who believed that what distinguished action research from other research was that it started with a practical problem rather than a theoretical question. Its emphasis on a re-educative and self critical approach to problems embedded in a social context made it an emancipatory form of research. McNiff (1988) commented that action research involved participants becoming critical of practice and so starting to develop theories and rationales for practice. It was this systematic enquiry made public which distinguished it as research. Reason & Bradbury (2001:1) defined action research as:

'a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview ..'

Brydon-Miller (2003) argued that with action research, knowledge was socially constructed, embedded in values and interaction which challenged unjust, undemocratic social and political systems and practices. Sturt (1999) pointed out that critical social theory underpinned action research, making it appropriate for exploring empowering aspects of health.
Origins of Action Research

Rapoport (1970) explained that different varieties of action research reflected the multidisciplinary nature of their origins. A group dynamic stream originating from Lewin in America and a parallel development in Britain, the Tavistock stream, brought together psychologists and other related disciplines which were committed to social engagement. Hart & Bond (1995) credited Lewin (1946) with the term 'action research' and whilst not the only originator of the work, did convincingly put the ideas together as a way of generating knowledge about a social system and at same time trying to change it. Lewin (1947:150) argued that the usual research methods of the day were surveys, which were only diagnostic, saying that:

'Research that produces nothing but books will not suffice.'

As with the Frankfurt School critical theorists, Lewin would have been influenced by the pressures of the recent world war which saw social change as a necessity to try to prevent further destructive potential. He placed an emphasis on individual and small group processes and whilst working with minority groups, he realised that actions to facilitate change were needed, with eyes and ears right inside social action bodies. Lewin (1948) found a real problem in leaders who believed that academics could tell community workers what to do, as traditional science would not help to resolve critical social problems such as poverty or minority issues. He believed that 'laws' did not tell about local conditions, nor could they prescribe a strategy for change. In this early action research, the researcher expected to be able to help the client, who did not dictate the terms of the research, although they would be expected to collaborate. Susman & Evered (1978:586) called Lewin's work:

'a pioneering approach to social research, which combined the generation of theory
with changing the social system through the researcher acting on or in the social system.'

Lewin’s concern with group dynamics led not only to action research, but to change theories such as force field analysis (Hart & Bond, 1995), which will be explored further in Chapter 6. An experiment with factory workers, planned by Lewin but carried out by others after his death, demonstrated that change was more effective and morale higher if workers were actively involved in its planning and implementation. The point made was that coercion was ineffective, whereas democratic participation was successful. In Britain the Tavistock Institute of Human Relations was also influenced by the recent world war. Consisting of psychologists and social anthropologists it was concerned with rehabilitation of returning prisoners of war. They attempted to integrate medical and social science for solving social as distinct from individual problems. Although their work was not named as action research, it contributed to and was similar to it (Hart & Bond, 1995). This organization also wanted to make newly developed psychological expertise available to industry.

McNiff (1988) traced the development of action research in education where Stenhouse in the 1970’s encouraged the turn away from the positivism of earlier education research, placing the emphasis on teachers as researchers central to education methods and using critical reflection in everyday practice. Freire’s (1993) approach was very like action research, with empowering teaching methods to deal with and facilitate change. Action research in nursing was a later development but had similarities to education. Whilst nursing was already using Lewin’s classic change theories, Hart & Bond (1995) believed that there may have been an initial
reluctance to engage with action research because of the fear that they would not be seen as an academic discipline in a time of positivist medical dominance. Waterman et al (2001) in a Health Technology Assessment Report encouraged its continuing use and concluded that action research was suited to developing innovative practices under a wide range of healthcare situations. Hart & Bond (1995) observed that in common with critical theory and feminism, action research had emerged as a result of criticism of positivist social science, as one which sought to empower participants. In Australia, theorists such as Carr, Kemmis and McTaggart (Carr & Kemmis, 1986, Kemmis & McTaggart, 2000, Kemmis, 2001), promoted a collaborative form of action research which clearly addressed power structures.

The Action Research Process

Action research uses spirals of cycles to discover the need for change and its systematic facilitation. Suzman & Evered (1978:588) described five phases necessary for a comprehensive structure of action research, involving diagnosis of a problem, action planning, action taking, evaluating and specifying learning. Action research would be oriented to create a better future, collaborative interdependence being essential and the participants having the ability to facilitate and regulate the cyclical process. Action research would generate theory grounded in action and could not judge what would happen beforehand, as events would be dependent on a particular situation and the people involved or as Brydon-Miller (2003:11) observed:

‘Action research is a work in progress.’
Hart & Bond (1995) described a four step framework of planning, acting, observing and reflecting which developed from Lewin’s early work. In reality, observed Kemmis & McTaggart (2000), these spirals might not be as neat as the description suggested, with stages overlapping, and initial plans quickly becoming obsolete in light of experiential learning. Winter & Munn-Giddings (2001) believed that although the inquiry might not be rigid, it did have to be systematic in the sense of being planned. Events and actions needed to be noticed and any changes in the complexities of practice recorded without interrupting them. This cyclical process would involve some kind of intervention and a research partnership, ranging from cooperation to collaboration (Waterman et al, 2001). Because this is integral to the nature of action research, it would mean that participants must have input at various stages to allow evaluation and changes to occur. Waterman et al (2001) link this to Rogers’ (1995) trialability, or partial adoption, where things were tried, sometimes in partial form before being fully changed (discussed in Chapter 6). The cyclical nature of action research allows problems such as conflicting beliefs, values and the nature of relations to be identified, so they are more likely to be addressed before forming barriers to change. To summarise, Kemmis & McTaggart (2000) observed that participatory action research had seven important features. It was participatory in that it involved people in examining their knowledge and was practical and collaborative, because it involved people in looking at their interactions and trying to improve them. It was emancipatory because it freed participants from the constraints of social structures and critical so that it could release people from constraints such as power relationships. Its reflexive and dialectical nature would aim to help people to
investigate their lives in order to change it and it would aim to transform both theory and practice through critical reasoning about both.

**Action Research and Evaluation**

The evaluative phase of action research is an essential part of the process. Winter & Munn-Giddings (2001:23) argued that organisations were more effective if they were continually evaluating and responsive to needs, which would lead to raised morale, encouraging a:

‘culture of inquiry and self evaluation. “Getting the job done” and “staying in line”,’ they argued, were not cost effective. Winter & Munn-Giddings (2001) suggested that action research used responsive evaluation, and that there was always an explicitly evaluative phase in order to make judgements about effectiveness. Hart & Bond (1995) believed that without evaluation it would not be possible to assess any progress or redefine the problem. Researchers needed to show how they performed the multiple repetitions of the action research cycles and how this was recorded (Coghlan & Casey, 2001). Evaluation needed to overtly challenge assumptions by exploring differing views and using the reflective process, interpretations being based in theory, with project outcomes challenged or confirmed in terms of those theories. Evaluation should be dynamic in nature, depending on collaboration rather than relying on the judgement of one person e.g. the researcher. This is what gives the methodology its strength and makes sure that what is done next is based on what has been seen to be best practice. The cycle is meant to be an ongoing improvement on the plans implemented just before it and a variety of means can be used, such as observation, interviews and questionnaires. Winter & Munn-Giddings (2001)
observed that evaluative evidence can rarely be scientifically controlled; instead it needs to be varied to reflect the complexity of the actual situations. In this case then, the evaluative phase can be a process of continued refinement rather than a process of assessment against set criteria. Evaluation always threatens to place participating stakeholders ‘at risk’ (Winter & Munn-Giddings, 2001), therefore care should be taken that its impact is not oppressive, but educational and empowering. I explore this further in Chapter 4.

The Collaborative Nature of Action Research

The main purpose of action research is to improve understanding of a situation in which there is close involvement. Susman & Evered (1978:600) argued that:

‘Collaboration between the researcher and the client system enlarges the domain of inquiry in organizational research from them to us. The knowledge we generate affects us not others; the researcher is necessarily a part of the data he or she helps to generate.’

Action research then, as its title suggests, actively involves practitioners in the research process, not just by being told what to do for the best, but by being part of the investigation, a data gatherer and a contributor of knowledge for new theories in their profession. Because of this involvement, they are more likely to become changed themselves, or empowered, beyond their involvement in a research project. This is a central value of the method, because in ‘traditional’ research, practice would not be expected to change in any way, but perhaps only described. Action researchers would need to investigate their own practice as well as that of others, since all are participants (Winter & Munn-Giddings, 2001). A strength of action research, argued Kemmis & McTaggart (2000), was that participants could help to transform practice
even if they had little experience as researchers. Meyer (1995) pointed out that this placed an important emphasis on links to self-reflection helping to empower practitioners to develop new insights and understandings of the practice situation, because the theory-practice gap is typically where new or improved practices are not implemented. Wallis (1998/9) argued that action research had the potential to generate and test action theories, whilst Holter & Schwartz-Barcott (1993) observed that it was designed specifically for bridging the gap between theory, research and practice. Professionals may know about theory but find it hard to put into practice for a variety of reasons. Although action research has been undertaken by individuals, this would lose an opportunity for a group of people to struggle democratically to change practices in which they were involved. People who work alone may not always disseminate their skills and also would lose the chance to gain from others (Winter & Munn-Giddings, 2001).

Because the participants must live with the consequences of their actions, good or bad, Kemmis & McTaggart (2000) believed that focussing on practices in a specific way made them more accessible and so capable of modification. Collaboration could be a social and educational process, meaning that action research concerned how groups interacted and responded to events in practice. This collaborative problem solving relationship between researcher and client would aim to raise awareness rather than any suggestion of social manipulation. Rather than being led by the researcher, this democratic collaboration would be more likely to make commitment authentic, where participants critique and influence their own situation (Hart & Bond,
1995). This empowering approach would mean that people were action players in the process, which illustrated Meyer’s (1993) belief that action research had moved on from the days of Lewin to a different paradigm of collaborative research – working with not on people.

**Knowledge Creation from Action Research**

Susman & Evered (1978:599) argued that if the world were constructed logically, then it might be possible to determine the consequences of actions beforehand. They stated that except in minor details, this did not tend to happen. Cook (1998) analysed her experience of action research which tended to look more coherent when written down in a linear way, which was opposite to the actual experience. She pointed out that in reality, even the beginning of a project was unclear, whilst with hindsight the changes that occurred seemed obvious. Cook wondered whether this was a way to access tacit knowledge and if the research was tidied up, the creative part might be left out. Susman & Evered (1978) stated that neither the client nor researcher would have better knowledge, but in a sense, they would both be experts. Action research tries to find the best way to implement what is seen to be best practice by practitioners in a specific context, place and time, thereby hoping to generate new theories for practice. Clinical practice is not a static entity, but constantly evolving, which implies that what is our best ‘truth’ today, might change with tomorrow’s knowledge, there being many such aspects of midwifery practice over the last 20 years which could be expounded to illustrate this. Hart & Bond (1995) reported
struggling to come to terms with the interrelationship between what was written about practice and what was actually done.

Meyer (1993) argued that critical social science emphasised the need for self-reflection, so that the theory developed depended on the meanings and interpretations of participants. Action research, being linked to constructionism and critical social science, values experiential knowledge, so the action taken would be more likely to create useful knowledge. The method emphasises the importance of practice insights gained during the research process rather than objective methods applied by ‘outsiders’. As some researchers have found, change may not happen, but even then, the participants are more likely to have learned something in the process. Kemmis & McTaggart (2000:596) felt that action research was different from other research because it was:

more obstinate about changing particular practitioners practices, rather than focusing on practices in general or in the abstract.’

Rolfe (1996) stated that even though research evidence may be present, some practitioners would not or could not implement it. He suggested that this may be because they saw no relevance in it, or that they found it impossible to implement. Waterman et al (1995) discussed their concerns surrounding nursing theories which might be interpreted as descriptions of actual practice, rather than idealistic notions of how practice ought to be. In social interaction, Winter & Munn-Giddings (2001:12) said that:

‘evidence in the form of generalisations does not build up into a prescriptive basis for action, even though perhaps organisation policy directors or government ministers might wish it did.’
Waterman et al (2001:57) explained that action research, because it acknowledges the complex nature of social situations and was flexible enough to respond to them, was able to be innovative. The basic elements of education, empowerment and support would be more likely lead to emancipation of the participants, concluding that:

‘With adequate support, action research has the potential to address many of the current challenges within the modern NHS.’

**Typologies of Action Research**

Winter & Munn-Giddings (2001) observed that there were a variety of types of action research which could be seen to overlap, yet have many common characteristics. Because action research has a pedigree of over 50 years, it had developed a hybrid of differing approaches which Hart & Bond (1995) felt a need to clarify. Trying to make sense of this diversity in a range of settings, they used the four core characteristics of collaboration, the solution of professional problems, the change process and the development of theory. The typology enabled identification of the characteristics on a continuum of the four broad approaches emerging from experimental research, organizational consultancy, education and nursing, and community development (Hart & Bond, 1996). The typologies were experimental, organizational, professionalizing and empowering (Table 8). With the experimental type, the researcher would identify the problem in advance and re-education would be defined in behaviourist terms to bring about the change, with the need to measure and quantify the change. The organizational type would have a social-psychological approach where the managerial group would define the problem and re-education would work to overcome resistance to change. In the professionalizing type, education would take a reflective form and be grounded in everyday experiences.
Problems would be identified by the professionals and improvement defined by them on behalf of users. In the empowering type, education would be consciousness-raising in the interests of less powerful groups and the agreed direction of change might be redefined depending on subsequent events (Hart & Bond, 1995, 1996). These apparent contradictions in definitions suggested Hart & Bond (1995), obscured the underlying pattern that made action research a distinct research approach.

Table 8  Action Research Typology  
(Hart & Bond, 1995)

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<tr>
<th>Consensus</th>
<th>Conflict</th>
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<tr>
<td>Experimental</td>
<td>Re-education tends to be defined in behaviourist terms to bring about change. More like the early days of action research, with Lewin’s change experiments and research to find general laws of social life</td>
</tr>
<tr>
<td>Organizational</td>
<td>Social-psychological approach to behaviour and perception. Managerial group define the problem. Emphasis on education and training to bring about change. Aimed at overcoming resistance to change</td>
</tr>
<tr>
<td>Professionalizing</td>
<td>Education takes a reflective form. Problem defined by professionals, grounding knowledge and action in everyday experience to develop a research base</td>
</tr>
<tr>
<td>Empowering</td>
<td>Education is about consciousness-raising. Education is rooted in everyday experience of vulnerable groups rather than being validated by abstract theoretical knowledge. Closely associated with community groups. Characterised by a stance against oppression, working with vulnerable groups. Has similarities to Freire’s work (1993)</td>
</tr>
</tbody>
</table>
Hart & Bond (1995) used seven criteria within each typology (Table 9) to illuminate different aspects within each. These will be used later to illustrate elements of my own project (Table 11).

**Table 9 Seven Criteria within each typology**

<table>
<thead>
<tr>
<th>Action research is educative</th>
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</thead>
<tbody>
<tr>
<td>It deals with individuals as members of social groups</td>
</tr>
<tr>
<td>It is problem focused in a specific context</td>
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<tr>
<td>It involves change interventions</td>
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<tr>
<td>It aims to improve and involve</td>
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<tr>
<td>It contains a cyclic process linking research, action and evaluation</td>
</tr>
<tr>
<td>It is based on a research relationship in which all participants are part of the change process.</td>
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</tbody>
</table>

Hart & Bond’s (1995) typology (Table 8), which was developed specifically for health and social care practitioners, was placed on a continuum of two alternative models in society, that of consensus and conflict. The organizational type might not deal well with conflict, so voicing disagreements could be a problem. In the professionalizing type, Hart & Bond (1996) felt that there was an overlap with the consensus and conflict ends of their continuum. They felt that this was one of its strengths, as both models could have limitations when working to improve services. The types are not distinct because in practice they overlap, and may shift flexibly during the study as it moves through the spirals of cycles. Cook (1998:99) described ‘stumbling around’ rather than working within a ‘concrete framework’. She worried that once something was accepted as a ‘model’, even if intended to be flexible, it could become like the accepted way. However, action research projects can have implicit agendas which can turn into major influences, so this typology could make it
easier to identify their impact when analysing events and give the overall sense of project’s direction, whilst not restraining flexibility.

An alternative but similar description was provided by Holter & Schwartz-Barcott (1993) who identified three approaches used in nursing. The ‘technical-collaborative’ approach aimed to test a specific issue and was based on a set theoretical framework, which was similar to Hart & Bond’s experimental type. The ‘mutual collaborative approach’ brought people together to identify a problem and intervene, which is like the organizational type. The enhancement approach tried to bring theory and practice closer together to problem solve, whilst helping practitioners to discover more about the problems by raising their awareness of the basis of them which has similarities to Hart & Bond’s professionalizing and empowering approach. Holter & Schwartz-Barcott (1993) stated that they found a few studies which used the mutual collaborative approach, but none with enhancement approach. They observed that the mutual collaborative approach tended to last as long as the involved practitioners were there to carry it out, but it might not last if they left. With the enhancement approach, the researcher questioned underlying assumptions and involved practitioners in reflecting on their own practice to bring about change, which would tend to bring about a more permanent change. Sturt (1999) observed that Holter & Swartz-Barcott’s (1993) enhancement approach fitted critical social theory because of its emphasis on the critical examination of practice and inclusion of self-reflection. Hart & Bond (1996) pointed out that a limitation of Holter & Swartz-Barcott’s typology was that it assumed that the situation would be static and also that the
researcher's philosophical orientation was what primarily determined the approach to research. Hart & Bond's (1995) approach however, differed because of its recognition that it was normal for a study to move through different stages.

Hart & Bond's typology can be used to examine the focus of some action research projects. Lauri & Saino (1998) used an initial survey to find a baseline situation in the care of women with breast cancer. The team constructed programs of care based on evidence and teaching sessions were provided. Questionnaires evaluated the success of the programme. This seems nearer the experimental end of the typology continuum, with some organizational and professionalizing elements. An action research project to try to reduce the negative impact of homelessness on young mothers, facilitated by Walters & East (2001) generated new knowledge grounded in real life. This project was judged to be empowering as the young women identified aspects of their lives that were more significant than just being 'homeless'. Waterman et al.'s (2005) project successfully changed practice in ophthalmic nursing care, using an empowering strategy, by accessing relevant literature, visiting other units with expertise, performing interviews with practitioners and holding regular meetings and workshops. Choucri (2005) used an empowering action research strategy which successfully supported midwives during group discussions to formulate and clarify their ideas about leading practice change. Munro et al (2002) used collaboration to discover midwives’ views regarding fetal monitoring in labour, using this along with evidence to draw up empowering guidelines which started a process of change towards less technological emphasis for birth. Merewood & Phillipp (2001) carried
out a successful project in America to increase breastfeeding in a hospital with very low rates. This project was similar to action research, but had no overt evaluation stage. Despite this, there was education of both professionals and mothers; wide involvement and consultation and a task force met monthly, suggesting a professionalizing approach.

The maternity unit where our own project was conducted was a small one, where the midwives were almost leaderless as the project started, because the Head of Midwifery had just retired, other senior people displaced and the higher management structure was undergoing a major restructuring. The main challenge for the project midwives was to re-discover the drive for change. The type of project was not chosen in advance, although I needed the midwives to be involved and own the change. Activities evolved through the collaborative process and in response to the needs of the project, as they arose. Within this project there were initial elements of the organizational type, but it was mainly professionalizing combined with the empowering type of action research. Due to the lack of evidence-based practice about breastfeeding, the problem emerged from practice and the project focus was to increase midwives’ autonomy by increasing their knowledge. Because of having to submit a detailed bid to gain funding for the project, aims and objectives were initially defined by myself. However this organizational element was quickly overcome by very early consultation via the focus groups and informal discussion in the clinical area. Despite the many challenges which seem reasonably common in action research projects, the midwives were gradually empowered to act as advocates.
for their clients by offering and/or providing evidence-based care. Changes in routines were explored and negotiated over time, at a pace with which the midwives felt comfortable. The focus groups were initially led mainly by me but after the first months, the agenda became more empowering and defined by the focus groups. Later the midwives gained more voice by reflecting on their practice and suggesting ways to improve it. Strategies for remembering the change were developed and later, discussions took place about extending skin-to-skin contact for women in theatre after caesarean section, an issue which had initially met with reluctance. In the project the drive for change was mainly from the collaboration of myself and the midwives, but as the empowering interview data from the women became available, their views and experiences were used to raise the midwives consciousness about the value of skin-to-skin contact. Table 11 illustrates the way that Hart & Bond’s (1995) criteria are related to the organizational, professionalizing and empowering typologies within our action research project.

**Challenges of Action Research**

Whilst action research can be a way forward and is now recommended by current professional guidance (Iles & Sutherland, 2001, Waterman et al, 2001), as an effective and empowering strategy for change, it may not be without its problems. Health professionals may be in a situation where empowerment or emancipation whilst aimed for, is difficult. Part of an action research project by Deery & Hughes (2004) included data from ethnographic observations of midwife-led care which produced shocked reactions from some midwives and initial resistance. This was
overcome by sharing the data, providing update sessions and collaboration to create action plans to improve care. Deery (2003, 2005) found that despite midwives perceptions of the possible future benefits of clinical supervision for their professional development they were reluctant to continue with the action research process and could find no time to attend meetings. Deery concluded that their working constraints encouraged them to develop strategies to help them to cope in present stressful situations rather than looking to the future. Meyer (1993) had to cope with a huge change in the workforce during the project. Reed (2005) undertook an action research project to develop a care plan which was agreed to be beneficial, for older people moving from hospital to a care home. Despite its benefits, one area did not use it, as it was ‘extra work’. Dewing & Traynor (2005) followed a reportedly emancipatory model in collaboration with practitioners to develop a competency framework, however practitioners did not like the outcome of preliminary findings and this nearly ended the project. Walton et al (2005) after identifying ways to improve the emphasis on normal birth met resistance from doctors. The project endured a difficult phase, but it did result in a change in the long term. Organisational change and resource constraints coincided with the beginning of a project facilitated by Cowley & Billings (1999) to introduce new health visiting practice. Some of the professionals involved had their own agendas and there were problems with aspects of change being imposed by management, however by persistently keeping communication channels open, a successful change ensued. Fraser (1999, 2000, 2002) in an educational action research project about midwifery pre-registration programmes, whilst not reporting many difficulties, did at one point highlight a lack
of response in one area of the project. These examples provide a small insight into the
determination and persistence required by those who undertake action research.

Action Research and Validity

In an attempt to counter possible criticism that action research is an easy option or
'low tech' research, the validity of action research will be examined. Turnock &
Gibson (2001) believed that most arguments about the reliability of action research
could only be done in a limited way, because of the individuality of each project, so
most literature seemed to examine validity. Long & Johnson (2000) argued that many
terms used to describe the basis for confidence in research essentially have the same
meaning, so there is no need to change the terms but to use different ways of
addressing the existing criteria. Hope & Waterman (2003) believed that would
provide opportunities for new considerations of the term validity. When first looking
at action research, Winter & Munn-Giddings (2001) suggested that the question
might be asked 'Is it really research?', 'Are the outcomes valid or generalisable?'
Waterman (1998), reported that papers about the validity of action research were hard
to find, so suggested other aspects to consider, which are distinctive to action
research. She observed that action research philosophy supports a critical approach
which recognised the need to identify and resolve contradictions in practice and could
motivate people to change and improve practice. The cyclical nature of action
research necessitated constant questioning of changes in practice, looking at what
was, what is and why change has happened or not. The argument being that this
process could add to its validity.
Coghlan & Casey (2001) proposed that the credibility of a research project should be judged on its usefulness, with the researcher demonstrating many action cycles and how these were recorded to show a truthful representation of events. Researchers needed to show how they challenged and tested assumptions through public reflection, so that their familiarity with the issues could be critiqued. They needed to show that other views had been taken into account and how their results were grounded in rigorously applied theory. Winter & Munn-Giddings (2001) argued that rather than analysing a supposedly static situation by not impacting on it, with the researcher separate from those being researched, action research worked towards change by being visible in the process. This was more realistic, they felt, because it is hard to be in a situation and not impact on it in some way. Hart & Bond (1995) observed that the positivist argument might try to ignore the role of the observer in the production of knowledge, yet it was itself a product of the human mind. Wallis (1989/9) felt that using an action research approach moved away from the perspective that viewed knowledge as an external reality, to one in which it was viewed as context specific and situational, with theory and practice forming mutually constitutive elements, in a dynamic relationship.

Kemmis & McTaggart, (2000) suggested that in most action research, researchers made sacrifices in methodological and technical rigor in exchange for more immediate gains in face validity. In other words, whether the evidence they collected made sense to them in their practice situation and whether that evidence could be used and further developed in transforming practice. They asked whether this made it
'bad' research even if it was 'good' in terms of its practical contribution to transforming practice and what those participating thought was relevant, appropriate and useful evidence. Kemmis & McTaggart (2000:592) also felt that loss of sophistication might be a price worth paying in most contexts of transformative social action. They believed that when participants lived with the consequences of the transformations they made, it provided a "reality check" on the quality of their work, whether or not this evidence might be 'low tech' in terms of research method or technique from an outsider perspective.

Brydon-Miller (2003) argued that action research tests validity more effectively than most other forms of social research because it tests knowledge in action by those involved and interested in the solution to a particular problem. Waterman (1998) believed that detailed accounts of reflexivity added to the validity of action research. The concern could be whether the data was a true account of the project and that the practitioners were also researchers. This would be countered by maintaining a questioning attitude, looking for opposing perspectives, moving between theory, research and practice, and using more than one researcher and method. This recognition of biases could be considered an important way of demonstrating the validity of the action research. Winter & Munn-Giddings (2001) added to this by saying that action research was a continuous negotiation between different perspectives and its validity was in the rigour of this process, not just in a claim to have made an accurate representation of reality. It also sought validity in a further area, that of openness of communication processes. The action research process, like
Habermas' (1987) communicative action principles, must show that differing views have been fully expressed and that judgements made have been open to scrutiny and debate. They also discuss the generalisability of action research, highlighting that although each project was individual, there might be aspects that could be illuminating to others, or:

'will 'resonate strongly’ with a wide variety of other situations’
(Winter & Munn-Giddings, 2001:21).

They suggested that not only were action research reports generalisable, but that they should be published to contribute to the development of knowledge.

Conclusion

In this chapter I have shown how my epistemological and theoretical stance underpins the action research project, where truth can sometimes be interpreted in an objective or subjective way. I believe that holding them together (Crotty, 1998) a shared truth can be constructed, that can inform our lives. I recognise that our perceived truth can be blinkered by the effects of institutionalisation, the language we use and the power of the 'norm'. This makes a critical stance essential to our emancipation. Whilst noting tensions between them, important theoretical viewpoints from Habermas, Foucault and feminism can converge to provide rigorous intellectual foundations for action research. I also believe that there is more to be learned about what it means to be a woman after so many years of patriarchy and medicalised midwifery and childbirth practices, which are explored in Chapter 5 and 6. The postmodern contribution to knowledge adds more depth to the discussion of women’s experiences and their need to find a new language to explain their lives and this is
explored in Chapter 7 with a furthering of the understanding of the female Imaginary and a ‘female, feminine’ language for birth. Despite being a challenging methodology, action research, because of its collaboration with others in the process of seeking improvements and empowerment in everyday life is a valuable research methodology to try to achieve change.
Chapter 4 The Story and the Method

Introduction

In this chapter I will explore the story of the action research project. For clarity I will first outline the chronological events and then focus on the cyclical process of the action research. Some of these issues are discussed in more detail in Chapter 5 and 6. The project was conducted in a small maternity unit, using focus groups, one-to-one interviews, teaching, role modelling and facilitation to work towards a change in practice. I will integrate the discussion of the methods used as they occurred in the project.


The action research project, funded by the Department of Health, Infant Feeding Initiative, the Breastfeeding Practice Projects (Dykes, 2003), enabled me to work on the project for two days per week for one year beginning in September 2001, to try to help women in an area of high social deprivation, who were least likely to breastfeed. The research aim was to increase midwives knowledge of best practice regarding breastfeeding and the implementation of best practice standards. The ultimate aim would be to improve up to 2,000 women’s access to best practice and possibly contribute to an increased initiation and continuation of breastfeeding, although this could not be demonstrated within the life of the project. The project was carried out in a District General hospital, which provided antenatal, labour and postnatal care, with an adjacent Special Care Baby Unit (SCBU). Midwives mainly worked either in hospital (rotating through all areas except SCBU) or out in community. At the start of
the project, breastfeeding although 'officially' valued, did not have a high profile and there was neither any in-service education nor a hospital breastfeeding policy, although one was in the early stages of being devised. Previous attempts to gain access to provide in-service education about breastfeeding had not been successful.

**Sept – Oct 2001**

The project began with some plans because they had been required by the research bid.

**Communication** – I approached midwifery managers and began to communicate with the midwives on the unit about the project.

**My clinical practice** – this was not a problem, as I was already a link tutor for this area, however, ethical approval was also gained.

**Focus groups** were aimed to be held monthly, although this was not always successful, it loosely followed this pattern through the year. Everyone was invited and the membership was fluid, depending who was on duty in the area on a convenient, reasonably quiet time on the ward.

- **The first focus group** established my clinical role as being ‘hands on’ when possible.
- A letter was sent to every midwife to explain the project.
- Two information sheets for women were to be devised about the benefits of breastfeeding and skin-to-skin contact.
- Teaching update sessions were to be held, aiming to be skills based and covering the benefits of breastfeeding, skin-to-skin contact at birth and breastfeeding in the first week.
Visits to two other units were agreed, to share other midwives’ experiences of evidence-based practice and the change process.

Role modelling was to be a key aspect of the early part of the project, and started in early October, when I provided care for a mother and baby who experienced skin-to-skin contact after the birth. This role modelling continued thought the year, but more especially in the early months. Experiences gained during these clinical sessions were helpful to share with midwives when discussing changes in routine. Being able to say ‘this happened yesterday’ gave more credibility to teaching sessions and discussions.

Sharing of experiences – Discussions in clinical areas were ongoing and an important part of keeping people involved, disseminating information about the project, discussing any changes and asking for suggestions.

Other clinical work I provided help on the postnatal ward if requested, especially if there were any problems with breastfeeding.

End of October 2001

- **Second focus group** – We discussed my visits to other units.

- Information sheets for women were proof read, discussed and adapted. These were also discussed with midwives outside the meeting. It was planned to give out the benefits of breastfeeding leaflet at booking clinic and the skin-to-skin contact one at around 34 weeks, when women were perhaps thinking more about the birth.

- I raised the issue of skin-to-skin contact in theatre.
Teaching sessions – These were planned as formal one hour sessions, but took midwives out of sight of the work, so following these first ones, they were adapted to be flexible and took place in the ward area. A workbook was provided to take away.

December 2001

An evaluation sheet for skin-to-skin contact devised and adapted after the first recorded skin-to-skin contact facilitation. Valuable comments from these evaluations allowed targeting of perceived difficulties. I began to get the first inklings of the challenges involved with changing long-standing routines.

January 2002

Comments on evaluation sheets showed that some midwives had facilitated skin-to-skin contact and others raised problems for its implementation. Information leaflets were being given out in antenatal clinic. They could be given out in draft form whilst awaiting approval by the Trust’s Patient Information Review Group.

- Third focus group – We discussed skin-to-skin contact and that women needed to know it was a bit more than ‘just a nice idea’. To address this, information leaflets were placed in all the birth rooms.

- The general feeling was that skin-to-skin contact was being talked about more.

- We discussed the changes in routine needed and whether it could happen in the operating theatre.

- Posters were to be displayed promoting skin-to-skin contact.
Interviews with women who had experienced skin-to-skin contact and midwives who had facilitated it were started this month and continued until May. Some encouraging feedback was obtained from both mothers and midwives.

**February 2002**

Comments were returned from the Trust ‘Patient Information Review Group’. The leaflets had been re-typed by their secretary and contained many ‘new’ typo’s, which were then criticised by the group, but this was eventually resolved.

- **Fourth focus group** – Midwives were becoming more vocal.
- We discovered that not many women were arriving on labour ward knowing about skin-to-skin contact. We later found out that there was a problem in the timing of leaflet distribution.
- Skin-to-skin contact at birth was happening more but was not yet part of routine. I fed back information from interviews - 4 women and 3 midwives to date.
- It was suggested incorporating questions about skin-to-skin contact in the computer birth records, so that midwives would become used to thinking about it.
- Midwives brought up the topic of skin contact in theatre and how this might be facilitated.
- A progress update Newsletter was discussed and agreed that it be circulated to all areas.
March 2002
A teaching session about breastfeeding was held for a group of community Sure Start workers.

April 2002
Computer records had now been amended.

- **Fifth focus group** – This was informal due to a busy day.
- Midwives proof read the draft Newsletter and offered suggestions.
- We discussed skin-to-skin contact in theatre with one midwife who agreed to fact find from a midwife who had done this elsewhere.

May 2002
During a teaching session I discovered a problem for some midwives in remembering to discuss skin-to-skin contact with women before the birth.

I was asked by health visitors to provide some breastfeeding update sessions.

- **Sixth focus group** – We discussed progress in how skin-to-skin contact was being offered. I shared the above problem of ‘remembering’ and we discussed various options, deciding on an ink stamp (saying ‘skin-to-skin contact discussed’) to put in the labour admission notes as a memory prompt. We decided to laminate the skin-to-skin information sheet and place it in all birth rooms.
June 2002

A bullet point list of the benefits of skin-to-skin contact was devised (See Table 18, p211), amended and placed in all the birth rooms to facilitate discussion.

July 2002

Pictures were obtained by me, which demonstrated how skin-to-skin contact might happen (see Appendix 3).

The last focus group was abandoned by me, as I had run out of steam.

Skin-to-skin contact figures for this month were 36%.

August 2002

Skin-to-skin contact figures for this month were 52%.

September

Teaching sessions were held for health visitors.

A second Newsletter was produced and circulated.

Funds had been obtained and a midwife appointed with a breastfeeding co-ordinator role in the Trust.

A summary of the events in the project are provided in Table 10.
Table 10  
Summary of Events in the Project from September 2001 to September 2002

<table>
<thead>
<tr>
<th>Communication</th>
<th>Sept 01</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan 02</th>
<th>Feb</th>
<th>Mar</th>
<th>Apl</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sept End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus groups</td>
<td>Ongoing</td>
<td>FG1</td>
<td>FG2</td>
<td>FG3</td>
<td>FG4</td>
<td>FG5</td>
<td>FG6</td>
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<td>Role modelling</td>
<td>Ongoing</td>
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<td>Visits</td>
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<td>Teaching</td>
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<td>Flexible</td>
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<td>Health Visitor</td>
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<td>sessions</td>
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<td>workers</td>
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<td>Skin-to-skin</td>
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<td>First</td>
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<td>Evals</td>
<td>of skin-to-skin contact</td>
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<td>contact</td>
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<td>Skin-to-skin contact posters</td>
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<td>Information</td>
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<td>Distribution</td>
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<td>leaflets</td>
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<td>Being</td>
<td>devised</td>
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<td>Interviews began</td>
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<td>Remembering</td>
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<td>Computer records amended</td>
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<tr>
<td>strategies</td>
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<td>Laminated information sheets in rooms Ink stamp in notes</td>
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<td>Newsletter</td>
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<td>Bullet point list in rooms</td>
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<td>Picture sequence in rooms</td>
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</tbody>
</table>


114
<table>
<thead>
<tr>
<th>Action research type</th>
<th>Distinguishing Criteria</th>
<th>How these relate to the project, demonstrating the shift of emphasis at different stages of the research</th>
<th>Specific strategies used in the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational</td>
<td>1 Educative base</td>
<td>Re-education. Enhancing organizational change towards consensus. Overcoming resistance to change.</td>
<td>Teaching sessions, early discussions of experiences of skin-to-skin contact.</td>
</tr>
<tr>
<td>Professionalizing</td>
<td>1 Educative base.</td>
<td>1 Reflection enhancing control, empowering professional groups, advocacy for clients, practitioner focused.</td>
<td>1 Teaching sessions and discussions of experiences. Communication. Production of information leaflets for women.</td>
</tr>
<tr>
<td></td>
<td>2 Individuals in groups.</td>
<td>2 Professional group with negotiated team boundaries.</td>
<td>2 Focus groups and discussions.</td>
</tr>
<tr>
<td></td>
<td>3 Problem focus.</td>
<td>3 Problem emerges from practice. Defined by professional group.</td>
<td>3 Practice not evidence-based so defined.</td>
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<tr>
<td></td>
<td>4 Change intervention.</td>
<td>4 Professionally led in the interests of research based practice.</td>
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<td></td>
<td>5 Improvement and</td>
<td>5 Defined by professional.</td>
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<td></td>
<td>involvement.</td>
<td>6 Identifies causal processes that are specific to the problem Spiral of cycles, opportunistic, dynamic.</td>
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<tr>
<td></td>
<td>6 Cyclic processes.</td>
<td>7 Outsider resources. Researcher practitioner merged roles. Practitioners evaluate evidence then disseminate to users.</td>
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<td>7 Research relationship,</td>
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<tr>
<td></td>
<td>degree of collaboration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowering</td>
<td>1 Educative base.</td>
<td>1 Consciousness raising, enhancing user’s control. User/practitioner focused.</td>
<td>1 Women’s voices from interviews. Strategies for midwives to remember change.</td>
</tr>
<tr>
<td></td>
<td>4 Change intervention.</td>
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The Action Research Project

The District General Hospital involved served a population with areas of high social deprivation, in North West England and demographic details illuminated this. The index of multiple deprivation rank, gave examples of 8,414 wards with ‘1’ being classed as the most deprived. Except for one more affluent ward in my project area, the rest ranged from 52 – 2,814, with 13 out of 20 wards below 2,000. This could be compared with South Cambridge which ranged from 4,702 – 8,377 (Neighbourhood Statistics, 2001). The national breastfeeding rate for 2000 was 69% (Hamlyn et al, 2002). The figures for my research area for 2000 were 57% breastfeeding initiation with a reduction of 12% on transfer home, which might only be 1-2 days later. The project aimed to help women who were least likely to breastfeed, by increasing midwives knowledge of breastfeeding and the implementation of best practice standards. The resulting improvement in women’s choices and satisfaction could contribute to an increase in breastfeeding initiation and continuation rates. The project could have reached approximately 2,000 women during the year. Facilitation and collaboration between academic and clinical practitioners aimed to reduce the theory-practice gap, engender ownership of the project, empowerment and motivation. It gave authority to the change process where the common perception was that breastfeeding rates could not be improved.

The setting was a maternity unit where women received care in separate areas for antenatal, labour and postnatal care. The three areas were adjacent to each other, forming three sides of a square, with (across the corridor) the Special Care Baby Unit completing the fourth side. Midwives worked either in hospital, where they
rotated regularly around the ward areas or in community, mostly undertaking antenatal and postnatal care, with the occasional home birth. Breastfeeding did not have a high profile, but work had recently commenced to formulate a breastfeeding policy, in which I was involved. I had previously attempted to gain access to this hospital in my role as clinical link tutor, to address the lack of knowledge on breastfeeding. I met reluctance from managers, who perceived that the midwives had no time to attend teaching sessions. The UNICEF Baby Friendly Initiative (BFI) (WHO/UNICEF, 1998) was not popular with the midwives, with most seeming suspicious of it.

**Access**

Before the project, as well as seeking ethical approval, I approached midwifery managers to gain clinical access. This was not a problem, as I was already the link tutor, holding an honorary contract and had continuously signed my yearly Nursing and Midwifery Council (NMC) statutory midwifery 'Intention to Practice' in that Trust since 1975 meaning that I could undertake clinical work. Because of the research bid I had some initial ideas of how the project could work and communication of these with anyone who might be involved was essential. At the end of September I began trying to reach as many people as possible.

**Sample and Data Collection**

All midwives working on the unit were potential research participants, as most would rotate to CDU in the year. When skin-to-skin contact had started to occur, a purposive sample (Robson, 1993) of eight women and eight midwives who had experience of it were approached for interview. These were not matched, due to
time constraints. An action research project led by Barrett (2001:298) facilitated women’s access to informed choices. She pointed out that everything that happened from the moment of commitment to the project was data with midwives and mothers:

‘adding another pattern to the weave of the fabric,’

and so it was with this project. Data was collected from my field notes and reflective accounts, which were usually meticulously recorded. Focus group meetings were recorded and also kept in a file on CDU. Interviews both of individuals and groups were taped and transcribed or written, which meant that I was grounded in the participant’s views, so guarding against the pursuit of my own ideas.

Ethical Approval

Ethical approval was gained from the Local Research Ethics Committee (LREC) and the University Ethics Committee. The LREC were reassured by the Department of Health funding (and therefore implicit approval) and I was asked to change only one sentence in the consent letter, which stated that the project had been approved, in case women felt coerced to participate. I was also required to write a courtesy letter informing the woman’s GP of her participation. I believe that this reflected the medical emphasis of the committee as they did not ask the same for her community midwife or health visitor, which would have been more appropriate. It was almost as if these women ‘belonged’ to the GP.

There was no mention of any potential harm I might cause women by my participation in their care-giving, which might have been a more relevant topic to
pursue. When approaching an ethics committee, Angrosino & Mays de Perez (2000) found that their proposals had to seem fairly complete to address the issues of doing harm. The research however tended to change as it progressed, and even if participants were protected as much as possible, it is impossible to remove all possibility of harm in a project based on human interactions. Angrosino & Mays de Perez (2000) described professionals working with people with disability, who used the term ‘the dignity of risk’, meaning that full participation in a community meant risk taking and mistakes happening. If sheltered from all risk it was perhaps not a real life. I felt that all participants would be protected as far as possible by my adherence to the Code of Professional Conduct (NMC, 2004a) and as a practising midwife, the Midwives Rules and Standards (NMC, 2004b).

Empowerment, Added Value and Remembering

I found that the action research cycles were not neat and tidy; sometimes seeming haphazard and only in retrospect could I see any sort of plan coming together (Table 12). Collaboration, dissemination of evidence and practical knowledge were the key to providing midwives with the resources necessary for successful change. The women’s stories added value to the reason for change and reminders prompted memory until it became part of normal practice.
**Focus Groups**

Focus groups were open to all midwives on the unit and were integral to the research project, ensuring that everyone was aware of what was happening and encouraging ownership. Group interviews straddle the line between formal and informal and can vary considerably (Fontana & Frey, 2000), having the potential to access those who might be threatened in a one-to-one situation. In a group people might contribute more, as they feel a safety in numbers (Kitzinger, 1994) and things can be explained with clarification from others. This group interaction reduces the researcher’s input, so altering the balance of power towards the group, giving more weight to participant’s opinions and allowing accessibility to collective stories and the ideas that they generate (Madriz, 2000). Wilkinson (1998) believed that research methods which isolate people from their social context are questionable for social constructionists, finding it surprising that most qualitative researchers used individual interviews. Although focus groups do not
generate the intimate data of individual interviews, they do examine how knowledge and ideas develop in a cultural context by highlighting group norms and with contemporary social research the researcher is more a group member. Angrosino & Mays de Perez (2000) proposed that there was more recognition of the impossibility of merging the observer and insider views in the search for truth which made collaboration even more important. Kitzinger (1994) argued that it was useful to use pre-existing groups because of their shared social contextual knowledge, helping collection of data on group norms.

Focus groups Chiu (2003) explains are not just to find out about where people are, but to involve them in change. Because a group need knowledge before they can participate in a change, facilitation is essential for a development of critical awareness, which Chiu (2003) believed had transformative potential for them. Group discussions can give participants a greater role in guiding the research project, which is consistent with equality (Reinharz, 1992). Heron & Reason (2001) argued that we should look at ourselves and our personal knowledge and this should be developed in collaboration with others engaged in the same activities. This allowed me to take my own ideas to the focus group, which ensured that my views were heard. I was part of the negotiation process though which all ideas were filtered, ensuring equity. This authentic collaboration with everyone fully involved and no one dominant voice is congruent with Habermas' communicative competence (Chapter 3) and an example of the attempt to dominate a meeting is discussed in Chapter 5.
Those who came to the focus groups were midwives usually working on CDU and once a senior midwife from the antenatal clinic. At the first meeting I outlined my initial thoughts, which I hoped would kick-start the project. I did not expect too much at this stage, however, there were some encouraging suggestions. Everyone seemed happy that I would be coming to ‘work’ rather than talk and I was offered a spare tunic and trousers to wear. The meetings were important for giving feedback, discussing progress or lack of it and exploring the realities of new routines and adapting them. If the ward was busy, meetings had to be adapted or cancelled. About half way through the project on a busy day, I abandoned the focus group and instead spoke to as many people as possible to discuss the ‘future state’ as recommended by Coghlan & Brannick (2001) to determine what parts of the project needed priority, these were:

- Women will be given information on breastfeeding at booking visit and throughout pregnancy as appropriate.
- Skin-to-skin contact will be offered as a routine at birth for all babies.
- Midwives will have an up-to-date knowledge of breastfeeding practice.

I was desperately in need of reassurance at this point as progress seemed so slow. Later in the project, more contributions came from midwives, with some innovative suggestions and practical tips for implementing them. Only one meeting was tape recorded which was not successful and the others were minuted by me. The value of tape recording for data collection, is discussed by Winter & Munn-Giddings (2001) who also believed that note taking could be valuable, by giving the researcher the opportunity to recap, saying something like ‘can I just check that I’ve got that right’, which ensures thinking time for the group. A focus group suggested that midwives in other Trusts could be contacted, who had special expertise, so I visited Lactation Consultant midwives in nearby Trusts where practicalities of skin-to-skin contact were discussed as well as
breastfeeding in general. Issues of importance to the project were raised such as the time taken for skin-to-skin contact and modesty for ethnic minority women. They had been through a similar change process and I was glad to learn from them. In one Trust, skin-to-skin contact was unrestricted because the mother and baby stayed in the same room looked after by the same midwives until discharge home. This meant that babies were rarely heard crying and breast engorgement was almost absent. During the planning period for ‘our’ new unit, this layout had been rejected, despite the advice of the (then) Head of Midwifery. I fed back this information to the focus group and to midwives in general conversation during my clinical hours on the ward.

**Teaching Sessions and Experiences**

I devised a one hour skills based teaching session to cover the evidence based facts about the benefits of breastfeeding. Breastfeeding skills for birth and the first week after birth were also covered, in view of the high breastfeeding discontinuation rate (Hamlyn et al, 2002). A workbook complemented the hour session, with an estimated four hours further study, with a second workbook available on request. A lot of the material in the teaching session was new information for the midwives and my current experiences of skin-to-skin contact informed and added credibility to the sessions. Information from this was adapted to form the information leaflets for parents (Appendix 1 & 2). The teaching sessions started in November and carried on throughout the project, including all grades of staff. Skin-to-skin contact posters were displayed in CDU and antenatal clinic, once sessions had started, in order to reduce pressure on midwives before they had knowledge of how to facilitate it.
One-to-One Interviews

Once ethical approval was gained, midwives were approached for interview and with verbal consent, were interviewed about their facilitation of skin-to-skin contact. During the next five months, women who had experienced skin-to-skin contact were identified and contacted by letter, detailing the project, asked to return a consent form in a stamped addressed envelope, contacted by telephone and interviewed in their homes. All participants were told that their anonymity would be protected, and that they could withdraw their consent at any time. The interviews, tapes and transcripts were stored securely. Pseudonyms were used and consent was gained to use the photographs (which were used later), both in the CDU rooms and for publication (Price & Johnson, 2005).

The traditional paradigm of a ‘proper’ interview according to Oakley (1993), appeals to objectivity and detachment rather than the concerns of those being interviewed. She recounted her own data gathering experiences where her attitude changed from that of gaining data for the research to that of gaining data for those researched. Heron & Reason (2001:179) highlighted that:

‘good research is research conducted with people rather than on people.’

Webb (1993) was concerned that research always involved the potential for exploitation, because the researcher took away the women’s words to be turned into transcripts and objectified. Literature on the potential for exploitation was discussed by Wilkinson (1998:120) with increasing recognition that:

‘the interview is not, and cannot be, a sterile instrument through the careful use of which ‘truthful’ reports and ‘honest’ reactions can be extracted from inside the heads of research participants.’

Miller (1998) interviewed women about childbirth, an area where professional domination was common; her challenge was to create a space where women felt
secure enough to tell their personal stories and I was careful to try to nurture this atmosphere of safety. Social constructionist researchers believe that the interviewer is part of the interview, helping to construct knowledge and giving the potential to explore socially constructed meaning through the interaction (Wilkinson, 1998). Interviewers, say Fontana & Frey (2000:647), need to recognise that interview participants are:

'actively constructing knowledge around questions and responses.'

Just by verbalising what happened can mean that perceptions of it may change so even if we feel that we have become close to participants, they may be still changing.

I found that I was not just collecting data, but could discuss issues with the women, for example answering questions about breastfeeding and informing the women who experienced skin-to-skin contact but did not know the benefits. My other agenda was that I wanted these women to spread the message to others. Researchers however, need restraint and listening skills in order to hear women's voices. Sometimes I was aware of the need for this and tried not to be too much of an evangelist when I was tempted to give information, even if it was not asked for.

Semi-structured interviews give opportunities for clarification and discussion. This access to women's ideas and memories, in their own words not the researcher's, is an antidote to silencing women's voices (Reinharz, 1992). The project interviews needed to be semi-structured, rather than totally open, because the data about breastfeeding and more specifically about skin-to-skin contact was
needed to feed back into the project. The interviews with both women and
midwives (with one exception when I was on the ward and forgot my tape
recorder) were ‘formally’ tape recorded. The first interview with a woman was
valuable because on reviewing my technique, I realised I needed to be more
polished, especially around the introduction to the interview, in that there were too
many ‘ummm’s and ‘you know’s’ and my probing questions changed as I gained
more insight into the project direction. After the interview, I stopped my car at the
first convenient place to write in my journal everything that I could remember
about the setting and what had happened. This was used to complement the taped
data. The interview transcripts were typed courtesy of the research funding, which
enabled me to spend more time in the clinical areas. Some of the comments made
by the women interviewed were fed back to the midwives, which added value to
both teaching sessions and discussions in the clinical areas.

Finch (1993) discussed the ease with which a woman researcher could elicit
information from other women, which raised ethical issues. She wondered
whether they were more used to accepting intrusion into their private lives, thus
making them vulnerable. I tried to be sensitive to issues which might cause harm
to either midwives or women interviewed. This extended to opportunistic data
gathered during field working. I observed midwives working and spoke to women
on the wards about their experiences. Because this occurred during ‘ordinary’
working times, they did not always give informed consent as such, but I believed
that my professional integrity would be their safeguard. I was reassured by
Reinharz (1992) who cited Fine’s (1984) work with vulnerable women, where a
dilemma occurred of whether to use opportunistically gathered data. She decided that as the women had confidentiality she could ethically use the data.

Clinical Experiences and Role Modelling
From the start of the project I worked in the clinical area. Initially this was a learning curve, involving orientation to the area and equipment as the unit had moved into a new hospital. I hoped that by working with the midwives, I would be perceived as a credible worker, who was willing to help. Silverman (2001) suggested that to understand the world firsthand you must participate rather than observe from a distance. Angrosino & Mays de Perez (2000) described a delicate balance between participation and observation and question whether anyone can be truly objective or even if this is necessary, saying that we should not expect 'subjects', but rather participants, engaging in dialogue. Decisions about the role taken will depend on the purpose of the research, the nature of the setting and the need to gain access to different kinds of data. Hammersley & Atkinson (1983:15) pointed out that the researcher cannot eliminate the effects of their presence, but should understand them by being reflexive about themselves because:

‘there is no way in which we can escape the social world in order to study it,’ and researchers need to be aware that their presence might change behaviour, as they bring their own self, with its talents and limitations.

My presence in the field, involved participant observation on a continuum from observer to occasionally almost (but not quite) complete participant. In the project, the first opportunity for role modelling, witnessed by an experienced midwife, took place within the first week. I cared for a woman in labour and she
experienced skin-to-skin contact with her baby, as we had discussed before the birth. Other clinical experiences followed which I shared with any midwife who would listen, as I was keen to raise the profile of the project. Hopefully I was sensitive enough not to go ‘over the top’ and risk people avoiding me. I also helped in any role that was requested of me, which included sharing my knowledge about breastfeeding challenges on postnatal ward. I did this willingly as I was also keen to enhance my own clinical skills.

A skin-to-skin facilitation evaluation form of was devised and amended in December (discussed in Chapter 6), its purpose being to stimulate debate amongst the midwives about how they might implement uninterrupted skin-to-skin contact. I was especially interested in how they would do this on a very busy day. This was unlikely to happen often, as the birth rate for this area was falling, but I perceived their misgivings. Discussions of personal experiences made the subject more alive and I felt that my own credibility was improved by detailed accounts of how the baby’s appearance changed for the better and how good the mothers found it.

New Routines and Remembering the Change

Leaflets for women about the benefits of breastfeeding and skin-to-skin contact were devised, amended and approved by midwives. Other minor changes were made to comply with the Trust’s Patient Information Review Group. A focus group decision was made to target the breastfeeding benefits leaflet at the first visit in early pregnancy and the skin-to-skin contact one at around 34 weeks gestation. In January, the antenatal clinic midwives began leaflet distribution with
no major problems reported and skin-to-skin information leaflets were available in CDU. Initially, in focus groups and informal discussions, we explored the realities of skin-to-skin contact and any necessary re-thinking of routines. Although this sounds deceptively simple, it was an obstacle to change. A focus group identified that it would be easier when women knew about skin-to-skin contact on arrival to CDU, as few women did at present. This identified a problem with the distribution of information leaflets, which is discussed in chapter 6.

I tried to follow the progress of change implementation through the year. Ways of recording skin-to-skin contact were aired, resulting in strategies for remembering the change (See chapter 6) and improving the information giving. Discussions about skin-to-skin contact in the operating theatre were re-introduced during the year, but not stressed and as the idea of skin-to-skin contact became more integrated into normal practice, it seemed to evolve naturally. A Newsletter was produced part way through the project, with suggestions from the focus group and distributed widely to hospital and community midwives, paediatricians, anaesthetists, and some interested Health Visitors. A final Newsletter was circulated to draw the project to a close summarising progress. Early figures for skin-to-skin contact showed an encouraging rise from probably nil at the start, to 36% in month ten and 52% in month eleven. Six months after the project this figure had raised to over 80%. The initial slow progress was a challenge, but the outcome justified our persistence. Table 13 summarises some of the main features of the project (which are also discussed in Chapter 6)
Table 13  Summary of Interventions and Outcomes of the Project

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus groups</td>
<td>Shared ownership and development. Disseminate progress.</td>
</tr>
<tr>
<td>Communication</td>
<td>Motivation and memory jogger. Increase profile about project and add to knowledge.</td>
</tr>
<tr>
<td>Visits to other units</td>
<td>Disseminate other midwives experiences.</td>
</tr>
<tr>
<td>Skills based teaching sessions</td>
<td>Increase in research-based knowledge and skills.</td>
</tr>
<tr>
<td>Information leaflets</td>
<td>Information for women and midwives – facilitate informed choice.</td>
</tr>
<tr>
<td>Posters of skin-to-skin contact</td>
<td>Information for women. Increase profile of project.</td>
</tr>
<tr>
<td>Evaluation forms for skin-to-skin contact</td>
<td>Find any problems, enabling problem solving.</td>
</tr>
<tr>
<td>Feedback from interviews of mothers and midwives</td>
<td>Give value and credibility to skin-to-skin contact.</td>
</tr>
<tr>
<td>Newsletters on progress</td>
<td>Increase profile of project and ownership. Disseminate knowledge.</td>
</tr>
<tr>
<td>Discussion stamp in notes</td>
<td>Memory aid.</td>
</tr>
<tr>
<td>Addition of computer questions about skin-to-skin contact</td>
<td>Memory aid, increase profile of project, to give credibility.</td>
</tr>
<tr>
<td>Bullet point list and pictures in rooms</td>
<td>Memory aid when discussing skin to-skin contact.</td>
</tr>
</tbody>
</table>

Data Analysis

A key part of data analysis in action research is not focused as much on constructing an interpretation as in traditional research, but in using it to show new possibilities for practice and learning through critical reflection on the data, not a single, final analysis of ‘results’ (Winter & Munn-Giddings, 2001).

Reflections on the data at one stage become the data informing the next stage and this carried forward the project. Miles & Huberman (1994:9) observed that data in action research involves the use of:

‘action-related constructs, ... and intellectual “emancipation” through unpacking taken-for-granted views and detecting invisible but oppressive structures.’
The ongoing data analysis of the project was conducted by myself, the midwives via the focus groups and informal discussions. Initial interview data did not constitute 'proof', but provided illumination and added value to the experience of skin-to-skin contact when giving feedback to other women and the midwives. Later, I returned to the data for a more in-depth analysis using the field notes, reflections, focus group minutes and transcripts from individual interviews. This broadly followed that described by Miles & Huberman (1994). Field notes and interview data along with related reflective comments were coded then sorted to identify themes, although as Miles & Huberman (1994) suggested whilst the final conclusion might not appear until data collection is completed, the themes are often recognised from the beginning, whether openly admitted or not. When analysing women's words about becoming mothers, an event influenced by both biology and sociology, Miller (1998) looked for three voices, the public, concerning professional definitions of birth, the private voice of lay knowledge and the personal voice representing the woman's sense of self which may contradict the others. I found elements of this in my individual interviews, with one woman starting to tell me something in a 'personal' voice when the tape recorder was switched off.

Mauthner & Doucet (1998:122) discussed the difficulties of describing what we do when analysing data, finding it difficult to grasp the 'unconscious' filters through which the world is experienced. They identified critical issues and then systematically scanned the data for examples of themes, using intuitive processes as well as following leads which were probably influenced by their own selves. They observed that a feminist argument is that understanding comes from being
involved with both the subject studied and the people involved combined with reflexivity, but basically:

'it remains a fundamentally subjective interpretive process.'

Like them, my data analysis was not a discrete phase but ongoing throughout and extending beyond the project. I lived and breathed the data during the year, using some of it to inform the project before coming to the final more detailed analysis.

Because clinical events were unpredictable and I worked alongside and interviewed individual midwives there was a potential risk of harming people, so I had to consider how some of the data would be viewed. Angrosino (1998) resolved this issue by deciding to use a form of 'alternative ethnographic writing' and to present the material in the form of fictional stories that preserved the truth of individual experiences, without making individuals explicit. Fine et al (2000) stated that rather than flooding the text with researcher's subjectivity which could silence the participants, they scripted a story which gave a semi-fictional portrait of each community. In a similar vein, narrative analysis (Polkinghorne, 1995) contains texts that are thematically organised into plots, allowing different data to be integrated using individual perspectives as a contribution to the outcome and illustrating why things happened as they did. Polkinghorne (1995:7;18) described a storied narrative as:

'a linguistic form that preserves the complexity of human action with its interrelationship of temporal sequence, human motivation, chance happening and changing interpersonal and environmental contexts.'

Narratives allow selection of many parts of events which happen to people over time, as long as they directly contribute to the outcome. He describes the story produced as:
"a temporal gestalt in which the meaning of each part is given through its reciprocal relationships with the plotted whole and other parts."

Polkinghorne argued that this was not merely a description, but a dialogical production resulting from interactions of those involved. Narrative must contain cultural contexts, values and an illustration of what life is like for each person. In this narrative, he felt that it was essential to recognise the role and influence of the researcher in forming the story and its plot. I used these ideas to inform ‘Eve’s Story’ in Chapter 5

**Validity of This Data**

As previously discussed, critical examination of what we do is vital, improves our awareness of the consequences of what we do, leading ultimately to questions of quality and validity (Chiu, 2003). Heron & Reason (2001) say that the validity of action research is enhanced because of co-operative inquiry, the inquiry cycles and moving several times between reflection and action with data feeding back into the cycle. Validity can be checked by participants to see if what they are doing goes against the prevailing norms of their culture and also whether it is outside universal standards. In other words, they ask:

‘Does it work?’ or ‘Can I get away with it’ .. ‘does it help us work out a viable alternative?’ rather than ‘Is it correct’ (Angrosino & Mays de Perez, 2000:689).

Meanings have to be tested for validity, otherwise:

‘we are left with interesting stories about what happened, of unknown truth and utility’ (Miles & Huberman, 1994:11).

Webb (1989) believed that a triangulated approach to data collection would enable us to see things from different angles, which she felt could add more validity to the findings, giving a more comprehensive view. This reality could be checked by participants and researcher, ensuring face validity. The project demonstrated
multiple action research cycles, detailed discussions, alternative views were aired and openness was demonstrated. The face validity of the project was demonstrated by the success of the change, which was achieved by a process of collaboration, negotiation and reflection on the interwoven cycles of change.

Conclusion

Having provided an overview of the project, I have detailed the story focusing on the cyclical process of the action research. Access and ethical concerns have been addressed and data collection discussed. Focus groups were one of the keys to its success, as collaboration meant that ownership of the project was more likely. Skills based teaching sessions empowered midwives to implement the change, as did constant discussion of how it would be done and reminders in order to change long standing routines. Evaluation of the success (or not) of any change and support and encouragement were vital parts of the spiral process. Interviews of midwives and women gave valuable data for use immediately to feed back into the project and for later more in-depth analysis. This process is congruent with the underpinning epistemology and theoretical perspectives discussed in Chapter 3.
Chapter 5  The Power Over Life

Introduction

In this chapter I will discuss and apply theories of power, examining their use to influence individuals and groups where they may be so culturally embedded as to be almost invisible. The ‘usual’ routines for birth before the project will be described and my realisation that power was embedded in and sustained them. Theories of power within the critical tradition (Galbraith, 1986, Simmel, 1986, Arendt, 1970, Lukes, 1974,) enable a clearer understanding of the hierarchical power structures, conflict and oppression which are enabled by organisations such as the NHS and hidden power such as in medical dominance which can control agendas or a person’s world view. Foucault’s (1972, 1977, 1980, 1988a, 1988b) theories will be explored, which although seeming to contradict the critical theorist view of hierarchical power, provide a deeper analysis of the diverse nature of power. This power is apparent in everyday actions, even originating from those who are powerless, as they survey themselves to maintain their powerlessness. Using a narrative approach (Polkinghorne, 1995), I will then apply all the above to the power structures recognised in the maternity unit before the slow change in practice occurred. This will be followed by a discussion of the need for the research project and the empowering work of Freire (1993)

The ‘Usual’ Routines: A Ritual for Birth

When a woman was admitted to this hospital in labour, she would be assigned to her own small en-suite room on CDU and a midwife would be allocated to provide care. The woman would be expected to get undressed and the logical
place to sit would be on the bed, which was central to the room, with one chair provided for her partner. A routine admission procedure would include filling in a set of standard case notes, assessing the progress of labour and performing an assessment of maternal and fetal well-being including an abdominal and vaginal examination. An electronic cardiotocograph (CTG) machine to monitor and record uterine activity and fetal heart rate would usually be attached and discussion of some issues which might arise during the labour would follow, such as the use of pain relieving drugs or the administration of an oxytocic drug during the latter stage of labour. Other aspects of labour could be discussed at this time, but there was no standard format beyond tick boxes to ensure some discussion of drugs to be used, the quality and depth of this being dependant on each individual midwife.

After the birth of the baby, the mother would be asked if she wanted her baby delivered onto her abdomen straight away or wrapped up. If the first was chosen, the baby might be left there, wrapped or unwrapped for about 10 minutes, until the third stage of labour was completed, then the baby would be taken, with parental consent, to be checked for normality, injected with Vitamin K to prevent haemorrhagic disease of the newborn (a rare bleeding disorder caused by lack of Vitamin K), electronically tagged for safety and dressed before returning to the mother or father. The baby might breastfeed at this time or wait until later on postnatal ward. If the baby stayed in skin-to-skin contact for longer, there was no way of knowing this, as everything happened behind closed doors. The importance of uninterrupted skin-to-skin contact between mother and baby was not generally recognised nor was it offered to women, unless by individual
midwives working in secret. In view of later events, I suspect that it did not happen. There was pressure to expedite completion of official documentation of the birth details and the standard practice was to suture the perineum if needed, give the woman tea and toast, then a shower before moving them all to postnatal ward. The room could then be cleaned and prepared for the next woman.

**Power? – Here?**

As I became involved in the research project, I was naïve in not consciously thinking that midwives could use power over women, perhaps not least because it impacted on my own history as a midwife and the cultural lens through which I viewed my world. At the beginning of the project, I observed a relationship of power which was held by some midwives over women. As my own eyes had been closed, I do not think that the midwives were necessarily aware that they held this power, but nevertheless, they wielded it by their adherence to routines, lack of evidence-based knowledge and the imposition of their values on women. The women and their partners tended to adopt a dependent role, accepting care given to them, even if they might previously have wished a different form of care. I should have had some insight, because about two years before this project, in a community setting, I met a woman who attended my antenatal skills sessions about breastfeeding, which included the benefits of skin-to-skin contact at birth. She was very keen to experience this, but when admitted to hospital in labour, she did not like to bring up the subject, because the midwife did not, and the events unfolded as directed by the midwife.
About 4 months into the project, in University I undertook a lesson for first year student midwives about the evidence base for the implementation of uninterrupted skin-to-skin contact between mother and baby. A comment was made by one student midwife who had worked as a health care assistant on a Maternity Unit before joining the programme. With a concerned expression on her face she said something like:

'This is all very well Mary, but what about the pressure on the midwives.'

By this, she meant the pressure of completing the tasks surrounding birth and caring for other women. I was teaching the students as if they were couples in a parent education class, so I turned the discussion round saying:

'Knowing the evidence-based facts about the benefits of skin contact for both you and your baby, what is your right, what would you choose?'

They all agreed that uninterrupted skin contact in a relaxed atmosphere was best. This began my thoughts about the power of the professional in hospital. I had not thought of these women as being oppressed during their births, where the midwife's adherence to a routine might interfere with the physiological benefits and special, unrepeatable and precious time of relationship building at the birth of a new family member. The routines of weighing, checking, dressing the baby and shower for mothers were being performed so that the midwife's jobs could be done by a certain time. This reminded me of my early nursing days, when we woke ill people up at 6am for a cup of tea, just so that we could report that it had been done along with the other routines, before going off night duty. Perhaps some are still imagining that they are giving a service out of the goodness of their hearts, not that they are being paid by women, albeit indirectly, to help them in their birthing.
Hacking (1986) suggested that power is not just one thing but many small piecemeal additions, which for various reasons go to make up a complex picture. People may unwittingly add small actions without knowing what they add up to. Knowledge is produced by the powerful, who say what its depth and breadth will be and power sustains it. This could be compared to a midwife defining what happens in the ‘normal’ birth process, which may not be the same as the physiological or ‘natural’ process which it may mask (Kahn, 1995, Odent, 2001a). This was reflected in women’s views surveyed by O’Cathain et al (2002) where the exercise of informed choice was found to be variable. Stapleton (2004) reported ethnographic data that saw midwives giving information which did not contradict routine practices with most women complying with the options presented. Kirkham & Stapleton (2004) concluded that whilst most midwives might speak of informed choices, they would ensure that women complied with what was usual practice in the unit. Hacking (1986:38) described the concept of irrigation, which concerns actions that keep the power relation hygienic and run channels of water to other areas, so the whole can flourish. Without the performance of certain acts, such as compliance, the power would rot and dry up.

What is This Power and How and Why is it Manifested?

Russell (1986:19) observed that power may be defined as ‘the production of intended effects’. Galbraith (1986) used three definitions of power around which I will base my initial explorations, namely condign power, concerning punishment, compensatory power, concerning rewards and conditional power, which is about changing beliefs. A dictionary definition (Fowler & Fowler, 1964) of ‘condign’ is: ‘severe and well deserved (usually of punishment).’
Galbraith (1986) discussed condign power, as having an element of punishment which involves submission to the will of someone else, because the alternative is perceived as even worse. Russell (1986) used the example of a galley slave who does not want to row, but wants to avoid the lash even more. A person who submits to the will of someone else might not admit their own beliefs and accept the other person's because the consequences of non compliance are too difficult or disruptive. It could be compared to a practitioner keeping quiet, or falling in line with poor practices advocated by others, because the consequences of any challenge are perceived to be worse. The punishment might not be physical, but would be punishment all the same. Other definitions fitting this category are coercion, compliance or force which Russell (1986) compared to a squealing pig being hoisted onto a ship, entirely against its will.

Compensatory power (Galbraith, 1986) is where submission is won by offer of a reward. This would be something of value to the person such as a salary for work performed, or the promise of employment for a student midwife. According to Russell (1986) rewards could act as inducements, which he compared to a donkey trying to reach a carrot and so moving forward. Conditional power (Galbraith, 1986) is used to change a person's beliefs. This might be by persuasion, education or a feeling that a course of action seemed right, which causes someone to submit to the directions of another person. Submission in this case seems to be what the person chooses, and might not be recognised as such. Galbraith felt that this power was central to the working of modern politics. Influence on public opinion could fall into this category and is often used in party politics, which Russell (1986:19) likened to sheep following a leader. Canter (2001) similarly discussed
the expert power which doctors hold over patients with their extensive specialised knowledge which has the power to influence actions, whereas the use of charismatic power, although it can be beneficial, might do harm, whilst the patients remain grateful as in the case of the late Harold Shipman.

**Power and Organisations**

I will now explore the use of power in organisations, as this seems to encapsulate all the forms of power described previously. Whilst force was the most effective for seizing power, Lenski (1986:245) explained, it was not the best for retaining and getting the best out of it, as it was costly to maintain. To work well, the new society must accept those in power. This may be achieved by the powerful writing the new rules for society, which then become part of the law. To illustrate this Lenski (1986:246) quoted Anatole France who wrote tellingly:

‘The law in its majestic equality forbids the rich as well as the poor to sleep under bridges, to beg in the street and to steal bread.’

Lenski (1986) used the Soviet Union in 1917 as an example, where a small minority seized power and transformed the educational system and mass media which then became an instrument of propaganda for the powerful. The use of this power then became identified with justice, but really it protected the interests of those who wrote the rules. The people meanwhile complied with the law because it was law. According to Lenski (1986) this was a more socially acceptable form of power and less likely to be challenged, but it tended to be more impersonal and people held power because they held a certain role, allowing them to do things even in the face of opposition.
Simmel (1986:205) discussed forms of power, such as the authority held by people in organisations like the church, state or a school, which gave them a reputation, a dignity, and power which would never have come from themselves alone. In other words, the authority ‘descends from above’. The person submitting must willingly co-operate and this would involve unquestioning compliance, so that neither coercion nor persuasion was needed. When subjected to this authority, Simmel (1986) observed that those who complied often felt defenceless. Russell (1986) highlighted a difference between ‘traditional power’ and ‘newly acquired power’. Traditional power could be used to ensure compliance because of long held custom, it does not always have to justify itself. This is usually associated with religious traditions which imply that non-compliance is bad or wrong. Examples of this are the Judeo-Christian beliefs about Sabbath observances, a Muslim woman’s style of dress, or working class historical customs, such as ‘knowing your place’ in society. In this way, compliance can rely greatly on public opinion and the habits of culture, which has hints of the National Health Service.

Galbraith (1986) described traits such as personality and organisations, which are associated with effective use of power. Personality can be either physical strength or the ability to persuade or create beliefs in others. The organisational trait however, was seen by Galbraith as the most important in modern societies and has its strongest relationship with conditional power, allowing the necessary persuasion and resulting submission to what the organisation wants. Organisations also have condign power, to inflict punishment and varying access to compensatory power depending on the property or funds they possess. Galbraith
(1986:220) went on to say that in big businesses today, the one dominant name, such as in the ‘Ford Motor Company’ has gone, replaced by the management team, or what he called ‘faceless organisational man’. This implied an anonymous power base, where no single named person is to be seen as responsible. Arendt (1970:38) felt that this bureaucratic power was possibly the strongest form of domination, in which:

‘no men, neither one nor the best, neither the few nor the many, can be held responsible, and which could be properly called rule by Nobody.’

This type of power does not rely on command but obedience. Arendt (1970:38) quoted John Stuart Mill (1861), who wrote:

‘The first lesson of civilisation [is] that of obedience.’

Arendt (1970:38) pointed out that

‘the instinct of submission ... is at least as prominent in human psychology as the will to power.’

In my personal experience of the NHS in the 1980’s an obstetrician decreed that all ‘his’ women who were admitted to hospital in labour, were to have the invasive interventions of artificial rupture of membranes and application of fetal scalp electrode (to record the fetal heart rate) as a routine, even if birth was imminent. In the 1990’s it became a routine that all women admitted to the labour ward had a CTG machine attached for 20 minutes, as a way of assessing fetal well-being, known as the ‘admission CTG’. Even though the National Institute for Clinical Excellence (NICE, 2001) guidelines now state that this is unnecessary or even detrimental, the practice continues in some areas because it has become an accepted part of the admission routine. Midwives may have submitted, even when they disagreed, because they did not wish to confront the condign power of those who upheld these routines or the traditional power implied by instructions written by those in senior positions in the organisation.
Power in Numbers

Organisations by their very nature are formed of groups of people working together for some purpose. The power of a group is only strong if they are cohesive. If someone is ‘in power’ they are in fact ‘empowered’ by other people to act in their name. The prime minister of the day would be unemployed if sufficient votes were not gained. Sometimes however, people in power succeed because of the inaction or apathy of the rest of the group. Arendt (1970:42) explained that although:

‘power always stands in need of numbers,’

minority groups sometimes win because the majority do nothing. She gave an example of a lecture, where there was a violent disruption by a minority of students. The majority in the class were unwilling to use their power to subdue the disrupters. The lecture broke down because no-one was willing to speak up.

Arendt (1970:42) explained that:

‘The merely onlooking majority, amused by the spectacle of a shouting match between student and professor, is in fact already the latent ally of the minority.’

Sometimes bad things are allowed to happen in practice but no-one makes a fuss. In childbirth, the liberal use of episiotomy, to prevent perineal laceration during birth, spanned the 1970’s, a practice imposed by doctors, with no research basis, but powerful ‘expert’ opinion. This changed in many parts of the world when midwives were strengthened by research evidence in the 1980’s and challenged the perceived condign power of the obstetricians (Sleep et al, 1984, Sleep & Grant, 1987). The doctors’ belief and practice followed later, as the improved outcomes for women became apparent.
The superiority of those who hold power, observed Arendt (1970:49), lasts as long as the power structure is intact i.e. as long as commands are obeyed and the ‘police’ are prepared to use their weapons. Weapons in this case, could be threats of punishment or deprivation. If the power structure is weak, they may continue providing they are unchallenged. According to Arendt (1970), there were many instances of impotent regimes which continued for years, either because there was no-one to test their strength or they were lucky enough not to be in a war and get defeated. She described the events in France in the 1960’s, when a student’s rebellion brought down the whole political system. No-one was more astonished than the students, because they were only intending to challenge the ‘ossified university system’ (Arendt, 1970:49). When someone has the strength to challenge a perceived power structure, the anticipated threat may not materialise.

A junior student midwife described to me her unwarranted fear on a surgical ward placement, before she challenged a nursing assistant’s instructions, which she perceived to be against the best interests of a patient. Similarly, the world did not end in 1983 in my clinical area when women were encouraged by midwives to enhance natural birth and reject unnecessary medical technology necessitating an uncomfortable and immobile labour in bed attached to electronic monitors.

**Is Power and Authority Enjoyable?**

When discussing aspects of power, Galbraith (1986) argued that we do not always realise the extent to which the purpose of power is the exercise of power itself.

Simmel (1986:203) discussed the joys of domination, where:

> 'nobody, in general, wishes that his influence completely determines the other individual.'
The suggestion here is that it is enjoyable for the powerful to have an influence on the lives of others, either by seeing the effects of domination or basking in the glow of grateful thanks for favours bestowed. If the domination were to totally overpower the other person, there would be no return of feeling to be appreciated by the one who instigated it, as Simmel (1986:203) said, it would cancel the very notion of society, e.g. societas leonina (socialisation with a lion) would not be socialisation where both interact.

**Hidden Aspects of Power**

Lukes (1974) pointed out that some arguments about power were inadequate because they were too committed to the study of ‘actual’ behaviour, and gave a misleading picture of how people excluded potential issues from political process. He described three dimensions of power. The one dimensional view of power is where A affects what B does and as Canter (2001) emphasised that this can be valuable in emergencies, as it is direct and to the point. The two dimensional view of power, is where A affects what B does by controlling the agenda, for example by steering the conversation away from or towards certain topics that might influence the outcome. If only harmless issues were raised, B would be prevented from bringing up any issues that might affect A. As Lukes (1974:16) illustrates, some issues are ‘organised into’ politics and others ‘organised out’, with issues being either removed before they have been raised; not reaching the decision-making stage or being destroyed in the decision-implementing stage. Humphries (1996), raised the issue of equal opportunities for women or disabled people, which in the 1970’s and 1980’s were being strongly emphasised, whereas she felt that today they seem to be being quietly organised out of the agenda by those in
power. Lukes (1974) described the use of power involving the inaction of a large company involved in steel manufacture which because of a desire to increase profits, contributed to environmental pollution. For many years, despite public protest the company did nothing to change this. Their tactic was evasiveness and sympathy, but inaction. If only there had been a fight, Lukes said, something might have been achieved.

It might also be assumed that if no conflict is visible in a situation, then there must be a consensus, which Lukes felt was not so. Canter (2001) included here the health professional’s power to silence clients by lack of time or poor communication. Research by Lock & Gibb (2003) described the power that ‘place’ had over women on a postnatal ward in hospital. The women felt that the midwives were very busy and any questions or requests for help were ‘taking their time’, so they did not ask questions. Power might be used if emphasis is given to the advantages of a drug, but not its side effects. Information given in most maternity units about the oxytocic drug Syntometrine might emphasise its potential benefits of preventing haemorrhage after childbirth, whilst omitting its possible emetic and hypertensive effects. This drug might be useful to those who are at risk of haemorrhage, but not necessarily to those women who are low risk, who may then suffer the debilitating nausea and vomiting marring the normal birth and bonding with their baby.

Lukes (1974) developed his arguments further by proposing the three dimensional view of power, in which the powerful control the world as others see it. He felt that it was the supreme exercise of power to persuade others to have the desires
you want them to have. He described this form of power as insidious, preventing people from seeing that they had a grievance, because they could not imagine any alternative. Either that or they could not see any way to change their circumstances, so they accepted them. This might be by adherence to a routine on a ward or women's expectations that the directions of midwives and doctors are not questionable. Lukes (1974) pointed out that a doctor may construct a world view for people, of disease and the overwhelming goodness of medical advances in treatment of diseases. People might think they follow their own choices, but they were being shaped by the power of medical knowledge, which said that reliance must be placed on medicine and treatment rather than no treatment or natural remedies such as improved diet, lifestyle changes or natural childbirth at home. Political control of information might influence a person's beliefs without their conscious knowledge, such as with advertising and the efforts of the mass media, and socialisation and influence in schools which can shape the beliefs of generations. The medicalization of childbirth with the wholesale transfer of birth from home to hospital in the 1960's onwards has influenced whole generations of women to believe that hospital is the only safe place to give birth. Today, only 2% (on average) of women achieve a home birth (NHS Maternity Statistics, 2004). Conditions have changed since the time when there was poor sanitation and housing and where large numbers of women died of puerperal sepsis; anaemia caused by poor diet; poverty and repeated childbearing. Despite this many people today still 'know' that hospital birth is safer than home.
A Foucauldian Perspective on Power

A further perspective on the operation of power may be gained from the work of Michel Foucault (Foucault, 1972, 1977, 1980, 1988a, 1988b). He wished us to see that the past was just as strange as the present (Kendall & Wickham, 1999:4). The implication being that:

'we should not look at how today has been produced by yesterday, but use history as a way of understanding the present.'

Hacking (1986:36) said that Foucault's thesis was that:

'.. every way in which a person can think of themselves as people and agents has been put together within a network of historical events.'

What people say at a certain time or place is not necessarily done consciously, the speaker being irrelevant to analysis of the 'conditions of possibility', or those things that had to take place to allow something else to be possible (Kendall & Wickham, 1999). Most of us look for causes when seeing events in society but Foucault suggested that we need to accept them as contingencies. In other words there is usually a good reason why people act as they do. Foucault (1988a:326) said however that people like judging, giving as an example:

'the last man, when radiation has finally reduced his last enemy to ashes, will sit down behind some rickety table and begin the trial of the individual responsible.'

Foucault talked of an anxiety in people that the road to walk was so narrow that only one could walk in it at any one time. The implication being that one is right and the other is wrong. Foucault (1988a:327) said:

'Ve have to walk in line because of the extreme narrowness of the place where one can listen and make oneself heard.'

He dreamed of a kind of criticism that would not try to judge, but bring a new understanding or vision. Taylor (1986:69) believed that Foucault exposed a
modern system of power which was insidious. Its strength lying in the fact that it might not be seen as 'power' but as science or even 'liberation'.

Foucault (1972:174) used his archaeology of knowledge to try to penetrate the complexities of the use of power and knowledge. He said that archaeological analysis:

'individualizes and describes discursive formations.'

Amongst a complexity of functions and working in many areas, it compares, contrasts looks at oppositions, linkages and confrontations. According to Foucault (1972:28) the discourse that is seen in public is really concealing that which is not said:

'and this 'not said' is a hollow that undermines from within all that is said.'

To find out more, we need to disturb the surface of things as they are presented, because events do not just happen, but are a result of many influences. We should look deeper than the superficial evidence they present and set free the problems that they hold. Foucault (1972:30) said that

'We must reconstitute another discourse, rediscover the silent murmurings, the inexhaustible speech that animates from within the voice that one hears, re-establish the tiny, invisible text that runs between and sometimes collides with them.'

So we must grasp statements in context, find out why they exist, find their limits and how they relate to other statements connected to them and find out what statements are excluded. According to Kendall & Wickham (1999), Foucault's archaeology helps us to describe 'statements in the archive'. covering the said, the unsaid and the visible. It looked at the formation and transformation of statements, describing such things as differences and continuities, in other words, the statements and arrangements that make up an organisation and finding out
whether what is said publicly is really enacted. Foucault (1972) said that first we need to find out who is able to speak, who has the qualification to do so, and who obtains power from speaking and why this is accepted as truth, which he felt was usually confined to a particular group. We could perhaps question the situations surrounding childbirth where a midwife or doctor is allowed to write the rules, such as those about hospital routines; what rules allow new statements, and what is the power-knowledge nexus that links all the above. The more a subject is examined in depth, the nearer we may come to a form of truth. Hacking (1986) interprets Foucault who said that truth is understood by the way statements are regulated, distributed and operated, and this is linked to power which named truth and continues to uphold it. Foucault (1988b:106) said that:

'What struck me, in observing the human sciences, was that the development of all these branches of knowledge can in no way be dissociated from the exercise of power ..... the development of chemistry for example, could not be understood without the development of industrial needs.'

This could be likened to the fact that the 'science' of obstetrics could not be understood without the development of women's need for help in childbirth.

An example given by Kendall & Wickham (1999:25), using Foucault's ideas on discipline and punishment is:

'Prison as a form of visibility produces statements about criminality, whilst criminality produces forms of visibility which reinforce prison.'

I find it fascinating that Foucault's work (1977) involving prisons can be used to look at childbirth, which in many circles is still known as a 'confinement'. My alternative applied to childbearing is:

'Hospital as a place for giving birth produces statements about childbirth.'

For example: Women need to be in hospital for birth and observed to make sure nothing goes wrong. Birth needs medical expertise because of its perceived
danger. Women lack personal control, having given it to professional. Midwives are the experts so most women accept their advice.

‘Childbirth in hospital produces ways of giving birth that reinforce hospital.’

For example: Midwives follow routines and women’s movements are supervised. The bed is the focus of the birth room, implying that is where birth takes place. Women wear night clothes and are cared for by ‘expert’ strangers. Machines monitoring labour progress and normality are in every room to ensure that all goes to plan. Time is measured and activities delimited on the judgement of a professional. Women are grateful for services given by the midwife.

Kendall & Wickham (1999) explained that archaeology was Foucault’s method, whereas this genealogy was a way of putting it to work or a way of linking it to our present concerns, uncovering the ‘conditions of possibility’ for a knowledge or historical event. They described Foucault’s genealogy as his main attempt to develop methodological weapons to help with the account of power, being seen as a successor to the archaeology, with a new concern, the analysis of power, which is ‘the history of the present’ or:

‘pointing out things about their origins and functions they would rather remained hidden’ (Kendall & Wickham, 1999:29).

If genealogy is seen as a history of the present, this might include knowledge of how some midwives have become medicalised rather than woman centred and using midwifery skills. Historically, a midwife was a ‘handy woman’ working independently in the community, using knowledge passed down in an apprentice-style training, which varied from bad to excellent. Many women suffered poor health through repeated childbearing and poor living conditions, which meant that childbirth was often dangerous. In 1902, midwives became regulated by an Act of
Parliament, with their practice controlled and dominated by the medical profession (Donnison, 1988). A progressive shift in the place of birth to hospitals meant that midwives also had to move with the women and so both became visible and under the influence of hospital structures and hierarchies.

When looking at issues of discipline and punishment, Foucault (1977:136) explained that society decides what a crime is; it is not a natural thing. If punishment follows a certain act, then fear can stop a person repeating it. Foucault’s work described the way that the ‘docile body’ had been produced by discipline. He said that:

‘A body is docile that may be subjected, used, transformed and improved’, to show how its proper function should be. Disciplinary power can be used by supervising time, space and movement, to instil the knowledge of this ‘proper functioning’. Foucault (1977:137) described:

‘an uninterrupted constant coercion, supervising the processes of the activity rather than its result and it is exercised according to a codification that partitions as closely as possible time, space, movement.’

Routines make it easier to manage people, and reduce individual differences. This means that speed and efficiency will be determined by the powerful for their own purposes. Foucault pointed out the need to centralise services in order to reduce the inconvenience of those in power and which would involve controlling movements, both of which would contribute to the production of an ‘analytic space’ (p141). Foucault (1977:60) said that:

‘Power is articulated directly onto time; it assures its control and guarantees its use.’

Time regulation allows more efficiency, so time wasting or idleness would not be approved of and speed would be seen as a virtue. Discipline is the specific
technique of a power that regards individuals as both 'objects and instruments of
take exercise' (Foucault, 1977:170) and is used to focus on the minor things of life.

Foucault described three instruments which were used to ensure the success of
this discipline, hierarchical observation, normalizing judgment and the examination. Hierarchical observation is used to make people visible, to transform them and control their actions. It takes disciplinary power to them, making it possible to know and change them. Foucault (1977) believed that hierarchical observation needed an architecture which allowed people to be made visible. The way that a building is organised can allow better observation and perpetual supervision, as Foucault (1977:170) said:

'stones can make people docile and knowable.'

This is part of the power of discipline, as surveillance tends to act in all directions:

'for although surveillance rests on individuals, its functioning is that of a network of relations from top to the bottom, but also to a certain extent from bottom to top and laterally; this network 'holds' the whole together and traverses it in its entirety with effects of power that derive from one another: supervisors, perpetually supervised' (Foucault, 1970:176/7).

Foucault's (1977) concept of normalizing judgment is about the ways of ensuring that people conform to a required standard of conduct. Taylor (1986) stated that this concept is concerned with bringing about a certain result, defined as good health or good function. A supervision which compares, homogenizes and excludes, in other words it normalises people's actions. It is a way of finding out what is permitted and what is not, with condemnation if these norms are not followed. Taylor (1986) said that this new philosophy of punishment, was inspired by the need to control, and people would be measured, classed, examined and so made a better subject to a control which tends to normalization. Examples of this would be conforming to a hospital routine or fearing to do something
which breaks the hospital rules. Porter (1998) felt that these judgements were usually made by experts, for example nurses, who used professional knowledge to define what was classed as normal, who fitted into this definition of normality and what was to be done with those who did not fit in. This is ‘the power of the Norm’, (Foucault, 1977:184).

Foucault (1977:27) argued that power and knowledge were strongly interlinked, saying:

‘we should admit that power produces knowledge ... that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.’

A midwife may hold expert knowledge which may not have been made available to women and their partners, which then enables her to say what should happen. Disciplinary power can be used subtly, but at the same time it imposes a compulsory visibility. Foucault’s concept of the ‘examination’ is integral to this, where a person is potentially always accessible. They may not actually be examined, but it would be possible at any time. Foucault (1977:223) believed that although society might imply that power is not exercised:

‘Its universally widespread panopticism enables it to operate, on the underside of the law, a machinery that is both immense and minute, which supports, reinforces, multiplies the asymmetry of power.’

Worse than this, just like the prisoner in Bentham’s panopticon, we realise we may be being monitored at all times, so we behave as if we are i.e. we survey ourselves, acting as moral wardens, a process Foucault called ‘subjectification’ (Porter, 1998). The aim of this is to generalise the docile ‘man’ required by our efficient, technical society, to produce an obedient, hard working conscience ridden, useful creature. Foucault’s ideas of knowledge, power and discipline along
with the other theories of power previously discussed, have been used to inform
the following narrative analysis (Polkinghorne, 1995) of the clinical situation at
the start of the action research project.

A Narrative Account: Eve’s Story and Mine

The outcome of this story for a woman named ‘Eve’ was that after entering
hospital for birth, events and choices were shaped by midwives and birth guided
towards a ‘normal’ outcome rather than being supported in a natural physiological
one. The question could be asked ‘How did this happen and what were the
contingencies that caused them’? Truthfully (?), as I reflected on the project
through Foucault’s eyes, my perceptions deepened and I saw other viewpoints.
The year long project seems to have passed very quickly, yet as I look at my field
notes during its life, time moved slowly, especially when nothing seemed to be
progressing. At the beginning, when I arrived in my lilac tunic and trousers, it
seemed that I had stepped back in time to when I was labour ward sister, before I
started on the academic pathway. Nothing basic had changed in the care giving,
except perhaps there was less emphasis on upright birth and more women
received epidural analgesia and caesarean section. The ward routines were more
or less intact and obviously, mothers still laboured and babies were still born as
before. I have fond memories of my care-giving and benevolence towards women
and this may be why it came as such a shock to me to realise that I was
historically implicated in some of the power relations which I discovered with my
newly opened eyes. This was an uncomfortable but valuable insight.
For a long time now, most births have been in hospital and women seem to believe it is the safest place, perhaps because medical opinion says so. When I interviewed Kathy about her birth experience, she said:

‘...I suppose it was a good idea being in hospital because they were monitoring everything weren’t they...’

This reminded me of Lukes’ (1974) three dimensional view of power, where people’s view of the world is shaped by others, without their even realising it. When I think about my power over women, it was surely influenced by the strong cultural norms of the day. As Foucault says, we must not judge, but look for contingencies that guided this. Current government policy relating to childbirth is based on the principles of choice, continuity and control for women (DOH, 1993). This ‘new’ (or old, depending on the length of your memory), way of working would mean that a woman and a midwife would know each other throughout pregnancy and childbirth, allowing trust to develop, choices to be discussed and hopefully, control taken by the woman. This type of care is seen as the gold standard, but has been too expensive for most Trusts to implement as a wholesale strategy. Some Trusts in the North West, including this one, tried to implement its principles and then abandoned it after a year as too costly, because first and foremost they must be cost effective. Many midwives were devastated, as they were just starting to see the benefits for the women. For the majority of women giving birth here a midwife is not a known person, and any midwife could be the one to care for them on their vulnerable day of childbirth.

Most antenatal care for Eve has been provided in the community, but three visits were made to the hospital antenatal clinic. Information about breastfeeding should have been given antenatally because international (WHO/UNICEF, 1998) national
(DOH, 2003a, 2003b) and local (Trust) policy is based on a wish to promote breastfeeding as the healthy option for babies and mothers. The Pregnancy Booklet, produced nationally is given out to all women in the hospital antenatal clinic; it contains information about infant feeding and promotes breastfeeding as the best way to feed babies. Skin-to-skin contact between mother and baby at birth is a way of promoting the success of long term breastfeeding (Anderson et al, 2003) and is advocated by the World Health Organisation (WHO/UNICEF, 1998). In theory, this means that all health professionals should be motivated to promote it. Eve saw a different midwife at many antenatal visits and responsibility for education was dispersed. Breastfeeding is perceived by midwives to be valuable, but the information is not emphasized for women. If policy ‘says’ that breastfeeding is best, yet the ordering of statements says that it is not as important as the Department of Health recommended universal screening of pregnant women for human immunodeficiency virus (HIV), then time will be allowed for HIV and not available for breastfeeding. Feeding might never be mentioned beyond asking a woman how she intended to feed her baby. The women I interviewed including Eve, had almost no information on breastfeeding and none on skin-to-skin contact at birth (except from me at a class).

Jane: Nobody actually said...how to do it or anything ... I don’t think it was really discussed.’
Mary: ‘So where did you get your information from?’
Jane: ‘Um...I just knew how to do it....previous experience...’

Mary: ‘When you were pregnant did you ever find out information (about breastfeeding) at parentcraft or did you have some information(from) before...
Paula ‘Um....no...only from talking to friends...’

During the project, in the hospital antenatal clinic, the staff identified difficulties with time, especially when it came to giving out the newly devised leaflets about breastfeeding. There was some discussion about the time it might take to give out...
leaflets about breastfeeding and the large amount of information given to women anyway, as it was perceived that most do not read leaflets. I remember sensing the same resistance repeatedly during the project. The leaflets were not given out at 32 weeks gestation, as planned, for quite some time into the project, although we did not discover this until later. The clinic midwives found it hard to attend my teaching sessions, so I agreed to try opportunistically, but they never achieved this. This could have been because the clinics ran like machines, with a constant treadmill of women waiting to be seen in a short time.

Eve is in labour, so she travels to hospital where she is taken to her birth room. She is supervised by a uniformed midwife, who wears a badge which names her and implies her right to hold authority in that Trust. Eve is then asked to change into night clothes, get into bed and undergo an examination assessing well-being, which includes being attached to a CTG machine to monitor uterine contractions and fetal heartbeat. This reminded me of condign power in that I do not remember any woman refusing this. Thinking about condign power, I was reminded of a conversation with Sue who was keen to experience skin-to-skin contact after the birth, having been to one of my parent education session on its benefits. She told her husband to make sure that it happened, implying that she might not be strong enough at the time:

Sue: ‘... I did actually say to John after seeing you, I did actually say to him...that I wanted her passed straight to me...you know...then John made sure that that’s what happened and he said...can she have her straight away.....’

Kathy told me about events after the birth, she said:

‘I had to go and feed her again and the midwife wouldn’t let me have a cup of tea or anything, I was really annoyed with her...because I needed...I was starving and...I’d lost quite a bit of blood I think...and I had a cream egg and I just needed some sugar you know...(oh yes)...she wouldn’t let me...would she (to baby)...started shouting at me...no you gotta feed your baby...and then when I
started to feed she was dropping off... I suppose she was still full of all the
drugs... she was falling asleep on me and the midwife came and she **made**
(Kathy's emphasis) her wake up and she come off my breast and I struggled to
get her back on the breast so I just turned around and started on the other
one... Well the midwife came in and started shouting at me ... what do you think
you're doing... I felt like telling her to F off... (laughs) because I was so tired
and so like shocked that it was a little girl I didn't realise she was going to be a
little girl... no I didn't... (to baby).'

I asked her why she did what the midwife said, implying that she did not need to
do this. Kathy said:

Kathy: 'You don't know though do you...'
Mary: 'No, but you would... now.'
Kathy: 'Yeah, oh yeah definitely... I'd be out within the hour after she were
born...'

Kathy apparently would rather avoid conflict, than deal with it. I had no midwife
perspective from this story and Kathy might have misinterpreted events, but the
fact remains that she perceived the power to be condign, whether or not this was a
true representation of facts.

To return to the story thread of Eve in labour, as the midwife is the expert in
midwifery care, she explains what she has found in her examination, she explains
what it means about Eve's labour and what will happen to her next, displaying
some hints of conditional and traditional power. Another woman, Karen speaking
of her birth experiences told me:

'I think it's all a bit of a mystery and unless you're very, very strong willed you
do tend to be in the hands of your midwife... because you feel like they know
best, they've seen it all before and therefore you're looking for guidance and so
you know it's almost, I felt, and I consider myself as being fairly intelligent and
sort of... um... and being able to say what I want but I still felt I almost wanted
them to tell me what to do in a sense...'

Eve, like Kathy and Karen, will probably never have met the midwife before and
must accept that she is a trustworthy, skilled practitioner to help her through such
an important day in her life. She will comply with what the midwife says, even if
she may be reluctant, for example, to undress or be examined. She may fear that
the quality of her care could be affected if she does not comply and this use of power is reliant on this. The midwife, knowing that the woman is in normal labour with no risk factors, attaches the CTG machine, which she is aware is not evidence-based (NICE, 2001) and in fact will statistically increase the risk of a caesarean birth. This demonstrates the relation between the ‘sayable’ guideline and the ‘visible’ actions of the midwife. She does this perhaps because of the condign power implied by the protocols which are written by the powerful but may not always reflect current knowledge. In fact the protocols in this unit do not now advocate CTG on admission for women in normal birth, yet it continues to be performed. The midwife may feel helpless in that if she does not comply, she may risk censure by those in more senior positions in the organisation, who might be seen as a distant organisational ‘they’. In reality, Eve and the midwife are complying in the exercise of power over them by their very actions, which sustain that power and which depend on it not being challenged. Eve might be surprised to find that night clothes are not essential for birth, a track suit might be more comfortable, and that she need not stay in bed for her birth. In fact, the track suit and no bed would encourage mobility and tend towards a quicker birth. If Eve stated her wishes, the midwife would probably ‘allow’ it. The midwife enjoys her work, and basks in Eve’s gratitude for her caring attitude and kindness on such a challenging day. She feels good about guiding her safely through the minefield of birth, perhaps never realising that the feeling stems from her position of power.

The midwife also feels comfortable with the choices that she offers Eve about her care. The choices offered however may be what she chooses to share and other information which she may not agree with or feel unable to offer are not
communicated. By doing this she controls the agenda, using the two dimensional power described by Lukes (1974). It is usual practice to offer an oxytocic drug to control bleeding during the third stage of labour. The midwife here may not feel competent in the natural, drug-free physiological process, because of the local norms, which mean that she has only learned about this theoretically in her midwifery training. She may also believe that a totally pain free labour using drugs is the optimum condition for women, without looking at the ensuing implications of this on the neonate who has also been subjected to them in-utero and then cannot wake up to breastfeed in the first days of life. She may not tell Eve about what is best for her baby after the birth, such as the physiological and psychological benefits of skin-to-skin contact with her baby. The midwife may not even know about this, as her world view of birth is what practices she has always seen here. Eve does not know any of this and accepts that what the midwife says will happen is in the best interests of both herself and her new baby. All the above demonstrates the complex power used in organizations and the acceptance of the authority embedded in the role of hospital midwife. This is without mentioning the compensatory power of the salary attached to the role, and the apparent free gift of care to Eve, who does not realise that she has already paid for it in her taxes.

I was intending to say that I cast no aspersions on any particular midwife, but I must cast aspersions on all of us, because of one of my actions during this project. I was looking after a woman who was in the early stages of labour, conscious that I wanted to give her the best information possible to enable informed choice, after all, I extolled this in the classroom back in University. When it came to
information about the previously mentioned drug Syntometrine, I froze momentarily, my mind working furiously because I had a dilemma. Should I tell her everything about the drug, including side effects, to enable her to choose? What if she then chose a natural, drug free third stage of labour? I knew that the management of a physiological third stage of labour was not common practice in the unit and that if it is managed badly, it could cause excessive bleeding. I settled pragmatically for the ‘party line’ as being the safest in this particular situation, because I could not guarantee being there when her labour ended. In this way I effectively controlled the agenda by using my expert knowledge and being selective in what I said. When I shared this with my group of students back at University, one of them said, with just cause:

‘Shame Mary!’

I am reminded of similarities with the midwives previously described in accounts from Kirkham & Stapleton (2004) who reconfigured women’s choices to fit practice. Professionals can try to influence women by comments which put their own norm in place, even if that contradicts best practice. Sue told me of a midwife who advised her to give her baby formula milk by cup, when the baby was reluctant to breastfeed. Sue said she found this difficult looking back and the implications of giving formula must have been obvious to her.

Sue: ‘Yeah, I actually did cup feed her .... it was on the third day when she wasn’t having any milk (from) me hardly...she was going nine hours without a feed...when the midwife came... she said to try her with a little bit of ... formula milk in a cup and to cup feed her because she said even though she’s asleep you’ll probably find that she will drink it ...and I did... she had about an ounce ... of formula, .. but then a couple of days after that she started picking up anyway... but...why she didn’t tell me maybe to express some (breast) milk and give it her by cup I’m not sure, she did tell me to give her some formula just so that I knew she had something inside of her because I was worried that she wasn’t feeding and that she was sleeping all the time and I just wanted to know that she was getting some food inside her. So she said to do that, which is what I did...’
I remember Karen telling of a conversation with her health visitor:

Mary: ‘I suppose when you think most women live 80 plus years, to think that you’d breastfeed for two years twice, it’s a very tiny part of your life.’

Karen: ‘Oh yeah and that’s quite a long time, because I know my health visitor said “How long are you intending to feed this one”…and I said “I don’t know really, we’ll see”. She says “I hope not as long as the first one”…and I said “well, you know…”

I am reminded of a focus group meeting where a midwife tried to use power to influence the meeting by dominating it with discussions about artificial feeding. Foucault asks us to look at contingencies, not causes, as there may be various reasons for actions and this midwife may have been anxious about coping with the change.

In our actions, what is right is decided by the society in which we act, in this case, the maternity unit. If the culturally constructed ‘normal’ action is that women are supervised, controlled in their movements by routines of professionals and shown how they should properly function, then there will be reasons why all these things have been allowed to happen. A hospital like this is a large organisation where hierarchical observation is enabled. Women like Eve come to hospital for their birth which makes them visible; making it is easier for the professional, to care for more than one person at a time. Women are vulnerable in hospital, and what happens is controlled mainly by the midwife, such as who may stay, how many people are allowed and whether babies are given contact with their mothers and for how long. The docility induced by the structures of the hospital can be felt by most people entering it, seeking permission as to where they can go, at what time and in what numbers. The admission of the woman to a room, tells her the boundaries of where she is allowed. Notices on some doors saying ‘Staff Only’ tell her that she is restricted in some way and is in someone else’s territory. If she
moves out of the permitted space, someone will no doubt put her right. One
mother hinted at this by her description to me of events after her caesarean birth,
when the baby was taken into another room:

Mary: ‘So while the baby was missing, how did you feel about that?’

Mother: ‘I felt like they were going to take her off us, because she didn’t belong
to us. It’s a really weird feeling... that we’d produced this... you expect
somebody to say she’s not yours really. We’re still getting used to the idea aren’t
we... (to partner).’

When women like Eve enter hospital they can become subjected to normalizing
judgment, which tends to homogenize the care given to them, saying what they
can and cannot do and this is determined by the powerful. If women behave in
similar ways, working life may be made simpler for the professionals, and as
women may have little knowledge of best practice, what happens tends to depend
on the midwife more than the woman, even though the mission statement on the
wall might value ‘family oriented care’. An assertive midwife or woman can
stretch the rules, but usually women do not know there might be a different way.
If Eve does not insist, she will get what the midwife wants, so midwives have this
power because it is given to them.

The routines of midwives tend to control the throughput of women within the
hospital and women tend to comply with midwives instructions because they are
seen as the experts. These routines are reinforced by other midwives’ perception
of the ‘norm’, and women must conform or be condemned. This applies to the
midwives as well as the women, especially those lower down in the ranking order.
Routines govern daily life, including childbirth, to ensure proper functioning.
Time is measured, with speed being seen as efficiency. Midwives mostly control
the agenda, as they provide continuous care, whereas doctors are more transient
presences. Normalizing judgment values efficiency, speed and routines. A woman with her own birth plan might be seen as difficult. The compliant patient and the good (conforming) midwife would be seen as the norm. A woman may be described as not coping, or taking a ‘long time’ to give birth, in this case, the events of birth will be regulated by routines. Professionals may make decisions about how long they may stay in any one place, such as after the birth, whereas if she is still in first stage of labour there is no problem having the room for hours longer, providing that it is not too many hours longer. The time after birth counts as time taken and once the baby is born, the clock ticks. Priority is given to clearing rooms quickly, and having all jobs done within a certain time.

Uninterrupted time after birth for the mother and baby can be limited by how long the professional can allow, before the room needs to be cleared for the next person. Sue told me:

‘...and this time...they did seem to leave us as well, whereas with Alex (two years ago)...I did feel quite rushed to be honest. When I think back now, and about what you were saying, when I came to parent craft classes, and you were saying how you should be let...you know...left for maybe for 40, 45 minutes at the least to have that ..contact. I don’t ever remember having that with Alex...because...I had him and then as I say John had him and my mum had him then he was given to me and then the next thing they were asking me to ... get dressed and changed ready to go onto the…..ward ...whether they were busy that day or they ...needed the room...I’m not too sure...’

Early in the project I held a teaching session for paediatricians. When watching the brief 10 minute video about skin-to-skin contact, they were very impatient for the baby to go on the breast immediately. They began heckling like ‘naughty children’ and saying things like ‘If that baby doesn’t go on the breast, I’ll put it on myself’. At the time I enjoyed the banter but later, thinking about their impatient reaction to ‘waiting’ for the baby to be ready, I realised how used they are to going into a situation and ‘doing’ something and then leaving. Their reaction was very medical and with their authoritative knowledge, they found it hard to ‘be
with' and stand by for nature to work in her own time. I now regret the timing of this session, as later on I could have shared women's stories or explained the apparently aimless (to them) movements of the baby which were ensuring a good supply of milk at the right time.

Even when the midwives started trying the new 'routines' during the project, they had some misgivings. I asked a midwife about leaving the mother and baby in skin-to-skin contact before the routine checks:

Mary: 'So then did you do all the routines afterwards?'

Helen: 'Yeah...like I wrote on the form (evaluation for project) I didn’t see it as a problem but I kept having in the back of my mind, “This lady’s still here”...you know she delivered at five...one minute past five something like that...and she didn’t actually go over until about quarter to eight and I was consciously thinking, “This lady’s still in this room” because we had a lot of ladies...’

Helen was still feeling the pressure of not conforming to the perceived norm of speed in clearing the delivery room. I asked Debbie (a midwife) about when she would weigh and check the baby after completion of skin-to-skin contact:

Debbie: ‘Suppose you could do a quick measurement and the weight and then do the rest of it like the Vit K and the dressing and the tags later on...just as its going (to postnatal ward)...I suppose you could do that...’

I asked Alison, a midwife, what might have been done differently on a busy day:

Alison: ‘I wouldn’t have done any different really...in my head I might have been thinking about rushing the process but it was such a good experience for her and...the baby was happy to be there and he was feeding so well you couldn’t have broken it. You wouldn’t have broken a breastfeed if you were busy wouldn’t you. Or it would have been a case of ‘shout if you need me I’m going to help someone out there’ kind of thing...you know I would have left her alone a bit more.’

Mary: ‘What if you needed the room? All your rooms are full and you’d somebody coming in.’

Alison: ‘I’d have to transfer her in skin-to-skin. Because...she was a model patient really to do it with so it wasn’t...you couldn’t not have done it really.’
I suggested to Helen that it would not matter too much if the baby was not weighed until later, as notes were often written up some time later, from jottings at the time of birth.

Helen: ‘It’d get missed, Mary, I think it’s better to keep your own jobs to your own area and know that its done and straight...cause they’ve got too many bitty things.’

I asked another midwife:

Mary: ‘So could you imagine transferring a women if the baby and her were still in skin contact? Not having completed your jobs... like the shower?’

Tracy: ‘...when ward’s busy quite often the whole unit’s busy and that’s when I could see a problem arising where something could get missed ... everybody just presuming somebody else has done it...they might think ‘oh it just needs dressing’, whereas I might have said ‘oh it needs its top to toe’ and then somehow along the line something could have been missed.’

Mary: ‘But lets say if you had interrupted that because you had to do, and then put the baby back on the mum’s chest but its not been to the breast yet and you had to move them, would you feel happy moving them still, with the .. mother and baby together...’

Tracy: ‘No problem ... my main worry is that with something like that the checks got missed, the vitamin K got missed, everyone’s presuming something else. The weight wouldn’t get missed because the mum would want to know the weight ...you know that would be the sort of (thing) that would perhaps highlight the problem.’

It is strange to think that the mother might be trusted to remember the weight, but not other things which might be important to her baby.

Foucault’s concept of the examination means that even though women and midwives are in their own hospital rooms, they are always potentially visible, as the space belongs to the hospital and professionals. Someone may enter to see what is happening at any time and judge whether their actions are allowed. This could be why some midwives had an undercurrent of stress and were conscious of perhaps breaking the rules of speed and efficiency. Even though there would usually be no-one there to see actions, people would tend to comply with the
routines just in case they might be discovered breaking them, making actual surveillance unnecessary because people tend to survey themselves, being obedient just in case. The end result is Foucault’s docile body, which has become subjected and improved to fit our hospital norms.

Eve who came to hospital at the beginning of this story left with her new baby feeling reasonably, or very satisfied, but she will probably never know what she might have missed.
Another Perspective on the Way Forward with Paulo Freire

The work of Freire (1993) complements that of other theorists of power discussed earlier, yet provides another perspective of dominance and oppression which can be seen at work in hospital organisations and then goes on to explore how both women and midwives can become empowered. Freire's (1993) work will be used as a basis for these explorations, as his philosophy matches the empowering needs of an action research process. I will examine why people may choose to be among the oppressed, and what might be done to help them in a way that fits the love inherent in Freire's conscientização.

Freire (1993) said that where there is oppression, what he called 'antidialogue' is necessary to the oppressor as a means of further oppression. The oppressor must silence the voice of the oppressed, which means that their voice is not recorded or taken into account. Freire (1993:111) argued that:

'when people are denied their right to participate in history as Subjects, rather than Objects, they become dominated and alienated.'

In other words, the people involved are not told everything, discussion is not encouraged and therefore their voice is not heard. The world seems unchangeable and so must be adapted to, as Freire (1993:119) explained:

'this is not 'being with people' or having true communication and the oppressor deposits myths that preserve the status quo', such myths as 'nothing can be changed in this place.'

It is essential that people believe in their inferiority and then they want to be like the powerful, perhaps being seen as 'good' patients or midwives who are unwilling to rock the boat, so are compliant. Freire (1993) in his work in Brazil, discovered that until the oppressed person 'discovered' their oppressor and so
their own awareness, they nearly always expressed fatalistic attitudes. As a Brazilian man said to Freire (1993:43):

'What can I do, I’m only a peasant.'

Freire discovered that this was sometimes interpreted as docility, or a ‘trait’ of character. Similarly in our project, for example, ‘Women in this town won’t have skin contact’ or ‘These women will not breastfeed’. Oppressed people cannot always perceive the ‘order’ which serves the interests of the oppressor, perhaps by conforming to routines, so that the midwife fits into the dominant culture. I asked Ruth what might happen at her next birth:

Mary: ‘What about skin contact next time?’
Ruth: ‘I’d just ask if I could have skin-to-skin contact ... because its my right to ask for that.’

Ruth gives the impression that the midwife might say no to her request and win. One midwife who was less than confident about the success of the change said:

‘Not that I’m against breastfeeding... but ....’

She wrote me a letter, showing her concern, saying that she had spoken to a midwife from a Trust who had gained the BFI award and apparently the hardest change to implement was skin-to-skin contact. She stated that this was not negativity, but her concern that the project would fail. I carefully crafted a reply thanking her for her concern but also saying that as I had read somewhere (and here I misquoted Robert Browning) that ‘a woman’s reach should exceed her grasp’ and I intended to go ahead with the plans. Freire (1993) found that oppressed people tended to develop a fear of freedom, taking refuge in security rather than liberty, but would often not realise this, confusing freedom with maintaining the status quo. They would feel more comfortable with routines, perhaps saying ‘We’ve always done it this way’; ‘We can’t do skin-to-skin here, it
takes too much time”; ‘Women won’t want it’ or the perhaps the unspoken ‘Midwives know best’

**Limit Situations**

Freire (1993) discussed themes in the way we live, which contain our ideas, hopes, doubts, values and challenges. He considered ‘domination’ to be a fundamental theme of our time. Themes can be found in the way people go about their daily lives, if they do not express them it does not mean that they are not there, only perhaps silenced. He described a limit situation, as one where it was implied that there were people who were either directly served by it or those curbed by it. Those served by limit situations would act to maintain the status quo, whilst others may not perceive it because of their oppression. Freire believed that the more people accepted the role in life that was imposed on them, the more they tended to adapt to it as it is, seeing it as unchangeable. Limit situations may not be without consequences for women, as some research suggests that powerlessness during childbirth can cause psychological damage to women (Oakley, 1984, Greene et al, 1998). Kirkham (1989) found that events during labour had a strong influence on women’s satisfaction depending on whether they were empowered or not.

At the start of this project I found limit situations to be alive and well. The antenatal clinic was too busy to give out leaflets and teaching sessions were inconvenient. A ward routine was seen as difficult to disrupt and it was perceived that things might be missed. Skin-to-skin contact would take too long and midwives were too busy. Skin-to-skin contact could not be done in the operating
theatre and definitely it was not for fathers. Sometimes I perceived apathy about discussing the project, and it was difficult for me to bring it up, even when the midwives were not busy. Freire (1993:83) said that liberation from limit situations comes when those curbed perceive this as the frontier between ‘being’ and ‘being more human’ rather than that of ‘being’ and ‘nothingness’, and then they might act to do something about it.

Towards Empowerment

If the use or abuse of power depends on the actors involved in a sociological exchange, then how can this power be used to promote equality. Hawks (1999) believed that power could be used in a good or bad way, but was necessary or nothing would be achieved. Hawks (1999) discussed the derivations of the word ‘power’. The Latin and Anglo-French derivation implied ‘to be able’ or ‘to have power’. Synonyms which she found in Roget’s Thesaurus were ‘influence, clout, prestige, control, authority, dominance, efficacy, command, force’. The words from which power was derived, Hawks (1999) explained, indicate that it means ‘To be able’, implying ‘Power to’ or effectiveness. The dictionary definitions are either connected to power as effectiveness or power as forcefulness i.e. ‘Power over’. Except for efficacy, the synonyms in the thesaurus imply forcefulness or ‘power over’. Hawks (1999) said that a focus on ‘power to’ can be found in references by women, nurses or educators, whereas much other literature focuses on ‘power over’ or forcefulness.
Conscientization

Freire’s work was with oppressed people in Brazil, where his methods seem to be similar to Hawks ‘power to’ concept. Freire (1993:17) described ‘conscientização’, (or the anglicised conscientization) as:

‘learning to perceive social, political and economic contradictions and to take action against the oppressive elements of reality.’

Conscientization is a method of liberating people from a situation of oppression, limit situations and helplessness. He explained that revolution was achieved through praxis, which was defined as reflection and action. Freire (1993) believed we must involve the oppressed using reflection; otherwise it would just be more instructions or slogans. People must change from the passive role of ‘Beings for others’ and being told what to do, to ‘Beings for themselves’. One way to achieve this would be by the problem posing approach to education which Freire argued, helped people in the process of ‘becoming’, and I feel that another could be action research. Freire described an empowering situation as a dialogue which was an encounter between two people, but which must not be an instrument of domination, of one by the other. Dialogue was not possible if one person was closed to contributions, or afraid for their position. Creating something new must involve love if it was to enable people to become empowered, Freire (1993:70) pointed out that love cannot exist with domination because:

‘domination is the pathology of love.’

Those who know about their world can change it, according to Freire (1993), but those who have lost humility cannot help or be partners in any change. The purpose of any change should be to liberate, not to win people over, and some would work to maintain the existing structures, whilst others would try to change
them. The process described by Freire seems very similar to the goals of action research, where people would meet, discuss, agree, make plans, involve and empower, but never force.

Freire (1993) said that once the issues were identified, stage two began, where because of people’s state of submersion in a limit situation, familiar themes would initially be found. The individual would then analyse their own reality to be aware of previous distorted perceptions and this could lead to a new reality. Freire (1993:96) talked poetically of:

‘knowledge opening up like a fan,’

where new themes were placed alongside the familiar ones. This would mean starting from where people were and building safely. In our action research project, once a routine was identified, such as the initial time after birth, new ways of working were identified, and discussed such as enabling skin-to-skin contact. After this, the knowledge could be built upon at an agreed time, such as in teaching sessions and then extending the new actions to the operating theatre, involving fathers and encouraging it on postnatal ward as part of the strategy for helping settle fretful babies. In action research, the researcher is a facilitator and co-worker, not someone from outside or above. Friere argued that leaders and people need to act together, but not everyone might have the courage for this. When this involvement and co-operation was avoided it could lead to inflexibility and instead of nurturing life, killing it. The action research process provides an opportunity to put Freire’s ideas into practice effectively and a good use of power would be to work together towards mutually established goals. Hawks (1999) argued that an effective strategy in the use of power was where both persons
engaged in an interpersonal process possessed self confidence and a power orientation of power as good. It would need one or more power sources, such as evidence-based knowledge and skills combined with such power skills as good communication skills, respect and concern for others (see Table 14). These are all congruent with Freire’s beliefs and could enable power structures to be addressed effectively.

Table 14 Power Sources, Power Skills

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<th>Power Sources</th>
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<td>Self confidence</td>
<td>Trust, communication skills, knowledge, concern, respect, courtesy.</td>
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<td>Power as 'good'</td>
<td>Hawks (1999)</td>
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<tr>
<td>Power sources</td>
<td></td>
</tr>
<tr>
<td>Informational</td>
<td>Identification – e.g. admiration.</td>
</tr>
<tr>
<td>Referent</td>
<td></td>
</tr>
<tr>
<td>Expert</td>
<td>Superior knowledge/skills.</td>
</tr>
<tr>
<td>Legitimate</td>
<td>Both agree an obligation to accept that influence.</td>
</tr>
</tbody>
</table>

Conclusion

Theories of power have been examined and applied to the project, illuminating the fact that practice is more complex than at first meets the eye. Power is hierarchical but also penetrates every area of our lives, for good or bad and understanding its constituents is essential in our appreciation of how people live, thrive and suffer in our society. Both pregnant women and the midwives who provide care for them are influenced by it, often unknowingly. In our efforts to be caring, and professional in our large institutions, we need to find out how power has affected what we do in our sometimes tacit, everyday actions. Unless we reflect on our practice with open eyes, we can never hope to achieve the standard of care to
which we should aspire. I feel that Freire’s concept of empowerment inherent in
his ‘conscientização’ is the perfect underpinning to the conduct of action research,
by attempting to use power in an ‘empowering’ way. In the project, as I discuss in
the next chapter, changes were implemented slowly, because the routines were
important and safe, discussions were needed regarding the implications of skin-to-
skin contact on this. To this end, empowering teaching sessions were devised, and
role modelling of the procedure helped to build confidence. Empowering of
midwives was enhanced by sharing experiences and thankfully there were always
some people willing to try, as Sue tells us:

Mary: ‘Did the midwife help you to do what you wanted after the birth, with
your son.’

Sue: ‘Yeah, they were pretty open to whatever I wanted really, they said do you
want him delivered straight onto your tummy and things like that…and um…they
were asking me all the time what did I want…’
Chapter 6  

Changing Practice

Introduction

In this chapter, for clarity I will call the research project ‘our’ project, because others are mentioned in the discussion. Having established the need for change in the previous Chapter, the most empowering ways to achieve this will be explored. Congruent with the goals of critical theory (Fay, 1987), which include critical feminist perspectives and the work of Freire (1993), I will examine how theories of change might enable people to see themselves in a different light and through enlightenment, offer them alternative actions within and relevant to their own social situation, so empowering them to act in order to become emancipated. Key texts relating to theories of change will be examined along with examples of their application, including that of our own project. I will highlight specific strategies which were successful in nursing and midwifery and others which were a challenge to the change process. These insights will then be related to our project by examining communication, collaboration, overcoming barriers to change and minimising resistance. The role of the researcher will be discussed along with the varied challenges.

The Drive for Change

A review of literature on the effects of implementing evidence into practice, by the National Health Service (NHS) Centre for Reviews and Dissemination (NHS CRD, 1999) reported that the political climate of the NHS had an emphasis on quality, evidence, guidelines and effectiveness in practice, which implied that a sound evidence base should be part of normal practice. Iles & Sutherland (2001)
comment that there is a huge volume of material about change management from many disciplines, concluding however, that new work does not necessarily supersede the old. The NHS, they said, needed people to become skilled at handling change, working within complex environments, with competing objectives and considerable restraints. They believed that there were no cut and dried solutions, because situations in practice were complex and dynamic. Nolan & Grant (1993) concluded, over a decade ago, that many years of research based criticism seemed to have had little impact in some areas of nursing and recommended a move away from academic work towards models which relied more on practitioner involvement. Although some thought that good innovations would ‘sell themselves’, Rogers (1995:7) believed that this was not generally the case. There seemed to be a great need for projects which facilitated actual changes to practice. Today, following government policy and initiatives, there seems to be an encouraging trend to fund and then share examples of successful change initiatives (Cameron et al, 2001, Dykes, 2003, NHS Modernisation Agency, 2003, 2004a, 2004b). Whilst not all change projects are completely successful, it is reassuring to note that the literature and research which concerned the successful implementation of evidence-based practice had many similarities to that which was used in our project.

Elements of Successful Change

There was a need to get a clear picture of what was happening believed Nolan & Grant (1993), before starting the change process in action research. Tolson (1999) began with a knowledge synthesis and developed an outline protocol for practice excellence, to establish its worth. A climate for change was created by teaching,
to modify attitudes and using opinion leaders to encourage the participants to own the change. In a project to facilitate the adoption of clinical recommendations, Snowden & Marriot (2003) used collaboration in setting up their project, resolving contradictions and responding to local circumstances. They highlighted that unless as much time and energy (or more) is put into talking to those who will implement change, including knowledge of local situations, it would not work. Dunning et al (1999) reported on their experiences from the PACE (Promoting Action in Clinical Effectiveness) programme. This was facilitated by King’s Fund staff and involved 16 projects in England for healthcare practice change. They reported that change could be achieved if there was a sound evidence base to work from and a project approach to implementing it. This was not seen as a logical linear task, but contained complex inter-related tasks requiring facilitation and flexibility to drive it forward. Essential components of a successful project were providing evidence, experience of managing change and a local knowledge, both of structure and relationships. Merewood & Phillipp’s (2001) project to increase breastfeeding rates was considered a big change, so their strategy was to take one problem at a time to make it more manageable. Another aspect of success was the quality of the support for the facilitation of the project. Choucri (2005) found that peer support of midwife project leaders during an action research project enabled them to clarify their ideas. This empowered them to facilitate practice innovation in specialist areas such as breastfeeding and care of pregnant women with diabetes. Munro et al (2002) used an action research project to empower a group of midwives to elicit midwives views and write their own evidence-based guidelines on fetal monitoring. Deery’s (2004) facilitative
methods supported midwives through the difficulties of implementing midwifery-led care to become empowered to continue with the change process.

An overview of systematic reviews of interventions promoting change by Bero et al (1998) found that multiple approaches worked best, such as educational outreach, participation in workshops and reminders. Things that had some effect were audit and feedback, local opinion leaders, and consensus. No effect was found from distributing literature or lectures, although they observed that these were probably the most common ways to try to introduce change. In a Cochrane systematic review to see if local opinion leaders influence change, Thomson O’Brien et al (1999) reported varied results, concluding that change might be more effective if combined with other measures such as marketing, reminders, audit and feedback. Rycroft-Malone et al (2002) found that it was best to combine approaches, using educational outreach, audit and feedback and computer based reminders, with facilitation playing a key role. Evaluation of the literature on enabling the implementation of evidence based practice by Kitson et al (1998), found three equal needs; the evidence for the change, the context and the way it was facilitated. Like Dunning et al (1999), they concluded that linear models often failed to help with the complexity of change.

Some of the approaches used seemed like common sense to me, but not all change strategies implemented them, to their detriment. In a project to try to improve routine communication between general practitioners and community mental health teams White (2004) reported that because there was no formal collaboration, practice only improved in the short term. Jankowski (2001)
reviewed the literature on the implementation of national guidelines at local level and found that clinical guidelines helped performance of general practitioners to some extent, but seemed to show that local factors should be taken into account. The outcome might have improved more if everybody had been involved in the planning process. Locock & Dopson (2001) interviewed various grades of midwifery staff in four Health Authorities, where there were different levels of progress for change, despite none having invested extra money. They found that the attitudes of clinicians had a strong influence on changes both positive and negative; discovering that the most positive factor affecting change was if opinion leaders worked with local professional opinion to overcome pockets of disagreement. They commented on the reality within the NHS of trying to force through unsupported change. The elements of a successful change are summarised in Table 15. It was also reassuring to read accounts of those researchers who were honest enough to record the problems they had encountered. In other words, they had not made their research too hygienic (Stanley & Wise, 1993), so that others could learn from them. Some situations were so difficult that the project was ended early (Ward & McCormack, 2000), with little change effected.

Table 15  Elements of Successful Change

<table>
<thead>
<tr>
<th>Finding credible evidence.</th>
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<tbody>
<tr>
<td>Consulting practitioners.</td>
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<tr>
<td>Working collaboratively.</td>
</tr>
<tr>
<td>Facilitating the transition from the present state to the desired one.</td>
</tr>
<tr>
<td>Using sound educational methods with skills based teaching.</td>
</tr>
<tr>
<td>Role modelling.</td>
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<tr>
<td>Support during the difficult transition time.</td>
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</table>
Rogers (1995:5) who since the 1960's, has been writing about the diffusion of innovations in organizations, pointed out that it is:

'the process by which one innovation is communicated through certain channels over time among members of a social system.'

His model of the diffusion of innovations seems to encapsulate many of points made in the literature about the implementation of change, whilst other recent practice projects have found other insights which will be explored next. Rogers (1995) believed that knowledge gave some understanding of how the innovation worked and persuasion helped to form a positive attitude towards it, followed by the decision to try. Sometimes partial adoption was tried first, which helped in coping with uncertainty. Following this, the participant might seek reassurance that the innovation was a good thing to do, which is why a supportive presence could help to sustain a change. The change agent was an important part of a successful diffusion and they needed to convince people that it could be done. The qualities of a successful change agent are summarised in Table 16.

Table 16 Qualities of a Successful Change Agent

<table>
<thead>
<tr>
<th>Quality</th>
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<tr>
<td>Give information initially, preferably by demonstration.</td>
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<tr>
<td>Be perceived as credible and trustworthy.</td>
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<tr>
<td>Be able to motivate people.</td>
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<tr>
<td>Spot problems.</td>
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<tr>
<td>Work with opinion leaders to influence peer networks.</td>
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<tr>
<td>Support people to carry on with the innovation.</td>
</tr>
<tr>
<td>Eventually by doing this, the change agent would put themselves out of business.</td>
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Rogers (1995)
Why Might Efforts to Change Practice Fail?

Senge (1990:18) argued that the way we have been taught to think could create learning disabilities. He believed that some people were so loyal to their job and its boundaries that they may see their role at work as the same as their identity as a person, i.e. ‘I am my position’. They may believe that there is ‘an enemy out there’ which causes a tendency to blame others if things go wrong. This means that it becomes harder to see the problem as being within the organization, and doing something about it will mean taking action against others outside it. It can often be hard to see the larger picture where events began some time before, rather than being an immediately apparent cause and effect. Senge (1990:58) also said that:

‘today’s problem might come from yesterday’s solution,’
as short term solutions might only have a limited life. One perceived solution to a problem could be to work harder, whilst still doing the same things perhaps involving our inability to see how we are contributing to the problem ourselves.

Some situations deteriorate so slowly that Senge compared them to a ‘boiled frog’, which will stay in gradually increasing hot water so long that ultimately it becomes unable to move to escape. Another important point is the assumption that we learn from experience, which could be a delusion. If we do not see the results of our actions, it may be beyond our ‘learning horizon’ (Senge, 1990:230).

West (1997:104) commented that organisations were often thought of as organisms, having a personality of their own and sometimes:

‘they develop immune systems to fight against attacks which threaten their survival or their form.’

This defence mechanism may be initiated without the conscious knowledge of the person. West suggested that these mechanisms are often disguised as caring and
diplomacy, citing previous failure of change efforts. In such an attempt, one midwife told me that I had chosen the hardest part of practice to try to change.

McCormack et al (1999) commented that practice development was not just a practice intervention, but changing the culture and context in which care is delivered. Practice development is complex, a fact that is often overlooked by linear approaches to change management, which is reminiscent of Schön's (1991) messy swamp of clinical practice. Ward and McCormack (2000) reported on their action research project to try to create an adult learning culture. They described a situation where there was a poor standard of care, education was topic based and the management style was directive which had led to a culture of dependency. Nurses needed 'authorisation' for any practice changes. One positive outcome was that a ward manager developed by becoming more positive and proactive, but as mentioned previously, the project was ended prematurely. McCormack et al (1999:262) believed that

'Culture constructs and controls how people perceive the world and how they act but it does so without people being aware of its influence.'

People can reinforce their culture by their daily actions, so it is necessary to help them by being sensitive to where they are coming from. There will be a need to address this for effective change. Gladwell (2000:150) describes the 'broken window theory', saying that:

'Behaviour is a function of social context.'

He emphasised that it was not necessary to solve big problems to improve the situation, which would be like improving the social climate by removing graffiti and other results of vandalism, to make the place look more cared for and so less prone to being spoiled. Writing about developing organizational creativity, West
(1997) felt that people may have a low tolerance of change because they had endured too much, citing examples from the NHS. Little seems to have changed here and people may still resist change whatever its anticipated benefits. I will now go on to analyse the change process in our project, applying theories of change. As it began, there had been a history of management difficulties and the current climate was ripe for growth to achieve change through the action research process.

**Communication and Selling Projects**

In a change project, it seems important to be an insider with local knowledge. Early action research by Lewin (1947; 1948) looked at problems experienced by minority groups. He felt that it was necessary to be involved inside social action bodies, rather than as outsiders telling people what to do. West (1997:2) observed that creativity in organizations:

> 'involves us in the constant discovery of new and improved ways of doing things; it means challenging well-tried and traditional approaches and coping with the conflict and change which this inevitably causes.'

He believed that creative ideas must be judged in the setting, and the biggest challenge was persuading others. The possibility of misunderstanding was always present, so everyone needed full information, because resistance to change could occur if it was seen as invading a vested self interest, or was disruptive. In any change process, it is better if people are involved, because seeing contributions carrying little weight means people feel devalued and may ignore the change. Dunning et al (1999) concluded that in a change project it was valuable to identify who was likely to support you, but not to assume that you will know this before the project starts, as some emerge later i.e. expect the unexpected. Some
sceptics may have practised for years without apparent problems and will probably believe they are doing the best they can. Many tend to feel that they have no time for changes, so the information should be presented carefully so it does not appear to be a threat.

Rogers (1995) stated that some aspects of an innovation would help with its diffusion. If the innovation was perceived as an advantage to them, for example by gaining more recognition, or was close to existing values, then this would facilitate its uptake. If the change was complicated, it might detract from success, so focusing on one thing at a time might be helpful, rather than trying to change everything at once. Kotler et al (2002) describe social marketing, a strategy which has similarities to action research, as a way to change health behaviours. This method began in family planning and spread to others areas in public health. Market principles are used to ‘sell’ behaviour change and the competition is not other organisations but the current behaviour. One of their projects was to increase breastfeeding rates. The problem was not that women lacked knowledge of its benefit, but that its implementation was too difficult for them. This stresses that success would be more likely if the difficulties were minimised. Using a similar strategy, Merewood & Phillipp (2001) when implementing changes in breastfeeding practice, worked on issues, such as creating a teaching framework, devising posters and notice boards advertising the change. They set up a task force co-chaired by managers and a physician, with representatives from all areas, which they felt was crucial. Their strategy was to create awareness, so they opened highly visible breastfeeding rooms, even though few women at the time were breastfeeding. Publicity was arranged, and artwork displayed in various
languages about breastfeeding. Staff education took place monthly, and information disseminated so that others could teach, called ‘Reach and Teach’ sessions. Educational and social support was provided for mothers especially those more vulnerable such as those with pre-term babies. They felt that the key to success were strong leaders, effective education and good communication which united all participants.

**Communication and Selling of Our Project**

At the beginning of our project I spoke either formally or informally to as many people as possible, including managers, midwives, students, Sure Start community workers. I was even invited to Sunday tea in the unit, reputedly a good time for informal chatting. I was keen to get midwives to own the project, so it was important that it started with them and on the first ‘official’ day we held a focus group. The team needed to own any ideas, not just accept mine, although I did have suggestions, I stressed that this was by negotiation and we should take it slowly, with nothing being imposed. Suggestions were made such as about the production and timing of giving out information leaflets and a letter to midwives, summarising the project.

Following this I continued my discussions with whoever I met. The proposed letter was devised and sent to all midwives. This outlined the reason for undertaking the project, the main points about action research and the focus group ideas for now and the future. I believed that this letter had good selling points; one was that the project was funded by the Dept of Health who wanted reports on progress. I also said that I thought it likely that the project and resulting
improvements in practice would raise the profile of the unit, especially as the Trust was about to merge with three others, one of which had achieved the Baby Friendly award and that our unit might be seen as a proactive one. Selling 'our' project was a good idea, but it was necessary to find out if things were working, rather than assume that they were going to plan. In reality, the information letters, all correctly addressed by name, were lying buried in a poor postal system. Each ward area had an open file in which all letters were placed. If a person was off duty for two days, then other post could easily obscure previous letters. There would be little motivation to go through a messy pile of letters just in case there was one addressed to the person concerned. I resorted to asking whether people had read their letter and then digging them out. In the old unit, each midwife had their own personal pigeon hole for post, but this was not carried on after the move. Perhaps this was one other reason for lack of initiative, as no-one ever knew what was going on. The two Newsletters produced in May and September, were to inform everyone about the progress of the project and to try to sell the idea to those who may not have been involved yet.

Later in our project, negotiations began to produce a video of skin-to-skin contact on the unit, following an opportunistic conversation with a media company who made health promotion videos. This was discussed and approved by the Trust, but never took off for lots of reasons, but mostly the timing of it. Despite this, there was much discussion and even pleasure within the unit at the thought that this might happen, and perhaps it helped to sell the change. Later, in April, an opportunistic semi-amateur video was made (negotiated by me, during a holiday) of skin-to-skin contact and from this the picture sequence was taken which was
used later for the posters in each birth room. I found this modern, more realistic ‘English’ video, to be more valuable for teaching sessions, replacing an older Swedish one.

**Implementing Plans: Role Modelling and Teaching Sessions**

Dunning et al (1999) concluded from their projects that involving patients could lead to better outcomes, especially if they were asking for the new practice. It was also more effective if local circumstances were taken into account. I hoped that by informing women what was available they might influence its uptake by discussing breastfeeding or asking for skin-to-skin contact. The information sheets were devised, proof read by midwives and adapted to fit the culture. There was a negative reaction from two midwives to the parts discussing skin-to-skin contact in the operating theatre and it was definitely not thought acceptable for fathers. Both were removed rather than confront people’s initial cultural objections at this early stage. This seems strange in retrospect and is an indication of how far the whole culture has now changed. The leaflets were distributed to antenatal clinic where they were meant to be given to the women, but more of that later. Iles & Sutherland (2001) reviewing the literature on change, say that transitional change has its foundation in Lewin’s work, where unfreezing from old behaviour is where someone starts to move towards change and is the first step before moving to a new position, and then refreezing in the new practice. Lewin argued that unfreezing might involve anxiety and needs psychological safety, when moving they need to identify a new role model and refreezing integrates the new point of view into their concept of self. I hoped that demonstrations by role modelling the new practice as well as teaching sessions would help with this.
Dunning et al (1999) suggested that in order to overcome barriers, it could be helpful to demonstrate the benefits of change and in our project I used role modelling whenever possible. In early October, I cared for a woman during labour and birth and the baby was held in skin-to-skin contact until she started rooting and tried to breastfeed. Later that month, on the postnatal ward, I had a valuable experience with a woman just returning from theatre after a spinal caesarean section. The baby was crying persistently and at my suggestion, she was put into skin contact where she settled almost immediately, going on to breastfeed successfully. Later in the day, the mother, sitting up in chair now, was enabled to hold the baby and position her well to breastfeed. Both these situations were witnessed by other midwives, which I felt was an effective beginning to the project. In November, I looked after a woman who had never heard of skin-to-skin contact before and after discussion about the benefits, following a relatively easy labour and birth, had skin-to-skin contact. When the baby showed signs of moving towards the breast, she went on to feed him artificially. This was an example of flexibility, hopefully saying that it was for all women, not just those breastfeeding. I spent many sessions over the year on the postnatal ward, helping women to breastfeed their babies. By November, the midwives started to be aware that I was there, by asking me to see women experiencing problems and on one occasion whilst on CDU, I could hear the howling baby, with increasing decibels coming round the corner, being ‘brought to me’ by a frustrated midwife.

The NHS CRD (1999) review concluded that although information about best practice is not effective alone, people still needed to know about it. Successful intervention was more likely if the educational outreach was by people with skills
to lead and apply it. A project to discover what research information was useful in nurses’ clinical decision-making, by Thompson et al (2001:386), found that the way research information is delivered is very important. Clinical nurse specialists were:

‘overwhelmingly classed as useful.’

They had a wealth of knowledge and experience, had responsibility for teaching and dissemination of research plus intuitive skills, suggesting they could discern good from bad research. These specialists could adapt information for local needs as they knew what barriers to overcome. They could also use multiple approaches such as one-to-one help, clinical audit, teaching and role modelling. Many nurses did not have skills to access resources such as libraries and databases and had difficulty interpreting research findings. They concluded that it is not research knowledge as such that carries weight, but the way it is delivered. Gladwell (2000) noted that word of mouth can spread very quickly, but he believed that certain types of people can make this an epidemic, one of these types are ‘Salesmen’ (salespeople?) who have the skills to persuade, even when people might not be convinced. They have rational and coherent arguments, a lot of good answers to commonly raised objections as well as energy, charm, enthusiasm and optimism. Gladwell (2000:49) calls this ‘The Law of the Few’ and that the first lesson of starting epidemics requires concentrating resources on a few key areas which might be the ‘Tipping Point’ for change. I aimed to be such a person and whether or not I had all Gladwell’s qualities, I certainly had the enthusiasm, as commented by one of the National Feeding Advisors at the Dept of Health at an interim progress seminar, who said it was:

‘Bouncing back off the wall of the building opposite.’
I also had more expertise in breastfeeding skills than most midwives in the unit, which I demonstrated clinically.

Robinson (1974) argued that we should teach at the right level. Some might not be trained to teach, and if too competent, they could perform unconsciously and be oblivious to newer people’s needs of a step by step process. This would make them unable to reach the consciously incompetent. Most skilled workers tend to become unconsciously competent. The ideal instructor must be aware of the step by step process needed, to assess what learners need to know. By constant reading of people’s reactions and evaluating teaching sessions, I hoped that I fulfilled at least some of these qualities. I certainly was not unconsciously competent about skin-to-skin contact, as I was myself taking on the innovation and still discovering new things as I went along.

Teaching sessions were held for as many people as I could reach and for all grades of staff including midwives, paediatricians, students of all kinds health care assistants, health visitors and lay community Sure Start workers. I did not reach everyone, although I certainly tried. The sessions were undertaken as long as the project ran, even the one in the last few days which entailed canvassing a medical student in the restaurant. Opportunistically, the first teaching session was for the paediatricians at the request of one who was pregnant and wanted to know more about breastfeeding. Mistakenly, one consultant deemed this ‘midwives’ knowledge’. Although doctors may have minimal influence on CDU, they can influence by their attitudes and more especially practice on the postnatal ward, Special Care Baby Unit and Children’s Ward. If this session had been done later, I
would have been able to influence their disruptive behaviour whilst watching a ten minute video about skin-to-skin contact by citing the research evidence about the apparently aimless hand and mouth movements of the baby before attaching to the breast which stimulates maternal oxytocin release and milk ejection. The first regular sessions were held in a room near to the unit and timed to last one hour.

Dunning et al’s projects (1999) found the best results if education was interactive, so that needs could be met, rather than just information giving. My sessions were very much skills based, with topics covering the first week of breastfeeding, using a doll, demonstrations, diagrams, discussions and a video of skin-to-skin contact. I felt the need to offer midwives an incentive to attend, based on past experience of reluctance, or inability to attend, so I promoted its portfolio value, with a certificate on completion of the workbook. After the start of the interviews, I used the women’s words to emphasise their positive views which hopefully made me a more credible facilitator and the innovation more convincing. There were some problems with leaving the unit, even though it was only across the corridor, as the midwives were out of sight and sound of the work and this might have inhibited people’s attendance. We discussed flexible sessions, which would stop and restart again according to the needs of the minute. If a midwife was called away, we might suspend the session altogether or continue and as on one occasion, finish the session later for the one midwife who was called away. This seems more time consuming in the short term, but was more effective in the long run as sessions were held which might never have been started just in case it became busy. There was also the valuable opportunity to persuade those who were ambivalent or even reluctant to come, by personal contact or peer pressure, as it is harder to refuse
someone who is standing in front of you, than waiting in a room out of sight. I remember walking down the corridor with a midwife who kept escaping the sessions saying ‘Oh go on! You’ll enjoy it’ I had known her for many years, so felt able to do this. Persistence sometimes pays dividends as she eventually came, as did a senior midwife who had negative personal experiences from her own childbearing days whose attitude changed considerably after the session. We were able to discuss implementing skin-to-skin contact in theatre, as this was an area where she potentially had influence. Another senior midwife however was in the process of changing jobs and she did not take the change on board until much later when I had contact with her in her new role in another Trust.

Evaluating Success and Minimising Resistance

Dunning et al (1999) discovered that it was important to find out what impact the change was having on practitioners, preferably in more than one area and being able to demonstrate success which was important for morale. In this way, problems can be found before too much time is lost. Senge (1990:104) talks of a strategy of resistance called ‘shifting the burden’ where there is a difficult problem demanding attention, such as reorganising a routine, so that people apply easy solutions which leave the basic problem unchanged. This was so in our project with the distribution of leaflets in the antenatal clinic

The Leaflet Saga

In early October, I discussed the information leaflets with the antenatal clinic midwives and how they might be distributed to women. From the beginning, the
clinic staff identified difficulties with time and I was told that women were already given a lot of information and that:

‘the women don’t read them anyway.’

I asked that they hold up the leaflet and mention two points from it, as this had been found to be effective at a neighbouring BFI Trust, when I visited it as part of my fact finding. I sat in with some initial consultations, with women in early pregnancy and afterwards the midwives agreed that they could have found time on this occasion to give out ‘our’ leaflet. During a week in January, a motivated midwife was allocated to clinic as holiday relief and the clinic was quiet, the two things combined meant that they felt able to give out skin-to-skin contact leaflets. They said they were unable to give out the breastfeeding benefits leaflets as well because there was no time to evaluate how it worked. I said something like:

‘Well if you just give out the leaflets, it is more than they get now.’

I hoped that this would remove some of the palpable pressure they felt and promised to ask them for verbal comments instead. At a focus group meeting in February, a midwife said that it would help if women came into the CDU already knowing about skin-to-skin contact, and hopefully that would start happening soon. In the event, follow up of this revealed that both information sheets were being given out at the first visit in early pregnancy, because it was easier. This meant it would take 6-8 months to filter through before women were coming in to give birth. Negotiations did start to change practice, but this was slow, and other contingency plans were devised, such as putting laminated information sheets in the antenatal clinic waiting room and in each birth room.

Gladwell (2000:258) says that:

‘Those who are successful at creating social epidemics do not just do what they think is right. They deliberately test their intuitions.’
In this case, if the delay had not been discovered by a comment at the focus group, the project might have been hindered. Lewin (1947) compared this risk of not evaluating actions, to the captain of a ship who alters the rudder and then goes below deck, whilst the ship goes round in circles.

**Skin-to-Skin Contact Evaluation**

In December, a box was put on CDU filled with forms to evaluate having facilitated skin-to-skin contact. I talked to the midwives about it, hoping they would fill them in. In January, quite a few evaluations had been filled in and we discussed them at the focus group. There were a lot of positive comments about how the women liked it, that babies breastfed and that it had caused no particular problems. However there was one heated comment which had to be dealt with sensitively. The midwife was afraid of what might happen if women were taking up rooms which were needed by others coming in. She envisaged that women would be there for 'hours'. I took this comment very seriously and tried to address the concern in a positive way by formulating the 'worst case scenario, which is discussed later. West (1997) believed that we should always look beneath the surface, continually asking 'why' of those who resist change and bringing subjects out into the open. Continually through the months we discussed progress, suggesting improvements such as that it would be better to give the evidence for skin-to-skin benefits in order for women to make a fully informed choice, rather than just implying that 'it was a nice idea’ or asking the closed question: ‘do you want skin-to-skin contact?’, with the answer yes or no. We discussed the realities of change of routine such as not interrupting skin-to-skin contact, a shower for
mother being taken later and the possibility of transfer to postnatal ward still in skin-to-skin contact, if the baby had not breastfed.

**The Time for Change**

Dunning et al (1999) in their projects, found that time was an important factor, as change projects usually take longer than expected. Rogers (1995) observed that adoption of an innovation tended to take place in an S shaped curve, with slow progress at first, gathering more momentum as more information filtered through and then slowing down as the majority took it on. He described five categories of human traits which follow the uptake of the change process, namely innovators, early adopters, early majority, late majority and laggards. Innovators are those able to cope with a degree of uncertainty and willing to take a risk by trying something new. In this project I could only see myself as the innovator. When starting the project I had never facilitated skin-to-skin contact properly, although I had done it partially in 1999. I had only seen the video, heard about how good it was from a lactation consultant, read about it and taught its principles to students. In the first days of the project, I cared for a woman who had an unsedated labour, who experienced skin-to-skin contact and the baby did all the amazing things that I had seen on the video. There had been an element of risk in this, because I was working with another midwife and I needed it to be successful. Rogers (1995) described innovators as those most likely to be outside the local social system, as to some extent, as a researcher, I was. The next group likely to try the innovation would be the early adopters who were more likely to be within the social system and have the greatest degree of opinion leadership. Rogers believed that these were the best ones to be encouraged by change agents, as they were not too far
ahead of the average and could decrease uncertainty by telling others of their experiences which might give them the confidence to try it themselves as it decreases risk perception, or what Rogers (1995:162) called ‘trial by others’.

An opportunistic discussion about skin-to-skin contact took place with two midwives at the midwives station, with other midwives gathered round. I asked to ‘interview’ the midwives. I had forgotten to bring my recorder, which seemed like a tragedy on the day, but on reflection, it meant that we talked more informally, in a public arena. If I had the tape we probably would have gone into a room and an opportunity for selling the project would have been lost. The woman gave birth during the night, with a supportive partner present. The midwives had discussed skin-to-skin contact beforehand and when the baby was born onto its mother’s abdomen, it stopped crying straight away. The midwife told us enthusiastically, it ‘just snuggled in’ and later the baby breastfed. The midwife said ‘Look at that, it does work’. They were intrigued to see that the couple were totally absorbed by their baby. They did quickly weigh the baby before the breastfeed, but it cried, stopping when returned to its mother. The baby did not have a long feed until after transfer to postnatal ward. On seeing this, the midwife commented that ‘It just did it when it was ready’. These midwives were early adopters with the advantage of being closer to the average and perhaps more able to relate ‘how to do it’ to their peers, but they had only partially adopted the innovation, as the baby was briefly separated for a routine. This is common in the early use of an innovation, until it feels safer and is another example of ‘trial by others’ (Rogers, 1995). Reflecting on this story provided some illumination to my puzzlement after the safe arrival of a baby who endured a long and difficult labour. He was distressed on his arrival, needing oxygen for a short time. When he was returned to his mother in skin-to-
skin contact, the midwife with whom I was working left to write the notes. I stayed to see a miraculous change in this baby as he turned from an anxious looking unhappy mite into a pink and relaxed cherub within about ten minutes. My enthusiastic trips to the midwives station to tell the midwife had little effect as she did not come to see for herself. Perhaps it was a case of ‘Oh, Mary’s off on one again’, or that the innovator is sufficiently outside the culture to be seen as unusual and unable to reach the more average majority. This confirms to me that although it was valuable for me to start the role modelling at the beginning, the most effective role modelling would be done by the midwives themselves, which is absolutely within the philosophy of an action research facilitator.

Another midwife, who I would have judged to perhaps have been in the late majority category, was helped to develop into an early adopter. In November she had attended a teaching session and seemed to enjoy it. In early December, I arrived on CDU and asked the midwives if they had discussed skin-to-skin contact with anyone in labour. The answer was “No”, so I suggested they might like to do. The midwife was persuaded by me to try, so she gave the information to the woman, who chose to experience skin-to-skin contact. After the birth, the parents and baby were left together. The midwife asked me if I wanted to come and ‘check’, but I said ‘no of course not’, as I wanted her to be empowered. The baby progressed to breastfeed. The midwife seemed very pleased, but I was ecstatic. I found it hard to understand, because this midwife had been to a teaching session, seen the video, thought it was a good idea, but not done it. She genuinely did not think of it. This led me to thinking about why learning takes place and how just knowing about something could be changed into action.
More than a video: Perspective Transformation and Ways of Knowing

Mezirow (1981) described perspective transformation as a negotiation of a succession of transformations in ‘meaning perspective’, where new experiences are assimilated and transformed by past experience. Perspective transformation can occur as a sudden insight or as a series of transitions over time, often giving a new sense of ‘agency’ or personal responsibility. During the project, I had an insight into the way that people learned which I called ‘More than a Video’, because personal experience of something seemed to make an amazing difference to attitudes and depth of knowledge. The following example is about skin-to-skin contact at birth. Here, I perceived a first level of knowledge to be talking about something, then seeing a video of it happening, whilst seeing a baby actually doing the same things in real life took the experience to a much deeper level. One father had listened to my discussions of the benefits of skin-to-skin contact and had seen a video of it. When his own newborn son started to move upwards searching for the breast by his own efforts, he gave an audible gasp. This personal experience immediately reached deeper into his self, causing a sudden perspective transformation. Midwives also described similar stories of amazement that it had happened whilst they watched. It was almost as if an event could happen for other people in ‘stories’, but may not work in practice ‘for me’. Perhaps like seeing a major event on the news compared to actually being there. I will relate a comparable learning experience which occurred during the project and before I started a day of study, which gave me a new sense of ‘agency’ and personal responsibility.
Friday 24th May    Separation Distress Call and Safety

On this morning, early, I walked along the canal path. Although the following ideas had been in my head, not consciously formed, for some time, I experienced a sudden perspective transformation (Mezirow, 1981), which stopped me in my tracks. For about six weeks, I had been watching a pair of swans who had built a nest on ‘my’ part of the canal, where the female laid six huge eggs. Naturally being a midwife I took a keen interest in the hatching. The mother swan sat on her eggs faithfully for five to six weeks whilst the male patrolled the surrounding water. A few days ago five chicks had hatched (NB nature’s perinatal mortality rate of 1 in 6). This morning the family were on the water and I froze to watch them swimming by. As they passed me, the male swan swam some distance ahead and the female, who was with the chicks, suddenly took flight and landed next to him. There was a frozen moment of silence (even I held my breath) and then the cygnets, suddenly realising that they were alone, bunched up tightly and with a communal distressed cheeping they webbed it as fast as possible towards their distant parents. On hearing their distress, the mother swan turned and swam powerfully to meet them, where she leaned down with her neck in a graceful swan’s curve, and seemed to be comforting the babies as they clustered around her head, quietened now.

I thought immediately of my own experiences of distressed human babies and my instinctive response to stop the distress cries. I had already experienced this phenomenon in the project, both directly and from talking to midwives. After commencing skin-to-skin contact, a couple were left with their baby, to be close together, knowing they could call. The bell rang a short time after, and the baby
was found to be wrapped up in the blanket and crying. Initially I found it hard to imagine why she had wrapped him. On reflection, she was extremely tired following a long labour and probably had had enough of everything concerning childbirth; the baby however, was distressed by the separation. I experienced the distressed separation cry when visiting one of my ‘interview ladies’ at home. The mother had just changed the baby’s nappy and was disposing of it in the kitchen. I had an almost irresistible urge to pick up and comfort the baby. I didn’t do it, because I felt I needed permission to handle someone else’s baby in her own home. Finally I could stand it no longer and shouted, ‘Shall I pick him up?’ The mother came back at the same time, so she did it instead.

I pondered on what was happening to make this knowledge become more meaningful and life changing. I have previously discussed Habermas’ (1973) emancipatory interest in knowledge which going beyond technical and practical knowledge, would by its reflexive connection allow a deeper awareness to develop. Connor (2004:55) discussed a similar concept, that of praxis which she defined as:

‘a meeting and melding of theory and practice.’

Freire (1993) placed praxis at the centre of his conscientization, as a way to help open up people’s minds to see new things. He understood praxis to be reflection and action where people change from the passive role of ‘beings for others’ and being told what to do, to ‘beings for themselves’. This involves knowing about the world in order change it.
Chiu (2003) pointed out that not all experience leads to critical awareness, as stereotypes could be perpetuated by discussion of experience without reflection. There must be a dynamic interaction between knowing about something and knowing how to do something. Lippman (1999:266) investigated the processes for women’s informed decisions about pre-natal screening. She concluded that some women draw on feeling and instinct or a sense from ‘deep inside’, an embodied knowledge, where information from many sources had been woven together.

Heron & Reason (2001) described four ways of knowing (Table 17). These four ways of knowing would be more valid say Heron & Reason, if they were congruent. Experiential knowing could occur when present for an event, such as seeing and hearing babies crying when separated from their mother or cygnets becoming distressed by separation from the mother swan. Presentational knowing would be able to connect and compare the images, with human babies quietening when returned to their mother or the cygnets clustered quietly around the swan’s head. Propositional knowing would recognise that both stories had a similar concept of distress and perhaps served some useful purpose. Practical knowing could use these skills to enact events differently. All the four parts share the same basis and so are congruent.

Table 17 Four Ways of Knowing

<table>
<thead>
<tr>
<th>Experiential knowing</th>
<th>Occurs through meetings and encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentational knowing</td>
<td>Gained through expressive forms such as stories or images</td>
</tr>
<tr>
<td>Propositional knowing</td>
<td>Through words or ideas</td>
</tr>
<tr>
<td>Practical knowing-how</td>
<td>Gained through exercising skills</td>
</tr>
</tbody>
</table>
Gustavsen (2003:156) observed that:

‘Understanding is .. something that plays itself out between three reference points: theory, practices as they are and practices as they could have been.’

This began my thinking about how our cultural norm became changed from having the baby protectively close at birth to separating it physically, either by a towel or by distance in the cot. In the 1980’s, when I tried to rock babies to comfort them soon after birth, why did I assume that I could do it better than the mother who was lying a few yards away on the birthing bed? Why did I feel that it was my responsibility to care for her child? What harm was I doing by depriving both of them of the benefits of close contact by dressing the baby and separating it from its mother? This process is not just a historical one; in 2002 I observed a television programme showing babies being born without an inch of flesh coming in direct contact with its mother. The babies were swaddled by a towel, so that only their faces could be seen. The protective instincts of parents towards their newborn offspring are an accepted part of our world. Who would dare try to take away the young of a wild animal, unless they had some form of protection against their ferocious anger? How did our human parents become so oppressed that they submitted to events that must have either hurt them or caused distress? What is even worse is the fact that they were encouraged to suppress these feelings, thinking that we, the professionals knew best. In the mid to late 20th century women were told that their babies could be harmed by spoiling them and that routine was essential to teach a child good routines and discipline. A generation or more of mothers went through the agonies of leaving their offspring crying in distress and loneliness, because they thought they were providing the best care for them. The natural event of birthing had been turned into a version of ‘normal practice’. Other examples might be our insistence on sterility at the birth, or
‘delivery’ as we called it, with our ‘clean’ right hand and ‘dirty’ left hand. We made a sterile field with paper towels around a definitely unsterile vulva and vagina. Then we compounded our mistakes by insisting that the woman lie down to give birth so that her body fluids from urethra, vagina and bowel could gather nicely for the baby to be born into. The ‘natural’ birth positions of standing or squatting were abandoned, yet this would have facilitated the disposal of waste products in a safer way, by gravity. These positions would also have necessitated the baby being taken up into the mother’s arms and held safely to her chest, near the next means of survival, her breast milk.

Some examples of separation and contact from our project were a baby separated from its mother after birth, where the mother felt loss and failed to establish an early relationship, which was resolved by skin-to-skin contact. A baby traumatised by a difficult birth, who was healed by the warmth and comfort of his mother’s body, a mother undergoing difficult post birth surgery who felt the separation from her baby acutely and was desperate to return to her. The mother and baby who were separated by the routines of professionals might never know what they have missed, but if a midwife does not offer this evidence-based best practice, then she could be contributing to the oppression of some of the most disadvantaged in our society – women and babies. If our hospital routines interfere with this, or midwifery peer pressure from colleagues bully the midwife into feeling unable to facilitate it, then midwives who are mainly women, contribute to the oppression of other women.
A Learning Organization

This leads on to Senge’s (1990) work about creating a learning organization, what he called the fifth discipline. Senge (1990:3) believed that problems would arise unless we saw our individual actions as part of a larger system, but that:

‘instead we focus on snapshots of isolated parts of the system, and wonder why our deepest problems never seem to get solved.’

If we want to build a learning organization, Senge believed that we must engage with five components, which are personal mastery, mental models, building a shared vision, team learning and systems thinking, which he called the fifth discipline. The aim should be for each person to have personal mastery with skills for lifelong learning and clear vision. Senge thought that although not always aware of it, we have personal mental models, which unconsciously reflect our view of the world like a mirror; he emphasised that when we start working with mental models, we should aim to turn the mirror to face inwards to encourage self awareness. Some midwives and women might have a mental model that breastfeeding is very hard, and that despite the best efforts of midwives, it can fail or that routines must be adhered to. Senge (1990) stated that the first step to change this is to build a shared vision, which binds people together. I tried to do this in our project by efforts to build a knowledge and skills base with a vision of practice which could be at the forefront of latest evidence. Senge argued that team learning was better than developing alone, because together more could be produced with shared experiences, which emphasises the value of open discussions and focus group involvement.
Routines and Remembering

Sometimes, improvements in a work process can reduce work in the long run, such as the fact that skin-to-skin contact at birth can reduce breastfeeding problems in the next days and weeks. This is an example of Senge’s (1990:69) fifth discipline of systems thinking involving:

‘a shift of mind from seeing parts to seeing wholes, from seeing people as helpless reactors to seeing them as active participants in shaping their reality from reacting to the present to creating the future.’

Senge (1990) believed that ‘systems thinking’ joined everything together, which could transform people from seeing problems as being caused by others, to seeing how we create our own problems. Senge proposed that we should aim for ‘metanoia’, which means a change of mind or a radical transformation of the whole mental process. He believed that if we saw the world with new eyes, we increased our ability to create and this was the basic meaning of a learning organization. Whilst the use of the best available evidence is a goal to aim for, Senge observed that people could never be their best by copying others, as they needed to find their own way. It is also a principle of action research that evidence needs to be adapted to local situations. An issue related to this in our project was dealing with long-standing routines. I tried to minimise resistance to the new routine by thinking of key points for implementing skin contact, which would involve a change in routine. I discussed this with as many as possible. To try to minimise perceived problems and responding to evaluation, we worked out a ‘worst case scenario’. This was where the unit was busy, there were no free rooms and there was a need to move mother and baby to the postnatal all without increasing the work on postnatal ward. The only routine that would have to be done with the baby separated from the mother, to maintain the status quo, would
be a weight and normality check. This could be done quickly and the baby returned to mother before too much disruption had occurred. Other 'routines' could be done whilst with the mother e.g. length, head circumference, security tags and intramuscular Vitamin K. The mother and baby could be transferred in skin-to-skin contact and the mother would only need to wash herself and dress the baby, which could safely happen later. Most agreed that this 'worst case' would not be likely to happen often, but it would give an escape clause before the actions had become absorbed into the routine. I shared what happens in some BFI hospitals, where this has been in practice for some years, but it was thought too risky to try for that now, as 'things might get missed'. This change needed to happen gradually and safely for some, so the mirror started to turn a little, hopefully giving a clearer vision of the value of the whole picture. In this case, the fact that babies might still be breastfeeding some months later.

As time progressed, the Roger's (1995) 'S shaped' curve became apparent, as midwives progressed from saying that skin-to-skin contact was 'being talked about more' to 'more people are trying it, although it is not yet routine'. We discussed ways of recording it after birth, as a way of assessing numbers and a senior midwife suggested adding a computer question to the records made of the birth. This would ensure each midwife commented on it by saying if it had happened, for how long and why it had not happened. Later in our project, a midwife made a comment that 'most women are offered it'. Subsequently, following a teaching session for midwives, I asked for an update of experiences. There was a pause, some offering comments but mostly not. One midwife said that it was not deliberate; but that sometimes a baby was being born and she
thought ‘Oh! I never asked her’. This was reinforced for me during an interview, where a woman who was reputed to have had skin contact, described a disrupted experience. It was thought to be a good idea to get a stamp to put into the admission record as a memory prompt saying:

**Skin-to-skin contact discussed**

This was agreed and within two weeks, the stamp was bought and all notes were amended.

When targeting problems, as well as helping people to remember, changes do not always have to be huge. Sometimes small changes in the right place can have a significant effect, a concept which Senge (1990) calls leverage. He believed that most people saw events in a linear way, looking for who was responsible, but he suggested that events are circular with feedback adjusting our actions. When actions first occur, there are enhancing factors and limiting ones which Senge called a balancing process. Senge said that to try to achieve leverage some people just push harder, but the answer was to try to identify and change the limiting factor. Lewin (1947) described force field analysis where driving and restraining forces are responsible for the state of equilibrium. There are three assertions, first that increasing driving forces will cause an increase in resisting forces, which produces more tension. Reducing resisting forces is preferable, as it allows movement to a desired state without increasing tension. Thinking through an adapted routine with a safety net for busy times would potentially apply leverage to our innovation and reduce resisting forces.
A further aspect of the integration is memory and remembering something new. Gladwell (2000) discussed a concept in cognitive psychology called ‘channel capacity’. This is the amount of space in our memory for information. He explained that there is a limit to how many things we can differentiate, such as musical notes or the number of dots seen at one time. This limit keeps our channel capacities in the general range, which would mean remembering 6-7 distinctions at one time. This he explains, is why phone numbers tend to have this number of digits. If we pass a certain boundary, we are overwhelmed. The ink stamp was a way to avoid memory overload. We looked at how the information giving could be improved. Earlier, I had wanted to put laminated information sheets in every birth room, but delayed whilst waiting approval from Patient Information Review Group. This was now rectified and copies were also placed in the antenatal clinic waiting room. A development of this was that a bullet point list of the salient, evidence-based benefits of skin-to-skin contact (Table 18) was devised and put on the notice board in each room, reducing the need to remember everything. Further improvements were adding a sequenced picture story of what might happen during skin-to-skin contact (Appendix 3), which could be used by both women and midwives in their discussions. These materials were also put into folders and given to the antenatal ward and clinic for their waiting areas.
Table 18     Bullet Point List – Skin-to-Skin Contact at Birth

<table>
<thead>
<tr>
<th>Skin-to-skin contact with your baby at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby is quickly and gently dried</td>
</tr>
<tr>
<td>Placed in skin-to-skin contact</td>
</tr>
<tr>
<td>Covered with warm blanket</td>
</tr>
<tr>
<td>Comforting for baby, soothes if crying</td>
</tr>
<tr>
<td>Helps mother-infant relationships</td>
</tr>
<tr>
<td>Baby keeps warmer</td>
</tr>
<tr>
<td>Heartbeat and breathing settles</td>
</tr>
<tr>
<td>Baby looks more content and pink</td>
</tr>
<tr>
<td>Protection against infections</td>
</tr>
<tr>
<td>Fewer problems with breastfeeding later on</td>
</tr>
<tr>
<td>If breastfeeding, minimises bleeding after birth</td>
</tr>
</tbody>
</table>

All babies are individuals, so they may breastfeed within minutes or take an hour or more

These developments were perhaps ways of making sure that the late majority and the laggards had a chance to embrace the change. Gladwell (2000) describes what he calls the ‘Stickiness Factor’, which means that the message has to be important, not loud or repeated, just good, but there also has to be something that makes it stick. These are often small and seemingly trivial things which can make it easy, by helping to fit it into everyday life. Gladwell (2000:259) says that unless people remember what they are told, they are not likely to change their behaviour. He says that:

‘by tinkering with the representation of information, we can significantly improve stickiness.’

Skin-to-skin contact for women having caesarean births was discussed at each opportunity, with the idea gradually infiltrating the system. It was thought to be better to wait until the idea was more of a ‘routine’ on the CDU before trying for another area. I asked a midwife to find out about how another Trust managed this, where it was part of their routine and eventually the subject was raised by midwives in a focus group, which I took to be a sign of progress. In May after a teaching session, a senior midwife promised to speak to anaesthetists in theatre
about it, but as I discovered much later, did not get the chance. Later in the project, we were discussing theatre progress again. One midwife said ‘it is happening’ but another said ‘some midwives are removing them (babies) earlier’. The senior midwife said ‘Well stop that’ in a definite voice, perhaps a reflection that a remnant of the culture of the unit was still alive and well and more mirrors still needed turning. This issue which had seemed problematic at first now seemed to be slotting in. A recent personal communication (2005), was that now, most women are assumed to want this opportunity in theatre.

Dealing with Problems

At some point in a focus group in January I mentioned the BFI. One recently qualified midwife said very quickly:

‘Why did you mention Baby Friendly! We’re not going for that are we?’

I had to beat a hasty retreat and say ‘no we are just trying to implement evidence-based practice’. This was an acceptable answer. Some discussion followed about a neighbouring Trust which had achieved the Baby Friendly Award, and the reportedly ‘coercive’ tactics used. There were anecdotal stories of husbands smuggling in bottles of formula milk for their wives to give their babies in secret. They could have asked for one on the ward, but did not want to risk censure. Although anecdotal, it was readily believed and did not help the project. This midwife wanted to discuss helping women with the practicalities of formula feeding, which I said was not in the remit of the project, although it did need addressing. The discussion was starting to become heated and at this point I tried to tell her diplomatically, that she was hijacking my breastfeeding meeting and that one of the midwives had said at the start that she was time restricted. The first
midwife was annoyed, so I suggested that she should develop this one herself. This midwife used a version of Lukes (1974) two dimensional power by trying to control the agenda, which I deflected. There were also hints of condign power, with which my very much younger self might have been intimidated. It also reminded me of West’s (1997) organizational immune system used to fight against things that threaten the present state. Another incident happened which highlighted some people’s inbuilt resistance mechanisms. On the day that pictures of skin-to-skin contact were put onto the notice board in each room to enhance discussions, I discussed this with the senior midwife, whose first tactic is to resist, before being in any way positive. I said ‘Well put them up for a couple of weeks and see how people like them, if not, we can always put them in folders later’. This seemed acceptable, and in the end they stayed up exactly as they had been placed and were found to be useful. An angry incident happened when a senior midwife suddenly appeared at my side in the antenatal clinic and spoke to me in a very aggressive and rude manner. She was full of anger about a breastfeeding book left on postnatal ward by a community midwife. This was no doubt a remnant from her own experiences, but I wondered why she would feel that she could use me as a scapegoat for her anger. She seemed to be seeking to blame someone else, reminiscent of Senge’s (1990:18) ‘learning disabilities’. Perhaps she perceived me as safe, like family, because I had known her for years. I felt I had to soak all this up without losing my own composure.

In the Antenatal Clinic one midwife usually looking defensive on seeing me. Her attitude always contained a variation of ‘It won’t work’. I felt that she would escape from me if she could. Later in our project I endured a session of what I call
‘circular moaning’, as it could never be solved. I went to sit with clinic staff for dinner and I saw this midwife groaning as she caught sight of me, so I promised I would not to talk about breastfeeding and she relaxed. However, I spent my lunch break listening to all their stress about overwork and pressure. I know I felt worse and they possibly felt better after this, but I could have told them that since the start of the project, my life consisted mainly of work and very little time off, but I just listened. Following discussions in January 2002, I understood that the clinic midwives were finding it hard to come to teaching sessions. We identified that a possible solution would be a Monday at midday, when that day’s clinic had finished, leaving an hour for a session just for them. Finally in April, such an opportunity occurred but on that day, even though they finished early, they were ‘too tired’. Sometimes I had the feeling that I should go away and leave them in peace. West (1997:106) observed that we should learn to be aware of when we are involved in, or colluding with defensive routines. In June when I went onto CDU, I felt that there was a wall of silence. People said ‘Hello’ and then nothing else and I felt in the way. I tried initiating a conversation and got little response. I decided to go for a walk to see if anyone else was available but everyone was occupied. I had no option but to return to CDU and make the best of it and eventually things improved.

Quite late in our project, CDU was quiet, so I asked to hold a focus group. My field note for that day said ‘Passivity rules OK’, as midwives were just standing chatting. Eventually two midwives and one student came, and the others continued standing by the midwives station. I found the apathy hard to bear but carried on with the meeting. In July on CDU I wanted to discuss our project but
found it difficult to bring the subject up, even though it was not very busy and midwives were sitting at the Midwives’ Station. No-one showed any interest in my new breastfeeding pictures and no-one asked to help with putting them up. My field note said:

‘I would faint if anyone volunteered any interest.’

I asked a senior midwife about tying up the ends of the project. We agreed that a further newsletter about what has been achieved would be a good thing. I was relieved and suggested we could have cakes to mark the end of ‘our’ project and everyone was enthusiastic about that. I recorded that:

‘I feel I have had enough here.’

The Action Researcher Role

In the clinical area, the midwives were keen for me to come and work as a pair of hands. I had experiences to share, especially in breastfeeding skills, but had not worked practically within the unit for about two years apart from visiting regarding learning environment issues for students and assessors. I was aiming to be an insider yet was still partly an outsider as a researcher which could and did cause me some challenges. Galvin et al (1999) performed an action research project, where tensions occurred at one point during the project because of communication problems. The practitioners expected more of the research team, but Galvin et al (1999) state that the philosophy of action research is that individual practitioners are required to be involved in the change. Eventually a compromise was reached, where one researcher became an insider working within the team and having a dual role. They observed that this sort of difficulty was common to action research projects and considerable effort was needed to maintain collaboration, it being important not to impose ideas. A clear idea of
boundaries and responsibilities in the research role is needed. Flexibility is needed in action research and Sloper et al (1999) concluded that it was an advantage to be able to change plans quickly, responding to needs. I felt that on a day to day basis, I was ready for anything. I had a wheelie trolley containing everything I might need; uniform, sandwiches, teaching equipment, such as doll, videos, handouts, and a tape recorder and notebook. My time was also flexible, as one clinical session went about four hours longer than I expected, when I stayed to help a woman give birth. Galvin et al (1999) realised that it was difficult to set clear objectives at beginning, as the nature of action research required constant renegotiation. I found this true, because if I thought I would teach, I would be needed to help on a busy day by caring for women in labour, or vice versa.

My instinct was to be helpful, but not to take the initiative too much as I wanted the midwives to be independent. Initially, I was more helpful, as their confidence was not high. Two midwives wanted me to explain benefits of skin contact to a couple and they would ‘listen’. I felt awkward descending on a woman I had not met before but this was part of my early role. I felt better when in uniform and acting as an extension of the clinical role, rather than as an outsider. I found that change takes time, much longer than I expected and sometimes I was desperate to see progress as things seemed to be standing still. Dunning et al (1999) also found this, saying that an action research project cannot be speeded up. No matter how well prepared, it was likely to take longer than expected, with the multiple tasks of finding evidence, arranging meetings, preparing materials for training, not to mention that the clinicians were busy. One project team said it was necessary to create a plan then double the time you estimated i.e. not under a year. Rycroft-
Malone et al (2002:8) said that there were not many evaluations of the concept of facilitation, but it could range from providing physical help to helping the team to review ways of thinking. They felt that:

‘The key to appropriate facilitation is matching the purpose, role, and skills (each of which can exist as a series of continua) to the needs of the situation.’

The role of a critical companion is described by Titchen (1998), as one who facilitates personal and professional growth, maturity and empowerment, and found that the initial facilitation style was very directive with a big educational input, reflection and role modelling. Sloper et al (1999) highlight that there is a dilemma in demarcation of the researcher’s role and where to draw the line between facilitation and intervention. They felt that ownership however should stay with key workers, to promote change.

The research role Tolson (1999:385) believed,

‘should be ‘mindful of the philosophical roots of the chosen research paradigm.’

In that project, there was a compromise between leading the change and the researcher role. One nurse called the researcher a ‘saprophytic researcher’ or a fungus which thrives in under-resourced areas. This was as Tolson (1999:389) pointed out:

‘a poignant symbol of unexpressed feelings towards research and those who engage in it.’

I often felt that nothing would happen unless I initiated it, but persisted nevertheless. West (1997) believed that sometimes the persistence of a few voices can affect the uptake of a new practice, providing they are confident and consistent, citing the case of the ‘Green’ lobby in influencing national policy. Being helpful was not just in this project, but a personal philosophy. I believe that if you give something you are more likely to get more back. This was so in the early 1980’s when I learned to ‘scrub’ in general theatre. I was there to enable the
setting of up a new maternity theatre, so I needed their expertise. Part of the whole role was clearing up and other mundane tasks which I did willingly. Because of this, I became part of their culture and progressed to being the scrub nurse for the operating lists which meant that I was an accepted team member. This philosophy extended to my role now. On CDU I joined in the work of caring for women as well as helping out. On postnatal ward I volunteered to work, as well as being requested to do so. I also performed other roles, such as helping midwives with personal CV's and portfolios for job interviews.

**Challenges for the Researcher**

Balancing my research working hours was always a challenge and although ‘funded’ for two days, this never really worked out properly. In University, other teachers filled in for me but I worked more than full time overall. At the Dept of Health initial presentation day in November they said that I needed support, but the problem was where to find it. Everybody at University was busy and there was often apathy for the project in the clinical area. I was still something of an outsider, even though I had known many of them for years. Combined with this, I was desperately trying to understand the theory and philosophy behind action research. I began to feel that I could not succeed, as the words seemed to mean nothing until I had read them a dozen times. One of my field notes says:

‘There must be an easier way than this!!’

When I started working in the clinical area, I was reasonably nervous at first and I needed the midwives’ support very much. The unit with which I was familiar had closed and the new unit, although a nice place, had store rooms and models of equipment that were different and I had problems finding my way around. I found
this draining, because of the emotional effort of trying to appear confident in front of both midwives and women. It was not the midwifery that tired me, but the administration tasks. I identified with Webb (1989) who, in a similar situation found there were times when she needed to show a bravado and conceal panic whilst trying to build up 'ward cred'. One benefit of this was that at least on CDU, I was not seen as the 'expert' who came in and told people what to do.

One frustration was when the information leaflets had to go to the Patient Information Review Group. This group were health professionals, but there was only one midwife, who did not always attend. Their secretary retyped my words to include many typo’s which were then sent out to the group for comment. I felt annoyed but decided to swallow down my anger. The next submission I sent on disc, inside a neat plastic carrier along with a hard copy. Unfortunately, this typist must not have been computer literate, because it was typed out again with even more mistakes. I admit to being very annoyed by this, perhaps more so than was needed, in view of its importance in world affairs. What annoyed my perfectionist personality was that those commenting from the group would think that I would send in a leaflet for approval with bad grammar and obvious spelling mistakes. Another annoyance was that they were not midwives and were criticising my work. They were however potential consumers, and if they did not like the words, then I realised that I should take notice.

Although there were good times during the year, I was usually longing for someone to show some enthusiasm. The project had an impact on me physically and I had more sickness than usual, as it sucked the life out of me. I had two chest infections and some mysterious spots in the July that never were diagnosed but
achieved ‘permitted’ time off to recover my strength. This now reminds me of the work done regarding the connection between the brain, behaviour and the immune system (Cohen, 2006). Some days I ran out of steam, so withdrew a little to lick my wounds and then went back. One day, after a time away from the unit, I had been dreading going back. As I entered the CDU I asked a midwife what I could do to help, she said ‘perhaps help on postnatal’. On reflection, I think it was not myself personally, but as a researcher I was an element of threat to her, because she had not facilitated any skin-to-skin contact yet. As the project ended, the inevitable withdrawal from the setting occurred. To dovetail with the project’s end, a midwife was appointed with responsibilities for breastfeeding. She had been to one of my sessions, and seemed to be learning new things. I had been doing teaching sessions for Health Visitors and had two more booked when her post commenced. She discussed these sessions with the Health Visitor involved and arranged to do them herself. I felt very upset about this and had to debrief with my colleagues. I felt rejected and angry because of all the effort I put into it and I could not even finish off properly. I had thought the new midwife would come and sit in, as she has done very little in the way of breastfeeding study or reading. In the end, I had to back off and let it go. I had read about difficulties for action researchers in withdrawing from the setting, but did not think I would be ‘ejected’.

**Conclusion**

I have demonstrated that there is an increasing emphasis on effective clinical practice, change management and sharing of good practice. Some of the strategies used in the project have been highlighted and related to relevant literature. I have
explored how change might unfold and compared this with events in the project, detailing strategies which empower people and create more self awareness, with seemingly small changes which had large consequences. When looking at the philosophical underpinnings of action research, such as critical social theory, and communicative action, it would seem that without the collaborative, facilitative and empowering nature of action research the change process might be more difficult. Fay (1987) argued that critical social science tried to enable people to see themselves in a different way by strategies of enlightenment, empowerment and emancipation. Habermas (1987) believed that the a person’s lifeworld was affected by the way that they tested the authenticity of their social interactions, linking them to usual everyday practices and adding any new knowledge which was perceived to be valid and congruent with the identity of the social group. The systems perspective however, involved rules and organizational structures. If the lifeworld became submerged in the system, then people might lose touch with it, seeing their world as reified and so begin to define themselves in line with system values, leading to domination and demotivation, as in the persistence of routines around the time of birth. An action research approach to change would be more likely to provide the facilitation and support necessary to enable these to be recognised and overcome, as it began to be in our project. A critical feminist perspective would also have something to offer to dominated groups such as women, both midwives and mothers who were influenced by the hierarchical and also insidious nature of power as discussed in Chapter 5. An action research project based on this perspective could encourage deeper learning and perspective transformation and find a way to value women and increase their self-esteem. It could be valuable because the knowledge gained and practice theory constructed,
could enable the midwives involved to have a voice relevant to their practice and so become empowered.

The research role is a challenging one and its high and low points have been discussed. Despite all the pressures, the project was a life-changing event for me, where I learned amazing things and celebrated great achievements. My rewards came from when things worked effectively, both with skin-to-skin contact at birth and breastfeeding challenges later. Working as a midwife was rewarding too; being able to use my years of midwifery experience by intuitively recognising progress in labour such as the transition stage, possible cord compression and judgments about fetal safety. A great joy was helping a woman give birth to a large baby using skills from my many years on CDU to keep the perineum intact when the baby was huge. Better yet was being observed achieving this by a midwife and medical student, and then the baby having skin-to-skin contact. After one long labour and birth a husband gave me a Polaroid photo of his son in skin-to-skin contact, deliberately missing off the mother’s face, so that I could use it for teaching purposes. I told him it was worth more than a gold clock to me. This was true for the whole project which challenged me and helped me to grow both professionally and personally.
Chapter 7  From Nature to Culture: The Theft of Birth?

Introduction

When I first saw uninterrupted skin-to-skin contact between mother and baby after birth, intuition told me that it was more than just the immediate benefit of breastfeeding and having a cuddle. The more I saw and read about it, I came to see that it could be an important relationship, where both gained in different ways but created something together that could have immediate and future benefits. This would be more than a closer relationship, possibly a deeper sense of self, or self worth and belonging. Freire (1998:35) believed that:

‘it is as necessary to be immersed in existing knowledge as it is to be open and capable of producing something that does not yet exist.’

Letherby (2003) believed that women’s experiences would be the starting point for a critical feminist production of knowledge and would value the personal aspects of experience. Maguire (2001:66) argued that we should provide more information on how our knowledge of practice was gained in case more ‘alienating knowledge’ was produced, with Irigaray (1996) wanting to see woman, rather than someone who is not a man. A useful convergence of feminist thought enables me to explore diverse experiences. In this search for meaning, I intend to discuss concepts of the body and separation of its parts, the effects of technology and the influence of time on birth. I will then begin to uncover the depths of knowledge almost submerged in the dynamic process of skin-to-skin contact; that of emotions, embodied praxis and through the search for the meaning of the concept of jouissance (Kahn, 1995), to explore some aspects of psychoanalytic theory.
Normal Practice? Separation and Technology

How did birth come to mean the almost immediate separation of the mother and baby, and with what consequences? This goes deeper than just the imposition of a routine, it affects the voices of women and the rights of both mother and child.

Recorded history argued Kahn (1995), leaves out the experiences of women, the mother’s body being separated from nature, the child separated from its mother and women ‘relegated’ to the culturally perceived lower ‘world of the below’. The male was however elevated to the ‘world of the above’ which dealt with spirituality, justice and the mind. Belenky et al (1997) said that typical male values of looking at the abstract and impersonal tend to be seen as the only viewpoint and have been called ‘thinking’. Problems arise when women are compared to men, because women’s ways of looking at life are usually seen as emotional and personal, and so perceived to be of lesser value. Rich (1977:42) pointed out that:

‘Institutionalized motherhood demands of women maternal ‘instinct’ rather than intelligence, selflessness rather than self-realization, relation to other rather than the creation of self.’

Kahn (1995:10) suggested that modern obstetrics can encourage women to doubt their body’s ability to give birth, so it might be best for women to examine and value life in a personal way, using real examples, rather than using objective theories. She elaborated that:

‘It seems beneficial to know that the writer who might lift off into the bracing air of theory, taking the long view, nevertheless comes from that tiny spot in the left-hand corner of the grain field.’

I will recount many moving stories during the course of this discussion, which are strongly underpinned by profound experience as well as theory, showing that women know a lot about the world of the above as well as that of the below. So how did the female body come to be regarded as of lesser value? In the 17-18th
century, the body was viewed as a machine and the female body more related to pathology. Menstruation was seen as degeneration and getting rid of impurities rather than renewal, even being compared to sweat in a man (Martin, 1992). Kahn (1995:4) suggested that natural birth processes could be seen as a challenge to patriarchal power, therefore in need of:

‘maintenance and standardisation’ which reduces them to ‘a set of physiological processes named by elegant theories and subject to surveillance.’

Balsamo (1997:21) asked how the body came to be seen as socially constructed, rather than formed by nature and how was this brought about? She suggested that:

‘making a boundary between nature and culture serves several ideological purposes,’

one of which was to reinforce the fact that culture and ‘man’ were higher than nature which would tend to have a ‘truth’ effect for the body. Jordan (1993:4) believed that childbirth was a complex mixture of physiological and cultural, with one not being available without the other. In her research into birth practices in various parts of the world, she found many cultural variations, which made sense to each group. She found that often:

‘practitioners will see their way as ‘the best’ way, the right way, indeed the way to bring a child into the world.’

In other words, an ideology guides what is viewed as normal. This makes childbirth a prime target for social regulation, and practitioners may actively resist any tampering with this ‘correct’ way or may even regard change as dangerous. Male philosophers projected their own imaginings on to the world observed Minsky (1996:194), so they would see themselves reflecting back as though that was the only truth, as with Irigaray’s speculum, (discussed in Chapter 3, p76). If one looks at life through someone else’s mirror, the reflection might seem true, but could really be a distortion, like the anorexic woman who thinks
she looks shapely whilst weighing four stones. A midwife might look at the birth processes and see 'male' values and truths reflected back. The woman, according to the perceptions of the midwife may seem to choose separation from her baby, whereas she is perhaps seeing through the mirror of the midwife's wants and needs, to 'get done' or civilisations' 'get on and hurry up' ethic, so birth is acted out influenced by the ideology of others.

Women interviewed by Martin (1992:77) seemed to feel that the self and body were separate. One interviewee said:

'Your body is something your self has to adjust to or cope with.'

and when discussing labour and birth, women talked of the contractions not my contractions. Martin (1992:85) told stories of mothers and babies separated at birth, with the resulting sense of loss. One woman said of the baby:

'It could have been a banana wrapped up in a blanket.'

Kahn (1995:36) believed that:

'Society teaches first lessons in separation and attachment in the way it structures birth, through instructions inscribed upon the mother's body that indelibly affect her as well as the newly emerged infant.'

Separation of mother and baby and replacing her breast with 'things' like dummies and comfort blankets suggested Willeford (1987:97), might be teaching them second best, perhaps teaching them to turn inwards for satisfaction. Early in the project, one woman who allowed me to care for her in labour had already declined skin-to-skin contact and her distressed baby boy was delivered by ventouse (vacuum) needing some simple resuscitation. Following this he was wrapped up and put onto her chest, crying. Her sister seemed keener to look at him than the mother. On the next day I visited her and it was good to see her looking more recovered, sitting up in the bed and smiling at me, ready to chat.
The baby however, was still unhappy and not feeding well, with symptoms of having swallowed mucus during birth. He was in the cot, just out of arms reach of the mother and fractious. As we talked, I became uncomfortable with his crying. I asked would she like me to pass him to her for a cuddle, but she declined, saying something like:

‘No, because I don’t want him to get used to being picked up and get spoiled.’

So there were no cuddles for that baby. This must be something learned from her family, culture or perhaps previous health professional advice. She seemed to believe that this was the best for the baby. Looking back, I am unsure whether full information about skin-to-skin contact was offered. In view of later events in our project, information content might not have gone beyond a choice of ‘do you want skin-to-skin contact or not’, without conveying full information on which to base an informed choice.

Jordan’s (1993) work with birthing Maya women in Yucatan, found that they were not separated from home, family or the usual everyday life. She found that if the birth location was unmarked and unspecialized in this way, the mother and child remained together from the moment of birth. In fact the Mayan baby was not separated from its mother for at least 20 days. A high degree of alertness and eagerness for interaction was noticed by Jordan (1993:73), in births where there was no medication, (i.e. not America) with an atmosphere of elation and touching and talking to the baby. In Western hospitals however, she found:

‘attentional and emotional distancing.’
with often a drugged mother and/or baby. The spatial arrangements were that
mother and baby were separated for routines and checking, thus shaping the
interactions of women and their partners.

By end of 1980's, Balsamo (1997:5) observed that the idea of a merger of the
biological with the technological body had spread through the Western culture, a
re-conceptualization of the human body as a 'techno-body' belonging to both
organic (natural) and technological (cultural) at the same time, a concept
previously thought to be incompatible. Davis-Floyd (1994) believed that society's
core values were very visible in the treatment of a body giving birth. She
described the technocratic model of birth as being a powerful way of controlling
it, by replacing the natural (associated with pollution, primitive ways and the
female) with man-made (seen as advanced, pure, celestial and male). Those who
only know technology cannot imagine life without it, stated Wagner (2001), so
tended not to notice it. In a similar vein, Davis-Floyd (1994) used the work of
Reynolds (1991) to describe the One-Two Punch which involved taking a highly
successful process, such as salmon swimming upriver to spawn. This was made
dysfunctional by damming the river, fixed with technology by taking the salmon
out, making them spawn artificially and growing the eggs in a tray. This was a
perfect example of destroying a natural process and then rebuilding it as a cultural
process. Knowledge was reduced to scientific research and description, which was
essentially about separation. The cultural management of birth is a perfect
to Header
the separation of mother and child, with the mother’s needs always subordinated to the supposed best interests of the baby, not to mention the organisation.

One technology described by Widstrom et al (1987) used on babies in the 1980’s sounds heart-rending. The babies observed, reacted with distressed, aversive movements suggesting pain, when a gastric tube was inserted within minutes of their birth. This was done to ‘prevent’ the risk of aspiration of stomach contents, but it reduced breastfeeding success. Davis-Floyd (2001) called this drive to improve nature, the technocratic imperative, saying that even though options for birth contain natural elements, most women are constrained by the technocracy, like the salmon in dammed up rivers. Women interviewed by Davis-Floyd (1994) demonstrated a belief in this ‘technocratic body’ and that life was controllable, through careful planning. They saw their body as a vehicle, with birth helped by technology as a mechanical process. One woman said that it felt good during her caesarean section, because the anaesthetist explained every step and she was intellectually present at the birth. Most of the women interviewed by Davis-Floyd worked 10 hr days, with the child being cared for in a nursery. The women stressed that they had ‘quality time’ e.g. 1½ -2 hr per day with the child. Davis-Floyd (1994:1132) argued that this was like:

‘a prosthetic device for the reconstruction of the continually deconstructed (mutilated) American family.’

Kahn (1995:116/7) told the story of a birth witnessed in America, where the newly born child was distressed, but the parents and doctor were laughing. She found it strange that it would be seen as normal for the child to scream, describing an encounter with Frederick Leboyer after seeing his film, ‘Birth without
violence' (Kahn, 1995:250). A Leboyer birth (Leboyer, 1977) was a relatively brief fashion in the 1970's where the newborn was placed in a warm bath soon after birth and encouraged to adjust to the world in an apparently more gentle way. In his book, one of the pictures underpinning this argument is of a child held upside down, suspended by the heels whilst it screams and the parents look on, smiling (Leboyer, 1977:11). On seeing the child in the bath appearing to be instinctively rooting for food, Kahn asked, ‘When is the baby given to the mother?’ She reported that Leboyer was annoyed and would not answer. She believed that his journey as a doctor from gynaecology (dealing with illness and death) to obstetrics (dealing with birth and life), meant that now he could give love to the baby. Kahn (1995) felt that this implied that the mother was responsible for the baby’s pain of birth. Leboyer (1977:24) spoke poetically about the mother during labour as ‘driving the baby out’ and that ‘she’ is the enemy. The revised edition, translated by Fitzgerald (Leboyer, 1991:34) had more muted language, but the mother is still an implied cause of the baby’s pain. Kahn felt that Leboyer stole the birth away from the mother by separating the baby from her. Leboyer (1977:68) described the moment the baby opened its eyes, saying that this look is unforgettable. The pictures show Leboyer, not the mother, holding the baby to experience this precious moment. The revised edition suggested that the mother might be so affected by the turmoil of birth that someone else had to take the baby. It was suggested that the mother would pass on her turmoil to the baby or may not know how to touch it correctly. The baby now needs peace, quiet and calmness, so this can properly be provided by a ‘loving midwife’ (Leboyer, 1991:91). Fitzgerald (Leboyer, 1991) said that the mother must be willing to let the baby be taken to put into the water, where he now feels safe. Now the child
opens his eyes, to see, but the question might properly be asked ‘to see what?’ He sees the midwife or doctor of course. The helper, by meeting the first gaze, has effectively stolen the birth from the mother. The feelings of the mothers cared for by Leboyer might not have been voiced, but it reminded me of instances in my own early career, where separation was the norm. I have a vivid memory of myself in the 1980’s rocking a newly born baby to try to stop it crying. The mother was lying on the bed alone, with the father silently watching me. I was probably on the benevolent side of the ‘as good as it gets’ scenario of that era, but in retrospect, it was almost ‘my’ baby, in my control, with my priorities and timing. Some women in our project described their disturbed experiences of birth with their last baby. One said that she did not hold the baby and perceived that the midwives might need the room to be cleared, because they were very rushed. Sue said:

'I don’t think I felt as close with him... I don’t know if that was the reason or not but I don’t think I felt as close with him straight away as I did with (this one) .. I did feel quite rushed to be honest... because...I had him (for a short time) and then .. (my husband) had him and my mum had him then he was given to me and then the next thing they were asking me to ... get dressed and changed ready to go onto the ward...whether they were busy that day or ...they needed the room ... I’m not too sure.'

Karen compared this birth to the last one, saying:

'... it was just a nice sort of atmosphere really and quiet and just that time with three of us really...much more so I think than the first time.'

Davis-Floyd (1994) described the American nation as founded on the principles of separation, which are passed on to others. According to Davis-Floyd (1994:1138):

'the real issue is not what is “best” in any absolute sense, but what aspects of culture are expressed and perpetuated, what cultural lessons are taught and learned during the production of new social members.'
Time and Birth

This leads me to consider the issue of time in our society. Davies (1990) believed that time was assumed to be as natural as nature but this lost sight of the fact that it was socially constructed. She described linear or clock time as male time, because it dominated society, saying that it was measured in atomic seconds, which marked out history. Clocks were seen by Davies (1990:29) as 'a further tool in man’s domination and control over nature.'

Clocks took over the earth’s or nature’s daily/yearly cycle, making time inflexible and becoming, said Adam (1992:160):

'an abstract value to be exchanged and bought, a finite quality to be used, allocated, budgeted and controlled.'

Helman (1992:36) called linear time monochronic or Western time, having a beginning and end and being compartmentalised into hours and minutes. Only one thing at a time could be done in each compartment. This time coordinates everything by schedules and appointments, even our relationships with others. Time is a container waiting to be filled yet at the same time moving along a conveyor belt and not fully used if left empty, so there is a value put on speed and efficiency as measured by the clock. We can also get the impression here of time running out, with its consequent stresses. Davies (1990) pointed out that the wrist watch, brings time to our personal lives, so that we notice its passing even more, portraying linear time with the symbol of an arrow, (Figure 1) saying that it pointed into an unending future but also to death. The invention of the clock had repercussions on the way that everyday life was lived. Workers during the Industrial Revolution, according to Martin (1992), had to be taught new ways of looking at time. Adam (1992:163) felt that it was important to stop thinking of
time as taken for granted, rather to allow nature’s time, which she felt was the symbol of life, a higher visibility. She said that all living beings were:

‘permeated by rhythmic movements….’

Kristeva (1986) believed that female experiences of time were linked to cyclical, repetitive time, whilst Davies (1990:23) pointed out that women tended to be concerned with the here and now, having a pace set to natural rhythms, which she depicted as the arrow forming a circle and thus marking out a space (Figure 1). More illumination was provided by Gilligan (1984), who found that female voices were more valuing of relationships and conscious of the needs of others whereas male comments were more about separation. Helman (1992:38) named cyclical time, polychromatic or non-Western time which was associated with female time and involved doing more than one thing at a time, being aware of others and the completion of an experience rather than in a pre-set time. Polychromatic time was not experienced as lost or wasted, and people tended to value relationships. Petr (2000) reminds us of Simak’s (1952:170), classic work of fiction, where the character says:

‘The way we keep time is to blame .. for we thought all the time that we were passing through time when we really weren’t, we never have. We’ve just been moving along with time. When we said, there’s another second gone, there’s another minute and another hour and another day, ... it was the same one all the time. It had just moved along and we had moved with it.’

This gives another view of:

‘our Western perception of “having no time”, in which present is only an infinitesimal part of time, a fleeting illusion dividing almost infinite past and future’ (Petr, 2000:121).
Even though clocks might dominate our social life, Adam (1992:157) argued that our bodies were also clocks which were set to the earth’s pulses and ‘bind us to nature’s rhythm’. Circadian rhythm is important for all physiology, both day and night, the seasons and menstrual cycles. Artificial light is a recent thing in evolution and means that we can now be active in the night, which might have implications for our natural body rhythms. A well known way of shrinking time is the use of air travel, with its side effects of jet lag, affecting body functions and well-being. Body rhythm and the natural environment therefore, along with the implications of social ‘clock’ time are important factors in our understanding of the connections between time and our health.

Adam (1992:155) proposed that ‘natural’ time was integral to social time and that we needed to understand the relations between them. Davies (1990) felt that it was important to understand who actually did influence the use of time. She said that because of women’s position in society, their use of time tended to be influenced by others, keeping them subordinate in society. Women often have competing linear and cyclical time that ‘weave complicated patterns’ said Davies (1990:37), which meant that they sometimes clashed. Frankenberg (1992b:22) discussed the
importance of time in hospitals, which was controlled by others. People may not normally conform to hospital time but the patient:

‘negotiates from a position of temporal disruption and uncertainty.’

Pizzini (1992) found that if a woman was giving birth at home, the break seemed less violent. Birth in hospital meant the imposition of institutionalised time, and was socially determined. Women told Pizzini (1992:69) that birth in hospital was like upsetting a balance or:

‘a moment of rupture, a life crisis.’

This might have been that the mother and baby had become separated or, she speculated, a combination of separation and the fact that body time had changed to socially defined time because of those who attended the birth. This reminded me of birth and skin-to-skin contact and the rush to complete it, to disrupt or even not to try it. Women in hospital giving birth have no need of a time for meals or other hospital routines as labour goes on at its own speed (more or less), yet ‘time’ becomes important once the baby is born. There is an obsession with the exact time a baby is born, I can remember the stress of knowing the exact time and asking worriedly after the birth ‘Did anyone see the clock?’ Pregnancy, said Kahn (1995:38), taught her new things, especially that a natural process unfolds in its own way. She cited a short Buddhist saying:

“Sitting quietly/doing nothing/spring comes/and the grass grows by itself”, which instructs against over-reliance on the will to make things happen.’

Spending time in skin-to-skin contact could be seen as ‘just lying there, doing nothing’, or ‘wasting time’, rather than waiting for the innate pattern of newborn survival to act itself out with the reduction of adrenaline and the start of the miracle.
Pizzini (1992:68) queried whether there was an ‘interior’ time, which she felt was closely related to body time, as opposed to a ‘social time-in-the-world’. This interior time she felt, could be described as arising from ‘involuntary’ memory which comes from past experiences, dreams and reality, a time when a person ‘goes inside themselves’, without worldly obligations. This time she argued, needed to be justified to our society and a reason given for its use, such as in pregnancy. I found when talking to women that time was not always ‘real’ because sometimes the words ‘straight away’ came to mean ‘soon’ or in 30 minutes or so, when the story unfolded. Hannah said that the baby went straight to the breast at birth, but when she talked through events, it turned out to be about half an hour later

Mary: ‘So you said when she came out she went on the breast straight away...’

Sue: ‘That’s right .... This time everything was a lot more relaxed, I just felt that I could have left the room whenever I wanted... you know if I’d have wanted two hours, I felt that they would have left me... they were ... everything was a lot more relaxed I felt this time...’
Mary: ‘...but did it seem like a long time?’

Sue: ‘No, it didn’t seem like a long time at all. It went really quickly... I was just really sat there talking to my husband and looking at her ... and it was lovely... and then when I looked at the time and actually got up to go and get changed and get myself ready to go on... to the ward, I didn’t ... realise how long we had been there for... yeah it did go really quickly... it does sound a long time an hour (yeah, it does), but yeah it wasn’t.... it did go really quickly...’

I asked Paula whether the baby was crying at birth. She said:

‘...he did a bit at first and he shut up as soon as he went onto me ... and then that was it, he just laid there, he didn’t really do anything.’
Mary: ‘So...how long...did he ... have a rest for fifteen minutes...or...’
Paula: ‘...I think the midwife said she’d leave us there for about an hour, but I don’t think it was quite that long, maybe about half an hour, three quarters of an hour... then I got showered and... moved ... but it didn’t feel that long at all ... just seemed to be really quick.’
Jane told me that after the birth, time just flew and didn’t seem long at all. Even though their family was waiting for news, they didn’t want to rush this first time with their new baby.

Midwives were also aware of time going by, (also discussed in Chapter 5) when they were facilitating women to have skin-to-skin contact, I asked it that had caused a problem

Helen: ‘... I’m not saying it was a problem... but consciously, you know at the back of your mind ... unconsciously perhaps I should be saying ...and I realised she was still there... Because we’re getting the notes done and we’re getting the room done and everything... so no it wasn’t a problem, but it could have been a problem if we’d have been much busier.’

I asked midwives how things might have altered if the ward had been busy

Alison: ‘I think I’d have been more twitchy then getting her (to postnatal) ‘I wouldn’t have done any different really...in my head I might have been thinking about rushing the process but it was such a good experience for her and he was ... happy to be there and he was feeding so well you couldn’t have broken it. You wouldn’t have broken a breastfeed if you were busy would you. Or it would have been a case of ’shout if you need me I’m going to help someone out there.’

Tracy: ‘Well ...for her particular case I didn’t have to .. change anything, it just happened naturally. The ward was quiet, there was no feeling of urgency to do anything else, so there was no problem there at all. ... and all the checks and everything were done afterwards. There was no reason to disturb her from the ward situation or from the point of view of her particular baby, because the baby was normal, it was healthy there was no problems.’

Some of the midwives’ comments taken from their evaluation forms, very early in the project, gave ideas of the pressure of time.

‘Both enjoyed experience but room was tied up for several hours following delivery, although it did not cause me a problem.’

‘But it was frustrating not being able to get on, if the ward was very busy it would be hard to maintain it for an hour.’

‘Tutors ought to be realistic in the length of time we can let the baby lie on the mother, whilst other urgent work is required.’
So even if the midwife wanted to facilitate skin-to-skin contact, they were still mentally constrained, trying to weave linear and cyclical time. Kristeva (1986) felt that feminists have demanded many different things, such as equal rights with men, securing a place in linear time; or different rights to men, which demanded the right to remain outside linear time. Perhaps it would be better if a new generation valued both cyclical time and linear time, without comparing the two as opposites, or limiting them. Davis-Floyd (1994:1139) asked whether at the point of disenchantment with technology:

‘our culture will turn towards those who never aspired to the technocratic goal for alternative mythologies – organic mythologies that can charter a vital and vitalizing dance to the music of an embodied earth.’

A New Culture and Skin-to-Skin Contact

So what does this time just after birth mean for women and their babies, and what reason can be given as to its importance? Why should women be encouraged to dance to the rhythm of the earth, as Davies-Floyd (1994) wanted them to do? Davis-Floyd (2001:S18) argued that technomedicine tends to dismiss intuition, but holistic practitioners see it as a primary source of authoritative knowledge. She believed that a ‘holistic’ midwife would be focused on the woman and her unique needs and rhythms. She described the theory of self-organising systems which stated that:

‘even the smallest event, if it happens in just the right place at just the right time can dramatically alter the whole system.’

Tritten (2002), a midwife and mother, having her third baby, experienced a birth that was very rapid and was completed before her midwife colleagues could arrive. She said that:

‘..as soon as Loren was out my midwife brain turned off ..... My mothering heart took over and I didn’t remember midwife thoughts at all.’
When the midwives arrived, they brought energy and commotion into the room and according to Tritten, stole her bonding time. This taught her that the birthing room is sacred ground, calling the first hour a holy time and space. Tritton says that there is a tendency to rationalize this bonding time, saying that it can happen later. She believes this to be untrue and feels that it robs the mothers of the best moments of their lives. The experience led Tritten and her colleagues to change their practice in the time around birth.

By interviewing women about their births, I gained a sense of their profound experience when the mother and baby (and father) are facilitated to just ‘be’ and explore their relationship. The women seemed to be saying that it was not just an optional extra, but that it felt ‘so natural’. I added to that my own experience and that gleaned from other midwives of watching that bond developing during uninterrupted skin-to-skin contact. The experience seemed hard for the women to put into words and they tended to look reflective, struggling to find words for their birth experience, saying words like:

‘amazing, weird, surreal, magical, relaxing, I’ll remember for ever, extra special, intimate, relaxed, rewarding, a strange feeling, relaxing yet on a high – buzzing yet calm.’

When I asked if their feelings could be put into words, Louise struggled to find words:

‘I don’t think you can, I think it’s just...um...it was just...so...nice feeling...feeling of excitement and...um...I think...mmm...I just wanted to cry really because I was shaking I don’t why but...um....I think it was the shock of ...such a rapid labour really ...no one can describe it really cos it was such an enjoyable...you know the after effects of it and it was such a nice feeling...you know a little person of your own to be on...on you.’

Ruth said:

‘Its amazing what your body can actually do...yeah...it’s a strange feeling’
Jane: '...they left us alone for over an hour...it was lovely...it really was...'
Mary: 'So what did it feel like?'
Jane: 'Phew...not sure you can put it into words...well it was just magical
.. lovely ... relaxed...very, very relaxing...'
Mary: 'So did it make you feel sleepy or just...
Jane: 'Oh no, we were on a high...we really were, we were buzzing...but ..
yeah...they turned the lights down low ... it was very warm in there .. it was
lovely, very calm...even brought the phone in so we could phone...I mean I
spoke to my mum...'
Mary: 'While he was on your chest?...that's a real family occasion...
Jane: 'Yes.'

I asked why she thought others should have the baby in skin to skin contact so
soon?

Jane: 'Because it's just magical...it was so lovely...We'll remember that forever
now...that first hour and a half we had with him....'

Karen said:
'it's just an amazing feeling that initial contact ... so having the actual body
contact rather than just physically being there .. was sort of extra special.... it
was just a .. very intimate feeling I suppose ... because it's not very often that
you sort of get that ... exposure of skin to skin because even subsequent feeds
tend to be with a babagrow on ..'

Ruth said:
'.. its just bonding, that instant bonding that you do get. It's lovely, it .. really is
nice. You don't mind that she's full of gunk and gooh ... it just felt so natural
I'm sure it feels nicer than a towel as well.'

Hannah said that she had heard that (skin-to-skin contact) made a closer bond
with the baby, so I asked her if she felt anything like that. She said:

'Yeah I did ... they can smell you and...I don't know...you're cuddling them as
well when you're not ... supposed to be...you know the rest of the time they say
oh don't pick them up too much because they get soft...especially with boys, I
feel...and .. so with this you can pick them up because you're feeding them
anyway and ...it just feels nice that you're doing that for them ...if I couldn't do
it I .. would feel a bit inadequate as a mum to be honest...'

Tracy (midwife):
'.. baby was obviously content and after that we did all the necessary checks that
we have to do to baby. She really, really enjoyed the experience .. and was
very, very relaxed so she was naturally just stroking the baby, just came
naturally to her... I think it's just the type of personality she was and the baby
very quickly calmed down, listening to her voice obviously, feeling her
touch...it was nice  and settled. Quite remarkable really.'

Helen, a midwife asked a woman, who had a long and difficult labour how she
found the experience. She described it as 'really good', Helen felt that this was a
bonus and might make up for the labour. Other midwives reported the women’s words, saying it was ‘What she wanted’, ‘was wonderful’, ‘rewarding’ or that they liked or enjoyed it. Women said that the contact felt natural and nice for baby as well.

If this kind of birth is not possible, then skin-to-skin contact alone may substitute as it did for one woman I cared for during the early weeks of the project. Rachel, who had a caesarean section under epidural anaesthesia, involving separation from her baby, was encouraged by me to have skin-to-skin contact on her return to the ward, as the baby was crying. I stripped the baby to her nappy and put her inside her mother’s operation gown. Within about five minutes she had calmed and ten minutes later she was rooting for the breast. I helped the baby to the breast, as Rachel’s movements were limited due to her anaesthesia. The baby breast fed well and I left the parents admiring their baby. Later Rachel shared that she had had a miscarriage the previous year and on becoming pregnant again, was afraid to attach to the baby whilst it was inside, in case she lost it. The decision for her caesarean section was made quite late and she felt it happened in a rush. One day she was going along as a pregnant woman and the next, admitted for surgery. When the baby was born she was taken to the paediatrician. Rachel saw her in passing, but not to cuddle. Later, when the skin-to skin happened, she felt an overwhelming closeness with her baby that was very special. This feeling was hard to describe, but it brought a lump to my throat with the depth of emotion in her voice.
Some might say that parenting should be equally shared, but Kahn (1995) argued that this denies breastfeeding and especially the first hour, with the intra-cerebral effects of oxytocin (Panksepp, 1992, Uvnäs-Moberg, 1998). Kahn (1995) described a father’s experience of holding his newborn, then passing him back to the mother when the baby started squirming. The baby opened his eyes and looked at his mother. The father in this story decided that fathers needed to work to create the bond with the newborn, whereas nature gave it to the mother and baby. Odent (1986:146) believed that men should have a more protective role in birth. He argued that today’s emphasis on men’s participation in birth was ‘feminisation’ of men. He observed that some would say parenting should be shared equally, but this denied breastfeeding and in the cycle of life there are other times when the mother is less of a focus. To expect the father to share all things equally at this sensitive hormonally influenced time could be imposing culture over nature. In the project some women valued the fact that their partner was present, and were usually concerned that he also share in the birth experience, although not necessarily skin-to-skin contact. Ruth said:

‘It was a wonderful experience and it makes you realise what your partner’s actually missing out on because he can’t breast feed, obviously, and they don’t put the baby straight onto his chest but straight onto your own and its just bonding, that instant bonding that you do get.’

Mary: ‘So, was your partner there…what did he think?’
Ruth: ‘Yeah, he was there…anxious…excited…he said he didn’t want to watch but he ended up watching and he said it was wonderful but scary at the same time…yeah he was over the moon…yeah really happy.’

Kathy said:
‘He was just totally shocked … he just couldn’t take his eyes off her … was totally immersed….’

Karen said:
‘Yes … he was involved .. he wasn’t involved in any of the handling to start with… and .. that was I suppose in a sense, negative for him because .. (at) .. the first birth (the baby) was .. handed to me but then handed to Peter and … the putting him to the breast … came slightly later … whereas this (time) I had .. the
Emotion and Embodied Praxis

This led me to try to discover more about the meaning of birth to mothers and in particular to try to define what they were trying to say. I have tried to illuminate this by piecing together clues from the literature arising from the words of the women, midwives and my own experiences. Minsky (1996) believed that no one theory could offer a definitive answer, but each had insights which could be used to analyse our reality along with other theories. Could the ability to feel and express emotion be a key to enabling deeper experiences? Lyon & Barbalet (1994:53; 54) stated that the medical body tends to be passive. It is:

‘the body the patients have, but not the body patients are in the full sense’

Yet some people:

‘experience themselves simultaneously in and as their bodies …’

The connection between emotions and actions is very complex, observed Lyon and Barbalet (1994:57), linking to the ancient limbic system of our brains. These social relations involving emotion were not just about the body as a ‘thing’, but the body as an agent. For example, when saying ‘my foot hurts’, it implies a feeling of pain ‘To say “I am in pain” indicates an emotion’. Maslow (1970:4) argued that if someone is hungry, it is not just their stomach that is affected; they are ‘hungry all over’. Emotion originates from and can have benefits in society, otherwise we would be machines, yet Lyon & Barbalet (1994:59) believed that emotion was still thought of by some as a ‘primitive’ part of us that was ‘lost’ by the development of reason. However they cited Reynolds (1981:38) who maintained that this was counter to the behavioural evidence, and that human evolution ‘does not climb the ladder of reason’. Actions have developed
simultaneously and are inseparable, using innate and learned behaviour which is non-hierarchical (Reynolds, 1981). This might be compared to the instinctive behaviour of both mother and child following birth, when allowed uninterrupted skin-to-skin contact. Lyon & Barbalet (1994) discussed Gibson’s (1966, p97) work, in describing the ‘haptic’ system which unlike the other perceptual systems, includes the whole body and its entire surface, being:

‘the sensibility of the individual to the world adjacent to his body by the use of his body.’

This is the way in which information about both the body and the environment is gained and implies an active nature. Lyon & Barbalet (1994:62) pointed out that:

‘emotion is essential to any conception of social life, as a link between embodiment on the one hand and the practical activity of social life, that is, the praxis of the body, on the other.’

The ongoing research into links between the brain, our behaviour and the immune system (Panksepp, 1992, Uvnäs-Moberg, 1998, Sanders, 2006, Cohen, 2006) are showing that there is still much more to discover about how our bodies work.

Ots (1994:116) suggested that in medical anthropological discussions, it had:

‘become practical to speak of … culturally inscribed, shaped or destined bodies.’

Elaborating on the meaning of the word ‘body’, Ots explained that in German, the word for body is körper, the objectified body, almost meaning a container to be filled. Contrastingly, the leib or living body is known as:

‘my body with feelings, sensations, perceptions and emotions.’

Leib is related to the Old English word for ‘life’, but has no equivalent in modern English, so making translation difficult. The word leib makes another aspect of the body more accessible, one which is more individual and more aware of life.

Ots (1994:117) said that:
‘through my leib, I am inserted into the world.’

Something has to touch us before it becomes personal, which means we are affected in some way or moved by it. As Ots (1994) observed:

‘someone’s grief becomes mine if it “presses down on my chest” or hits me in other perceivable ways.’

Culture and social relations, says Ots (1994), could limit the leib, for example if they were highly structured. The Chinese concept of the body places the mind within the heart, according to Ots and this is believed to be the basis of health. Emotions are understood as ‘the utterings of the body’, which in excess can harm the body, so emotional behaviour or the leib in Chinese culture is stigmatized.

Petr (2000) explained that in Traditional Chinese Medicine, yin and yang are opposites but inseparably paired, for example, the body and qi which is dynamic essence. Without this mutual interconnectedness, no change would be possible.

Ots (1994:118) researched a public group activity in China called ‘qigong’ where breathing therapy was practised for health reasons. Some qigong groups started using movements and sounds, such as dancing, crying and laughing. The establishment accepted qigong as beneficial, but tried to suppress the ‘emotional’ ones. Explanations were offered for the spontaneous movements, such as the expression of suppressed emotions. When interviewed by Ots, the explanation given for the culturally stigmatized spontaneous movements was given in a culturally accepted way. Not initially, but over time, the interviewees revealed a complex emotional world. This meant that they had to learn to trust the researcher before opening up their feelings. One man admitted that it helped free suppressed emotions but would not write about it because it would have meant not being taken seriously. One person, reaching the spontaneous movement stage, gave way to (Ots, 1994:127):
‘a feeling of his unstructured leib which was intimately connected to happiness.’

Ots (1994:134) observed that:

‘...the leib cannot be thought of, it must first be experienced.’

He suggested that the structure of society would define the way that leib was understood. It could make us deny it, diminish it or change its expression, and as he found in China, superficial observations might not find the true leib. So if through skin-to-skin contact, women are enabled to experience leib, it could be connected to happiness and well-being.

Jouissance, Pleasure and Love

The closest description that Kahn (1995:16) could find of the joy or happiness of birth was that by Jameson (1983) who used the translated work of Barthes (1975) to discuss ideas of ‘jouissance’, which Kahn interpreted as:

‘an experience that is “sexual, spiritual, physical and conceptual at one and the same time.”

This was the one word which began my search for the meaning of the first moments of birth for mother and child. The words above may sometimes be difficult in our culture, which contains no adequate words for the nuances of meaning for the many faces of love and sexuality. When I began my midwifery career in the 1970’s, midwives would exclude a woman’s partner from any occasion which might imply intimacy. When vaginal examinations were performed, the man had to leave, as if he had never been involved in anything to do with the reproductive act and conception, not to mention ‘love’ whatever the word was taken to mean. The establishment then had only just started to ‘allow’ the partner to be present at the birth.
My search for the meaning of jouissance led me to Lacan’s theories, the role of the unconscious mind and psychoanalytic theory. Minsky (1996) explained that psychoanalytic theory proposed the central role of the unconscious in all identity. It suggested that all meanings could be misunderstood and psychoanalytic theory was powerful in helping to find new ways to understand the complexities of our social world. There are two different psychological spaces, the Self (Ego) or what we consciously think about ourselves and the Other or unconscious. Fink (1995) Lacan’s work to describe ‘Otherness’ as something that is foreign or alien. He proposed that it was only by touching the Other that change could happen. This has relevance then, to the women I interviewed and my own experiences and perspective transformations. Rich (1977) believed that though mothers always carried the imprint of their birth experience, they could not always understand it. As a new mother, with a constant lack of sleep, Rich (1977:32) explained:

'I remember thinking I would never dream again (the unconscious of the young mother – where does it entrust its messages, when dream sleep is denied her for years.)'

Minsky (1996:16) pointed out that:

'The words ...through which we structure and interpret the world consciously, have meanings we can never totally pin down because of the ever-present potential of the unconscious to disrupt meaning.'

Your mind sometimes knows things that you have not consciously asked it to, like the waking moment in the early hours of the morning, where insights related to the study of the previous day surface, words which must be written down or risk being lost for ever. The unconscious mind had perhaps assembled all the reading and thinking that had been done disjointedly and joined it with life experience and skills, to make something bright and shining ‘new’. Fink (1995:43/4) observed that people who stated they were ‘the author of their own ideas’ e.g. ‘I am the
kind of person who ...’, reject the unconscious mind. They seemed to be saying that they knew all about themselves. We may do something because of events in our life or conscious choice, but when we cannot explain why we have done something, perhaps out of character or incongruent with our intentions, we try to find a ‘rational’ explanation for it. Psychoanalysts believe that ‘thinking’ plays a smaller part in actions than previously believed (Fink, 1995:20). The unconscious is not what you ‘know’ about yourself, but what registers despite yourself. As Fink (1995:23) stated:

‘you don’t actively grasp it, but rather passively register it.’

Perhaps this enriches the part of the unconscious that Lacan called the ‘real’.

Lacan believed that a newly born baby had not yet been influenced by language or taught how to live in society. He named this time ‘real’. Once language (the Symbolic) and social rules start to be taught by the parents, as they must be if the child is to grow and learn, this will overwrite the ‘real’. Lacan (Fink, 1995:23) said that:

‘“the letter kills”: it kills the real which was before the letter, before words, before language.’

In other words, reality cancels out the real. During socialisation, the body is progressively overwritten with experiences and a baby’s ‘real’ is influenced by others. Fink (1995:94) argued that animals have instincts which tell them what to do in certain situations. He believed that humans did not have this, but must first have had chance experiences to build upon for their actions. This is clearly not the whole picture, because no-one tells a newly born child to act out the pattern of survival in searching for its mother’s milk. The newborn ‘real’, with no imposition from outside to change, can lead to innate survival patterns. Only if we impose our symbolic onto it, by wrapping or separating the baby from its mother,
will we prevent its occurrence. Returning to Fink’s argument, when a baby cries its parents must decide what its needs are, which could be due to such things as cold, hunger or loneliness. If the parent responds to all these needs by giving food, the discomfort, coldness or pain will be understood by the baby as having ‘meant’ hunger (Fink, 1995:6), and in this way, the Other is shaped. Fink (1995:27) suggested that the newborn’s ‘real’ was never completely lost, some residue would always be there and this could be symbolised as real 2. So we all have the real but it is overlaid.

Fink (1995:61) believed that existence was gained through language, but ‘being’ was supplied only by reaching the real, which perhaps could be achieved through intense emotional experiences. I wondered how else the ‘real 2’ of the adult might be reached. Consider the influence of a drug where I am not ‘myself’ alone, but my self is influenced in some way by the actions of the drug. When a woman is birthing and breastfeeding her baby she is influenced by hormones from the limbic system which reach back into our ancient history. Hormones such as oxytocin and beta-endorphins are meant to ensure successful birth, breastfeeding and continued mothering, through a time when life might be difficult with sleepless nights and a high demand, hormones for the survival of human kind. A natural birth, skin-to-skin contact with the baby and influences from a cocktail of hormones (Buckley, 2003), might make it easier to reach Lacan’s real 2. The mother may feel it, reaching something, some feeling, some emerging new language for this experience, as the mothers tried to do when I interviewed them.
Skin-to-skin contact can be an intense experience which may also be related to pleasure. Barthes (1975:17) wrote about this, but found it hard to describe, saying it was:

‘...that moment when my body pursues its own ideas – for my body does not have the same ideas I do.’

He elaborated on this, saying that it might be impossible to speak about it, only to speak in it, suggesting that experiences are felt, but words are elusive. Braunstein (2003:103) drew on Lacan’s theory of desire and jouissance, saying it was a complex term but that:

‘If we think about the loss in meaning that is sustained in going from jouissance to enjoyment, we will realise that jouissance is not a feeling of pleasure or an experience of joy.’

Lempiainen (1997) discussing Irigaray’s work believed that jouissance and sexuality were easily mixed when reading, but they were not the same. She felt that trying to understand the concept was like:

‘trying to catch something but just when almost reaching it or grasping it, it slips and fades away.’

Lempiainen (1997:108) is saying that jouissance resists definition, yet it may be that both jouissance and pleasure could be a way to connect to Lacan’s real.

If we try to discipline the body Jameson (1983) argued, it could limit its effectiveness or even damage it, by trying to perceive with our rational, cultured self, rather than hearing the fainter vibrations of the ‘libidinal body’ itself.

Jameson (1983:10) attempted to put his own words to the almost indescribable feelings of jouissance, saying that as you tried to describe the ideas of things into images or names, there might be a break in the process, when:

‘suddenly that taboo and unimaginable “outside” breaks the thread for an instant: this fresh, wet air of spring on my face .... Pleasure is finally given the consent of life in the body, the reconciliation – momentary as it may be – with the necessity of physical existence in a physical world.’
Jameson believed that this pleasure was a personal thing, involving a relationship between the body and nature. Perhaps immediately after birth, the baby may still be thought of as a part of the mother’s body, as essentially in survival terms, it must be. So here Jameson seems to be saying that what comes out of experiences is for us to discover. We may well benefit from being open to respond to events, without interference from our busy and overfull ‘sensorium’. Life in our quick fix society tends to be something that we have to ‘get on’ and achieve, like linear time, rather than letting it unfold at its own pace. Early in this project, some people seemed to feel that waiting a whole hour for a baby to find its way to the breast was a long time. This echoes my experience with the paediatricians who could not even wait ten minutes for a video to show highlights of this hour process, but wanted to get on and put the baby to the mother’s breast themselves. Jameson (1983) asked how people could distinguish between real pleasure and mere diversion. He discussed the huge expansion of the leisure industry and how it invades our unconscious selves. What we class as pleasure in this sense has perhaps subtly changed our expectations. We might have been affected by ‘images of things’ rather than real life itself, like people who live their lives second hand through soap operas and television stories. The rise in emphasis on production in late capitalism said Turner (1994:27), has emphasised the:

‘… plasticity of personal identity.’

This means that people may feel able to produce their own social identities, rather than just taking on that of their family or community. Lyon & Barbalet (1994:51) however, believed that our perception of what we are is influenced by consumerism such as advertising, and this is relatively passive. We are influenced to want goods which are meant to help our pleasurable experiences, but also to be
able to express 'the self'. The body could be seen as a possession, used for such things as social advancement, display and impression management (Goffman, 1959). Doing nothing may seem like idleness, or time wasting, but it is perhaps necessary to enable us to listen to the deeper voice from within us and respond to it without the pressures of our civilised, cultured, leisure or pleasure values. It may be that a 'natural' event cannot be disciplined or repressed, if it is to unfold as it will. Any interference could change what is 'natural' and substitute our own socially constructed 'normal'. This reminds me again of the Buddhist saying previously quoted by Kahn (1995):

'Sitting quietly/doing nothing/spring comes/and the grass grows by itself.'

The feelings experienced by skin-to-skin contact, if seen in a limited way, without any depth of knowledge as to its value, could be seen, suggested Jameson (1983), as self indulgent, or even corrupt, perhaps vaguely 'earthy' or related to sexual pleasure. Fink (1995:60), also revealed that jouissance had two sides, both the innocently pleasurable and the disgustingly repulsive. Skin-to-skin contact without the sacred context of birth and a mother's love could be seen as a dark side of jouissance, just as rape is the dark side of sexual intercourse within a loving relationship. Jameson (1983:14) felt that the right to a specific 'pleasure' if it was to escape the complacencies of hedonism, must be able to:

'stand as a figure for the transformation of social relations as a whole.'

Skin-to-skin contact in the right environment might be a profoundly satisfying and deep emotional experience, but it is also soothing for the separation distress cries of the newly born, and seems to have a protective function in our survival, dating back to ancient times. Kahn (1995:386) pointed out that:

'It takes nothing away from women's lives to acknowledge the maternal body; it does not mystify or glorify women to feel the 'goddess' in simple acts of the
body-in-relation. Surely, if the sacred is not immanent in ordinary life, where ought it to be?’

Farwell & Maiden (1992) remind us of the spirituality of birth in other cultures, such as in Tibet, where childbirth is a sacred moment. Western culture as previously stated is unusual in not having spiritual rituals around birth, as birth in hospital tends to reinforce the medical model (Walsh, 2002). Fink (1995:25) argued that because of socially constructed reality, the implications were that if there were no words in that society to describe something then it was not seen to exist. Kahn (1995:118) found that women who had no spiritual language had difficulty expressing their feelings. Some people might require help to put words to these experiences just because they are so hard to describe. Kahn (1995:75) emphasised that women have mostly ‘silent words’ that belong to birth, which go unrecorded, because childbirth whilst so common is not visible. She suggested that there was a language, but that it was deeper than words and came from experiences of the body. Belenky et al (1997) found that some women in their study were seen to be ‘silent’, as they depended on others for a voice. They never came to see themselves from the inside. Some women however, found that childbirth was a turning point in starting to value themselves. Kristeva (1986:206) highlighted that:

‘The arrival of the child ...leads the mother into labyrinths of an experience that, without the child, she would rarely encounter: love for an other, a slow apprenticeship in attentiveness, gentleness, forgetting oneself – without masochism, or destroying your own personality.’

Is The Baby Real?

Women I interviewed in the project, struggled for words to describe their experiences, but demonstrated it without words, by their emotions, in the telling of their stories and maybe in tears. When the baby was first born, the mothers seemed to be telling me that the baby was almost a stranger and there was a sense
of shock that this baby was here. Klaus & Klaus (1985:106) also observed that as soon as the baby was born the mother began to replace the imagined baby with this real one, which was often very different. Emotions were very apparent, as one woman described to them:

"That he was real is overwhelming. Somehow when he's inside he's real but isn't real and then when he's on the outside you think, my goodness, it really is a baby and somehow it's a surprise. He was looking us over and looking the world over. It was a two-way kind of thing that fascinated me. He was responding to us but he was a stranger. I was delighted to have him but in some other ways we were discovering each other with the child. We were a threesome."

Skin-to-skin contact is not the beginning of the relationship, intra-uterine time is, but it is an important re-affirmation of identity. One new mother said to me:

"I can't believe that this is the baby inside me."

Ruth said:

"... I think for some people you don't believe you're actually expecting a baby until the baby's there and it's just like the reality kicking in ..."  
Mary: "...When they're inside and they're kicking you, they must be a very real person and yet when they come out what's the difference?"  
Ruth: I don't know... it's just really strange when they're inside, it doesn't feel real at all...well it didn't for me...other people might have different experiences, but to me I thought, 'yes there is a little person in there', but it wasn't until she was actually born that you think my (goodness) we produced this little bundle."

Kathy said that she was shocked. When I asked Sue what it felt like she said:

"...I was bit shocked really when she was born that she was a girl because I was convinced I was having a boy..."  
Sue's baby was taken away for a short time at birth and she remembers saying:

"... "Give her to me", you know, I wanted her...and then...when they put her on me I was just shocked and ...amazement really that I'd got this little girl cos I wanted a girl secretly...but I was a bit convinced that it was a boy maybe just because I had a boy already...I just couldn't...believe that I'd had a girl...it was lovely really."

Louise could see a comparison with the baby kicking her inside, she said:

"It was such a nice feeling for me to have .. and then she was kicking me (inside) once when I had...the midwife...seeing to me and she (the baby) wouldn't let the monitor be put on her cos she kept kicking out...so I could tell that she was going to be a lively and kicky baby ... and the moment she came out she was...kicking .. and .. trying to communicate with me and...just looking around and seeing."
This early time seemed important for mothers by completing the transition from intra-uterine to external life. Kahn (1995:42) discussed the closeness of a mother-child relationship which reaches back to the birth, where:

'The body imprint of our beginnings was like the criss-cross grass sticks mark left upon the hand I lean on, when I take it away from the ground.'

Kahn (1995:94) created the word 'maialogical to represent the mother/child dyad. 'Ma' is described as the root word derived from the child's cry for the breast – thought to be a universal language and found in many parts of the world. She said that:

'A 'maialogical perspective envisions a dialogic relationship based on the subjectivities grounded in the body, beginning with the original dyad of mother/child and moving outwards .. The act of birth becomes a kind of language exchange through the body ... ushering into society the child, who, in turn, from birth "speaks with its body".'

Kahn (1995) reported that some anthropologists said that no part of human life escaped influences from culture and history, yet she believed a maialogical lens could spot one that is, that is a birth that is undisturbed.

The Gaze Between Mother and Baby

Klaus & Klaus (1985) produced a classic book that is almost all pictures of the time following birth. In some circles this might be considered light reading, but the pictures of newborns illustrate the point they are making, more than a page full of words. This is perhaps a way to reach the leib (Ots, 1994), or real (Fink, 1995) part of our selves. It is, as they say, a book for watchers, who may see startling sights, if they have the eyes to see them. If there is a quiet, dim environment, and handling is minimal, the newborn begins to adapt to the world. It is quiet, alert, hands touch the mother's skin, its eyes open wide and it looks at
its mother. This eye contact is very special, as perhaps Leboyer felt. During interviews by Klaus & Klaus (1985:104) mothers reported feeling:

'warmly close to their infants after the infant has looked at them, acknowledging the importance of relating to the baby through eye contact.'

This demonstrated an innate ability to communicate. Before the mid 1960’s, it was believed, despite mother’s observations, that the newborn brain was at primitive level. For embodied praxis to be effective, you have to be in the right place at the right time. For birth, this means being influenced by birth hormones, then experiencing undisturbed skin-to-skin contact with your newly born child. Odent (2001a) described the surge of catecholamines just at birth, leading to a state of alertness, giving energy to the mother. This happens for the baby too causing it to be wide eyed and with dilated pupils. According to Odent (2001a:S42), this made the mothers:

‘fascinated and delighted by the gaze of their newborn babies.’

Eye to eye contact is an important feature of a beginning relationship and this meeting of eyes between the mother and baby was something that I witnessed several times during the project. When the baby had calmed and rested, this was usually followed by a period of activity prior to breastfeeding. The baby started to look around and the first gaze was connected between mother and child – a ‘heavy’ moment, almost of frozen time. That gaze reaches parts of the brain that are receptive, meeting a ‘stranger’ yet someone known already from inside. ‘Is that really you’ the mother seems to be saying. One birth I witnessed encapsulated this very intimate moment which had a profound effect on me and thankfully was recorded on video. Mother and baby a ‘part’ of each other in pregnancy but not seen; birth is strong and heavy; after birth, the baby is full of adrenaline to survive.
transition to extra-uterine life; resting a moment, adrenaline subsides and facial
description and colour improves. Then the baby pushes upwards towards 'that
smell'; he pauses and looks up, meeting his mother's gaze; she says softly 'Hello'.
A world opens up, which is full of emotion and tentative beginnings, a connection
and introduction. 'Who are you?' she seemed to say 'Is that you?'. Rich (1977:32)
wondered how mothers and children survived the struggles of the early years,
saying that:

'Probably that mutual recognition, overlaid by social and traditional
circumstances, was always there, from the first gaze between the mother and the
infant at the breast.'

A woman, for whom I provided care, had a difficult birth, where the baby was in
mild distress at birth and needed some simple resuscitation. As soon as possible
he was returned to his mother in skin-to-skin contact, looking irritable and
'worried'. Within about ten minutes he became 'pink and contented', with a rosy
glow about him. After about 20 minutes, he was alert and having slight hand to
mouth movements. His eyes were wide open and he was looking up at her,
meeting her gaze. I asked Jane about this at her birthing, she said:

'I mean he was wide awake then for that first hour...he was absolutely
wide awake...'
Mary: So did he keep looking up at you?
Jane: 'Yes...'

These stories seem to be about the discovery of love. Dolar (1996:132) told of
stories of love, observing that 'Their eyes met' is common to all cultures, legends
and literature. Dolar explained that love is often prescribed, for example, you
cannot choose parents or country of birth, because that choice has 'always
already' been made and society expects us to love parents, family and country.
Love is classically represented by the gaze and the return of the gaze is of vital
importance. This is said to recognise what has “always already” been there, since the beginning of time’. Dolar (1996:133) believed that this first time was already a repetition and that:

‘seeing the beloved for the first time one recognises him/her as somebody one has always known.’

Perhaps for once we see instead of just looking. When the fetus is inside the uterus or just born, women may have difficulty in identifying with the ‘person’ of the child. The baby has ‘always’ been there and yet now is ‘really’ there, someone who is always already there to be loved. Carter (1998) pointed out that scientifically, love was a hypothetical concept which was rarely investigated, as it was seen to be beyond experiment. For this reason, researchers usually looked at attachment, which might be thought of as the same thing. There are similarities between romantic love and parental attachment, because the same biological processes are involved. Social attachment provides a sense of belonging, security and so reduces stress. After birth, a complex interplay of hormones (e.g. cortisol and smell) influence both mother and baby by facilitating the development of attachment (love) which is beneficial to both in terms of survival and quality of life. Carter believed that oxytocin may increase the mother’s tolerance of her newborn baby, so could strengthen maternal behaviour by making her want to be with the baby. The hormones at birth, prolonged contact with the newborn and endorphins have a role in attachment, provided it is not disturbed. Although human attachment is complex, Odent (1986) believed that early contact helped the newborn’s capacity to love. Maslow (1970) proposed the idea that a child started to show first signs of interpersonal ties and selective attention, some months after birth. This famous philosopher would almost certainly not have seen the newborn gaze, because men were not involved in birth. This knowledge however, was
perhaps held by some women. Gilligan (1984:77) discovered ideas emerging from
women with whom she was discussing morality. They spoke clearly not about
justice, but about care and response to people and problems of responsibility in
relationships. She said that women:

‘in talking about morality were in fact talking about love.’

She felt that it would be too simplistic to divide this equality by gender, but
believed the emphasis existed. Gilligan (1984:79) said that Western thoughts were
founded on a fundamental separation between other and self, whereas women,
repeatedly ‘blur the distinction’. Gilligan (1984) described comments of girls that
portrayed connection, such as in activities of making friends which contrasted to
boy’s words, which were more about separation. Perhaps this could be something
like the maialogical bond between mother and baby (Kahn, 1995) and that of
Davies (1990) discussed earlier, of marking out a space in time.

Irigaray (1996:109) discussed issues of love in society, explaining that to say ‘I
love you’ risks making that person into an object, or the property of the other
person. She would like to substitute ‘I love to you’, highlighting that:

‘I love to you means I do not subjugate you ...I speak to you, not just about
something; rather I speak to you.’

The ‘to’ guards against depriving another of freedom inside a relationship.

Irigaray felt that we should be able to be quiet and listen to other people, without
our own agenda. This seems to be saying that there must always be the possibility
for change; otherwise I would not really be listening. Listening to you means that
I must be ‘available’ and capable of not speaking. This gives you the space to
show your self:

‘a still virgin space-time’ (Irigaray, 1996:118).
This reminds me intuitively of skin-to-skin contact between the mother and baby. The newly born is enabled to be itself and speak to its mother, not wrapped up and silenced, as a possession of another person. I Love to You, means that I offer to you my body heat and my skin which comforts you; my smell of pheromones and colostrum which draws you to my milk, your life sustainer and my arms which will protect you.

The Voices of Women
Mothers and babies have been influenced down the ages by culturally imposed rituals surrounding birth (Van Esterik, 1989, Helman, 2001), with our present technological age seeming to support separation. Women who choose this separation might be guided by this ideology thinking that it is ‘normal’. In Chapter 2, I discussed the physical and psychological benefits for uninterrupted skin-to-skin contact at birth, yet a woman’s perception of the cultural ‘norm’ must be respected. Despite this, because of the available evidence, both in Chapter 2 and this Chapter, it would be empowering to offer women full information to enable her to make choices about what happens at birth. Time is a part of life, yet by adding pressures to complete an experience quickly and move on, the experience of cyclical time might be missed. Comparisons by women who had experienced both separation and contact after birth valued the uninterrupted time they had with their newborn babies. Uninterrupted skin-to-skin contact between mother and baby has the potential to enhance emotional well-being. Writers such as Barthes (1975) and Jameson (1983) seemed to be on the verge of defining this embodied praxis yet the experience was almost beyond their vocabulary, a difficulty shared by some of the women in the project.
Kristeva (1986) believed that more and more women were finding that childbirth was indispensable to the discovery of all that being a woman entailed. Martin (1992:163) critiqued Odent’s words about birth, where he described women moving back down time, to a simpler animal like, unselfconscious state. She felt this was like relegating women to the ‘natural’ realm rather than to culture. Whilst I can see the point of Odent’s comments relating to the primitive brain, Martin (1992) also has a valid point and perhaps we should be seeing birthing women as engaged in a ‘higher order’ activity, where the body and mind are integrated.

Lempiainen (1997:107) argued that if the male is the subject called ‘A’, then the woman, by inference must be ‘minus A’. She pointed out that writers like Irigaray would like to create space for B’s, and C’s, which would discover a woman not defined by male values but newly written. Irigaray (1996:20) suggested that:

‘...it is not a matter of changing this or that within a horizon already defined as human culture. It is a question of changing the horizon itself – of understanding that our interpretation of human identity is both theoretically and practically wrong.’

It would be better to become ‘this’ woman or man, said Lempiainen (1997:30) with each gender reaching from the natural to the spiritual and from nature to culture and defining woman by looking at woman and not comparing her to man.

Kristeva (1986:200) stated that there was an urgent issue for women, that of finding their place, both in what had been handed down to them and in what they want it to become. Kahn (1995:5) would like to be part of movements which are trying to create new images and write new words for birth.
In Maslow's work on motivation (1970:22), basic needs have to met, at least in part, if other higher needs are to be attained. Maslow said that self-actualization is the need to become everything that we are capable of, that is:

'what humans can be, they must be.'

If these higher needs are gratified, it would tend to have health benefits, such as more happiness and richness in life, more self respect and love for others. Perhaps some (many?) women are being encouraged to be content with more basic needs such as surviving the day of birth and beginning parenthood, rather than achieving more life enhancing experiences. Kahn (1995) believed that finding a language of birth was vital, but the challenge was not to replace one single view with another. She felt that she learned a lot about her body by giving birth, not least that her body was that of a woman, not a body that was not a man's. In other words, her body was doing unique female things, which were fundamental to life. Martin (1992) also observed that the maternal body had the potential for strength as women were used to a constantly changing body. Kahn (1995) suggested that telling stories, in other words valuing personal experience, could enrich our understanding in a deeper way and grand theories might turn out to be no more valuable. Whilst my reading of theory to illuminate women’s experiences of skin-to-skin contact is not 'proof' as such, in life there is always more fullness that could be experienced. Until recently in our evolution, Odent (2001a:S45) believed that women could not deliver babies and placentas without releasing a complex cocktail of 'love hormones'. He observed that in many countries today, most women have babies without fully releasing these hormones and he felt that we needed to raise questions about our civilization. All the more reason then to re-
discover the ecstasy of birth described by Buckley (2003) and the need to value
skin-to-skin contact and the time it takes, in the right atmosphere.

Conclusion

A woman’s body is not inherently faulty, but it needs the right atmosphere and
circumstances to show its true potential. We should at least consider the
alternatives when separating mother and baby to conform to linear time or the
socially constructed equal sharing of roles with modern men. If fathers knew
about the maialogical bond in the time around birth (Kahn, 1995) they might
value their role in protecting the mother and baby at this vulnerable yet special
time. An ideology which valued the earth’s pulses in cyclical time and quietly
listening to the language of women, might value nature’s time as vital to the well-
being of our society. If women knew about the potential for a profound emotional
experience it might help them to discover their potential for embodied praxis or
jouissance, which could enrich their unconscious minds, the ‘real’ and make
something new by allowing it to unfold as it will. This might add spiritual
dimensions to birth and allow for mothers to feel the impact of that gaze, that
connection with their newborn and encourage love to develop.

Midwives have a role in enabling women to see birth through the mirror of love,
so that this might reflect back onto the events around birth and could facilitate the
weaving of time, rather than influencing it, thereby encouraging women to be
more open and to expect more at the first meeting with their baby and so learn
more about themselves and what is possible. Some women may never know that
there is more, which is like living in the cellar of your life, thinking it is the
penthouse suite. This does not mean that we should not try to tell them that there is more to be experienced. At some point in our busy lives perhaps we could all make a space with cyclical time, to renew our strength and feed our soul. Some might say ‘what’s the point’ (of that). Others might reply that there does not have to be one, but emphasise the importance of valuing the here and now rather than rushing headlong down linear time and missing life. One small event can alter the course of life, such as having a midwife who encourages skin-to-skin contact which could change the course of a woman’s whole life.
Chapter 8 Discussion and Conclusions

In this Chapter, I outline the main findings of the research showing how its aims were met and highlight the practice knowledge which was generated. The value of action research as a strategy for change and my own learning will be addressed along with what I might do differently if I could repeat the study. I will address the limitations of the study and make recommendations which arise from it regarding midwifery practice, education and future research.

This action research project undertaken in a small maternity unit, used facilitation and collaboration to enable midwives to provide evidence-based care around the time of birth, thereby becoming empowered themselves and potentially enabling the women they cared for to become empowered. Before the project, power was used to shape women’s choices by the application of medicalised routines and time restraints around the birth process. Collaboration through focus groups and other discussions ensured that midwives were involved in planning, acting and evaluating the way that the changes were made, so that the strategies were owned by them. Skills-based education, role modelling and support were a crucial part of its success, enabling the midwives to offer women information for choices about breastfeeding and uninterrupted skin-to-skin contact at birth so that it became a more realistic option. Data obtained from individual interviews of women who had experienced skin-to-skin contact enhanced the value of the change. Midwives who had facilitated it provided ongoing examples of its implementation to encourage those who had yet to try it. Whilst enabling the changes, this sharing of stories from the interviews with women and experiences of facilitation from midwives also provided a basis for a new language about birth. At the end of the
project, women received breastfeeding information antenatally, which was reinforced when in labour, with the choice of uninterrupted skin-to-skin contact being offered and taken up in most cases. This meant that the aims of the study, which were to increase midwives knowledge of breastfeeding and implement best practice standards, so improving women’s choices, seem to have been met. An important point to celebrate is that through the action research process, midwives achieved change, even though they were relatively disempowered.

Limitations
This study cannot form any basis for generalisation to all midwives and women in the UK, as it was carried out in a small maternity unit and strategies used were individual to that particular culture, however there are valuable transferable concepts, as well as insights about how to approach an action research project and how to survive it. There was no absolute proof that the aims of the study were met regarding the increase of midwives knowledge, apart from the number of women having skin-to-skin contact and the midwives ability to discuss it, both informally and in meetings.

Due to limitations of time, some aspects of the inquiry were beyond the scope of this study. There was no information on whether the midwives were giving information effectively, except for my interviews with women which took place relatively early in the change and later interviews might have added more knowledge. Most interactions between midwives and women were not observed and only a small number of the many women accessing the service were interviewed by me.
Power and Culture

This thesis provides an illumination of events around birth, not least in their inherent power structures. It extends midwifery knowledge because it has shown the effects of both diffuse and hierarchical power, in this case the imposition of medicalised routines by midwives on a potentially normal birth. Critical social science, which includes aspects of critical feminism, recognise the effects of dominance on people’s lives and seeks to enlighten and transform. I have discussed in Chapter 5, the complexity of power and that people can add to it unknowingly because of its implicit nature in the routines of daily life (Foucault, 1977). Hidden power can control the agenda determining the care offered or alter a person’s world view (Lukes, 1974) so that they perceive no alternative to the care they are allowed to have by professionals. Before this project, women lacked information or were given partial information about breastfeeding and contact with their babies after birth which reinforced the power structure. The pressures of linear time were an issue for midwives, with the needs of the institution being paramount. Routines were enacted which reinforced separation of mother and baby as in the necessity to complete case notes which required details about the baby’s weight. There was a fear of forgetting some part of the routine if it was not done before transfer of mother and baby to postnatal ward. This demonstrated Foucault’s (1977:137) ideas of the use of disciplinary power which supervises time, space and movement to show what ‘proper functioning’ should be as defined by those who hold power. This regulation allows efficiency, with speed being seen as a virtue. However, as Foucault (1988a) emphasised, we should not apply blame, but look for the contingencies behind what is done. This enables a return to the discussion in Chapter 5 (p151) where Foucault’s (1977) ideas of
prison were used to illustrate the power that a hospital can hold to alter birth practices. My original interpretation:

'Childbirth in hospital produces ways of giving birth that reinforce hospital', can take on a new meaning if childbirth becomes more focussed on women's needs and a gentler way to introduce a new baby into the world. This study, by addressing these contingencies has added to knowledge of how the context of midwifery care can be changed.

What happens to the maternal body during birth, as has been argued, is socially constructed (Davis-Floyd, 1994, Jordan, 1997, Helman, 2001, Adams, 2005,). When looking at birth, the issue of defining the meaning of 'back to nature' could be difficult. Authoritative knowledge usually governs events, as with a medicalised approach which reinforces separation of mother and baby. This technocratic ideology, where separation of mother and baby has held sway for at least the last few decades, may guide what women view as 'normal' so that it could be seen as the right way or even the only way. Women may seem to choose, yet be guided by their implicit cultural values passed on between generations. Actions or rituals could be guided by professionals to regulate women with choices being adapted to fit current practice, as found in a qualitative study by Kirkham & Stapleton (2004) of midwives’ provision of information to clients. It is impossible to imagine with any certainty what might happen with a completely natural process, yet there seem to be common features which can be observed during an undisturbed birth where after a period of enhanced recovery from the birth, the mother facilitates the baby to find its way to the breast (Widström, 1987, Righard & Alade, 1990, Kahn, 1995, Tritten, 2002, Buckley, 2003). Midwives
then, could never insist that any one way was right; however culture is not static and can be influenced by others. This gives some leeway in providing evidence of an alternative way, providing that it is balanced and full to enable informed choice rather than informed compliance (O’Cathain et al, 2002).

Whilst there is a large and growing evidence-base about the benefits of breastfeeding and skin-to-skin contact (Chapter 2), it might not be the choice of all women and as described in this study, some women chose not to take it up. It could be argued that uninterrupted skin-to-skin contact might come to be another imposed ritual, influenced by whose knowledge was authoritative and on whose territory the birth took place. A different power may have been exerted on the women in our project by being given information about skin-to-skin contact, both antenatally and in the birth rooms, along with the picture sequence on the walls (Appendix 3). There could be a dilemma if this ‘new’ knowledge were given in a prescriptive way, meaning that one set of rules was replaced with another. If used to coerce women, then this might be judged to be oppressive depending on whether the written statements in the new information leaflets and portrayed in teaching sessions matched the actual actions carried out by the person who interpreted them (Foucault, 1972) i.e. coercion not information. The BFI 10 steps (WHO/UNICEF, 1989) (Table 1) were meant to be evidence-based guidelines to enable informed choices for women. If however they were communicated in a way which implied blame for those who did not comply, then they could be seen as coercive.
Dykes (2004, 2005) undertook an ethnographic study in a large and busy maternity unit. This had a strong breastfeeding culture, underpinned by the Baby Friendly Initiative (BFI) guidelines, but which also had midwifery staffing challenges. Dykes found evidence of some procedures such as uninterrupted skin-to-skin contact (BFI, Step 4) being implemented in a ritualistic way, where midwives might follow the letter, but not the spirit of the BFI. Complying with Step 4, in a regimented way rather than in a relaxed, supportive atmosphere could mean that women perceived what was implicitly being required of them i.e. to hurry up, so negating its benefits. This procedure might be a new extension of power, but in this instance, something that we agree with. No doubt the infant feeding advice given in the early 20th century (Van Esterik, 1989) was given for the same reason, albeit entirely without the more credible evidence-base of today. The Baby Friendly Initiative could contain elements which might be interpreted and implemented by individuals in a coercive way, and as discussed earlier some of the midwives in the project did perceive it as a hierarchical, almost punitive set of rules. For this reason, in our project I always spoke of evidence-based practice rather than referring to the BFI. Foucault’s (1988a) example of a narrow path, where only one could walk at a time illustrates the tendency of people to interpret their chosen belief as the only right way, giving no-one else the opportunity to voice an alternative. However, if there was coercion, I was not aware of it from the interviews with the women and the midwives or in the clinical areas apart from Kathy’s comment (Chapter 5:158) where she perceived hints of condign power from her midwife on postnatal ward when she was allegedly told, ‘You’ve got to feed your baby’. Based on the computer records, many women apparently chose not to experience skin-to-skin contact or ended it early. I use the word
apparently chose', because it cannot be proved whether there was any midwife influence on this. It is important that we do not create a new ideology which overpowers women, thereby removing their choices yet again. However, they do deserve to be given the best available evidence which might open their eyes to see how they have been constrained by limit situations (Freire, 1993) potentially masking the unique experiences of birth and its value to both themselves and their babies.

Education (including role modelling and support) gave midwives potentially empowering knowledge in both theory and practice whilst information given to women raised their expectations so that they could ask about breastfeeding and skin-to-skin contact. The knowledge given to the women would help to reduce the power of the hospital as a place 'owned' by the professionals, and the actions that sustained it with women becoming docile bodies (Foucault, 1977) in the charge of professionals. This might reduce the idea that childbirth needs our 'help' and encourage it to unfold in its own way, as with the uninterrupted actions of skin-to-skin contact of mother and baby and breastfeeding. Midwives could gain satisfaction from helping women to achieve something unique to them, rather than expecting them to be grateful for favours bestowed from a professional power base. Examples of separation were provided by women in our project, from their previous births (Chapter 7) where they described a very different experience of being separated from and subsequently in some cases not as close to their babies. Helen, a midwife thought that undisturbed skin-to-skin contact might make up for a woman's long and difficult birth, perhaps providing mother and baby with mutual comfort (Chapter 7, p240). Rachel, who had lost a child in a previous
pregnancy, had a caesarean section this time and felt a lack of emotion for her baby at birth. She had been afraid to allow herself to feel love for this child as a protection against the pain of loss if it happened again. After the birth the baby seemed distant as she was not offered skin-to-skin contact. On arrival on the postnatal ward, this was facilitated and she described a welling up of love for her child (Chapter 7, p241). Personal experience can be compelling and these examples and my own experiences of seeing the newborn transform from anxious, pained or 'lacklustre' to a contented, relaxed pink is a small miracle that could be enacted after almost every birth, whilst especially benefiting the more difficult ones. Following a medicalised birth this might be the event that enables women to recover and gain a sense of having achieved something worthwhile.

There may be many ways of giving birth, but there seem to be some important elements that are grounded in biology. Perhaps uninterrupted skin-to-skin contact might also be seen as a step forward to nature, with instinctive actions that manifest themselves if allowed to do so along with influences of the endocrine system on behaviour and mood. The comparatively recent evidence from literature in Chapter 2, the women's words and my own experiences lead me to conclude that skin-to-skin contact can be healing both physiologically and psychologically and have long-term consequences. This means that at least women should know about it and have the chance to choose it as it is supported by a sounder knowledge base than separation, which is only based on the authoritative knowledge of the dominant medical model of care. The difference would no doubt be very apparent to the babies who might have benefited from this gentler start to life, but unfortunately could not tell their carers how unhappy they were except by
their separation distress cries. Women need to know why and with what effects their babies are being removed or subjected to interference, to be able to choose what is best for themselves to ensure informed choice.

**Time**

A thread running through this thesis is the concept of time and it would be useful to re-conceptualise the use of time around birth. A linear view of time would perceive it as something which must not be wasted, but always filled with routines or actions which are perceived to be valuable. I have explored Foucault’s (1977) ideas that power was applied to time, to control its use, with speed and efficiency being valued and usually dictated by those in power, which in a hierarchical structure usually means the professional. There might be pressure to complete the time after birth to include the elements desired by the routine, rather than forming relationships in the new family. In this way, the use of time could change depending on who was present at the birth. Time might be perceived through a cultural lens, such as when uninterrupted skin-to-skin contact was seen as wasting time or just lying there doing nothing, which some women in the project perceived. A baby can cry for a long time when separated from its mother, before eventually being silenced by exhaustion, when it might be interpreted as having successfully settled to sleep. Alternatively, time which flows in nature’s time, ensures the completion of an experience rather than of a task and values the rhythm or the body. This kind of time seems to alter perceptions and some women in the project found that ‘time just flew’, perceiving only moments to have passed rather than 30 minutes or an hour. Nature’s time would enable a different use of time, where the baby would recover from the birth, reduce its adrenaline levels by
being in skin contact, begin the massage-like movements of the breast which ensure the availability of colostrum and then be ready to feed. Being in the right circumstances at the right time can enable events or disrupt them, perhaps resulting in missing major events in life such as the time of birth.

Cyclical time can not be fitted easily into linear time as a midwife in the project found when concerned with completing routines or waiting for a ‘long time’ for the baby to breastfeed, but it could provide a glimmer of light within a medicalised approach to birth. Cyclical time could be promoted providing that its value is related to both midwife and woman with enough ‘time’ to think about it and discuss it perhaps enabling a cultural shift of expectations and see birth in a different light. This information would be better before the birth, as we tried to do in our project, to allow the woman and her family some reflective time to adjust their cultural expectations which might include immediate weighing of the baby so that phone calls could be made within minutes of the birth. They might come to see that the first hour or so after birth could be an extension of the birthing process and not to be disturbed – i.e. to honour the maialogical time (Kahn, 1995, see Chapter 7, p255) where the mother and child are seen as a dyad, with the two bodies being treated as one at birth, enabling embodied praxis and a language exchange between them.

Mirrors, language and love
The concept of mirrors and reflections occurred repeatedly in the literature. Lempiainen (1997) believed that the background mirror of life reflected a male image whilst Minsky (1996) spoke of philosophers, who by projecting their own
imaginings onto the world saw their own personally constructed truth, which could contain distortions. This would apply to anyone who only saw their own point of view or 'what we always believe and do' as the whole truth. The midwives, who in our project were all women, were potentially affected by some images reflected from the mirror of technology. Senge (1990) argued that our personal mental models reflected our view of the world, suggesting that we should work with these reflections, by trying to turn people's mirrors to face inwards to encourage self-awareness, which is what action research works to achieve. If midwives did this, they would be more likely to enable women to see through the mirror of love and reflect this back onto the events around birth. Perspective transformation (Mezirow, 1981) is an important learning experience and facilitators are in a position to encourage people to really see, rather than just being physically present in a situation. This might involve story telling as I did with the women’s experiences and discussions of practice between midwives.

An important part of this thesis is the contribution to a new language for birth, giving value to women's unique experiences. Irigaray (1996) proposed the development of a female language, because what is known about women has tended to be from a male point of view i.e. the 'masculine feminine'. Irigaray wanted us to set the 'female feminine' free. This thesis contributes to this by examining the language for birth, which is steeped in words and actions about routines and time constraints from 'masculine, feminine' origins and replacing them with 'female, feminine' words, about birth which is achieved by women, described by women and which can strengthen them. It contributes to definitions of concepts such as jouissance and embodied praxis, with such feminine intuitive
words describing an experience is ‘buzzing’ yet also ‘calm; ‘relaxing’ yet ‘on a high’. These words would not be in the dictionary of authoritative medical knowledge, yet they speak of women’s knowledge and experiences of bodily praxis. Emotion can make embodied praxis possible, leading women along new paths, as a living body rather than a container to be moved from place to place. Birth hormones which promote alertness in the mother and baby combined with early close contact could predispose them to make eye contact and form a relationship, perhaps saying an implicit ‘Is that really you?’ as one mother implied by the way she said ‘Hello’ to her baby, progressing from asking ‘Is it a boy?’ to saying ‘Hello young man’. Odent (1986) believed that the primal brain facilitated subtle behaviours which enhanced love. Robson’s (1967) early observations spoke of women’s profound feelings for their babies when their eyes first met. This significance of the meeting of eyes is common and Dolar (1996) spoke of the discovery of a love, which was ‘always already’ there. If the mother and baby are to be encouraged to find this love, then those who provide care for them should experience it too. The English language has a poverty of words for the concept of love. Campbell (1984:82) defines one form as ‘agape’ love or:

‘the love which risks self in order to enhance value’

Freire’s idea of conscientization, involves love, which helps free people from domination (which he defines as a pathology of love). If something new and empowering is to be created in a change process, Freire argued that it must involve love. Irigaray (1996) would have us speak of a love which does not subjugate, but guards against depriving anyone of freedom in a relationship, to listen to someone. I believe that this thesis demonstrates an empowering process for both midwives and mothers, moving them from domination (even if
benevolent) to love. It could also be a part of a process of rediscovering midwifery for some who have been submerged in medical values.

Action Research

Whilst research is needed to describe and explain, I would argue for the need to maintain the drive for practical projects such as action research for fear that we may continue to donate our care in a compassionate way whilst still benevolently doing it wrong. This thesis is an original contribution to knowledge concerning an effective change in practice. A way of researching that is steeped in clinical practice, involvement and facilitation. Action researchers must live with the dynamism and effects of the changes, which enables them to gain insights not available to visitors. The power of small action research projects such as this is that they apply change principles to unique individual situations and create the change process from within. Brady (1994) pointed out that Freire’s (1993) methods with Brazilian peasants were not meant to be transferred unchanged to any other setting, as no method should be reified, but applied individually. Collaboration is vital in an action research project and group processes should be emancipatory and reflexive, making them authentic for that group The importance of working together to overcome difficulties and find solutions for a particular situation which might not be relevant elsewhere, was crucial to the success of the project as knowledge was dependent on the judgement of others to integrate it into the culture. For this reason, practitioners were involved from the earliest opportunity, thereby removing the risk of imposing what was thought to be best by outsiders. Discussions needed to be free, all contributions of equal value, debated and challenged as in focus groups. This process should aim to be free
from any one dominant voice in a group, with its members testing the sincerity of other people’s words by objective language, subjective feelings and social norms to judge their truth (Habermas, 1987). Consensus would be dependent on believing the sincerity of the group members, which includes that of the researcher.

A facilitator can seek to help people best by accepting them where they are at the start of the change process, but never losing sight of where the project is aiming. Encouraging self-awareness in the action research process can prevent the unquestioned social construction of beliefs and actions which perpetuate reified practices such as routines around birth. A known routine however, is economical of effort and this must not be underestimated because coping with professional life may seem challenging enough without extra issues such as a change process to deal with. Midwives might need help, especially initially, to overcome institutionalised learning disabilities and it is part of the role of a facilitator to help them overcome reification. They might need help to see that learning from experience does not have to mean unchanging practice or perpetuating the wrong practices. In an action research process, limit situations (Freire, 1993) can be recognised and midwives become empowered to escape from them in a safe way, at a safe speed and using strategies identified by themselves. It is important that anxieties are taken seriously and ways found to address them, rather than trying to force people to accept ideas unthinkingly. This can be achieved more effectively by enablement, seeking to involve and facilitate them to become empowered in the tradition of Paolo Freire (1993).
The facilitator can effectively encourage self discovery by endeavouring to open people's eyes, by teaching at the level where they are comfortable and allowing knowledge to open like a fan, with new ideas projected alongside the more comfortable ones. They should be approached in ways which will keep their self respect intact, i.e. give them knowledge and the means to change before they risk failure. It is valuable to sell changes well, by finding some means to make them attractive, so reducing Gladwell’s (2000) broken window effect (chapter 6, p184) and also to ensure that change contains elements that make its implementation feel good, such as telling the women’s stories about how midwives had helped them.

Facilitators would benefit from awareness of the importance of critical evaluative comments, such as the midwife in the project who wrote about being unable to keep women on labour ward for hours, which highlighted the long held routines that needed to be addressed. If the underlying reasons for this comment had not been taken seriously it might not have been seen as an opportunity and a vital strategy to enhance the change might have been missed. Seemingly small actions can lead to important changes such as the comment during a teaching session where a midwife said that it was sometimes hard to remember to give information about skin-to-skin contact until it was almost too late, which enabled the identification of strategies for remembering the change. Rather than censuring a person for ‘forgetting’, it was seen as valuable as it probably reflected a common difficulty and this midwife had the courage to voice it. Sound skills-based education during the project provided an empowering basis on which to build changes in practice yet it must never be assumed that just because you have ‘told’ someone and they agree with you, that they will either remember or have the courage to try it without extra support. This insight enabled the conversion of a
potentially late adopter of change into an early adopter by following education with direct support in the clinical area (Chapter 6, p199). Real examples of success during the project were used as a 'how to do it' guide for those who had not tried the change, which is congruent with Freire’s conscientization and is a strategy to encourage perspective transformation.

Many midwives today are used to seeing women for a very short time, so their actions may be beyond their learning horizon by not having the benefit of continuity of carer which would allow consequences of actions to be seen. Evaluation is one of the keys to success in action research by making the results of our actions overt. During a project, it is essential to prevent inadvertent drifting along, by asking evaluative questions. It must not be assumed that agreed actions are being carried out, as something or someone might be preventing it, making the evaluative phase vital before the next planning stage begins. The benefits of active evaluation in the project were apparent, otherwise the information leaflets might still be waiting to be distributed, routines unchanged and midwives still forgetting to discuss breastfeeding and skin-to-skin contact with women. Some women who were reported to have ‘had’ skin-to-skin contact described a disrupted experience and this fed back into the study with strategies for improving information giving and talking through a pragmatic change to the set routine.

The process of change in action research usually takes longer than estimated. Change cannot be rushed if it is to be a lasting one, as people must be given the opportunity to examine their practice in safety, moving at their own pace and changing practice in a way relevant to their own circumstance. Our efforts in the
project might also have had longer term consequences, just by raising issues and asking questions. This can start a process of questioning, opening eyes to see covert social practices and taken-for-granted habits and routines. Since completing ‘our’ project, more emphasis has been placed on breastfeeding practice in the Trust, by the allocation of resources. At the end of this debate, I see that we have two choices, either to continue to provide what we have always done, or to facilitate an enhanced beginning for new generations of babies and their mothers. We have the opportunity to facilitate parents to become empowered to care for their babies in the best way possible by showing them that love at birth is an end in itself, but might also be the beginning of something much more.

What I Might Do Differently

Whilst the role of the facilitator is to be supportive of others, personal support is important for them as well, enabling them to be strong during the challenging times and also enabling safe debriefing. Before beginning another action research project, I would try to set up a personal support network or perhaps share the work with another facilitator. If repeating this study, I would seek the help of a midwife who could have been a more active participant from the outset or possibly involve the women in looking at change. It might have been useful to compare interview data from midwives and women from the same birth, to try to see both perspectives and also to endeavour to spend more time in the clinical area focussing on midwife/mother interactions. Ultimately though, I can have no real idea of what I would do differently if the study was repeated, as each action research project is unique and its direction and focus are dependent on the
collaboration of the participants. This is why action research is such a challenging methodology.

**Recommendations**

**Research**

- Action research can be considered a valuable methodology for addressing change in practice, but is not for the fainthearted, as it requires involvement, flexibility and interpersonal skills.

- Whilst knowledge is helpful for a change process, it is not effective alone, as support is needed to enable change in practice. The facilitator should not lead the change however, but enable the participants to find their own way. Action research is a valuable way to do this, providing it is based within an empowering framework, where all participants are equal.

- Action researchers would benefit from reading the work of Paolo Freire (1993, 1998) and develop insight into power structures, along with a desire to improve practice.

- The researcher should attempt to trust that they will eventually see through the muddiness of the action research spirals, as they sometimes seem to be very unclear and ever evolving.

- It is important to keep a record of events from the beginning of a project, as progress can be slow with participants becoming used to changes gradually and not realising how much their practice has transformed.

- Researchers involved in practice situations would benefit from an awareness of a balance in what is ‘expected’ of them and try not to do everything, as their role consists of more than just a clinical worker.
• Action researchers would benefit from the ability to see the good in people and search for reasons behind any efforts to sabotage change.

• It is valuable to use the opportunities that action research provides to support those who would not normally be first to adopt change.

• It should not be taken personally if people occasionally try to avoid you, as it probably has more to do with their own reaction to the change process.

• If empowering strategies are so successful that the participants forget that it was your idea in the first place, this must not be taken personally, as a critical feminist position is surely an empowering strategy so that practitioners are the ones who effect the change and own it.

Practice

• Women deserve to know the current evidence about uninterrupted skin-to-skin contact, preferably antenatally so that they can choose for themselves, providing that full information is given, rather than the minimalist ‘which do you want’. However, all practitioners would benefit from an awareness of the socio-political aspects of the rituals around birth, with the influences of routines, time pressures as well as women’s expectations.

• It would be helpful to recognise that women, both midwives and mothers are influenced by their culture but not bound to it – i.e. ideas can be changed if the evidence is good enough and support is given.

• Wider family involvement would be useful as there can be cultural expectations such as passing the newly born baby to be held by others and phoning home too soon which necessitates disrupting that first special time.
• Recognition needs to be made of the risks of coercion in replacing one power ideology with another. Technology, whilst providing improvements in some areas of high risk, might cause problems in low risk birth. This means that women need balanced knowledge so that they become empowered rather than coerced to choose the experience of undisturbed birth without disruptions which would enhance innate newborn behaviours and breastfeeding success.

• Skin-to-skin contact can be considered valuable for all mothers and babies, but most especially after a difficult birth.

**Education**

• Pre-registration education for all students – midwives, nurses, health visitors - as well as for practising midwives would benefit from sound evidence-based and practical knowledge of breastfeeding.

• Research teaching at all levels would be enhanced by including action research as a valuable methodology alongside the better known ones.

**Future Research**

The possibilities of repeating this project in other areas remains a useful strategy for change. Action research might be beneficial looking at the way care is coordinated between CDU and postnatal wards. This could address the barriers between what one group of midwives perceive as their own routines, which might be inflexible and could have an impact on mothers and babies. A project exploring the use of rooms within a maternity unit might be helpful, as in the Trust which I visited where all rooms were designated as multi-purpose. This would mean that
the same midwife would be caring for the mothers and babies before and after
birth with no division of ‘tasks’, or problems of moving to a new area.

Conclusion

In order to allow judgements of the worth of any research, the beliefs
underpinning it must be laid out as findings are always viewed though the lens of
the self. I did not choose a professionalizing/empowering approach to action
research, but rather it chose me as I am committed and motivated to enable others
to become empowered, especially the most vulnerable. I believe, in this day of
medicalization and professional power, that women giving birth and newborn
babies potentially hold the greatest power, that of bestowing love, relationships,
nurturing and health. I have gained valuable insights from the project both in
understanding of breastfeeding and also in human nature, not least my own. I have
had ecstatic mountain top highs and lonely valleys and survived to tell the story. I
hope that this account will be helpful to others, in the feminist tradition of passing
on knowledge, successes and challenges. I am grieved for women in the last
decades of the 20th Century who were denied the opportunity to experience ‘good’
breastfeeding by our inappropriate and medicalised care and advice and still bear
the scars. Conversely I am full of hope that this trend can be and is being reversed.
Government targets for increasing breastfeeding (Maternity Care Working Party,
2001, DoH, 2003a), mean that this drive for change is less likely to go away and
nor should it. A great deal of evidence exists of the benefits of breastfeeding and
early mother and baby contact, the complexity of which we are only beginning to
discover, not least of which is the ability of the newborn, in common with other
mammals to access the source of milk mainly by its own efforts.
Appendix 1  

Skin-to-Skin Contact Leaflet  

Information Sheet for Parents  
What is the latest information about caring for your baby immediately after its birth?

When your baby is born, we recommend that you are given your baby to hold, in close contact, as soon as possible.

In practice, this means that your baby will be **quickly and gently dried**, then laid facing down onto your front, with **skin-to-skin contact**. It would help to be wearing a **front opening shirt** or loose necked T-shirt.

There is no need to worry about being embarrassed as you and your baby will be covered with a **warm blanket** and you and your partner given time together, possibly for about an hour, to get to know your new family member. This is your special time, although the midwife will be on hand if help is needed.

If your baby needs any help at birth, then skin to skin contact could start as soon as he or she is returned to you for a cuddle

**Why is this important**

When a baby is born, it has come into a very different world – it will be brighter and noisier than when it was inside your womb.

A very **comforting** feeling would be to have a cuddle from your mother, hear her voice and her familiar heartbeat, which you heard inside her womb.

During this close contact, your baby will come into contact with your own normal skin bacteria. This will transfer to the baby’s mouth and skin, giving **protection against infections**.

This is a special time for all babies, when they instinctively progress from resting, to exploring, to seeking food. This process can be variable and can take up to an hour. The important thing is to let your baby feed when he or she is ready.

**What does research say about skin to skin contact?**

Babies in skin to skin contact with their mothers will **keep warmer** than if put under a heater and will warm up more quickly if they are cold.

Skin to skin contact helps to **calm your baby and regulate its heartbeat**. This can also work later on, if at any time your baby is very fretful. It can also help with mother-infant relationships.

This should be an **unhurried and uninterrupted** time, as babies who are removed for too long, will not show the same benefits. If you wish to know your baby’s weight, it is possible to weigh the baby quickly and then return to the
mother, without disrupting the process, but it is best to wait until after your baby has fed.

When your baby shows that it is ready to feed, it can latch onto the breast or be given a formula feed if that is the mother’s choice.

Babies who have skin-to-skin contact and go to the breast at this time, tend to have fewer problems with feeding later on, and they tend to be breastfed for longer.

An advantage of early breastfeeding is that it will help your womb to contract and minimise bleeding after the birth.

If your baby is not able to have this contact immediately, then it will benefit from contact as soon as is possible afterwards. If you need to have stitches after the birth, holding your baby may help to distract you from any discomfort.

If your baby is born prematurely, it may benefit from skin to skin contact when it is able to be outside the incubator.

If you have any questions about caring for your baby immediately after its birth or skin-to-skin contact please ask your midwife.
Appendix 2 Benefits of Breastfeeding Leaflet

What is the latest information about Infant Feeding?

We want you to know these facts, before you decide whether you want to breast feed or bottle feed your baby. If you want any more information, please ask your midwife.

The Facts

Health Benefits to the Baby – Did you know that:-

**Breast milk contains anti-infective factors**, which help prevent gastro-enteritis and chest infections in your baby. The first milk, or colostrum, is especially high in these factors. Formula milk does not have these factors, because it has been processed from cow’s milk, which unfortunately destroys them. Formula fed babies have higher hospital admission rates.

**Colostrum** is the first milk to be produced by the breasts. This acts as a mild laxative, which helps the baby to pass meconium, (the dark tarry motion that the baby passes in the first days). This helps to prevent jaundice. Formula milk cannot contain colostrum, because the calf is given this by the farmers, to prevent illness.

There is a special factor in breast milk which helps the development of the baby’s gut lining. This can prevent allergies (such as asthma and eczema) by stopping foreign proteins from passing through.

When a baby breastfeeds, it opens its mouth wider than a baby using a teat. The physical action of breastfeeding opens the tube connecting the middle ear and the throat. Like when your ears pop as an aeroplane takes off and you have to move your jaw and swallow. This means that there is less chance of middle ear infections. The same action can mean the baby may have clearer speech and straighter teeth.

If you have a family history of diabetes, you need to know that it is possible for your baby to get an auto-immune response to a protein in cow’s milk, which could cause childhood diabetes to develop.

Breast milk is easily digested, nutritionally balanced and ready made by your own body, so it will not upset your baby. This is why it is so valuable for those babies born too early, (as well as the protection from infection).

Formula milk is made mainly from cow’s milk and is very highly processed to try to match breast milk, and has other additives. Although it cannot be the same, it is a blessing for those mothers who cannot breastfeed. It has been said by baby milk manufacturers that many mothers may make up formula feeds incorrectly, so you will need to learn this skill.

Some studies have shown that breastfed babies are more intelligent. This is why formula milk manufacturers add these proteins (Taurine) and fats (LCP’s) to the formula milk.
Breast milk is at the right temperature, is readily available 24 hours a day, and makes travelling easier – you only have to take yourself. Formula milk can be easily made up from the powder, but you need to buy the equipment and have access to a kettle, sterilising kits and of course you must buy it.

Health Benefits to the Mother. Did you know that:-

If you breastfeed, your womb will go back to its previous size more quickly, which will help to minimise bleeding after the birth. As you are providing nourishment for your baby, you will use up more calories and your weight should reduce more quickly. If you formula feed, you will have to reduce your calorie intake to do this.

Breastfeeding can protect against breast cancer before the age of 50. The longer you breastfeed, the greater the benefit. There is also evidence to show that it may prevent some ovarian cancers.

Calcium is one of the main building blocks for your bones. When you have breastfed, the calcium in your bones is renewed, making your bones stronger. This means that women who have breastfed tend to have fewer hip fractures over the age of 65.

Some Practicalities of Feeding
You will probably need to feed your baby frequently in the early days, to develop the capability to make as much milk as your baby needs in the months to come. For this reason, breastfeeding can take more time and effort initially. If you have not breastfed before, you will need help to learn breastfeeding skills from health professionals or other women who have breastfed themselves. Later on, breastfeeding can make life easier.

Formula feeding is said to be easier initially, because it can be done by anyone, but usually it is the mother who gives most of the feeds. Mothers who breastfeed can express milk for someone else to give to the baby if they have to leave them in later weeks. Some women say that breastfeeding can create a special bond with the baby, because they have nourished the baby themselves.

If you return to work, you can express breast milk to leave for your baby. This can cause extra work, but some babies will feed little in the day and then make it up when you come home. Formula fed babies can be given bottles whilst you are at work.

Breastfeeding can suppress your fertility, so that you have longer between pregnancies. If it is important that you do not get pregnant again, you should use other contraceptive methods. If you bottle feed, you tend to become fertile sooner.

Some women feel embarrassed to breastfeed in front of other people. Many women find that as they become skilled at breastfeeding, it can be so discreet that no-one knows that they are feeding a baby.
Those who feed babies by a bottle usually find no problems when feeding in public, however they do have to take the equipment with them.

Whichever feeding method you choose, all midwives will support you in any way that they can.
Appendix 3

Pictures of Skin-to-Skin Contact

1. Just born - what a strange world!

2. Settling down

3. Feeling safer now

4. Are you my Mum?
5. Looking for food

6. Attaching to the breast

7. Breastfeeding

8. Full and sleepy
Appendix 4 Evaluation of Skin to Skin contact at birth

**Evaluation of Skin to Skin contact at birth**

Had the woman received a leaflet in antenatal clinic?  
Yes  No

Did the woman agree to have skin-to-skin contact?  
Yes  No

When did skin-to-skin start?  
i.e. approx how many minutes from the birth  
............. Mins

How long did the skin-to-skin last approximately?  
............. Mins

Did the baby breastfeed?  
Yes  No

How long after the birth did the baby feed?  

Did the mother receive analgesia in labour?  
Yes  No

How long before the birth was analgesia given and what was it?  

Did the mother make any comments on the experience?  

Did the skin-to-skin contact create any problems for you?  
Yes  No

If Yes – what were these?  

Did you interrupt the process to do any ‘routine’ procedures during this time (weight, top-to-toe)?  
Yes  No

If Yes, what needed to be done?  

If yes, how long was the baby separated from its mother?  
............. Mins

I would be grateful for any comments/reflections/thoughts/feelings/suggestions on the process of skin-to-skin contact.  

........................................................................................................................................(PTO)

**Time and Date of birth/ Name of Midwife (Optional)**  

..........................................................................................................................................................
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