Sociological Aspects of the
Mother/ Community Midwife Relationship

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Abstract

The relationship between a mother and her community midwife is often described as 'special'. The objectives of this research were to discover what was 'special' about the relationship on the one hand and what was distinctive about the role of the community midwife on the other.

In the course of this investigation, it became apparent that there was a profound lack of fit between the professional paradigm, which dominates the midwifery literature and incorporates a masculinist ontology, and the perspective of mothers themselves. Accordingly, the thesis reviews the relevant midwifery literature, critiques the professional paradigm, and develops a non-dualistic, feminist metatheory, the personal paradigm, within which the experiences of mothers may more adequately be understood. A corresponding critique is developed of scientific sociological methodologies.

The research objectives were achieved by combining indepth interview and observational methods, involving approximately 100 interviews with approximately 50 research subjects and observation of approximately 11 community midwives and 200 mothers. Of the interview sample, twenty-four mother/community midwife dyads were analysed longitudinally. Approximately one third of these emerged as Routine, Appreciative and Special respectively. Special relationships were woman centred, supportive and emotionally invested. Routine relationships, by contrast, were instrumentally defined and clinically oriented. The mother's outlook most strongly influenced relationship outcome; with the midwife's outlook influencing its plane of
The data suggest that women seek a personal rather than a professional relationship with their community midwife. The midwife's distinctive contribution is to offer such a relationship, psychosocially oriented, within an appropriate social setting, the community. Midwifery thus understood provides a radical basis for a feminist critique of the professional paradigm.
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Chapter One

Introduction
To be a midwife is to be 'with woman'. Historically and symbolically, the midwife has been the professional most closely associated with childbearing women; supporting and attending her antenatally, intranatally and postnatally. In England, approximately 70% of deliveries are conducted by midwives; and midwives continue to provide almost all primary postnatal care and, in many Districts, half or more of the primary antenatal care. The bureaucratization, medicalisation and professionalisation of childbirth have threatened the association between mothers and midwives. But the association remains and is being reasserted by professional and consumer groups. It is also increasingly recognised that midwifery is most appropriately and effectively practised by providing continuity of care within the mother's own community (Cronk & Flint 1989).

I experienced community midwifery first hand when I had my own children. My relationship with my community midwife felt very special. It was an intimate and personal relationship; in which I related to her as a person, not a mere professional. It also felt very different to that developed with my GP, who in other respects provided identical antenatal clinical care. Discussions with other mothers validated this experience. The research is an attempt to capture and understand these experiences sociologically; an example of 'feminist praxis' (Stanley (ed) 1990).

I had two objectives. The first was to identify what makes some mother/community midwife relationships 'special'. The second was to identify the distinctive characteristics of the community midwife's role. These objectives were achieved using observational and interview data. Following a pilot study, I conducted an observational
study of 11 midwives at work in the community. I then conducted an interview based study involving six full time midwives from this sample. I interviewed (separately) 24 mothers/ community midwives pairs, 4 per midwife. I also interviewed a separate sample of six mothers, each of whom had been nominated by one of the six midwives as having had a 'special' relationship with her. All midwives worked within the same District Health Authority; thus holding organisational factors reasonably constant and so permitting analysis of variability between relationships.

It soon became apparent that existing approaches in the academic and professional literature could not capture what mothers understood from experience; for they obscured the very processes I wished to reveal. Consequently, I also became interested in the construction of academic and professional knowledge; and sought to reveal ways in which dominant conceptualisations obscured and invalidated personal experience, at both substantive and methodological levels. I also sought to evolve an approach appropriate to the processes I wished to explore.

The thesis works thematically at several different levels. Firstly, I develop a critique of the 'professional paradigm' which dominates the midwifery literature. Secondly, I elaborate an alternative metatheory, the personal paradigm, which reveals what the professional paradigm obscures. Thirdly, I develop a corresponding critique of scientific sociological methodologies. Finally, I present the substantive analysis, couched within the metatheory of the personal paradigm.

These themes are explored in Parts One, Two, Three and Five/Six respectively. In Part
One, I outline ways in which the 'professional paradigm', which dominates the midwifery literature, precludes an understanding of the mother/community relationship grounded in mothers' viewpoints. Unlike the personal paradigm, which yokes mothers and midwives together, the professional paradigm dissociates them, placing them in different planes of being. In addition, the professional paradigm emphasises the professional's activity, domination and control of the client. Finally, it employs a dualistic ontology which artificially polarises, and normatively prefers, thought over feeling, minds over bodies, objectivity over subjectivity, formal over informal knowledge, and professionals over clients. In these ways, it obscures the personal, emotional and relational emphases of mothers themselves. In Part Two I develop an alternative metatheory, the 'personal paradigm'. This incorporates those aspects underemphasised in the professional paradigm, including emotion, subjectivity, and informal or biographical knowledge, into a synthetic ontology. Thus thought becomes an aspect of feeling, personal experience relevant to professional knowledge, and so on. This provides an ontology within which the mother/community midwife relationship can be visualised; for it accentuates personal, emotional and biographical factors. I go on to suggest that the mother/community midwife relationship is more adequately conceptualised as a personal than a professional relationship.

Part Three presents a corresponding critique/reconceptualisation of sociological methodology. I suggest that the norms of empirical science, which dominate the methodological literature, rely on the same normative dualisms as the professional paradigm. Accordingly, it dissociates 'methods' from their context of application and obscures the personal, biographical, social and emotional processes which infuse the
method. It also completely contradicts my own experiences as a researcher. I suggest that feminist methodology has highlighted these shortcomings but without fully unearthing its ontological contradictions. I conclude Part Three by presenting an account of my own experiences as a researcher, couched within the personal paradigm.

Part Four of the thesis outlines the research design and methods employed in the research, located within the personal paradigm but with a more abstracted emphasis. Parts Five and Six present the empirical analysis. Part Five presents an analysis of 24 mother/community midwife relationships. The distinctive feature of the analysis is that it uses the same conceptual framework to analyse mothers and midwives; unlike the professional conceptualisation, which dissociates them. I conceptualise relationships as a blend of the outlooks of both parties. An outlook comprises a personal disposition on the one hand and a role orientation on the other. Each is anchored in the emotional and social biography of the mother or midwife. I suggest that the mother's outlook is the strongest determinant of relationship outcome. However, the midwife's outlook influences the plane of being within which the relationship operates, and so the character of the relationship which develops; for example, into a practically, socially or emotionally based relationship.

The analysis suggests that approximately one third of relationships are 'routine', 'appreciative' and 'special' respectively. A routine relationship typically involves a mother who has an instrumental outlook and a clinical orientation. A special relationship, by contrast, is marked by an emotional rather than instrumental outlook and a supportive orientation. It is woman centred, emotionally invested and supportive.
An appreciative relationship contains elements of special and routine relationships. Specific experiences are also important; and a community delivery, unavailable to most, is significantly more likely to result in a special relationship. These results are confirmed and extended through analysis of the separate sample of six 'special relationship' mothers.

Part Six of the thesis uses data from all sources to examine the distinctive role of the community midwife. I suggest that her role comprises the '3Rs' of Relationship, Role and Real social context. The Relationship is personal, intimate and emotionally supportive. The Role is psychosocially oriented, in contrast to both GPs and Health Visitors. The community context is 'real'; ie. the site of the mother's emotional and practical concerns and so an appropriate site for psychosocially oriented midwifery care. Part Seven concludes the thesis by summarising these themes and considering how ideological constructions of women in personal and professional relationships precludes attention to their needs. Midwifery, understood within the personal paradigm, provides a radical alternative to oppressive social constructions.

As noted above, the thesis is dedicated to understanding and improving the experiences of childbearing women. It is organised principally as 'feminist praxis', thus understood, rather than as a contribution to particular academic disciplines or specialisms. The latter cross cut the thesis in a way which does not permit easy reference. Thus, although relevant literatures exist, for example, the sociology of the professions (Freidson 1973; Etzioni 1969; Johnson 1972; Dingwall & Lewis 1983; see Morgan et al 1985 for a review), including within feminist discourse (Roberts 1981a,
1981b, 1985; Curtis 1990; Oakley 1986i), these are not reviewed in their own right; for they are concerned principally with classic sociological preoccupations with power and the social characteristics of professional groups, and have little to say about the distinctive or positive contributions of the midwife. Accordingly, they are cited only where they further the thesis (for example, Oakley 1984d, 1992). In place of such a review, the midwifery literature is examined in detail, for what it reveals and obscures about the needs of childbearing women. The purpose of such a review is to aid the development of a perspective more appropriate to 'woman centred' midwifery practice. The thesis also has an interdisciplinary emphasis appropriate to such enquiry.

To assist the reader, the pseudonyms of each midwife and her four mothers have been matched by letter. Thus the first names of Anna and her sample of mothers, including the 'special' sample, all begin with the letter A; Carol and her mothers, letter C; Elizabeth and her mothers, letter E; Joanna and her mothers, letter J; Laura and her mothers, letter L; and Veronica and her mothers, letter V. The pseudonyms are given in Chapter 9, together with summary biographical details. Minor amendments have been made to quotations where this would assist the reader.

Parts Two, Three and Five of the thesis are prefaced by extracts which use creative writing to illustrate the academic themes explored in the thesis. These extracts are printed in italics. The creative writing conveys the natural history of the thesis and my creative development through it. It is also an economic expression of the main arguments of the thesis; and thus illustrates the power of emotion to condense and illustrate academic ideas.
I have included an extended bibliography at the end of the thesis. This includes all those texts which I have consulted and been influenced by in the course of the thesis, not merely those cited in the main body of the thesis itself. I hope that this assists other researchers.
Part One

The Perfect Professional
Overview

For the last three centuries, midwives have had increasingly to compete with medical men for the privilege of delivering women's babies. To be a 'midwife' is to be 'with woman', the etymological root of the noun. Until the sixteenth century, midwives had almost always been women. Symbolically they were both feared and revered, representing women's powerful sexual and creative energies. The Church took trouble to control them. For better or worse, midwives' skills were empirical, pragmatic and acquired through experience and apprenticeship. But the rise of medicine and the invention of forceps gave men both the power and the means to overcome this fearful female monopoly, to establish male supremacy and control (Donnison 1988; Oakley 1977b). In essence, battle has been drawn along these lines ever since. On the one hand there is woman, experience, intuition and allegiance. On the other there is intervention, difference, medical/professional control and abstract knowledge.

But battle wages not just between midwives and medical men but also, more subtly, between mothers and midwives. There has never been a simple identity of interest between them. Increasingly, midwifery has become 'professionalised'. But midwives' occupational heritage places them closer to women and thus more proximate to the tensions of two competing intellectual tendencies, which for simplicity I term the personal and professional approaches respectively.

Chapters 2 and 3 explore these tensions in more detail. Chapter 2 provides an historical overview of the protests against medicalised childbirth and examines the 'renaissance' in midwifery. I suggest that the muted response of the midwifery
profession to medicalised childbirth illustrates the subordination of midwifery to medicine; an echo of the inter professional and sexual conflicts noted above. On the platform of these protests however, midwifery has begun to reassert itself and has gained in power and influence. As part of these developments, midwifery has reclaimed its ideological heritage as caregivers 'with woman', supportive and allied with childbearing women. They have taken their distance from the medical model of childbirth and begun to articulate a distinctive midwifery approach.

In these ways, midwives have therefore established a niche in the space created by protest, as mothers' professional allies. But this ideological banner obscures tensions and differences between the interests of mothers and the professional self interests of midwives. I explore these differences through a review of midwifery research in the 1980s, concentrating in particular on research which advocates woman centred midwifery. I suggest the need more sharply to distinguish sources of difference, and identify the professional paradigm as an important part of the conceptual apparatus which divides mothers and midwives.

Chapter 3 examines ways in which the 'professional paradigm' stands in the way of midwives and more 'woman centred' midwifery. I suggest that midwives have rejected the medical model, but without relinquishing the conceptual apparatus, the professional paradigm, which supports it. I suggest that this perspective dominates the midwifery literature yet is conceptually incompatible with the priorities of mothers themselves. Chapter 3 examines the manifestation of a professional perspective in relevant midwifery research and consider the difficulties of construction to which this gives rise.
Part Three of the thesis goes on to outline an alternative paradigm, which more adequately captures mothers' experiences and outlooks.

The titles of the chapters reflect these arguments. 'Silent Protests' refers to the subdued response of the midwifery profession to medicalised childbirth, attributable to their subordinated position vis-à-vis the medical profession. 'Is it a Boy or a Girl?' refers to the distinctive position of the midwifery profession, at the juncture of the competing professional and personal paradigms, and asks whether midwifery will develop along the masculinised lines of the professional paradigm or develop more fully a woman centred approach.
Chapter Two

Silent Protests: Midwifery and Medicalised Childbirth
The 'medicalisation' of childbirth is the culmination of a series of encroachments on childbirth, including male, medical, professional and technological encroachment. Male encroachment on childbirth has a history in England dating back to the seventeenth century (Donnison 1988: 23) and the emergence of the 'man midwife', symbolized by the obstetric forceps which midwives were prevented from using. In the nineteenth century biomedicine developed as an intellectual perspective, and this, together with the consolidation of the medical and surgical professions and technological developments, encouraged obstetric intervention and experimentation (Donnison 1988; Arney & Neill 1982). By the 1970s even 'low risk' childbirth had become medicalised, institutionalised and increasingly centralised. A series of Government committees and parliamentary reports encouraged these developments. The Peel Report of 1970 envisaged with approval the prospect of a 100% hospital confinement rate (MacIntyre 1977). In 1927, the first year for which complete figures are available, only 15% of live births occurred in institutions, including poor law institutions (Campbell & McFarlane 1987:12). (In 1900 the figure was approximately 2%). By 1974 96% of births occurred in hospital (Cartwright 1979:1). In one sample of mothers drawn from a London teaching hospital in 1974, 98% had an episiotomy, 52% an instrumental delivery, 79% an epidural, 41% induced or accelerated labours and 59% artificially ruptured membranes (Oakley 1986c:86). This was the heyday of medicalised childbirth.¹

The dawn of protest to medicalised childbirth came through the media. A BBC television documentary, Horizon, in January 1975 entitled 'A time to be born'; a Sunday Times article written by Louise and Oliver Gillie – 'The Childbirth Revolution' dated 13.10.74; and 'The vital first hours' dated 20.10.74, Sunday Times Weekly
Review, were particularly influential in sparking a public debate (Flint 1989:33,38). Subsequently, three key influences of relevance to the development of midwifery can be detected in the debate. Firstly, 'consumers' rights were asserted through the offices of the National Childbirth Trust (NCT) (Flint 1989:33; MacIntyre 1980). In this way, the 'consumer view' developed in association with demands for less interventionist (ie. more 'natural') childbirth. There were other tendencies within the 'consumer' movement. The Association for Improvement in Maternity Services (AIMS) was devoted to greater choice in pregnancy and childbirth rather than non intervention per se (Beech 1989). There was also the Society to Support Home Confinement (SSHC) and pressure from a number of Community Health Councils. But the abiding association has been between the 'consumer' perspective and 'natural' childbirth.

The second development was in academic sociology. A number of medical sociologists departed in an unprecedented way from the norms of the medical profession. They began to oppose the perspective of orthodox medicine, (which construes behaviour, such as non attendance or non compliance as problematic) and made visible and validated the perspective of subordinate groups, including childbearing women (Oakley 1979, 1980; Graham & Oakley 1981; Cartwright 1979; Reid & McIlwaine 1980; MacIntyre 1980, 1982; Garcia 1982; O'Brien & Smith 1981). Much of this literature was inspired by a feminist commitment to the validity of women's experiences; to making things better for women using their experiences and perspective as a political agenda. Unlike the 'consumer' lobby, the sociologists did not necessarily advocate 'natural' childbirth (cf MacIntosh 1989); the emphasis remained on the political and epistemic validity of women's personal experiences. Consistent
with this perspective, and the identity it implies between personal and professional concerns, a number of sociologists published accounts of their own experiences as 'consumers' of maternity 'care' (Comaroff 1977; Hart 1977; Oakley 1979: Preface).

These studies challenged the presumption that experts (in this case obstetricians) know best by highlighting conflicts and disparities between the interests and perspectives of obstetricians and childbearing women. This challenge was posed most directly in Graham & Oakley's 'Competing Ideologies of Reproduction: medical and maternal perspectives on pregnancy' (1981); a paper which dismissed obstetricians as guardians of women's interests by denying that their perspectives coincided.

The third influence was more threatening still to obstetricians because it challenged them on their terms. Medical epidemiologists challenged the scientific and medical credentials of obstetric practice itself (Chard & Richards 1977). An enactment of Cochrane's injunction to make medicine 'scientific' (Campbell & MacFarlane 1987), it challenged the supremacy of clinical experience. This was implicitly discredited along with overzealous interventionism. The researchers advocated a scientific, research based approach to obstetric practice utilising the logic, methods and formal rationality of natural science. The preferred research method was the Randomised Controlled Trial. In these ways, the epidemiologists exposed the 'unscientific' nature of existing obstetric practice, raised the spectre of iatrogenic consequences arising from obstetric technologies, policies and procedures, and argued that obstetric practice must be made more scientific. It put the onus on would-be-interventionists to justify their actions in scientific terms.
Each of these influences can be detected in midwifery research in the 1980s. The sociological literature has been incorporated into policy directed midwifery research which emphasises women's own needs and priorities.

Three main areas of concern emerge from this body of research: the discrepancy between women's expectations of antenatal care and their experience of it; the dissatisfaction expressed about clinic timing, siting and organisation; and the quality of communication with the staff. (Graham & McKee 1980, cited in Garcia 1982:84)

Underlying these dissatisfactions was the wish for more flexible and personalised care, continuity of care and good communication between women and their care givers.²

The 'consumer' perspective, with its emphasis on 'natural' childbirth, and the 'scientific' challenge to obstetrics, have been incorporated in different ways. The naturalistic emphasis of the consumer lobby was ideologically akin to that of midwifery; and midwives have come to represent the ideological alternative to medicalised childbirth. The interests of mothers and midwives are ideologically allied through their joint subordination by medical practitioners, their mutual ideological preference for a 'normal', non pathological and non interventionist approach to childbirth, and the historical association of midwives as 'with woman' during labour, supportive and attuned to her needs. This has been the ideological and political platform for a renaissance in midwifery: a critical questioning of hitherto accepted obstetric and midwifery interventions and the development of a distinctively midwifery based philosophy, policy and practice of childbirth (see below). These developments also draw on the epidemiological challenge.
The 'scientific', epidemiological challenge has also been incorporated at a methodological level. The National Perinatal Epidemiology Unit has been central to this development through its advocacy of the RCT. Its influence extends directly, through original research and publication (Enkin & Chalmers (eds) 1982; Chalmers et al (eds) 1989a, 1989b); and indirectly, through consultation (for example, with the NCT, Cartwright 1979 and Flint and Poulengeris 1988), and through collaboration (for example, Oakley et al 1986) across a broad range of maternity and midwifery research. The RCT method is not the only research method used within the NPEU (Garcia et al 1987) but it is heavily advocated and employed (Enkin & Chalmers 1982; Campbell & MacFarlane 1987). It has been powerfully advocated and has become a dominant evaluative research method within the maternity services field; and finds expression in practitioner based midwifery research (see below). This benefits science and midwifery profession, by establishing the midwife's professional and scientific credentials on the one hand and extending science's ideological hegemony to include the psychosocial sphere and empirical, low-tech, midwifery skills.

Midwifery Research in the 1980s

The medicalisation of childbirth was associated with an effective decline in the role and responsibilities of the midwife, particularly in the 1960s and 1970s. But, notwithstanding the chorus of dissent from consumers and academics, the response of the midwifery profession was muted. The Association of Radical Midwives (ARM) was founded in 1976 by a group of student midwives alarmed at the threat posed to midwifery practice by obstetric domination of childbirth and concerned to 'reroot'
midwifery as a vocation 'with woman', a supporter and expert in the field of normal pregnancy and childbirth (Flint 1989:35).

Apart from this, the voice of the midwife was scarcely heard. Institutional protest from midwives was conspicuously absent. Others initiated the protests. Midwifery was reactive rather than proactive. Moreover, the response, when it came, was ideologically in conflict with itself. On the one hand, it was founded on an ideological affinity with mothers, as professionals 'with woman'. On the other, it was the action of a professional group anxious to reestablish its own identity, autonomy and professional credentials. Midwifery research embodies these tensions; serving the interests of midwives by championing the interests of mothers. Accordingly, insufficient attention has been paid to ways in which the interests of mothers and midwives may conflict; in particular to ways in which a professional perspective obscures the preferences of mothers themselves. Relatedly, there has not been a sufficiently thoroughgoing recognition of the disparity between a medical and midwifery perspective. Midwifery continues to labour under the conceptual framework of its medical counterparts.

Midwifery research in the 1980s developed in six main directions. Firstly, there have been analyses of the role, policy and practice of the midwife; reflecting concern at the erosion of her role and responsibilities and seeking to re-establish a distinctive and autonomous midwifery profession (Royal College of Midwives; Association of Radical Midwives 1986). These discussions emphasise the autonomy of the midwife as an independent clinical practitioner dealing with normal (uncomplicated) childbearing and
identify her as a facilitator of good family relationships and provider of education, advice and support.

...midwives in Britain are qualified to provide care on their own responsibility throughout pregnancy, labour and the puerperium, to recognise those signs of abnormality that require referral to medical staff, and to provide advice, information and support from early pregnancy to the end of the postnatal period...midwifery is concerned with all the main elements of maternity care, the clinical, the advisory and the supportive. (Robinson & Thomson 1989:1)

A commonly accepted definition of a midwife and her role is that adopted by the International Confederation of Midwives.

A midwife is a person who, having been duly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

She must be able to give the necessary supervision, care and advice to women...to conduct deliveries on her own responsibility...She has an important task in health counselling, not only for the patients, but also within the family and the community.' (Association of Radical Midwives 1986: Introduction)

But such definitions remain professionally centred and located. Each concentrates on the midwife, rather than the mother, and the nature of her professional responsibilities. Each has an object orientated relation to the 'patient'; one in which the active midwife acts ON the woman, the object of her practice, and 'GIVES the necessary supervision care and advice'; 'conducts' deliveries, and 'counsels' 'patients'. In this way, they incorporate an orthodox concept of professionalism (see below) which alienates midwives from mothers and thwarts a proper understanding of the distinctive contribution of the midwife from the mother's perspective. From the professional perspective, women are divided into midwives and mothers, experts and non experts,
professionals and patients and there is no point of connection between them. A professional perspective is founded on an epistemological divide; one which recognises only formal knowledge exclusively vested in professionals, one which denies the validity of individual experience (Roberts 1985). Hence the stress in the definition cited above on training, education and certification; an emphasis it shares with other professions and one which stands in contrast to the Association of Radical Midwives' 'basic principles' (Association of Radical Midwives 1986).

Secondly, there has been empirical research investigating the role and responsibilities of the midwife. In 1979 a survey was commissioned by the DHSS to examine the role and responsibilities of the midwife (Robinson 1985a). This was principally concerned with improving the professional status of the midwife. It arose from concern at the midwife's contracting role as she changed from independent practitioner to a health team member and sought to consider any curriculum implications (Robinson 1989a: 9). The survey was supported by the Royal College of Midwives (RCM) and Central Midwives' Board (CMB); who were concerned that medical staff were not fully 'utilizing' their valuable midwifery resources (ibid: 9). This diplomatic conceptualisation accommodated as it resisted medical domination of maternity care.

This survey was therefore concerned with the professional status of the midwife rather than the subordinated position of mothers. It had a limited agenda: to investigate the (im)balance of professional power, especially in relation to the provision of primary health care, and to provide training appropriate to the midwife's anticipated future role. There was no formal incorporation of the protests and insights of those consumers,
The survey drew attention to the erosion of the midwife's role and responsibilities, particularly in respect of decision making in antenatal and intranatal care in consultant and GP units and within the community (Robinson 1989a:16-17). The report also highlighted: a high degree of replication by medical staff of tasks performed by the midwife; their appropriation of decision making, despite the fact that most clinical care continued to be provided by midwives (ibid:16-19); a tendency for midwives' responsibilities to be most severely curtailed in the specialist consultant unit (but a tendency for this to occur in all 'team' situations (ibid:17); an undermining of midwives' confidence in their ability to take responsibility (ie. make decisions) (ibid:19); a disparity of perception between medical staff (even between themselves [ibid:25]) and midwives as to responsibility for the management of normal labour (ibid:25); and a tendency for unit policies to curtail clinical autonomy (ibid:26). In these ways, the report highlighted medical domination of maternity care and demonstrated how inter professional, organisational and environmental strictures (for example, consultant unit vs GP unit) can curtail midwifery practice. In general, the more specialist the unit the more severely was the midwife constrained. This tendency was exacerbated by the further restrictions that unit policies imposed on midwifery practice. In general, the more specialist the unit the more completely was clinical procedure dictated in advance by prescribed and mandatory unit policies.

In the 1980s, these themes have been taken up as part of an initiative to provide less
medicalised, more woman centred midwifery care. Garcia and Garforth (1989) refer to Askham and Barbour's Scottish study, which examined the role of the midwife in both hospital and community locations. It found a greater degree of involvement by doctors in routine intranatal care in Scotland than in England; together with policies prescribed to that effect. This appeared to be a situation generally accepted by midwives (ibid:25–6). In England the Maternity Services Research Group based at Cambridge examined the effects of organisational structures on midwifery practice and professional attitudes. They compared the role and responsibilities of the midwife in 2 and 3 'tier' consultant units; the former with a senior house officer/consultant medical staffing structure, the latter with the more conventional SHO/Registrar/Consultant arrangement. They found that in the three tier structure (the more common arrangement in England) the role of the midwife was more constrained, the dominant consultant 'style' was managerial and midwives were more likely to have an interventionist style of practice. In the case of two tier structures interaction was more 'personalised' (ie. less mechanical and anonymous) and there was greater likelihood of interprofessional conflict between midwives and SHOs. Midwives within the two tier units tended to be and to wish to be more autonomous and have greater decision making responsibilities (although this was a further source of interprofessional conflict with SHOs) and they continued to carry out most routine clinical procedures (Green et al 1986). That is, within the 2 tier structure midwives were generally more assertive, self confident (as professionals), responsible and autonomous; but dependent on the personal commitment of the consultant.

The study did not demonstrate an identity of interest between mothers and midwives
but it did suggest an identity of fortune. In consultant dominated units, neither mothers nor midwives had autonomy. In these units midwives were concerned with their own grievances and lacked concern for mothers. In two tier units where the consultant had a 'hands on' orientation, the ethos of the entire organisation was more 'woman orientated' and thus both mother and midwives were given more consideration. In this situation the midwife did not automatically identify with the mother. Rather, she was concerned to develop all aspects of her professional and clinical expertise and was therefore keen to assume control of a range of interventionist practices usually controlled by medical personnel, including suturing, episiotomies, topping up drips, monitoring and artificial rupturing of the membranes; although as stated above she was less inclined to implement these procedures than her '3 tier' counterpart. Her definition of 'normal' childbirth, that is her definition of the professional parameters of midwifery, had sufficient latitude to enable her to intervene in these ways and still label the process normal (in this case common) and so the legitimate province of the midwife. Further, the midwife in the two tier structure was not prepared to allow women to initiate events: that is, they were inclined to 'give' choice to women but were not prepared for women to 'take' control (for example, by having birth plans and definite preferences regarding intranatal care).

This suggests that in each case mothers remained subordinate to midwives and that their treatment depended upon the social position of midwives within the unit. The study therefore demonstrates that there is no simple identity of interest between mother and midwife. Moreover, midwives and mothers had characteristically different outlooks and priorities.
The third major study to develop themes similar to those arising from Robinson's research was conducted by Garcia et al (Garcia et al 1987; Garcia & Garforth 1991; Garforth & Garcia 1987), the 'Policy and Practice in Midwifery' study. The study was conducted for four reasons; to broaden quality of care criteria away from mortality indices; to evaluate hitherto neglected 'routine' aspects of midwifery care; to assess the significance of policies on midwifery practice; and to facilitate the adoption of midwifery care sensitive to the needs and wishes of the women receiving such care.

In general, Garcia et al found that: midwives viewed policies more positively if they were involved and/or consulted during their preparation; midwives found policies more restrictive if medical involvement in them was high; and there was greater flexibility and brevity in policy documents which midwives co-produced, i.e. a tendency to trust the midwife's professional discretion. There was an increasing tendency for midwives to be involved in drawing up midwifery policy documents but subject to varying degrees of control by medical staff; the very minimum degree of control still apparently entailing medical sanction of all midwifery policies. The study also found a correlation in practice between involvement of medical staff in producing detailed policy documents and their direct involvement in care giving and decision making, even in 'low risk' cases. That is, the less medical involvement the greater the professional autonomy of the midwife. This is now a well documented finding (Robinson 1989a; Green et al 1986; Garcia et al 1987; Kirkham 1989; Humphrey 1985); although it is not established whether this finding also holds in the '2 tier' organisations of Green et al's (1986) study.
The work of Garcia et al provides further indication that there is no coincidence of interest or perspective between mothers and midwives. For example, their priorities on admission may be very different (Garforth & Garcia 1987:10). In general Garcia et al found mothers' needs for privacy, information, good communication and the continuous presence of a birth attendant (for example, her partner) were not always met. One third of midwives mentioned only clinical priorities when admitting a woman (ibid). In this way this study contributes to the literature on communication between care givers and receivers (Oakley 1980, 1986c; Cartwright 1979; Garforth & Garcia 1987; Kirkham, 1989); a theme developed in more detail by others (Adams 1987 in relation to communication styles; Kirkham 1989 in relation to the communication of information; Methven 1989 on the 'midwifery process') (see below).

The fourth trend in midwifery research has been practice based. Research midwives and social scientists have each devoted attention to defining appropriate clinical practice for a revitalised midwifery profession. The tendency has been to apply the philosophy and methods of the epidemiologists to evaluative research. A number of existing obstetric and midwifery practices have been subject to critical scrutiny using the Randomised Controlled Trial method. Midwives are establishing a research and increasingly a 'scientific' basis to repudiate some existing practices and to establish their own. The RCT is increasingly employed in evaluative research, both in respect of 'hard' (clinical) and 'soft' (psychosocial) outcomes. Randomised Controlled Trials have been conducted by midwives to evaluate the effectiveness of hitherto 'routine' aspects of midwifery practice such as perineal shaving, the administration of enemas, and the use of episiotomies. In addition a RCT has been conducted to evaluate a
'Know your Midwife' scheme (Flint & Poulengeris 1988). A RCT trial has also been conducted by Oakley et al (1990) to assess the effectiveness of social support (provided in this instance by research midwives) on perinatal outcome, provided to mothers at risk of producing a low birth weight baby. Other evaluative research not utilising the RCT method include: routine aspects of midwifery care (Garcia et al 1987, referred to above), the effectiveness of 'enhanced' midwifery care in meeting the health needs of women in deprived circumstances (Evans 1987), the provision of postnatal support (Ball 1989), the antenatal booking interview (Methven 1989), management of the third stage of labour, communication styles in midwifery (Adams 1987), the provision of support and information during labour and delivery (Kirkham 1989), the provision of support in a number of special circumstances, and comparing the relative effectiveness of home and hospital antenatal care and deliveries (see Cronk & Flint 1989).

In addition, midwives have made a number of proposals for reorganisation of maternity care (Association of Radical Midwives 1986; Royal College of Midwives 1987) in a manner which fully utilizes midwifery skills; including the provision of midwives' clinics and the exclusive provision of care by midwives in low risk cases in consultant units. (See Robinson 1989b for a review of practitioner based midwifery research in the 1980s.)

Research has also gained a higher profile in the 1980s. Annual 'Research and the Midwife' conferences have been held since 1979; a Midwives' information and research resource centre was established in 1985 (MIDIRS) (Flint 1988:36) and a new
journal with a research emphasis, 'Midwifery'. In addition a growing number of papers are being published regarding the conduct and dissemination of research (for example, Walton 1985). The 'Midwives, Research and Childbirth' series (Robinson & Thomson (eds) 1989, 1991) is a further contribution; indicating the substance, methodology, methods and implications of a number of important contributions to midwifery research during the 1980s and so increasing the profile of midwifery research knowledge.

So midwifery increasingly has an evaluative, research based and scientific dimension regarding clinical and psychosocial aspects of midwifery practice, which functions both to distinguish midwifery from obstetrics and to establish midwifery's professional credentials. I shall suggest in Chapter 3 that this skews the profession along lines incompatible with its own critique and a full appreciation of its distinctive contribution to maternity care.

The fifth development has been the elaboration of what Flint terms 'sensitive midwifery' (Flint 1987); that is, woman centred, psychosocially sensitive midwifery practice. Significantly, however, there is little research investigating the interpersonal relationship between mothers and midwives. This silence is attributable to the very paradigm which many midwives incorporate into their research. Instead, the emphasis has been on the provision of a professional service to the mother adequate to her needs. I shall examine the sources and consequences of these difficulties in Chapter 3. For now, however, I outline the key findings of this research, since they are relevant to the substantive aspects of this thesis. 'Sensitive midwifery', has three
central themes: continuity of care, good communication between mother and midwife, and personalized/flexible care. I shall deal with each of these in turn.

**Continuity of care**

Continuity of care and team midwifery have developed together. They were specifically addressed in Flint & Poulengeris's 'Know Your Midwife' research, which used the RCT method to evaluate and compare continuous midwifery by a small team of midwives with conventional (i.e. fragmented) midwifery care at the hospital (Flint & Poulengeris 1988). Outcome measures included mortality and morbidity and psychosocial effectiveness up to six weeks following delivery; including feelings of control during labour, self confidence as a mother, feelings towards the baby and satisfaction levels. Although there have been other studies of and references to the importance of continuity of care (Association of Radical Midwives 1986; Royal College of Midwives 1987; Humphrey 1985; see Robinson 1989a), this is the most significant research contribution.

The 'Know your Midwife' research tested four hypotheses: feasibility; satisfaction for mothers; safety; and cost effectiveness. They found that under the 'Know your Midwife' scheme (KYM) mothers received better continuity of care than the control group and spent less time in hospital both antenatally and postnatally. No clear effect emerged in relation to feelings about labour in the immediate postnatal period (2 days after delivery) or about the baby or level of breastfeeding help required. But there
were significant effects both pre delivery (on the woman's sense of preparedness and readiness for the baby) and 6 weeks postdelivery on her self esteem and retrospective feelings about childbirth. They experienced greater choice and were subject to less intervention during labour, received less analgesia, had fewer instrumental deliveries and, in the postnatal period, felt a greater sense of achievement and control during labour, measured at 6 weeks after delivery. This is consistent with Oakley's finding that women who experience loss of sense of control are more likely to experience postnatal depression (Oakley 1980:142). The KYM women also had a more beneficial relationship with their midwives: they felt more cared for, more able to discuss matters and more prepared for childbirth and early motherhood. They felt a greater sense of self esteem as a mother and were more satisfied with their antenatal and postnatal care than the control group. All these outcome differences were statistically significant (Flint & Poulengeris 1988:68-101). Other correlates with a 'satisfied' outcome included: normal delivery; preparedness for labour; happiness in the immediate postnatal period; choice of position during labour; good staff/patient communication; the presence of caring staff in the postnatal period; feelings of managing in the immediate postnatal period (ie. at 2 days after delivery); feelings of control at 6 weeks following delivery.

Unfortunately, the authors do not discuss the relative importance of these correlations, their interrelationship or their implications for the central hypotheses. But it is clear that women's satisfaction levels were correlated with feelings of control, choice, a normal delivery and a supportive, communicative and caring interpersonal environment. Satisfaction was negatively associated with increased levels of analgesia;
an association which persisted at the 6 week stage (ibid:279–296).

**Communication**

The importance of good communication between mothers and midwives has been highlighted by a number of authors, including Flint & Poulengeris (1988); Jacoby (1988); Garcia et al (1987); Cartwright (1979); Oakley (1980, 1986c); Robinson & Thomson (1989); Methven (1989). It has been centrally addressed by Adams (1987) and Kirkham (1989).³

Adams videotaped 10 consultant unit deliveries conducted by midwives. Using interaction analysis she evolved a typology of midwifery communication styles during labour and delivery. Two 'styles' emerged: that of the 'educator/encourager' on the one hand and the 'director' on the other. The former was the one mothers found most satisfying. Her style was characterised by a readiness to communicate her knowledge as appropriate and to 'allow' the mother more control over the delivery. The 'directive' midwife on the other hand 'retained her knowledge' and contained the mother's behaviour by a constant repetition of directions (ibid:11). Adams notes that these styles corresponded to the paradigms of childbirth cited by MacIntyre (1982): the 'directive' midwife adhering to a medical, pathological view of childbirth–as–illness, separated from its psychosocial context; a condition requiring expert control and knowledge (Adams 1987:94). The 'educator/encourager' on the other hand employs a paradigm of childbirth which emphasises its 'normality' (ie. an altered state of health undergone by healthy women); an event under women's control; a process embedded
in a social and psychological context. Significantly, Adams found a greater tendency for midwives registered prior to 1982 to have a directive style. Adams cites the DHSS study in 1984 which indicated that 38% of midwives' time is spent communicating, compared with 35% doing 'midwifery and nursing' tasks (Adams 1987:7). She also cites a study by Shields (1978) of the 'subjective needs' of 'labouring patients' and concludes that 'it was clear from her analysis that knowledge and understanding, which included education, direction and conversation, combined with physical care and medication, were the most satisfying to the patients' (ibid:17). Her policy recommendations include: further encouragement of direct entry; the development of a lay language to facilitate information exchange; the teaching of communication skills and the provision of continuity of care. She also recommends 'organisation of care that provides more personal links between the midwife and the mother, so enabling them to communicate on a more social as well as professional level in order that the social significance of childbirth will be increased' (ibid:iii); a recommendation of great significance to the mother/ midwife relationship but one relatively undeveloped in her analysis. That is, she draws attention to the need to appreciate the culturally embedded context of childbearing, but she does so, I shall suggest below, within a professional perspective which places social and emotional distance between mothers and midwives.

Kirkham's research (1989) is more specifically focused on the communication of information. She identifies different types of information required by the woman during labour in order to orientate themselves; including information as to time, place and likely events (Kirkham 1989:120). She investigates the extent to which these
needs are satisfied by midwives and concludes that the communication of information may be inhibited by: midwives' class based presumptions about who needs information; labelling patients; the organisational setting; the inhibiting influence of senior on junior staff; and by feelings of inexperience or inconfidence within midwives.

Kirkham attributes variations in the flow of information (and thus differences in the orientation of the midwife to the mother) to the institutional context within which such interaction occurs. Within a consultant unit neither mother nor midwife have control and the mother is rendered a passive work object to be acted upon by the 'shop floor worker', the midwife. Within a GP unit the information flow is improved and it is suggested that this arises from the relative absence of technology and intervention, the relatively greater freedom and control of both mother and midwife (although the GP unit is characterised as the midwife's domain). Home deliveries however occur in the mother's domain: the midwife is a guest. It is suggested that the mother takes more clinical decisions in that environment than the midwife in a consultant unit (for example, as to whether/when to rupture the membranes). The flow of information in that setting is described as 'normal for that household' (ibid:133).

Kirkham also identifies a midwife who 'waits on' the birth. In these circumstances she listens closely to the mother and the relationship is one between equals, satisfying to both parties (ibid:133–4). Although 'waiting on' the birth occurred in only 'a few' cases (and in only 1/90 of the consultant unit births observed) the implication is that good communication is more likely to occur in GP units and especially in the case of home
births. The fact that it does not appear to occur consistently in those contexts does, however, problematize her thesis of the organisational determinants of such variation; a difficulty which my research has had to address centrally and which will be examined in Part Five of the thesis.

Laryea's work (1989) has also demonstrated that barriers to communication may arise from fundamentally differing orientations of the mother and midwife regarding the transition to motherhood; a social vs a biomedical perspective respectively (ibid:183). She outlines some conflicts to which this gives rise.4

**Personalized/flexible care**

Communication is also an important aspect of personalised and flexible care. The concept of the 'nursing process' has been applied to midwifery care by a number of researchers (see Robinson 1989b), who advocate the development of plans of care tailored to the needs and requirements of the individual mother. In her analysis of the booking interview Methven (1989) illustrates the shortcomings of the conventional booking interview which typically consists of a series of closed questions designed to elicit factual detail appropriate to a purely obstetric history. Her research demonstrates the inadequacy of the most prevalent communication style, the closed question accompanied by few probing devices, even to elicit the obstetric information. It also suggested that the booking interview relied in practice on completion of an obstetric factsheet and thus overlooked important psychosocial detail. In consequence mothers and midwives encounter each other as party to a medical model which construes the
woman as an obstetric object. Methven advocates a more holistic concept of care, which recognises the importance of psychosocial factors and respects the wishes of the mother. She also suggests that more flexible, varied and sensitive communication skills and a less instrumental orientation are essential aspects of the midwifery process (ibid:52–9).

Methven does not consider what an appropriate mother/midwife relationship may consist of, except in the purely instrumental sense that the relationship should facilitate the midwifery process. This is a shortcoming shared with many others and will be discussed in more detail below. But some of her observations suggest that midwifery practice has a relational aspect to midwives as well as mothers. For example, she notes that those midwives most likely to stress the relational aspects of the booking interview were those who worked in the clinic on a permanent basis; whereas those working there temporarily, who could not be sure they would meet the individual woman again, de-emphasised that aspect and elected not to 'get involved'. Perversely, those were the very midwives most likely to be conducting the booking interview.

The sixth research direction in the 1980s has been historical. Historical analyses have highlighted gender conflicts at the root of medical attempts to control childbearing (Donnison 1988; Oakley 1982, 1986i; see Robinson 1989a).

Another theme in the literature of the 1980s has been the direct or indirect value of the midwife as a source of social support for the mother (Oakley 1984b 1986f; Oakley et al 1986; Buckle 1988; Oakley & Rajan 1991; Evans 1987). This literature has been
conducted more by social scientists than research midwives and has a characteristically different orientation. It will therefore be considered in Part Three of the thesis.

Summary

Three broad tendencies in midwifery research in the 1980s can be identified from this analysis. The first has been a political orientation away from obstetric supremacy; reorientating the field of enquiry towards the nature and quality of the care provided by the principal care giver, the midwife and institutional/interprofessional impediments to appropriate and autonomous midwifery practice. The second, related tendency has been an attempt to redefine the role, policy and practice of midwifery so orientated. This has involved a critical reappraisal of medical procedures in midwifery practice, the ideological recognition of midwives as practitioners 'with woman' and a corresponding conceptualisation of childbearing as 'an altered state of health' inextricably embedded in and influenced by psychosocial factors. The provision of continuity of care, and the development of team midwifery and the 'midwifery process', have been central to this reorientation. Finally, as part of a broader tendency within obstetric and epidemiological research in the maternity services field, the dominant research orientation has been evaluative and the dominant epistemology empiricist and the favoured method the Randomised Controlled Trial. There has been an increased emphasis on the psychosocial aspects of care but within an intellectual framework which favours knowledge rather than experience. Knowledge has become the province of the expert, residing in experiment not experience.
The midwifery profession suffered from the medicalisation of childbirth but was not part of the initial chorus of dissent. Accordingly, it has been reactive rather than proactive; and this has impeded its attempts to articulate a distinctive midwifery philosophy of childbirth by keeping it confined within the professional paradigm, which serves medical rather than midwifery practice. Consequently, I shall argue, the interests of both mother and midwife are being articulated within a perspective which ultimately denies them. Not only does this contradict midwives' own ideological objective, to be 'with woman'; it increases conflict and division between mothers and midwives. The rhetoric of allegiance obscures these difficulties. Moreover, the needs of childbearing women have not been sufficiently distinguished from the professional interests of midwives.

The renaissance in midwifery has therefore left it without a coherent paradigm from which to build a distinctive midwifery policy and practice. There remains a residual and unanalysed commitment to the professional perspective which underwrites medical practice on the one hand; and a related commitment to the research paradigms of the epidemiologists on the other. In consequence, I shall suggest, midwifery research is developing on an uneven footing, with its policies inclined in one direction and its paradigms in another. This threatens to obliterate the insights and implications of the protests of the 1970s; and thus the possibility of recognising the distinctive contribution of the midwife to childbearing women. There are strong suggestions in the literature that these tensions will result in midwives adopting an orthodox conception of their professional role and relationships. The manifestations of these difficulties are explored in Chapter 3.
Notes

1. Medicalisation and its consequences were most marked in relation to childbirth, the 'acute' area of maternity services. Antenatal care has its own, but not dissimilar, history. See Oakley (1986i).

2. Writers such as McIntosh (1989) may suggest that this reflects middle class priorities. But while there may be class differences, there are significant similarities. The need for good communication, for example, does not appear to be an exclusively middle class concern. (Cartwright 1979)

3. Although as Adams (1987) correctly suggests, it has been interpreted in a narrow sense as the communication of information. Only Adams (ibid) and Methven (1987) really deal with the wider concept of communication; and they do so within a paradigm which I shall suggest nullifies the insight.

4. Laryea's research (1989) has some significant methodological problems however which mean one must be circumspect about interpreting the findings. See Chapter 3.
Chapter Three

Is it a Boy or a Girl?

Developments in Midwifery:

the shape of things to come
Why is one woman still aware of her community midwife's working hours a year after she last had need to know? Why does another claim to love her? Why did a third 'really mourn' the end of their relationship? Why does a fourth think her 'a saint', a fifth want her to be 'a friend'? Why is a sixth disappointed not to know her 'as a person', a seventh upset by her brusqueness, an eighth by her indifference? What on earth is going on?

I began this research as one of the women referred to above. From my own experiences and discussions with other mothers I became aware that the mother/community midwife relationship has a significance over and above its 'professional' functions. The mother/midwife relationship is often described as 'special' (Flint 1987; Page 1988; Cronk & Flint 1989). I wanted to know what was 'special' and distinctive about it in the community setting.

This remains the central focus of the research. However, early in the research I became aware of a profound lack of 'fit' between this viewpoint and the 'professional paradigm' which dominates the midwifery literature. The clash of perspectives is so fundamental that there seems to be no way of incorporating what mothers tell me is important or 'special' with prevailing conceptualisations of midwifery practice and the mother/midwife relationship. Consequently, I have also become interested in the processes by which knowledge is constructed in academic and professional discourses.

In this chapter I suggest that a 'professional' outlook is conceptually blind to the processes which make the relationship 'special' to mothers. It thereby overlooks
important ways in which community midwives are (or can be) supportive of mothers. This I shall suggest is part of a wider incapacity to consider human relationships, emotion and biographical experience as integral aspects of midwifery. This oversight is in turn explicable in terms of the ontological assumptions which support a professional perspective. A 'professional' outlook divorces mothers from midwives and midwives from themselves. I go on to consider how the concept of social support, suitably conceptualised, can accommodate what women are saying in a way that a professional perspective cannot.

For reasons I shall explore in the following section there is virtually no clue in the research literature to what mothers or midwives themselves hold to be special about the relationship; and this despite recognition that a 'special' relationship does, or can, exist.

The best insights into what Cronk and Flint call 'that special relationship ...on which so much depends' (1989:9) come less from research than from primary sources, such as the one quoted below.

> Mothers and midwives are intertwined, whatever affects women affects midwives and vice versa – we are interrelated and interwoven....To be a midwife is to be with women (the meaning of the Anglo-Saxon word) –sharing their travail and their suffering, their joys and their delights... (Flint 1987: Preface, viii;1)

This implies two related aspects to the 'special' character of the relationship: a personal relationship between women and an emotional connectedness across the professional/client divide. This echoes the findings of my own research; which indicated in addition the rooting of the relationship in mothers' 'real' vital concerns.
My research suggests the midwife's distinctive contribution lies in three aspects, which I have termed the '3 Rs': the Relationship, the Role and the Real social context respectively:

The Relationship. The relationship was 'special' to the women interviewed to the extent that it was a personal relationship; akin but not identical to friendship. Moreover, it was indissolubly a relationship between women. They stressed the importance of a confiding, trusting, close relationship which had them, their emotions, experiences and concerns, at its heart. Pregnancy and childbirth is in this sense a process of self-exploration, which some women seek to share and understand with their community midwives. Such women want their midwife to be 'like a friend' to them.

In addition mothers valued the midwife's 'cultural qualifications'. Some valued the fact that she was a woman, others that she was a mother. Mothers frequently expressed the wish or the pleasure of knowing their midwife 'as a person'. If she was a mother, this was an important basis for sharing experiences and drawing the relationship closer. To many women, these cultural qualifications were important sources of professional expertise; encouraging empathy and social and emotional awareness. For these women, mother and midwife were drawn together through their social and psychological identities. Womanhood and motherhood symbolised their mutual grounding in a shared perspective and experience.

These sorts of orientations and priorities bear a startling similarity to the intimate
relationships identified as central to the concept of social support (see below).

**The Role.** The subjective, psychosocially oriented role of the community midwife concentrates on *feelings and experiences*. It also engages the midwife's culturally acquired 'ways of being' and 'ways of knowing'. This combination of professional role and cultural capability is a powerful and valued one. It is an important basis of the personal relationship referred to above. In addition, it places mothers and midwives in the same 'plane of being' and so engages the midwife's personal as well as professional resources. In addition, it enables mothers, through the medium of their midwives, to gain access to other women's experiences of childbirth. Midwives' are valued from this perspective for their psychosocial sensibility; an empathic and supportive orientation and a rich and detailed knowledge of women's experiences. This is an intensely subjective conceptualisation of midwifery. Midwives are the hourglass of women's experiences of childbearing.

**The 'Real' social context.** The community context is *situationally appropriate* to the role; rooting it within the psychosocial context it serves. It is interwoven into the fabric of women's real, vital, immediate practical and emotional concerns. Mothers usually feel more relaxed in their own homes and experience greater intimacy and personal connection in that setting. These visits also tend to be more leisurely. On this construction, the community context is both permissive (of the relationship) and situationally appropriate to women's own concerns and priorities.

My research, grounded in the mother's viewpoint (as I interpret it), places mothers and
community midwives firmly in the same 'plane of being', on the same 'side', in the context of an emotionally and practically important and supportive relationship. On this construction what is 'special' is the human relationship within which midwives' skills and knowledge are embedded. What they value as 'special' and distinctive is an emotionally connected supportive relationship which both draws upon and expresses women's culturally acquired skills and experiences; and one which is embedded in women's 'real' concerns and situations.

This conceptualisation visualises skills, knowledge and orientations not normally considered within the ambit of professional practice. It is a perspective which finds few echoes in midwifery research and in the following sections I suggest why this may be the case. I shall argue that the professional paradigm, which dominates most midwifery research, is incompatible with a thoroughgoing appreciation of what mothers in my research have identified as valuable and distinctive about their relationships with their midwives.

Research Regarding Mother/Community Midwife Relationships and Community Midwifery

If we turn now to consider how the mother/community midwife relationship has been understood in the academic and practitioner based literature to date we find an almost total silence. The relationship between a childbearing woman and her midwife has been almost entirely neglected. This is an oversight all the more surprising when one considers that midwives are women's primary professional maternity care givers; that
midwifery is increasingly community oriented; that increased research attention is being paid to the psychosocial aspects of maternity care; and that midwives are reestablishing a distinctive professional role, practice and research tradition, a central tenet of which is the provision of care supportive and 'sensitive' to the needs of the mother (Adams 1987; Flint 1987; Kirkham 1989; Methven 1989; see Chapter 2).

If the relationship is recognized at all it is characterised as an orthodox, if caring, professional/client relationship (Methven 1989; Ball 1989; Laryea 1989; Robinson 1989a, 1989b). It is recognised that the relationship is, or can be, 'special' (Flint 1987; Page 1988; Cronk & Flint 1989) but there has been no attempt to specify how or why. This is part of a wider failing to incorporate the concept of human relationships into midwifery practice.

Further, notwithstanding policy statements in favour of community based midwifery care (Association of Radical Midwives 1986; Royal College of Midwives 1987) there has been no attempt to specify what is distinctive about the mother/midwife relationship in the community. With the exceptions cited below, existing studies emphasise hospital rather than community midwifery and distinguish them for pragmatic or organisational rather than conceptual reasons. Robinson's summary of her national survey of midwifery roles and responsibilities (Robinson 1989) included responses from community midwives and found important variations in response relative to hospital midwives (Robinson 1985a). But she does not consider these discrepancies or give possible explanations; her principal concern is with interprofessional conflict within the hospital environment. Similarly Ball's analysis of
the value of postnatal care in facilitating the 'adjustment' to motherhood concentrates substantively and methodologically on hospital based postnatal care. For example, postnatal care in the community is analysed using questionnaire responses alone whereas hospital postnatal care incorporates observational, interview and questionnaire responses (Ball 1989:155–161). Flint & Poulengeris' 'Know your Midwife' research (1988) did not include systematic comparison of shared care, as opposed to hospital care; this was the subject of a sub study, instigated at the suggestion of third parties. Laryea's work investigating mothers' and midwives' perceptions of motherhood (Laryea 1989) involved interviews with mothers, hospital and community midwives; but the observational work was confined to the hospital alone. The concept of 'team midwifery' masks the differences still further. In practice, community midwifery is seen as a variant of hospital based midwifery practice, and a less glamorous version at that.

One study which does devote itself to community midwifery is that carried out by Humphrey (1985). This publication, reporting a study conducted in 1981, does not discuss method or methodology in detail, but her findings suggested that those mothers who booked for GP or home delivery wished to have a 'good relationship' with the midwife whom they anticipated would attend the delivery; felt that during the antenatal period the midwife had more time and expertise than the doctor; and indicated the importance of the midwife's social identity as a woman as well as her professional role. When the midwives did attend delivery this was 'undoubtedly' her most important role (ibid:349).  

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In the sections which follow I outline the 'professional paradigm' and trace its influence in midwifery research. I suggest that it is the dominant, if implicit, perspective; one conceptually blind to social relationships in general and therefore incapable of comprehending what mothers consider 'special' about their relationships with their community midwives in particular, including the personal and relational aspects mothers themselves emphasise.

Outline of the Professional Paradigm

Although one can distinguish a profession, a professional, professional practice and the professional/client relationship each is informed by the same underlying ideology. A profession is, inter alia,

...a superior type of occupation...that requires advanced education and training. It thus has a specific and exclusively owned body of knowledge and expertise. A profession organises and, to some extent, controls itself by establishing standards of ethics, knowledge and skill for its licenced practitioners. (Oakley 1984d:27)

Professional knowledge is exclusive, formal, discrete and cerebral. A professional is a person in possession of specialist abstract knowledge who thereby stands in privileged relation to his or her clients. Professional practice is the application of professional knowledge in an object oriented relation of domination and control, whether of a body, a mind or a situation.²

In these ways, the professional paradigm, or worldview, enshrines and prefers the culturally revered values of rationality, objectivity, formal knowledge, culture, and
control, themselves associated with masculinity, in opposition to those of nature, caring, emotion, experience and subjectivity, which in turn are associated with femininity. This preference is underwritten by ontological distinctions between object(ivity)/subject(ivity); rational(ity)/non rational(emotion); knowledge/experience; mind(culture)/ matter(nature) (Wagner 1986; Oakley 1992).

In this way the professional paradigm exemplifies "normative dualism"; a process in which things that may be complementary or even inseparable [are conceptualised] in terms of exclusive disjunctions (either/or but not both)... They then value one disjunct more highly than the other. (Garry & Pearsall 1989:xii)

In the professional paradigm, facts, reason, knowledge and science are concertinaed along an epistemological drawstring called objectivity. These are the attributes normatively preferred in the professional paradigm. Moreover, the professional paradigm recognises only one, 'professional', way of knowing.

In summary, then, 'professionalism': i) prioritizes professional practice; ie. the active application of formally constituted knowledge; ii) is incompatible with 'relational' analysis because it situates professional and client in wholly different 'planes of being'; and iii) prefers rational, formal knowledge, which it homogenizes and then monopolizes.

As Oakley notes (1984d), some sociologists, recognising the contradictions this poses for a female professional have labelled professions with a predominantly female
workforce 'semi professions' (Etzioni 1969)). Other sociologists, recognising the masculinist normative preferences inherent in such a conceptualisation of 'professionalism' have questioned whether women should strive to become professionals at all. Addressing the nursing 'profession' Oakley suggests:

If a profession is by definition male dominated, then nurses might as well give up. Alternatively, nurses might ask the truly radical question as to what is so wonderful about being a professional anyway...the current crisis of confidence in medical care should tell us that professionalisation is not the only answer. (Oakley 1984d:27)

The implications of this argument have not been fully articulated in relation to the developments taking place in midwifery. As noted earlier midwives are beginning to redefine the role, policy and practice of the midwife. One aspect of this has been the assimilation of 'caring' as a professional standard and objective. But this reversal of the 'care vs control' dichotomy in the medical professional model has led neither to a critique of related dichotomies, or, more radically, a critique of the normative dualisms on which the intellectual edifices of professionalism and science have been erected. Accordingly, midwifery continues to be articulated in a language appropriate to medicine not midwifery.

The midwife has a central place in the provision of care in pregnancy and childbirth, as it is in her role in particular that the main elements of maternity care – clinical assessment and monitoring and the provision of advice and support – are combined. (Robinson 1989b: Introduction)

Such phraseology reflects in part the pragmatic necessity of a dialogue in the language of the dominant partner. But it also illustrates a persistent tendency to conceptualise midwifery care in a conventional, object orientated way in a manner which denies
points of connection between professional and client and appropriates power and control to the 'expert'. The difficulties to which this gives rise are examined below.

**The Inadequacy of the Professional Paradigm**

The paradigm is inadequate to the analysis of the mother/community midwife relationship. It is conceptually blind to the relationship as a dyad on the one hand and the points of connection within it on the other. That is, it is unable to explain what is distinctive and 'special' about the relationship to mothers and, in a different way, midwives. It separate mothers from midwives and midwives from themselves.

There are four particular difficulties:

1. The professional paradigm fails to situate mothers and midwives in the same plane of being. It has no relational basis. This leads to two particular shortcomings. Firstly, it denies the validity and relevance of the midwife's biographical self to professional practice. This is part of a larger failure to incorporate a subjective viewpoint. It denies the social self, and thus the possibility of sensitising biographical experiences; and the psychological self, the midwife's culturally acquired 'ways of knowing' and 'conscious subjectivity'. That is, it alienates the midwife from herself; constructing her 'personal' and 'professional' self as entirely separate.

Secondly, it denies points of connection between women. Mothers and midwives are conceptualized as if they inhabit mutually exclusive social spaces. The paradigm
cannot accommodate the social and psychological identities which inscribe relationships between women in general; and so cannot appreciate the gendered basis of the mother/community midwife relationship in particular. That is, it eclipses something of profound importance to women. It cannot to explain many of the most emphatic statements they themselves have made; for example the importance of their community midwife being a woman, the desirability of her being a mother and so on.

2. The professional paradigm prioritizes professional activity and professional knowledge. The subject/object dichotomy, which underwrites the professional paradigm, allows no point of contact between mother and midwife. It denies the interactive, connective, basis of their relationship. 'Professionals' perceive their clients in object oriented, egocentric terms according to the dictates of their own professional agenda.

This has two consequences. Firstly, in practice, emphasis is given to the activity and concerns of the professional: ie. to professional practice. It invites practitioners to atomise the professional relationship and to fashion instead the entity 'professional practice'; a discrete body of knowledge and expertise divorced from the context of application. Secondly, if the relationship is considered at all, as in some analyses of the 'midwifery process', it is instrumental to the professional objective; for example 'the provision of advice and support' (Robinson 1989b), rather than conceptualised in its own right.

But the relationship is often of value to mothers in and of itself; not instrumental to
the provision of advice and support but an instance or expression of it. That is, it is 
the human relationship not merely the service which is valued. It is not a package but 
a process and the professional paradigm cannot see it. In order to understand the value 
of the relationship as it is lived, in order more fully to appreciate how midwifery is 
part of the social network, an aspect of social support, a real human relationship 
between two people, the professional paradigm has to be relinquished.

3. The professional paradigm alienates women from their own experiences. The 
language of professionalism does not articulate the women's own experiences. It is 
unable to accommodate what mothers value about their relationships with their 
community midwives. It 'alienates them from their own experiences' (Smith 1988:86). 
It is the language of disinformation. It denies the need for a 'relationship' except for 
purely instrumental purposes. It undermines women's own feelings. Women can be 
heard wanting a close personal relationship with their midwives:

    I'm hoping that a midwife will be almost like a friend's relationship 
    with you.

yet recognising these as 'outlaw emotions' (Jaggar 1989:145):

    But apparently that's unprofessional...you don't bring yourself, your 
    own experiences, into that sort of thing...that's what I've heard...but I 
    don't know whether I agree.

4. There are other, derivative, difficulties. For example, the professional paradigm 
constructs and prefers 'knowledge' over 'experience'; so that research, rationality and 
training are preferred over individual experience, whether professional or personal. 
The midwifery profession itself appears to be stratifying along these lines. Bodies and 
minds are also dichotomized, robbing mothers of their minds and midwives of their
bodies; this in turn aligns women with nature and men (professionals) with culture. It also deemphasises the practical basis of many professional skills and overlooks the manual basis of much professional work.

In short the professional paradigm is a way of constructing knowledge and human activity; one which relies on a series of ontological dichotomies, which polarise professionals and clients, midwives and mothers in turn. It is an ontology without a subjective viewpoint; ill disposed to relational analysis of any sort, and capable only of articulating instrumental, object oriented relationships. It is conceptually blind to subjective relationships since there is no point of connection between expert and subject, whether of knowledge or orientation. It is entirely incompatible with the overwhelmingly affective, connective, relational aspects mothers identify as 'special'. Such a conceptualisation prevents midwives perceiving their relationship with the women for whom they care in anything other than an object orientated way; for example, as one of value in its own right, rather than as a series of encounters instrumental in 'the provision of advice and support'. There is no way of differentiating the role of the midwife from that of the medical practitioner, except as a matter of emphasis. Further, in failing to challenge professionalism's normative dualisms the entire edifice remains intact. On this construction 'care' will always remain less central to professional practice than 'clinical assessment' and 'monitoring' and the 'provision of advice'.³
The Professional Paradigm in Midwifery Research

The professional paradigm has, to varying extents, underwritten most recent midwifery research, in particular practitioner based research. In consequence, it has, with very few exceptions, had precisely the emphases noted above. It has researched midwifery from a professional perspective at the expense of discovering the social, subjective, relational and emotional aspects of midwifery practice which the professional paradigm leaves out.

As noted in Chapter 2, emphasis is now being given to the psychosocial aspects of midwifery practice (Flint & Poulengeris 1988; Methven 1989; Adams 1987); in particular using the concepts of 'sensitive midwifery' and the 'midwifery process'. Both of these concepts emphasise relational factors such as continuity of care, good communication and flexible care. But the underlying paradigm is 'professional' and dichotomous and cannot accommodate a connective, dyadic, relational perspective.

Therefore, notwithstanding the popular professional perception that 'the relationship between mother and midwife is fundamental to good midwifery care' (Association of Radical Midwives 1986, cited in Oliver 1988:23) and despite research which suggests: i) the importance of midwifery care to the mother (Humphrey 1985; Flint and Poulengeris 1988); ii) that mothers are important to some midwives (Kirkham 1989; Adams 1987; Flint and Poulengeris 1988); and iii) a number of studies which make sensitivity to the mother's situation a prerequisite of good professional practice (Methven 1989; Ball 1989) there is no research, and no means to research, the
relationship itself.

The professional paradigm involves errors of commission as well as omission. These manifest themselves in the existing literature in three ways: methodologically, conceptually and ideologically.

**The Professional Paradigm and Research Methodology.**

In methodological terms there are four tendencies, each reflecting the normative dualisms identified above. Firstly, in observational research, there is a tendency to align midwives with 'fact' and mothers with 'feeling', thus reproducing the object/subject and fact/value divides. Ball's study of postnatal care, for example, had a research design in which mothers' subjective impressions were assessed by means of interviews and (closed) responses to attitudinal statements, while 'facts' or 'events' were obtained by reference to observational work, secondary sources and interviews with the midwife (the exception being in relation to the timing of the baby's first feed) (Ball 1989:156–7). When midwives were consulted as to subjective feeling it is in the context of providing an object oriented professional opinion. The relationship between mother and midwife and the midwife's conscious subjectivity, including her feelings, are overlooked.

Secondly, research midwives seem to experience ethical and role conflict in relation to clinical issues rather than, for example, in relation to the exercise of professional power over a woman. Laryea (1989), for example, intervened by alerting a midwife
to a baby with a tendency to vomit but did not intervene when asked to arbitrate in a dispute between a mother and a midwife regarding the mother's right to pick up (or 'spoil') her baby if she so wished (ibid:180;179). This demonstrates an implicit and orthodox concept of the professional role of the midwife.

Thirdly, there is a tendency to align expert knowledge (be it that of the professional midwife or the researcher) in opposition to lay knowledge. Methven (1989), for example, utilized data regarding the 'relationship' from observational work and interviews with the midwives, but not from interviews with the mothers (ibid:60).5

Finally, a number of researchers presume rather than problematize both social 'reality' and research methodology. There are several such tendencies. For example, the 'Midwife Research & Childbirth' series (Robinson & Thomson (eds) 1989, 1991) presents research findings along with explicit methodological discussion. But there are a number of omissions in the discussions attributable to blind spots within the professional paradigm. Firstly, a number of authors employ participant observation in research without adequately considering the relationship between researcher and researched. For example, despite the implication that mothers knew she was a midwife, despite the fact that she conducted her observational work on the postnatal wards and despite the fact that she used the staff rest room and took meals with them, Laryea considers the wearing of 'civilian' clothing and attendance in the mother's dayroom to 'sit and talk' with them sufficient to ensure integration into the mother's subculture (Laryea 1989:179). She refers to 'unpleasant feelings' engendered when she was in the 'company of women who expressed strong views about certain members
of staff and was then seen by those same mothers to be having tea with the staff members' without considering the impact this will have on the women, the data they will impart, and the ethical propriety of the situation.

Relatedly, many researchers employ grounded theory without considering the researcher's capacity to perceive and interpret 'social reality' at all (Adams 1987; Kirkham 1989; Laryea 1989).

Other authors, (for example, Ball 1989; Methven 1989; Porter & MacIntyre 1989; Robinson 1989a; Laryea 1989) attempt implicitly or explicitly to 'triangulate' observational and interview data; but in none of these cases is any attempt made in the methodological discussion to 'pin down' the data; for example, to demonstrate that a particular attitudinal statement arises from or is directly related to observed events. In all cases it appears that observational and interview data are obtained in relation to temporally distinct events and synthesized in analysis without reference to the fundamental methodological questions this raises. That is, certitude which arises from questionable methodological design is attributed instead to the social world. There are also tendencies both to presume that social reality exists and is accessible (Laryea 1989; Methven 1989; Kirkham 1989); and to assert rather than examine the adequacy of research design and methods. Ball for example declares one advantage of the use of factor analysis to be the reduced likelihood of bias from the researcher (Ball 1989:159). She fails to consider ways in which statistics bias findings; the potential distortions built into decisions to employ a particular research design; for example, one in which women are observed only in the hospital environment despite the
acknowledged significance of 'antecedent' factors; the appropriateness of 'closed' scaled responses as a means of eliciting women's responses; and the theoretical assumptions built into the choice of questions and rating criteria and their inferential value as indications of actual behaviour (Ball 1989:159-162).

Relatedly, there is a tendency to ignore the theoretical content of factual observation. Both Laryea and Kirkham, for example, claim to produce complete observational accounts. Laryea claims to have recorded a 'full description of the activity' described (Laryea 1989:179). She also suggests that 'Incidents that were expressions of attitudes...were recorded fully' (ibid:179). Methven also implies an exhaustive account of interaction has been achieved when she states that she recorded the verbal features of a conversation in a tape recording and the non verbal features on checklist, 'thus providing a script of both verbal and non verbal exchange between the interviewer and interviewee' (Methven 1989:45). Robinson claims that her research methods have 'validity' on the basis of what appears to be mere reliability between methods (Robinson 1989a:11).

It could be argued that these tendencies derive from empiricist approaches to social research rather than from the application of the professional paradigm. But each is informed by the same underlying ontology. Both presume where they should problematise. Both claim absolute and superior knowledge. Both rely on the normative dualisms referred to above. These omissions demonstrate in a research role the same unelaborated certainties noted earlier in relation to the professional paradigm. Both result in the elevation of expert knowledge. These epistemic tensions are apparent in
the upsurge within midwifery of a research based philosophy of practice. If the midwife 'knows', the research midwife knows more.

During the 1970s, the view steadily gained ground that midwifery practice and education should be based on research findings rather than on custom and tradition...if a profession is to develop a research base successfully it requires not only practitioners willing to undertake research but also colleagues who are willing to support them in the process and a programme of dissemination and implementation of findings...this is turn requires a 'research awareness' in the body of the profession who may not be undertaking research themselves. (Robinson & Thomson 1989:3)

The Professional Paradigm in Research Design

Studies of communication between mothers and midwives are conceptualised and researched in ways which emphasize the importance of communication in one direction only: from midwife to mother. This gives expression to the epistemic supremacy of professional knowledge. The midwife is cast as the active expert and knower, in contrast to the unlaundered lay experience of the mother. This shortcoming is consistent with an object oriented paradigm of professional care. Thus Adams' (1987) research design elicits a typology of midwifery communication styles despite a methodology (interaction analysis) whose distinctive characteristic is to highlight the mutually negotiated basis of social interaction.

If communication from mother to midwife is recognised it is conceptualised in an instrumental way which fails to challenge (in fact it extends) the relative statuses of professional and lay knowledge. Thus although Methven's work (1989) highlights some differences between medical and midwifery approaches to the antenatal booking
interview it fails to challenge the underlying 'professional' similarities. There is no challenge to the hegemony of professional knowledge, no modification of the professional viewpoint, no recognition of points of connection between professional and client. In fact the professional's hegemony is extended from clinical to psychosocial expertise. Although Methven recognises that 'the antenatal booking interview as currently undertaken is oriented towards obstetrics rather than midwifery' (ibid:59) and although therefore 'midwives are unwittingly regarding the childbearing woman as an obstetric object rather than a person with hopes and fears, views and opinions, personality and relationships' (ibid:59) the appreciation of these psychosocial phenomena occurs within the orthodox professional viewpoint which casts the professional as active expert and knower. The psychosocial domain thereby becomes the legitimate extension of professional expertise. The 'midwifery process' then consists ultimately of data elicitation and appropriation by the professional midwife, to facilitate, in Robinson's phrase 'the provision of advice and support' (1989b). Methven sums it up when she suggests that: '...midwives are not availing themselves of the opportunity to establish a supportive relationship within which the woman feels encouraged to discuss any problems or concerns they may have' (Methven 1989:59, my emphasis).

The Ideology of Professionalism

The ideology of professionalism leads a number of researchers to assert policy implications not strictly warranted by their research evidence. That is, it is assumed that professional practice is 'a good thing'. McIntosh's work illustrates this tendency.
Notwithstanding that the body of research on which his paper draws indicates marked social class differences regarding women's orientation to childbirth and its management (according to which working class women are more pragmatic about the experience of childbirth and more acceptant of intervention); and despite evidence suggesting that professional sources of information are relatively unimportant to such women (cited as a source of information in 4 out of 80 responses) (McIntosh: 1989: 193); and despite the consistency of this finding with other research on information sources and social support (Jacoby 1988; Wood 1985a; 1985b), McIntosh nonetheless advocates greater professional involvement and intervention: a) to educate mothers antenatally; b) to improve communication during labour and delivery; c) to give better explanations regarding those interventions actually performed (ibid: 212). Although McIntosh tailors these recommendations to the research evidence where he can, the underlying prescription does not derive from it and tends to contradict it.

Other research displays similar difficulties (Ball 1989; Laryea 1989). The implications of Ball's analysis of postnatal care, for example, suggest that the interests of the mother would be best served by the midwife abandoning professional practice altogether. The only significant correlations attributable to midwifery care in her analysis was firstly between feeding the baby in the first hour after delivery and 'satisfaction with motherhood'; and secondly between particular aspects of postnatal care (such as not giving inconsistent advice, and ensuring adequate rest for the mother) on 'self image in feeding' (itself one of five correlates with 'emotional well being') (Ball 1989: 164–171). On this analysis one may conclude that the midwife's
influence is very limited: antecedent sociocultural factors, for example, lying outside her control yet significantly associated with 'emotional well being'. On a strict construction of the research evidence the only policy indications are in favour of professional withdrawal: ie. leaving the mother to get on with it and not interfering. Not surprisingly, this is not the conclusion she draws. She suggests that there is 'considerable evidence that the management of care in the delivery suite and in the postnatal period affected the adjustment process' (ibid:172). (In fact such 'delivery room' management, as noted above, consists of giving the baby to the mother to feed in the first hour after delivery, which is correlated with 'satisfaction with motherhood'. Delivery room care thus defined was of equal, and postnatal care of smaller, statistical significance than life events and other correlates [ibid:164]). Despite the absence of any research evidence to suggest a positive contribution arising from the provision of advice, observation and influence, Ball concludes that 'midwives in particular have much to contribute to the emotional health of mothers and babies' and suggests that this will be achieved by more, not less, involvement (Ball 1989:172–3).

Laryea's conclusions also bear little relation to the empirical results of her own research. She says that

The data showed that the observations made by the midwives were irregular and inconsistent...The women's medical records did not contain the depth of information to enable the midwife to make a full assessment of an individual woman's needs. The information form the daily ward reports on the woman's progress was brief and did not always mention the emotional aspects of care and talking with woman depended on how busy the wards were and the number of staff available. (Laryea 1989:186)

But no data to this effect were presented in the body of the research paper itself, the
principal theme of which was competing medical and maternal perspectives on motherhood. In addition, the implicit association between attitude and activity was not elaborated or substantiated, so no inferences could be drawn from that source. Further, despite the observation that midwives should 'adopt a holistic approach to care, rather than to continue to see it primarily from a biological and medical perspective' (ibid:187) she adopts precisely the latter perspective in order to articulate the 'needs' of women.

It was observed that women were not free to pick up and cuddle their baby...This approach defeated the object of rooming in...Thus the woman's approach was guided by instinct while the midwife's was based largely on speculation. (ibid:185)

It is in 'scientific' research that the contradictions implicit in midwifery research are posed most acutely; those arising from the incorporation of the normative dualisms of science and professionalism, including objective/subjective, rational/non rational and knowledge and experience. As noted in Chapter Two, in obstetric clinical research the Randomised Controlled Trial (RCT) has been vigorously advocated (Chalmers & Richards 1977; Enkin & Chalmers 1982; Chalmers et al (eds) 1989a, 1989b), and this has overwhelmingly influenced the design and methodology of much midwifery research. Such research recognises the epistemic validity of scientific evidence alone. A direct opposition is asserted between 'experience' and 'knowledge'. Enkin & Chalmers, for example, refer to the 'shaky foundations of authority and clinical experience' and caution 'conscientious clinicians' to base clinical practice on the results of scientific evaluative research arising from the conduct of 'appropriately designed research' (Enkin & Chalmers 1982:278). Although they acknowledge that 'many things
that really count cannot be counted' (ibid:285), they provide no means of reconciling that sentiment with the asserted superiority of scientific over other sources of knowledge.

This has three particular consequences for midwifery. Firstly, it denies the validity of the midwife's biographical experiences as a legitimate aspect of professional knowledge, and the skill and knowledge arising from 'professional' experience. The complementarity of research, knowledge and experience is underemphasised. Secondly, it denies the possibility of learning through identification with the client because it asserts an epistemie distinction between lay and professional knowledge corresponding to 'objective' and 'subjective' states, (knowledge and experience respectively). In so doing it implicitly (and erroneously) asserts the epistemic purity of scientific research through sole reliance on 'objective' knowledge, methodologies and practice (Knorr-Cetina 1981). Thirdly, it asserts the possibility of confining 'subjectivity' to discrete and manipulable variables, and to research subjects. In this way it becomes divorced from other indices or outcome measures (for example, degree of medical intervention during labour and delivery) and from the research process itself.

As noted earlier, this methodological configuration systematically contorts the perspective arising from my own research; which suggested that the importance of the mother/community midwife relationship lies precisely in those sources of 'knowledge' which the empirical scientist denies: the midwife's professional skill and experience on the one hand and her personal and cultural qualifications on the other. The personal, affective and relational aspects of midwifery practice are crucial to both
mother and midwife. Flint's 'Sensitive Midwifery' (1987) abounds with examples of the importance of biographical experience and empathic identification to midwifery practice. Personal, emotional and biographical experiences are crucial aspects of the professional process. But this insight is denied by the ideologies of professional, scientific and research knowledge. A scientific perspective denudes the mother/midwife relationship and denies its richness and complexity.

This brings us to the central contradiction of the 'professional' and 'scientific' perspectives. Each has a terminal logic for midwifery. Since both assert only difference between the professional/researcher on the one hand and the subject on the other they are unable to appreciate the distinctive contribution of the midwife to maternity care; and thus the midwife is expendable and can be substituted.

Flint & Poulengeris' (1988) research, for example, was inspired by knowledge of the importance of midwifery care for mothers. A full appreciation of this aspect of midwifery would involve theorisation of the relational and emotional aspects of her role. But it becomes abstracted in the research as 'continuity of care'. On this construction anyone who can provide continuity of care can reproduce the important aspects of midwifery care. This limitation is apparent in The Association of Radical Midwives' document 'The Vision' (Association of Radical Midwives 1986), which is unable to distinguish adequately the respective roles of GP and midwife. Indeed the GP's claim to provide continuity of care seems the stronger since s/he will see the woman both prior to the pregnancy and subsequently.
Similarly, Robinson's research (1989a) into the 'role and responsibilities of the midwife' documents the erosion of the midwife's autonomy and responsibility. But her arguments for their reinstatement (that the existing situation involves a duplication of resources; that it doesn't allow midwives adequate training and responsibility; that it frustrates attempts to devise appropriate curricula; that the care provided at present is fragmented) (ibid:32–33) could be used equally to argue for the abolition of midwifery and the full provision of care by general practitioners. Robinson hints at the resolution to this paradox when she refers to the midwife's greater accessibility and wider role orientation over that of the general practitioner; and Cronk & Flint (1989) hit the nail on the head when they assert that the mother/midwife relationship is 'special' (ibid:9). But, as suggested earlier, the 'professional' and 'scientific' paradigms limit the opportunities to develop these insights and establish a fully rounded appreciation of the role and importance of the midwife.

This is the wider constraint on the moves in the 1980s to develop forms of practice, knowledge and skills that are distinctive to the midwife. 'Professionalism' and 'empirical research' as presently understood and articulated inhibit as much as they encourage this process: they constitute a threat to the professional practice of midwifery.

The Mother/Community Midwife Relationship as a Source of Social Support

At this stage it may be useful briefly to consider an alternative conceptualisation which can illuminate those aspects which mothers emphasise but which are obscured
by a professional perspective. The concept of social support is helpful here; although it too can be and often is appropriated to the professional paradigm and thus loses its analytic value.

What do we mean by social support? As Oakley suggests, there is no consensus and few coherent definitions (1992:26–27). Common sense suggests that it is human assistance which makes life either better or easier for the recipient. Such support may be social, practical, emotional or financial and depends upon the subjective needs of the recipient. Duck, for example, defines a social network as 'the group of people with whom a person is involved (usually friends)' and suggests that "social support' refers to the help they provide or are felt to provide" (1986b:208). In practice however it concentrates less on what people actually do and more on how people feel in relation to certain critical others (and for this in some respects it can be criticized).\(^7\)

Duck (1986b:211) notes that 'social support' is a concept commonly employed in the context of epidemiological research investigating two distinct hypotheses. The first is that social support can act as a mediating buffer between life events (the independent variable) and illness (the dependent variable). The second is that the absence or disruption of social support can predispose to ill health. In this context social support tends to mean a nexus of close (socially and emotionally) supportive relationships. As Duck notes, 'intimate relationships with a small number of persons are what really counts' (Duck 1986b: 209).

The concept of social support is therefore first and foremost a concept which
emphasizes the importance of close social relationships to an individual's well being; that is, the importance of intimacy. As Lin (1986) notes,

Maintenance of a healthy status, no matter how it is defined, requires sharing and confiding among intimates who can understand and appreciate one another's problems. (Lin 1986:28)

Moreover, it situates supporter and supported in the same 'plane of being'; which is not to suggest that they experience or perceive the relationship in the same way. The concept of friendship does a similar thing. From this viewpoint it is possible to see how a professional relationship can be socially supportive. The concept usefully summarises much of what childbearing women mean when they call the mother/community midwife relationship 'special'. What they mean is that they are seeking a close, supportive (both practically and emotionally) relationship with their community midwife; one grounded in their real situations and experiences; one within which they can share their experiences and feelings with an understanding, empathic companion; one in which they can engage the midwife 'as a person' and share through her the experiences of other childbearing women.

In drawing attention to the primacy of close, confiding, relationships, the concept of social support highlights precisely those factors women themselves identify as the basis of the 'special' and distinctive aspects of their relationships with their community midwives.

Oakely et al's interventionist RCT research offered practical and emotional social support by research midwives to women at risk of having a low birth weight baby (Oakley 1992). Compared to the control group, this produced statistically significant
improvements in maternal and perinatal outcome; thus confirming statistically the
importance of community based midwifery social support (Oakley et al 1991). This
illustrates how the concept of social support can direct attention away from a clinical
perspective to a social perspective, to powerful social and clinical effect.

However, it is also interesting to note in this connection that, contrary to the stress
laid in the social support literature on the idea of reciprocity, many women valued
the absence of reciprocal obligation with the midwife as professional caregiver. That
is, in a situation of personal need it demanded nothing in return. Relatedly, some
noted with relief that they didn't have to do the reciprocal emotional work with their
midwives which friendships required. They also indicated that friendships may be
more bounded than a professional relationship; enabling them to be open and
vulnerable with their midwives in a way they could not with their friends. These are
important aspects of social support within a professional relationship which the
existing literature tends to overlook. These points are discussed in more detail in
Parts Two and Six of the thesis.

Summary

This chapter has outlined what childbearing women find valuable and distinctive about
their relationships with their community midwives. I have juxtaposed the outlooks
implied by the concepts of social support and professional care and suggested the
inadequacy of the latter to an understanding of what women themselves value; and by
extension one important way in which midwives can be socially supportive of
mothers. I have suggested that a 'professional' outlook ruptures points of connection between mothers and midwives on the one hand and the personal and professional 'self' on the other in an unwarranted way. Finally, I have indicated the prevalence of a professional outlook in practitioner based midwifery research to date and have demonstrated some of its consequences.

What implications does this have for future research, policy and practice? It suggests that mothers and midwifery research are facing in different directions. If midwives want to be 'with woman' they will have to do it without the professional paradigm. This does not mean that their outlooks have to be identical or wholly subjective. But the orientation of a 'caring professional' is not thoroughgoing enough.

As Methven's work (1989) indicates, language and concepts are among the most powerful definers of situations. If midwives really wish to challenge the medical model in their own practice they have to address the professional paradigm which supports it. This is no small task, for ultimately it entails a critical reevaluation of how we know what we know, who defines it for us, what goes on inside our own heads, and where we stand in relation to others. It restores mothers and midwives to the centre of the process, but in so doing it poses as many challenges as it meets. This is a challenge other 'professionals' (among them sociologists, scientists and social workers) must also turn to face.¹⁰
Notes

1. Evans (1987) and Oakley et al (Oakley 1992) have conducted intervention studies which use community midwives and research midwives respectively as social support resources for mothers in the community. These are analysed below in a discussion of the concept of social support.

2. See Morgan et al (1985) for a review of the literature on the sociology of the professions. The literature is not elaborated in detail here because it does not assist my own analysis.

3. See Williams (1978) on the history of nursing, and the tension between the drive to professionalise nursing and the caring bedside skills.

4. Kirkham (1989) is the only obvious exception.

5. Appendix B to the paper presents a questionnaire which contains limited enquiries about the relationship to the mother.

6. In the 1977 volume they suggest this is not the case; but this runs counter to the emphasis in their arguments.

7. It either ignores the practical and material aspects (see Lin 1986) or sees them within the context of relational analysis rather than as important in their own right. (This is not to deny that practical help has psychological and social aspects). Duck (1986b:214) makes a similar point when he notes that a person with plenty of social support may incidentally be getting more help.

8. See Lin (1986) for a review.

9. It is possible that Lin (1986) in particular emphasises this more than most, but it pervades many related fields, such as theories of friendship (see Furnham 1989).

10. See for example Whittaker, Garbarino & Associates (1983). This text illustrates the same internal tension about professionals' relationships to the lay community that midwifery has to face. See especially the Preface and the chapter by B. Blythe.
Part Two

The Perfect Unprofessional
Overview

Part One of the thesis offered a critique of professionalism in midwifery research. Part Two offers an alternative conceptualisation; one which makes visible those aspects of midwifery practice overlooked by the professional paradigm. Chapter 4 outlines its ontological foundations. Chapter 5 presents the metatheory employed in the substantive analysis. Together, these comprise the 'personal paradigm'; a non dualistic feminist metatheory which accommodates the complexities of women's social locations and experiences. In Chapter 5 I characterise the mother/community midwife relationship as a personal relationship constituted within the personal paradigm.

Part Two is prefaced with a piece of 'creative non fiction' which expresses the concepts incorporated into the personal paradigm. It refers to an occasion when I visited my own midwife and began to understand sources of 'specialness' in our own relationship.
April 1990

I went to visit a friend the other day. We hadn't seen each other for ages, about two years. I arrived at her house, couldn't raise a response, so went round the back, where I found her cleaning windows. We kissed each other politely and I offered to help with the windows. She said she'd show me around the house. This she did, explaining her plans for, and the history of, each room as she did so. We chatted about mutual friends. When we reached her study, I gave her a gift: a book, on women's friendships, which I'd read with her, and her friends, constantly in mind. I put the kettle on for coffee while she changed her clothes. I showed her some photographs of my children. She showed me photographs of children, mothers and babies. We took our coffee and biscuits into the garden.

We talked about many things. We spoke about my research. She feels some ambivalence about it, but this we did not discuss. We had an ostensible conversation and an implied conversation, the latter packed with emotional implications we felt unable to pursue. We hoped to heal emotional wounds beneath the surface by placing a gauze across it, endowing it with the balm of human contact. We gave what we could in spite of our discomfort.

It began to rain. I helped her collect the washing from the line, chatting as we did so. We went indoors, made more coffee. The balm had started to soothe us. We felt better.

We sat on the floor, drank coffee, and treated ourselves to a proper conversation. We
discussed most things: paintings one minute, religion the next. Mixed up marriages as we breathed in, child abuse as we breathed out. Friends, family, work, pleasure, music, and art were taken in. Beneath the surface of manifest meanings, new meanings were being configured. Each utterance had echoes which rolled through the form of our friendship. Every word was a process, every touch was a smile.

Communication between women has this connected quality. Women's talk does not denote, it connotes. It continually constructs and deconstructs, affirms and denies, aspects of the relationship of which it is part. It signifies, both linguistically and emotionally.

...So she told me about (the repairing of) her relationship with her daughter. Family occasions, pub lunches and new stereos were mentioned. Steeped in this scenario it was with some surprise that I realised that she was now talking about premarital and oral sex. Packed into this conversation was a whole chorus of meanings. Ostensibly about what she felt unable to discuss with her daughter, it was impliedly about what she felt able to discuss with me. In this way she extended and redefined the boundaries of our own relationship. We had spoken to each other and developed our relationship without saying anything.

My friend specialises in embedded conversation of this sort. It is very subtle, very skilled, very effective and very powerful. Messages are communicated on the breeze of implication: all are touched by it but there is nothing for the outside observer to see.
Detailed personal knowledge. Mutual understanding. Unconditional acceptance. Subtlety and sensitivity. Making and remaking. Shadows of difficulty. This is the emotional basis of relationships between women. This is the art of communication between them. This, in fact, is a mother/midwife relationship.
Chapter Four

Being and Knowing: a new ontology
We do not think of the ordinary person as preoccupied with such difficult and profound questions as: What is truth? What is authority? To whom do I listen? What counts for me as evidence? How do I know what I know? Yet to ask ourselves these questions and to reflect on our answers is more than an intellectual exercise, for our basic assumptions about the nature of truth and reality and the origins of knowledge shape the way we see the world and ourselves as participants in it. (Belenky et al 1986:3)

I regard feminist philosophy as primarily concerned with the construction and development of concepts and models adequate for the articulation of women's experience and women's practices. (Whitbeck 1989:69)

Part One of the thesis outlined ways in which the professional paradigm and empiricist methodology exemplify 'normative dualism'; an orientation deriving from a Cartesian ontology (Lloyd 1989:115–116) which interprets 'things that may be complementary or even inseparable in terms of exclusive disjunctions (either/or but not both)...They then value one disjunct more highly than the other...' (Garry & Pearsall 1989: xii). Examples include: subject and object, thought and feeling, rationality and emotion, knowledge and experience, conscious and unconscious, the self and society, masculine and feminine, to name but a few. The normative preferences enshrined within masculinist discourse express male rather than female experience and so represent a form of cultural subordination in which the experiences and voices of women are not heard (Garry & Pearsall 1989:47–48).²

The ontology outlined here conceives of reality as multifaceted and interdependent. It has the form of a crystal: one facet cognitive, another epistemological, another methodological and yet another substantive. Together they lock together and comprise a whole. The whole is a value, known from within. Yet it also has a context: held by someone, viewed by someone, shining lights which only which its environment permits.³ From this perspective, it is possible to visualise truth and knowledge as three
dimensional things; to view truth in relation to knowledge, seeing in relation to knowing, knower in relation to known; to see that each suffuses the other in a complex interdependence.

This is in contrast to the normative dualisms of professionalism and empiricism, which commit themselves to one dimension and have only one way of knowing. If dichotomous thought is deconstructed, academic knowledge, research practice, and everyday experience, can be conceptualized in their rich, multifaceted complexity. As noted in Chapter 7, we begin to see variability, differentiation, diversity and dynamics, rather than the flat and lifeless juxtapositions of dualistic conceptions. We see ranges and dimensions to everything: emotion in formal knowledge, rationality in experience, common sense in science, love in professional practice, biography in professional expertise, a 'professional' self as well as a 'personal' one and so on. Such a conceptualisation makes no a priori distinction between formal and informal knowledge, subjective and objective knowledge, thinking and feeling, knowledge and experience or professional and client. It is the ratio or emphasis, and not the category itself, which distinguishes them and according to which criteria of adequacy emerge. A differentiated ontology is likely to be particularly important to the understanding of women's situations and experiences; since it is relational, mobile and multifaceted in the same ways as are women's 'ways of being', 'ways of knowing' and the realities of their daily lives.

This formulation has strong affinities with Whitbeck's (1989) concept of a feminist ontology. She suggests that a 'self—other' opposition is characteristic of patriarchal and,
in a different way, individualistic representations. Consequently, it is not enough to highlight the neglected side of dichotomous thought, or to celebrate essentialist female identities, since this leaves intact masculinist intellectual categorisations. This thwarts an understanding of nurturance and interdependency, which she suggests is a distinguishing feature of a feminist ontology. She suggests object relations analyses, including those of Mitchell and Chodorow, suffer in this respect (ibid:53–59).

Whitbeck posits instead a feminist ontology which is differentiated rather than dualistic, non oppositional, and incorporates a new view of the person and of ethics (ibid:51;62–65). It is a 'mutifactorial, interactive model of most, if not all, aspects of reality'(ibid:63); which theorises relationships with others, founded on analogy and differentiation rather than opposition, at the heart of knowing (ibid:62).

The ontology is based on an understanding of the relation of self and other as a relation between analogous beings. The nature and extent of the analogy is something to be determined in each case...another distinct being may, and usually does, possess some of the same characteristics as the self....On this view the person is understood as a relational and historical being. One becomes a person in and through relationships with other people...the realization of the self can be achieved only in and through relationships and practices. (ibid:68)

This formulation gives rise to immediate difficulties. It is itself essentialist in that it has unlimited applicability. In addition, there is no way of knowing how the limits of analogy, and thus differentiation, are reached. But what is useful is the way it seeks to overcome dualistic categories and posits identity through relationships and nurturance as central to being and knowing. These themes: a non dualistic, multifactorial analysis; a relational, differentiated self visualised as central to what is
known; and self realisation through cooperative engagement with others are central to the personal paradigm. Some of these themes find expression in different ways in Bologh's feminist model of erotic love as sociability (i.e. as mutually pleasuring, stimulating or empowering) (Bologh 1990:213). This is discussed in Chapter 14.

I describe my perspective as 'a personal paradigm' for a number of reasons. It visualises the knower as integral to what is known. Unlike the 'professional paradigm' it is non dualistic and emphasises connection rather separateness, and differentiation rather than absolute division, without lapsing into relativism or essentialism. Finally, it is a located, relational ontology which places values/morality at the heart of knowing.

This is, I believe, an ontology more adequate to women's experiences. It may be suggested that it is itself essentialist; that there is no definitive 'woman's experience' (Ferguson 1989); that each of us can speak only for ourselves. This may be valid but it is a false reductionism. It is possible to speak beyond the particular without lapsing into essentialism or dualism, though ultimately one's account remains located. This ontology arises from my experience in the world; and is appropriate to my understanding of mother/community midwife relationships. But it also finds echoes in recent feminist philosophies (Stanley 1990b; Garry & Pearsall (eds) 1989; Harding 1987a); which suggests it has a significance beyond itself. I develop a sociological interpretation of research, relationships and community midwifery based upon it; but am able to articulate it only because it is a way of being shared and articulated through others. Together, we find a voice.
Notes

1. My thanks to Carol Bates for suggesting a title along these lines.

2. This is not to imply that men inevitably or invariably experience reality this way, nor that women's experiences always oppose it. This would be to fall prey to dualistic thinking by positing essentialist gender categories, man–woman (Whitbeck 1989:51). But one cannot dissociate theories of being and knowing, i.e. of ontology and epistemology, from the agency of the knower. And, as Whitbeck notes, dualistic thinking expresses a masculine standpoint and psychology grounded in an oppositional orientation (Whitbeck 1989:51).

3. Note that using this metaphor the researcher, for example, is both part of the truth and yet separate from it; i.e. is reflexive.
Chapter Five

Locating Ourselves: Self,

Feeling and Friendship
Chapters 2 and 3 drew attention to the ways in which the professional paradigm is unable to accommodate the distinctive and special characteristics of the mother/community midwife relationship. Thematical, this is the counterpart to those chapters. I shall suggest that the personal paradigm 'fits' where the professional paradigm does not. This chapter develops the concept of a personal relationship constituted within the personal paradigm. This provides the metatheoretical framework within which the substantive analysis presented in Parts Five and Six of the thesis can be understood. Key findings from the research are summarised below to indicate the relevance of the metatheory developed here.

A 'personal relationship' denotes an orientation in which people are viewed relationally, emotionally, and biographically. This concept embraces all of the '3Rs' (Relationship, Role and Real social context) which characterise the midwife's role, not merely the first. It is also appropriate to the analysis of specific relationships, developed in Chapters 10 and 11.

The relational aspect refers to the location of 'self' in relation to 'other'. The emotional aspect refers to the predominantly affective orientation each party has to the other; how each party 'feels' about the other. The third, biographical, aspect refers to the development of a relationship akin, but not identical, to a friendship. Each of these aspects influences the other.

For ease of presentation I shall deal with the biographical aspect first, followed by the relational and emotional aspects. I draw on social psychological, psychoanalytical and
sociological sources respectively. This gives rise to great complexities of construction, since each is predicated on different and sometimes conflicting analytic assumptions. Each however can be reconciled to the ontology outlined in Chapter 4 and it is this which overcomes the interdisciplinary incompatibilities and lends the analysis its coherence.

Summary of the Distinctive and Special aspects of the Relationship

Parts Five and Six of the thesis detail the distinctive and special aspects of the relationship. They may be summarised as follows. Firstly, the women interviewed generally wanted a personal relationship with their community midwife and experienced their interaction in personal not instrumental terms. They reported a social and psychological identity with midwives as women. They could 'open up' more easily to another woman; feeling women to be in touch with each other's feelings and emotions and socially more central to the childbirth experience.

It was also important to women to know their midwives 'as a person', in particular whether they had children of their own (and in general they preferred it if they did). They also believed personal biographical experience was an invaluable source of professional expertise. Women referred to the wish to 'compare notes' about their respective experiences and of the knowledge and sensitivity midwives' personal experience of childbirth makes possible.

So, women want to know their caregivers as people (similar to themselves) and to
share biographical experiences and knowledge. They like to know their midwives.

Secondly, midwives were valued for their supportive, psychosocial orientation towards women. In particular, they have a subjective appreciation of women's experiences; this was seen as an important source of expertise. In this way, midwives embody other women's experiences. Unlike the doctor, they support in practical, emotional and relational ways; ways less available to the general practitioner. They 'get to know' and care for women as people 'in a big way'; they make your babies 'special'; they are approachable 'as a friend'; they are known 'as a person'. They advise, counsel, reassure and provide clinical care within this emotional and social context. Their role is social and emotional rather than clinical in emphasis.

It also occurs within a 'normal' and appropriate social context. The community situation emphasises and facilitates the social and relational aspects of the midwife's role. Midwives reported that within a community context they can better establish relationships and 'get to know the mothers as people' and this increases their job satisfaction. Women reported that within their own homes in particular they feel more relaxed, and that meetings are more informal, more 'chatty' and more conducive to 'getting to know each other'.

These are the themes which the following metatheory helps to clarify.
Biographical Aspects of Relationships: the psychology of friendships

There are sociological and psychological analyses of friendship. Neither is adequate in itself for the personal paradigm. In general, the sociological accounts are too sociological, and the psychological accounts too psychological. As Allan (1989) notes, the psychological perspective has dominated the literature. However, his own account attempts to interpret friendships as social facts, without reference to the personal perceptions and emotions of the subjects (ibid). This is incompatible with the analysis developed here. The psychological accounts, on the other hand, are psychologistic (ibid). There is little or no theoretical accommodation of class, gender, ethnicity or other sociological variables, and all relationships are analysed within the same conceptual embrace.² On the other hand, they do address cognitive and some emotional processes. To develop the personal paradigm, I have adopted a synthetic, eclectic approach, but concentrate here predominantly on psychological accounts of friendship.

I outline communication within friendship, friendship as a developmental process and the formation of friendship; and go on to consider whether and how the concept of friendship assists the analysis of mother/community midwife relationships.

Human communication has a number of facets, each of which expresses the relationship of which it is part. There is: territoriality/proximity (including the arrangement of bodies); non verbal communication (body language); and verbal communication.
In general, close proximity indicates liking and/or intimacy and there are socially appropriate bodily boundaries within which we conduct our various relationships. Physical contact generally connotes intimacy or vulnerability/passivity. Bodily proximity or contact is hardly ever without emotional consequence; although its meaning and implication varies depending on who does what, where, to whom and why.

Non verbal communication conveys perceptions and attitudes about oneself, the relevant 'other' and the relationship or interaction to which they are party (Duck 1986b: ch.2). It involves both encoding and decoding messages: that is, of communicating one's own perceptions and feelings on the one hand and interpreting the communications of the other person on the other. It is suggested that nonverbal cues are 4.3 times more effective than verbal cues in influencing the observer's impressions of the speaker (Duck 1986b:68).

Verbal communication can also carry 'hidden' messages. The structure of verbal interaction as well as the content influences the message conveyed (ibid:64). Pauses, silences, patterns of conversation between individuals, fluency, accent, rate of flow, intonational patterns, linguistic style and so on all have social meaning and are socially situated (ibid:ch.2). The impression we gain about the orientation of individuals is influenced by verbal and non verbal communication and the interaction of one relative to the other (ibid:ch.2).

So what does this tell us about friendship? Verbal communication between friends has
a fast rate and turnover of conversation is frequent, covering almost any topic. The communication is socioemotionally rather than task oriented. Finally, 'a 'low form' of language code is typically employed: that is, a linguistic style which is 'informal, unplanned, casual, direct and simple. It is the more familiar form of everyday speech' (ibid:57).

Human communication therefore has verbal and non verbal aspects and, quite apart from its specific content, verbal communication between friends has a characteristic pace, range, content, orientation and linguistic style.

Turning to the development of friendships, three useful concepts emerge from the literature. The first, sociability, draws attention to the social contexts within which friendships characteristically occur. Furnham (1989) suggests that friendships characteristically occur

...where people from homogeneous backgrounds come together and take part in a shared social activity, in a pleasant environment where social rules and conventions emphasize polite, open exchange, people tend to initiate friendships. (ibid:108)

Duck (1986b) also draws attention to the strategies one adopts in order to become friends. These include an intention to become friends, strategic self disclosure and creating a good impression, including developing mutual trust, concern and caring and exchanging commonalities (ibid:87).

The second concept, routinisation, addresses the symptomatology of friendship and indicates how friendships may arise from the contingencies of routine daily activity.
Duck (1986b), for example, asserts that behavioral measures of friendship are better predictors of relationship growth than purely cognitive ones. He highlights ways in which friendships can be pragmatic, embedded in and developing from the contingencies of routine daily activities.

The third concept, *intimacy*, draws attention to the relatively high degrees of self-disclosure within friendship relationships. In general, as friendships grow so does the amount of 'open communication'. This concept embraces 'negative openness' (expressing negative as well as positive feelings); 'non verbal openness'; 'emotional openness' (opening up rather than concealing their emotions); 'receptive openness' (a willingness to listen to other people's intimate disclosures) and 'general style openness' (an overall impression of openness) (Duck 1986b: 84–85).

Friendship relationships can therefore be said to be characterised by trust, verbal intimacy and open communication and, at least in its formative phase, by mutually shared activities and routines. Moreover, as Duck suggests (ibid), friendships are founded and conducted on more than mutual attitude reinforcement. They are contextually situated and generated. They arise from and are bounded by 'real' situations and contingencies, individual agendas, priorities, emotions and biographies. Many friendships are inexplicable except in these terms. They are sustained by 'out of interaction' thought and feeling. These aspects are as much if not more important to an understanding of friendship than cognitive (attitudinal) similarity. Psychologists also suggest that proximity, familiarity, rewardingness, similarity and to a lesser extent complementarity are all significant predictors of friendship (Furnham 1989).
How useful is the psychology of friendship to an understanding of the mother/community midwife relationship? It is worth recalling at this stage that the significant aspects of the relationship were: firstly, an emotionally connected personal relationship; secondly, a psychosocial orientation; and thirdly a social setting which facilitates social support in practical, emotional and social senses.

Psychological theories of friendship have tended to be rationalist and economic in orientation. Exchange theory suggests that friendships are governed by maximising calculating values, such that they will be terminated when cost exceeds benefit. Gain-loss theory has a similar conceptual underpinning. Depth theory is more subtle, viewing 'all friendship as a developmental process where two people engage in give-and-take, and disclosure of personal information, and which stresses the basis of trust and possibility of reciprocal self disclosure in friendship relationships (ibid:106).

As Furnham (ibid) notes, psychological theories are to varying extents underwritten by the concepts of optimality, reciprocity and multiplicity of criteria; ie. the concepts of laissez faire economics. For our purposes the most important is the requirement of reciprocity. This fundamentally limits the usefulness of the theory for this analysis; firstly because it is rationalistic and so cannot conceptually accommodate the synthetic rationality outlined in Chapter 4, which includes emotionality, and which is critical to an understanding of the empirical data; secondly because it relies on a concept of reciprocity inappropriate to professional/client relationships; and thirdly because it launders unconscious, conflictual and power processes from the analysis.
To some extent observers might find all of the above theories callous, computational, economic models of a psychological process, that have no room for selflessness, altruism or non reciprocated friendship. (ibid:107)\textsuperscript{5}

In order to appreciate the emotionally grounded personal relationship between mother and midwife one needs a gender based theory of self which is absent in the literature on the social psychology of friendship. In order to appreciate the socially supportive aspect, a sociological perspective is required (see Chapter 3). And in order to appreciate the role of the midwife, a conceptual embrace wider than 'laissez faire' friendship is required.

Duck's (1986b) account is conceptually more useful but retains a cognitive rationalism and a psychologism, noted earlier, which limits its utility. Both psychological and social psychological accounts are more useful at a descriptive level. On these terms, considering this literature, the mother/community midwife relationship both is and is not a friendship. It is a bodily and socially 'proximate' and intimate relationship which develops its own routines and shared behavioral scenarios, occurs in increasingly 'friendly' social contexts (that is, as the relationship advances relatively more interaction occurs within the mother's own home), is characterised by friendly, 'low code' linguistic exchanges and 'open communication' to a degree unusual within professional/client relationships (though this varies in practice). The historical and professional function of midwives is to be 'with woman': her trusted supporter, helper and friend. They therefore develop some of the histories, routines, activities and 'open communication' manifestations of friendships, on which Duck, for example, lays emphasis. In these ways they mimic, socially, developmentally, and in terms of
communication style, the 'pragmatic' kinds of friendship arising from 'proximity', or in this particular case the obligations of professional practice.

On the other hand, they are not voluntary, a point which is underemphasised in the social psychological literature, and there is an absence of mutuality and reciprocity which undermines the claim that the mother/community midwife relationship is a friendship. How can it be said that 'birds of a feather flock together' of a midwife whose clients come from varied social backgrounds and in the context of a relationship which is not strictly reciprocal but supportive in one direction only?

So the literature reviewed above is helpful at a descriptive, rather than a theoretical, level in that it directs our attention to processes overlooked within the professional paradigm, or else viewed instrumentally, and so inappropriately. It does not help us explain the 'special' character of the mother/community midwife relationship at a conceptual level. In particular, women's friendships have an emotional/relational basis which this literature neglects. What is needed is an explanation of the emotional basis of women's attachment: despite the structural dissimilarity it bears to friendship relationships. In addition, they need to be understood as anchored in 'real' needs and situations. The 'friendship' literature skates across the surface of the things which matter most in the mother/community midwife relationship. Additional concepts are required: including an explanatory theory of self and emotion on the one hand and a sociological perspective on social support on the other (see above). These are not simply 'variables' in the range of human relationships; they are central to the concept of women's friendships in general and the mother/community midwife relationship.
Women's Friendship Relationships: a psychoanalytic perspective

The texture of women's relationships, from the most intimate friendships and love relationships to the most cursory of acquaintances contain within them the similar elements of compassion, sympathy, and identification. It is these elements, the emotional gullies in which much of female living occurs, that allows us to talk of a specifically female culture that has the capacity to embrace all women. Women can share intimacies with each other... (Orbach and Eisenbaum 1988:16-17)

A number of feminist psychoanalysts have applied psychoanalytic theory to the analysis of relationships between women (see Whitbeck 1989). Orbach and Eisenbaum (1988) have specifically analysed the psychodynamics of women's friendships from an object relations perspective. Women's friendships on this account are founded on their relationship with their mother. In essence, the theory is as follows. An infant's primary relationship is with its mother. Boys' patterns of individuation and identification lead them to develop a concept of self which denies intimacy and connection in relationships. Girls' individuation processes on the other hand involve identification with a mother whose socially structured role: i) defines women as the satisfier of others' needs; ii) denies the woman's personal need; and iii) denies women the possibility of autonomy. Women exist to service the needs of others. It is this role which the girl incorporates into her self concept through identification with her mother.

This has three important consequences. Firstly, women's friendships are characterised by 'merged attachment'. This means in effect that there is insufficient developmental
closure of Self. This means that their friendships with each other are insufficiently differentiated too. The consequence is an insecure affirmation of sameness within the friendship relationship. Secondly, women define themselves as carers. Babies and children are loved and cared for most immediately by their mothers. Girls identify with their mothers. Girls therefore identify themselves as carers. Carers do not have personal needs. Self resides in the needs of others. Carers therefore become highly attuned to those needs, feel them as their own, and experience personal responsibility for satisfying them.

Thirdly, women's friendships do not easily accommodate individual need, autonomy or difference. Ambivalence is bred into women's friendships. On the one hand women are intensely significant to each other: i) because of the primary mother/daughter relationship; ii) because of their mutual capacity for intense merged attachment; and iii) because they are specialist carers and nurturers. But there is a down side. Women are not permitted personal needs, to be different, or to have independence within the context of their relationships. Orbach and Eisenbaum (1988) suggest that feelings of envy and competition between women arise from the ambivalence born of these conflicts.

This conceptualisation of women's friendship has a number of problems, both internal to itself and for the purposes of this analysis. Firstly, there is conceptual slippage between the frustrated needs of all infants and the denial of need in women. The 'deep neediness' from which a capacity to nurture arises springs as much from mother-child as from mother-daughter relationships, which Orbach and Eisenbaum recognise but
do not adequately incorporate into their analysis (ibid:50). Secondly, the explanatory power of the theory is limited by its ultimate restriction to the orthodox confines of object relations theory. Self and emotionality are located too deterministically in early childhood relationships, leaving no room for multiple sources of self identity and development or the integration of conscious and unconscious processes in later life. There is also no theoretical recognition of other bases to women's friendship relationships. This fractures the analysis; so that although they make the valuable observation that many women derive 'crucial aspects of their identity' from the workplace the insight is conceptually uninformed and in conflict with the analytical framework. The text strains in the direction of differentiation but is shackled by a dualistic, determinist theoretical framework. Consequently, the analysis has to rely on ad hoc explanations of autonomy, differentiation and multiple sources of self identity in women and so does not assist the analysis of relationships founded on difference or arising in the workplace, for example, between professionals and clients, in any obvious way.

Finally, women's friendships have to be rescued from the brink of critique in this account; there is no analytic distinction to rescue what profits women from what undermines them. The distinction is common sensical or intuitive, not theoretical, and is implicitly predicated on the supposition that self advancement in the public sphere is good for women's psychological health and development. There is no theory of reparation in women's relationships: this is assumed to follow as a matter of course from 'talking it through': a rather odd suggestion given the ineluctable influences of the primary relationship hypothesised elsewhere. These tendencies seem to arise from
the attempt specifically to explain conflicts between ambitious feminist women.9

In summary, this work concentrates too much on unconscious processes, early childhood, identity between women and 'peer' relationships. Nonetheless, it contains many insights of great value to the analysis of mother/midwife relationships in the community setting. It is particularly helpful in explaining the basis of psychological and social identities between women, which I earlier identified as one of the central tenets of their 'special relationship'. In particular, it helps us understand:

i) a professional/client relationship as one with the power of a primary relationship, steeped in emotion; one which may directly correspond to, as it invokes aspects of, the love, attachment and dependency of the original mother/daughter relationship. To an extent unlike almost any other adult relationship, the mother/midwife relationship, geared to practical and emotional support, has the capacity to invoke the emotions of enablement and dependency in the original mother/child relationship. This analysis therefore provides us with the means to appreciate why midwives are so important to mothers in emotional terms. In this sense, Orbach and Eisenbaum's analysis complements Chodorow's (1978) (see Oakley 1980).

ii) That these emotions permeate the sociological as well as the psychological aspect: they are 'intrinsic to the contact' (Orbach & Eisenbaum 1988:16). As Orbach and Eisenbaum note:

For many women intimate relationships with women-friends, sisters, aunts co-workers are a bedrock of stability in their lives. The emotional texture of women's friendship is woven into the of their daily lives. There is an exquisite intimacy to female friendship, the sharing of experience... (ibid:18)
As noted earlier, most mothers viewed midwives subjectively and emotionally, wanted a personal relationship with them, wished to share experiences with them, and connected with other women through them.

iii) That one cannot completely separate the practical and emotional aspects of midwifery practice. In a situation of some vulnerability and practical and emotional need, all practical help has an emotional aspect and vice versa. It therefore enables us to perceive the emotional basis of the social support they offer.

iv) The capacity within women to nurture and the need women have to be nurtured. Orbach and Eisenbaum's analysis sharpens our understanding of why women are particularly skilled in the art of communication; why midwives stress sensitivity and empathy as integral aspects of their professional practice; and a further reason why mothers want their community midwives to be female. As Orbach and Eisenbaum note,

   Since early childhood women have learned to be attentive listeners and good givers and this is evident in their friendships where they can give each other support, understanding, comfort, sympathy and advice. (ibid:17)

In addition the concept of merged attachment helps explain the intensity of women's need to be nurtured by other women and the undifferentiated aspect the relationship can have.

   Consequently, in adult female friendships we can observe how frequently one or both members in a friendship have an unconscious wish to merge with the other person, to be 'mothered' and cared for, to receive the nurturing that they
In the mother/community midwife relationship therefore one may find a coincidence of sociological and psychological need for nurturance on the part of the mother and a propensity to care in precisely those ways on the part of the midwife.

v) Orbach and Eisenbaum's analysis also enables us to understand that hostility and resentment are endemic to the psychology of caring, if caring is founded on merged attachment. This enables us to understand how carers may become unsympathetic to the needs of those for whom they care and, more remotely, the negative emotions women may experience through fear of abandonment. We can see sources of conflict in a 'caring' relationship. Their work is also helpful, though not at a theoretical level, in helping us understand the importance of differentiation in relationships between women.

In summary, Orbach & Eisenbaum's analysis enables us to theorise the relationship between mothers and their community midwives as one informed by powerful emotions, to which a concept of the gendered subject is crucial. It remedies the deficiencies of the social/psychology of friendship in this respect. Social psychology gives a description of friendship and psychoanalytic theory the infusion of self and emotion into friendship relationships. What neither of these schools of thought offer is any insight into the 'real' basis of the relationship. For this, the concept of social support, outlined in Chapter 3, is needed. In addition, a sociological conceptualisation of self and emotion is required; one which remedies the crude identification of
emotion with the unconscious and rationality with the conscious mind, which in
different ways underwrites social psychological, psychoanalytical and sociological
accounts.  

Emotions and Social Relationships: a sociological perspective

The sociology of emotions is still in its infancy in the UK but interest has been
gathering since the mid 1970s. Thoits (1989) divides the field into 'micro' and 'macro'
approaches. She notes that more work has been done at the micro (social
psychological) than macro (structural-cultural) level of analysis. She points out that
'considerable gaps exist in sociological knowledge about emotions.' She observes that
at the 'micro' level work is more theoretically than empirically developed; whereas at
the 'macro' level 'work is more often empirically descriptive and speculative than
theoretical' (ibid: 338).

Four areas of interest can be identified at the 'micro' level. Firstly, and predominantly,
attention has focused on the conceptualisation of emotion. This debate, which engages
social constructionist and symbolic interactionists on the one hand, and 'positivists' on
the other, centres around the links that can be specified between 'situational stimuli',
'physiological changes' and 'expressive behaviour' respectively (ibid: 319-320); in
simple terms whether emotional expressions can be reduced to physiological states.
In either case emotion is seen as a dependent variable.

The other main concern at this level has been the elaboration of aspects and functions
of 'emotion culture' on the one hand (including feeling and display rules and norms); and the conceptualisation of the actor as motivated and active within it on the other (see Thoits 1989 for a review).

Two particularly influential approaches at the micro level have been the symbolic interactionist and social constructionist perspectives. For the latter, emotions emerge in social relation to the other and are therefore socially constituted. The social constructionists (especially McCarthy 1989 and Coulter 1986) invest their energies in what is, in effect, merely a baseline definition of the social. Thus McCarthy, for example, rests her metatheatery on little more than a restatement of Mead:

...emotions are part of the conscious relations, actions, and experiences of selves. Emotions are not "inside" our bodies but rather actions we place in our world...."imagery is not mine because it is shut inside a particular skull" (Mead 1982:66)...emotions and feelings originate and develop in social relations... (McCarthy 1989:57)

On this account we have no theory of the self save a Meadian one which, as we shall see below, confines the actor to a particular aspect of consciousness (ego based and without a theory of the 'autonomous I') and a particular sort of mental/physical activity (behaviour, gesture, rules and action). It also gives rise to an overdetermined notion of emotionality.

The symbolic interactionists, on the other hand, are located within a different metatheoretical framework and a positivist epistemology capable in principle of synthesising the perspectives of biological and social science. This perspective suggests that the individual constitutes and is constituted by an emotional culture
which helps define individual emotional experiences. Emotions operate as a 'signal to
the self', as a way of communicating to the self how one is situated within a social
context. Emotion therefore functions as an interface between inner and outer worlds,
between the 'I' and the 'Me' of Mead. Clearly, this both an abbreviation and an
oversimplification but it is the bare bones of those sociological insights relevant to this
thesis.

In principle, therefore, the symbolic interactionist perspective can conceptualise
emotion as a 'way of knowing' and so aid a sociological understanding of emotionality
in the mother/community midwife relationship. But a detailed consideration of this
perspective reveals significant limitations. I illustrate these difficulties by reference to
Hochschild's 'The Managed Heart' (1983). This work takes the symbolic interactionist
account as far as it can go for the purposes of my own analysis; and so illustrates both
the utility and ultimate limitations of a symbolic interactionist conceptualisation of self
and emotion.

Hochschild's 'The Managed Heart'

Hochschild's (1983) work, which analyses the emotional processes and emotional
constructions of flight attendants in the work place, will be considered at three levels:
for what it says about feeling, the social self, and metatheory respectively. At each of
these levels, her analysis has something to offer but contains conceptual difficulties
which limit its utility for this analysis.
Emotions

Hochschild's analysis is extremely valuable in that it attempts to incorporate at a theoretical level different levels of consciousness (and unconsciousness), feeling and social processes; ie. to synthesise psychological and sociological approaches to self and feeling. But further consideration reveals that her analysis of emotion is teleological, functionalist and biologistic; and this diminishes the value of the analysis. Drawing on Darwin's concept of emotion as gesture, action manque, imagined readiness for action on the one hand (ibid:219), and Freud's concept of the signal function of anxiety on the other, (a function which she extends to all feeling), she suggests that emotion is 'a biologically given sense' with a status analogous to our other senses. It is a means by which we know about our relation to the world.' (ibid:219) Undistorted feelings, then, operate to signal to the self how one is situated in the world. 'Emotion is a sense that tells us about the self-relevance of reality.' (ibid:85)

She summarises her theoretical orientation towards emotion thus:

To sum up, I am joining three theoretical currents. Drawing from Dewey, Gerth and Mills and Goffman within the interactional tradition, I explore what gets "done to" emotion and how feelings are permeable to what gets done to them. From Darwin, in the organismic tradition, I posit a sense of what is there, impermeable, to be "done to," namely, a biologically given sense related to an orientation to action. Finally, through Freud, I circle back from the organismic to the interactional tradition, tracing through an analysis of the signal function of feeling how social factors influence what we expect and thus what feelings "signal." (ibid:222)

The problem is that, far from completing the circle, she has in fact squared it. That is, she has attempted to synthesise levels of analysis which are not homologous. The
'organismic' theory of Darwin and the 'signal function' of Freud are both models in which the social acts as 'elicitor' to the emotional/biological. But one of sociology's most important insights has been to indicate that emotion can be socially constructed; this indeed is one of Hochschild's own contributions at the 'deep acting' level. Put simply, the better view may be that the social elicits the emotional/biological rather than the other way around.

Moreover, on Hochschild's own construction, emotion clearly has more to it than simple biological or teleological functions. In this way, it escapes the confines of symbolic interactionism and its "social behaviourist" housing and requires a radical rethink of the way we conceptualise emotion. Notwithstanding Hochschild's bridge through the concept of 'prior expectations' (a cognitive formulation within the social behaviourist tradition), the implications of her own analysis take her farther than symbolic interactionism allows her to go. In this way, she robs herself of her own insights. All her ideas concerning the social construction of emotions and self, and the socially contingent and existentially active subject, become hived off at the level of theory or collapsed into biological/teleological function.

In addition, Hochschild works with an essentialist concept of emotionality. Drawing on her analysis of the flight attendants, she suggests, in effect, that the norms of the workplace corrupt the 'signal function of feeling' by prescribing feeling rules which dictate how workers should feel and behave in the work setting (ibid: preface; 19).

These are the processes by which emotions become distorted in the workplace. But
what exactly is it that is distorted? Hochschild does not indicate how uncorrupted flight attendants might feel in that setting. She has an essentially libertarian view of the self set against a coercive commercial structure; and it leads her to some naive formulations about the (implicitly) unsullied character of non commercial or private feelings: 'In private life, we are free to question the going rate of exchange and free to negotiate a new one.'(ibid:85)

The Self

Unlike many sociologists (for example, McCarthy 1989; Coulter 1986) Hochschild recognises the need for a social theory of self. 'To develop the idea of deep acting, we need a prior notion of self with a developed inner life' (Hochschild 1983:216). But her conceptualisation of the 'self' is largely implicit, uneven and deeply problematic, and this vitiates her insights. She advances on Mead's interactionism in theorising the 'I' as well as the 'Me' (ibid:212). But this is itself dualistic, for she lends the 'I' an authenticity that is problematic. In effect, self represents the hardware and feelings the software and social influence is confined to the latter.

There are two particular difficulties with the conceptualisation of self. Firstly, there is no attempt to develop a theory of self in the main body of the text (Denzin 1984:50), even though she implicitly relies on it a great deal.

A social self may be theorized in a number of ways; firstly, as a self reflexive actor, in the symbolic interactionist tradition; secondly as a self conscious actor; thirdly as
an authentic 'inner' self waging war against an alienating and fragmented social environment; fourthly as an autonomous self (the 'I' of Mead); and finally as a psychic whole, including its conscious, unconscious, physical, intellectual, emotional and spiritual aspects.

Hochschild's conceptualisation is uncertain but appears to involve the first, third, fourth and fifth of these conceptualisations. Her analysis inclines us to believe both that cultural rules can affect unconscious functioning, and that unconscious functioning is the repository of authentic feeling. She makes elliptical references to a multidimensional, Freudian concept of self and psychic structure and associates feelings with the (unconscious) id: '...he had little to say about how cultural rules might (through the superego) apply to the ego's operations (emotion work) on id (feelings)' (Hochschild 1983:210). This conceptualisation is linked to the emotional dualisms (authentic vs inauthentic) noted above (ibid:7;30;34;47;226). There are scattered references throughout her work to ego as both consciousness and not self. In this way she conflates different levels of psychic structures (especially the ego and the id) with authenticity vs acting. Implicitly, authentic feeling is located in the unconscious id, although this contradicts her suggestion that feeling rules may be unconscious.

An authentic self is implicitly relied upon but its source and motor (the id) is neither elaborated nor its link to the ego experience made explicit. In essence, she assumes the existence and functioning of a fully and phenomenologically constituted 'self' which she then goes on to examine in specific aspects of its ego function only; even
though this aspect of her approach, especially the implicit equation of authenticity and authentic feeling with the id, requires detailed elaboration.

Secondly, her analysis is unduly restricted by a symbolic interactionist perspective. This gives the analysis a cognitive emphasis and a very narrow sphere of analytic interest. She concentrates, in effect, on gesture on the one hand and cognition on the other. These priorities derive from the social behaviourist emphasis on conscious display/gesture in the interactive process.

So ultimately she deals an extremely specific aspect of ego function and extremely limited emotional experience. Both aspects are illustrated by her concept of the signal function of emotion. This is a teleological view derived from Freudian theory; in which anxiety operates at the interface of the ego and id, signalling to consciousness danger from either the inner or outer world. But she strips it from this psychic location and seeks, without further comment: i) to transpose it to an ego based function; ii) to extend the signal function to all emotion; and iii) to tack on a theory of cognition (ie. prior expectation). This is consistent with a conceptual emphasis on ego function and display and results in a restrictive view of emotional functioning, an impoverished perspective on 'self' and a theorisation which fails to develop its own potential. No explanation is offered of the origin, expression, phenomenology or unconscious aspects of emotion; and psychic structure becomes collapsed beneath a biological function, signalling to the self, and no further connections are explored. The 'self' she concentrates on is dealt with and theorised at the conscious, 'ego' level only. This is a significant shortcoming consistent with the confines of a symbolic interactionist
So despite the importance of such concepts as 'deep acting' we are left with a crude view of emotional function, an essentialist view of the self and a merely cognitive and behaviourist gangplank ('the template of prior expectation') connecting the two. She robs herself of her own insights by operating within the orthodox confines of symbolic interactionist thought; a Goffmanesque concept of self on the one hand and a functionalist social behaviourist problematic on the other.

Metatheoretical Aspects

So Hochschild's theory fails adequately to conceptualise either private feeling or the multifaceted self. These difficulties are related to the underlying epistemology.

Hochschild juxtaposes the 'organismic' with the 'interactional' theses of human emotion (Hochschild 1983:Appendix A). In this way she implicitly denies interactionism's debt to Darwin, a legacy nonetheless elaborated by Swanson (1989), and so denies the way that interactionism builds upon reductionist, Darwinian concepts of emotion. But they operate within the same epistemological paradigm; that of positive science. The contribution of symbolic interactionism, or social behaviourism or cognitive science, as it is alternatively termed, is to highlight the centrality of the actor's cognitive processes to social action. It is this element, not its distance from biology or biological processes, which creates a social as opposed to a psychological or biological theory. The symbolic is the mediating variable between stimulus and response: hence 'social
behaviourism'. The metatheoretical continuities remain intact and unchallenged.

AsThoits (1989) notes,

In contrast to constructionists, symbolic interactionists are more willing to recognize the influences of basic emotions in human action... Emotions, then, are the joint product of generalized arousal and specific sociocultural factors. (ibid:320)

Referring to both Denzin and Hochschild, McCarthy suggests:

It is not unfair to say that many leading sociologists of emotions, in varying degrees and with different emphases, view emotions primarily as psychological-physiological states that have sociocultural concomitants. (McCarthy 1989:53)

She refers, in addition, to the idea, which is 'relatively common among social scientists'

... that sociologists should move toward the establishment of a synthetic science of emotions; they call for an integration of the findings of physiology, psychology and sociology - in popular jargon, the search for the interface between culture and biology. (ibid:52)

The efforts of Hochschild are part of this endeavour. Far from the dissociation Hochschild suggests, Mead followed Darwin from the same metatheoretical stable:

Mead (1909, 1934) and Dewey (1907, 1917, 1922) ground social psychology in the functionalist metatheory that they developed from Hegel and Darwin. (Swanson 1989:5)

If we recall from Hochschild that Darwin conceptualised emotion teleologically as action manque, as readiness for imagined action, and that Hochschild follows Darwin in this respect, seeing emotion as 'our experience of the body ready for an imaginary action' (Hochschild 1983:220) we can begin to make more sense of her division of
emotion into three components, following Gerth & Mills: gesture (or 'behavioral' sign), as she notes, a Darwinian idea within an interactive context; conscious experience (following Mead's cognitive emphasis); and biological process, an emphasis compatible with both Darwin and Freud. (ibid:213)

We can also begin to appreciate the rationalist, cognitive, behavioral and action emphases in the work of Goffman and others. For they all deal with restricted concepts of self and emotion; for example, the ego based self directly engaged in social interaction/social display; the constitution and reconstitution of rules by the cognisant social actor. Though Hochschild attempts to go beyond the limited ground thus delineated by Goffman, she only partially succeeds because of the metatheoretical limitations of the approach she engages.

At a metatheoretical level, her analysis, incorporating Darwinian, Freudian and Meadian influences, could be reconciled within the epistemology of positive science. But this still leaves the theoretical weaknesses noted above; in particular the collapsing of psychic structures and processes beneath the biologically grounded signal function of feeling. It is also worth noting that her approach leaves positivist methodology intact, making it possible to theorise emotion without looking methodologically at the researcher's emotions. For the researcher is still a 'scientist' on this view, able to operate with affective neutrality. She thus fails to address some obvious implications of her own analysis; a shortcoming shared with other 'interpretive' scientists.

The formulations of the social constructionists and symbolic interactionists are
inadequate within the context of the personal paradigm. The social constructionists
(especially McCarthy 1989; Coulter 1986) invest their energies in what is, in effect,
merely a baseline definition of the social. Thus McCarthy, for example, rests her
metatheory on little more than a restatement of Mead:

...emotions are part of the conscious relations, actions, and experiences
of selves. Emotions are not "inside" our bodies but rather actions we
place in our world...."imagery is not mine because it is shut inside a
particular skull" (Mead 1982:66)...emotions and feelings originate and
develop in social relations... (McCarthy 1989:57).

On this account we have no theory of the self save a Meadian one which, as we saw
above, confines the actor to a particular aspect of consciousness (ego based and
without a theory of the 'autonomous I') and a particular sort of mental/physical activity
(behaviour, gesture, rules and action).

The symbolic interactionists, located within a different epistemological framework, a
positivist one, are, in principle, able to synthesise the approaches of biological science,
ethology, positivist psychology, and sociology. However, there is in reality an
epistemological tension between the social relational emphasis on symbolic meaning
and a purely positivist science in which bodies, realities and emotions are apparently
open to inspection without symbolic mediation through both actor and researcher.

So how should self and emotion be conceptualised? I suggest that the symbolic
interactionist formulation, especially that of Hochschild, is helpful as far as it goes in
theorising the cognitive aspects of conscious mental activity at the interface of the
self/autonomous 'I' and the social, including the 'Me'. But the conceptualisation of
'deeper' and alternative dimensions to self and emotion, and the social influences thereon, is altogether inadequate: it presumes what it should seek to explain. To advance, it is necessary to surrender both the behaviourist foundations and the positivist underpinnings of the symbolic interactionist perspective.

The work of Edward Moss (1989) is worth considering here. As noted in Chapter 4, we need to understand the knower as well as the known and to theorise thought and feeling, subject and object, fact and value synthetically, not dualistically. We need in particular to be able to theorise the emotional aspects of cognition. And we need to be able to turn cognition through to a different dimension and see it suffused with biographical meanings and influences, which in turn inform our cognitive processes. And this is merely the tip of the iceberg. For this is the complex which will also enable us to understand the socially situated 'self' as itself multidimensional; to see it as unique and autonomous on the one hand, yet essentially social on the other, as self-reflective and purposive yet also unconsciously motivated, as operative at several different levels of meaning, and as both rational and irreducibly emotional.

Edward Moss' work is a step in this direction. It presents a cognitive model of mind (amongst other things) based in cybernetic control theory. According to this model the mind has a threefold structure: the sensory apparatus, consciousness and memory respectively. Within this structure, mental processes take place in two cycles: a predicative cycle, which is the focus of immediate attention, and which is largely conscious, and a higher order, purposive cycle which identifies and works towards the achievement of desired goals and which is generally unconscious (ibid:68–71).
Together, these processes constitute the activity of mind.

In the arena of consciousness, thought and feeling, present, past and future are inseparable. Any predication at the focus of consciousness evokes from memory (the mind manifold) associations which are governed by rules of association influenced by thresholds of stimulation. When we experience something at the focus of consciousness resonances are evoked from the mind manifold, and this is part of the experience itself. All experience has at least four variable aspects: form, quality, intensity and relationship; in addition it also has perceptual and conceptual aspects. The outcome of such associations is to create a hue which uniquely colours every experience:

...a blended resonance of many ideas sounding together...this shifting blend of ideas recognized in their simultaneous impact, not in their separate individualities, constitutes the moving emotional coloration of our lives, and so determines the qualities and intensities of consciousness.... although we can verbally identify a few classifications of emotion in a broad and approximate fashion – rage, fear, love, anxiety and so on – the precise shade of emotion experienced on any one occasion is so complex a blend that it is unique to that occasion and virtually unrepeatable. (ibid:125–6)

He goes on to liken the associations evoked at the centre of an experience to the harmonics (or dissonances) which accompany musical sounds:

Just as the timbre of musical sounds is determined by the superimposition of many overtones, and the harmonic or dissonant effect of notes sounded together is determined by the simultaneous resonances of the notes and their overtones, so, I would argue, the emotional coloration of the predications at the focus of our consciousness is created by the resonance evoked from the mind-manifold by the individual ideas built into the syntactic order, as these interact with each other and reverberate again with the manifold. The result is a constantly changing superimposition of many ideas together. (ibid:127)
These resonances are experienced in their emotional totality as part of the experience itself:

We are never conscious of the innumerable individual ideas which resonate in this moving cloud of association, any more than we hear the individual overtones of musical notes. We are conscious of them only in their collective emotional impact. But they are there all the time and they have enormous effect, not only on the quality and intensity of our experience, but also on the flow of our thought, because they tend to raise or lower the thresholds of resistance to stimulation in particular directions. They constitute what in Freudian terms would be described as the unconscious mind. Any such description, however, would be a misnomer; for this unconscious component is not a detached complex working in separation from the conscious mind...it is a component or aspect of consciousness itself, and inseparable from consciousness. (ibid:127)

Moss's conceptualisation places emotionality at the centre of the decision making process, within the context of the (largely unconscious) purposive cycle (ibid:177). It provides a framework within which we can begin to theorise the depth and range of our individual experience, of our 'selves', of emotional and biographical influences on the 'self' and of its social as well as psychological aspect. Through such concepts of resonance, form, quality, intensity and relationship, and through specifying points of intersection of the two cycles, he begins to integrate our understanding of the synthetic mutuality of consciousness and unconsciousness on the one hand and thought and feeling on the other. It suggests that every living experience has both unconscious and emotional aspects, though its precise influence varies uniquely; and that each influences our experience of social reality, the goals we seek and decisions we make. It rescues both biography and emotionality from intellectual oblivion: both can be theorised at the core of the experiencing self.
Such a model has great value because it transcends dualistic thought at a substantive level. It enables us to integrate emotional and biographical influences and resonances. It also enables us to visualise researcher and researched within the same epistemological frame of reference; and so to begin to understand how the professional and the personal, knowledge and experience, relate and intersect.

Summary

This chapter has elaborated concepts of self, feeling and friendship which, situated within the synthetic ontology of Chapter 4, constitute the personal paradigm, a metatheory within which mother/community midwife relationships may be understood.

The relationship corresponds more closely than one would imagine to descriptive accounts of friendships. There is no simple reciprocity or equal disclosure within the relationship, neither is it voluntary. But there is a relatively high degree of intimacy and open communication. Moreover, there are boundaries to, and ideological constructions within, friendships. This means that mother/community midwife relationships often offer greater intimacy and support, and greater scope for vulnerability and emotional expression, than do many friendships. That is, as Part Six of the thesis suggests, in some senses they are more like friendships than many friendships.

A theory of women's friendships is essential to an understanding of the
mother/community midwife relationship; and this is indicated by the women themselves when they emphasise personal, biographical and emotional aspects of their relationships with their community midwives. One cannot mask the face of the 'caregiver' and expect an analysis adequate to women's experiences.

We must understand the activities of the community midwife, including her practical and emotional support of the mother, in these terms. If we look at what midwives actually do, within an analytic context sensitive to gender, then we come closest to an appreciation of how midwives can be friends to mothers. The midwife has a personal, subjective relationship to the mother and a psychosocial orientation. In addition she works with her real, vital, immediate practical and emotional concerns. These three aspects are the basis for the friendship and the 'special relationship'.

Nonetheless, because of the conceptual difficulties outlined above, I use the concept of a personal relationship, rather than friendship, to illustrate mother/community midwife relationships. This characterises the relationship as intimate, emotionally connected and gender based; and situates the parties in the same plane of being. Situated within the personal paradigm, it also accommodates difference, complexity and conflict.

The personal paradigm replaces positivism and does away with the need for a behavioral, ego based or scientific sociological perspective. Within the context of this chapter, Orbach and Eisenbaum's contribution (1988), set within the cognitive framework of Moss (1989), provides the basis for a theoretical understanding of the
emotional and relational aspects of the mother/community midwife relationship. Duck's (1986b) analysis of friendship adds descriptive colour. Each of these is to be understood within the ontology outlined in Chapter 4; for it is this which enables the intellectual synthesis to be made.
Notes

1. This reinforces what others (such as Kirkham 1989) have said about different social settings: that within the consultant delivery unit the doctor is boss, within GP units the midwife is boss (but more sensitive to mothers) and within the woman's own home the mother has control and health professionals are guests, which facilitates 'woman' orientation. However, my research suggests that there are differences of orientation within the same (i.e. community) setting, and this departs from Kirkham's analysis.

2. Duck (1986b) does suggest the need to see psychological phenomena in social context (ibid:3). But he seems to mean by this 'outside the laboratory'. Also he does deal with childhood relationships but this is an obvious exception to the general point.

3. Medical encounters provide an obvious exception. Vulnerability refers to the 'touched' rather than the 'toucher' in the medical context.

4. At a later stage it is often sustained by 'out of interaction' thought. Duck (1986b) suggests that many of our important relationships are of this 'perpetual but dormant' kind.

5. Interestingly, this problem is now being faced by sociologists engaging in analysis of relationships, for example, Finch (1989). The analysis of friendship and emotion in social science lags well behind that of rationality, and theorists therefore face conceptual paucity when they attempt to tackle emotion, making economistic models relatively more attractive.


7. Duck (1986b) describes different kinds of emotions, including different sorts of love, but not within a relational framework. Moreover it is an analysis geared to heterosexual relationships rather than friendship relationships between women.

8. This implies that women do not easily accommodate the needs of other women, for this would force them to confront their own unacknowledged needs. This is consistent with data in my own study suggesting that women find it difficult to have needs in general in their friendships, and unreciprocated needs in particular.


10. See Hochschild (1975). Some people have begun to make a start on this; including Finch (1989); Duck (1986b); Orbach and Eisenbaum (1988) and Jaggar (1989). Orbach and Eisenbaum's and Duck's attempts are seriously limited in the ways suggested in the main text of this chapter.

11. It is the mixture (or admixture) of Hegel and Darwin which signals the problems for symbolic interactionism.
12. Some aspects of Moss' theory are problematic for this thesis; which has been incorporated in its unproblematic aspects according to the logic and synthesis outlined in this chapter.

13. In practice, the analysis developed in Parts Five and Six of the thesis concentrates on consciously recalled experience. But it is not confined to it, either in theory or practice. A significant theme in Chapter 11, for example, is the importance of subcognitive experience (i.e. experience outside conscious awareness) for the development of the relationships. But the theoretical aspects of this experience, and the dynamic operation of the psyche, receive relatively little analytic attention and is not linked to established psychoanalytic theory in these areas. Accordingly, the analysis remains sociological rather than psychological in orientation.
Part Three

Taking It Personally
Overview

Part Three of the thesis applies the critical perspective developed in Part Two, and the alternative ontology of Part Two, to sociological methodology. If the midwife's 'ways of knowing' are more broadly based than the professional paradigm suggests, so too are the sociologist's. Sociological methodology therefore requires critical scrutiny in much the same way. In Chapters 6 and 7 I examine the epistemological foundations and shortcomings of selected empiricist and feminist methodologies respectively. Chapter 8 presents a methodological account of my own research in a way which addresses the omissions this reveals. (For a more detailed elaboration of the research design and methods see Part Four of the thesis.) Knowledge is revealed as an ontological complex, not an epistemological absolute. From here it is possible to connect one's personal and intellectual autobiographies (Stanley & Wise 1990); to connect the personal and the professional, knowledge and experience, thought and feeling. Consistent with this perspective, I begin this section by presenting extracts from my research notes which capture the emotional roots of my own intellectual journey.
First Draft of Chapter 6. March 1990

Persuading myself that writing a chapter on methods can be interesting is rather like trying to convince myself that I do like green vegetables. However necessary the act, however compelling the reasons, the prospect simply isn't palatable. Rather than just accept my fate, I would like to take the opportunity to enquire what I find so hard to swallow about sociological methods, why the benefits they claim to confer are so fundamentally indigestible, and whether there is an acceptable alternative. If I do not succeed in the latter endeavour, at least I hope in the process to have swallowed my fare so that I may claim the benefit...

Second Draft of Chapter 6. April 1990

I find it extremely difficult to know where to begin, proceed or end. This is my second attempt to write a first draft of this chapter. There is a voluminous literature on sociological method and methodology. I cannot write an appreciation of it because, by and large, I do not appreciate it... It suffers from a tendency to view knowledge and understanding as if it were a simple function of the gaze of the researcher, a reflection of the object under scrutiny...I think that many 'textbook recipes' are hopelessly complacent in their assumptions; both about the purity of their own knowledge and the impurity of other people's... My scepticism is so thoroughgoing that it is almost inevitable that I will fail to do justice to the merits of the contributions I examine; both because they are not meaningful to me and because my concentration has been impaired by lassitude and angry note taking by turns.
There is something very different about my view of the world and social enquiry within it compared to the prescriptions enshrined within methodological texts. One of the difficulties I have is that their programmatic formulations underestimate and constrain the creativity of the researcher. 'The research act' is for me primarily and essentially creative. The methodological recommendations people make have a lot to do with the way they see not only social science but their own social world. And it does seem to me that they see it differently from the way(s) I see it.

These suggestions clearly have strong parallels in the methodological formulations of some feminist writers. I would probably not have been able to state these views in the way that I have were it not for them. But what is equally clear to me is that I am saying what I am saying not because it is a 'feminist' thing to say or do but because it is how I think and feel. Both substantively and methodologically, the research I want to do stands closer to their conceptualisation of social reality and my position within it than it does to the rest of them. The fact that what they say intuitively makes sense whereas the other conceptualisations intuitively do not is an important affirmation of the claims, validity claims if you like, they are making.

Of Feminist Methodology. April 1990

I have just returned from a conference in which the importance of feminist organisation was repeatedly affirmed. At the same time, those engaged in that activity seemed demoralised. Our numbers had dwindled — we needed an 'issue'. We could not find an editor for our newsletter. We did not always acknowledge each other outside
'the women's room'. Having fought for space there seemed little to inscribe within it.

Twenty years of struggle and where have we got? The vision of the 70s now seems an illusion. Women's consciousness has not been raised; we do not have a universal identity; none of us are liberated. There are fewer feminists than there were: some who once loved it now renounce it. And all around us skulks postmodernism, ready to annihilate us.

Those who started their careers together have found a plateau in a craggy hierarchy that once seemed sheer. Resting there they feel tired, confused and different. They are not like the rest of us, only themselves, so they stick together and prepare for the next ascent, without really knowing why.

Sitting at that conference, watching and listening, I felt an optimism that others may not share. Decades of exposure at the cutting edge of politics may pit one's confidence and expectation. The realisation that utopia cannot be crafted may inhibit one's vision. But that doesn't make community less important, it makes it more so; for the times of hardest struggle are those when there seems no hope, prospect, love or community. Through the dustcloud of combat dawns progress. Reading the texts below I felt the same sense of optimism, for they represent the blossoming of thought made possible by the feminist movement. If feminism in the 90s has something different to say to feminism in the 70s, so be it. Though it may seem bewildering to some it seems coherent to me and I hope in the sections which follow to demonstrate how. It may be true that the ideas elaborated here are not, in their new guise, 'authentically
feminist', if by that is meant that they reiterate the issues of the last 20 years. Rather, they represent the enabling of new thought and new possibilities, built on the experiences of the past. It is that continuity, that heritage, which identifies the future with the past.
Chapter Six

Method in our Madness or Madness in our Method?:
the limitations of scientific sociology
One cannot forget that there are many approaches to the human scene, ranging from the philosophic to the journalistic, and that the only thing which distinguishes sociology from these other approaches is its method. (Bierstadt 1977:44)

The pursuit of quantification not only leads us away from an appreciation of the person as a whole but ensures that a great deal of energy is expended in 'proving' rather obvious facts. Current journals and books in the field...abound with studies which painfully reach unsurprising conclusions...conclusions so humble that the studies make sense only if one realizes that the authors are addressing a readership deeply sceptical about the importance of personal factors...Such studies would seem to be less an exploratory search for truths than a translation of known truths into another idiom... The reluctance to recognise the personal element... derives from many sources. These include the dominance of 'science', the fear of intimacy, the masculine ideal in professional work... male envy of childbearing and childrearing... and society's antagonism to growth and change. (Lomas 1973:45; 1987:9)

Sociological method is to sociology what midwifery practice is to the midwifery profession. It is a warrant of professional expertise: 'a specific and exclusively owned body of knowledge' (Oakley 1984d:27). Founded on the object oriented professional paradigm it appropriates knowledge and expertise to itself. It has no interior concept of subjectivity. It renders knowledge objective and autonomous; divorced from contexts of discovery and application, from sociological subjects, and from individual sociologists.

Scientific sociology therefore both 'believes in' and prefers: i) rational, formal, abstract knowledge; ii) a real external world; and iii) a causal ontology. This leads to difficulties comparable to those outlined above in the 'professional' paradigm. It i) prefers and prioritisates sociological 'practice' and the acquisition of a discrete body of knowledge; ii) situates researcher and researched in different 'planes of being'; thereby obscuring and deemphasizing the situational/ relational bases of research activity; and
iii) it rationalises and homogenizes knowledge, which it then monopolizes. Debates within sociological methodology are debates about appropriate methodology on these terms.

The methodological literature is vast and the points of contention numerous. I have therefore provided a brief historical overview and gone on to select two contemporary contributions to the debate, which advance on the epistemological formulations of classical empiricist sociology, those of Bryman (1988) and Fielding & Fielding (1986). I point out the ways in which these contemporary contributions remain hedged by enlightenment epistemology and thus subject to the shortcomings outlined above. To narrow the field in this way is not to overlook those methodological contributions which in various ways attempt to overcome the difficulties I identify; for example, the feminist tradition (considered below); the existentialists, phenomenologists (Hunt 1989) and to an extent the ethnomethodologists. Rather, it is an attempt to identify core difficulties with the presumption of abstract method, in turn rooted in the idea of scientific sociology. The contributions examined are significant attempts to overcome the critique of empiricism and establish more sophisticated methodological theory and practice. Yet I shall argue that they remain fundamentally tied to the same problematic epistemology.

Bryman's work will be examined in the context of the debate about the relative status of the 'qualitative' and 'quantitative' research; and Fielding and Fielding's for their contribution to the 'multi method' debate. That is, Bryman's work will be examined as a contribution to the 'problem-led' approach to research design and method
selection, posited as an alternative to the epistemological approach; and Fielding & Fielding's as a reformulation of the 'triangulation' debate and validity claims associated with Denzin. Each in its own way argues for methodological pluralism and makes epistemic claims which depart from the conventional alignment of quantitative with scientific and qualitative with humanist/idealist perspectives. Each is relevant both to midwifery research, examined above, and my own research design, examined below.

I shall make three points. The first is that, notwithstanding appearances to the contrary, the scientific paradigm is central to much qualitative methodology. In particular, the symbolic interactionist and naturalist perspectives, which underpin classic ethnographies, are explicitly scientific in orientation. This leads to a distinctive set of methodological preoccupations in empirical research which restrict the vision of sociological methodology.

The second, examined in relation to Fielding & Fielding's work, is that the concern of such methodologists has been restricted to issues generated according to the logic of scientific discovery. In particular, instead of attending to the 'context of scientific discovery' attention is confined to the 'context of justification' (Harding 1987b) (ie. the orthodox preoccupations with representativeness, reliability and validity) within qualitative as well as quantitative research. This severely limits the validity claims they are able to make about their research.

The third theme, examined in relation to Bryman's work, is that in suggesting a 'problem-led' basis for methodology and research design, methodologists do not
thereby transport themselves from the world of theory and philosophy into the real
world. On the contrary, that formulation as it stands is less than adequate because it
works with an implicit rather than explicit theory of knowledge. Although this may
suggest a way forward\(^2\), as presently constituted it is a profoundly conservative option
which deproblematises knowledge and works with an unelaborated concept of what
'reality' is.

**Historical overview**

Sociology is preoccupied with method and methodology; reflecting, suggests Bryman,
its 'pre paradigmatic' state. The qualitative research tradition, which has existed for
over 50 years, has been largely on the defensive in this debate. Until the 1960s the
debate was less about place of a specifically scientific epistemology within sociology
and more about the methodology most appropriate to the scientific study of society.

The quantitative paradigm derived

...from the nineteenth century writings of Comte, Ward and Spencer. Their
conceptualisations assume that all sciences are quantitative, cumulative and
statistical in nature. The unity of all science, their work supposes, consists of
its method and not of its substance. (Denzin 1978: Pt. 1 p.2)

Symbolic interactionists and naturalists worked from a different metatheoretical
premise.

The symbolic interactionists (who trace their perspective from the works of
James, Dewey, Mead, Cooley, Simmel, Park, Blumer, Strauss, Becker,
Thomas, Goffman and others) assume that human societies are negotiated,
emergent productions. (ibid Pt 1:1)
But both approaches claimed to be scientific in approach: it was their conception of a model of science appropriate to the study of human social life which differed.

The quantitative and qualitative schools rest their *philosophies of science* upon antithetical principles. Quantitative sociology rests upon what may be termed the *principle of objectivism*...symbolic interactionists ... base their philosophy of science upon the *principle of subjectivism*. (ibid: Pt 1,2–3, bold = author's emphasis; italics = mine)

The naturalist position did not involve a renunciation of a science of causation in sociological explanation. It was not until the rise of phenomenological sociology in the 1960s that a serious epistemological challenge was made (Bryman 1988:105). So what appears to be a diversity of methodological approaches in fact amounts for the most part to a debate about the best way of conducting empirical social science.

The debate about 'quantitative' vs 'qualitative' research should be understood in this context. It was not about different epistemological approaches. Rather, it concerned the logic of social scientific explanation; specifically whether methodological monism was either possible or desirable. 'Qualitative' methodologists preferred an approach to the science of causation founded on the logic of analytic induction (or variants such as 'grounded theory') rather than Popperian hypothetico–deductivism. The central issue therefore was the status of formal theory in scientific explanation. This in turn gave rise to marked methodological differences, and it is this which marks the putative opposition between 'quantitative and 'qualitative' methodologies. This does not, as is conventionally suggested, amount to debate about 'fundamentally different epistemological frameworks for conceptualizing the nature of knowing [and] social reality...' (Filstein 1979:45, cited in Bryman 1988:105). Science's normative dualisms
remain unchallenged. Accordingly, even in 'qualitatively' oriented research methodology one can detect: a) a belief in the 'real' world; b) an ontological belief in, and an epistemological preference for, rational knowledge; and c) emphasis and priority on scientific (causal) explanation and its justificatory strategies.

There have been two key attempts to transcend the quantitative/qualitative divide. The first has been to shift attention away from the epistemological issues; to disentangle method from methodology, to insist that the selection of method is a technical issue arising from the problem or topic to be addressed. On this construction, methods are a means to an end. The second, related, tendency has been to insist on the complementarity of sources of data: the multi-method approach. These tendencies will each be considered in turn.

Bryman and the 'Problem Led' Solution

The choice of sociological methods is often said to be determined either by the sociologist's epistemological preferences or by 'the problem' under consideration. These are seen as opposed positions. Bryman is one of the more recent contributors to the debate and I shall outline his argument below. Having done so, however, I shall suggest that to define a 'problem' is to adopt an epistemological position, albeit an implicit one, since one's epistemological position, broadly understood, influences one's definition of 'the problem'. The opposition asserted between epistemology and problem based solutions to methodological choices is an apparent rather than a real one since they are different aspects of the same thing.
Bryman draws attention to the 'widely held convention' that quantitative research is founded on positivism, which in turn is equated with a philosophy of natural science (Bryman 1988:14). It is underpinned, Bryman suggests, by a commitment to: methodological monism, phenomenalism, an inductivist approach to the accumulation of facts (which in turn refine theory), a deductivist approach to the testing of theory, and an epistemological commitment to objectivity (that is, the elimination of values from scientific research procedure and scientific knowledge) (ibid:14–15). This is contrasted with the philosophical underpinnings which are said to underlie qualitative research. These are phenomenology, symbolic interactionism, verstehen, naturalism and ethogenics respectively (ibid:51–61). This gives rise to different methodological preoccupations; the quantitative researcher with operationalisation, causality, replication; and the qualitative researcher with a concern to describe events 'through the eyes of' the subject, to emphasise process and to refine theory by sifting it through factual observation (ibid:56–69). In consequence, Bryman suggests, quantitative and qualitative researchers employ different methods. The quantitative researcher relies upon structured survey techniques, experimentation, secondary analysis, structured observation and quantitative content analysis (ibid:11–13). The qualitative researcher relies relied upon participant observation and unstructured interviewing, the life history and group discussion (ibid:49).

Bryman's contribution is to challenge the alleged link between quantitative/qualitative research traditions and particular philosophical positions. He shifts the focus of attention away from the epistemological basis of research design and methodology towards a pragmatic 'problem oriented' one (ibid:125); suggesting that the choice of
research methods is properly determined by the research problem under review. In some circumstances quantitative methods will be preferable, in other circumstances qualitative methods and in still others a combination of such methods (ibid:173).

Bryman's formulation has a certain popular appeal in that it opens up the possibility of advancing beyond the esoteric conceptual confines of philosophy, theory or methodology and engaging in real empirical work addressing real empirical problems. Closer examination however suggests that his formulation is fraught with problems. These may be summarised as follows.

The most serious problem concerns his conceptualisation of science. Whilst he stops short of suggesting that quantitative research has been associated with a philosophy of science and qualitative research with a distinctively social, non scientific philosophy, the emphasis of his analysis is in this direction. Thus he suggests that 'unlike much writing about qualitative research' the ethogenic approach is perceived as a scientific approach. He fails to draw out the scientific credentials claimed for symbolic interactionism and naturalism by its own advocates, such as Denzin's 'scientific' principle of subjectivism and the validity claims made for triangulation by Denzin and other naturalists. Instead, he suggests that

...a view that the scientific method provides a poor basis for the study of people, coupled with a commensurate endorsement of a position like phenomenology, will propel an investigator in the direction of a qualitative approach. (ibid:105)

That is, he emphasises phenomenological/ epistemological challenge, which we have seen glosses over the scientific epistemology of qualitative research established prior
to the phenomenological challenge (ibid:70).

Whereas quantitative research was described in the previous chapter as drawing the bulk of its inspiration from a natural science approach, and from certain tenets of positivism in particular, qualitative research derives from, and has been stimulated by, traditions which are distinctively different from such an orientation...Why then does one find a fairly sudden increase in interest in qualitative research when (check) some of the intellectual traditions on which is supposed to rest and the methods with which it is associated predate the 1960s? Two factors are particularly noteworthy. First...considerable disillusionment with the fruits of quantitative research...The second factor is the growing awareness of phenomenology...This work seemed simultaneously to offer the epistemological basis for a critique of quantitative research and a novel approach in its own right. On the one hand, the growth of phenomenology acted as a spur to congruent perspectives, like symbolic interactionism and verstehen; on the other hand it spawned interest in methods like participant observation and unstructured interviewing, which seemed to allow the phenomenological approach to be set in motion. (ibid:70, author's emphasis)

This passage illustrates one of the difficulties with Bryman's work. Because he adopts the role of historian it is difficult to ascertain what is narrative and what assertion. Nonetheless, one can agree with him that phenomenology popularised qualitative research without accepting that symbolic interactionism is a 'congruent perspective' or that 'qualitative research traditions' are 'distinctively different' from positivist ones.

So Bryman stresses the dispute about methodological monism and fails centrally to address the underlying epistemic similarities between quantitative and much qualitative (ethnographic, symbolic interactionist, Weberian, naturalist and even in some aspects phenomenological and ethnomethodological) work; and this he is able to do by overlooking a pre–Popperian philosophy of science based on the very positivist tenets which underwrite much qualitative sociological work.³ Bryman's presentation is therefore seriously misleading in that it concentrates on the natural scientific
dissimilarities rather than the scientific similarities between qualitative and quantitative research. It is more appropriate to suggest that an underlying epistemological agreement about the appropriateness of a social science of causation has nonetheless been associated with methodological differences of opinion, which are represented by the traditions of qualitative and qualitative research respectively.

This leads to the second difficulty, which is his conceptualisation of 'the problem'. Bryman contrasts 'philosophically' based method selection with a 'technical' one; according to which the nature of the research problem determines the research strategy. One difficulty, of course, which he recognises but does not accommodate, is that the researcher's theoretical and methodological inclinations will influence the definition of the problem. There is no reality external to the researcher, no independent problem awaiting solution. Having denied the epistemological basis of research methods and problem formulation but without any other concept for articulating social or academic perception, Bryman is left without a language with which to articulate the problem. In this respect, his analysis fails to take us as far as Fielding & Fielding. 'The problem' remains without definition and solution.

Both these difficulties are underwritten by a failure to distinguish 'philosophical' from 'epistemological' issues; although one may surmise that the former refers to the logic of scientific or social scientific discovery, whereas the latter is concerned, as he says, with what constitutes 'warrantable knowledge' (ibid:5). His failure to make this distinction clear results in a tendency to subsume the latter within the former and thus to dispose of the problem of how we know what we know by way of dismissing the
'philosophical' bases of quantitative and qualitative research. In consequence, he fails entirely to address the epistemological status of 'the problem' and the 'technical' solutions he advocates.

A third source of difficulty is his failure adequately to define what the terms 'qualitative tradition' and 'quantitative tradition' actually mean. Having denied a necessary link with a particular epistemological position he is forced to link them with the methods with which they are associated (ibid:11,46); a tendency which runs contrary to the logic of his own argument. This reflects a wider failure to distinguish epistemology from methodology from method: none of these terms are defined and the concept of methodology does not seem to appear at all. If the 'quantitative and qualitative traditions' have no necessary philosophical grounding and are 'associated' (but not defined in terms of) particular methods, it is difficult to see what they are; indeed I could find no definition of them. This leaves him only with the concept of atomised methods with, as we see below, fixed potentialities.

A fourth difficulty is his tendency to opt in and out of arguments; so that, for example, it is not clear whether he is advocating a 'technical' approach to methods on the basis of a 'problem-led' initiative, or whether he is merely reporting this as a possible approach. On one page he refers to the injunction to attend to 'the full complexity of the social world such that methods are chosen in relation to the research problems posed'; on the next he suggests that tailoring 'research strategy to the problem at hand' may 'obscure deeper issues in the issues addressed by qualitative and quantitative research' (ibid:173–174). The difficulties of interpretation to which this
gives rise are compounded by his tendency to oscillate between giving methodological
determinacy to 'the problem' on the one hand, and on the other suggesting that
different methods are appropriate to 'different kinds of research problem' (ibid:158).
The latter is clearly a much more restricted kind of formulation because the potential
of different methods is fixed independent of application.

Finally, Bryman has a very limited concept of the researcher's influence on the field
of study. Discussion of this aspect of social research is confined either to theoretical
bias (ibid:76), strategic selectivity in empirical observation (ibid:73–81), 'reactivity
effects' (ibid:76–77) on the research field and 'ethical, political, ideological
considerations' which may 'impinge on choices of method' (ibid:111) in the case of
feminist research. Although he acknowledges that

...the researcher, the discipline, the culture to be translated and the culture into
which it is translated from an interwoven amalgam of elements. (ibid:80)

this is in the context of discussing problems of qualitative research. He adds that
these sorts of issues are 'inherent in any attempt to provide an interpretation of other
people's interpretations for a social scientific audience' (ibid:81) but this implies that
no such problem exists if interpretative understanding is not an objective. There is no
recognition of non formal sources of knowledge within the academic world; or of the
possibility that the researcher's biographical knowledge may affect his/her sensitivity
to significant issues 'in the field'; or of the possibility that all such orientations may
influence the researcher's definition of 'the problem'. Yet the sociology of health and
illness abounds with examples of the conceptual constraints pragmatic/ policy oriented
'problems' impose on social issues; for example, the 'problems' of maternal smoking
during pregnancy or women's 'non attendance' at antenatal clinics, the limitations of
both of which 'problems' has been highlighted by alternative conceptualisations
(Graham 1976; Garcia 1982; Evans 1987). Other authors have suggested that this may
go beyond the inevitable need to make a choice in the selection of research 'problem',
and may affect the adequacy of that choice. As Harding suggests, the implications of
this are profound; for the social location of the researcher may influence the adequacy
of the analysis. That is, the 'context of discovery' may be as important as the 'context
of justification' to the adequacy of a piece of research (Harding 1987b).

Bryman may claim that he is agnostic on this issue, (although this would be
contradictory), and this would accord with convention. But the implication of
Harding's critique is not only that the quality of the research 'topic' is affected by the
context of discovery but so too are the potentialities of the methods themselves. For
example, a young feminist researcher conducting unstructured interviews with a young
mother would have a different 'effect' than a middle aged man. The concrete social
relations between researcher and researched infuse the method, fixing its potentiality
at the point of application, not in the abstract but in the particular.

Therefore the definition of the 'problem' will influence the potential of the method. So
too will the orientation of the researcher, both to the research 'problem' and to the
researched. It will also be influenced by the orientation of the researched. The
potentialities of particular research methods cannot be frozen within them in the
manner which Bryman and others seek to suggest (Bryman 1988:172–3). By this, I
am not suggesting that methods are infinitely malleable; rather, I am disputing the
point and source of configuration.

In summary, Bryman overlooks critical epistemological similarities between quantitative and qualitative traditions. This leads to an untheorised conceptualisation of the 'research problem' which relies on an implicit and positivist epistemology, and a profoundly conservative one at that. This ignores the possibility that one's epistemological position, broadly understood, and one's 'definition of the problem' are different aspects of the same thing. This locks concepts and meaning into fixed configurations and projects them onto the 'external' world. This has two methodological consequences. Firstly it leads him to attribute fixed 'technical' potential to research methods; divorcing methods from the context of application. In this way he extracts human agency and social relations from sociological method and generalises inductively on the basis of particular applications. Secondly, it gives him a very limited concept of the researcher's influence on the field of study; reflecting science's exclusive concern with the 'context of justification' over the 'context of discovery' (Harding 1987b). Discussion of the researcher's conscious subjectivity is limited to orthodox confines such as 'reactivity' effects, 'ethical considerations' and interpretative difficulties in qualitative research and research reports (Bryman 1988:73–81).

Triangulation, Rational Knowledge and Causal Explanation

There have been two key attempts to transcend the quantitative/qualitative divide. The first, noted above, has been to shift attention away from the epistemological issue, to
disentangle method from methodology, to suggest that the selection of methods is a 'technical' issue arising from the 'problem' or topic to be addressed. On this construction, methods are a means to an end. The second tendency has been to insist on the complementarity of sources of data; the multi-method approach. The relation between the two tendencies is summarised by Sieber as follows:

The original polemic between advocates of field methods and of survey research was mediated by the assertion of Trow and Zelditch that the nature of the problem dictates the method to be applied. Later on, Webb et al rejected a commitment to any single method in solving a particular problem because of an inherent bias in all techniques. Their argument in favour of multitechniques is based on an assumption of interchangeability - otherwise it would be meaningless to insist on cross validation. (Sieber 1978:362)

One of the earlier formulations of the 'multi-method' approach comes from Sieber who claimed that a 'new stye of investigation' was produced by combining fieldwork and survey methods and collecting the same type of data from both sources (ibid:359). His contribution is to suggest: a) that the same sort of data (for example, frequencies, events and norms) can be elicited by means of a variety of methods and b) that the argument in favour of a 'multi-method' approach rests on the strengths of particular methods rather than the limitations of all methods (ibid:359–362).

But he fails to problematise that definition of the 'problem' to be addressed, the logic of constructing a methodological argument on the basis that it happens 'in reality', or to justify the view that different 'sorts' of data can be elicited to equal degree by different methods. That is, he fails to address the nature and sources of data at all, but rather presupposes them. Like Bryman, his argument entails the attribution of presumed and invariant qualities to specific methods. He specifically rejects the
presumption of interchangabililty of methods implicit in appeals for cross validation (ibid:362); methods are considered not only divorced from 'reality' but also from each other. His is the most inflexible form of the multi–method argument then; on his analysis methods have fixed and invariant qualities which are different, mutually exclusive and divorced both from the context of discovery (the definition of the problem) and the context of application. The function of the method, or the interrelation of methods, resides within it; like a set of cutlery whose meaning, complementary functions and social relation to each other are put there by the manufacturers.

'Triangulation' is a methodological rationale for 'multi method' research strategies and has been associated with attempts to transcend the quantitative/qualitative divide. However it belongs more centrally to the House of Justificatory Strategies, in particular as a test of concept validity, within the logic of scientific explanation; and so exhibits all science's normative preferences and methodological preoccupations.

Denzin distinguishes four principal types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation (Fielding & Fielding 1986:25). The concept of triangulation derives, according to Fielding & Fielding, from surveying, and the basic idea is to locate oneself by reference to two or more landmarks. Somewhat confusingly this idea, which concerns orientation within a given experiential perspective ('getting one's bearings') is applied in social scientific methodology as a device to shift one across perspectives, as if from perception to reality. That is, it is used as a test of concept validity. As Fielding &
Fielding note,

In research, if diverse kinds of data support the same conclusion, confidence in it is increased. Implicitly this is only to the degree that different kinds of data incorporate different kinds of error. (ibid:24)

They continue:

The basic procedure is to check links between concepts and indicators by using other indicators. This does not complete the test. Even if results match, there is no guarantee of valid inference. There may be systematic or even random error which leads each indicator to the wrong conclusion. (ibid:24)

This latter qualification in itself presupposes that 'reality' exists outside the researcher's formulation of it; hence the possibility of a 'wrong conclusion'. Triangulation becomes a prop for empiricism, an interface between objective (empirical) and subjective (theoretical) discourses.

Any object which can be theoretically conceived and empirically located can be measured. (Denzin 1978:104)

The logic of a symbolic interactionist perspective should lead one to conclude that the only realities are subjective ones. However by confining the concept of second order subjectivity to theoretically driven observations, rather than, for example, including the biographical experiences and emotions of the researcher; by externalising validity criteria to a presumed real world, to which different instruments have different sorts of access and measure (rather than construct) in different sorts of ways; and by defining methods in terms of a pragmatic rather than an esoteric orientation, Denzin seeks to recover to qualitative research a subject/ object division and thus the possibility of predictive, objective, inductive science (ibid: X, 104).
On this basis, Denzin is able to derive scientific measurement techniques. These include: theoretically relevant measured objects; a multi-method approach; assessing the adequacy of methods in relation to their 'ability to be employed in the field situation'; measurements and observations framed in the language of those studied; and all measurements to be as reliable and valid as possible (ibid:104). He emerges from this excursion with an empirical science geared to generating universal causal statements based on the comparative method.

Causal analysis...represents the major goal of the naturalistically oriented researcher... Naturalists ...attempt to frame their causal explanations in terms of universal statements...When engaging in the research act, investigators should endeavour to build upon those techniques which have preceded their research... It is continuity of this order that makes science an emergent yet orderly process. (ibid. 129–130;105, his emphasis)

Once again, this leaves unanswered the central questions: how is the problem conceptualised – is cognition rational and purely theoretical; do we all have equal access to the same 'real world'; and do we understand the same thing by the answers given? That is, is social science wholly contained within theory and method in the manner suggested? Would men and women, for example, define, investigate and interpret data in the same way?

Fielding & Fielding and the Multi-Method Approach

More recent work, although considerably more sophisticated, exhibits the same fundamental preferences. The work of Fielding & Fielding (1986) is a good illustration. It emerges from the naturalist qualitative tradition and attempts to develop
a multi method strategy to qualitative analysis using the metatheory of 'structuration'.

It challenges the conventional distinctions between macro, variable centred, quantitative, hypothetico-deductivist methodologies on the one hand and descriptive, normative, qualitative methodology on the other.

Fielding & Fielding depart in a number of important respects from science's conventional Articles of Faith. Firstly, they relinquish the search for absolute truth.

What is important is that we accept the inevitability of the need to interpret, founded on an acceptance that absolute objective knowledge...is a standard but not a practical goal...all our pronouncements must be regarded as interpretations...neither qualitative nor quantitative data enjoy special claims to treatment as 'objective'. (ibid:37, their emphasis).

Secondly, and relatedly, they reject Denzin's validity claims for triangulation; firstly because it makes unwarrantable assumptions about compensatory capacity between methods; secondly because it is underwritten by a concept of objective reality; and thirdly because it implies that 'bias' can be confined to methods alone (ibid:31–34).

Thirdly, they restore the activity of the researcher to the centre of the research process; suggesting that it is the researcher and his or her cognitive processes that should be scrutinised and systematized in order to render research more rigorous and scientific.

Triangulation, or the multiple-strategy approach, is no guarantee of internal or external validity...the real target for such efforts at quality control is the researcher.

When pressed about validity and reliability, qualitative researchers ultimately resort to their own estimation of the strength of the cited data or interpretation: we have heard such responses many times. (ibid:24)
Fielding & Fielding's concept of triangulation is therefore designed to

...lessen recourse to the assertion of privileged insight ...Triangulation puts the researcher in a frame of mind to regard his or her own material critically, to test it, to identify where to test it further doing something different. (ibid:25,24)

Fourthly, they reacquaint and reunite the cognitive discourses of lay and professional perception. That is, they link the worlds of 'first' and 'second' order enquiry, removing the taint of difference from both. They note that the 'absurd consequence' of an epistemic distinction between research and other social activity is

...the paradox that, while culture members themselves check claims against facts and employ causal explanations, the researcher must refrain from the same. Naturalism secures its 'escape from relativism' only by artificially separating theories of how members and researchers make sense of social reality. (ibid:39)

They suggest that a more adequate premise would be one that 'emphasises the continuity of all data gathering processes, whether by lay persons, natural scientists or social scientists' (ibid:31). Embedded in the quotation above is also the important idea that social life is not purely 'rational' in the way naturalists would have us believe, but linked, in ways open to dispute, to other interests (eg. material interests, social position etc.).

Finally, they make the critical distinction between different levels or aspects of understanding, both in everyday discourse and research activity.

Chladenius, an eighteenth century scholar, actually saw interpretation as an occasional and pedagogical pursuit. Interpretation involved 'adducing those ideas that are necessary for the perfect understanding of a passage' but did not
serve to indicate the 'true understanding' of it. 'Understanding' and 'interpretation' were different. For the most part, understanding was immediate, registering meaning on the surface...Husserl argues that we cannot conceive of subjectivity as antithesis to objectivity; by doing so our concept of subjectivity would be conceived in objective terms. (ibid:36–37)

But their analysis does not challenge the hegemony of science in its various guises. Quite the contrary; the idea is to make social science more, not less, scientific (ibid:22). In this way, all the old assumptions, priorities and agendas are smuggled back in. Their own 'escape from relativism' is to seek recourse to the traditions canons of science with exclusive emphasis on the context of justification, ie. scientific methodology. Their approach differs not in the quest for scientific explanation but in the procedures they adopt and the areas they target for attention; in their case the researcher's interpretative acts as well as 'methods' per se. Through greater attention to the cognitive activity of the researcher (see below) and in conjunction with the concept of structuration, Fielding & Fielding envisage the possibility of a nomothetic, comparative micro–empirical sociological research tradition, yielding data amenable to statistical and comparative analysis and leading in principle to inductively derived generalisations (ibid:15–25).

We cannot work (or do anything else in life) without summary, abstract and generalisation but we must be prepared to subject these glosses to skeptical interpretation. Rejecting absolute versions of truth, and the feasibility of absolute objectivity, is not the same as rejecting the standard of truth or the attempt to be objective. (ibid:33)

Accordingly, their scientific preoccupations rob them of their own insights regarding:

i) The agency of the researcher in knowledge production. The researcher is fixed in
practice with a rational intellectual cognition. An approach with clear affinities with artificial intelligence, it becomes precisely that. The importance of the researcher's biographical resources, her status in and her non rational 'ways of knowing' the world, are selectively underemphasized. Reliance is placed instead on rational methodological procedures as the only sources of concept validity.

ii) Methodological pluralism. They work with a baseline but nonetheless absolute concept of social facts as 'things' 'real' and 'external' to representations of them; of discourses in a common language; of competing interpretations. They retain a persistent and underlying empiricism. Interpretation is still no more than a focus on reality, even if reality is a shade less absolute than before.

iii) Relatedly, they retain a sense of methods inscribed with fixed potentialities (ibid:27); divorcing methods from the context of application as did Bryman.

iv) The ontological unity of 'professional' and 'lay' knowledge. This is one of their most interesting suggestions. Taken in conjunction with the idea that social life is multifaceted, and that social scientific enquiry is similarly structured, by extension it can conceive that emotions and feelings are important aspects of cognition, and that social life and sociological understanding potentially has a far greater breadth and depth than has hitherto been accepted. This would require a theory of first and second order knowledge, in place of extraction techniques. However, having visualised these possibilities Fielding & Fielding sacrifice them at the alter of empirical science. The role of scientific procedure is to rationalize even intuition: truly to render intelligence
'artificial'. An extension of their own insights (devoid of scientific preoccupations) would have suggested how 'social reality' may be perceived independently either of 'empirical facts' or 'formal theories.' The 'ways of knowing' indicated by their own analysis are therefore stifled by an orthodox preoccupation with scientific procedure, scientific method and scientific validity claims.

So their potentially radical insights regarding methodological pluralism, the visibility of the researcher in the production of sociological knowledge, and the unity of sociological and everyday cognition remain unexplored, strangled at birth and stifled by scientific orthodoxy. The researcher becomes merely another research instrument, whose activity must be rationalised and moderated; and research methods once again acquire a priori capacities within a fixed scientific discourse.

Summary

This chapter has suggested that the methodological distinctions drawn between qualitative and quantitative research obscure epistemological similarities which commit both 'traditions' to a perspective which denies the agency, social location and ways of knowing (or not knowing) of the researcher on the one hand; and prefers science's normative dualisms on the other. Chapter 7 considers the feminist contribution to methodological debate. Feminist methodologies address both these shortcomings, offering both critique and corrective to orthodox empiricism. But I shall suggest that they, too, have their own limitations, which some feminist methodologists are now beginning to address. In Chapter 8 I present my own methodological account,
specifically addressing the omissions identified in Chapters 6 and 7.
Notes

1. Lomas is referring to psychiatry and psychoanalysis respectively but his comments are appropriate here to empirical science, not merely to quantification.

2. To me the value of this suggestion lies in the possibility it opens up of seeing knowledge as sedimented and thus recognising that there is no absolute distinction between formal and informal knowledge, knowledge and experience. Knowledge is multi faceted and sedimented, as is common sense and reality.

3. He does however draw this out more later when he examines the positivist (phenomenalist) undertones of much ethnomethodology, but does so as if this is his own insight rather than a product of his original conceptualisation of the field: see p.119–120

4. The injunction to replace philosophical with technical approaches is profoundly misleading and conservative, since it will be oriented in all likelihood to policy based 'problems' and research funds.

5. In principle you can have intuition and other spurs to the imagination but if it can't be rationalized it is thereby less adequate.
Chapter Seven

Ways of Knowing, Ways of Growing:

issues in feminist methodology
Chapter 6 drew attention to the omissions engendered by the epistemology of empirical science and suggested the need for a revised approach more capable of articulating the experiences of researcher and researched. Feminist methodology offers such an alternative; being both critique and corrective to 'malestream' methodologies. But, I shall argue, its strength as critique is its limitation as corrective; for it has developed in symbiotic relation to orthodoxy. Accordingly, it fails at a methodological level to displace a 'malestream' ontology. Some more recent feminist methodology is beginning to address these issues, but the residues of 'malestream' ontology remain.

I begin by defining some terms. By ontology is meant a 'theory of reality' (Garry and Pearsall 1989:47). A feminist ontology questions both what is real and for whom, and examines critically the dominant representations of reality, philosophical and otherwise.

...it is male experience that is reflected on in metaphysics [ontology]...it is a customary part of the privilege of the dominant group to be in the position to define reality for themselves and for their subordinates. Naming and defining reality are among the ways in which the dominant group takes and keeps possession of its world....women have had the world mediated for them by men...feminists are challenging this allocation of philosophical concerns. Feminist philosophers address questions that spring from women's experience, pertain to women's ways of being...Feminist philosophers are carefully scrutinizing the dichotomies of self–other, spirit–matter, mind–body, and active–passive, for these dichotomies reflect the fundamental opposition of male–female, dominant–subordinate, and valued–devalued beings. (ibid:47–8)

An epistemology on the other hand is a 'theory of knowledge' (Harding 1987b:3).

Sociologists of knowledge characterize epistemologies as strategies for justifying beliefs: appeals to the authority...of observation, of reason and of masculine authority are examples of familiar justificatory strategies. (ibid:3)
Feminists have subjected to critical scrutiny the supposition that reason and rationality are superior forms of knowledge (Garry and Pearsall:109); have claimed that 'the voice of science is a masculine one' (Harding 1987b:3); have begun to develop perspectives which authenticate women's ways of knowing (Bologh 1990); and have reevaluated emotion and female experience as legitimate sources of knowledge (Jagger 1989), 'a practice of feeling, thinking and writing that opposes the abstraction of male and bourgeois scientific thought' (Rose 1983:87) and is applicable to both academic and lay knowledge (Smith 1988).

A methodology is a 'theory and analysis of how research does or should proceed' (Harding 1987b:3). A feminist methodology may include questions specifically directed at the role and application of particular theories (ibid:3); it may comprise a social philosophy based on feminist epistemology and ontology (Smith 1988; Moulton 1989; Sherwin 1989; Stanley and Wise 1984, 1990); or it may develop theories of appropriate (or inappropriate) methods for use in feminist social research (Oakley 1986d; Finch 1984; Graham 1983b; Acker et al 1983; Duelli–Klein 1980; Roberts 1981a). As Harding has noted, these distinct but related aspects of academic enquiry are often conflated or confused (Harding 1987b:2).

What is Feminism?

Notwithstanding what Delmar terms the 'sclerosis' of the movement, academic feminism is founded on certain core concepts. These are usually referred to as a 'baseline definition' (Mitchell and Oakley 1986; Delmar 1986). But I prefer to use the
term 'core concepts' because this indicates that they are central to feminism rather than a lowest common denominator.

These core concepts are central to feminist methodology but have become deeply problematic in methodology terms, as belief in absolute knowledge and common gender oppression, abate. This difficulties persist notwithstanding the enormous intellectual impact of academic feminism in the last 30 years; which has resulted in devastating critiques of whole disciplines (Oakley 1980); paradigms, including science (Rose 1983, Keller 1982); and intellectual traditions and methods (Oakley 1986d, Graham 1983b, Finch 1984, Smith 1988, Harding 1987b); and which continues to do so (Garry and Pearsall 1989); resulting in the development of alternative, flexible, interdisciplinary intellectual practices (Sherwin 1989:27) tapping alternative sources of knowledge (Smith 1988; Harding 1987b; Acker et al 1983).

Feminism is founded on the idea that women's have a shared social position as a socially oppressed 'class'. This is the basis of shared interests, identities, experiences and sisterhood. In turn, it requires a feminist perspective on the part of its members; that is, a perception of women as an oppressed social group. So feminism requires feminist consciousness. Moreover, feminism's theory of political consciousness has as its starting point the concept of consciousness raising, with feminist consciousness as the standard to which consciousness should be raised. Finally, it is committed to the validity of oppressed individuals' experiences as sources of knowledge; whether this is conceptualised in empiricist or materialist terms.
In each of these aspects feminism, whether a marxian version or not, proceeds from and utilizes the ontological assumptions of revolutionary politics which are in turn informed by dialectical materialism. This legacy remains quite explicit in the work of some important feminist theorists (Harstock 1987; Smith 1988).

Feminism therefore embraces three questionable core concepts; firstly that feminist consciousness is both 'true' and desirable; secondly that women share a common situation/experience; and thirdly that the experiences of oppressed women have an essential validity. These beliefs have in turn underwritten its methodological preferences noted above (Acker et al 1983:423).

**Feminist Methodology**

Feminist methodology is both critique and corrective. On the one hand, at the very minimum it criticises intellectual traditions which render women 'either invisible and/or subject to a priori categorizations' (Oakley 1989c:28). On the other it corrects for these deficiencies using its own methodological principles and priorities.

**Feminist Methodology as Critique**

In the early to mid 1980s attention was concentrated on the development of a methodology of feminist research methods and practice. There were attempts to identify a distinctive 'feminist method' (Duelli Klein 1980) (this has since been criticised); methodological critiques of orthodox formulations of research methodology,
methods and practice (Oakley 1986d; Finch 1984; Graham 1983b); a number of corrective texts articulating practical experiences of empirical research, and the moral, political and conceptual dilemmas to which they give rise (Roberts 1981a; Bell and Roberts (eds.) 1984); and identifying the social relations which both structure the research process and which are embedded within research method and methodology (Graham 1983b; Oakley 1986d).

The methodological critique of 'malestream' empiricism has three aspects. Firstly it is suggested that the 'context of discovery' is just as important to adequate and valid explanation as the 'context of justification'; a claim which undermines one of empirical science's methodological mainstays. Traditional empiricism dismisses the 'context of discovery' and this leads to the overemphasis on methodological procedure and a deproblematized conception of 'the problem' noted in Chapter 6 (Harding 1987b).

Secondly, as Harding notes, traditional empiricism does not direct researchers to locate themselves in the same 'critical plane' as their subject matters (Harding 1987a:184). This has two consequences. Firstly it fails to account for the social context of research; overlooking the social consciousness and situation of researcher and researched on the one hand and their social/interpersonal relation to each other on the other. Secondly, such conceptions of the research process and research knowledge lack interior concepts of subjectivity; erroneously warranting themselves independent of human agency and subjectivity. This shortcoming has also been noted in the work considered in Chapter 6. Thirdly, in consequence of the androcentrism the foregoing indicates, empirical research norms should be followed more rigorously or abandoned,
depending on whom one reads (ibid).

Feminist methodology therefore visualises aspects of research practice and research knowledge which malestream methodology habitually and systematically neglects. This includes the human agency of the researcher, the situation of the researched and the social relation of researcher (and research) to researched. (See Acker et al 1983; Harding 1987b; Smith 1988; Oakley 1986d; and Finch 1984 for work which situates the researcher in relation to her/his research; Acker et al 1983, Oakley 1986d and Finch 1984 on the need to account for the social situation of the research subject; and Acker et al 1983, Oakley 1986d and Finch 1984 on the relationship between researcher and researched: insights which nonetheless feminists have failed fully to apply in their own work.)

**Feminist Methodology as Corrective**

In the early to mid 1980s the practically orientated methodological formulations noted above predominated. However there were some more philosophically oriented methodological contributions (Smith 1979; Weskcott 1979; Elshtain 1981, cited in Graham 1984b), the precursors to more recent work elaborating the philosophical aspects of feminist methodology and attempting to identify a distinctive epistemology (Harding 1987b; Smith 1988; Garry and Pearsall 1989; Stanley (ed) 1990).

Feminist methodology has developed its own distinctive characteristics which Harding (1987b) characterises as follows. Firstly, feminist methodology uses women's
experiences as new 'empirical and theoretical resources'; that is, feminist research 'generates its problematics from the perspective of women's experiences' (ibid:6–7). Secondly, it encompasses a new purpose, that social science be 'for women' rather than 'of' them; that is, its purpose is to benefit and be of use to women in their struggle against oppression) (ibid:8). Thirdly, it envisages a 'new subject matter of enquiry' which locates 'the researcher in the same critical plane as the overt subject matter'(ibid:9); that is, it requires that research, and the researcher, be conceptualized in similar terms to, and in relation to, the researched.

In addition it has developed its own practice principles, that

... research should contribute to women's liberation through producing knowledge that can be used by women themselves; [and] should use methods of gaining knowledge that are not oppressive; should continually [question]...the dominant intellectual traditions. (Acker et al 1983:423)

It has also developed marked methodological preferences and priorities. These are: i) in favour of qualitative research, the exploration of individual experience (implicitly the experience of the oppressed or powerless), and a reduction of social distance between researcher and researched; and ii) opposed to hierarchical, coercive concepts, methods and practice, identified implicitly with quantitative research.

Problems with Feminist Methodology

But feminist methodology has a number of fundamental difficulties of its own, problems evidenced in its methodological priorities. These link in turn to problems in feminism, the parent social movement.
The problem is that the core concepts which have inscribed feminism and feminist methodology are, for want of a better term, 'modern'; a legacy from its roots in revolutionary politics and the standpoint of the oppressed. Notwithstanding their critique of empiricism, feminism's own concepts inscribe a belief in an external reality in which inhere real structures which define women's shared social position and experience, and from which issues 'true', revolutionary, feminist consciousness. Additionally, those structures oppress women as a class; though this may be cross cut by other structures, for example, class. By making these assumptions, feminism and feminist methodology deproblematise their own core concepts, their own ways of knowing. Ultimately, it is this which undermines feminism from within.

This has a number of serious consequences for feminism and feminist analysis (Harding 1987a). In methodological terms one of the most serious shortcomings is that, in placing exclusive emphasis on the shared interests and identities of women, feminist methodology loses touch with its own insights regarding the need to make visible and problematise the social situation and consciousness of researcher and researched, and their social interrelation. Feminist methodology deproblematizes these very issues by issuing intellectual securities on the basis of the researcher's feminist consciousness. It fuses the position and interests of women in feminist social consciousness and elides difference and conflict between them.

Feminists' preference for qualitative research (Oakley 1989c:28), for example, deproblematizes communication between women in the research situation. It assumes that experience can be articulated by the researched and understood and communicated.
in turn by the researcher. It also relies on a shared identity and empathy between
woman researcher and researched to the exclusion of considerations of power and
exploitation and communication problems within that relationship (Acker et al
1983:428; Graham 1984b; Cotterill and Letherby 1991a). Finally, it renders qualitative
methods transparent and fixes other methods with bounded capabilities. There are
frequent metaphorical allusions to 'giving women their voice' (Millman and Kanter,
1975; Smith 1988) and 'shattering the silence' of women (Graham 1983b:135). Whilst
this was an important conceptualisation of the task in the 1970s, it is not a convincing
methodological or philosophical position.

To prefer qualitative research alone is to overlook one of feminism's most important
methodological insights; namely that methods are next to nothing outside particular
social contexts. These breathe life into and configure them. Neither qualitative nor
quantitative methods are immutably fixed (Roberts 1990). To appreciate the historical
context which led to this preference is not to justify it methodologically. One has to
question the issue of 'inherent limitation' of methods and methodologies equally in
relation to quantitative and qualitative research: Oakley (1989c) has begun to address
the difficult issues which this raises in relation to the RCT method favoured in
epidemiological research.

Similarly it is not so much what feminists say as what they don't say about social
distance that needs further scrutiny. The tendency has been to highlight the importance
of the relationship between researcher and researched; to problematise social distance
between researcher and researched; to seek to reduce social distance between women
In this way feminist methodology highlights 'mutuality' (Oakley 1987a) and gender identity at the cost of other sources of difference. As Acker et al note (1983), there is in this scenario the real risk that feminists will end up researching only those very much like themselves. Even an undifferentiated concept of gender identity is problematic, suggesting the 'merged attachment' which Orbach & Eisenbaum (1988) identified. What is needed is an internal concept of difference. To merge women in this way is to launder the conflict from our lives and relationships in a way which overlooks our multifaceted selves and situations. It also homogenizes and deproblematizes the researcher's 'ways of knowing' and means of access to the research subject.

Feminists' understanding and conceptualisation of experience requires critical review for similar reasons. Experience is to methodology as consciousness is to feminism. But the concept of experience has outlived the concept of feminist consciousness (Delmar 1986) and the companion concept of sisterhood. If sisterhood is problematic, so too is experience. But there has been no corresponding critique of experience; on the contrary it remains central to the feminist problematic, a feminist subjective epistemology, and the feminist critique of androcentrism in academic discourse (Harding 1987a, 1987b; Smith 1988; Garry & Pearsall 1989; Sherwin 1989; Whitbeck 1989; Ferguson 1989; Jaggar 1989; Stanley (ed) 1990).

Harding's suggestion that women's experience is a 'resource' is a diluted version of an
epistemological issue which feminism has at its core; namely the range and validity of claims to know from experience. There are three main conceptualisations of experience in the feminist accounts. Firstly, experience may simply constitute a resource, integral to but distinct from objective knowledge. This is broadly the position of the feminist empiricists discussed by Harding (Harding 1987a). On this account, women's experiences lead researchers to research appropriate issues, using appropriate methods, and determining what constitutes an adequate solution.

Secondly, it may extend to a far more thoroughgoing subjectivist epistemology such as those proffered by Stanley and Wise (1984), and Smith (1988). For Smith, 'The fulcrum of a sociology for women is the standpoint of the subject. A sociology for women preserves the presence of subjects as knowers...The standpoint of women... directs us to an 'embodied' subject... (Smith 1988:105–108). This entails the 'stronger' epistemological claim of what Harding terms the 'feminist standpoint' theorists, for whom privileged knowledge claims can be made for the experiences of women as an oppressed social group.

Women's experiences, informed by feminist theory, provide a potential grounding for more complete and less distorted knowledge claims than do men's. (Harding 1987a:184–5).

Thirdly, implicit in feminist empiricism is a tendency according to which experience constitutes valid knowledge in and of itself. Experience understood in this way is a coherent outgrowth of a phenomenalist, positivist ontology. Feminist empiricism contains the strongest (if implicit) epistemological claims for the validity of subjective experience; it is conceived of as knowledge, a reflex arising from social position. This
is the implicit epistemological warrant of much empirical feminist research (for example, Oakley 1986c:3).5

Some of these difficulties are identified in the postmodern critique. As Garry and Pearsall note,

...there is a tension within feminism about postmodernism. On the one hand feminist philosophers concur with the postmodernists' rejection of the white male 'grand narratives' of traditional philosophy.... On the other hand, postmodernism seems to undermine some important aspects of feminist theory as well. For insofar as feminist theory is making universal claims about reality or about right and wrong, it, too, is in line for postmodernist deconstruction. In addition, postmodernists call into question the possibility of a gendered, stable subject – the self–which is a key feature of feminist theory and practice. (Garry and Pearsall 1989:2–3)

This is a caution which may be applied equally to feminist statements about women's experiences. Experience and consciousness are counterpart concepts in feminist research and equally problematic. The subjectivist epistemology and the second of the empiricist formulations each amount to essentialist views of subjective knowledge.

In these ways, feminist methodology employs in a different capacity the very dualisms (subject/object knowledge/experience and rational/nonrational) which elsewhere it criticises and simply turns them on their head. It employs empiricism's normative dualisms in reverse. It thereby imports many of the same difficulties; including flat, unilinear deproblematized concepts of self, social structure, social scientific knowledge and 'lay' experience; dualistic constructions of academic knowledge as objective expertise (Harstock 1989:160–162; Smith 1988: Ch.3) and deproblematized 'immersion' accounts of feminist research practice (Smith 1988:110).
Finally, feminist methodology tends to an overhasty dismissal of non qualitative research. Again it is less what is said than what is not said that needs to be examined. The critique of 'androcentric' research (of 'traditions rendering women either invisible and/or subject to a priori categorizations' (Oakley 1989c:28) has been conflated with a methodological critique (of 'oppressive methods') and a methodological corrective (doing non oppressive, ie. feminist research). There is no qualifier to a critique which identifies women and men (and their competing interests) with opposite sides of a range of epistemological dichotomies. Women are sealed into subjective experience/knowledge, men into objective in an unwarranted way. In the past

The intellectual danger reside(d) in viewing science as pure social product; science then dissolves into ideology and objectivity loses all intrinsic meaning (Keller 1982:593)

What is needed is not the elevation of the normatively neglected aspects of dichotomous thought, or the unqualified critique of the privileged aspects. Rather we need to develop a synthetic ontology capable of blending both. In the present day, the response to essentialism has been postmodernism. Instead of the tendency to overdetermine knowledge there is now a tendency to underdetermine it, to strip it of any validity claims. But relativism is not an answer to absolutism. Keller's comments of 8 years ago apply today in a different guise.

It is important to recognize that the framework inviting what might be called the nihilist retreat is in fact provided by the very ideology of objectivity we wish to escape. This is the ideology that asserts an opposition between (male) objectivity and (female) subjectivity and denies the possibility of mediation between the two. A first step, therefore, is to reconceptualise objectivity... (Keller 1982:594)
Summary

For the purposes of this analysis the most important aspect of feminist methodology is that it situates researcher and researched in the same critical plane or 'plane of consciousness' (Harding 1987b). It thereby renounces the manipulative, object oriented approach inherent in the professional paradigm (and by extension midwifery practice and sociological methodology) and enables us to see social life relationally.

Feminism has been both critique and corrective: corrective action, corrective concepts, corrective methodologies. It is stretched between what is and ought to be. But the opposition which makes it so powerful viz a viz orthodox sociology limits it as an autonomous account. It has a symbiotic relationship to orthodoxy. Feminism as a way of thinking, feminist methodology as a way of doing, cannot be understood except by reference to that from which it seeks to distance itself. It is not independent. It is subject in reverse to orthodoxy's normative dualisms, and these restrict its vision.

Such a polarised conceptualisation severely limits the ability of the social scientist to do justice to the complexities of the mother/community midwife relationship, and the research process. Feminist methodology does not lend itself to the situation of the professional woman for example; her ways of being and ways of knowing, or to power and conflict between women, or to the analysis of love and friendship in a professional relationship. These mix levels of analysis in a way feminism cannot easily accommodate.
'Normative dualism' commits itself to one dimension. It has only one way of knowing. What is needed is the deconstruction of dichotomous thought so that academic knowledge and research practice, and everyday experience, can be conceptualized in their rich, multifaceted complexity. We need to stress variability, differentiation, diversity and dynamics over the static, flat and lifeless juxtapositions of dualistic conceptions. We need to see ranges and dimensions to everything: emotion in formal knowledge, rationality in experience, common sense in science, love in professional practice, biography in professional expertise, a 'professional' self as well as a 'personal' one and so on. A differentiated analysis along these lines is likely to be particularly important to the understanding of women's situations and experiences, as subjects and researchers; since it is relational, mobile and multifaceted in the same ways as are women's 'ways of being', 'ways of knowing' and the realities of their daily lives. Some feminist methodologists and philosophers have begun this important task by locating and embodying knowledge within the experiences of the knower (Stanley (ed) 1990) and within a non dualistic ontology (Garry & Pearsall (eds) 1989). Chapter 8 is a contribution to that discourse.
Notes


3. This makes it difficult to understand difference between women.

4. Here feminism joined forces with other trends in sociological enquiry.

5. It may be objected that knowledge in this sense arises not from experience per se, but from experience acquired from a particular social location. I do not dispute this, but even so there are two epistemological warrants; one that knowledge arises from social position, the other about experience yields knowledge within a social location. It is this second sense that is phenomenalist; for it assumes that knowledge arises automatically from experience so structured and thus overlooks ways knowledge is actively constructed through experience. It also inclines us to view experience as 'truth'. Similar difficulties encumber the 'standpoint' theorists assumption that they can unproblematically assimilate the viewpoint of the oppressed group, although this difficulty is overshadowed by the greater difficulty of justifying the political scientist's superior knowledge.

6. Notwithstanding some residual difficulties noted earlier in this chapter.
Chapter Eight
Taking It Personally. Sources of Insight in Sociological Research: towards a sophisticated sensibility
I reflect upon my role in the research setting. Sometimes I am fraught, attuned only to sweaty anxieties, oblivious of sweet understanding. Sometimes, increasingly, I am secure; then I am able to give (and receive). In this active, empathic, receptive state, I am part of the moment itself, buoyed by the tide of which I am part. And at that moment I am touched by feelings not fact, attuned to process not form. I see eyes shining bright smiles, while others are brimming with grief. I hear vibrant hopes, or deflated tones from those who know better than to need. I hear admonishing echoes passed down through generations; and watch actions speaking louder than words. I feel the power of touch, the anguish of need, the anonymity of mid stream existence. I learn not to judge or run or fear; and find that trust softens reticence in time. And I know that I cannot appreciate any of this without a sophisticated sensibility, able imaginatively to engage the emotions it discerns. This is the starting point of my own academic enquiries. [Extract from field notes]

At moments of disappointment and difficulty I have been advised, 'Don't take it personally.' Well intentioned this advice this may be, but it does not succeed in its task. I do take it personally. I do. In recent months I have come to see this less as a shortcoming and more as an intellectual resource. I have begun to wonder why such advice needs to be given; what it reveals and what it obscures. Impersonal approaches perpetuate the myth of abstract, disembodied knowledge (Stanley 1990b), strip understanding from its social and biographical roots (Harding 1987b), and obscure the agency of the knower and their ways of knowing (Garry & Pearsall (eds) 1989). They reduce the researcher to an automaton and her brimming, sentient intelligence to mechanical data collection procedures. This chapter has a different agenda and explores some of the possibilities which unfold when researchers do 'take it personally'; that is, when they understand the social and emotional sources of their own academic insights.

Working from the researcher's viewpoint (Smith 1988), I explore three dimensions of research work:
i) The first is the **sociobiographical context**. All research has such a context and sociobiographically inspired research such as mine is merely one end of a continuum. I suggest that many of the analytic insights which we call 'academic' are in actuality culled from our personal resources and biographical experience (Greed 1990b; Wise 1990b; Cotterill & Letherby 1991, 1992; Ribbens 1991). Understanding this, and exploring it, not only acts as a welcome corrective to the disembodied view of sociological knowledge; it also enables us more fully to appreciate the sources and boundaries of insight. In my own research, many of the insights were incompatible with the existing literature; without personal experience they would have been unavailable to me.

ii) The second dimension is the **emotional context** of academic work; a rich and vital source of knowledge whose epistemic significance has been almost entirely overlooked in sociological methodologies.¹ The researcher is fully and emotionally engaged in the research setting, active in the making of the moment; and this is the case even if s/he is socially marginal. This has two consequences. Firstly, one's own emotional complexes are necessarily implicated. These need to be understood and elaborated for they have sociological as well as psychological significance (Bologh 1990; Rothman 1986; James 1989; Hunt 1989; Cannon 1989) and may impede as well as advance the research. Secondly, one's emotional responses attune the researcher in the research setting, sensitising her/him cognitively and analytically, and making possible a rich and sophisticated sensibility which is an important source of insight (Rothman 1986; Greed 1990b; Oakley 1986d; Williams 1990; Wise 1990a, 1990b). In these ways the researcher's emotional responses are integral to the direction, priorities and ultimate
validity (or otherwise) of the research.

iii) The third dimension is the most neglected, namely the personal significance of academic endeavour. I explore this dimension through the concept of personal transformation. Research work is a creative, imaginative process in which the researcher is both artist and tool (Hunt 1989). Moreover, I am intricately bound up in it and it in me; and each of us is transformed in the process. Again, this has both personal and sociological significance. Conducting the research has been the vivid, emotional and educational experience acknowledged by others (Cannon 1989). But it also has a wider significance, both more and less personal. The research has been the vehicle for a turbulent journey of self exploration; a way of reaching my own inner needs. But as I grasp them I realise that they have a wider significance, for they speak of social and emotional oppression; of the dues I have paid as I struggled to fit in a world defined from the interests and vantage point of others. Nestled at the heart of personal need is therefore a profoundly sociological message.

In the sections which follow I explore each of these dimensions in turn. I conclude by the wider implications of this analysis for our understanding of the sociological research process.

**The Personal and the Professional**

If 'academic' means something or someone

Scholarly, (& by implication) abstract, unpractical, cold, merely logical... (The
then I am not an academic. My motivation is emotional, and my insights biographically based and packed with feeling. Not a whiff of disinterested enquiry; I am passionate about what I study. As the glow of personal embers cools on the academic page, setting into cold grey matter, so knowledge loses its life, its vitality, its history and its future. I hope in these pages to show how misleading that would be. My biographical and emotional experiences constitute the analytic backbone of the research.

There are some obvious and compelling senses in which the research is biographically anchored. It explores relationships which develop between mothers and their community midwives and arose from personal experience when I had my own children. In addition, my domestic situation and a touch of creative accounting, enabled me to accept the financial disadvantages of postgraduate work.

But the biographical influences go beyond issues of motivation and material circumstance. They permeate the hallowed halls of academic knowledge. The insights derived from personal experience explain the analytic direction of the research, constitute its most important base ingredient; and they predate my return to academic work. Moreover, biographical insight situated me at a creative adversarial tangent to much academic and professional wisdom. Not only did the insights in fact derive from personal experience but they could only have been so derived. The academic and professional literature I read was conceptually blind to the very processes I wished to explore.
Two birth reports written within days of my children's births indicate attributes of the midwives' orientation and practice style which I valued. In the first I noted the importance of sensitivity, trust and a sense of not being 'taken over'. The second report echoes similar themes, together with explicit recognition of the emotional aspect of midwifery practice.

I was aware on both occasions of the strength of attachment I felt for the midwives and that I experienced 'goodbye' as a loss. Such deep seated emotional responses surprised me, steeped as I was in a professional training as a solicitor. Subsequent discussion with other mothers suggested that this was a common response. In subsequent correspondence I noted:

I was fortunate in having the benefit of an excellent community midwife. As a result of my own experiences and discussions with other mothers I was struck by the importance (potential or actual) of the midwife as a source of support, understanding and experience for the mother in a social and medical environment with a different agenda and set of priorities. [Letter to M. Richards]

Here then, many months before the research was even funded, are clearly stated what remain some of the most important substantive research insights; that the relationship has sociological and psychological aspects which render it unique and important; possessing a significance over and above its professional functions.

I began to read the relevant professional and academic literature. What soon became apparent was that the insights gained from personal experience had been almost entirely neglected by academics and health professionals; obscured by the object oriented, dualistic paradigms operative within midwifery, epidemiology and many
sociological methodologies. In the first term of my PhD I wrote of the 'inconfidence interval' I had uncovered and began to elaborate an alternative ontology which conceptualised knowledge, experience and cognition synthetically rather than dualistically.

Thus personal insight ran headlong into the most fundamental assumptions of most midwifery research and sociological practice. Not only were these insights derived from personal experience, they could only have been so derived. Or, more accurately, they could not have been derived from the literature I read.

Emotionality in Social Research

Our emotions permeate every aspect of our being. A sophisticated sensibility entails a direct engagement of 'self' (or some aspect of it) in the research setting; an emotional response is an inevitable consequence of such engagement. It is therefore imperative to understand our emotional responses in at least two senses. Firstly, the researcher needs to understand the emotional context of the research; to reflect upon, and be attuned to it in order: i) to understand sources of insight (or ignorance); ii) to appreciate the emotional significance of the research for them, for this will influence its direction; and iii) to assess its impact in the research setting (for example, one's anxieties may be extreme yet have little effect on others, depending on the setting). Taken together, this amount to the suggestion that we become articulate about our own emotional profile.
The second sense is more immediate and considers one's emotional resources from an existential perspective. I shall suggest that our emotional responses constitute key cognitive and analytic resources in the 'here and now' of the research setting; capable of yielding important sociological insights.

The Emotional Context of Social Research

My own research was the site of a major intrapsychic struggle between feelings of love and security on the one hand and anxiety and insecurity on the other. This struggle manifested itself personally, in traumatic and highly charged experiences of fieldwork; professionally, in the substantive investigation of emotional intimacy; and politically, in linking my feelings to a wider struggle to transcend social and emotional subordination.

Women, pregnancy, and babies, have always been very important to me. Each was implicated in a search for comfort and security. Midwives, especially tender, sensitive, kind and available ones, sit plum in the centre of those emotional needs, which were reexperienced with particular intensity during pregnancy and childbirth. The research issue, 'specialness', represents something very profound and personal; the exploration of it is also an exploration of me and vice versa. It moves in both directions at once.

So the attraction of the research was the memory of an emotionally rewarding experience when I had my own children, the deeper needs that it engaged, and the conviction that others may experience or want a similar experience. It gave me an
example of a different way of being, one I wanted and needed and one explicable in feminist terms as a need to connect with myself and other women in socially subversive ways (Jagger 1989; Orbach & Eisenbaum 1988). At the same time, however, it dragged up the source of the need, the ongoing experience of emotional repression, subordination and insecurity. The pleasure and the pain were inextricably intertwined, part of the same complex. Exploring the pleasure calls forth the pain.

Anxiety and Insecurity in the Research Setting

It is hard to believe, much less to convey, how anxious I felt as I conducted the research.¹

1. I experienced acute anxiety whenever I visited a 'gatekeeper' or did any observational work. I displayed all the physiological symptoms of acute anxiety: including sweating, mind blitzing and a dry mouth. I resorted to taking a 'panic pack' on my observational outings: this included talcum powder, anti perspirant, changes of clothes, chocolate bars and mints.

2. I became obsessive about consent (see Chapter 9), all too ready to believe myself unwelcome and intrusive. Consent was compulsively and insecurely sought. I obtained consent from two ethics committees when one would probably have done; the consent of two senior midwives and each GP whose patients were involved; and the consent of each participating midwife and mother. Each interviewee (about 50) received a detailed set of Notes and her written consent was obtained. Each woman who was
observed (about 200) was given an explanatory letter and her consent sought at each stage of the observation. I 'risked rejection' (which was how it felt) in this way hundreds of times in the course of the research and I was absolutely exhausted and wrung out at the end of it.

Obtaining consent in this way was a major procedural accomplishment. It would be easy to present this as good practice (which I believe it is) but the point here is that it was underwritten by anxiety and low self esteem as much as by ethical imperatives. This in turn is attributable to the intrapsychic risks I was taking.

3. I developed a 'contamination complex', imagining myself to be the bearer of all manner of viruses and bacteria which would infect the babies and other unfortunates with whom I came into contact. I frequently postponed postnatal interviews for this reason, at great inconvenience to me (and no doubt to others). Indirect contact with the mildest of bugs was enough to cause me sleepless nights; direct contact was an absolute disaster.

Once again such concern has some merit. Memories of my own feelings as a new mother sat rock solid amid the intellectual niceties and pragmatic compromises of social research and steadfastly refused to be moved. But I knew too that much of my distress resulted from high levels of personal anxiety centring around the dangers of intimacy and emotional disclosure.

4. I had an acute fear of rejection arising from fear of defeat and fear of exposure.
Every refusal to participate or expression of disinterest was experienced as a catastrophic event from which it took some time to recover. I remember receiving my first 'consent form' back from a midwife; a refusal which curtly stated, 'Dear Ruth, I do not wish to participate in your research.' I opened it on the morning of my daughter's birthday and it stunned and undid me. Each incident of this sort cut like the flash of a knife. Had I merely an 'academic' interest in the research I would have stopped then if not before: this was pain I normally sought to avoid at all costs.

A Sense of Security in the Research Setting

If anxiety/ insecurity is the 'wound', a sense of inner security represents the healing or restoration. This provided a platform and a resource for the research relationship and the interpretive act.

I conducted interviews in both secure and insecure moods and the difference was striking. When I felt secure I felt nourished and did not feel personally threatened by the hostilities or anxieties of others. Rather than manipulating, manoeuvring or extracting data and then withdrawing, I felt the wish to reach out and know people in their particularity; to join with and understand them and to share to the extent we were able. I was flexible, calm and open. I accepted more and sought to control less.

When, on the other hand, I was insecure, I was brittle, analytic and more aloof; preoccupied usually by my own internal tensions. These interviews felt like a wasted opportunity and an abuse of the person who had agreed to be interviewed. I was not
attuned and I lost my way, felt clipped and cliched and asked questions ritualistically.

Over time I began to realise that I had personal reasons for finding some people 'difficult'. Stoical, unresponsive or reticent people unsettle and panic me, for I fear they do not have the emotional warmth and responsiveness I crave. Conversely, I most liked people who were themselves friendly or articulate about their feelings. This cannot be without significance in the context of a 1:1 interview discussing feelings, emotional responses and relationships.

Gradually I learnt not to make instant judgments about people and not to react defensively. On a number of occasions I braced myself on the doorstep for a short and tense interview with someone who appeared 'difficult' only to find that after about an hour their orientation changed, the interview 'gelled', the conversation flowed and we talked for another hour or more. Subsequently, these people were amongst the most interested and involved.

A Sophisticated Sensibility

The researcher is engaged in an existentially 'real' social setting, however duplicitous or conflictual their status within it may be (Fielding 1990; Oakley 1986d). An emotional response is therefore inevitable (Hochschild 1983). We need, as noted above, to understand our own emotional profile. But we can also interpret our immediate responses as cognitive and analytic resources in the here-and-now of the fieldwork experience, as a 'hands on' way of apprehending our subject.
Our emotional responses may aid a sophisticated sensibility in two ways. Firstly, properly understood, they have a sensitising, cognitive function which alerts us to the meanings and behaviours of others. They make possible a sensitive attunement predicated on our capacity to empathise, which in turn depends upon our personal and emotional resources. Secondly, a sophisticated sensibility, grounded in our emotional responses, has an important interpretive function. It is a medium through which intuitive insight and inchoate knowledge arise, and this in turn depends on the availability of similar emotions and/or experience (whether imaginatively or actually) within our own biography.

The Research Moment as Real: Cognition

The research experience is primarily an existential not a cerebral matter. The researcher experiences people in their full immediacy, in the steamy hothouse of life; not secreted away for cerebral deliberations, but here and now, demanding, aware. The researcher is active in the making of the moment and a rich and sophisticated sensibility is engaged.

I noted above that anxiety was a dominant emotion in my own observational fieldwork and this had some important cognitive consequences. I became highly sensitised to the emotional undercurrents of the exchanges I observed; spotting distancing techniques, intended and unintended manipulation, engagement and disengagement, love, affection, support and anxiety to name but a few. I doubt that I would spot them so well in more confident mood, even though my interest in the substantive area (emotion) remains.
There were times when I felt paralysed by anxiety yet my analytic sense remained intact. On one occasion, my anxieties alerted me to a midwife's displays of power and hostility towards me on a delivery suite. I became attuned in such circumstances to precisely those emotions and manoeuvres which either caused me anxiety or else helped to relieve it.

This is not to suggest that we confine ourselves to the personal significance of subjects' actions. This would clearly be misleading. If someone behaves malevolently towards me, this has a significance beyond itself. It may indicate hostility, hierarchy or defensiveness and it is this one would wish to explore. This, however, is achieved through grasping the behaviour emotionally (for example, feeling the malevolence), and then working with and beyond that to the sociological insight.

Personal responses do not guarantee empathic understanding but they do in my experience foster a sensitivity to commensurable experience and are thus important sources of insight (Williams 1990; Greed 1990b). I was often instantly aware of the soothing effects of emotional attitudes such as reassurance, support, acceptance, welcome and trust in alleviating my anxieties. This vulnerability informed me anew of the importance of such attitudes to mothers who may themselves be feeling ragged and vulnerable. Over time this awareness developed into a sort of cognitive skill; a reflex recognition of subjects' orientations which drew on my own social and emotional repertoire but evolved increasingly into a quasi autonomous capability.
The Interpretive Function of Emotion

One's emotional responses are an integral and appropriate consequence of being part of the moment. In my own research, I found my emotional resources gave me insight into the substantive aspects of the research. Without them, and their biographical foundation, neither the motivation, the understanding or the sensibility would have been present. Far from being an encumbrance my positive feelings were the most essential resource in research dealing with the deep emotions engaged during pregnancy and childbirth. The following extract describes my emotional response to a home birth I observed:

It was the most comfortable experience anyone could have had... No one was anxious, no one was new, we had each, in our own way, been there before... Silver threads of friendship drew us all together, immersing us in this most profound of experiences. We each drew on and gave of what was within; love, understanding, moments of mutual acceptance. The ties that made this possible were in turn renewed; friendships nourished and deepened in the process. Through shared experience we were all enriched; affirming, confirming and growing... To share a birth experience... is profoundly rewarding and marks an indelible deepening of relationships; a uniting of bonds in the inner depths of experience. [Extract from field notes]

These are the feelings and memories which are the stuff of this research. This is where it is anchored, this is what it explores. This is the best way I have of attuning myself to reports in interviews of emotionally intense experiences; for example, one woman's suggestion that she 'loved' her midwife, another's that her community delivery was the sort of experience every woman should have.

My own experiences, whether as a mother or researcher, do not guarantee understanding; for understanding transcends experience. But it remains important to
appreciate how our personal biography creates and situates us viz-a-viz the research; and I for one would not have attempted this particular piece of research without such feelings and experiences to draw upon.

Personal Transformation

Of all the biographical omissions in sociological accounts this is probably the most thoroughly overlooked. At first glance this seems entirely sensible, since the object of scrutiny is the research not the researcher. But further consideration suggests that if, by extending Oakley's argument (1986d), one's 'personal identity' needs to be invested in feminist research, it follows that the research in some way influences or affirms one's personal identity.

Research work, especially a first experience of it, stirs up all sorts of emotions and identities. It is a major life event. Moreover, the researcher's creative and emotional energies go into the making of the product; understanding the researcher is therefore an important clue to understanding the direction, significance and internal validity of the research (Cannon 1989). In addition, my own experience suggests that such reflection yields important sociological messages about the links between the personal and intellectual autobiographies of the researcher (Stanley & Wise 1990).

I have from the outset pondered my predicament with some bemusement. Why did I turn my life around and decide to do a PhD? Only now am I becoming aware that the research has been a vehicle for a journey of self exploration. It is as if the research
both creates and maps out the space within which I can examine myself, others and particular human relationships. Such reflective, inner examination would be quite impossible in the scorching din of professional practice, when all that can be heard are the impossible demands of others. I needed an environment which was 'nice and quiet', like the atmosphere some midwives create around birth. The PhD provided it.

From the start of my literature review I was outraged at the intellectual cover up of emotion, intuition, and human relationships in the name of expert or academic knowledge. Mine was an approach which stood in direct opposition to almost everything I read. So I began to read more widely and found I was basking in writing dwelling in feeling; sensing these were much closer to the truth I wanted to tell (Alberoni 1983; Flint 1987; Oakley 1986g, 1986d; Spender 1986; Kirkham 1989).

I felt profound internal connections being made when I discovered that my research was about love (in its broad sense) and friendship. The emotional circuit complete, my creative impulses started to flow. I started to write creatively, fiction and poetry, the first for more than 10 years. The style of my academic writing changed; more lyrical, less brutal, and much more easy to read. The difference was apparent to others. 'I don't know what's happened but something has,' someone said as she read my work, and that just about summed it up. I too knew something had changed; some loving, permissive, creative chord had been struck, but I did not know how or why. I was only aware of an academic connection and the emotional effect. Only now, years later, can I start to see the links.
I began to realise how I had operated in so many relationships as if I was a puppet; acting on cue, playing a part, wooden but apparently real. Never mind the cost; I thought emotional tolls were universally borne. I came to realise that midwives symbolised what I most wanted but denied; love and care. It was the quietest revolution ever, dissolving through to the truth, a moment of calm and unspoken acceptance. Knowing in an instant what I had always denied: the depth of my love, the extent of my pain, the need to feel and experience both.

Out of this painful, turbulent, healing process is being released a personal philosophy, a new way of being and knowing. This inner glow could not be seen in the neon glare of our uncaring culture but it is nonetheless profound. It has taken me full circle, but one which has spiralled to deeper levels of understanding. I began my research wanting to know what was meant by calling a relationship 'special'. In the process I have discovered why I needed to know. The research did not begin as a personal journey or a feminist one but it has moved profoundly in both these directions. My emotional responses signalled sources of personal pain and pleasure and located those feelings and frustrations in particular social relations. The feminist literature provided the intellectual insights which enabled me to understand the subordination of feeling and intimacy as part of the subordination of women. It provided both critique and corrective to social and intellectual pretensions I did not share and enabled me to begin to articulate a more appropriate ontology consistent with the way I feel. At a substantive level, the research has given me examples and insight into how to support and be supported, to love and to care; and this may prove the most enduring reminder of the personal significance of academic endeavour.
Discussion

We are working in the margins of cognition and the borders of knowledge. From this vantage point we see knowledge refracted as if through a prism and so come to appreciate the spectral complexities of the pure light of reason, the aspects of which had once seemed simple and pure. This paper speaks of the need for a new approach to sociological methodology, one which more fully incorporates both the research subject and the researcher as living, feeling, situated subjects (Stanley (ed) 1990). Experience, emotionality, biography, immediacy and subjectivity have been mistrusted, and the values of abstract rationality preferred.

At an epistemological level an appreciation of emotional and biographical sources of insight challenge what Garry and Pearsall have termed 'normative dualism'; a strategy in which aspects of knowledge are artificially dissociated and one disjunct normatively preferred over the other (Garry & Pearsall 1989). Much professional and academic work has been forced through an epistemological purifier. The result is academic knowledge which does not reflect and cannot capture the priorities of those it seeks to understand. A more appropriate conceptualisation from my viewpoint is to construct the concept of truth holistically. Viewed this way knowledge has the form of a crystal: one facet cognitive, another epistemological, another methodological and yet another substantive. This permits us to visualise truth in relation to knowledge, seeing in relation to knowing, knower in relation to known and to see that each suffuses the other in a complex interdependence.
This leads on to the second epistemological implication: the adequacy of the knowledge which is constructed. One implication of the foregoing is that the context within which the research 'topic' is generated both permits and sets limits on what is achieved. A methodology which confines itself exclusively to the research setting narrowly conceived is therefore narrowing its sights; the validity of a piece of research also depends crucially on the context within which the problematic was originally conceived. In Harding's (1987b) terminology, the 'context of discovery' is at least as important as the 'context of justification' to the value and validity of a piece of research.

The first section of this chapter draws attention to research problematics and insights grounded in the biographical and emotional experiences of some women, including me; and which I have subsequently discovered to be conceptually incompatible with the perspectives dominant within the relevant professional and academic literature. I hope to have demonstrated how inextricably bound knowledge and cognition are to their contexts of production, how misleading the gloss of disembodied knowledge and abstract rationality is, how important it is to understand the context within which research problematics are generated and, equally important, the links these have to our concepts of knowledge and truth. They exist in a state of mutual interdependence.

In cognitive terms we need to be able to theorise thought and feeling, subject and object, fact and value synthetically, not dualistically. We need in particular to be able to theorise the emotional aspects of cognition, what they are and how they vary, for these have been seriously overlooked. And we need to be able to turn cognition
through to a different dimension and see it suffused with biographical meanings and influences.

Moss (1989) likens the unique associations evoked at the centre of an experience to the harmonics (or dissonances) which accompany musical sounds. These resonances, he suggests, are experienced in their emotional totality as part of the experience itself (Moss 1989:177). This suggests that every experience has unconscious and emotional aspects, though its precise influence varies uniquely; and that each influences our experience of social reality, the goals we seek and decisions we make.

Such an approach has great value from a methodological perspective. It rescues biography and emotionality from intellectual oblivion: both can be theorised at the core of the experiencing self. It enables us to visualise the researcher as well as the research subject as socially and emotionally situated and to begin to understand how professional and personal knowledge and experiences relate and intersect.

This leads to the third of the 'larger' issues I wish to consider, the methodological. It suggests the need to consider sociological research as a **living process**: one which inevitably engages biographical and emotional meanings in researcher as well as researched. The researcher's 'self' both permits and sets limits on what can be achieved and the researcher in turn is changed by the research act.

'Taking it personally' requires us to become articulate about our social and emotional resources and their utility or otherwise in the context of the research. In making this
suggestion, I am not denying that abstraction has value, overlooking instrumental orientations, or intending that we should concentrate on our insecurities or celebrate our strengths. If 'taking it personally' means taking offence, being precious, or feeling totally undermined then it will not teach us anything about the social world, although maybe much about ourselves. But if we are to extend beyond ourselves to sociological understanding it remains imperative to appreciate the ways in which we are socially and emotionally constituted, both to the advantage and detriment of the research.

I hope in this chapter to have restored the living context to my own experience of sociological research. I have suggested that my own research has been biographically and emotionally rooted and have tried to consider some of its sources and consequences.

Through conducting the research, I have come to appreciate the sociological significance of my own feelings and biography. I understand the socially structured emotional links between my personal, professional and political priorities; how a personal need for emotional and social connection finds expression in feminist critiques of 'malestream' academic and professional life and the delineation of alternative ontologies, epistemologies, methodologies and modes of academic expression (Bologh 1990; Stanley (ed) 1990; Garry & Pearsall (eds) (1989); Smith 1988; Harding (ed) 1987). I can now connect my personal and intellectual autobiographies (Stanley & Wise 1990).
Notes

1. Hunt (1989) cites some exceptions, but these tend to be 'confessional' accounts of emotion.

2. In part this is the anxiety of the novice, who has neither experience, success nor familiarity to defend themselves with. Others have explained anxiety as marginality Fielding (1990). My own anxiety bears both explanations, together with anxiety derived from commitment but is I believe rooted centrally in the complex described above.
Part Four

Methods of Discovery
Chapter Nine

The Evolution of a Research Strategy
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Parts Two and Three have highlighted the need to interpret research, professional and 'lay' activity and meaning within the same frame of reference. From this perspective, there are no hard and fast distinctions between the way experts and non experts know, experience or exist in the world. In particular there is no absolute distinction between objective and subjective knowledge. Our knowledge and experience always has a subjective element. We are all located subjects.

This renders a conventional methods chapter redundant; for there is no objective 'fact' to recount, objective authority to cite or standard to meet. This chapter therefore presents what Oakley (1992) terms the 'natural history' of the research project, understood in this context to include the subjective world of the researcher. This chapter is written in the first person. Not only does a personal account feel more honest than a retrospective, disembodied view; it also explains more accurately the methodological decisions I made.

I begin by describing the evolution of the research strategy and go on to outline the methods employed. I then describe the sample design and selection criteria and outline the social characteristics of the research subjects. From here, I consider access and ethical issues arising in the course of the study and conclude by considering subjects' experiences of taking part.

Research Alims and Research Strategy

The research was first and foremost a journey of analytic exploration; a process of
uncovering inchoate knowledge from within my own experience. This journey took top priority; and methodological considerations were harnessed in its service. I consulted methodological texts but found them distracting, so different was their direction to mine. When I sought to implement them into data collection and analysis I found they skewed the analysis, and deprived me of my inner direction and purpose. Accordingly, I decided to proceed intuitively, seeking to make explicit those intuitions as I went. For better or worse, this is a study which has been conducted on its own terms.

The analytic issues I wished to address were: i) what do women mean when they describe the mother/community midwife relationship as 'special'; and ii) what is distinctive about the role of the community midwife. I conducted a pilot study prior to registering the research; consisting of recorded, in depth interviews with six mothers whose details were obtained from a maternity consumer group in the same DHA as was studied in the doctoral research. The sample was biased in favour of older, middle class, first time mothers. Two community midwives from another DHA were also interviewed. None of those in the pilot study took part in the doctoral research.

From the pilot study I gained three methodological insights. Firstly, the research had to be grounded in the mother's viewpoint, as understood by me, rather than that of the academic or professional establishment. As noted in Chapter 8, the insights were unavailable elsewhere. The methods chosen must service this end. Secondly, I began to appreciate sociological 'method' as a contextualised, situated, embodied skill; not an abstract, impersonal tool. Thirdly, I came to understand the research process as one
of making explicit what is known inchoately. I noted in the pilot study report how research is conducted in a state of 'intellectual peripheral vision', which relies upon intuitive direction. I noted in my pilot study report how

...on the basis of the pilot work I have become convinced of the need to see methodology less as a 'discipline', 'approach', 'technique' or 'tool' and more as an emergent, negotiated result of the interaction between the interviewer, her psychological disposition and her (related) academic interests; the nature of the subject matter (in this case very personal); and the sociological and psychological (and biological) situation of the interviewee. It is a pragmatic solution to the interplay of these elements and to see it as a tool is to reify those social relations. In an important sense the most appropriate methodology is the one the researcher can carry off in the circumstances. It soon became clear to me that I could not conduct those interviews satisfactorily...on anything other than...an informal basis. [Pilot study report]

Research Design and Methods

On the basis of the pilot work I was satisfied that a subject centred, informal interview was the best way that I as a researcher could engage this topic with research subjects whom I saw as very like me. I didn't just want to 'know', I wanted to grasp the drama of each woman's experiences. The informal, indepth interview seemed the most appropriate method. This choice was also warranted by the exploratory nature of the research.

I also decided to conduct a limited observational study to familiarise and sensitise myself to midwifery practice. In the course of negotiating access I was offered the opportunity of observing all participating community midwives at work; rather than just the one or two I had anticipated. I decided that this was too good an opportunity to miss; offering the opportunity for direct exposure to the midwifery care of scores
of women, tasted on a palate highly sensitised to such experience. Accordingly, the observational aspect of the study was broadened, and I abandoned ideas to produce a questionnaire for distribution to a wider sample of subjects.

So the research combined observational and interview methods. I decided to confine the study to one district health authority. This enabled the organisational conditions to be held reasonably constant, so as to permit analysis of variability along sociobiographical and relational lines. (In general, in this district health authority, antenatal care is provided principally in the community, with community midwives and GPs seeing mothers at alternate visits; and all are served by the same district hospital. Exceptions are detailed in Chapter 10.) The DHA selected was local; for reasons of convenience and access, and because I knew the 'special' relationships I wished to explore frequently arose within it. It is in a predominantly white, middle class suburban area in the south east of England. I aimed to study all 18 community midwives within this DHA, but for reasons given below this was not possible. A total of 12 community midwives took part. Of these, 11 were observed and 9 were interviewed. One was interviewed but not observed. Clearly, a two thirds sample is less than ideal. It appears that some of those not participating sometimes had unsatisfactory personal relationships with some of their clients; although this is not true of all. There was little opportunity to examine unsatisfactory relationships. This limits the scope of the analysis but does not defeat the main analytic objective; which was to understand 'special' relationships. I am confident that the sample who participated enabled me to achieve this objective satisfactorily within this DHA.
However, it also follows that one DHA, with its particular organisational framework and social stratification, cannot speak for all. There is significant variation in the provision of community care between DHAs, a variability compounded by the introduction of a variety of 'Know Your Midwife' schemes designed to familiarise mothers and midwives and provide continuity of care. Some at least of these schemes aim to blur or eliminate the distinction between hospital and community based midwifery. In addition, notwithstanding my sample selection criteria (see below), the social composition of clients within this DHA means one must acknowledge that the research may not speak for the experiences of other social groups; for example, ethnic, inner city or materially deprived groups (see below).

Methods of Data Collection

The research therefore combined observation as an observer/participant with informal, indepth interviews; involving approximately 100 interviews with approximately 50 research subjects and observation of approximately 11 community midwives and 200 mothers. The observational sessions were tape recorded, and contemporaneous notes were taken using an observation sheet (see Appendix 1a). The interviews were taped and based on the appropriate interview schedule (see Appendix 1b, 1c and 1d).

The study concentrated principally on detailed analysis of indepth interviews with 24 mother/community midwife dyads, four per midwife. Mothers party to these relationships were interviewed once in late pregnancy and again 2–3 weeks after delivery. Interviews were timed in this way to capture the relationship at its most
intense; this being the time when mother and midwife have most frequent contact and when, in most cases, the mother is practically and emotionally most engaged with childbirth and thus with the midwife.

I also interviewed a separate sample of 6 mothers, each of whom had been selected by their community midwife (the same midwives as in the sample referred to above) as having had a 'special' relationship with them (see below). This enabled me to validate and refine my understanding of 'special' relationships.

I also conducted an extensive observational study, shadowing 11 midwives at work in the community for approximately two working days each, in antenatal, postnatal, clinical, home and delivery situations. The purpose of the observational study was to familiarise myself with the community midwife's role and to learn of differences of practice style. This operated as a source of self education, as a way of sharpening the analytic focus of the study, and, most importantly, as a source of data about the practice styles of the six principal midwives (see below).

Further details and discussion of the research design and methods, and the sample selection, are given in later subsections of this chapter.

Data were elicited and recorded using the following methods:

Observational study

i) Tape recordings
ii) Contemporaneous notes of 'set up' contacts (e.g. telephone calls)
iii) Fieldwork notes (usually recorded in the evening of the observation day).
iv) Summary sheets (contemporaneous notes during observation
sessions)

Interview based study

i) Tape recordings
ii) Interview schedules
iii) Field notes (usually recorded on returning home from the interview)
iv) Clinical notes (to establish dates of visits)
v) Summary sheet on interview schedule
vi) Birth Reports
vii) Contemporaneous notes of initial contacts

Methodological analysis

i) Diary
ii) Ongoing notes and reflections on notes
iii) Ongoing reflections/self analysis of 'personal' themes (dreams, emotional responses etc.)

All of these sources of data were drawn upon in the data analysis but not exhaustively so. In practice, I concentrated on the fieldwork notes in the observational study, the transcripts in the interview based study and the ongoing notes and personal reflections in the personal methodological analysis.

I did not make complete transcripts of the interviews, both because it was impracticable and because I felt it unnecessary. Verbatim transcripts emerge from the empiricist fantasy that the meaning and significance of an interview can be captured objectively and entirely; and overlook the subtle and active analysis required to give it sociological meaning. I therefore made partial transcripts, punctuating them with analytic comments at the time of transcription, when the data was most fresh, vivid and fully at the centre of consciousness.
The schedules and summary sheets used are reproduced in Appendix 1. The summary sheets recorded basic sociometric, obstetric and professional contact details for each mother. The interviews were structured around a set of core questions. For the mother, these included her relationship with her midwife, her perception of the midwife's role, differences in the roles of GP, health visitor and community midwife respectively, personal social circumstances, the community context, previous childbearing experiences (if relevant), birth experience this time, the woman's own outlook, and her response to participating in the study.

The interview schedules and transcripts used similar analytic classifications, thus permitting both comparative analysis and a degree of correspondence between the questions asked and responses given. In practice, however, the significance of different themes varied between interviews. The occasional core question was omitted from almost every interview. This has produced disappointing response rates at some points in the analysis; but, to compensate, it did produce rich data appropriate to the particular research subject, in almost every interview. Moreover, insight is not obtained through 100% response rates; in principle it can be achieved with one response. The interviews varied considerably; some being more socially grounded, some more psychologically grounded, some more cohesive on the first occasion, some the second, and all bearing the distinctive signatures of research subject and researcher.

The observational and interview data yielded different and sometimes paradoxical insights. From the observational study I lived through the drama of mother/midwife
relationships and understood variability in practice styles and the way this characteristically defined relationships. But I was also surprised to find contrary instances; cases where woman centred midwives became remote and disapproving and professionally centred midwives opened up. I was also surprised to find how easily some women seemed to accept incongruous or even adverse encounters.

The interview data on the other hand conveyed more of midwives' own self perceptions and less of the practice 'lapses'; but this in turn fleshed out their dominant orientation. The mothers' interviews were invaluable in helping me to appreciate variability of outlook between women, and in giving detailed insight into how relationships operated and how women experienced midwifery practice. But it tended not to discriminate very well between the popularity of different practice styles and the characteristically different relationships to which they tended to give rise, tending to highlight what was valuable within each particular style.

Sample Design and Selection Criteria

The district health authority in which the research was conducted divides its midwives into six teams. The community based midwives operate, in practice, in nine pairs, making a total of eighteen. Just over half of these were full time. The most common arrangement was for a full time midwife to be partnered by a part time midwife. I observed and/or interviewed a total of twelve midwives from seven of these pairs. Eleven of them were observed for two working days in the community.
I wished to examine a number of relationships in depth, from the perspectives of both parties. This would permit a dynamic analysis of relationships as a blend of the outlooks. Accordingly, I asked the seven full time midwives, including at least one from each team, who were participating in the study to select a sample of six mothers in late pregnancy, to be selected from the list of one GP in accordance with the following selection procedure:

**Procedure for Selection of Mothers**

Please invite every mother who meets the criteria set out below to take part in the research. If she agrees, please give her the brief introductory letter (enclosed) and let me have her contact details. I will then get in touch with her and explain about the research in more detail. If she wants to take part, I shall provide her with a copy of the Notes for Mothers (copy enclosed for your reference).

**Selection Criteria**

i) Is she one of Dr X's patients? (ie. the GP who agreed to the involvement of his patients)

and

ii) Is she between 30 and 37 weeks pregnant?

If so, please invite her to take part. A total of six mothers is needed.

[Letter to community midwives]

Please let me know if any mothers are not asked, or do not wish, to take part.

Each sample of six mothers was to include one first time mother, one 'mulitparous' mother, one working class and one middle class woman. However, I found it simplest not to specify the class and parity criteria in the instructions to the midwives but to select them retrospectively from the sample actually provided. This proved a simple and effective way of meeting the criteria.
The rationale for the sampling criteria and procedure was as follows. Firstly, I wished to explore relationships involving all the full time midwives. This permits analysis of a range of relationships with the principal midwifery caregiver. Secondly, I wanted to study a range of relationships, both to ensure the study had sufficient analytic scope and to permit analysis of variability between relationships: hence the selection criteria. Thirdly, I wanted the study to have a longitudinal element so that developments in relationships over time could be observed; enabling the relative importance of outlook, stage of pregnancy and critical experiences to be established. After some deliberation, I limited the interview based study to women in late pregnancy onwards, when mother and midwife have most frequent contact and, in general, the mother most needs the midwife. Thus, the interviews were conducted at the most intensive stage of the relationship.

In practice, midwives adapted the selection criteria according to their own practice orientation. Elizabeth, the most rule guided midwife, followed the selection criteria assiduously. Anna, interested and socially aware, tried to select appropriate, interesting and interested women. Carol, consistent with her withheld disposition, found it difficult to ask favours of women at all and struggled to come up with five names. Laura had the blanket consent of the GPs at her surgery and selected in accordance with the selection criteria, consulting the mothers first. Veronica provided a list of names, in accordance with the selection criteria except in respect of the GP's list, but failed to consult the mothers first, leaving this to me. This reflects her professional orientation. Joanna's sample was selected by her predecessor. I am not aware of any mothers who refused to take part at the selection stage; although I believe some
midwives used their discretion about who they asked.

In retrospect it was impractical to limit the sample selection to the list of one GP per surgery; firstly because this is too small a sample to draw on and secondly because midwives care for many GPs' patients. The procedural complexities this posed, and the interprofessional hierarchies it exposed, will be considered in the Ethics section below.

I was aiming in practice for a sample of five women for each midwife meeting the selection criteria and this was achieved, with one extra for Anna. This gave a total interview sample of thirty six mothers. All but two of these women were interviewed in late pregnancy, usually between 36 and 40 weeks, and once in the early postnatal period, usually between the second and fourth postnatal week. Of the two exceptions, one delivered before the antenatal interview, and so was interviewed only postnatally, and the other withdrew from the study following delivery of a handicapped baby and so was interviewed only antenatally. In addition I asked each midwife to select a woman they had recently cared for with whom they felt they enjoyed a 'special' relationship. This group of women was also interviewed, but only once. Data from these women have been dealt with separately from the main sample, in Chapter 13.

A total of nine midwives were interviewed, using the interview guides reproduced in Appendix 1, plus the Director of Midwifery Services. I also collected data and interviewed some women from booking clinics, but this aspect of the study was not included in the final data analysis because it was peripheral to the main thesis.
In summary, the interview based study involved a total of forty three mothers (seven of whom formed a subsample of 'special' relationships) and seven full time midwives. I conducted a total of approximately one hundred and two interviews; eighty one with mothers, twenty with midwives and one with the Director of Midwifery Services. The average duration of the antenatal meetings with the mothers was 2 hours and 3 minutes, of which the interview accounted for on average 1 hour and 45 minutes. The postnatal meetings lasted for on average 1 hour 48 minutes, with the interview accounting for on average 1 hour and 5 minutes. The meetings with the midwives lasted for on average 1 hour and 45 minutes, the interview taking on average 1 hour and 30 minutes. The range of aggregate meeting durations with the main sample midwives was from 1 hour and 45 minutes with Joanna to 5 hours and 45 minutes with Elizabeth. I spent approximately twenty two working days out in the community observing eleven midwives and observed approximately two hundred women receiving antenatal and postnatal care. In addition, I attended one home birth. All seven midwives in the main sample were both interviewed and observed. The number of midwives interviewed was less and the number of mothers interviewed more than originally anticipated in the research protocol (9 vs 15-18 and 42 vs 27-30 respectively).

For the purposes of data analysis, it was impractical to work with such large numbers and such extensive information. Accordingly, I decided to reduce the main sample from seven midwives to six and five mothers per midwife to four, in accordance with the original research design and selection criteria specified in the research protocol. The deselection rationales were as follows.
Criteria for Selecting which Subjects to Analyse

1. In each midwife's sample I need
   1 working class woman
   1 middle class woman
   1 first time mother
   1 second or subsequent mother

2. Examine those which illuminate research issues

3. Ensure a representative range of sample responses

4. Exclude those least successful and specify reason (e.g. tape failed at the interview, had to leave early, missed an interview, one of the very early interviews etc.)

Having ensured that the first of the selection criteria had been met I went through and deselected those women whose data duplicated that obtained from similar women, or concentrated on issues not later developed. Shy women, or women interviewed early in the study, were more likely to be eliminated; as were those where there were difficulties with the interview, such as the tape recording failing or the interview being cut short.

Pauline and her sample of mothers were deselected because this team was served by a local community hospital as well as the central hospital which served the others. Antenatal care within this team was therefore organised differently.

Women were explicitly asked whether they had discussed the research with their midwife. The 21 replies indicate that they did not, beyond acknowledging its existence. This minimises the possibility of the data being subtly contrived between the parties for the purposes of the research. The variability of relationships observed also tends to suggest that any such influence is minimal.
Sample Characteristics

Social Characteristics of Mothers Interviewed

There are, in effect, four samples of mothers. Firstly, there is the main sample of mothers selected for interview. There were thirty six such mothers. Secondly, there is the subsample of twenty four mothers whose interview data was analysed in Part Five of the thesis. Thirdly there is a separate subsample of seven mothers, selected by midwives for their 'special' relationship with them. The data of six such mothers were analysed. Finally, there is the observational sample, numbering approximately two hundred. The social characteristics of the first, second and third of these groups is analysed below.

The age range of the thirty six mothers was 16–43. Their age distribution is given below.

Table 9.1. Age Distribution of Main Interview Sample: Mothers

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>2</td>
</tr>
<tr>
<td>20 – 24</td>
<td>3</td>
</tr>
<tr>
<td>25 – 29</td>
<td>13</td>
</tr>
<tr>
<td>30 – 34</td>
<td>10</td>
</tr>
<tr>
<td>35 – 39</td>
<td>7</td>
</tr>
<tr>
<td>40 – 44</td>
<td>1</td>
</tr>
</tbody>
</table>

N = 36
Their social class distribution varied according to the criteria employed. An intuitive classification, incorporating cultural and material criteria, indicates that one third were working class, two thirds middle class, although two of the former were affluent. An modified orthodox classification, based on partner's or own occupation if no partner, indicates that 8/36 were working class. An educationally based classification, which classifies women who received post basic full time education or training as middle class, suggests that 15/36 were working class, 21/36 middle class.

The vast majority of the women were married (32/36), 1 was cohabiting, 2 were single parents without a partner and 1 a single parent with a partner. All were white. Most lived in owner occupied housing, (26/36), 3 in private rented housing, 5 in council housing, and 2 with their parents. Nearly one third (11/36) were first time mothers. The sample is therefore skewed in favour of white, middle class, married, older multiparous respondents.

Of the analysed sample of 24 women, 9 were first time mothers. The age range was 16–43. The age distribution is printed overleaf:
There was therefore a greater concentration of women in the 25–29 age group and slightly more older women in the analysed sample. This sample met the sample criteria specified above (1 working, 1 middle, 1 first time and 1 experienced mother per midwife sample) both in terms of parity and any definition of social class employed; save that Laura's sample was exclusively middle class if the occupationally based classification is employed.

Of the separate sample of analysed 'special' relationships, all were white, married and middle class, except on an intuitive classification where one, Claire, was working class. Their ages ranged from 31–40 years. Five were aged between 30 and 34 and one was 40. None was a first time mother.

Characteristics of the Analysed Midwife Sample

Twelve midwives participated in the study. Seven were both interviewed and observed.
Data from six of these were analysed. Summary details of these six is also presented below.

These six midwives were all community based at GPs' surgeries. All were experienced midwives: having an average of 6 years full time experience in the community and 5 years in the hospital. All were sister grade. All qualified after first training as a nurse. The youngest was in her late 20s, the oldest in her early 40s. Four were married, one divorced, one single. Three were mothers. All were middle class, except on an intuitive classification when one was working class. All were white.

Obstetric Characteristics of the Interviewed Samples of Mothers

The total figures cited below vary slightly, depending on available data. Most women in all the samples had a normal vaginal delivery (74%, 67% and 100% for the respective samples). Of the total interview sample, 17%, and of the analysed sample, 21% had a caesarian section. In both samples, 12.5% had a forceps delivery.

Many district health authorities, including this one, now try to ensure that women know the midwife they meet during labour and delivery. Of the main sample, 60% did not know their midwife. Of the analysed sample, 58% did not know their midwife. However, all of the special sample knew their midwife. Put another way, only 39% of the main sample and 42% of the analysed sample knew their midwife, compared to 100% of the special sample. Moreover, this is a generous interpretation of the figures, construing any degree of recognition at any stage during labour and
delivery as 'knowing' a midwife. In practice, this often amounted to little more than recognising one face out of two or three midwives encountered. These figures are also inflated by the community deliveries (home birth or domino delivery). Of the main sample, 20% had a community delivery, of the analysed sample, 25% and of the special sample, 100% If the figures are adjusted for this, it emerges that only 22% of the main sample who were delivered by hospital midwives recognised any midwife they encountered.

The data yielded figures on continuity of care and these are presented in Tables 9.3 and 9.4. They refer to the percentage of total antenatal and postnatal maternity care which was received by the woman from her community midwife, rather than, for example, from her GP or another community midwife. The tables give snapshot figures but need to be interpreted with care. Firstly, the figures are based on planned contacts. Antenatally, in most cases, these are approximately half the possible number of contacts; the remainder take place with a GP. Secondly, one midwife's figures are very high because she does the 'wees and weights' at every clinic rather than total care at every other clinic. Thirdly, another midwife's figures are low because she did not return to work in the community until most of her mothers were about to deliver.

The figures suggest that the present system delivers reasonable continuity of care. Tables 9.3 and 9.4 present the figures for the main and analysed samples respectively. No data are available for the special subsample because only one postnatal interview was conducted.
Table 9.3 % Contact with Community Midwife: Main Sample

<table>
<thead>
<tr>
<th>% Contact</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 49</td>
<td>9</td>
</tr>
<tr>
<td>50 - 59</td>
<td>22</td>
</tr>
<tr>
<td>60 - 69</td>
<td>17</td>
</tr>
<tr>
<td>70 - 79</td>
<td>30</td>
</tr>
<tr>
<td>80 - 89</td>
<td>13</td>
</tr>
<tr>
<td>90 - 100</td>
<td>9</td>
</tr>
</tbody>
</table>

N = 29

Table 9.4 % Contact with Community Midwife: Analysed Sample

<table>
<thead>
<tr>
<th>% Contact</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 49</td>
<td>10</td>
</tr>
<tr>
<td>50 - 59</td>
<td>24</td>
</tr>
<tr>
<td>60 - 69</td>
<td>17</td>
</tr>
<tr>
<td>70 - 79</td>
<td>31</td>
</tr>
<tr>
<td>80 - 89</td>
<td>10</td>
</tr>
<tr>
<td>90 - 100</td>
<td>7</td>
</tr>
</tbody>
</table>

N = 24

Is there any correlation between the degree of contact and relationship outcome? No reliable correlation emerged, save that routine relationships tended to cluster at either end of the scale and both appreciative and special relationships were more likely to have more than 60% contact. There was a tendency for routine relationships to have less continuity of care, and appreciative and special relationships overall to have more.
However, an equal number of routine relationships had high contact figures. On these figures, continuity alone does not explain relationship outcome.

Summary characteristics and pseudonyms of each of the analysed sample of mothers and midwives is given in Table 9.5 overleaf.
Table 9.5 Pseudonyms and Summary Biographical Details

<table>
<thead>
<tr>
<th>Subject</th>
<th>Pseudonym</th>
<th>Summary Biographical Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mw1</td>
<td>Anna</td>
<td>Married, mother, m.class, early 40s</td>
</tr>
<tr>
<td>Mw1M1</td>
<td>Abigail</td>
<td>Married, multip, m.class, mid 30s</td>
</tr>
<tr>
<td>Mw1M2</td>
<td>Alexandra</td>
<td>Co-hab., primip, w.class, late 20s</td>
</tr>
<tr>
<td>Mw1M3</td>
<td>Alice</td>
<td>Single p'nt, multip, w.class, late 20s</td>
</tr>
<tr>
<td>Mw1M4</td>
<td>Amanda</td>
<td>Married, multip, m.class, mid 30s</td>
</tr>
<tr>
<td>Mw1MS</td>
<td>Ann</td>
<td>Married, multip, m.class, early 30s</td>
</tr>
<tr>
<td>Mw2</td>
<td>Carol</td>
<td>Married, no children, w.class, mid 30s</td>
</tr>
<tr>
<td>Mw2M1</td>
<td>Camilla</td>
<td>Married, multip, m.class, mid 30s</td>
</tr>
<tr>
<td>Mw2M2</td>
<td>Caroline</td>
<td>Married, multip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw2M3</td>
<td>Celia</td>
<td>Single parent, primip, w.class, teens</td>
</tr>
<tr>
<td>Mw2M4</td>
<td>Christine</td>
<td>Married, multip, w.class, late 20s</td>
</tr>
<tr>
<td>Mw2MS</td>
<td>Claire</td>
<td>Married, multip, w.class, early 30s</td>
</tr>
<tr>
<td>Mw3</td>
<td>Elizabeth</td>
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</tr>
<tr>
<td>Mw3M1</td>
<td>Emily</td>
<td>Married, multip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw3M2</td>
<td>Eve</td>
<td>Married, multip, m.class, late 30s</td>
</tr>
<tr>
<td>Mw3M3</td>
<td>Elaine</td>
<td>Married, primip, w.class, early 20s</td>
</tr>
<tr>
<td>Mw3M4</td>
<td>Ellen</td>
<td>Married, primip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw3MS</td>
<td>Esther</td>
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</tr>
<tr>
<td>Mw4</td>
<td>Joanna</td>
<td>Single, no children, m.class, late 20s</td>
</tr>
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<td>Mw4M1</td>
<td>Jackie</td>
<td>Married, primip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw4M2</td>
<td>Judy</td>
<td>Married, multip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw4M3</td>
<td>Jill</td>
<td>Single, primip, w.class, teens</td>
</tr>
<tr>
<td>Mw4M4</td>
<td>Jenny</td>
<td>Married, multip, m.class, early 30s</td>
</tr>
<tr>
<td>Mw4MS</td>
<td>Julia</td>
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<tr>
<td>Mw5</td>
<td>Laura</td>
<td>Div'ed, no ch'drn, m.class, early 40s</td>
</tr>
<tr>
<td>Mw5M1</td>
<td>Lesley</td>
<td>Married, primip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw5M2</td>
<td>Linda</td>
<td>Married, multip, w.class, early 30s</td>
</tr>
<tr>
<td>Mw5M3</td>
<td>Louise</td>
<td>Married, multip, m.class, late 20s</td>
</tr>
<tr>
<td>Subject</td>
<td>Pseudonym</td>
<td>Summary Biographical Details</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Mw5M4</td>
<td>Lydia</td>
<td>Married, multip, m.class, late 20s</td>
</tr>
<tr>
<td>Mw5MS</td>
<td>Lucy</td>
<td>Married, multip, m.class, early 30s</td>
</tr>
<tr>
<td>Mw6</td>
<td>Veronica</td>
<td>Married, mother, m.class, early 40s</td>
</tr>
<tr>
<td>Mw6M1</td>
<td>Vivien</td>
<td>Married, multip, w.class, early 40s</td>
</tr>
<tr>
<td>Mw6M2</td>
<td>Valerie</td>
<td>Married, primip, m.class, early 30s</td>
</tr>
<tr>
<td>Mw6M3</td>
<td>Vera</td>
<td>Married, primip, w.class, late 30s</td>
</tr>
<tr>
<td>Mw6M4</td>
<td>Virginia</td>
<td>Married, multip, m.class, mid 30s</td>
</tr>
<tr>
<td>Mw6MS</td>
<td>Victoria</td>
<td>Married, multip, m.class, early 30s</td>
</tr>
</tbody>
</table>
Access and Ethical Aspects of the Study

The simple story is that I negotiated access via the Director of Midwifery Services in the relevant DHA; who gave her consent to the study. Following this, I obtained gained the approval of two ethics committees, the District Health Authority's and the University's. But beneath the liberal concept of 'consent', conflicts lie concealed.

Four particular ethical issues emerged during the study. Firstly, it became apparent that the District Health Authority's Ethics Committee was not an impartial watchdog of patient's interests, but embodied clear epistemic and professional preferences. This caused major procedural difficulties. The District Health Authority's 'Guidelines for Applicants' is entitled 'Code of Practice, Supervision of the Ethics of Clinical Investigations', November 1989'. This presumes either that only clinical investigations fall within the remit of the District Health Authority's Ethics Committee, or that guidelines pertaining to clinical investigations are appropriate for all research.

Secondly, the code stipulates that, for research in the community involving patients, GPs must approve the research prior to submission to the committee. In a telephone conversation, the secretary to the ethics committee confirmed that the relevant professional for the purposes of my application would be the GP, not the midwife. This meant that I needed the consent of more than twenty five GPs to a piece of research which did not concern them. The only viable option was therefore to restrict my sample to women on the list of one GP per surgery. This was the procedure eventually settled on.
But the GPs did not wish to become involved. Their disinterest could have thwarted the whole project, had not a midwife acted on her own initiative and telephoned me directly, expressing her interest. Eventually, each midwife approached a GP personally to obtain approval, and this was duly given. The application got through the Ethics Committee on this basis; although it remained an unworkable procedure. We eventually sidestepped most of the difficulties by notifying GPs of the research via their representative on the Obstetrics Committee. But the formal requirements remained unworkable for non medical research and researchers.

The situation becomes still more unworkable if one considers the Guidelines of the Medical Research Council (Medical Research Council 1985). The guide states that in research involving contact with patients to obtain information a medically qualified director must be appointed (ibid:6); even though in other medical research contexts information about patients may be transferred without their knowledge or consent (ibid:5). I therefore had to consider whether, in seeking consent from GPs, I was encouraging them to breach the Medical Research Council’s guidelines. I decided that this was not so because my research does not fall within the Guidelines; although the authors of the guidelines would clearly prefer that it did.

The effect of these codes and procedures is effectively to preclude academic research in health and illness not headed or approved by a medically qualified person. Moreover, if one attempts to meet these requirements, one encounters indifference or hostility. According to this frame of reference only medical practitioners, at the apex of the professional hierarchy, are competent to act as gatekeepers and researchers on
If one survives this procedural minefield one then enters the politics of informed consent. I shall briefly mention three dilemmas I encountered in the course of the research. The first concerned midwives' consent. I sought the informed consent of all midwives. But it became apparent that the research was to become a political issue between antagonistic factions within the organisation. The research clearly aroused a great deal of anxiety and animosity amongst a small group of midwives. Other midwives told me of times they had stumbled across an antagonistic midwife denouncing the research. There were clear indications in the fieldwork that this had unsettled other midwives who were subsequently reluctant to take part even though they had signed a consent form to say that they would.

The dilemma was what to do about this, given the requirement of informed consent. Did professionals have the right to opt out of a piece of research investigating a legitimate aspect of their working practice; one sanctioned by their Director of Midwifery Services and approved by two ethics committees? It was also one in which their role was that of gatekeeper to women for whom they cared; refusal to participate meant that those women also lost the opportunity of taking part.

It was my view that they had the right to refuse for three reasons. Firstly, I believed they should have the same freedom of choice as any other research subject. Secondly, I felt that this particular piece of research investigated matters so personal that they were for the purposes of this research 'private' participants. Thirdly, none of the ethical
guidelines the research was subject to made any distinction according to the status of
the participant.

But the Director of Midwifery Services was enthusiastic about the research and
concerned about dissent regarding legitimate research from midwives with whom she
had had disputes in the past. She advised me of clauses in midwives' contracts of
employment, requiring them to participate in research. The dilemma was whether to
invoke it. But this would have conflicted both with the ethical guidelines to which the
research was subject, and my own feelings about participation.

In the event, no midwife was compelled to take part. Eventually, all but one full time
community midwife in the DHA took part (see above). A combined total of two thirds
of community midwives participated. Two did not take part even though they had
consented. So approximately one third of community midwives within the district
health authority did not take part. Some of this was due to natural wastage, such as
a midwife taking maternity leave. I decided not to contact two of them because it
seemed by that stage appropriate to concentrate on the full time midwives. But this
left a total of five who did not wish to participate; two of whom were emphatically
opposed.

The final dilemmas concerned involved the ongoing research. As noted in Chapter 8
I assiduously sought the informed consent of all participants. Each subject in the
interview sample received a detailed set of Notes, explaining the nature of the research
and her rights in relation to it, and signed a consent form confirming she had read it.
Each mother participating in the observational research, where I accompanied the midwives on their rounds in the community, received an explanatory letter which included my telephone number. Their consent was sought in advance of most of the meetings by the midwife. Mothers in the observational study were given an explanatory letter. (These documents are reproduced in Appendix 2.) Mothers were approached via the midwife.

Notwithstanding these safeguards, it was clear in practice that consent arose from trust and goodwill as much as from reading the Notes. There were occasions during the observation when I felt it would have been better for the woman had I not been there; usually when they themselves were anxious about something. There were also occasions when I was surprised at the degree of open disclosures from the midwives; and I felt I ought to be reminding them of the relevant section of the Notes, which made clear that all information may be used. And there were times when my own feelings as a mother intruded into the research and I felt guilty knowing that if mothers knew what I knew they would not consent to the observation; for example, that we had just visited a house whose occupants had chicken pox. It was also clear that notwithstanding their consent a number of women initially felt anxious about the tape; in effect, I subordinated their feelings to the needs of the research. Interestingly, however, these perceived objections diminished as I became more confident in my role.

I resolved these dilemmas only with great difficulty; for as explained previously they impinged upon my own anxieties and insecurities. But I adopted a pragmatic view and
contented myself that women had the opportunity not to participate or to withdraw, although this is less true of the observational sample. However, this raises the question of whether one is unfairly trading on the trust and goodwill women invest in their midwives. I drew some comfort from the fact that there were some refusals, indicating that many women did feel able to voice objections. As others have pointed out, if you don't have a refusal rate you probably don't have effective consent procedures. Of forty four mothers women in the interview sample, two withdrew; one because her baby was born with congenital abnormalities and the other because she felt ill and worn out at 38 weeks. None of the approximately two hundred women in the observational sample refused to allow me to attend their meeting with their midwife and none subsequently withdrew; although one woman was initially doubtful. There were times when I felt women had little moral choice but to agree.

More women objected to the tape. In the observational sample two women refused the tape at home; and two at the antenatal clinic, plus a third who wanted it switched off at delicate moments. Carol avoided visiting one family with me (although later we did); and Anna did not contact me for a home delivery. Both these avoiding manoeuvres occurred at the start of the observational research. Some women in the interview based study also had reservations about the tape recorder, although none refused and their objections had diminished by the end of the study.

I also faced the uncomfortable realisation that participants, especially the midwives, may define the research task or interpret the data differently to me. In part this is a tension between academic and policy oriented research, in part an inevitable
consequence of a different social location. For the latter reason, I did not offer to discuss my findings with each individual midwife or mother. This is because there is an interpretative aspect to the research which some may find disappointing or hurtful, or at least not reflecting their own self perceptions. Moreover, in this research it is sometimes difficult to disentangle data regarding mothers from data regarding, and I have assured each of anonymity viz a viz each other. I have offered to make a general research presentation however, and would if asked produce transcribed data.

Taking Part

Between refusal and consent lies 'compliance' and anxiety. The refusal and consent rates are not really reliable indicators of women's emotional responses to being researched, especially in the observational research. A more reliable indicator is their initial, spontaneous response; although these may indicate initial anxieties which later dissipate. Nonetheless they do speak of real discomfort at some stage with some aspects of the research.

No woman in the analysed interview sample refused to be taped. But 29% (7/24) expressed some apprehension, reservation or anxiety. These mothers were Alice, Emily, Jenny, Lesley, Linda, Louise and Lydia. It is interesting that all of Laura's sample expressed anxiety; three quarters of whom were from an anonymous middle class housing estate which lacks a sense of community. Of the remaining mothers, Linda was anxious, Alice inconfident and Jenny inhibited. Their comments included the following: 'A tape - you didn't tell me about that.' (Linda); 'You're not going to
tape me are you?' (Alice) and 'Do you have to?' (Lesley and Alice). There are some signs that these were initial rather than enduring anxieties. None of the remaining women made any comment; save for Judy who said she was a bit self conscious at first but then forgot about it. The worst part for her was trying to remember what she said. This is probably the most common, unspoken experience.

Of the analysed sample, 29% (7/24) directly or indirectly requested details of the published research (Camilla, Caroline, Emily, Judy, Jenny, Lydia and Virginia). In addition at least four others were explicitly interested in the research (Amanda, Judy, Linda, Valerie); making it likely that about 45% of this sample of mothers were, or became, genuinely interested in the research.

As expected, women asked questions of me just as I asked questions of them. They fell into three general categories. Firstly there were research related questions: was I enjoying it, how many women were involved, had I attended any deliveries, how was the research funded, how was I implementing the research and so on. Secondly I was biographically situated: being asked about my domestic situation, particularly about my children, plans for future children and experiences of pregnancy, childbirth and motherhood. Thirdly, I was asked questions about midwifery and motherhood: had I heard any horror stories, how did other women feel, were many other local women involved, questions relating to the organisation of care locally, questions about maternity benefits, about my understanding of other women's experiences, and questions about midwives. These questions seemed to serve different purposes. The first and second type were social overtures which developed and broadened out the
relationship from a research based one to a more socially based one; drawing us together on the basis of common experience in one sense and unique experience in another. The third category of questions were 'orientation' questions and seemed to represent an attempt by some women to situate themselves in relation to other women, or else to ascertain information which they had been unable to obtain elsewhere. During the fieldwork, I felt that first time mothers were more likely to ask the 'orientation' questions and second time and subsequent mothers the social/relational questions; but this is not confirmed by the recorded notes.

Women seemed to find the Notes (reproduced in Appendix 2) helpful where they wished to be better informed. On one occasion they alerted a mother to the fact that the midwife was also to be spoken to about their relationship; which until then she had not appreciated. Overall, however, the Notes appeared to be useful either as a general reference if needed (which usually they were not) or as an amplification of the verbal introduction and overview which had already been given either by the midwife or me.

How did women find taking part? During the interviews, I felt that at least half participated as a courtesy but without any real commitment. This may be so, but the data suggests that most women got something out of it and a significant proportion found it in some way beneficial. The chief benefit appears to be the opportunity for reflection and self exploration it presented, rather than for any social support it provided; and this response is consistent with the approach I took in the interviews and the central themes of the research itself. In the words of one midwife (Veronica)
I asked 'lots of searching questions'; about women's outlooks and relational orientations as well as their particular relationships with their midwives. The following extracts illustrate such responses. In these and all subsequent extracts from the field notes, 'M' denotes 'mother', 'Mw' denotes 'midwife' and 'R' denotes 'researcher'.

M: ...you actually make me think about things that I haven't thought about...
R: [How have you found taking part?]
M: Fine...It made me think after the first time though quite a lot...I found I was analysing myself a lot more, because it got quite into families and stuff...I find it quite interesting and I'm not frightened of looking at myself...you bounced back some interesting questions that made me reflect... [Judy]

M: Just goes to show, doesn't it, it's chatting normally...It would put me off a little bit [if formal interview] because you're conscious that you're being asked a format rather than a flowing conversation. [Judy]

R: [How was taking part; was it what you expected?]
M: No it wasn't. I was thinking, 'Oh God, I don't know what to say,' things like that. No, it's brilliant, I've got everything out of my system really actually thinking about it. [Jenny]

M: I got to know Carol in that time; because do you know I'd talked to you before...it was funny because I was aware of questions you'd asked me, you know about whether Carol opened up about herself as a person. Well that morning she did a bit [attending Camilla in early labour], because we were just chatting generally, almost like a family together...and I felt that relationship growing...because of the conversations I'd had with you I thought, 'That's good, Carol's beginning to talk about herself.' [Camilla]

R: [How have you found taking part?]
M: ...Yeah, it's been good having to analyse a bit about the experience and what's been good and what you think about it; and I suppose it's all added to the birth experience actually, because it's all connected with what is an incredibly intense emotional experience in one's life and it's almost added to it as an extra bonus really... [Camilla]

The midwives who participated were helpful, introduced me positively into the social scenario and were interested and enjoyed taking part; although some found it time
consuming. Like mothers, they seemed to find it a more thought provoking exercise
than they had expected, but in a generally positive way. Some of the difficulties they
had, for example, concerning confidentiality and the provision of social class
information, are largely attributable to the spoiling tactics of the antagonistic
midwives. Overall, midwives did not seem to mind being 'shadowed' and are used to
having people accompany them on their rounds; they found it, on the whole, easier
than having a student present because they did not have to teach or involve me. There
were only very few occasions on which it was possible, they felt, that my presence
may have affected the interaction. Some midwives were implicitly reluctant to have
me attend deliveries, mostly because of a concern to protect the mother's privacy. I
noticed a tendency for midwives' feelings and insecurities to be projected onto the
mother; and where the midwife was or became more relaxed the anticipated problems
diminished. Only Laura seemed significantly bothered by the tape and this only in the
observational session. In the event, this data was not transcribed.
Notes

1. But this is not the pragmatism identified by Bryman (1988). His is a 'horses for courses' argument within an empiricist discourse which conceives of best applications, of best methods, for particular research issues. This decontextualises the research and overlooks subjectivity, firstly in the selection of research topic and secondly in the dynamics of the research process.

2. These were the intrinsic considerations. I also worked throughout with an extrinsic standard: the legitimate objections of a hostile audience. This was one basis for greater rigour; including cross checks, double checks, caveats and qualifications. It could be said that the intrinsic considerations led to exploratory rigour; the extrinsic to justificatory rigour.

3. Mothers routinely receive maternity care every four weeks from 12 weeks to 28 weeks of pregnancy, every two weeks from 28–36 weeks, and every week from 36 weeks to delivery. On discharge from hospital, they receive, in most cases, daily visits until the 10th postnatal day. They can expect to see a community midwife for about half of these antenatal visits and all of the postnatal visits.

4. Pauline's results have been excluded because the care is organised differently there.

5. Based on an intuitive classification of social class. See Chapter 9 for discussion of the different classifications employed.
Part Five

Love and Friendship in a
Professional Relationship
Overview

Chapters 10–16 use the personal paradigm as the metatheoretical framework of the data analysis. Chapters 10 and 11 develop a typology of relationships using the analysed sample of 24 relationships. Chapters 11–13 identify the analytic characteristics of 'special' relationships; Chapters 11 and 12 through an analysis of variability in the 24 relationships which comprise the main sample, and Chapter 13 by analysing the characteristics of a separate sample of 6 relationships experienced by both parties as 'special'. Part Six, comprising Chapters 14–16, develop a typology of the 'distinctive' characteristics of the community midwife's role; in particular the way it differs from that of the GP and the health visitor.

The analysis in Parts Five and Six advance beyond the professional paradigm which dominates the research literature. I suggested that the professional paradigm overlooks personal factors in professional practice and produces a static, atomised, object oriented gaze which dislocates mother and midwife and fractures the social dynamic. These tendencies combined remove the midwife from scrutiny and locate her in a different and privileged plane of being to the mother, despite a professional ideology to the contrary. My analysis departs from the professional paradigm by treating mother and midwife, with minor variations, in conceptually the same way; by emphasising the importance of personal and emotional factors; by developing a dynamic analysis which considers the input and blend of both parties; and by developing a theoretical framework which accommodates the unique biography of the individual on the one hand and contemporaneous social influences on the other.
The analysis also departs from a tendency in the practitioner based literature to imply that the social setting heavily determines practice style. Kirkham (1989: 133–134) for example implies that different settings permit different styles of practice. This may be right but it requires further elaboration so that we may understand variability within particular practice settings. My own analysis permits analysis of variability by concentrating on one role (midwifery), within one social setting (the community) and one DHA; subject, with minor exceptions, to the same organisational and employment conditions.¹

These chapters also incorporate a view of feeling, the subject and relationships developed in Chapter 5 within the context of the personal paradigm. Chapters 10–13 in particular highlight the personal constitution of the social self through an exploration of these three concepts. This is an almost infinitely complex area, a point of intersection for psychoanalysis, cognitive psychology, theology, sociology, anthropology, and culture theory; and embracing key theoretical, methodological and epistemological debates within each discipline (Lutz & White 1986:405–406). The phrase 'the personal constitution of the social self' suggests that the subject is emotionally and biographically constituted through creative interplay of inner and outer world. We cannot confine social influence to the outer world. We cannot confine the self, emotionality and biography to the inner world. We cannot dissociate subject and object, thought and feeling, conscious and unconscious processes. Rather, the distinctions refer to different ways of being in the world, different blends and emphases. But no absolute distinctions can be made, no dualisms can be invoked. Such a conceptualisation does not produce consensus or eliminate conflict. On the
contrary, it enables us to appreciate the complexities of social life and the manifestations of psychic and cultural dislocation (Miller Baker 1986).

This perspective views the subject as culturally and historically constituted, not pan cultural (Rosaldo 1984). It is multifaceted, incorporating conscious and conscious aspects. The conscious aspect employs both discursive and non discursive symbolism, which in turn suggests that the expression of feeling is neither confined to the unconscious nor dissociated from rational thought in the way Freud led us to believe (Lomas 1987:42). This suggests that our cognition is not purely rational but inextricably emotional; and that the significance and meaning of a social encounter is a blend of immediate experience and biographical echoes.

All living experience, and all human relationships, incorporate the 'self' thus constituted. The self is actively engaged in the constitution and reconstitution of itself, culture and relationships (Thoits 1989). Human relationships are a blend of the social and emotional biographies of the parties to it, located in a particular social setting and experience. This is always constructed on an individual template. Human relationships take account of the other, but neither the experience nor the meaning is symmetrical. There are no shared psychologies, meanings, realities or intersubjective understandings, but only unique constitutions. But some blends are more harmonious, appropriate, or emotionally intense than others. Moreover, although experience is unique, and existentially real, it is saturated with social influence. This enables us to connect individual experiences and to develop sociological understanding; to link the constitution of an individual to the social situations of which s/he is part.
This is the metatheoretical framework within which the substantive analysis proceeds. The analysis uses concepts developed during data collection and analysis. This locates the analysis around its subject rather than vice versa.\textsuperscript{2} Part Five begins with the opening extract from a short story I wrote in the throes of data analysis. It uses the story of Rachel, a nurse whose approach was transformed from a professional to a personal perspective through her own relationship with her midwife, to illustrate many of the themes developed in the research: the limitations of professionalist and dualistic approaches; the synthetic links between thought and feeling, knowledge and experience, and minds and bodies; sensuality and intimacy as distinctive aspects of a woman's orientation; the importance of friendship, trust and intimacy in women's relationships, including that between mothers and midwives; the influence of social position on inner experience; and the struggle to reconcile ways of being and ways of knowing.
October 1991

With a sigh and a groan Rachel unclasped her belt and let her dark blue sister's uniform fall to the floor, the mantle of responsibility gratefully surrendered for the night. The late shift was always exhausting, the surgical ward acutely so, but now at last it was time to take care of herself.

Water rained noisily into the large deep bath and she was glad to be home. Leaning forward, she added lashings of blue bath foam to the hot stormy water and stared incredulously at the passions erupting beneath her. The water was doing such violence to itself, spitting furiously as it seized the cool blue stream; converting it in a frenzy to a frothy white foam, admitting the residue reluctantly to the diluted backwaters where passions lay spent at the end of the bath. Are pleasure and pain always so inseparable, she wondered; is passion always so turbulent? She did not know and for now she did not care. She closed her eyes and took a long deep breath, deftly exchanging the petty stresses of the working day for the warm mists of the personal. She drank it all in, then stepped back to a more temperate climate and finished undressing. As she moved she glimpsed her reflection, absorbed by the steamy white clouds on the mirror. Involuntarily she drew herself in, straightened her back, tightened her tummy and turned to a profile; but it was late, incongruous and unnecessary and with relief she restored the contours of repose. Spines are curved and flexible, she thought; let nature have its way. She glanced at herself again and this time her reflection approved; blushing slightly and smiling and burying herself indulgently in the soft warm pillows of her favourite pink bathtowel.
Rachel lowered herself into the bath and was immediately overwhelmed by an intense shiver of pleasure. She had long since recognised this response as every bit as intense and important as an orgasm. But it is a simple pleasure, sensual not sexual, and so has been overlooked and underexpressed. Dissociated from thought and expectation, it has never been demanded of or anticipated and so remained a simple delight, experienced anew on every occasion. Sensation exploded upon her, rippling from her head to her toes. She lingered blissfully over the dying sparks, which echoed the intense crescendo and gently brought her down.

Cushioned by the bubbles she lay back and reflected contentedly over the day. She was good at what she did and others saw it too. She had returned to nursing transformed by a career break which had produced two children and quietly revolutionized her outlook on life. Always ambitious, she had realised as a student that nurses were basically of two types: the carers of the saintly stereotype, who nurtured patients and doctors and mopped up the spills of medical practice, and the managers, whose clinical cool led them effortlessly into executive roles, where power rewarded competence and the professional values of efficiency, effectiveness and detachment prevailed. Joanna knew she had potential and had no intention of becoming anybody's doormat (or angel) and she quickly assimilated a professional outlook and was speedily and effectively promoted. She had a sharp eye for sloppiness and sentimentality and at the time of her career break held the post of 'Senior Nursing Officer with Responsibility for Research'; a senior position which combined operational, managerial and research roles. She was widely held responsible for the infusion of a credible, research based nursing philosophy and practice at the hospital;
and the successful implementation of a number of Randomized Controlled Trials (RCTs), the results of which were now awaiting publication in professional journals.

When she became pregnant her prestigious position within the hospital afforded her the best that money could buy. Her pregnancy was skilfully and scientifically managed by the antenatal team in the internationally renowned consultant unit. She didn't even have to visit her GP. She was personally attended during her first 'confinement' by Mr William Ramsbottom, Consultant Gynaecologist, Obstetrician and Infertility Specialist, himself an experienced researcher and clinician. But it was the worst experience of her life. The bloody man had no idea how to relate to a woman in labour. When she asked how her labour was progressing, he strapped her to a monitor, inhibiting her movement and intensifying the pain. When she cried out for support, he administered pethidine, as if as an antidote. When, disoriented and bewildered, she screamed in distress he muttered about forceps. He was trying to insulate her from the pain, but she was numb and dissociated already. A pudendal block was administered and an episiotomy performed; but the baby appeared and spared her the forceps. She was swiftly and effectively sutured with catgut; much to the annoyance of the mutinous community midwives, whose job it was to relieve her weeping, infected perineum by removing the spiky stitches, which owed their existence to a Randomized Controlled Trial but steadfastly refused to dissolve.

Later, she wept in the arms of her midwife and sensed in her response an alternative to medicalized childbirth. For her second delivery she took her midwife with her.
Second births are always easier they say: this one was simply different. The pain was there but in place of solitary terror lay a diffuse and shared experience. She did not want to be made remote by gases and pethidine. She wanted to remain connected to this woman, her supporter, whose steady gaze and gentle touch melted inhibition and stirred her own inner resources. She didn't know where it came from, it didn't really matter. She only wanted it to continue, and birth gain meaning from a different script. And this it did, as different from the first experience as isolation is from loving. She had no need to ask how the baby was coping; she knew she was progressing. When she reached for support she was held and stroked, encouraged and embraced. When she just knew that she couldn't go on and told them so, she was congratulated, for she had just announced the transition and would soon would be giving birth. When the baby was born Rachel cried; and cried again when it was time to say goodbye to her midwife; for she knew how important her precious gift had been.

For out of differences such as these Rachel had learned of the enduring value of 'caring' in people's lives. And this was a lesson daily reinforced by the experience of mothering, which grafted her to the human race, and it to her, imprinting the needs of others upon her in an irrevocable way. So when, three years later, she returned to work, it was with a new agenda; one which recognised and respected people and their feelings. She was no longer prepared to compromise or be compromised in the name of efficiency or science and devoted her energies to a critique of both. She was surprised to find herself pushing against an open door. Others too had spotted the imposter, principally the consumer groups; and consumer sensitive hospital trust managers were quick to spot the commercial value of 'caring'. So Rachel was
surprised and gratified to find herself promoted again, this time in service of emotional needs; and she busied herself developing a counselling service, writing critiques of the professional and scientific paradigms she had helped establish, and working towards the establishment of a more integrated and nurturant environment.
Chapter Ten

Analytic Framework for the

Interpretation of Relationships
Chapters 10-12 develop a typology of mother/community midwife relationships, conceiving of them as a dynamic blend of the outlooks of both parties, located in particular experiences and social settings. They also examine sources of variability in such relationships. Finally, along with Chapter 13, they examine the characteristics of 'special' relationships. Chapters 10-12 concentrate on the 24 relationships comprising the analysed sample. Chapter 13 examines the separate sample of relationships selected as 'special' by each of the six midwives in the analysed sample.

The methods of data collection, analysis, and sample selection are elaborated in Chapters 9. Briefly, the research combined informal interviews with mothers and community midwives with a subsidiary observational study. The main interview sample comprised seven full time midwives and five of each of 'their' mothers. A total of thirty six main sample mothers were interviewed. The sample was reduced to six midwives and twenty four mothers for data analysis purposes. Each midwife was interviewed in depth and observed at work for two days. Each mother, bar one, was interviewed twice: once at approximately 36 weeks pregnancy and again approximately 2-3 weeks postnatally. The interview schedules are reproduced in Appendix 1.

Each relationship was conceptualised as a blend of the outlooks of both parties, within the context of particular experiences, giving rise to particular outcomes. An outlook comprises a disposition and a role orientation. A relationship therefore had eight analytic elements: the disposition, orientation, specific experiences and outcome perceptions of each of the parties. For reasons explained in Chapter 9, the analysis
was grounded in the mother's viewpoint; the midwife's providing the essential backdrop.

The disposition of a person refers to their personal characteristics; discerned at the interview, and during observation in the case of the midwives. Disposition is subdivided in different ways for mother and midwife, reflecting their different social location. The midwife's disposition was divided into six subcategories: self engagement, emotional engagement, energy, attitude, emotions, and disclosures. Self engagement refers to the extent to which she appeared 'herself', invested and engaged in her work. Emotional engagement refers to the degree of emotional investment in her work. These may co-vary. A midwife may be emotionally engaged but not self engaged, but not usually vice versa. Energy refers to the midwife's particular interests; where her enthusiasms and priorities lie. Attitude refers to the midwife's attitudinal approach to midwifery issues and practice; ie. how she 'comes across'. Emotions refers to those feelings identified by the midwife as arising in the course of her professional practice. Disclosures refers to the general degree of self disclosure displayed by the midwife in the course of her dealings with mothers.

The mother's disposition was divided into three aspects: self engagement, plane of being and energy. Self engagement carries the same meaning as for midwives. Plane of being refers to the aspect within which a woman appears characteristically to engage; for example, emotional, intellectual, social, practical, task. Energy refers to her emotional priorities, as with the midwife.
Orientation, on the other hand, refers to a person's definition of the midwife's role. The midwife's orientation is subdivided into type, focus, and priority. Type refers to the sort of relationship she commonly establishes with the mothers. These vary but consistent patterns can nonetheless be discerned. The relationship may be open or closed; ranging from an instrumental professional relationship to a more socially based, personal one. If relationships deepen emotionally one would expect them to broaden socially and personally. Biographical detail is no guarantor in itself of emotional depth but it is usually an indicator of it (see Chapter 14). Focus establishes whether her principal focus is herself or the mother, the professional or the client. It also specifies subcategories and priorities. This allies closely with the 'energy' aspect of the midwife's disposition. Priority refers to the midwife's professional priorities. These are summarised as clinical, advisory or supportive (practical or emotional). They may be further subdivided.

Focus and priority are independent concepts. One midwife may prioritise emotional support but focus on the midwife. Another may prioritise emotional support but focus on the mother. The former will tend to give rise to 'professional' and the latter personal support; and this inclines relationship in characteristically different directions.

The mother's orientation is divided into type, definition, and attitude. Type refers to the sort of relationship apparent at the mother's antenatal interview. Definition refers to her definition of the midwife's role. Attitude refers to her emotional outlook within the relationship.
Specific experiences of relationships are elaborated descriptively and linked to the parties' dispositions and orientations. The outcome criteria, based on the mother's responses unless otherwise indicated, are: type, importance, feelings of 'specialness', orientation, and goodbye/gift. Type of relationship is defined above. This category permits longitudinal examination of changes and developments in the relationship over time. Importance refers to the self-perceived emotional importance of the relationship to the mother. The concept of specialness refers to the extent to which the mother experienced the relationship as 'special'; although the sociological concept develops beyond this. Orientation is a second stage longitudinal assessment of the mother's definition of the midwife's role. This time it is recorded at the end of the relationship and thus constituted by a greater degree of lived experience. Goodbye/gift refers to the mother's emotional response to the termination of community midwifery care. The giving of a gift, or card, or the inclination to do so, is taken as indicative of a deep and positive emotional outcome, though its precise meaning and importance may vary (Mauss 1954; Rucker et al 1991).

It will be appreciated from the foregoing that the indices do not amount to a popularity index for each midwife or her style of practice. Rather, the analysis is structured to reflect the conceptualisation of the relationship as a dynamic blend of both parties' outlooks located within specific experiences. The typifications have a descriptive element, permitting analysis specific and appropriate to that individual/relationship, and an analytic, classificatory element which permits comparative analysis between relationships.
The analytic classifications 'disposition' and 'orientation' understand mothers and midwives within the same conceptual embrace whilst recognising their different situations. In particular, the midwife's dispositional categories reflect her more instrumental role within the relationship: we cannot claim to be seeing the 'private person'. And mothers, unlike midwives, are interviewed in the context of one main midwifery relationship only. Their 'orientation' is therefore more loaded with particular experience, less of a general orientation. Nonetheless there is variability between women cared for by the same midwife and this lends it some validity as an indicator of predisposition as well as of actual experience.

This in itself speaks of the complexities of deriving any sort of classification. I cannot, of course, claim to have captured the 'real' person or experience, whether mother or midwife. The classifications are derived through the medium of the researcher, the research topic, the research interview/observational setting, and the subject's response to all three; quite apart from her part in the relationship itself. One has to recognise the complexities of construction to which this gives rise. It could be suggested, for example, that the data speaks not of the relationship at all but merely the research subject's response to the research, in particular the interview situation. There is, after all, no necessary correspondence between a sociological interview and 'real' mother/midwife interaction.

It is not possible to fathom 'real' data independent of the 'interview' scenario/effect, for two reasons. Firstly, the latter is the medium through which the former is transmitted. Secondly, both are subject to and mediated by the person and
interpretations of the researcher. My own response to this has been to work with the complexities as creatively as possible; to acknowledge and fine tune my own subjectivity, to synthesise data where possible as a methodological checks, and to use the methodological limitations as sources of epistemological enquiry.

I should also make clear that although the sociological concepts draw heavily on subjects' personal experiences, they are not limited to them. Indeed, this would be impossible. The subjectivity of the researcher, and the reader in turn, is integral to the analysis. Sociological concepts, such as 'specialness' and 'relationship', are analytic not descriptive, whatever the level of abstraction. In the former case it would be an inadequate concept if it had no counterpart in the research subject's experience. But even here there must be qualifications; some women, for example, found the relationship special but I have classified it as appreciative.

The remainder of this chapter presents profiles of the six midwives comprising the analysed sample. Each midwife is depicted on her own terms, in a personal profile and, in Table 10.1, according to the classifications outlined above, thus permitting comparative analysis between midwives.

Midwives' Profiles

Anna: the 'intimate midwife'

Anna is white, middle class, married and has three teenage children. She is very open
in her professional relationships, engaging herself directly in the woman's social and emotional world. She is woman centred and psychosocially oriented. She seeks to incorporate herself and others in the same plane of being and to connect psychologically (emotionally), socially (biographically) and physically (through touching, hugging, kissing and 'open' non verbal communication). Giving, sharing and intimacy in the same plane of being are the hallmarks of her practice. She is warm and empathic and operates almost entirely in intuitive and emotional planes. She is proud and confident in her professional work and opens herself up to support and positive approbation. She is very sensual and gentle.

Unlike any of the other midwives analysed, she is finely attuned to the psychosexual and physical aspects of childbirth and this is complemented by her naturalistic 'alternative' philosophy of childbirth. She incorporates her philosophy, and thus herself, whenever possible. She is at her best with women who share a similar philosophy of childbirth or who are warm, open or interesting to her in some way. She is a great giver/ enhancer of confidence and builds strong, emotionally intense, exclusive personal relationships with the women; many of which, stratified along the lines indicated above, become extended into personal friendships. She is the most open of the midwives analysed and the one most intensely oriented to the emotional aspects of childbirth. She is non threatening to mothers, although some find her 'perfect'. She is very much 'herself' in her practice. Through openness, intimacy and womancentredness, she acquires enormous power and influence in her professional relationships.
Carol: the 'brick'

Carol is married with no children and is working class on an intuitive classification, otherwise middle class. A series of difficult personal relationships in childhood and adulthood have left their emotional mark and she is emotionally and personally withdrawn and vulnerable. This vulnerability, and the need for connection it expresses, is masked by a caring but practical 'get on with it' orientation which some find brusque, some 'motherly'. She is loyal and committed to her work. Her sympathies and support lie with working class women and/or those vulnerable with clinical or social 'problems'; and she is less invested in caring for middle class women. She expresses her caring in practical ways, by 'doing things' for people, rather than by engaging in expressive emotional support. She is woman rather than professionally centred. She works to get to know women's practical situation and this knowledge grounds both the person and the relationship sympathetically within the woman's social context. The hallmarks of her practice are working class/problem identified, practical caring and woman centredness.

But her disposition and her orientation are in some conflict since she finds it difficult to be open. She discloses very little of herself in her professional work. The disclosures she makes are biographical rather than emotional. She finds it difficult to touch people. She does however use jokes as a means of open expression and as a way of cementing and confirming the relationship. She gains emotionally from her work but experiences it as more painful and stressful than Anna, reflecting her underlying vulnerability. She is a supporter of natural childbirth and 'alternative'
approaches but not exclusively so and is pragmatic about its application.

Elizabeth: the 'perfect professional'

Elizabeth is a middle class, married mother with one daughter. She is a warm, enthusiastic, very caring person who is anxious to please and has a strong reparative need to help others; linked to her relationship with her mother, whose love she wanted but didn't sufficiently get, and her siblings, for whom she felt responsible. She has an inner sense of herself and of feelings as bad or dangerous, though this is disguised by her warmth and empathy. It may, however, explain an anxiety and tendency to rule guidedness; ie. to be 'good' and compliant. Her personal needs for care and understanding are met in relationships with women rather than men.

These characteristics manifest themselves in a role orientation which is professionally centred but with a strong emotional disposition to help and understand others. However, her rule guidedness leads her to a clinical/advisory orientation in which she 'helps' women principally by giving them information. She likes teaching parentcraft. Her role orientation is predominantly towards teaching/information giving. There is also a rule guided concern with routines, feeding regimes and so on, related to the clinical preoccupations noted above. So her disposition and orientation are in some conflict. She is in many ways the 'perfect professional' because her practice is concerned with all aspects of midwifery (clinical-tasks, advisory-information and supportive-empathic) and she practises with a warm and sympathetic demeanour. However her investment in being a 'good professional' tends in practice to lead with an over concern with tasks and information giving at the expense of genuine
engagement in the psychosocial aspects and engagement in the same plane of being. In practice, with limited time and other pressures, the tasks tend to predominate. Her 'professional' orientation places her in a different plane of being to mothers. Moreover, since feelings are 'bad' there is some emotional resistance to full engagement in the raw passions of childbirth and the emotions experienced by women.

**Joanna: a 'real friend'**

Joanna is in her late 20s, single with no children. She is forthright and down to earth. It feels as if something wild is engulfing her from within and she enacts this aspect of self: i) in heavy partying; ii) in denial of some vulnerable feelings (her own or others); iii) in her amusing, subversive, disruptive sense of humour; iv) in her direct and forthright manner; v) in her direct and open relationships with others; vi) through aggression: 'I'm aggressive'.

She needs to be open, to let the tensions and aggression out. Social barriers create further tension which she seeks to release. She likes to connect with people as people and carves open, peer type friendship relationships with the women, with whom she projectively identifies. This allows her to express a caring and sensitivity one would not at first meeting expect: 'That's what I try to do, treat women like I would want to be treated myself.'

So she identifies with the women for whom she cares; needs to be needed; is directly engaged in peer type relationships with them with the social barriers down; she needs
to be open with them and relate as herself; and has strong inner feelings, an inflamed sensitivity which provides the basis for her loyalty and sympathy. She uses humour to break through barriers and relieve tensions, both of which she finds intolerable due to her own inner tensions. She relates to women socially, in peer based relationships, offering friendship and social/practical support: 'I'm not there for the house, I'm there for them...I don't just want to know what they're feeling. I want to know all about them... I want them to feel I'm a friend as much as their midwife.' She is more socially than emotionally oriented. The emotional aspect comes from her disposition and projective identification more than her role orientation.

There is also a subsidiary, clinical, career based orientation, linked to the opportunity work provides for self respect. There is some anxiety associated with failing to meet clinical, but not social, barriers; indicating that they stem from different aspects of her disposition.

Laura: a 'faded flower'

Laura is middle class, divorced with no children. She is a complicated character to observe. She is introverted, a tendency compounded by depression, past and present. She yearns for close relationships and intimacy but her emotional retreat and pessimistic outlook make this unlikely. As she says, her expectations are high and she is bound to be disappointed, which then devastates her.

She is sympathetic yet cavalier to the emotional needs of mothers and has an unmet
need to be cared for by her colleagues. Her tendency to repudiate and her disengaged disposition means she rarely connects reliably with the woman's experience. This disposition defeats her supportive, psychosocial orientation; but the latter is itself fractured by a medical/clinical aspect. When the latter is in evidence she is less sensitive, less engaged, and more instrumental.

So her disposition and some aspects of her orientation situate her in a different plane of being to the mother; although occasionally she transcends this. She tends to 'do to' or 'do for' rather than share the experience. This means she tends not truly to 'get alongside' women in the way she clearly wants, needs and aims to. So although she is 'open' with women, and does have a friendship type orientation, emotionally it is a watered down version of what she might otherwise achieve; diluted by a withholding ambivalent disposition on the one hand and a bifurcated role construction on the other.

**Veronica: the 'old style midwife'**

Veronica is middle class, married, with three adult children. Affection and caring are key to her disposition. Practical, down to earth, giving and acceptant, she likes others who are the same. At the same time, she shows some resentment of unreciprocated giving.

These aspects of her disposition can be detected in her orientation to midwifery. She is warm and affectionate. But she also expresses approval/disapproval if professional standards are met/not met; for example, she approves 'good mums', and disapproves
of bottle feeding, smoking, and carelessness about infection. She reacts similarly if her own dispositional values contravened; for example, she finds the needs of some women 'selfish'. Her role orientation is orthodox, instrumental and professionally and task orientated. She is engaged in the midwife's role but leaves her private self behind; open but concealed. Her 'professional' role definition in some ways supports and in other ways confounds her genial disposition. But she sees one of her central tasks as opening up communications and feeling from mother to midwife; and this mitigates to some extent the effect of her professionalist orientation.

Table 10.1 overleaf summarises the outlooks of the respective midwives.
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Key:

- A = anxiety
- B = burden
- Con = concealed
- Eng/E = engaged
- Int = intimate
- Neg = negative
- Pro = professional
- Rev/= revealed
- SEst = self esteem
- T = task
- Ad = advice
- Cl = clinical
- Emot = emotional
- Hi = high
- Loy/L= loyal
- Pos = positive
- PrS = pract. supp.
- R = repudiatory
- S = self
- Str = stress
- Wh = withheld
- Aff = affection
- Clo = closed
- EmoS = emot. support
- Id = identified
- Med = medium
- Pra = practical
- SEng = self eng’d
- Sup/Su/S= support
- Wo = woman
Comparison of Midwives' Profiles

The profiles presented above and in Table 10.1 illustrate that there are significant variations in community midwives' outlooks. These differences are explicable in terms of their personal biographies.

Nonetheless, some general observations can be made. The most important comparison would appear to be the midwives' role orientations, since these define their approaches to midwifery. At first sight the parallels are between Anna, Carol and Joanna on the one hand and Elizabeth, Laura and Veronica on the other. The former group is unambiguously women centred, whereas each of the latter group is professionally centred. But there are significant differences of orientation within each group. Thus Anna inclines to a psycho–emotional, Carol to a practical, and Joanna to a social construction of a woman centred orientation.

These differences are in turn attributable to dispositional differences. When this is taken into account, a three rather than two fold distinction emerges; between Anna and Joanna, Elizabeth and Veronica, and Carol and Laura respectively.

Anna and Joanna have dispositions and orientations which complement each other and which incline them to communicate with mothers in the same plane of being; though their practice styles are in other respects very different. Anna emerges as the most intimate and Joanna as the most sociable. Both are inclined to develop friendships from their professional relationships. Anna suggests that many of her close friendships have developed this way.
The other four midwives have dispositions and orientations in conflict with each other. Put simply, Carol and Laura have open role orientations but closed dispositions, and Veronica and Elizabeth have open dispositions but closed role orientations.

In Carol and Laura's cases, their dispositions defeat their orientations. Each has an orientation which is woman centred, like that of Anna and Joanna, and is oriented to the supportive aspects of midwifery care. But each has a disposition which frustrates this. Carol has difficulty openly engaging in the relationships she forms, finds it particularly difficult to engage in social/physical contact (for example hugging), and has difficulty engaging openly and expressing herself emotionally. Laura has a discontented and unhappy disposition which means that she remains relatively withdrawn, preoccupied with nurturing herself. She is the victim of inevitable disappointments as reality fails to meet her needs and perfectionist expectations.

Elizabeth and Veronica, on the other hand, have closed orientations but open dispositions; ie. orientations which frustrate their dispositions. That is, their dispositions incline them to engage with others in warm and caring ways but their role orientation confounds them. Each of them works with a 'professional' role orientation which centres attention on them and their formal clinical and task requirements, rather than on the supportive or psychosocial aspects of the relationship. Veronica, an old style midwife, can be brisk and task orientated. Her role definition embraces good communication and this allows a caring disposition to suffuse her clinical practice. But it means that mother and midwife remain in different planes of being; a difference accentuated by a perceived disparity in biographical circumstances. Many of her
relationships are therefore affectionate but ultimately instrumental. Elizabeth has a warm and caring disposition with a strong reparative need to help others. But her role orientation, linked to her dispositional tendencies to be 'good', a 'perfect professional', and to avoid basic passions, inclines her away from the psychosocial and in favour of clinically, routine and measurement based role aspects. This dilutes the emotional intensity of the interaction and the possibilities of sharing the experiences and the relationship.

If orientation is considered alone, a two fold typology develops, between woman and professionally centred orientations. Anna, Carol and Joanna emerge as woman centred midwives inclined to the supportive role, and Elizabeth, Laura and Veronica emerge as professionally and clinically centred to varying degrees. I call this the 'orientation' typology. If outlook (ie. disposition plus orientation) is considered, a three fold typology brackets together Anna and Joanna, Carol and Laura, and Elizabeth and Veronica as having warm and personal, remote and personal and warm and professional outlooks respectively. This is the 'outlook' typology.

How helpful are these typologies as a means of understanding and predicting relationship outcome respectively? In themselves, they are not intended to have predictive value; the argument of the thesis being that relationships have to be considered as a blend of the outlooks of both parties, located in particular experiences. A typology of one party yields significantly less than the full picture. Nonetheless, the orientation typology has a limited predictive and interpretive value. As will be seen, it accurately identifies those more likely to have 'personal' relationships with their
clients. Moreover, there are more 'special' relationships with this group of midwives (4 vs 3 respectively).

But it is equally clear from these figures that orientation does not predict relationship outcome decisively. It also classifies as similar midwives whose relationships are characteristically very different. So the orientation typology has a baseline utility in both predictive and interpretive senses. But in itself it is not the fully story; neglecting emotional and biographical factors which infuse the midwife's role orientation and give her outlook its distinctive character.

The outlook typology distinguishes those with open dispostions and orientations, open orientations but closed dispositions, and closed orientations but open dispositions respectively. From this, we may expect Anna and Joanna to develop personal relationships with the women, but relationships of characteristically different sorts; intimate on the one hand, peer group friendships on the other. In addition we would expect Elizabeth and Veronica to have affectionate, 'special' relationships with at least some mothers, but these not to develop into personal relationships. Carol would elicit loyalty and gratitude from 'problem' cases, but not develop personal relationships. Laura remains an exceptional, disaffected case; with a women centred commitment fading into remoteness.

This has no greater predictive value than the orientation typology.

Moreover, neither the orientation nor the outlook typology can accommodate a large number of confounding cases. Thus, Elizabeth tends to have closed relationships
notwithstanding her disposition; Carol to have some close relationships, playing to her strengths, notwithstanding her dispositional difficulties; Anna to have some routine relationships notwithstanding her intimate orientation; and Veronica to have some affectionate relationships notwithstanding her professional orientation. Laura's and Joanna's outcomes are as one would expect from an analysis of outlook alone. Taken alone, as predictors of relationship outcome these typologies would be seriously misleading. This, as noted earlier, is consistent with the argument of the thesis.

But as a means of understanding the dynamics of relationships, the outlook typology adds a great deal, because it blends in the emotional biography of the midwife, giving the analysis a third dimension, anchored in the emotional biography of the midwife. It colours in the depth, complexity and variability of midwives' outlooks; and so helps us understand the trajectory within which individual relationships develop. In the process, we acquire greater predictive insight. For it appears from Chapter 11 that although relationships have to be considered as blended, they are blended in characteristic ways. It appears from the data that the mother's outlook is the more important indicator of outcome (evaluated from the mother's viewpoint). But the midwife's outlook influences the plane within which the relationship develops; for example, whether it is emotionally, practically, socially or clinically oriented. That is, the mother's outlook indicates the degree of emotional depth she will invest in the relationship, and thus relationship outcome, judged from her point of view. The midwife's outlook influences which mothers, of the range she encounters, she may establish a 'connection' with and with whom she may develop a special relationship. This in turn suggests that midwives, as practitioners, have greater power to dictate the
instrumental aspects of the relationship, whereas mothers have greater power to do so emotionally.
Notes

1. There are a number of different primary health care teams within which different midwives practice. All midwives except Laura take alternate antenatal clinics. Laura does 'wees and weights' only, the doctor conducting the antenatal clinics. The social constitution of the areas differ; Anna, Carol and Veronica work in areas with a greater proportion of working class mothers. All midwives are 'sister' grade.

2. This has obvious affinities with what Glaser and Strauss term 'grounded theory'; but without the methodology of analytic induction or a positivist epistemology.

3. This is an exception to the general rule, which analyses them similarly. But the overarching conceptualisation remains the same.

4. In practice, I did not find this a particularly intractable methodological problem: most people seemed to talk quite openly and I made the methodological decision that they were telling the truth as experienced by them in the absence of evidence to the contrary. Only occasionally did I become aware of an 'interview effect' distorting the experience they recollected. The greater problem was a conceptual one of the validity of eliciting data from people whose orientation meant that they were not emotionally connected with the issue under discussion; for example, talking about 'specialness' with those who did not experience the relationship as special, emotional intimacy with those whose disposition denied it, and so on. It is also worth noting that notwithstanding these reservations, a wide range of responses was evident in the interviews in similar social situations and with the same interviewer; suggesting that the responses do indicate a variability within the actual relationships.

5. Cf. Anna who often stays in touch yet has very similar biographical circumstances to Veronica.
Chapter Eleven

Feeling or Function?: an analysis of 24 mother/ community midwife relationships
Chapter 10 described the analytic framework within which mother/community midwife relationships would be understood and presented profiles of the 6 principal midwives. This chapter presents brief summaries of 12 of the 24 relationships in the analysed sample, two per midwife, couched within this framework. The analytic implications are then discussed. Six conclusions are drawn from the data. Firstly, I suggest that relationships develop into one of three types: instrumental, appreciative, or special. The mother's outlook is the most important influence on relationship outcome, judged principally from the mother's perspective. Routine relationships are instrumental and clinical; a means to an end. 'Special' relationships, by contrast, are psychosocially oriented and affectively intense; akin but not identical to friendship. Appreciative relationships combine both elements. Secondly, a 'special' relationship arises only when there is significant emotionality in the mother's outlook combined with a psychosocial orientation (although this need not be present at the outset). Appreciative relationships, by contrast, are marked by gratitude but may develop in the absence of a psychosocial orientation or significant emotionality in the mother's outlook. A routine relationship is marked by a relative absence of emotionality, (or emotional complications) and the presence of instrumentality, in the mother's outlook. An instrumental or clinical outlook in the mother is incompatible with the development of a 'special' relationship.

Thirdly, a 'special' relationship has distinctive developmental characteristics, again characteristic of friendship. In particular, it 'fans out'. That is, as it deepens emotionally, so it broadens socially; becoming more open and incorporating the midwife more 'as a person'. Fourthly, although the mother's outlook influences whether or not a 'special' relationship develops, the midwife's outlook influences the plane
within which such a relationship is oriented; for example, emotional, social or practical.

Fifthly, and significantly, most of the 'special' relationships involved a community delivery. Fractured relationships, which did not involve a shared delivery, rarely developed this way. In the unusual cases where they did, all involved the sharing of a significant emotional event in the past or present. Conversely, it was unusual for a community delivery not to be experienced as 'special'. Finally, special relationships are almost invariably mutually so.

Four relationships were analysed per midwife, using the selection criteria and methods detailed in Chapter 9. For the sake of brevity, I have limited the case studies to two per midwife. One is chosen because it typifies that midwife's approach; the other for its broader analytic significance. However, the accompanying tables and concluding discussion in Chapter 12 present data in relation to all 24 relationships.

Anna, the 'Intimate' Midwife.

A midwife engaged and revealed in her professional role. All the indications are towards openness, intimacy, sharing and reciprocity. She is inclined to close, intimate professional relationships which operate intuitively, emotionally and physically. She is woman centred, located in the same plane of being. She exudes a gentle, quiet, confident and joyous demeanour. She is inclined in favour of natural childbirth. She is at her best when open and authentic and finds warm, socially similar, clever,
interesting or different mothers most easy to relate to.

The two case studies selected are Abigail and Amanda; the former because it illustrates how Anna overcomes barriers to intimacy which her relief midwife is unable to overcome; and Amanda as an exemplar of the 'intimate' special relationship Anna typically cultivates.

Abigail

A professional, middle class second time mother. Anna was her community midwife last time so they have an ongoing relationship. Abigail was engaged but had a highly intellectual disposition which masked an emotional vulnerability and anxiety about incompetence. She describes herself as a 'fairly confident extravert type of a person.' She was brought up in a diplomatic family who were, and are, 'not terribly good at relating.' She comes over as highly competent, professional, controlling, instrumental, vehemently factual and anti experiential. But this disguises a deeper emotional need, a desire to communicate with people, and an anxiety about vulnerable feelings. She had to work out in her twenties that she, like everyone, was 'worthwhile'. Knowledge represents her dominant means of control. Professional or emotional incompetence frustrate her immensely; for they excite her anxieties and threaten her intellectual defences.

These themes are echoed in her orientation; which is clinical, professional and instrumental, but with a latent sociability. She often construes the social dimension of
professional interaction as extraneous or unprofessional, even though it has been helpful to her in the past and resulted in the extension of her friendship network. There has to be equality of status; a principle she engages in her own professional work, and also uses defensively: 'If they're being invasive to me I'll be invasive to them.' She views health professionals instrumentally. They are a 'corporate body' and interchangeable. She was the only mother in the analysed sample who preferred to see the GP rather than the midwife. This is because she gets more information out of them and this reinforces her defences. She reverts to a clinical/instrumental orientation when her feelings are inflamed and thus her defences mobilised: 'I don't care if you've had a long delivery... just weigh my baby and get lost!' She finds Anna's social and relational orientation acceptable but extraneous: '...she's just sort of sitting; 'you don't have to, I don't need to know about your family and you don't need to find out about mine.' She accepts Anna's overtures because she perceives her as competent, self assured and giving. However, she finds Suzy, the relief midwife, unacceptable because of her emotional vulnerability and reserve, which excites Abigail's own anxieties. She '...tries to be friendly and wants to know about you but she doesn't let you into herself. Now I think if she did then it would be completely different. I didn't hit it off with Suzy the very first meeting...it was all her attempt to be friendly ...and I just thought it was all just unprofessional...I don't like being overintimate, particularly when your emotional state is a bit uncertain.'

Anna, on the other hand, pulls it off. She finds Anna competent, confident, sensitive and giving. She feels they are socially similar. Unusually for Abigail, she seems happy to relinquish some control and initiative to Anna. She liked it when Anna popped in
at the delivery and welcomed Anna's suggestion that she start breastfeeding. She treats
Anna's visits as social occasions and notes Anna's timeless air and personal
commitment; recalling with pleasure how Anna visited her to see the new baby even
though she had been signed off while Anna was on holiday. She says, 'She gives the
impression that she'd like you to be interested in her life just as much as she's
interested in your family life and finds her friendly, chatty and intimate. 'She can go
to the point of being bosom pals...I won't say verging on the unprofessional...'

The 'outcome' measures reflect the admixture of the mother's and midwife's outlook.
Abigail wondered at first if the social aspect of the relationship was appropriate; but
once it developed its appropriateness became irrelevant. She was equivocal on whether
the relationship was special or not. She found it 'reassuring' and would miss it if it
was not there; nice but not particularly special. 'They're certainly not very important
for me,' she noted and said that she would not use either them or the health visitor as
a general emotional support. However, she feels there's 'no difference' between their
relationship and friendship and feels it could develop into one.

Anna says, 'I just find her lovely.' 'I like her very much, she's interesting to talk to.'
She notes that, 'She's very brusque...but she doesn't mean anything by it, it's just she's
very intelligent, isn't she, it's just how she is.' She confirms that Suzy finds Abigail
'increasingly difficult...she worries about even going into the house.' They plan to keep
in touch.
Amanda

A middle class married second time mother. A very spiritually aware woman. Her spiritual orientation makes her highly attuned to love and care but there is a second aspect to her disposition which values competence and self possession.

Her orientation echoes her disposition: a proper respect for professional authority and competence, but aware most of all of the supportive aspect. She is oriented to all the classic things in a 'special' relationship: the emotional and supportive aspects of midwifery, the impact of different social settings (home vs surgery vs hospital), an emotional preference for the home setting, and the role differences between midwife and GP. She is attuned to trust, continuity, personal knowledge and support, and shared experience within the relationship. Community midwives offer: trust, personal support and reassurance; with trust as the relational/ emotional bond. She also has definite preferences for 'natural' childbirth.

Anna was her community midwife last time too. This time they shared a domino delivery and a wonderful birth experience. 'It was what I hoped for and an awful lot more. It was an amazing experience...totally because of Anna...it's what every woman's experience should be I think.' 'I would have shared it with anybody...if you could bottle it and sell it you'd make a fortune; but I mean that is how it actually feels...it made me want to go and tell everybody, it really did. Anna helped her through a difficult point in labour by saying, 'Say a prayer, you can do it.' This is Anna's equivalent of the 'stern talking to' some other midwives deliver; much more gentle and
encouraging. She describes Anna as 'quiet, sensitive, very efficient'. Both she and Suzy have 'both got you as their patient right at the centre.' Anna is lovely and easy to talk to. They share interests in common, including spiritual commitments and preference for natural childbirth. She is sensitive and sharing and makes Amanda feel secure. In particular, she makes her feel personally important, not just one of a number. The relationship was deepened, she feels, by having Anna deliver her.

Amanda demonstrated all the expected outcomes, beautifully expressed. It's to be treasured really. It's not something you could write down; it's just something that I'll keep...It's what every community delivery should be. It's certainly what every woman should feel...' She valued both supportive and advisory aspects, consistent with her two faceted orientation. The relationship was special; including a connection arising from shared spiritual beliefs. She notes how, 'They make you feel you and your baby are special.' and found it 'very very hard' to say goodbye because of the bond which had been established. She bought Anna a special gift and plans to keep in touch.

Anna experienced Amanda as a 'very caring person, very kind person.' She found the delivery satisfying both because it was a good delivery, compared with her awful first experience: 'she's intact, baby a pound and a half heavier, she's breastfeeding. It was just no problem.'; and because of Amanda's obvious delight at the experience. She noted how physical Amanda was, with lots of 'hugs, kisses, cuddles.' Anna paid an impromptu visit to see the baby with her daughter. She found Amanda still euphoric: 'Mum, look what we've done... She was like licking cream, and holding my hand and squeezing it and hugging me and everything.' She acknowledges, 'She is pleased isn't
she?' and says, 'I am pleased that it had been right for her because the first time had been terrible.'
Analytic Summary of Relationships involving Anna

Table 11.1: Summary Outlooks and Outcomes: Relationships with Anna

<table>
<thead>
<tr>
<th>Outlook</th>
<th>Mothers</th>
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<tbody>
<tr>
<td>Disposition</td>
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<tr>
<td>Self</td>
<td>Eng/Diseng/Eng</td>
<td>Diseng</td>
<td>Eng</td>
<td>Diseng</td>
</tr>
<tr>
<td>Plane</td>
<td>Int/Soc/Pract</td>
<td>Soc</td>
<td>Pract</td>
<td>Int/Emot</td>
</tr>
<tr>
<td>Energy</td>
<td>Def/Amb/Pract</td>
<td>Amb</td>
<td>Pract</td>
<td>Sp/Comp</td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Type</td>
<td>Open/Open/Open</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
</tr>
<tr>
<td>Definition</td>
<td>I/Cl/Cl/Car</td>
<td>Cl/Car</td>
<td>Cl</td>
<td>Sup/Adv</td>
</tr>
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<td>Attitude</td>
<td>LSoc/Casual</td>
<td>Casual</td>
<td>Value</td>
<td>Value</td>
</tr>
<tr>
<td>Outcome</td>
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<tr>
<td>Type</td>
<td>Open/Open/Open</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
</tr>
<tr>
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<td>No/Apprec/Apprec</td>
<td>Apprec</td>
<td>Imp/Adv</td>
<td></td>
</tr>
<tr>
<td>Special</td>
<td>No/Yes/Yes/Yes</td>
<td>Yes/Adv</td>
<td>Yes/Imp</td>
<td></td>
</tr>
<tr>
<td>Orientation</td>
<td>Cl/Sup/Reas/Adv</td>
<td>Sup/Reas</td>
<td>Adv/Sup</td>
<td></td>
</tr>
<tr>
<td>Goodbye/gift</td>
<td>Relief/Ok/Sad</td>
<td>Ok/Sad</td>
<td>Sad/Hard</td>
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</tbody>
</table>

Key:

- Adv/ad = advice
- Amb = ambivalent
- Cl = clinical
- Def = defensive
- Emot = emotional
- G. = gift
- I. = instrumental
- Inflex = inflexible
- L = latent
- Reas = reassurance
- Soc = social
- Sup = emot. supp.
- Antag = antagonism
- Apprec = appreciative
- Comp = competence
- Diseng = disengaged
- Eng = engaged
- Grat = gratitude
- Imp = important
- Int = intellectual
- Pract/pr = practical
- Sp = spiritual
- Suff = sufficient
- Wh = witheld

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Table 11.1 summarises the outlooks and outcomes of the respective relationships involving Anna. We can see that all the relationships are open. 3 mothers thought it special, for different reasons; the same 3 found it sad or worse to say goodbye; and were appreciative, very appreciative or found it very important. The same three had a role orientation at the outcome stage, with role or attitude indications antenatally, appreciative of emotional support. These three were socially dissimilar by class (one working, one lower middle, one middle class) and parity (one primip, two multips). The heavily intellectualised defensive orientation of Abigail, the remaining mother, distinguishes both her and the relationship outcome from the others; although it is noteworthy that she is keeping in touch with Anna and plans to visit her home.

The outcomes could not be distinguished by the mother's disposition (two engaged, two disengaged), plane of being (save Abigail who was heavily intellectualised as a defence against feeling) or energy; except that the two closest relationships, Alice and Amanda, both devoted energy to emotional matters within the relationship. On this data, a clinical role definition, such as that of Abigail, is incompatible with an appreciation of the relationship as special. Alice's role definition, on the other hand, changed from clinical to include a supportive element. Her orientation was also attitudinally modified. The most emotionally intense relationship was not the longest established one (Alice) but the domino delivery. The two key indicators of a special relationship on this data are: i) a community delivery; ii) traces of emotionality in the mother's outlook, with an outcome orientation which prioritises the supportive aspect.
Relationships involving Carol, 'The Brick'.

Carol is married with no children. A series of difficult personal relationships both in childhood and adulthood have left their emotional mark and she is emotionally and personally withdrawn and vulnerable. This vulnerability, and the need for connection it expresses, is masked by a caring but practical 'get on with it' orientation which some find brusque, some motherly. She is emotionally committed to her work. Her sympathies and support lie with working class women and/or those vulnerable with clinical or social problems. She expresses her caring in practical ways, by 'doing things' for people rather than by engaging explicitly in emotional support. She is woman rather than professionally centred but finds it difficult to invest herself openly and emotionally in the relationships. She discloses little of herself in her professional work and the disclosures she makes are biographical rather than emotional. She is a supporter of natural childbirth and 'alternative' approaches but not exclusively so, and she is pragmatic about its application.

The two relationships presented here are with Camilla and Christine. The first illustrates ways in which a domino delivery deepened and altered the relationship. The second depicts the practically supportive relationship characteristic of Carol.

Camilla

She is a middle class second time mum who knew Carol as a relief midwife last time. She is spiritually committed and describes herself as 'an outgoing 'people' person'. She
treasures pregnancy, which indicates an emotional sensitivity of relevance to midwifery. The dominant aspect of her disposition is the emotional/spiritual; together with a more latent social aspect, specifically a need for company, and a sensitivity to practical needs.

Consistent with this, her orientation includes a strong emotional and supportive element. She needs to connect with the midwives and have an emotional bond with them. 'It is a very intimate sort of time, isn't it...so you need a bond there.' To date, however, she feels closer to Katy, the relief midwife, whom she saw more of last time; finding her 'more open' and having a 'particularly close feeling' for her as a result of a spiritual affinity and sharing a difficult birth experience. Also, noticeably, the relationship with her has fanned out (see Chapter 14) easily because this coincides with Katy's own orientation. They are both 'people people'. Within the context of a secure and intimate relationship, she values the midwife's practical help and advice and her clinical expertise and so relies on her in all senses. Even at the antenatal stage, she feels the relationship with a midwife is special.

But at the antenatal stage with Carol, she feels the spiritual/emotional dimension, social element and the shared deep experience are missing, all of which she enjoys with Katy. But she still has a positive attitude towards her. She finds her 'very caring; I'd happily ask her anything.' So antenatally it was a solid professional relationship, but Carol was not so much a 'close friend' and there was not the 'stronger bond' she has with Katy. The relationship has not 'fanned out'. 'She [Carol] probably doesn't chat so much openly about her own feelings or social life or family.'
But Carol delivered the baby and the relationship gelled during the prolonged intimacy of early labour in Camilla's own home. 'A lot of bonding happened in that time. I got to know Carol in that time.' Carol opened up more about herself as a person more, so they were 'almost like a family together... automatically you then feel closer to somebody... and I felt that relationship growing... I immediately could have warmed towards her then as a person.' Her talks with me helped alert her to what was happening. Their talks embraced spiritual matters too which 'helped me warm towards her.' For the delivery she felt 'relaxed' and trusted 'everything would be ok'. But there are hints even here that she didn't achieve the depth and intimacy that she felt in relation to Katy. Although 'it was a real community delivery' she was in a lot of pain and Carol gave her 'a very stern talking to which was just what I needed'.

So Carol is being related to on the basis of an orientation which really favours other midwives; and although it worked very well and was a close and special experience it remained fairly context specific and did not appear to fan out in the way characteristic of friendships. In this way, it was almost bound to fall short of the mark since this sort of relationship does not play to her particular strengths. There was no real talk of the practical or social aspects, or only insofar as they expanded the emotional or appreciation of her clinical skills.

But this is no more than a caveat. There were all the outcome indications one expects of a 'special' relationship, except that Camilla valued all aspects of the relationship without explicitly prioritising the supportive. But this links to her holistic orientation and the indications were that she valued it all very highly. There are other strong
indications of the importance of the emotional aspect: '... I think giving birth is an incredibly intense personal emotional experience which the people that you share it with, provided that they have been a help and a support, it creates a very deep – from my side a very deep bond... I think that they've been there and shared in the delivery which is as I say the most intense emotional experience. It was very important... the fact that we shared that day together, with all its ups and downs. It's a shared experience isn't it; I mean shared experience creates a bond, it's what marriage is all about...' She refers to the sense of 'rapport' and 'oneness' so important to her. She gave a gift, found it very hard to say goodbye, and hopes that Carol will pop in for coffee. She wonders of Carol, 'Do you care intensely about me in the same way that maybe I do about you now because we've been through this together?'

There are some lovely passages from Carol, who also found it a deeply satisfying experience. She notes how Camilla desperately wanted a relationship and felt they 'gelled very very well'. For Carol the lovely parts were the 'sheer joy' in the house, which she agreed was 'special', and the physicality, touching, hugging and giving, which she found 'lovely'. She agreed that the time spent at home during the early stages of labour was critical to consolidating the relationships. It permitted a social bond to be established through an initial chat over coffee in early labour. When she returned after doing a couple of visits she found 'it had switched', the mood had changed and deepened and they didn't need to chat all the time. In addition, the extended time shared together, the circumstances (early labour) and the location (home) helped Carol to understand Camilla personally, which she feels she hadn't really done before. Until that point she had simply seemed 'caring' and 'very positive'
but, this implies, she discovered deeper dimensions to her during that time together.

Carol agreed that 'yes' it was special. It was 'very sad' to say goodbye. She concludes, '
... but her joy, everybody's joy... was so tremendous. And that you were so lucky to
be there to share -sharing - she gave something to me, do you know what I mean,
being allowed to share that. It was wonderful.'

Christine

She is a lower middle class second time mother who has working class roots and lives
on a working class estate. Her first child is 12. This is Christine's second marriage.
She has not been cared for by these midwives before.

She works full time and is neither practically nor psychologically integrated into her
local community. I experienced her as very friendly but also self sufficient. There was
an autonomy and instrumentalism about her which chaffs somewhat with her
friendliness and sociability. She is task oriented. Her energy goes into her projects
more than into social connection. But she was very friendly even so. She feels that she
is virtually a first time mother; deskilled by the demands of a new baby. This unsettles
her competent goal directed disposition. Her emotional vulnerabilities are expressed
through her relationship with the baby and the older child. She is very direct.

She sees midwives instrumentally, in a task oriented way, but the sociability remains
important though generalised; for example, she sees midwives, if friendly, as
interchangeable. There are two main aspects to her orientation. Firstly, she appreciates
them greatly, but in an instrumental /advisory/ clinical capacity. She is vulnerable in
relation to the baby and appreciates the midwives because they make you feel 'you're
not alone' and offer sound practical advice. They reassure her and give her a safety
net. Secondly, she is unsure about the legitimacy of the social and biographical aspects
of the relationship. This ambivalence reflects her own split about professionalism: with
high professional standards on the one hand and a need for sociability on the other.
She said, 'Oh no' they didn't talk about their personal life to her, even though other
data suggests strongly that they did. This reflects a psychological sleight consistent
with conflicts in her outlook: 'I don't know whether they're supposed to do it.' For her,
the midwife is really just a different kind of expert; one who meets her strongly felt
needs for sound practical advice.

She found both midwives 'very friendly'. Carol was more 'motherly'; an indulgent
description from a woman whose situation, (working class with clinical problems),
plays to Carol's strengths. She got to know Carol more postnatally, at the house,
having coffee. 'Carol's mine' she said. Carol is 'motherly... I imagine her at home
knitting'. Katy is more into 'health things'. She was surprised when Carol also
suggested homeopathic remedies. She enjoys the social side of the relationship but
there's a sense that it is not the main priority for her. She is geared more to Carol's
outlook and strengths than those of the relief midwife. Like Carol, she tends to a
closed but committed professional relationship. So they match each other in many
ways, although Carol's withdrawal is more a product of vulnerability than choice.
In terms of outcomes, what comes over is a split, the one identified all along. Her outcome role orientation indicates a professional orientation; they're like a nurse to her. Her priorities, in descending order, are: the baby, her own check, advice, problems, chat. Chat is the bottom priority. In the interview itself, a much more intense appreciation of the midwife comes over. But it remains largely subcognitive, not disturbing her cognitive orientation and priorities. She feels they are 'vital' and was sorry to see them go. She bought them presents. She can't express the extent of her appreciation and she feels as though she has lost a friend. So emotionality operates subcognitively and in conflict with her cognitive outlook; making itself felt but not in the way characteristic of emotionally intense 'special' relationships.

Carol felt, 'We seemed to click.' She felt her to be 'a forthcoming personality... It was a very open relationship from the start.' She mentioned her clinical problems and antenatal anxieties. She identified Christine's orientation: that she would ask what she needed to ask professionally and only then would the coffee and talk follow. As Carol says, 'She seemed to compartmentalise.' She felt it was as close a relationship postnatally as with Camilla, but missing the special feeling that came from attending the delivery. She felt she was the type of personality who 'would just sit down and discuss anything you wanted to discuss.' So Carol felt at ease with Christine and it appears that Christine brought Carol out.
Analytic Summary of Relationships involving Carol

Table 11.2. Summary Outlooks and Outcomes: Relationships with Carol

<table>
<thead>
<tr>
<th>Outlook</th>
<th>Mothers</th>
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<tbody>
<tr>
<td></td>
<td>Camilla</td>
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<tr>
<td>Disposition</td>
<td></td>
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<tr>
<td>Self</td>
<td>Eng</td>
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<tr>
<td>Plane</td>
<td>Emot</td>
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<tr>
<td>Energy</td>
<td>Sp/Soc</td>
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<td>Orientation</td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>Closed</td>
</tr>
<tr>
<td>Definition</td>
<td>Sup/Adv</td>
</tr>
<tr>
<td>Attitude</td>
<td>Emot</td>
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<tr>
<td>Outcome</td>
<td></td>
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<tr>
<td>Type</td>
<td>Open</td>
</tr>
<tr>
<td>Importance</td>
<td>Imp</td>
</tr>
<tr>
<td>Special</td>
<td>Yes</td>
</tr>
<tr>
<td>Orientation</td>
<td>All</td>
</tr>
<tr>
<td>Goodbye/gift</td>
<td>Hard.G.</td>
</tr>
</tbody>
</table>

Key:

Adv/ad = advice  Antag = antagonism  
Amb = ambivalent  Apprec = appreciative  
Cl = clinical  Comp = competence  
Def = defensive  Diseng = disengaged  
Emot = emotional  Eng = engaged  
G. = gift  Grat = gratitude  
I. = instrumental  Imp = important  
Inflex = inflexible  Int = intellectual  
L = latent  Pract/pr = practical  
Reas = reassurance  Sp = spiritual  
Soc = social  Suff = sufficient  
Sup = emot. supp.  Wh = withheld
Table 11.2 summarises the relationships involving Carol. The outcomes are in some ways surprising. All were open relationships, except for Caroline, which was friendly but not open. Three of the four relationships were open. All either bought a gift or experienced sadness at the midwives' departure. All were appreciative, grateful or more. All found it special or made some other expression of emotional connection, like losing a friend or being closer to the community midwives than the GP. It is significant that all the most intense emotional responses and connections came from the woman who had the domino; even though, it is clear that antenatally she would have preferred to have been delivered by the relief midwife.

Why are these outcomes so favourable when other mothers have indicated that Carol can be brusque, or too withheld or withdrawn for their liking? The domino accounts for the outcomes in Camilla's case. In the remainder, the critical factor seems to be that they in some way appeal to Carol's strengths. In Caroline's case their practical/pragmatic orientations coincide. For example, they feel similarly on the single most important aspect of that pregnancy, whether or not to have a caesarian. Celia is a single, teenage, working class mum and so is a high priority for Carol. Christine lives on a council estate and has clinical problems and so again is a priority. In addition her disposition is practical, like Carol's, she is friendly, which helps Carol come out of herself and be more secure. Christine's bounded concept of the relationship fits the sort that Carol would happily establish anyway: friendly but not over intimate. So with the exception of Caroline, these are examples of Carol at her best. With Camilla this was prima facie not so. But the domino delivery, and the outlook of the Camilla and her husband, incorporated the midwife and turned it from a closed to an open relationship.
As with Anna, the mother's outlook is an important indicator of a close relationship, in that they all include supportive, emotional or appreciative aspects. With Carol, the practical or advisory emphases of Celia and Christine did not militate against the development of the relationship because it accords with her own emphases. It does seem, however, to affect its emotional intensity. Only Camilla demonstrated the combination of emotionality and an orientation inclined to the supportive which is characteristic of 'special' relationships; notwithstanding that all of them experienced it as special.

In Carol's sample Caroline, the most disengaged and emotionally/ intellectually defended person had the least satisfactory relationship. These outlook indicators bear out those of Anna. No other aspects emerged as significant to relationship outcome. However, this sample strongly suggests that emotional investment is required if the relationship is to be 'special'; a supportive orientation is not enough.

The sample also illustrates well how the midwife's outlook influences the relationships which ultimately develop; for example, a successful relationship emerging with Christine through the convergence of their outlooks. It is also significant that only one relationship was open in the antenatal period. Carol's relationships appear to develop postnataally, when the practical aspects of her role are more prominent and when there are frequent visits in the home. This is in contrast to Anna who had open relationships with all the mothers antenatally, when there is more time to develop 1:1 relationships.
Relationships involving Elizabeth, 'The Perfect Professional'

Elizabeth is the perfect professional. She selflessly withholds and conceals herself in service of others and the relationships therefore tend to be rather one sided. She is practical and warm and derives a lot of self esteem from her work. Her warm and communicative disposition inclines her to open relationships. However, her orientation leads to an emphasis on all aspects of midwifery care but in a facilitative way which falls ultimately within a professional definition of the situation and so inclines to service rather than sharing. In practice much of her energy is devoted to the informational and advisory aspects of midwifery and to clinical measurement and tasks. The psychosocial is relatively less prominent in practice although she is personally well aware of it and compassionate.

I have chosen to present the relationships with Emily and Eve. The first indicates a relationship which fails to connect, despite a home birth, which normally brings mother and midwife together. The second illustrates how Elizabeth generates respect and gratitude yet remains behind professional and emotional barriers.

Emily

Emily is a middle class second time mother with no previous contact with Elizabeth until she moved to the area in mid pregnancy a few months ago. She has a withdrawn disposition and an emotional need to be mothered. She has 'never been particularly open', appears discontented, and has found it hard to find a really good friend since
she moved to the area. In the interview she was courteous and forthcoming but seemed disengaged. She seems not to enter into relationships; rather, she experiences them in isolation. She appeared emotionally restrained, almost depressed. She is logical and decisive but likes to others to affirm her decisions. She values communication but in a one way, egocentric way. She identifies strongly with her own child and is very loyal to her.

She thinks of midwives instrumentally, as nurses more than doctors. She wouldn't go 'so far' as to say they were a friend. But within the clinical orientation she recognises an 'extra dimension' which is that they get to know you (not vice versa, consistent with her disposition) and your feelings. So she has a tacit recognition of the supportive dimension but within an instrumental one sided role definition.

So the key to the extra dimension for her is that Elizabeth knows what's bothering her and will help her get what she wants; like a mother meeting the needs of a child. Her outlook is emotionally but instrumentally defined. There is no biographical or relational aspect to her relationship with Elizabeth; for example, she doesn't know if she's got children. The relationship alleviates her anxieties but there is no sense of it being emotionally satisfying.

She saw Elizabeth a few times antenatally and on all but one occasion postnatally. Despite an uncomplicated home birth Emily had relatively little to say about the experience; she was more forthcoming about discussing her difficulties than reflecting on herself. She felt Elizabeth was 'competent', but 'not one to waste time on chatter'.

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So Elizabeth, a chatterer, has, it seems, picked up the discontented emotional cues and responds as expected by being diligently professional. The relief midwife on the other hand, who did chatter, was 'a very nice person'; suggesting that this is the approach she prefers. She was still more enthusiastic about the health visitor, who acted as the firm mother Emily apparently desires.

The outcomes indicate more feeling than one would expect. There was some sense of emotional engagement, but this was undeveloped and not revealed to Elizabeth. It also remained subcognitive and unincorporated into her formal role definition. She felt deflated when Elizabeth left and half did, half didn't, think of getting Elizabeth a card; she thought Elizabeth may be embarrassed. She added, 'It's her job and apart from the fact that it was at home she hasn't really done anything... really sort of special.' This appears to be a good example of a self fulfilling prophecy in a mother's outlook; one which jangled the midwife's anxieties and elicited a defensive response. So it was a blended relationship, but in an unsuccessful way.

In contrast to Emily, Elizabeth had lots to say about the relationship. She was clearly troubled and upset at the difficulties, which excited her own insecurities. She found her unrewarding and 'a winge', 'emotionally immature', 'ungrateful', 'anxious', 'not one of life's copers'. She found her 'disappointing'. She said you expect some kind of 'rapport', 'you do expect a reciprocal thing'. She said that usually 'you have a bond with them' in home births and this didn't happen with Emily. She felt Emily was happier with directive attention, like her mother gives. When the health visitor treated her this way she was met with gratitude and a hug. Elizabeth felt she had given Emily
100% but even so had not given her what she wanted (a firm parent), and Elizabeth felt it was an unsatisfying relationship.

Eve

A middle class second time mother, she has a handicapped child and this has changed her dramatically, apparently in two ways. On the one hand, it has made her more open; less narrow minded, more aware of others and their feelings and more tolerant and acceptant. On the other, paradoxically, it has made her more closed; more cynical and judgemental about others, and it has exacerbated a tendency to close off and deal with things herself, to 'cope' rather than seek comfort. There are hints of emotional defensiveness. She helps others in their grief but does it in practical rather than empathic ways. She is forceful, funny and likeable, but with her in the defensive position of control. She will 'come out' but she won't let you in. She disguises feeling with humour. She gets what she wants from the social services system and her friends.

There are three aspects to her orientation. Firstly, she uses it as a clinical service, especially for antenatal diagnosis, even though she knows the tests are not particularly informative. One has here a sense of her cut off from sources of support. Secondly, and consistent with this, she retains an emotional barrier towards professionals. 'You don't want your innermost soul exposed.' It would put her off to have someone she knows well deliver the baby. Thirdly, she has an ultimately 'professional' orientation to Elizabeth. She values her as an expert and draws on her practical experience, particularly in facilitating the adjustment to motherhood in the early days at home.
This has an emotionally supportive aspect but within an instrumental definition which incorporates Eve's emotional withheldness.

She was more vulnerable postnatally than antenatally and this enabled her to appreciate the supportive aspect of Elizabeth's role. Her outlook shifted from extractive, advisory and slightly cynical, to an appreciation of personal support and care. She found Elizabeth practical, caring and confident and liked the way the mother was placed at the centre of concern. She found Elizabeth 'very understanding', 'very conscientious', 'just very sort of normal'. She was 'very compassionate'; and she 'oozed confidence'. 'It made you feel good actually' to feel that 'you're the most important person'. 'I found that very reassuring and very pleasant.' The relief midwife, on the other hand, was more glamorous but she wouldn't go to her with a problem.

However the relationship did not develop a personal aspect and there was none of the 'fanning out' characteristic of special relationships. Elizabeth did not talk of her family, for example. Eve has a stronger relationship with the health visitor, whom she has known longer and who has helped her in relation to her other child.

Both Emily and Eve commented on the discontinuities of care in the antenatal period, which adversely affects the building of relationships. Both these relationships were conducted when Elizabeth was becoming disillusioned by her working conditions; and it appears that she may respond to early tensions in the relationship by closing down and being diligent but to an extent insincere; being the 'perfect professional' but without her heart being in it.
The outcomes indicate that it was 'more than' a friendship, and 'more than a professional relationship' too. She valued the practical advice and support postnatally but was glad when the visits stopped so she could get her routines organised. However, she was 'quite sad' about it.

Elizabeth liked Eve, but felt part of the system that was being used. She knew some intimate details but not all. The relationship was clinical more than emotional, but friendly too. They got on fine but it was 'straightforward'. Elizabeth notes, '...she got what she wanted out of me; and I think that's the measure of Eve...she does take what she wants from the system and good luck to her. But I felt that we were friendly.'
## Discussion of Relationships involving Elizabeth

### Table 11.3 Summary Outlooks and Outcomes: Relationships with Elizabeth

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<thead>
<tr>
<th>Outlook</th>
<th>Mothers</th>
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<td>Emily</td>
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<td>Disposition</td>
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<td>Int</td>
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<tr>
<td>Type</td>
<td>Closed</td>
</tr>
<tr>
<td>Importance</td>
<td>Routine</td>
</tr>
<tr>
<td>Special</td>
<td>No</td>
</tr>
<tr>
<td>Orientation</td>
<td>I/Supp</td>
</tr>
<tr>
<td>Goodbye/gift</td>
<td>Deflation</td>
</tr>
</tbody>
</table>

**Key:**

- Adv/ad = advice
- Amb = ambivalent
- Cl = clinical
- Def = defensive
- Emot = emotional
- G. = gift
- I. = instrumental
- Inflex = inflexible
- L = latent
- Reas = reassurance
- Soc = social
- Sup = emot. supp.
- Antag = antagonism
- Apprec = appreciative
- Comp = competence
- Diseng = disengaged
- Eng = engaged
- Grat = gratitude
- Imp = important
- Int = intellectual
- Pract/pr = practical
- Sp = spiritual
- Suff = sufficient
- Wh = withheld

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Table 11.3 summarises those relationships involving Elizabeth. Surprisingly, all Elizabeth's relationships were closed and none of them were thought special, although Emily thought it unique and Eve thought it more than a friendship. There was some sense in all but Elaine of sadness, shock or deflation that she was no longer coming, reflecting the personal regard in which she was held, but none of the mothers had an emotionally intense relationship with her. None of the outcome orientations was centrally geared to emotional support, although there was a hint of it in the home birth (Emily), and practical support was valued by Eve and to an extent by Elaine.

What should be pointed out is that Elizabeth stuck most religiously to the selection criteria, again consistent with her disposition to be conscientious and 'good'. Two of the women were first time mothers. This is unusual, most samples only had one. It is less likely that the psychosocial aspects of role will be developed or appreciated by a first time mother, firstly because their priorities may be different (being oriented more to obtaining information and advice); secondly because the professional norm may be medical and the midwife's role has to be learned over time through experience, and thirdly because there is no chance in this DHA of the emotionally important experience of a community delivery. Also one has to consider the subcultural attitudes of those interviewed. Each midwife's sample had distinctive characteristics and none of those interviewed had an outlook clearly disposing to 'special' relationships. But Joanna's sample seemed similarly unpromising from that point of view yet the outcomes were very different.

It should also be noted that three of the four (Emily, Eve and Elaine) had instrumental
or professional orientations, which as noted above is unfavourable to the development of close relationships. The fourth mother, Ellen, had a cynical attitude to the emotional dimension of professional work. But only one woman, Emily, still had that orientation at the end. There was therefore some capacity to change in response to experience and need and this shift occurred. One has therefore to consider whether Elizabeth's own practice style biases in favour of this sort of outcome. It therefore seems possible that these mothers responded to Elizabeth's disposition, which they liked. But her orientation, in the two cases considered above, fed off the mother's own reticence; exacerbating preexisting professional barriers to the further development of the relationship. This paradoxical set of outcomes in Elizabeth's cases therefore suggests that the midwife, as the more powerful party, sets the parameters of the relationship; with the mother dictating the level of intimacy.

Relationships Involving Joanna: 'a Real Friend'.

A single woman in her late 20s with no children, she is wickedly funny and loyally supportive. Like Anna, she engages with mothers in the same plane of being, but in socially rather than emotionally intense ways. She is intent on being 'herself' at work and in her professional relationships and herself identifies fiercely, loyally and sometimes defensively with the women. She is open, woman centred and psychosocially oriented and engages in peer type friendship relationships with the mothers. Her disposition and orientation thus coincide, as they do with Anna. Other aspects of her orientation include a clinical, abnormal tendency, related to a quest for self respect, and a repudiatory tendency within her own disposition.
I have chosen to present Joanna's relationship with Judy and Jill respectively. The first describes the development of a deep and mutual relationship, in the absence of a domino delivery but consolidated through a difficult postdelivery experience. The second demonstrates how Joanna typically orientates herself in relationships and overcomes the inhibitions of others.

Judy

A middle class health visitor and a second time mother. She has a warm, outgoing cheerful personality and establishes relationships easily. But both she and her husband are used to supporting others and being emotionally self sufficient. She tends to keep the 'deep me' or aspects of it buried even from intimate relationships. Conflicts in the past with her mother seems the source of a sense of inner chaos which she suppresses by setting herself high standards and projecting a competent coping persona in the public world. This, and routines, keep her from falling into private chaos. So there are two levels of feeling apparent in her disposition; an outgoing sociability, evident in a 'bubbly' personality, and a more conflictual, concealed dimension.

She feels the need to be a 'super' mother and indulges in a frenzy of activity to stave off post natal depression. Midwives are valued at a cognitive level as a source of informed, objective, competent support; validating her subjective choice, over which she often feels confusion because it touches the emotional quagmire. This reflects the two key aspects of her disposition, the objective competent one, represented by the midwife, and the unsure and confused feeling based one, in which her preferences are
located. In addition, she sees midwives as advocates and sources of emotional support; though it remains important that her competence is recognised. She invests heavily at an emotional level in her relationships with midwives.

She got to know and like Joanna in hospital when she had her first baby and again when she met her on the community. Like Jill, she feels Joanna is 'normal' and there to help. She developed friendship type relationships with her last midwife and is doing so with this one. Both have conducted their visits to her house at lunchtime and had their sandwiches at her house. She finds Joanna caring and fun, echoing Jill and Jenny's experiences. She trusted her. Joanna was sensitive to Judy's need for objective validation of her decision to have a caesarian. She is also attuned to Judy's need to have someone in authority tell her to lower her standards regarding housework and competence when she's just had a baby.

In addition, Judy experienced a crisis with the medical profession, when they refused to accept that she was experiencing abnormal levels of postoperative pain, and Joanna helped her through this over a period of several days when she was feeling absolutely desperate. She was 'a friend who believed me' and she offered much needed emotional comfort, including a cuddle, and emotional support, visiting up to 28 days. She was instrumental in getting the difficulties resolved for her. She lived through the crisis with Joanna, keeping in touch via the home rather than the hospital, and this deepened the relationship. The relationship with the relief midwife, by contrast, was pleasant but 'just routine'. So both women are inclined to peer relationships and invest emotionally in them. Judy's need for an advocate found expression in Joanna's projective
identification and woman centred orientation.

This relationship was 'special'. It was special because she was 'there for me'; i.e. supportive. She describes the relationship as being 'like a friend', one 'who sticks by you'. She is also, importantly, 'a friend with the knowledge to do it' having both professional power and professional expertise, the former which she needs and the latter which she values. So the relationship was protective and woman centred, founded on care, expertise and informed advocacy, and Judy was emotionally invested in it. The relationship 'fanned out', although it was already open, shading into a personal friendship, since consolidated, with Joanna confiding details of difficulties in her personal life. Judy bought Joanna a card and inscribed it with a special message; and they will be keeping in touch.

Joanna says she felt closest to Judy out of all the mothers in the sample. They were 'like long lost friends'. It was a personal sort of relationship from the start this time. Joanna noted that Judy had remembered personal details about her from last time and asked about them. She 'felt really close to her' and cuddled her and kissed her when she was going through her postnatal ordeal with the medical profession. She didn't want the relationship to end and both parties wanted to stay in touch.

Jill

A single, working class, teenage, first time mother. The important themes for her are recognition and acceptance (i.e. making a mark) on the one hand and freedom and
independence on the other. Babies represent an extension of self, something to look after and love in a way she seems to lack. She has a conflictual relationship with her mother and dislikes adult coerciveness.

She thought midwives would be formal and was pleased when they were not. She invests a lot emotionally in professional relationships, such as with the community midwives and social worker, provided that it is friendly and peer oriented. She values the 'questions and socialising' with the midwives; the former typical of first time mothers, the latter markedly not. She is aware of their professional expertise compared to her friends and mother. So she has a diffuse professional orientation but within that she invests emotionally if it is friendly, acceptant, sociable and peer oriented. She thinks it's a special relationship even at the antenatal stage.

She didn't see Joanna until after the delivery and hadn't wanted to leave the relief midwife. But the 'social' midwife and the 'social' mother clicked 'straightaway'. The social/peer themes predominated in Jill's replies: she liked the humour, openness, peer relationship, biographical connections and commonalities. Jill was emotionally engaged and would like to go out for a drink with Joanna. She liked her dry and bawdy sense of humour and her down to earth manner. She knew that she 'cared'. She also valued the 'time' she was given, that the midwife did not rush off; and she appreciated her protective and supportive behaviour. In this climate, Jill opened up, asking Joanna questions which she may not have done if the relationship had not been open. She thought Joanna was 'brilliant', 'fantastic', 'bubbly' and she 'cracked me up'. So Jill got what she wanted and needed: a peer group type professional relationship.
in which humour and mutual disclosures gelled the relationship. In addition she was cared for as she wants to care for the baby.

Joanna was the most important of the midwives she encountered. She felt that Joanna taught her a lot. But essentially it was the friendship/supportive aspect which most mattered: this combined confiding, reliance and helpfulness. The friendship aspect arises from the talking and confiding (and sharing a laugh etc); the sense of specialness comes from talking, reliance and help. That is, specialness is more than friendship, embracing a professional element as well. She was 'like someone you'd meet down the pub' and this is what Jill likes. But because it operated within a diffuse professional orientation, it operated, in essence, to facilitate the professional relationship and was not a friendship in itself, unlike with Judy. This in turn is attributable to social rather than emotional factors; i.e. it would be socially inappropriate for Joanna to have a peer relationship with her; and the teenage Jill had a diffuse professional role orientation. It had been 'fantastic', she had 'done so much'. She expressed the common feeling that Joanna will go to great lengths for you. The social element reasserts itself through the wish to keep in touch; but Joanna has no plans to visit her, unlike with Judy and Jenny. Consequently, the 'special' element evolved in this relationship into a deep feeling of affection and gratitude.

Joanna thinks Jill is 'brilliant'. She likes teenage mothers because of their honesty and openness and because they are 'up front'; i.e. direct. She was surprised and gratified to get a card and picture from Jill as a thank you gift and notes that those with little money often give most. But it appears that Joanna is not engaged in the way Jill is,
because there is no future in a peer relationship with Jill, although she liked and admired her. So her caring is limited to an extension of her professional role; doing whatever she can beyond the signing off period to help if Jill contacts her, rather than extending the relationship into a personal friendship. Arrangements were made to keep in touch with Judy and Jenny but she 'left it open' re. Jill: she is to get in touch with Joanna if she needs anything. She sent Jill a card from holiday, thanking her for the gifts she had been given.
### Discussion of Relationships involving Joanna

**Table 11.4 Summary Outlooks and Outcomes: Relationships with Joanna**

<table>
<thead>
<tr>
<th>Outlook</th>
<th>Mothers</th>
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<tbody>
<tr>
<td></td>
<td>Jackie</td>
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<tr>
<td><strong>Disposition</strong></td>
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<tr>
<td>Self</td>
<td>Diseng</td>
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<tr>
<td>Energy</td>
<td>Wh</td>
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<tr>
<td><strong>Orientation</strong></td>
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<tr>
<td>Type</td>
<td>Closed</td>
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<tr>
<td>Definition</td>
<td>Cl/Adv</td>
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<td>Attitude</td>
<td>Lat.sup</td>
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<td>Closed</td>
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<td>Importance</td>
<td>Liked</td>
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<tr>
<td>Special</td>
<td>No</td>
</tr>
<tr>
<td>Orientation</td>
<td>Cl/Adv</td>
</tr>
<tr>
<td>Goodbye/gift</td>
<td>Ok</td>
</tr>
</tbody>
</table>

**Key:**
- Adv/ad = advice
- Amb = ambivalent
- Cl = clinical
- Def = defensive
- Emot = emotional
- G. = gift
- I. = instrumental
- Inflex = inflexible
- L = latent
- Reas = reassurance
- Soc = social
- Sup = emot. supp.
- Antag = antagonism
- Apprec = appreciative
- Comp = competence
- Diseng = disengaged
- Eng = engaged
- Grat = gratitude
- Imp = important
- Int = intellectual
- Pract/pr = practical
- Sp = spiritual
- Suff = sufficient
- Wh = withheld

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Table 11.4 summarises those relationships involving Joanna. With the exception of Jackie who was incredibly reserved, all the relationships ended as open ones with two women definitely keeping in touch with Joanna and another intending to. Two were emotionally highly involved in the relationship. The continuities in each of their profiles is quite marked despite highly dissimilar social circumstances; Judy is a middle class second time mother, Jill a working class mid teenage single parent first time mum. Both had engaged dispositions and were socially oriented. Both were open in the relationship and oriented to its supportive aspects; although Judy, the one who developed the closest relationship, was more exclusively emotionally oriented, whereas Jill was more oriented to its practical and socially supportive aspects and also to advice. Both outcomes emphasised a supportive orientation. Both gave a personalised card or gift. Both thought the relationship was special.

The other two also had a social orientation but were disengaged and had instrumental orientations which, as noted earlier, tends to defeat personal relationships. In the case of Jenny this was overcome to an extent by the combined effect of a domino delivery and in particular the help she received through her postnatal problems which engaged her more emotionally. Jackie was so closed and withheld that her outcomes really needs to be analysed on their own terms. Jenny, however, is an interesting illustration of the power of the midwife's definition of the situation. She had a reputation as a 'difficult' mother with the other midwife, yet Joanna established a social aspect to it consistent with her own outlook. So Joanna is keeping in touch with a woman with a reputation with her colleague for being 'difficult'.
On this sample, Joanna has a high 'stay in touch' rate, consistent with her outlook in favour of peer relationships. Anna does the same though for different reasons. This is an outcome all the more remarkable when one considers that she did not meet most of the mothers until or just before delivery in these pregnancies; although she already knew Judy from a previous pregnancy. Joanna's loyalty, care and commitment were highlighted; and her biographical openness was indirectly acknowledged. All these aspects are consistent with her outlook. This sample again confirms that an instrumental orientation disinclines to the development of a personal or special relationship. In Jill's case, there was a professional element, which normally shifts the relationship from special to appreciative (see Chapter 12) but in this case her high degree of emotional investment overcame it. There was also the expected correlation between a disengaged and emotionally remote sense of self and a routine set of outcomes; even in Jenny's case where they are keeping in touch. Joanna therefore appears to build loyal and committed peer group relationships consistent with her outlook; and the impact is discernable in the outcomes.

Relationships Involving Laura: 'The Faded Flower'

Middle class and divorced with no children, Laura is oriented to all the 'right things', but with her optimism and commitment on the wane. She does fewer deliveries than she used to and often appears preoccupied and emotionally detached, even when she is aware of the mother's needs. Despite a psychosocial and woman centred orientation, her disposition leaves her centred on her own emotional needs, and with a tendency to repudiate and detach from others. This means she doesn't connect reliably with the
woman's experience, although there are suggestions she does with some women. Her disposition therefore defeats her supportive psychosocial orientation and places her in a different plane of being to the women. She tends not truly to 'get alongside' women in the way she clearly wants, needs and aims to.

I have chosen the cases of Linda and Lydia to illustrate Laura's relationships. The first is a longstanding relationship in which the mother hoped for, but did not get, a domino delivery; with clearly discernable effects on her experience of the relationship. The second illustrates a 'special' relationship, but one geared more to the appreciative than emotionally intense end of the range.

Linda

A third time mother, working class on an intuitive classification, otherwise middle class. She describes herself as a feeler, not a thinker, and an extravert. She needs to feel in control. She has trouble expressing her feelings and preferences and an inner anger rages within her in consequence at not being heard. Her frustrations and needs get bottled up by a need to be nice and not make a fuss, making her more frustrated and angry. She suffered with postnatal depression when she had her last baby and was counselled by her GP.

She likes people who alleviate or soothe her anger; in particular, people who are attentive but relaxed and calming. She is geared to the emotionally supportive aspect of midwifery. She likes midwives who listen and are constructive. She needs continuity to feel secure and known. This doesn't eradicate her anxiety (she then
worries about being a fool, and she still feels out of control and angry) but it makes a significant difference. Discontinuity of care plunges her into a situation which makes her anxious; an environment she feels she cannot control, subject to hospital policies she may not want. This gives rise to the possibility she may have to 'make a tremendous fuss' to get what she knows she wants. This increases her anxiety and, by contrast, her appreciation of the value of emotional support and continuity of care from her midwife. The 'special' aspect of the relationship comes from the sociable relationship within which emotional support is couched.

Laura was her midwife all through her other pregnancies and delivered the last baby. Linda hopes for a domino delivery this time. However, Laura seemed unaware of the importance of a domino delivery and of the way it would mitigate Linda's anxieties. She also seems unaware of her need to trust, communicate and be understood and soothed. Linda likes the way Laura is laid back and jokes, and appreciates the opportunity she has to talk and communicate her feelings. This enables her to communicate her deep feelings, which usually remain unstated and frustrated. She feels she can shout and scream at Laura in labour and it would be ok, she would still be contained. Laura misses these significances. For example, when Linda asked about pain relief, Laura just gave 'reassurance' rather than linking her enquiry to anger and her episode of postnatal depression. She also doesn't seem to appreciate the importance of the domino delivery to Linda. So Laura seems out of touch with Linda's priorities.

Linda found Laura friendly and easy going and doesn't know anyone who 'didn't like her or consider her a tower of strength.' Seeing her gave her 'a boost' when she was
becoming depressed. This time she has had extended conversations with Laura and feels she listens, and is constructive, honest and down to earth.

The relationship is consistent with her orientation. But the 'special' dimension comes from the social aspect of the relationship, once the relationship 'fanned out'. They discovered they had a mutual friend. Laura confided some personal feelings to Linda and has also called to ask her advice about buying a cat. They got more friendly from there and the relationship now includes social chat. So Linda was highly enthusiastic about her relationship with Laura and attuned to those aspects which characterise 'special' relationships.

But Laura was unable to deliver the baby; and it was striking how Linda's outlook had changed postnatally. She denied the importance of a domino delivery, initially disguised her disappointments and appeared more casual about the relationship, in contrast to her eloquence antenatally. She seemed to feel a strong sense of being let down and unwanted and she felt anger which she expressed through complaining at the relief midwife. She still gave the expected outcome responses but with less emotional intensity. Now she suggests the relationship is special because of its personal character: she is someone who cares, has seen you at your worst, and with whom you have no front. The social dimension has dropped from the picture; reflecting her disappointment. In addition, there were clear signs again that Laura missed some important things; for example the importance of a proper goodbye. She left without concluding the relationship, and revisited only by chance. This gave Linda the chance to say goodbye properly and made her feel somewhat better. She concludes
that it did not work out as she had hoped, and she was disappointed.

It is quite difficult to interpret Laura's outcome measures, because she speaks objectively, as if she hadn't been party to the relationship. She notes that they get on 'well'. It's 'very easy', 'you get to know her'; but makes the relationship sound a bit one way. But she then makes two apparently inaccurate remarks; firstly that there's 'usually nothing much wrong' with Linda and secondly that 'she wouldn't have been unduly distressed' if there was no domino delivery. She recognises that the delivery is the key to a relationship, because there you are most intimate, most needed and the mother is most dependent on you; but suggests that she and Linda already had that in their relationship and you don't lose it. She balked at the suggestion that some mothers find it hard to say goodbye: 'the majority know that it's a relationship for a fixed time.'

**Lydia**

A second time mum from a 'middle class' housing estate. On first contact she seemed unhappy and antagonistic. However, she disclosed quite a lot and said she needed support and encouragement. She says she's a worrier, especially about the birth because of a bad previous experience. She says she's an extravert who needs contact with people. There was quite a lot of social talk in the interview, she asked me quite a few questions, and disclosed and shared quite a lot.

Compared to most other mothers in the analysed sample, I was struck by how much more attuned she was to the supportive aspect of midwifery; in particular the social
and emotional. She seeks out relationships with people to create a space for the airing of worries and the enjoyment of social contact. Her last experience of hospital midwifery was a bad one, with brusque and efficient midwives. She wants more kindness and caring. So she seeks in midwives support, encouragement, reassurance, information and informed support to alleviate her anxieties. She needs 'soft contact' of this sort.

Lydia prioritises the supportive and advisory aspects to alleviate her anxieties and encourage her. This is an orientation towards emotional support and advice, but within what is ultimately an instrumental definition of the situation. The social dimension of the relationship is relatively less important to her orientation but develops from her disposition; in particularly her extraversion and need for social contact with people. She gets from Laura informed reassurance and advice, but possibly not 'soft contact'. She wants a domino delivery.

Laura was her community midwife last time and she felt 'encouraged' by her. Their relationship fanned out to include details of Laura's personal life, including her holiday. They also bumped into each other when out with the new baby and Laura came rushing over to see them. There are still signs, however, that Laura did not pick up cues about specific anxieties; for example her anxiety about perineal trauma and about the brusque attitude of the hospital staff last time.

Nonetheless, this does not appear to have troubled Lydia. The relationship developed and broadened. There was more of a social aspect to it even than before in the
absence of first time mother's anxieties and with the delivery safely out of the way. Laura felt it was like a friend coming round, and Laura took a personal interest and was involved with the child too. But the relationship still operated within a baseline service orientation. It remained mainly advisory/reassurance with the social aspect the icing on the cake. She feels it is special because she's seen her through and knows her anxieties; reflecting her dispositional priorities. They had shared the overall experience together. It was sad saying goodbye because it marked the end of a phase of her life. But the more emotionally intense relationship was with the hospital midwife; who by coincidence delivered her first time round, when they had not got on well. This delivery repaired the damage of the first; and she felt sympathy for the midwife, who was experiencing professional difficulties at the time. It was this latter relationship which marked the moment Lydia genuinely came out of herself into the relationship with the other, rather than just having her needs met. She says the relationship with the hospital midwife was special because they shared an important experience together. She did not share this with Laura and this reduced the intensity of that relationship. She was closest to the hospital midwife, who shared an experience with her and got her safely through a delivery which at one time threatened the life of the baby.

Laura thought Lydia 'super'. She was aware of her anxieties but in a slightly ironic way. She correctly identified the anxieties and said it was 'plain sailing' once the fear of perineal damage was out of the way after the delivery. She sounded engaged with Lydia in a way she did not when talking of Lesley, Louise and possibly even Linda.
### Discussion of Relationships involving Laura

#### Table 11.5 Summary Outlooks and Outcomes: Relationships with Laura

<table>
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<tr>
<td><strong>Outlook</strong></td>
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<td><strong>Disposition</strong></td>
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<td>Orientation</td>
<td>Cl</td>
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<tr>
<td>Goodbye/gift</td>
<td>Relief</td>
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</table>

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- Eng = engaged
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- Int = intellectual
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- Suff = sufficient
- Wh = witheld

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[314]
Table 11.5 summarises those relationships involving Laura. The parameters of all the relationships were fixed in the antenatal period. Two were closed (Lesley and Louise) and two open (Linda and Lydia). Both the mothers in the open relationships were self engaged. Both were explicitly oriented to the supportive dimensions. Linda was also emotionally disposed whereas Lydia engaged through her social needs and her anxieties. Both felt the relationship was special but the dispositional difference coloured the relationship which ultimately developed, with less engagement in the latter case. The latter relationship was therefore valued less for itself than as a service ultimately; and when she engaged emotionally with the hospital midwife a feeling of greater closeness emerged. These two cases again suggest the importance of emotional engagement to a special relationship; although Linda's expectations were disappointed when Laura did not attend the delivery.³

Their orientations also distinguish these women from the other two. Both Lesley and Louise deferred to the GP and had clinical concepts of midwifery care. Louise had an instrumental orientation apparent in the postnatal period; this invariably frustrates the relationship. Lesley had a dismissive attitude to community midwifery care but there were signs that had the response and care system been different a more social aspect may have developed to that relationship. Lydia had some instrumentality in her orientation, but this was counteracted by other aspects of her outlook, in particular, emotionality, and social and supportive orientations.

None of the women interviewed were delivered by Laura, consistent with her tendency to fewer deliveries. At the time of the interviews Laura was suffering from incipient
depression and a crisis of confidence in her work. This was clearly apparent in the second interview, compared to the first; her tone was more detached and almost sorrowful. This appears to have had its impact on these relationships; with signs that Laura was oriented more to her own emotional needs than those of the mothers, with whom she frequently appeared out of touch and unsympathetic, despite an orientation to the contrary, and despite an awareness in some cases of the exact nature of the woman's misgivings or anxieties.

All of these mothers except Linda lived on the anonymous middle class housing estate which tends to foster high mobility, emotional isolation and a service mentality. The organisation of care marginalises the midwife antenatally; confining her responsibility and duties at the antenatal clinics to 'wees and weights'. Several mothers noted how this inhibits relationship formation. Once again, Laura is out of touch; for she believes this is a good system for casual chat and relationship building. So the combination of the estate culture, the organisation of care and Laura's personal disaffection and disposition, together with a high work load, militated against the development of close personal relationships.

Relationships involving Veronica: 'The Old Style Midwife'

Veronica is middle class, married with three adult children. She is practical, down to earth and acceptant and she likes others who are the same. She is engaged as a person in the midwife's role but leaves her private self behind. Her disposition and orientation are in some conflict. Affection and caring are key to her disposition. But she has an
orthodox professional orientation which places her and the mother in different planes of being and which tends to be professionally and task centred. However, part of her orthodox concept of role is a concern with opening up the lines of communication between mother and midwife and this imports something of her caring disposition into her professional orientation.

I have chosen the cases of Valerie and Virginia to illustrate aspects of Veronica's relationships. Valerie illustrates how the experience of childbirth can bind and develop relationships, turning a wary relationship into a close one. Virginia is a good illustration of a relationship 'special' on both sides.

**Valerie**

A middle class first time mother having a planned home birth. She experiences the world egocentrically rather than relationally. She is sensitive but doesn't really engage in relationships; tending rather to withhold and receive it into herself. She likes to have a sense of control. She has a distinct, 'alternative' philosophy and likes to live life on those terms. She agrees she's 'not terribly' expressive unless she's on her own. She tends to withhold emotionally outside her family and close friends, a tendency noticeable in her comments about her relationships at work, with her midwife and with me.

There are several aspects to her orientation. On the one hand she has a pro midwife philosophy of childbirth. She wants a home birth because it is an intimate family
occasion appropriately taking place at home and she does not like hospitals, associating them with being out of control. She prefers midwives to medical practitioners as her birth attendants. But this positive orientation towards midwives is counteracted in several respects. Firstly, one senses that she won't let anyone in emotionally. Secondly, at the antenatal stage, she had an instrumental view of professional relationships; even though this contradicts her own philosophy. Midwives are treated in a similar way to work colleagues: at one remove. She relies on midwives for clinical care only; getting her advice from the NCT and support from her family and husband. She says, 'I wouldn't dream of looking to someone outside my immediate relationships for any kind of support.' Of Veronica she says, 'I haven't even given her the opportunity of getting closer.' Thirdly, she has had to struggle for the right to a home birth; including overcoming the resistance of her midwife. This antagonism surprised and disappointed her. Consequently, she has had to debate, negotiate and compromise to achieve her home birth.

This is the woman Veronica described to me as a 'silly girl' for wanting a primip home birth. Valerie says 'she wasn't very pleased' and agrees that initially they were more like adversaries than cooperating partners. She had to 'compromise' and agree to a managed third stage. She felt that 'I had to do everything myself' and that Veronica was not the advocate she expected when negotiating a home birth and facing antagonism from the GP. She got the feeling that 'it was going to be a bit of a battle.'

But she had a good home birth experience (Veronica's relief delivered) and felt that 'it does have a hell of an impact.' The relief midwife became 'a substitute for my
mum', a source of 'informed support'. Her husband was the main emotional support. She felt the 'physicality' of childbirth 'broke through the barriers' and she felt very positively towards the attending midwives, both for their distinctive approach and for their handling of the GP. She would have preferred the relief to continue seeing her after the delivery but once she saw Veronica again she was happy to go on seeing her. She wasn't too disappointed Veronica and the student didn't deliver because it was clear they were genuinely disappointed they'd missed the delivery and were excited about it. 'So even though they hadn't been there it seemed like they'd been thinking about it.'

After the first postnatal week the relationship with Veronica deepened and fanned out and Veronica started talking about her family and her husband's work. It is unusual for her to mention her husband. Veronica brought along some photos to show Valerie and offered to give her her old television, which she was replacing.

This is the biggest change I've come across in a relationship between the antenatal and postnatal interviews, attributable to the psychological impact of the home birth. Both mother and midwife opened up and the relationship developed significantly. Valerie opened up during the birth experience. Veronica was pleased that the birth experience had been so good. 'It was wonderful that you had such a really great time together.' She accepted that the home birth was right for her; which marked a change of heart on the issue. Valerie felt it would have been nice to have Veronica all through but she was happy with what she got. She thinks midwifery is 'an incredible profession. I'd love to be a midwife.' She says, 'I didn't think that the relationship with the midwife
was even that important before. Now yeah it is, God, yeah.' The daily visits meant that she got to know Veronica 'very well, very quickly'. She agreed she let people in more. She valued the midwives' experience, expertise and the fact they are there for you; ie. 'with woman'. It is an important rite de passage and it changes your relationship with the ones you shared it with, making the relationship special. It is a blend of personal support and professional expertise. She was a substitute for her mum. She said it was a bit like saying goodbye to a friend; but that was 'crazy' because her own friendships normally take years to develop and mature. She bought a card and chocolates for Veronica.

The observational data indicates clear disapproval from Veronica that Valerie wanted a home birth. In the session I observed Veronica got cross with her because she'd changed GP and forgotten some of the information she'd been given in the booking clinic. She was unsympathetic, disapproving, and showed it. Postnatally she had a different attitude. She felt it was right that she had had a home birth because she's a 'shy thing'. She was sorry that she couldn't be at the delivery, and felt Valerie was sorry too. She agreed that getting to know her made her feelings and wishes more intelligible.

**Virginia**

A middle class fourth time mother, trained as a health visitor. She agrees that she's a forceful character. She has a high need to control; appearing to be a 'regulator' (Raphael Leff 1986). She is vulnerable about being vulnerable. Yet underneath it all
she wants to hand over during labour. She wished she'd had no professional training so she could be like everybody else. She feels expected to be in control as a health visitor. This tension is played out in labour. She needs someone with whom she can let go of that need, diminish the tension, handle it if it surfaces and contain her.

This seems to reflect some tensions within her family. There is some strain in the relationship with her mother; she feels she has to behave appropriately, and she says she is more on guard with relatives. She feels as close to Veronica as with family but it's 'easier'. So, unable to express vulnerability with her mother and other relatives, she turns to friends and some professionals for support.

She needs a midwife who can contain her. In her relationship with Veronica she overcomes the inhibitions in her relationship with her mother. She can let go, behave as she feels, and it will be accepted. She likes Veronica because, 'I can just let go you see and she can take over.' The delivery was 'a family sort of gathering really'; a telling metaphor considering that she has unrelaxed relationships with them and wouldn't want them at the delivery. 'I felt at ease with her'. 'I felt safe with her'. She has to trust before she can relinquish control and Veronica gave her that confidence. She was 'sympathetic' and 'compassionate'. 'A problem is shared with someone you know.'

Virginia and Veronica are casual colleagues who know and like each other. Veronica conducted Virginia's last domino delivery; and that cemented the relationship. Unlike her relationship with her mother, 'I didn't feel that I had to behave myself at all' during
the delivery. Veronica was firm but flexible, like a firm practical loving mother. 'They know how it takes you.' So there was none of the conflict over containing and being proper she has with her mother. 'She'd accommodate whatever I want.'

Postnatally, 'they know you don't they?' so you feel 'much more at ease'. She would have mentioned 'any little problem'. She says she feels as close as having a relative there with Veronica, but it's easier. They can detect difficulties because they know you so well. They 'take you as you are'; they are 'with woman' in effect.

The relationship had 'fanned out' before the postnatal period. It had all the expected 'outcomes' measures: it was a special relationship; the goodbye was sad but mitigated by the fact they would see each other at work; 'she will always be part of our family really'; they will invite her to the christening; and they want to get her involved in the family. She found the supportive aspect most important; but then she corrects to the clinical, reflecting her professional training.

Veronica was aware of the competence/ vulnerability tension within Virginia: 'When she's in labour she's more of herself.' She felt Virginia could be 'herself' with her and she was 'thrilled' to do the delivery. Says that Virginia 'desperately wanted' her to deliver her. 'It makes it very special' if they want you there. Her caring disposition comes out strongly, but it is implicit rather than explicitly at the centre of her outlook.

She showed me photos of the post delivery period. They gave each other a big hug. She felt '...it's very special' and said 'Oh obviously Virginia' when asked which of the
sample mothers she felt she had the most special relationship with.
### Discussion of Relationships involving Veronica

**Table 11.6 Summary Outlooks and Outcomes: Relationships with Veronica**

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<tr>
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**Key:**

- Adv/ad = advice
- Amb = ambivalent
- Cl = clinical
- Def = defensive
- Emot = emotional
- G. = gift
- I. = instrumental
- Inflex = inflexible
- L = latent
- Reas = reassurance
- Soc = social
- Sup = emot. supp.
- Antag = antagonism
- Apprec = appreciative
- Comp = competence
- Diseng = disengaged
- Eng = engaged
- Grat = gratitude
- Imp = important
- Int = intellectual
- Pract/pr = practical
- Sp = spiritual
- Suff = sufficient
- Wh = withheld

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Table 11.6 summarises those relationships involving Veronica. All but one of the mothers found the relationship with Veronica special. All except that one mother was oriented to its supportive aspect; although the support dimension they identified differed. In the one close relationship which was nonetheless closed, the woman, Vivien, felt gratitude rather than any emotional intensity and gratitude more than sadness when they left. This relationship emerges in Chapter 12 as appreciative rather than special. All three of those who found it 'special' had dispositions which included an emotional aspect either in their plane of being or energy priority, in contrast to Vera who had a practical orientation and whose energy was invested in her social network. The relationship with Valerie underwent a radical change from start to finish; beginning with the pejorative 'silly girl' for wanting a home birth for a first time delivery, and ending with an extended relationship comparable in intensity to friendship, in which the mother wished to become a midwife and the midwife offered the mother her old television! The key experience here was the home birth which broke down the barriers evident in the antenatal orientation; which was instrumental, (usually fatal to a relationship), clinical, had no positive emotional aspect, and was adversarial. Valerie's reserve was broken through the birth experience and this opened up both sides to develop a close relationship.

Of the three who found it special two had a home birth or domino and these provided the emotionally more intense outcomes. These have been classified as special in Chapter 12. Vera did not find it a special relationship; she disputed the advice Veronica offered and this antagonised her and made her dismissive. Interestingly, however, she shares with Lesley and Louise a deferential preference for the GP.
Vivien shares this to an extent too, but with a clear realisation of the distinctive aspects of midwifery, which she picked up on in the course of the relationship. Veronica's caring disposition came across strongly in the relationships, except with Vera. Vera and Valerie experienced Veronica's professionalist orientation in different ways: Vera in the unwelcome advice which was dispensed, and Valerie through the appellation 'silly girl' indicating her disapproving tendency. Overall, however, the benefits of Veronica's disposition seem to have come over more markedly than the limitations of her orientation.

Chapter 12 considers the implications of these findings and classifies each of the 24 relationships referred to here as routine, appreciative or special respectively.
Notes

1. Some extracts in this chapter may also be reproduced elsewhere.

2. Although their orientations differed in other respects, making one an appreciative and the other a special relationship.

3. Note too that Lydia, as with many other mothers, experienced the relationship as special even though I have classified it as appreciative.
Chapter Twelve

Aspects of Mother/ Community

Midwife Relationships: a discussion
Chapters 10 and 11 presented an analysis of 24 mother/community midwife relationships. This chapter assesses the implications of that analysis. Table 12.1 overleaf presents an overarching classification of the relationships, depicting them as routine, appreciative or special, on the basis of the outcomes described in chapter 11, validated by the researcher's intuitive recollections. Tables 12.2, 12.3, and 12.4, which follow, reproduce the outlook and outcome data presented in Chapter 11, organised in accordance with this classification. (Names and classifications have been abbreviated.)

It will be seen that 8 of the relationships were routine, 9 were appreciative and 7 were special. This amounts to roughly one third of each type, with slightly more appreciative than special. These are analytic rather than experiential classifications. 13/24 of the mothers experienced the relationship as special, but I have classified only 7 of these as 'special' relationships; the remainder being classified as 'appreciative'. None of the 'routine' relationships was experienced as 'special'. The significance of these distinctions will be discussed below.

Classified this way, it becomes apparent that 15/24, or approximately two thirds, of the mothers came to appreciate the supportive aspect of the midwife's role and developed varying degrees of emotional attachment to her. These two elements, a supportive orientation and emotionality, are present in appreciative and special relationships but almost entirely absent in the routine relationships. Approximately two thirds (15/24) of the mothers were sad at the very minimum to say goodbye to their midwives. Of these, only one, Emily, had a routine relationship.
### Table 12.1 Classification of Relationship Outcomes

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Table 12.2 Outlooks and Outcomes of Routine Relationships

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N.B. See key on page 334.
Table 12.3 Outlooks and Outcomes of Appreciative Relationships

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Table 12.4 Outlooks and Outcomes of Special Relationships

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### Key to Tables 12.2, 12.3 & 12.4

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(She was the woman who had a home birth.) All those who felt sad to say goodbye had come to value, to varying degrees, the supportive aspect of the midwife's role. Only two mothers in 'routine' relationships appreciated this aspect. Moreover, as noted above, none of the routine relationships was described as special by the mother; and the majority, (5/8) found it emotionally unimportant.

All of the 'special' relationships were experienced as such by the mothers. On the other hand, some described it as special but on the basis of other indications I have classified it as appreciative rather than special. The 'special' relationships were identified by me intuitively, from my own feelings and recollections. These relationships also emerge as significantly different in the analysis itself. In special relationships, the emotional and supportive dimensions are paramount and couched within a woman centred relationship. These are the relationships enjoyed by Amanda, Camilla, Judy, Jill, Linda, Valerie and Virginia. Five of the seven special relationships included a mother whose disposition was emotionally based; ie. operated in an emotional plane of being. Moreover, the remaining two mothers, Jill and Virginia, had strong emotional elements elsewhere in her outlook; Jill in an emotional investment in acceptance, and an emotional attitude in her orientation, and Virginia through vulnerability in her disposition and a need to be contained by her midwife in her orientation. No woman with an emotionally based disposition developed anything other than a special relationship; except for Eve whose self sufficiency distanced her from the relationship. These relationships also 'fanned out' in the way elaborated in Chapter 14. That is, as they achieved emotional depth, so they broadened socially. All of the the special relationships were open, but only one of eight routine relationships
was. Of the appreciative relationships, two thirds were also open. Women could still have an appreciative relationship within a closed relationship, but it was more likely that such a relationship would be open. Moreover, 6/7 of the women in special relationships had an engaged disposition, compared to 2/8 routine relationship mothers, and 6/9 of the appreciative mothers. Self engagement and type of relationship therefore discriminates well between special and appreciative relationships on the one hand and routine relationships on the other.

Mothers in appreciative relationships had social and practical, rather than emotional, dispositions. Of these mothers, 3/9 had practical based and 4/9 social dispositions. Of the remaining mothers, Eve was disposed to practical and supportive aspects and Christine to social and task dimensions. Some mothers (5/8) in routine relationships also had socially or practically based dispositions, but this was compounded by emotional complexes which dissociated them from the midwife. Such emotional complexes were evident in 6/8 mothers in routine relationships, compared to 3/9 appreciative mothers (Caroline, Eve and Jenny). Some mothers in special relationships also exhibited emotional complexes of this sort (Amanda, Valerie, Judy and Virginia), but this is counteracted in most cases by an emotionally based disposition. So mothers in appreciative relationships were less emotional on the whole; ie. their dispositions were not emotionally based and they were least likely to have conflicting emotional pressures within the relationship. Mothers in routine relationships had dispositions which were not emotionally based (with the exception of Vera, who was antagonised by her specific experiences with Veronica). But they were the most likely to have within their disposition conflicting emotions which operated to dissociate them
from the mother/midwife relationship. It is not that they were unemotional, it is that
the emotions were likely to be problematic for the relationship.

The orientation of the mother is slightly more complicated, but indicates that those
women with an orientation towards midwifery as support were significantly more
likely to develop a special relationship. 6/7 of the mothers who had special
relationships had this orientation. The exception was Valerie, who was changed by
events. Moreover, all of these women explicitly included the supportive aspect in the
'outcome' measures, the majority (4/7) citing this aspect alone. Only 1/8 of the routine
relationship mothers had such an orientation, and only 2/8 such an outcome. None of
them cited the supportive aspect alone and the vast majority (6/8) failed to cite it at
all. Rather, mothers in routine relationships were the most likely to have a clinical,
professional or instrumental orientation. All of these mothers had such an orientation,
compared to only one mother in a special relationship (Valerie), whose attitude was
changed by specific experiences, and 3/9 mothers in appreciative relationships.
Mothers in appreciative relationships, on the other hand, were significantly more likely
than mothers in routine relationships to refer to the supportive aspect. 5/9 such women
had a supportive orientation, 6/9 referred to it in the outcome measures. But only one
cited it exclusively in orientation or outcome (Vivien and Caroline respectively),
compared to 4/7 mothers in the special relationships. Compared to the routine
relationship mothers, they were significantly more oriented to advisory and supportive
aspects of community midwifery (8/9 vs 4/8 respectively). Compared to the special
relationship mothers, they were significantly more oriented to the clinical aspect of
community midwifery and more likely to have an instrumental definition of the
situation (3/9 vs 1/7 respectively).

In summary, just over half of the mothers experienced the relationship as special. More than two thirds appreciated the supportive aspect of community midwifery to a significant extent and developed some degree of feeling, either deep gratitude or more, within the relationship. All of these women found saying goodbye sad or worse. Of these, 7 women developed what I have termed a 'special' relationship, characterised by an emotionally based disposition in the mother coupled with an orientation predominantly appreciative of emotional support within a woman centred relationship. 5/7 women in special relationships exhibited such a disposition. No other mother did, with the partial exception of Eve. Within the relationship, all became predominatly oriented to the supportive aspect of midwifery (the seventh was a first time mother and so included the advisory aspect)\(^4\) All experienced the relationship as emotionally important or special. All gave gifts, compared to only two others. None had an instrumental or clinical outlook. These are the characteristics of special relationships.

Appreciative relationships, on the other hand, are characterised by the development of a supportive relationship, but one which develops within instrumental boundaries. It is the service which is paramount rather than the relationship; the relationship is a means to an end. The mother's disposition tends to be social or practical rather than emotional. At some point in her profile there are elements of emotionality, but this does not predominate. Some of these women have orientations similar to those who went on to develop special relationships, but overall they were more likely than the latter group of women to have clinical or instrumental orientations. Most significantly,
they did not have the emotionally based disposition typical of mothers in special relationships. So the blend of instrumentality and emotionality configure the relationship in a different way to the special relationship. The relationship is more one sided, task defined, and subordinated to the service being provided. Although the mother may develop sincere feelings of gratitude and affection for the midwife, be sorry to say goodbye, and experience the relationship as special, emotionality and support are instrumental to the service, or a byproduct of it, rather than its defining features.

These relationships do not need to be woman centred, emotionally intense or explicitly supportive to be successful. Their outcomes reflect this. All of the appreciative relationships resulted in feelings of gratitude or appreciation rather than deeply felt emotional attachment. Over two thirds of them (7/9) were experienced as special, but in no case was the relationship emotionally important. These women felt gratitude or appreciation rather than deep seated emotional attachment. The appreciative relationships were likely to be sociable, but without the emotionality of the special relationships. By contrast, all of the special relationships were experienced as both emotionally important and special. Most significantly, all of the special relationships were preeminently emotionally supportive. Two thirds of the appreciative relationships included this aspect but only in three cases (Alice, Caroline and Christine) did it have an emotional quality. In addition, 8/9 of the appreciative relationships had other aspects to their outcome orientation, compared to only 3/7 of the special relationships. The other factors most commonly identified were clinical skills and advice.
The routine relationships were characterised by an instrumental, clinical orientation and a lack of emotionality in the mother's disposition and within the relationship. Typically, the mothers in these relationships worked with a clinical and instrumental role orientation and a disposition marked by the absence of emotionality or else the presence of complicating emotions. The combination of relative lack of emotionality and a clinical, instrumental role orientation configured these relationships from the start; and there is a high degree of congruence between the initial and outcome orientations; suggesting that instrumentalism is a decisive negative influence militating against the development of an appreciative or special relationship. Only Valerie's developed beyond that point. Three of the mothers also had a deferential attitude to the GP, which again detracted from the midwife's role. Three of the mothers had an intellectual disposition which, untempered, encouraged further instrumentalism in the relationship. None of these mothers found the relationship special or important. Some, however, appreciated it to an extent; in particular the mothers who had relationships with Elizabeth. These were the only 'routine' relationship women who identified any supportive element in their final orientation. The remainder were oriented to different aspects of the relationship; predominantly clinical skills and advice, perceived instrumentally. So routine relationships are marked, to varying degrees, by instrumentalism, a clinical orientation and a lack of emotional attachment or appreciation.

The midwife's outlook was not a good indicator of relationship outcomes: the 'woman centred' midwives, Anna, Carol and Joanna had four special relationships, the 'professionally centred' midwives had three. But it can be said that the relationships
which develop as 'special' take on the defining characteristics of woman centredness, emotionality and support, which each of the woman centred midwives is, in different ways, inclined to. The midwife's outlook, on the other hand, strongly influences the plane within which relationships are likely to develop (and by extension, one suspects, the people with whom such a relationship is likely to develop). This phenomenon manifests itself too in patterns of gift giving. The 'professionally centred' midwives are less likely to receive gifts; and when they do they are symbolic and indirectly given. Anna, Carol, and Joanna, for example, received personally chosen gifts from all the women in special relationships, from both samples, (except that data on this point is not available in relation to Claire). Elizabeth, Laura and Veronica, on the other hand, received no gifts from the analysed sample of 24 mothers; except that Veronica offered Valarie her TV, a symbolic gift; and Veronica either took or was given photos of the post delivery scene with Virginia. These are gifts but not straightforward ones; reflecting the difficulty of negotiating role boundaries. Similarly, from the 'special' sample considered in Chapter 13, Elizabeth was sent flowers (an indirect gift), Laura was helped to buy a car and Veronica was given a birth report.

So it can be said that the mother's outlook is the most important determinant of the level of emotionality in a relationship, and thus of relationship outcome, judged predominantly from the mother's point of view. The midwife's outlook, on the other hand, influences the plane within which the relationship develops. In practice, this means that some midwives, for example, the psychosocially oriented ones, are more likely to develop intimate, personal and thus special relationships. But comments about relative influences have to be tempered by an appreciation of the relationship as

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blended. In some cases, for example, Carol's with Camilla, the mother's outlook develops the midwife's. There are also significant differences of orientation and changes in the relationship over time; in Valerie's case, for example, from very unpromising beginnings.

One can identify other predisposing factors: special relationships in this sample are more likely to be with middle class mothers who share a supportive orientation, a preference towards natural childbirth and who had or have had a community delivery. But there are exceptions within the special relationships; for example, Jill is a working class first time mother not disposed to natural childbirth and Judy had a caesarian section. There are also women in the main sample who share these characteristics but did not develop a special relationship; for example, Emily, who had a home birth and Jenny who had a domino delivery. In both these cases, the mother's outlook left them indisposed to the development of a special relationship.

At the beginning of Part Five, I suggested that the midwifery, practitioner based literature incorporates a professional paradigm which ignores the importance of personal factors in professional practice; encourages a static and object oriented view which removes the professional from the picture and objectifies the mother; is socially overdetermined in carrying the implication that the 'correct' social setting would yield appropriate midwifery practice; and overlooked the degree and the sources of variability within the same formal role and social context. This analysis was designed as a corrective to this approach; one which would analyse mother and midwife within the same conceptual framework, although differently situated; emphasise the
importance of personal and emotional factors both to a midwife's outlook and to emergent relationships; conceive of relationships in dynamic terms as a blend of the respective outlooks of the parties and the experiences they shared; highlight variability and difference within the same formal social setting and role; and emphasise the synthesis of biographical echoes and contemporary experience in the social constitution and reconstitution of the individual.

At a metatheoretical level the analysis was predicated on a conceptualisation of human relationships as a dynamic blend of the biographies of the individuals party to it; engaging multifaceted selves operating simultaneously at more than one level of meaning and consciousness. It stressed a view of the self as active in its own making; socially yet uniquely constituted, with no commitment to symmetrical experience or shared meaning within a particular relationship. Cognition was conceived of as irreducibly emotional.

Whatever else they are, professional relationships are personally defined and enacted. Although structural similarities can be traced between different midwives, the descriptive appellations (the 'intimate' midwife, the 'brick', the 'perfect professional', the 'real friend', the 'faded flower' and the 'old style midwife') indicate how each has a unique cast and hue related to the midwife's emotional biography. Moreover, emotional factors in the profiles of both midwife and mother were key to understanding the priorities each had within the context of the relationship and central to an understanding of which relationships were more likely to gel into an emotionally intense 'special' ones. We saw too the chimes of the past in the emotional responses
of the present; for example, in Elizabeth's tendency to become ever more good and professional when her emotional sensibilities were being offended, for example, if a mother was ungracious or exploitative. This appears to be a direct reenactment of the emotional drama of her childhood, when her 'bad' feelings and needs were repressed in an effort to win the approval of her mother. We saw that experience may have meanings of which we are unaware. The emotional aspects of the mother/midwife relationship frequently existed subcognitively: mothers would talk of them obliquely but often this awareness failed to reflect itself in the formal orientation; and this cognitive unawareness had implications for the experience and relationship itself. The importance of immediate experience was demonstrated through analysis of the role of domino deliveries in redefining, in most cases, the parameters of the relationship. We saw that as relationships deepened they fanned out to embrace the personal biographies of the midwives. This tied the midwife into the relationship more openly and emotionally. Some midwives, for example Anna and Joanna, defined their relationships in these terms and so tended to experience them in this way even if the mothers did not. This also illustrates how relationships are neither symmetrical nor shared. It was unusual to have a relationship experienced with similar emotions and intensity on both sides. Laura, for example, had special relationships despite appearing out of touch with her clients. This is attributable to a previous relationship and domino deliveries. But overall, the experiences of mothers and midwives in special relationships were congruent; ie each was emotionally attuned to the other.

Emotionality, supportiveness and woman centredness therefore emerge as key to the special relationships. But it should also be noted that five of the seven special
relationships (Amanda, Camilla, Judy, Jill, Linda, Valerie, and Virginia) involved a community delivery at some stage in the relationship. One of the remaining two involved a close relationship already established. As Chapter 14 demonstrates, emotionally deep and supportive experiences bind mother and midwife together; whether this is the joy of birth or the anguish of bereavement. But experience alone does not produce a special relationship. Two community deliveries did not produce a special relationship, although one of the women is keeping in touch with her midwife. One has to look at what is experienced and with whom. Much depends on the outlooks of the parties. Here, the indications were that the mother's outlook (emotionally sensitised and supportively oriented) was critical to a special relationship; with the midwife's locating it within a particular plane.5

The following chapter looks in more detail at special relationships, the central focus of this thesis; using a separate sample of special relationships further to examine their nature and characteristics.
Notes

1. This led me to qualify the classifications of Ellen and Jenny, from appreciative to routine and routine to appreciative respectively.

2. Jenny was not sad, but she is having ongoing contact, which mitigates against sadness.

3. Other women also exhibit conflicting emotions but either this does not impinge upon the mother/midwife relationship centrally (for eg. Lydia and Alexandra), or the need to connect predominates (for eg. Judy and Virginia). In Virginia's case, the need to be contained predominates, and she has had previous experience of a domino delivery.

4. Camilla's final response suggests she values all elements, but she does so highly, compared to the appreciative relationships. Moreover, there are subcognitive indications which construe support, including through advice, as the dominant orientation, although it is sometimes difficult to disentangle this from her high levels of appreciation.

5. Within parameters appropriate to the role of community midwife; itself distinctively personal and supportive. See Chapter 14.
Chapter Thirteen

Needing and Knowing: the nature of special relationships
Chapters 10–12 have examined 24 mother/community midwife relationships. This chapter explores the experiences of a separate sample of 6 mothers nominated by each of their respective midwives as party to a 'special' relationship with them. Each midwife identified one woman; and each of these women was interviewed without any refusals or withdrawals.

This section analyses these mothers using the same criteria as in the previous chapter, thus permitting comparative analysis with relationships both 'special' and not special in the main sample. I also analyse them in their own terms, further to highlight the analytic characteristics of 'special' relationships.

The women in the 'special' sub sample were interviewed only once, in the early postnatal period. There is therefore no longitudinal element to this analysis. Accordingly, there is only one, retrospective, analysis of orientation and 'type' of relationship respectively. This does not diminish the analytic power of the analysis, because, as explained in Chapter 10, this is not a causal analysis and 'outlook' is therefore not an antecedent variable.1 The main difference from the main sample interviews was that the analytic focus was more exclusively on the relationship and its characteristics than on the mother and her social context.

These relationships were analysed as a validatory strategy, intended to test, refine and extend the understanding of special relationships developed from the analysed interview sample of 24 relationships. However, the fact that the sample was selected by the midwives as 'special', rather than in accordance with the criteria specified for
the other interviewees (see Chapter 9) introduces an extra element of complexity. In particular, it requires emotional engagement in the midwife as well as the mother. However, as noted in Chapter 12, a degree of mutuality is evident in the other 'special' relationships, so this not mislead us. It also leads to a better appreciation of the emotional satisfaction for midwives of delivering a mother whom she knows and has cared for. It also sharpens our understanding of the midwife's influence on the plane of being within which such relationships develop.

Each of the mothers is profiled in turn. Their profiles are also classified in Table 13.1 according to the analytic criteria detailed in Chapter 10, thus permitting comparative analysis between these special relationships and those referred to in Chapter 12.

Ann

A fourth time mother, middle class but living on a working class housing estate in poor financial circumstances. Her fourth baby had just been delivered by Anna at home and they had previously shared a domino delivery.

Ann's disposition centres on emotional connection between women. She is a feminist who finds in feminism an expression of her own disposition.

It's really difficult to define in a sentence. Just being aware of being a woman and what a woman's place is in various societies; how most societies are really patriarchal and they impose and position women. And being aware of that and having the confidence to work out what you want your position to be and sticking to that rather than just accepting what the society you live in says. [Ann]
She exists in an emotional plane, and acknowledges and respects the capacity to give to others. She describes childbearing as 'the most creative thing you can possibly do... Creating life is the ultimate. Art effort seems totally insignificant in comparison.'; statements indicating the emotional importance of the event with which midwives are associated.

Her orientation to midwives reflects this disposition. She associates male health professionals with domination and control. She speaks of the time she visited a consultant to obtain permission to give birth in the unit of her choice.

And he absolutely just tore my birth plan to pieces. He just put me down to all the students; about eight students gathered round, while I was lying on my back with my legs open. He didn't tell me to close my legs again. You know, 'Lie down, open your legs'; and then gathered his students around and immediately started reading out my birth plan. And he said, 'Are you a teacher or a journalist?... He was just so rude and arrogant in the way that middle class men are. I could have just slapped him round the face, and I was there having to get his permission so I just had to bite my tongue basically.' [Ann]

Subsequently her midwife asked her to write expressing her thanks to the consultant, 'so creepily I did; but I did it for other women, I didn't do it because I wanted to be nice to him.'

Midwifery, on the other hand, connects women emotionally. She implicitly associates midwifery with the support and affirmation she identifies in feminism.

I think Anna being a midwife and the fact that she's a radical midwife and that her whole style to midwifery was that of really caring about women; and from the feminist background I find that extremely supportive. [Ann]

So midwifery engages women in an emotional, intuitive plane and locates them in the same plane of being. Consistent with this, her orientation is towards the supportive
rather than the clinical or advisory aspect of midwifery: 'The supportive one, definitely.' Hers is an orientation which appreciates woman centred caring.

Engaged in this way, her relationships with Anna and her previous community midwife were emotionally very intense. She said to her first community midwife, 'It's amazing the strength of feeling I have for you.' She found saying goodbye extremely traumatic.

My mum was there and I didn't want her to be, she was in the way. And I kept trying to suggest she go and make cups of tea and things. And [first midwife] knew. I could barely talk and when I did my voice was all wobbly. I was just so full of emotion. And when I went to the door she gave me a huge hug and a real tight squeeze and a kiss and said that it was very special to her too...I actually bawled my eyes out after she'd gone...I just wept and wept and wept...and I just had to let it all out on my own. It was grieving...

[Ann]

Ann gave her a letter which told her how she felt. Her midwife called back and said, 'I've got that letter on my dressing table. It's the most beautiful letter anyone's ever written me. She said, 'I just read and reread it over and over again. It's absolutely lovely.'

A similar relationship developed with Anna. The relationship incorporates both Anna's own qualities of intimacy and sensitivity and Ann's appreciation of emotional giving and respect for midwifery skills. Asked to sum up how she felt about her she says,

I love her. I find her a really amazing person. She inspires me in a lot of ways. She gives so much tenderness and affection which you can't help but feel back for her. And as well as that I admire her professional skills as a midwife... Anna somehow inspires awe and confidence. [Ann]

She wrote a letter for Anna because
I wanted her to know that she'd made me feel really special, really wonderful. And I think that's a pretty marvellous trait in her personality. It's something that comes from her and the fact that she's prepared to give so much of herself that she can make me feel so special. And that deserves acknowledging. She also gave her a gift. Anna sent her a card thanking her for allowing her to be there for two wonderful deliveries. [Anna]

She refers to the importance of 'warmth and sensitivity and genuine interest and caring for other women... and babies.' She was also struck by her confidence and sensuality; both of these are characteristics of Anna also noted by others. The feeling she had is 'like when you first fall in love. A brand new relationship, so jittery.' And suggests that Anna's anticipated sabbatical influenced her decision to get pregnant.

I don't like to look too deeply into how much knowing that Anna was going to be leaving made me get pregnant so quickly. But I feel really positive about the fact that I managed to get back into regular contact with her again through the antenatal sessions. Because I needed that... it has helped me come to terms a lot with being so hung up on her. And I feel much more comfortable with her. But I think I needed this extended regular contact. [Anna]

Nonetheless, she still found saying goodbye very difficult and she 'felt really tearful'.

They now have a close friendship and are keeping in touch.

Claire

This was a domino delivery; ie. a delivery in the hospital by the community midwife. Claire is a second time mother, working class on an intuitive classification, otherwise middle class, who had experienced a traumatic first marriage in which she was physically and emotionally abused. She offers and appreciates emotional support through adversity. As she says, 'I think that a relationship grows with a crisis or with
an experience you go through with a friend.' She makes deep emotional connections with only a few people; in contrast to an easy sociability which she displays to all.

Consistent with this, she is oriented to the supportive aspect of midwifery. The doctor, being both a professional and a man, is remote from her and does not understand her; whereas Carol supports her unconditionally. 'Carol's seen me at my worse [in labour] and she still likes me; and that helps, that helps any relationship.' She does not have to be strong with Carol and notes 'there aren't many people you can feel like that.' So in this case the relationship coheres less through the sharing of intimacy than supporting and affirming someone through difficulty.

The delivery, and the midwife's role within it, is therefore the key emotional experience which forges this relationship as a special one. The relationship also operates at a social level; with Carol unusually open about her personal life, encouraged by Claire's practical allegiances and problems and her open disposition. At Claire's suggestion they are keeping in touch on a social basis. Carol's particular orientation is alluded to. Like one of her friends, Claire finds the relief midwife 'too perfect'; whereas, "Carol has got her problems. She did come in some days and her hair needed a brush. You felt, 'Oh I'm not the only one..."' Carol's loyalty, support and woman centredness also impressed itself upon the relationship: at one stage Carol volunteered to visit her at home because her blood pressure was rising and she knew Claire was very tired. She felt '... the relationship deepened and changed from the delivery, definitely... I think I trusted her more... She took me through it. She knew me better than I knew me through that labour... I was never frightened like I was with
the first one.' She felt the relationship was special and they are keeping in touch as they have developed an 'embryonic friendship'.

Esther

A middle class second time mother. Elizabeth assessed her in early labour at home, but Esther did not expect her to deliver her and was pleased and surprised to find when she arrived at hospital that Elizabeth had troubled to locate a relief midwife so that she could attend this delivery. Esther is a personnel manager and as with others similarly employed she makes a distinction between emotions as a 'commodity' and the real thing. This, together with a respect for competence and professionalism, is a persistent theme in her outlook. She is professionally attuned to the level of competence a professional displays, but also to the importance of 'that bit extra' which distinguishes competence from excellence. There were few references to emotionally profound connections with people, beyond noting that childbearing is 'such an emotional time' and that midwifery engages with that. Her orientation therefore anticipates more an appreciative than a special relationship, and reflects her disposition: she first mentions the importance of the clinical aspect of midwifery but concludes with 'the supportive'. She believes midwifery is emotionally engaged and sincere work.

Her specific experiences with Elizabeth and during labour illustrates these aspects. A persistent theme in her accounts of labour is the fear of abandonment and/ or conspiracy: her husband for example was a 'lying sod' for suggesting that the
contractions were five minutes apart rather than more frequent. She appreciated Elizabeth as someone who bridged that anxiety gap. She also appreciated that she gave 'that bit extra' and made the experience personal rather than merely professionally competent. It made a big and unexpected difference to her to have a familiar and trusted midwife deliver her. At first she had been relatively unconcerned when Elizabeth could not deliver her but adds, 'I hadn't had her then; I didn't know what a difference it would make.'

As I say, when she said she couldn't do it I thought, 'Well she can't do it' and that was it. I wanted to be getting on with it and get to the hospital and you feel you're ok then, they've got the painkillers there; I'll get there and I'll book my epidural. She actually said to me, 'Do you think you'll have an epidural this time?' and I said, 'Oh yes.' And when I got there I did feel entirely different, the fact that she was there and she'd taken the trouble to be there... I was really surprised and I was really pleased, obviously; it was nice to have a familiar face... I actually felt it was much more personal, the actual delivery was much more personal... It just made such a difference, somebody who knew me, knew what I'd been going through all day because I'd been in touch with her... She'd taken the trouble to be there.... She was keeping an eye, we weren't just abandoned. [Esther]

As with Claire there is the emphasis on Elizabeth's participation and personal familiarity with an important emotional event; weaving her into the fabric of the experience. However, it is not merely a matter of 'being there'; the quality of the experience is determined by the casting of the event within the context of an established and trusted relationship. She compares her feelings for the midwife who delivered the first baby (whom she did not know) and Elizabeth:

It was different... I was very grateful and very pleased... but that was that really... But this time with Elizabeth it was an immediate feeling that it was what Elizabeth had done... I felt from my point of view the whole thing was much more complete and tidy... she had made the difference... I've always found her a very pleasant person to deal with... with her I feel it's a very personal and special service you get... It's made quite a difference to me... It was a very personal relationship. [Esther]
Here we can see how the mother's experience emerges as a blend of the characteristics of both mother and midwife. Elizabeth is 'the perfect professional', with an emotional commitment, warmth and care for the women; characteristics which find expression in Esther's own sensitivity to 'that bit extra', a 'personal relationship' and a 'special service.' Note however that this relationship does not have the intimacy of Anna's relationship with Ann; rather, it orientates around respect and appreciation. This reflects Esther's outlook and Elizabeth's ultimate orientation to a professional role. There are no hints that the relationship developed into the open one characteristic of a developing friendship.

She and her husband were immensely grateful to Elizabeth and sent her flowers. She felt that they got 'quite close' to someone and remembers that last time she was 'very sorry' that there would be no reason for her to come in again. She remembers thinking, 'Well I shall have to have another baby' to have the contact with her again.

**Julia**

A middle class mother who was attended by Joanna from midway through the labour of her second child. Outwardly her disposition is pragmatic, sociable and proper. She respects competence and professionalism but also appreciates friendliness. Her sociable rather than emotional needs for people come over most obviously; she appears practical, pragmatic and supportive of others. There are hints of emotional suppression: it was not easy to draw her on emotional rather than sociable or supportive aspects of the relationship. But this conceals a high degree of emotional
sensitivity.

Her orientation includes some fixed preferences regarding the approach to delivery and maternity care; she wanted someone with a 'natural' approach to childbirth and happy to incorporate homeopathy into maternity care. It was important to her to have a midwife who respected her autonomy and her wishes. In addition she wanted someone she knew and who knew her and her medical history so that the delivery could be geared to individual rather than policy imperatives. This is the cornerstone of her orientation; to receive experienced and competent midwifery care centred on her right to realise her own preferences regarding childbearing. This dominates her orientation, with the social and personal preferences deriving from her disposition. She can therefore happily entertain an 'old school' midwife provided she is appropriately oriented. Emotional warmth and connection is second to this; but one met by meeting her orientational requirements. She was therefore content with a midwife in the past who is reputedly a 'difficult' character according to her colleagues and my experience because she enabled Julia to realise her own wishes. On the other hand she experienced another midwife as both directive and unfriendly and this was not acceptable. She does not mind a merely professional service but finds it nice to have friendliness as well. Her formal orientation reflects this: she says 'I suppose you've got to say the clinical and advice' are most important. Trusting their professional judgment is key and familiarity permits trust to grow in appropriate cases.

So her disposition is outgoing and sociable and this infuses an orientation which is relatively formal. The emotional aspect of her disposition remains relatively
understated. The specific relationship therefore bears the hallmarks of Joanna's orientation, towards peer friendships, since Julia would not presume or incorporate this herself even though she values friendly practitioners and comes over as friendly herself. She found her relationship with Joanna more open than with other midwives and preferred it 'because I knew her.' 'I never ever got to talking to Doreen about what she did out of hours; whereas with Joanna I know she likes theatre and she has a boyfriend up in Manchester.' Joanna was also an advocate for Julia during a complicated delivery, preventing the senior registrar from imposing a forceps, episiotomy and epidural on her. 'She very much included you.' Having her at the delivery made 'quite a lot' of difference although she feels the relationship would have developed that way anyway.

The 'outcomes' indicate an emotionally more intense connection than this narrative indicates; suggesting that emotionality is a suppressed but latent aspect of her disposition. She was 'dreading' saying goodbye to Joanna and says, 'I get very emotional; and that gets worse as you get older. Saying goodbye to anyone I find difficult... its just extra support and it's very hard to quantify.' 'It's just very personal I suppose. They see you at very vulnerable moments, probably making an exhibition of yourself.' Like Claire and Lucy (below) the intimacy derives from access to an emotional aspect usually hidden from view. Her sociable and practical disposition therefore has, in retrospect, a strongly emotional aspect. She gave her midwife a highly personalised gift; a painting she herself had created in a style she knew Joanna liked. She said 'I knew I'd be upset' at saying goodbye, but when the time came it was not so bad because she expects her to pop back. She feels Joanna 'could have been a
friend'.

Lucy

A middle class second time mother who knew Laura as an acquaintance because they both belong to the same choir. Her disposition is intellectual, emotionally reserved and withdrawn. She is normally controlled and a private person who reveals relatively little of her inner emotions. However, there is a strong emphasis in her talk on respect for the individual, and this is consistent with her strongly held religious beliefs. The first delivery had ended in a caesarian delivery and she felt one reason for this was that, 'I wasn't forming the relationships with the midwives.' She had friends who had had midwifery care from the 'Know your midwife' team in London and she had been impressed by how positive they were about their experiences and how well they appeared to be coping. When she was pregnant this time she approached Laura who offered to conduct the delivery, notwithstanding a previous caesarian section. Lucy's orientation on this occasion was greatly influenced both by her own previous negative experience and her friends' positive one. She 'definitely' valued the social support most. A strong emphasis on individualised, woman centred, supportive midwifery care therefore emerges in her orientation, together with an emphasis on natural childbirth. This engages a concealed emotional commitment in her disposition. As she says,

Originally, before I'd had Andrew I'd thought, 'I don't know that I want anyone around that I know,' because of what I might do. I don't know how I might react. Because I'm a reasonably controlled person... [But] having gone through it once and felt that I'd suffered the disadvantages of not knowing my midwife I was happy to change and have somebody that I knew. [Lucy]

She worried that she would feel self conscious being examined by somebody that she
knew but found that it enhanced rather than detracted from the relationship. The specific relationship therefore encouraged Lucy to lower her own boundaries, which she was willing to do because of her friends' and her own previous experiences. This made an intimate relationship and communication possible and an experience of midwifery centred around the woman and her wishes and needs. This is consistent with her disposition. Lucy also valued competence (a consistent theme with the 'special' mothers), caring and experience.

I felt from the little that I knew of her that she was very good and very caring and very very experienced; and I felt that I wanted much more of a 1:1 relationship...I felt the difference with Laura was that because she had got to know me as a person, by the time Peter arrived I could relate to her and could explain to her what I wanted. And she went much more with me...I felt she listened to what I wanted beforehand and went along with my wishes; because she understood them before we got there because we talked about it. [Lucy]

She felt she listened and wanted to hear and, 'I just felt that she cared... I was an individual to her, I was important to her, I wasn't just another on a line.' She felt Laura was instrumental in securing for her a relatively straightforward delivery from a relatively difficult labour (slow, baby having trouble descending, previous caesarian) and that her expertise helped avoid another episudal and caesarian. Asked what she most valued she said,

Oh definitely the social support; definitely her being there and being in control; and just the whole atmosphere that she gave the whole thing was the vital part for me... that made the whole thing very different and for me that much more special... It was a much nicer atmosphere; it was very personal, very intimate... [Lucy]

The social as well as the professional relationship deepened through sharing this experience.

I would say that I feel very close to her now; whereas she was an acquaintance before. I'm always very pleased to see her and feel it's something very special
between us; and feel that the whole relationship has been enhanced – because it went well and because I'm grateful for what she did. Because I do feel if it had been in other hands things would have gone differently... It's been good from my point of view because I shared it with her and it was a special experience for me. It's nice to have that contact with someone, to get the feedback about the birth afterwards, to be able to talk to someone about it. And I think for her too it was nice to share the experience of something going well... [Lucy]

So like Ann, Esther and Julia she stresses the value of ongoing contact after the delivery; in this as in most of the 'special' cases (Ann, Claire, Julia) extending into friendship. She goes on:

I would say now she's a friend in that she will drop in and there's mutual pleasure in seeing one another. It's not a case of, 'Right, that's all over, let's forget about it and get back to where we were before'; things have definitely changed. I would think now that she is a friend. [Lucy]

She and her husband sent her a card and helped her choose a car. 'We wanted to say thank you and we wanted to say you made it very special and we were very thrilled that you were there and able to join with us in that.'

Victoria

A fifth time mother, new to the area and experiencing a domino delivery for the first time. She has a balanced, pragmatic, practical and sociable disposition, similar to Julia. Like Julia, she also had an emotional disposition, but this was understated in the interview and tended to be apparent only in the 'outcome' measures. Her orientation was the most orthodox of all the 'special' mothers but still included an emphasis on natural childbirth, like Ann, Julia and Lucy. She turned mainly to the doctor for
medical advice and to verify what Veronica had said because she did not trust her emphasis on 'alternative' treatments. As she got to know her better her trust increased and increasingly she confided in her.

The specific relationships developed with her husband as much as with the particular midwife. Her husband had written birth reports for each of the deliveries and was always highly involved in the labours. This was the first labour in which the midwife was as important to Victoria as her husband was. The midwife and husband 'set up a mutual admiration society for each other.' This facilitated the relationship between mother and midwife. She found Veronica very sympathetic and encouraging and the relationship deepened, as with Camilla for example, in the early stages of labour when Veronica was popping in and out of the house to check on progress. They 'got very friendly' and 'we got very close'. Veronica 'made me feel as if I was so special'. She felt the relationship was important to Veronica too. She wished she had delivered them all and found saying goodbye 'quite sad'. 'Yes it was ever so sad and I think she was quite sad as well.' Veronica asked for a photograph of the baby. They are not keeping in touch however and Victoria finds the early termination of the relationship difficult, especially since she does not plan to have more children. She feels she got to know her as a person and that they discussed aspects of Veronica's biography. The delivery was a shared experience which deepened the relationship in a way which would not otherwise have been possible and that is not possible with a health visitor. She felt it was 'a lot more special' with Veronica than with any other midwife she had encountered.
The relationship therefore appears to draw on the emotionality latent in Victoria's disposition and explicit in Veronica's disposition; but the relatively formal and orthodox role definitions both have meant that it did not develop from an open professional/client relationship into a friendship. The intensity of the relationship appears to derive in part from the incorporation of an expressive and involved husband into the mother/midwife dyad. They gave Veronica a copy of the husband's birth report, which praised Veronica highly. Veronica commented that this relationship, though extremely satisfying, was not as close or special as that with Virginia, her colleague.

Discussion

So what do these examples indicate about the nature of 'special' relationships? Table 13.1 summarises the relationships using the analytic classification developed for the main sample of mothers.
Table 13.1 Summary Outlooks and Outcomes: 'Special' Sample

<table>
<thead>
<tr>
<th>Outlook</th>
<th>Ann</th>
<th>Claire</th>
<th>Est’er</th>
<th>Julia</th>
<th>Lucy</th>
<th>Vct’ia</th>
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<td>Soc</td>
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<td>Emot</td>
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<td>Definition</td>
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<td>Sup</td>
<td>Cl/S</td>
<td>CAS</td>
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<td>Insp</td>
<td>Id</td>
<td>App</td>
<td>A/C/F</td>
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<td>Importance</td>
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<tr>
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<tr>
<td>Go’bye/gift</td>
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<td>K</td>
<td>NK/G</td>
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Key:

App = Appreciative
C = Competence
Ce = Concealed emotionality
Clo = Closed
Emot = Emotional
G = Gift
Id = Identifies with
Int = Intellectual
NK = Not keeping in touch
Ort = Orthodox
Soc = Social
Sinc = Sincerity
--- = Data unavailable

A = Autonomy
CAS = Clinical, advisory and Supportive
Cl = Clinical
Eng = Engaged
F = Friendly
Hi = High
Insp = Inspired
K = keeping in touch
Op = Open
Pra = Practical
Sup/S = Supportive
W/h = withheld

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There are six significant indications. Firstly, each mother had an emotionally attuned disposition; although in the case of three of them (Julia, Lucy, Victoria) emotionality was concealed beneath less emotionally intense sociability. Other indications, for example, class are variable as in the sample analysed in Chapter 11. Secondly, no one had an instrumental orientation; again confirming the incompatibility of an instrumental outlook and a special relationship. Thirdly, the women have consistently similar orientations and the relationship consistently similar outcomes, as indicated by the mother. Each woman was oriented to the supportive aspect of community midwifery practice; usually as part of their formal orientation but in two cases (Julia and Victoria) subcognitively and diffusely through an appreciation of 'friendliness'. Each valued the woman centredness of the midwife's approach and each experienced the relationship as both important and special. With the exception of one (Esther) each relationship was open and fanned out (ie. deepened and broadened) into an emotionally important friendship; although one with distinctive characteristics. In four of the six cases the parties are keeping in touch and in the remaining two cases the mothers indicated a strong wish for the relationship to continue. Each woman found saying goodbye very difficult; this was mitigated only by the possibility of continued contact. Five of the six mothers gave a gift as a symbol of her appreciation. (Data is unavailable on this point from Claire).

Fourthly, each woman had a community delivery; providing an important shared experience which deepened the relationship. Only Julia felt that the relationship could have achieved the same depth without it; and this reflects her pragmatism. Taken together this means that each woman felt a sense of mutual emotional connection with
her midwife, enhanced by the sharing of a profound emotional event, childbirth. Each was also a second time or subsequent mother because a community delivery was not available to first time mothers in this DHA; although most of these mothers point out that the support and familiarity of a community midwife is even more important for a first time mother, notwithstanding 'team' midwifery.

Fifthly, notwithstanding the consistency of the outlooks and 'outcome' measures, the relationships were unique and blended. As with the main sample, each bore the hallmarks of the midwife's own outlook, and this defined the relationship's plane of being. Anna's was oriented towards intimacy, Carol's towards solidarity, Elizabeth's towards dedicated professionalism and Joanna's towards peer friendship. Veronica's relationship was more open than one would expect, but had the affection and dedication associated with her disposition, and the abrupt termination characteristic of her orthodox role definition. Laura's relationship was assisted by the weaving of the midwifery relationship within an ongoing social relationship, overcoming her tendency to emotional disengagement at the time to the research.

Finally, many of the women (Ann, Claire, Esther, Julia and Lucy) valued the professionalism, competence and experience of the midwife. In some cases this reproduced the schisms of a 'professional' outlook elaborated in Chapters 2 and 3. The outlooks of Julia and Esther reflect their struggle to incorporate a 'professional' perspective into a personal one. But others, for example, Ann, conceptualise professionalism differently. As she says,

A professional conjures up a completely different idea to someone who is professional. A professional is... something very objective... but I would
describe Anna as very professional... that they're confident, very adept at doing their particular job and they do it conscientiously and with thorough knowledge. [Ann]

This is a perspective which reconceptualises professionalism within the personal paradigm. It forges an alternative conceptualisation devoid of the dichotomies, objectifications, hierarchies and emotional denials which characterise the professional paradigm.

It is worth noting that these were not invariably 'easy' deliveries. Ann and Claire had relatively straightforward deliveries but Esther had to overcome fear, Julia had an undiagnosed breech delivery, Lucy a previous caesarian and a baby who was not descending on this occasion, and Victoria an accelerated labour nonetheless proceeding slowly. Neither is it a simple matching of middle class mothers with middle class women or of attitudinal similarity, for example, in favour of natural childbirth. While each of these tendencies exist (for example, both mothers and midwives were predominantly middle class), this was not necessarily the basis of the relationship. The most intimate relationship for example (between Anna and Ann) was forged despite social differences. And while there was an undoubted tendency in favour of natural childbirth, and a marked preference in some cases (Ann and Julia) for non interventionism, this was more the consequence than the cause of a successful community delivery. Esther, for example, confidently expected to have an epidural on arrival at hospital, until she realised her community midwife was there to deliver her. Victoria was suspicious of the alternative approaches favoured by Veronica.

The key aspect was the development of an emotionally invested, supportive, woman
centred relationship, sometimes running contrary to the midwife's orientation; facilitating an experience in which the woman felt involved, at centre stage and secure and in which mother and midwife were perceived in the same plane of being. This corresponds closely to the findings elaborated in Chapters 11 and 12 about the nature of special relationships.

Part Six of the thesis considers the distinctive aspects of the community midwife's role; the sociocultural conditions within which such relationships may develop.
Note

1. In principle, such data can be gathered postnatally even in the analysed sample examined in Chapters 10–12 and still be valid, just as information can be gathered about specific relationships in the antenatal interview.
Part Six

The Role of the

Community Midwife
Overview

It's got to help being a woman, I think that's got to help. It's something that's very important to that woman, is that she's pregnant, the most important thing in the whole of their life, to most of them anyway... They'll want to do everything right. We're there to give them that advice, to let them hear the heartbeat, to tell them what position their baby's in – therefore I think getting them closer – it gets me closer to the baby, having a palpate and saying, 'Oh here's this baby's little legs' and things. I'm not just feeling the position, I'm trying to get to know this baby. They've got someone to chat to, they've got someone to come to regularly, they know where you are, they know how to get hold of you, and that's half of it – they don't ever ring you but they know you're around. You build up a friendship with them – you've got more in common because you know a lot about what they're going through... It's a more realistic setting; you're at a surgery or you're at their house, they're not sitting in a great big clinic waiting to be seen by a stranger each week. It's continuity. And I guess you just get to know each other's personalities a little bit more. [Joanna. My emphasis]

It's very intimate. It's a very intimate part of your life anyway. And I think probably opening up your worries and fears. It's such a short – you see them for five minutes don't you, prior to really going in your own home, plus the alternate visits normally, and it's in a very clinical setting; so it's not the sort of place you'd normally have a friendship as such. And yet they're going to come into your home the week after you've had a baby when you're very very vulnerable emotionally and physically... So I think that it's probably that you are more you than ever. You haven't got your usual make up and barriers...In the community it's different again because it is in your own home. So they are seeing you in the raw a lot more; because it's your personality stamped all over your home. [Judy]

Part Five of the thesis developed a typology of mother/community midwife relationships. Part Six addresses itself to the broader issue of what is distinctive about the community midwife's role, rather than 'special' about the relationship. It therefore has a broader sociocultural focus than Part Five, and presents an ideal type of the community midwife's role, in order analytically to establish what is distinctive about it.

The analysis draws predominantly on the observations and experiences of the mothers,
and is grounded in their viewpoints. Midwives' comments have been added where this would complement or illustrate the analysis. I have, however, attempted to indicate sources and degrees of variability in responses where this arises in the data; and I identify quotations in a way which permits cross reference to the analysis of variability in the preceding chapters.

I divide the relationship into three aspects, the '3R's': the Relationship, Role and Real social context respectively. I suggest that women seek an intimate, emotionally supportive personal relationship in the same plane of being with their community midwives. The relationship that women seek to forge therefore stands in direct opposition to that conceptualised within the professional paradigm. This in turn provides the basis for the distinctive Role of the community midwife. I compare and contrast the role of the midwife, GP and health visitor, as experienced by the women in the sample. I suggest that it is the psychosocial emphasis of community midwifery which marks it as distinctive. I go on to consider midwives' 'ways of being' and 'ways of knowing' within that orientation. Finally, I consider the 'Real' social context of community midwifery, and compare this with other social locations such as the hospital. I suggest that the community context is situationally appropriate to the role of the midwife and to the needs of their clients; situating community midwives at the heart of women's needs and experiences. These three aspects mark the distinctive characteristics of the community midwife's role and makes possible a qualitatively different experience from that available from other sources.¹

So the essence of the role of the community midwife is that she is a close, intimate
and enduring supporter; possessing a social situation (close to the woman), a set of professional skills (midwifery) and a role orientation (psychosocial) nearer to the totality of the woman's experience than almost any other person, including in many cases her partner. The midwife is the hourglass of women's childbearing experiences.
Chapter Fourteen

A Personal Relationship
PAGE

NUMBERING

AS ORIGINAL
Childbirth is, to most women, a major social and emotional experience.

It is a tremendous thing, the most important thing that happens in a woman's life is becoming a mother; more important perhaps even to a woman than to a man. Because it doesn't change him to such an extent; he doesn't physically give birth. However much he might want to be involved and be a part of it, he doesn't have to. And the person who's with you at that time is very important. I mean I can remember my own midwife clearly to this day and I thought she was wonderful. [Elizabeth]

I think it's a time when your emotions are so raw that you're very open, very receptive...very trusting. You want to talk, you want to have an intimate relationship I think. [Anna]

They play quite an important role in your life at a time when you're feel a bit vulnerable and you treasure the input that they've had. [Camilla]

So childbirth is an important life event, fundamentally changing women's physical, social and emotional experiences and identities; and this inclines them to seek personal support. The person who supports them assumes social and emotional importance. The extracts convey the emotional magnitude, the 'specialness', of the experience. Midwives are centrally implicated in an important, intimate and emotionally intense life experience.

Women's relationships with their community midwives develop within this emotional context. The community midwife is in most cases the woman's principal professional caregiver. So women seek an emotionally supportive personal relationship with her. Integral to the relationship is sociability, defined by Bologh as follows:

By sociability I mean a relationship in which the presence of one makes a pleasurable difference to, affects, the other. Each party considers the other not an object to be used or avoided as in the patriarchal model of social life as conflict but a subject whose active presence affects one's senses, brings pleasure (or displeasure), a subject with power to affect my senses and my feelings in a positive way... Emotional interest, physical, sensual or aesthetic interest, intellectual interest, or explicitly sexual interest, or all of these may be aroused by another. [Bologh 1989:213, author's emphasis]
Sociability has social and emotional dimensions within the mother/community midwife relationship, each operative within the personal paradigm. Sociability at a social level has three main dimensions. Firstly, sociability complements the psychosocial role of the midwife. Mothers, whatever their orientation, engage community midwives socially. This enhances the psychosocial dimension of the relationship and allows some reciprocity, but within safe limits which do not onerously burden the mother. Sociability in this sense also anchors the relationship more firmly within psychosocial reality. Secondly, sociability, incorporated within the personal paradigm, includes ways of being and knowing appropriate to the mother's priorities, perspective and experience. The person, biography, sensibility and 'cultural qualifications' of the midwife become central to her role and expertise, and the midwife knows the mother subjectively. Finally, sociability evidences an emotional deepening of the relationship. This I have termed the 'fanning out' of the relationship. Here the social and emotional dimensions of sociability are most closely intertwined. As the relationship deepens emotionally on the mother's side, so she seeks to incorporate the midwife more fully and personally into the relationship; to know her as a person. As it deepens emotionally, so it broadens out socially.

At an emotional level, the relationship centres on sharing; firstly, of an important and 'special' life event, and secondly of a deep emotional experience, be it joyous, such as the birth of a baby, or traumatic, such as a perinatal death. These two elements, the social and the emotional, are interwoven. Together they reinforce the personal character of the relationship and situate mother and midwife in a woman centred relationship in the same plane of being. This is enhanced by the midwife's role and
social location in the community.

This chapter deals with each of these aspects of sociability and emotionality and concludes by considering similarities and dissimilarities between the personal relationship thus depicted and women's friendships relationships.

Sociability as Social Connection

Personal Aspects of Midwifery Practice

Midwives sometimes comment with some surprise that mothers want to know about them as a person. But, as Anna observes, it is a way of incorporating the midwife into the relationship as a person in her own right.

...they'll talk about it generally, ask me about my children. And they're interested in the photo which I've got there [of her children, pinned to her diary]. I think it's part in a way of introducing yourself as a person, isn't it; not me saying, 'Look here I am' but me saying, 'Look here are my children.' It can relate a little bit quicker to you perhaps. [Anna]

Some women were unable to distinguish the characters of the different midwives, but this was unusual. Most women drew clear and appropriate distinctions between them. Whatever their orientation, women sought to incorporate the midwife into the relationship in this way. Most women wanted to know whether the midwife has children. Others asked questions appropriate to the midwife they encountered; asking Joanna about her boyfriends and Carol and Laura about their days off, holidays and hobbies. They also enquired about midwifery, including details of rotas and visits; the
demands of the job, for example being called out at night and being on call; and
genral chat such as what has been on TV. Some mothers also take the opportunity
to know of other women's experiences through the midwife.

Such sociability exists whatever the orientation of the woman. It enhances the
psychosocial aspect of the relationship and introduces an element of reciprocity which
would otherwise be missing. But observational data suggests that sociable exchanges
arise in characteristically different ways, depending on the state of development of the
particular relationship. In less familiar relationships, they occurred at the beginning
and end of the encounter. In more familiar and established relationships, on the other
hand, social exchanges arose throughout the session.

On one occasion, for example, Carol visited a woman she had met only once before
and who had a deferent, clinical orientation. The social dynamic was amicable but
formal. Carol was sympathetic and sociable because the woman was working class,
and she drew herself into the family by engaging the children. The social initiatives
came from Carol until we were about to leave when the woman suddenly struck up
a conversation, asking:

M: Have you got many more to go?
Mw: Another five I think.
M: Any clinics?
Mw: An antenatal clinic and a booking clinic. [Extract from field notes]

This woman developed the relationship by empathising with the practical concerns and
workload of the midwife; consistent with her material situation (the mother of five
children under seven on a low income) and also with Carol's own orientation.

The mark of a developing relationship is the extent to which such exchanges extend into the clinical space. One relationship involving Anna was at an intermediate stage between a formally and a personal defined relationship. In this case the communication process was open and the talk ranged beyond the clinical to other role appropriate subjects, such as other midwives and other babies. Mutual jokes extended the relationship further. But the personal detail was exchanged at either end of the meeting. This punctuated sociability indicated it was still a semi formal relationship, despite its informal and jovial tone.

An open, personal relationship which has 'fanned out' does not have this abrupt social element; the social, personal and professional are blended into the clinical space. One such occasion was a visit to a woman who had the previous night been attended by Anna at a home birth. When we arrived they hugged each other. Anna said little during the routine examinations, but it was an easy, not an awkward silence. But the mother needed to relive her experience. She told Anna that the room would never be the same again; how she felt 'very old' in the night; how she was glad she liked the baby — she had not liked the feel of its foot in the womb. Anna, knowing the mother, and having been there, could share and enhance the reliving experience. She observed, 'Your delight was just immediate.'

They resumed ongoing discussions of Anna's personal life, not consigned to the extremities of the clinical session but blended into the heart of it. Anna's daughter had
just passed her driving test. The mother, empathising, observed: 'You got in and congratulated your daughter who was very pleased ...' The talk switched spontaneously to discussion of the labour; why she had 'niggled' the previous day, why she had felt antagonised by the second midwife, why Anna had been irritated with the GP for talking through the contractions. Anna lifted the baby from the moses basked, wished her 'Good morning', washed her, then cuddled her for a full five minutes, silently marvelling at her. She too began to relive the birth experience. 'She's big ...I could see she was big from her head when it was coming out... But she came out in a great rush.' She said the baby was slightly jaundiced, then pointed out a 'little mark' by her ear; adding, comfortably, 'A lot of people do -I've got a little mark...' She showed her and explained how her own daughter had had a little hole there.

Without asking the mother, Anna gave me the baby to cuddle, adding, 'I bet it's been a long time since you held such a young baby'; thus incorporating me into the sharing experience. Taking our leave, she informed the children who had now joined us, 'We'd better go ...and see some more babies.' These are the drifts of a blended encounter, the mark of a relationship which was 'special'.

So women seek to enhance the social aspect of the relationship. It accentuates the psychosocial dimension of the relationship and restores parity. It connects mother and midwife through their social identities and gives them 'something in common' to overcome social inhibitions. In this way the midwife is incorporated 'as a person' into the relationship, cast in the same plane of being; in contrast to the professional paradigm which dissociates them.
Cultural Qualifications and Personal Expertise

Sociability, set within the personal paradigm, also prioritises aspects of knowledge and expertise important to mothers but overlooked within the professional paradigm. Unlike the integrative function of sociability, addressed above, and the symptomatic development of sociability, outlined below, each of which signals something beyond itself, sociability in this second sense values the midwife's biography and sensibility instrumentally; for what it adds to the midwife's skill and understanding. I will consider cultural qualifications first and 'ways of being' and 'ways of knowing' second.

Cultural Qualifications

A cultural qualification is a form of expertise or understanding acquired experientially in the course of a midwife's personal life, which enhances the quality and effectiveness of her professional work. This is a source of knowledge and understanding relevant and appropriate to childbirth; overwhelmingly immediate, vital, emotional and bodily based, and only secondarily cerebral, abstract, rational or detached.

Cultural qualifications are valued because, at their best, they develop in the midwife a capacity for empathic understanding and encourage greater sensitivity to feeling.

R: [What relevance do your own experiences have?]
Mw: You can understand it can't you, how they feel. Apparently you shouldn't...put your own experiences over. It's bound to make you more sensitive to how a person's feeling. It makes them more comfortable... They say they feel more comfortable knowing I've had children. [Anna, my emphasis]
Two cultural qualifications were explored in this study: the importance of being a woman and a mother respectively. The former is difficult to discuss in academic circles because it lays one open to the charge of essentialism. Moreover, it was not a cultural qualification which mattered to me when I had my children. But 'being a woman' raised a lot of spontaneous comment in the interviews. It was explored both directly and indirectly (through an exploration of the cultural disqualification of being a man).

Mothers and midwives felt that 'being a woman' was helpful to midwives in three ways. Firstly, direct personal experience of menstruation, tender breasts, hormonal fluctuations and so on improve her understanding of women's health issues. Direct experience informs in a way which abstract knowledge cannot and this improves understanding.

...I do feel that midwifery is a job that is exclusively suited to women. I think women understand, even if they haven't had children, they understand about menstruation, tender breasts, thrush, internal examinations... and stuff like that, you know, just about being a woman. I know I've heard all the arguments and I'm sure that there are some particularly sensitive men but it's interesting that although men can train as midwives the uptake is very slow; not many men want to do it. [Elizabeth]

Yes, definitely, because of our emotional fluctuations due to hormones which men don't experience and don't understand. He never cries for no reason. They don't feel it and understand it whereas another woman does. [Camilla, my emphasis]

Secondly, gender creates a social identity and understanding between women, which in turn facilitates easier and more open communication. Valerie, for example, notes the importance of hearing a woman's voice during labour.
This is important for me because of the way I remember hearing their voices; that the women's voices were so calming and got through everything. [Valerie]

In addition, it fosters better empathic understanding. Women are also associated with greater caring, support and intimacy.

I think if you go through the centuries you'd probably find it's always been like this... Probably most cultures, or primitive cultures, had a group of women there... I think in a way we've gone too far the other way, with a lot of the situations where it's all very hi-tech; she's got hardly anybody to comfort her. Her body is almost taken away really in some cultures, Canadian and American. [Anna, my emphasis]

Finally, a number of women preferred women for intimate examinations. However, this was more commonly expressed as an aversion to men conducting such examinations and so is analysed below in the subsection dealing with men.

Not all women felt gender important in these ways. Carol and Louise agreed that women understand each other better but felt this gave rise, in some cases, to an unsympathetic approach. That is, there is understanding but not compassion, and there may even be sadism. Examples cited in the fieldwork (not involving these midwives) included a case where a woman's abdomen was drawn on, another was slapped, another's hair was pulled and others were reprimanded. Anna refers to some midwives' readiness to defeat a woman's wishes regarding labour by intervening or giving the mother false information. These caveats defeat essentialist arguments about gender but do not invalidate the general point.

In practice, comments about being a woman were often subsumed beneath comments about being a mother. The cultural disqualification of being a man attracted more
direct comment than being a woman. Most women, 62% (15/24), would accept or be open minded about having a male midwife, but only 4/24, or 16% do so without qualification. That is, only 1 in 6 women accepted the prospect without further comment; and when comments about motherhood are taken into account, the figure falls to one respondent, Vivien. Reasons for accepting a male midwife centre on abstract, impersonal criteria, precisely those which mothers underemphasise in the personal paradigm. Reasons include: they are qualified; they are like a doctor; it depends on the person; and it's just their job.

The vast majority, 86% (19/22) of those responded who commented, had some objection or reservation. The objections centred around four themes: mothers could not have the same intimate relationship with a man; men are less understanding; women feel less relaxed with men; and men are positively offputting. The following quotations illustrate each of these themes.

If she came in and I was in the bath for example, I wouldn't feel inhibited. But I think if some chap walked in and I was in the bath I'd get out pretty quick. It's just the way we've been brought up, it's totally ridiculous. If he'd delivered the baby it might be different but I'm not convinced really. [Virginia]

I don't feel that a male midwife would have understood that I was feeling that much pain... and I just feel that a man, however nice they are, wouldn't have given me the same kind of sympathy as a woman. Maybe they would, and maybe that's unfair, but I don't know I would have burst into tears so much with a man...because I wouldn't have felt as if I could have been so free emotionally. [Judy]

Your modesty comes back after having the baby... when [Paula] came round...I'd had a very big clot in my pad and it was very big and I was quite worried about it. So I kept it for her, for when she was coming the next day. I wouldn't have done that if it was a man, no way... If you're not going to be able to talk to the person about your problems, what's the point? [Christine]

It's stupid because I showed my body to James but I don't know... I don't like other men touching my body. I still creep a little when Dr Smith does it... I
much prefer a woman to a man. [Jill]

Notwithstanding their open minded comments, it is clear that the mother/community midwife relationship is strongly gender based in favour of women, making the idea of a male midwife unwelcome, at least in principle, to the vast majority.5

Women were more consistent about motherhood as a cultural qualification? Nearly half, 45% (9/20), felt that it made no difference to midwifery, or felt there were other more important qualities, such as experience or gender. Two thirds of these women added no qualifying remark, compared to only 27% on the issue of male midwives. Only one woman, Vivien, accepted the idea of male midwives without drawing attention to an incompatible cultural qualification, motherhood, which she valued.

Most women, 70% (14/20) of respondents, felt that motherhood did make a difference; making the relationship closer, the advice more appropriate, improving understanding, and creating a bond from shared experience. The extracts cited below illustrate each of these themes.

...when all is said and done it's a unique experience for a woman... and really and truly unless you have been through it you cannot share it with anybody else. [Amanda]

To find out your midwife is actually a parent and has been through birth themselves is quite important...I feel some midwives who haven't, can be - they knew everything sort of clinically and by the book, understandably... [Camilla]

Like Elizabeth is a mum, she's been through it all herself anyway hasn't she; I think she's got two children hasn't she? So I think it's nice because they do know what you're going through, they do know how you feel... [Elaine]

There are a lot of midwives in there [hospital] now with children of their
Cultural qualifications are no guarantee of a sensitive approach or a special relationship. Indeed, sociability in this sense may be in tension with the integrative and symptomatic dimensions; as in the case of Lydia, who felt motherhood would make a positive difference to midwifery practice but reconsidered when she realised that the personal relationship she was forming was with a midwife who had no children. Other women point out that professional experience, coupled with a supportive role, can compensate for the absence of cultural qualifications. Overall, it appears that women are seeking 'informed support' and associate cultural qualifications with such support. An experienced supportive professional may learn from other sources. But there is no suggestion in the data that the latter is a substitute, but rather a compensation; and the cultural qualifications of womanhood and motherhood, and the cultural disqualification of manhood, therefore emerge as highly significant to the meaning of the relationship.

Ways of Being and Ways of Knowing

Sociability within the personal paradigm highlights aspects of midwifery practice obscured or diminished within the professional paradigm. These centre around the midwife's ways of being and knowing respectively (Stanley & Wise 1990). I outline some of these sources of expertise and go on to use a practice issue, the use of black silk as a suture material, to exemplify the epistemic challenges that the personal paradigm poses for the professional.
A woman centred orientation requires receptivity and readiness in the midwife. Assuming this exists, how does the midwife 'know'? Midwives mentioned six particular ways of knowing and all facilitate a way of knowing mothers subjectively: personal and professional experience; intuition and empathy, (including listening, imagining, understanding, appreciating relevant information, engagement in the same plane of being and talking through experiences); close attention to sensory information, (especially touch, direct experience (rather than abstraction) and close observation); a close relationship; personal commitment; and an appropriate working environment and conditions.

From this perspective, the midwife's main resource is direct, proximate experience of childbearing women. Experience inclines the midwife away from exclusive emphasis on clinical outcomes, and a preoccupation with personal needs and performance, towards greater emphatic concern for the experience of the mother and greater relational awareness.

Experience is acquired and transmitted through the sensory, cognitive and emotional skills of the midwife. She uses all of her senses, including her 'sixth sense' of intuition, to get as close to the woman as she can. This is only possible when a close and trusting relationship exists; and this in turn depends upon the midwife's personal commitment, biography and relational skills.

The extracts overleaf illustrate each of these aspects.
...when you're an experienced midwife you don't have to concentrate on the delivery and you're much more concerned with how you're managing and coping with the labour with the woman; whereas we seem to be focused on the delivery... [Veronica's student midwife]

It's very much a 'hands on' job, midwifery; and although the textbook can say, 'The baby's in such and such a position', when you've actually got two fingers in a vagina, how do you know what such and such a position is? [Carol]

...you can tell even when she feels your tummy, just through someone's hand you can feel their confidence. [Alexandra]

Well I think you use all your senses. I mean you can tell when a woman walks through the door at the antenatal clinic more or less how she is... You can just tell how they look, whether they look at you or not, whether they seem happy. I feel I am quite good at that because I can say to somebody 'How are you?' and they'll say 'Oh fine' and you'll sit down and look at them. And that's important, that you sit down and you don't pick your pen up and start writing, that you do sit and keep your hands still and say — ... and out it all comes; and they'll dissolve into tears and I think 'Well that's ok, you know, let them let it out'. When you go into people's houses in particular you get a sense of how things are, relationships between the partner, her in-laws, whatever help they've got organised, there are children, and you can see how they're coping. [Elizabeth]

... afterwards we'd had a giggle about it. Carol teased Theresa [student midwife] because a few times she wasn't quite alert enough to notice — obviously because she's learning. Whereas even though you didn't sense it Carol was obviously watching it all the time, even though I didn't feel watched; and she would suddenly nudge Theresa and say, 'She wants the gas.'... It was all nice and relaxed, which I think was nice for Theresa too. [Camilla]

I had this uneasy feeling that I couldn’t be a proper nurse unless I could deliver a baby which would make midwives howl to hear me say it now, but that is how I felt at the time... I decided I would quite like to see a baby born, this is how I got into midwifery... I was allowed to go down to the GP unit and see this lady having her first baby. And I was really lucky because the midwife looking after her was a lovely midwife who was very calm and very quiet... It was just the most fantastic thing; it was so peaceful. I thought everybody would be rushing around with hot water... I thought it would be very dramatic and rushed and of course it wasn't like that at all. It was slow and peaceful. She seemed to almost deliver this baby in slow motion and she knew exactly what to do... I just went on from there. [Elizabeth]

M: I was listening mostly...I think I had my eyes shut mostly. But her voice, hers and, it's funny, and Sarah's. Something about listening to the two female voices talking very softly and calmly about something
very mundane was really good, it was really reassuring.

R: What was it about them being female voices?

M: I don't know but it was, because the doctor's sort of did the opposite for me. I don't know, it was a different tone. It was quieter, it was more comforting.

R: Theirs was quieter?

M: Yes... He came in at roughly the same time as Sarah and I can remember hearing him saying things like, 'You mustn't do it that way, you must do it that way... And I was feeling quite cross with him. I don't think I said anything but I was feeling quite cross with him. And then almost immediately Pam was saying, 'You're doing really well; try such and such.' And it was a different emphasis that made it much easier to do what she was saying whereas I ignored what he was saying. [Valerie]

I've learnt very much from observing the experienced midwife. With regards to the pain relief I remember when I was out with Anna and I remember her saying when she does deliveries, 'Oh I haven't used pethidine for so many years.' And frankly I didn't believe her. I thought, 'Oh goodness, those ladies must have needed it.' And I couldn't believe it, the difference that it made. Because of your training and all this talk about pain relief in labour. But when you actually see it in action, when you see an experienced midwife with the mother, and that relationship they have together; and it just works, it just absolutely works. If the mother knows the midwife and trusts her she doesn't need it, she doesn't need it, and I've seen it working. And an experienced midwife can judge that and you can't learn that out of textbooks. We learn through observing... [Veronica's student midwife]

...and I think one of the things, again coming back to being on the community, is having the time to listen to people and talk through their experiences with them; and it's amazing what you learn from just talking to somebody about their labour. And I think it makes you understand a lot more. [Carol]

Yes, women tend to be very interested in midwifery. They like to hear about other people's experiences and stories and that they're not actually alone in feeling as they do... [Carol]

But I cannot be detached and I think my practice would suffer greatly if I tried to be like that; I would lose far more, or the women I look after would lose far more, than they'd gain, if I did it from a distance and tried to do it 9–5... The telephone calls can be a nuisance; sometimes when you're off duty you do just want to be away from it. But once I pick up the telephone to speak to people I revert back into my professional role and I can't be off hand with them. Tara [her daughter] will say, 'Well she is in fact off duty, but I will get her for you'... And then I get on the phone and I'm warm and nice and she's 'For God's sake, mother.' And I recognise what she's saying but if you like I have chosen to be that way. [Elizabeth]
The personal paradigm does not entail the substitution of one dualistic perspective for another but it does reveal tensions between the two perspectives. Given the dominance of the professional paradigm in midwifery research, the increasing professionalisation of midwifery, and the epistemic preferences for formal research knowledge, especially evaluative research employing the RCT method, this enshrines, it is worth considering these tensions in relation to an actual practice issue.

Randomised Controlled Trial research suggests that black silk is no more effective a suture material than dissolving sutures. A review of the research evidence suggests that practitioners' continued preference for black silk may reflect ease of administration rather than greater comfort for the patient.

Absorbable sutures (Dexon) have been compared with non absorbable skin sutures (silk, nylon or Supramid) in six controlled trials. The groups repaired with absorbable sutures generally had less pain and used less analgesia in the first few days after delivery. No clear effects have been noted on long term morbidity.... The handling properties of silk...are probably the best of all suture materials, and it knots easily and securely. These latter characteristics almost certainly explain silk's continuing popularity for perineal repair, despite the fact that it results in increased discomfort. (Enkin et al 1990:242)

The authors recommend that the practice of using black silk should be abandoned in the light of the available research evidence (ibid:364). They also make the important point that the technique and skill of the individual operator are as if not more important than the suture material used; but significantly, individual skills are less researched, since they are not easily amenable to RCT analysis.

As Oakley notes, formal and academic knowledge represents a masculinisation of what
some of us may already know; creating specialisms and expertise which serve hierarchical purposes (Oakley 1992:Ch.12). Moreover, formal knowledge may actually clash with experiential knowledge; creating competing knowledge bases based on logic and empirical experience respectively. In this light, it is worth considering women's experiences of suture materials. It has been pointed out to me, not least by a senior midwifery manager, that women's preference for black silk sutures is misguided because they compare, in effect, more serious with less serious perineal trauma and attribute the reduced discomfort to the suture materials rather than the level of trauma. Nonetheless, black silk was a popular suture material with those women who had experience of it; a preference shared by the majority of community midwives. This includes one woman, Jenny, who tore worse on the occasion when she was sutured with black silk; indicating that the 'degree of trauma' argument is not conclusive. I asked Jenny whether the second, more severe tear, stitched with black silk, was more uncomfortable.

M: No, it wasn't. I could sit down more easily. I don't know why because there was more this time and they went right round to the back. So I thought it would have been far worse. It was really uncomfortable when I coughed.
R: ... A lot of people say it's a lot more comfortable.
M: Yes, that's what the chap that stitched me up said, that it's softer or something isn't it? [Jenny]

This preference was borne out by other women's experiences.

R: What sort of stitches do you want if you have stitches?
M: Oh silk stitches, I've had them with him and my second. And there you didn't even know they were there... It's just a totally different ballgame that was... I didn't get on with that catgut. I mean it was alright at first and then it started to heal, it was like sitting on barbed wire. And Laura said, 'Oh we'll have those out,' and as soon as she did something about it it was alright... Oh far more comfortable... That was one thing I was quite sure on... [Lydia]

Virginia also found black silk
... absolutely fantastic... You can't feel them you see, that's the good thing about it... I just think they're wonderful. [Virginia]

These experiences are affirmed by most of the midwives.

I read an interesting article in MIDIRS the other week about perineal trauma and about suture materials, and they were saying, this article said that black silk is absolutely out – you know we used to use black silk in the past– and they are more painful and if anybody is routinely removing perineal sutures then they ought to look at their practice. Now if I have a woman who has had a broken down perineum the first time round I will tell her, 'If you need stitches the next time round, when they're stitching tell them, ask them to put black silk in.' They heal so much better, it is more comfortable, you don't seem – some women react to cat gut – and the insertion points begin to look sloughy and if it starts to break down I just take out every bit of cat gut I can see, because it's going to aggravate the infection and inhibit the healing process. And I didn't agree with this article. And here it was in MIDIRS. And funnily enough I had a lady, I didn't deliver her... and she had an awful perineum the first time... I said to her about the black silk and... she said 'It's so much more comfortable', and healed beautifully... [Elizabeth]

They're more comfortable for mums to sit on; and usually you don't have a reaction set up to the black silk which you do to the catgut. You get these awful sloughy holes with the catgut around the area, which often responds well once you just take the stitches out. [Laura]

Virginia reports that Veronica 'loves' black silk. Carol and Joanna also report black silk is preferable because women find it more comfortable to sit on. Both midwives also referred to the difficulty of removing continuous subcuticular stitches if they were causing problems. Anna felt that black silk helps perineums to heal well but did not appear to have an overall preference.

Data validated within the personal paradigm therefore suggests at the very least that there are circumstances in which black silk is experienced as more comfortable and that this is worthy of further investigation, notwithstanding formal knowledge to the contrary.
Sociability as an Indicator of Intimacy

Sociability in the third sense signals an increasing emotional depth to the relationship. As the relationship deepens emotionally on the mother's part, so it 'fans out' socially, extending beyond the boundaries of the midwifery role and incorporating the midwife into the relationship in a wider social context. As it deepens emotionally, so it broadens socially. The mark of a developing relationship is the extent to which the social dimension of the relationship extends into the clinical space. Sociability in this third sense will be explored in the following section as an aspect of emotionality.

Sociability and Emotionality

M: It was a relief when I was in labour to see her because I'd seen her around in the clinic; but Joanna just walks in and she smiles and it lights up --. Well you think you're safe, you feel safe. And then to see her on nights was just a comfortable feeling; it was like having an old nanny there that you've known from childhood... And then in the community I just got to know her better because I was seeing her in my own house, so she was my guest, and I was coping fairly well, apart from feeling a bit --; and we were much more on a one to one, so I feel that rather than me being the patient, her being the nurse, we actually were more friends. And then this time we've gone on from that, we are still friends again, rather than going back to the patient/nurse --

R: So... it's a much more personal thing than the patient/nurse thing?

M: For me it is, yeah. [Judy, my emphasis]

This extract conveys beautifully the subtle emotional colouration of a relationship in it various developmental phases. It captures the need for security and trust in labour; the sense of safety and comfort derived from familiarity and an established relationship; the early development of friendship from contact in the comfort of the
woman’s home. It shows how the emotional, developmental and experiential aspects of the blend together in her subjective experience of the relationship.6

Bonds are formed from the sharing of intimate emotional experiences. So it is with childbirth. The deepest bonds are formed between mothers and community midwives who have shared an emotionally intense experience, be it the joy of birth or the trauma of bereavement.7 Birth, as Ellen notes, is ‘a very intimate experience to share with somebody.’ Bonds may be formed unilaterally, but it is more usual for them to be mutual (although not symmetrical). As this occurs, so the social dimension of the relationship is redefined. The emphasis switches from a role based to a personally based relationship, with the consequent ‘fanning out’ noted above, as the midwife is taken in from a personal perspective. These three elements, emotionality, mutuality and familiarity, are the core constituents of a close personal relationship.

The following examples illustrate these points. The first concerns a delivery conducted by Anna, an unexpectedly difficult delivery involving a shoulder dystocia, which required the baby to be resuscitated. The delivery was traumatic for all those involved, but rather than the separation characteristic of professional encounters, the parties suffered the experience together, the anguish and the relief. This deepened their relationship, which has subsequently developed into a friendship.

I’ve had some bad ones. Got the shoulders stuck in one, it was awful, dreadful. I’d got another midwife in with me because it was taking a long time, it was getting past what I would have considered the norm. And she was very good and very good backup and we were both there luckily. And the baby did need resuscitation by a doctor, it was quite stressed. I went out and the father was there and I was just so shaken. The whole thing was so awful. I found it more emotional perhaps because normally on the community you don’t get this do
you, so when a situation like this hits you I find it hits me more deeply. He just put his arm round me and when we went back in we were all in tears, the three of us lay on the floor in this pool of blood – because she’d had a squatting delivery – all with our arms round each other. Because the baby had come back alright. It was such a relief. In walked Dr Jones, the GP. He took one look at the pool of blood everywhere and thought, ‘Thank goodness I’ve come now, not earlier.’ [Anna]

She adds, 'But we're friends, it hasn't affected us; in fact perhaps it drew us closer together. As a couple, they're friends now.' Sharing drew them together.

Anna also makes another important observation. She suggests that, 'The signs had been there all along; she'd had a rough time the first time, that's why she wanted me there...'. The underlines the interdependence of personal attachment and emotional support; and reminds us again of the distinctively supportive role of the midwife.

These points are also illustrated two other cases mentioned by Anna. The first involved a 'high risk' delivery for a mother who had recently had a heart attack. Notwithstanding the medical complications, the mother wanted Anna to deliver her. Anna agreed. She felt the strength of their relationship, and her own approach, would minimise the stress on the mother, and minimise the likelihood of medical and obstetric complications. In the second case, however, she felt uncomfortable with the prospect of delivering a mother who had had a caesarian, and whom she did not know. Katy, the relief midwife, on the other hand, did know the mother and was happy to conduct the delivery.

Mw: I had a girl recently, I'd delivered two of her others and she had a heart attack while she was pregnant. She saw Mr Richards while she was in intensive care at St George's. She said 'I still want Anna to deliver me.' The thing was, it didn't worry me at all, but there was another delivery, Katy did it, with a woman who had had a caesarian previously. It didn't
bother Katy doing it at all but I was praying I wouldn't have to do it.

R: Why did the one bother you and the other not?

Mw: [Pause] I think it was because I knew her and I felt that it would be more stressful for her being wired up to a drip and having people she didn't know than having it nice and quiet like I do it... and keeping her at home for as long as possible... When I took her in she was 8cms... All the others on the delivery suite were waiting outside, I knew they were, and breathed a sigh of relief when the baby was born.

R: [Why didn't she want to do the other one; was it because she didn't know her?]

Mw: I don't think I did, in fact Katy booked her. [Anna]

So in these circumstances mutual commitment, a personal relationship and personal knowledge led each midwife to support a mother through a delivery which otherwise they may have sought to avoid.

These cases also illustrate how both parties have to be invested in the relationship. Bonds are formed through emotional commitment and connection in the same plane of being; ie. through mutuality and subjective knowledge. Each party has to give of themselves and find themselves affirmed in the response of the other party.

R: What is it about midwifery that makes you want to go when called?

Mw: Well you have got to know the women quite well by then; you are involved with them. And I suppose you feel that they want you to, they know you, and it's you that they want there. [Elizabeth, my emphasis]

Midwives consider authenticity essential to a good mother/midwife relationship.

... People as a midwife will tell you things. I give a little bit of me and I get a bit back so I think you've got to have friendship there to a certain degree. [Carol]

Elizabeth makes a similar observation: 'I think the more you put in the more likely you are to develop on a friendship basis if you like.' Laura extends this to biographical as well as psychological investment:
I think if you're not prepared to reveal something of yourself you can't expect to get something back from somebody else. It's got to be a two way thing. You can't keep yourself aloof at the same time as expecting someone else to reveal their vulnerability. It's just not on. [Laura]

Moreover, there has to be a basic congruence, a sense that they are sharing the same experience, that it has the same meaning, that they are connecting, for the deepest attachments to occur; although their outlooks and experiences may in other senses be different.

Yes I look forward to going to an appointment with either midwife... because I feel yes there is a genuine interest and love and care; and I almost get the feeling from both of them that they're quite as excited about the wellbeing and safe delivery of this little one as I am, that it matters to them. It's almost as important to them as if it were their own child. Yeah, it's something you share with them isn't it. [Camilla, my emphasis]

Central to this is sincerity, a sense that the midwife is authentically engaged and involved.

I've also heard that they wave to people in the street that they now... that they've remembered from three years ago... They appear to genuinely mean what they say... I think it's really them isn't it...you've obviously got to do it because you love the work. [Christine]

Ellen, a woman accustomed to emotional manipulation in her own professional work, notes with some surprise:

No actually it doesn't feel like a professional encounter because you imagine that she wants to be there, and that if it was her day off that's what she'd choose to do. I'm sure it isn't but she does give you that feeling. That's probably quite important as well. [Ellen]

This commitment is returned by mothers, who care deeply for midwives thus invested. Camilla, for example, comforted a midwife she knew well, who was upset at having to resign her post.
...the last time she did my home visit was just before she was due to go... and I sensed what a difficult decision she was finding this. And I sat on the sofa and gave her a cuddle because she got a bit choked up in talking about it. And because I feel that sort of friendship with her I just sat down and put my arms around her and waited till she collected herself and told her I understood what it must be like...having to give up what she so loves... [Camilla]

It is worth noting that emotional involvement is frowned upon according to the professional practice; indicating self indulgence or subjectivism. Elizabeth experiences this as a dilemma. On the one hand she retorts, 'Is there anything wrong with that?' i.e. midwives getting involved. On the other she criticises other midwives by the same standards for possessiveness and self elevation. Anna also describes a situation in which she was criticised in her professional appraisal for a tendency to overinvolvement, even though there was no corresponding criticism of her clinical practice.

Notwithstanding this difficulty, midwives also recognise that the deepest relationships arise from emotional connection, although they usually locate it within the mother. Elizabeth notes that her relationships gel with:

... usually the women I've delivered yes. Often primips who are often very insecure and lacking in confidence, who need a lot of my time... and I see them around and they're very cheery and still greet me like a friend. And you know you've had a particular bond there. [Elizabeth]

Laura agrees that bonds tends to arise with those who have experienced problems. One such contact was with a woman whose baby suffered an intrauterine death.

...our relationship became strong in her pregnancy because she had an intrauterine death... And I think because I'd gone in at that particular point when both were in so much need in a way and didn't know how to deal with the situation I virtually took over... So the relationship got very deep on an emotional level very early on. So it developed from there really. [Laura]
In this and similar cases there is an 'immediacy' to the relationship. 'So you've got to get in there when the emotions are really raw...'

So women seek an intimate, emotionally supportive relationship with their community midwife; one which engages them in the same plane of being, is mutually emotionally committed, in which the midwife knows them intimately and subjectively, and one within which they receive social support. This stands in opposition to the professional paradigm, which objectifies and dissociates them. They seek a relationship of emotional attachment, not instrumental service giving.

Community Deliveries

The analysis above suggests that childbearing women seek an intimate, supportive personal relationship with their community midwife. Her role, social context and professional skills place her closer to the woman than any other professional caregiver; and enable the mother to receive a degree of unilateral support and intimacy unusual even in personal relationships. These distinctive characteristics of community midwifery find their strongest expression in delivery situations.

Notwithstanding organisational strictures, and the need to rationalise what one gets, 23/24 mothers indicated a preference for a community delivery; that is, a delivery by a community midwife either at home (a home delivery) or in hospital (a domino delivery). Only 6/24, or 25%, actually received one. The reasons for their preferences were both emotional (for example, a bond has developed, she would feel
more secure, it alleviates anxieties, she simply prefers it); and relational (the midwife
knows her and she knows the midwife, it consolidates the relationship, it is more
supportive and sharing and it results in a better quality of care).

I think if when I'm in labour I ring up and I know Veronica's coming, I'll just
sigh a big sigh: 'Oh, I'll be alright now.' Whereas if I'm not I suppose I'll be
a bit on guard... I just think it will be slightly more traumatic really,
emotionally; I don't think physically it will be any different. [Virginia]

It's such a personal, intimate, precious time – the thought of actually going
through that with someone you really don't know and maybe you don't click
with or you just haven't had time to build up a relationship with. I think you
feel more inhibited as well. [Camilla]

R: [What difference would it have made do you think if Joanna had been
at delivery?]
M: Oh a lot.
R: How would you have felt then do you think?
M: I think then I would have felt that somebody actually cared. I think she
probably would have been a bit more helpful in finding out who was
operating. And I think she would probably have been a bit miffed on
my behalf if he hadn't introduced himself. She's have stuck up for me
a bit when I was vulnerable... Joanna would have been much better
because I would have felt there was somebody actually there for me.
[Judy]

R: What difference do you think that it's made, seeing the same one every
time...?
M: Oh you feel that they know you. As the pregnancy goes on there's little
things you think of and you ask them. Whether they remember or not,
you just feel that they do. I think it would be nice for everyone, as
long as they liked that midwife, to have the same one the whole time
through. [Alexandra]

Emotionality in the sense I discuss in this chapter arises from trust and familiarity
within an established relationship; through the sharing of profound experiences. This
is to be distinguished from the mutual projections which arise from sharing such
experiences with a relative stranger; although this may give rise to emotional
attachments of a different kind. Many mothers draw such a distinction; and birth
reports involving known, anonymous and committed caregivers differ significantly.
Hence it is more than a 'doula' phenomenon (Klaus et al 1986).

Team midwifery attempts to overcome the problem of anonymity by aiming for deliveries to be by midwives known to the mother, whether or not this is 'her' community midwife. But even this does not permit a 1:1 relationship of the kind discussed here to develop; and team midwifery thus results in significant losses as well as gains. As Emily notes, women may not wish to express intimate details and vulnerabilities with a series of practitioners; the relationship grows as trust and familiarity develop from the sharing of intimate information and experience on a 1:1 basis. 'Knowing' one's midwife is not enough; it has to be couched within an intimate relationship founded on trust, personal knowledge and continuity.

Anna's experiences attest to the importance of this distinction. She is commonly greeted from days off or holidays by an immediate delivery call; the mother having unconsciously deferred the onset of labour until Anna was available to deliver her, notwithstanding that the relief midwife is also known by the mother.

Mw: She said I was the one who suggested the home confinement; because she felt so secure from that second on. So whether that had something to do with it –. She said she always felt so confident when I was around, she wanted me there to deliver her... whether she influenced it I don't know. It was odd that she rang up an hour after I took the 'on call' on.
R: Well you can't help thinking that there's something in it.
Mw: Well it's happened so many times, seriously; I've come back from holidays and I've gone straight into a delivery. [The Director of Midwifery Services] laughs about it – she says I come back all refreshed and look like death the next day... [Anna]

Most community midwives have direct experience of how a close and trusting
relationship acts as its own form of pain relief during labour; eliminating the need for anything more than entonox in uncomplicated deliveries.

R: [What is it you like about the delivery?]
Mw: It's so intense I suppose, isn't it; I think it's getting somebody through that process and feeling positive about it. Not just without pain relief — but that's something as well for a lot of people — but just to do it so quietly and so gently and show them they can do it. I mean I had eye contact with that girl last week; she didn't take her eyes from mine, every contraction, it was almost piercing into me... even if she was holding somebody else's hand she said, 'Look at me.' I was kneeling in front of her and I got stiff legs all week because I was crouching in front of her... She said, 'Look at me, hug me.' And that was her pain relief I suppose because she didn't have anything else. [Anna]

A community delivery can enhance the birth experience, consolidate and deepen the relationship, and offer the woman the vital opportunity to relieve her experiences with the midwife party to it.

R: [I suggested that the delivery often gels a relationship.]
Mw: Well it does, it's bound to isn't it, that's the one thing that would, more than anything... I'm sure it does. Not always, it doesn't always, it's often there before. It's almost like an ultimate gift isn't it really, if you're there for that as well. Some don't mind who's with them, they really don't, which astonishes me still. They don't know what they're missing do they... they can't imagine what they're missing. Because one lady said, 'No I don't really care who delivers me.' Afterwards she said, 'No I think I would like you there.' And after she said, 'My goodness Anna,' she said, 'I'm going to broadcast it.' 'No, she said, 'I thought it would be like last time.' She didn't realise that it could be so different with a different person. She just presumed everybody was going to come in and say, 'Well you're going to do this, and this... [Anna]

Women invest enormously in these relationships; and although most are philosophical if a community delivery does not occur, the emotional consequences live on in a diminished and disappointed experience, whatever the compensating merits of the hospital delivery. Linda was one such example. Another was Eve; whom Elizabeth
examined in early labour but was unable to deliver because of her other commitments.

Mw: She was very disappointed that I wasn't able to deliver her. I said, 'I'm really sorry that I can't come in; I'd love to be able to,' and she said, 'Well it's helped, it's helped just knowing I am actually in labour.' 'And I did feel bad about it.'... [Elizabeth]

She saw Eve for the last time just after my postnatal visit.

And she said, 'I have mentioned, I did say that I think that it was wrong that you couldn't come in with me.' She wasn't blaming me; and that she thinks that there ought to be some sort of system. And I wholeheartedly agree with her and I felt I'd let her down. [Elizabeth]

Of the relationship Elizabeth said,

I thought that it was good, I thought that it was open, I thought she trusted me... I think that she would have been thrilled to have me there...She just did want a domino. [Elizabeth]

Some women, such as Lydia, formed the strongest emotional bond with the hospital midwife who delivered them. Nonetheless, the nature of this relationship still differed from that with the community midwife, because she did not know her. She sums up the difference as follows.

Yes I think it is. [Special, with both hospital and community midwives.] I feel as if there's something special between Pam, having delivered, like there was with Sue; and there is something special between Laura, knowing Laura, having gone through the nine months, and all your anxieties and worries, things that you want to ask, and finally you've got your baby... I don't feel as if I know Pam, I don't feel as if she knows me as a person, but she obviously experienced something that I experienced, it feels like together. Whereas Laura knows me as a person more but she didn't actually have that experience, we didn't share that. [Lydia]

In community deliveries, as the extract at the end of this chapter indicates, the emotional experience and the social relationship intersect; giving rise to a qualitatively different experience from that either with an unknown hospital midwife or a community midwife who did not attend the delivery. Many women who experience
community deliveries find the relationship special and wish to keep in touch. Sometimes this is one sided, but significantly, as Anna notes, 'it's usually both ways' when there has been a delivery.

Discussion

Because of its supportive and emotionally intense character the mother/community midwife relationship is often likened by mothers to a friendship. But I suggest that this is a metaphor, used in the absence of an appropriate language within the professional paradigm. I conclude this chapter by considering the differences between the relationships thus depicted and friendship in more detail.

There are some similarities between the mother/community midwife relationship and women's friendships, and these were elaborated in Chapter 5. But from the mother's point of view the relationships are different in a number of crucial respects. In essence, women are seeking an intimate, supportive, personal relationship with their community midwife. In some ways this is more bounded, because more instrumental, than are friendships. In other ways, it is less so. Women's comments make it clear that intimacy is more the ideal than the practice with many of their friendship relationships. Moreover, it is also clear that many such friendships are founded on the denial of personal need, such that vulnerability either fails to find expression, or else the service has to be returned. Women often feel unable to ask for or receive emotional support from their friendships when they are vulnerable. Relatedly, women's needs for practical support, and the emotional needs they encompass, are glossed and
denied by the obligation to reciprocate. In many friendships, women are unable to escape their position as emotional labourer and an ideology which casts them as selfless carers. The mother/community midwife offers relief from these constructions and allows them to have needs without feeling guilt or the obligation to reciprocate. Beyond that, women are seeking emotional connection and understanding within a woman centred relationship; in this respect it is similar to women's friendships as depicted by Orbach & Eisenbaum (1988).

On the mother's part, the indications are that the role boundaries are more around her friendships than her relationship with her midwife. That is, she can permit the midwife to see her as vulnerable in a way that she cannot permit of her friends. (Conversely, confidentiality creates safe boundaries around midwifery.) She can confide in her midwife in a way she cannot in her friends. She can expect advice and assistance from her midwife in a way she cannot from her friends. She can also avail herself of non reciprocal social support from the midwife in a way which she typically cannot from her friends. The advantage of the midwife is that in a situation of vulnerability and need she can help and demands and expects nothing in return.

And you can say, 'I want help' and they'll give you their help to the best of their ability without asking for anything in return, without any feeling that you are indebted to them. It's just nice to have someone that's neutral I think. [Judy]

I would say it isn't totally between equals because I'm needing her support so she is probably more of an emotional support to me and I am not to her; whereas in a friendship generally it is a two way reciprocal thing. Yes, so I would say it's slightly emotional dependence... probably it's quite strong. Possibly I felt it quite intensely which is maybe why I found facing day 10 and saying goodbye quite hard. [Camilla]

Actually no I don't think I would like it so much [if the midwife was a friend].
I have a friend who is a midwife... I think I'd feel a bit more bothered about how she was feeling and concerned about her needs; because in a friendship you have needs on both sides. Whereas I feel quite definite I need her more... [Valerie]

It's a bit one way. It's a bit like me and you; you know an awful lot about me and I don't know anything about you. [Emily]

In addition, the midwife has power and expertise unavailable to friends. Joanna, for example, was able not only to sympathise with Judy's treatment at the hands of the medical profession, when the extent of her post operative pain was normalised, but was able to do something about it.

Joanna was quite indignant ... but then she went and did something about it and sorted them out... [Judy]

From the midwife's point of view, the relationship differs from friendship in a number of respects. Firstly, some midwives have an instrumental definition of their role (see for example, Elizabeth and Veronica). Secondly, even in personally oriented relationships such as those depicted above, the midwife's personal needs are relatively understated. As noted above, the relationship is relatively one sided. In a friendship, her personal needs and agenda assume greater prominence and there is less restriction to an outlook centred on the needs of others. Finally, even where relationships achieve the emotional depth of friendships, there are often social inhibitions which preclude it; for example, where a working class mother is 'friends' with a middle class midwife.

Well I suppose proper friends are the ones you have social interaction with aren't they; you go to each other's houses or do things together. I think if some of the mothers saw where I lived they'd be a bit put off; whereas they accept me totally in a uniform. They ask me, do I live on the estate; they've no idea. Because my life is so different from some of theirs... like flitting abroad or going up to London. It's like two sides of my personality... Let's say you had all your husbands together, you wouldn't really gel as a foursome. I do feel it
would be offputting if they were struggling on without heating in a council house and they came to my house... [Anna]

But as noted above, what often happens is that once intimacy is achieved the woman then wants the relationship to fan out and incorporate the midwife within a broader context. At this stage some relationships founder and others can prosper and there is social differentiation of the continuing relationship along lines consistent with the orientation of the midwife. Anna establishes personal friendships with some women, and stays in touch with others (with whom it would be difficult to have a social friendship) via the surgery; although she has been godmother to the children of some of these families. Carol stays in touch with some 'problem' cases and working class women, but this is not that common. Elizabeth seems to fear rejection and not to keep in touch except to say hello in the street. She also finds herself too busy. Joanna seems to stay in touch with those with whom she can have socially appropriate peer friendships. Laura stays in touch with some for coffee but it tends to phase out. She may develop friendships with some who have had emotional traumas; but they tend to take the initiative. Veronica tends not to stay in touch because they talk about babies; on occasions when she has she finds they fizzle out over time. She has stayed in touch with a few other women; such friendships, if they are to develop, must also incorporate her husband.

So the community midwife operates within role boundaries which differ from personal friendship. If the relationship develops into a friendship it has to adjust. This means that the emotional and instrumental role boundaries thrown around the midwife recede. The role of midwife carries responsibilities of competence and control. The mother remains the centre of attention. The situation remains instrumentally defined; and it
is bounded in space and time. This inhibits the midwife's personal involvement; although some (eg. Anna and Joanna) have more personally open relationships with the women than others. This transition can occasion some vulnerability in a midwife; for example, Elizabeth, who fears rejection.

If a friendship develops, the definition of the situation changes; from one focused on the needs of the woman (whether professionally or personally centred) to one which incorporates midwives equally. Veronica suggests that the conversation and focus of concern shifts to a broader base than pregnancy and children. Finally, the midwife's personal agenda becomes more prominent. The midwife and her personal concerns take centre stage along with the mother. Joanna notes that, 'It changes; they're interested in you as a person.'

I think it takes a while to adjust...from being the midwife to being a friend and letting yourself go, totally as you. I'm not a midwife now, we're just friends, forget the midwife bit. It takes a while but it does work because a lot of my close friends are ex-mums. You've got to trust yourself totally to them as you, you're not just the midwife. Because you wonder then why they wanted you – was it just because you had a nice delivery. You hope they like you totally as a person... [Anna]

I conclude with an extended extract from Amanda. It refers to a domino delivery and illustrates a number of the themes addressed in this chapter; in particular the way the experience of childbirth is enhanced by being couched within a familiar, trusting and secure relationship with a community midwife. There were no such depictions of a hospital delivery; although many emotional connections were established. There were many such accounts of community deliveries.
M: I wanted a community midwife, yes, I did. Given the choice I had hoped it would be. Given the choice I had hoped it would be Anna as well.

R: And was it what you hoped it would be.

M: It was what I hoped it would be and an awful lot more. It was an amazing experience... totally because of Anna. Yes, it was totally different from Paula and its what every woman's experience should be I think.

R: Really, as good as that.

M: As good as that, yes.

R: Brilliant.

M: I mean, I can think of other things to do on a Monday morning, but, yes, she just made it really.

R: What did she do; can you identify it?

M: Well first of all I think it was just her reassuring manner, that everything was going as it should be and she helped me feel that I was in control of it; whereas when Paula was born it was very high tech - you know, she was monitored and forceps and epidural and everything. And it was just so totally different. I think just the reassurance that she gave that I was doing alright: even when I was sort of getting to the end and I remember hearing myself saying, 'No I can't do it any more, I can't'. And you know she said, 'Yes, you can and you've got to because that's the only way the baby's going to come.' And its the continual reassurance that the baby's doing all right; and yes it was just her whole professional manner really... She was very good as far as Mike was concerned as well [involving him]. It was real sort of shared experience. There was no point that we felt she was sort of the medical person present; she was part of the whole situation, she was one of the active people involved in it all....We were both totally overwhelmed about what had happened and how she had made the experience for us. And she said it had been an experience for her as well, which was lovely. And we were just given so much more time. I remember when Paula was born were were very quickly whipped out of the delivery room and up to the ward. Here, we were left together for ages. And she brought a telephone into the room, it was all little things like that just made it; and no rush to get out and into the system or anything....Absolutely marvellous, it really was...

R: Did that make it hard to say goodbye to her?

M: Very, yes it did, very very hard. Because in a funny way its almost like a sort of initial bonding when the baby's born, that then just bonds you with them. And you know the initial bonding you have when the baby's born, there's also that sort of feeling with the person who's delivered your baby. And yes, it was very very hard, very hard.

R: Did you have that feeling with the person who delivered Paula?

M: Ahm, no, not to the same extent, although she was lovely. But I was just one of a number. I mean I still am to all intents and purposes but you were just made to feel very individual, I think that was the difference. I mean, yes, we were very grateful to the midwife who
delivered Paula but it was a different —... Right at the very end, that moment just before he was born, I was thinking, 'I really can't push any more, I've pushed all I can' and Anna suddenly said to me, 'Come on, say a prayer, you can do it.' And it really sort of brought me up and kept me going and he was born within the next couple of minutes. It was amazing.

R: [Did you get her a gift?]
M: Well we did buy her something. We bought her a picture. It was one of those things where I knew what I wanted but couldn't go into a shop and say, 'I want this'; I knew it immediately I saw it. We both agreed that that's what we were going to do. But as you say it was only a very very small token of all that we'd had.

R: Have you got any plans to keep in touch with her?
M: Well yes, we have actually. She said to me before she went... she wants me to go up there... which would be lovely. She's such a lovely person. And it really did make the experience. That's not to say that Suzy is any lesser qualified because I'm sure the experience also would have been a wonderful one but I think Anna was right for us... It's to be treasured really. It's not something you could write down; it's just something that I'll keep.... It's what every community delivery should be. It's certainly what every woman should feel.... I think because the two of them were so different, because I felt so awful after I'd had Paula, I felt uncomfortable, and I did feed her but it was difficult because I had to lie down; whereas I had no stitches this time... I got up afterwards and had a bath and really felt so positive and so elated and so wonderful and I'm sure that was due to Anna's skill as well in how she actually delivered him. Because those first few days when you've got a new baby, you're tired and they are hard work initially, and all of a sudden you're plunged into broken nights, and if you feel uncomfortable and sore, somehow it makes the whole thing more difficult; whereas with him because I was sort of fit and I was up and moving about quite easily it just made it much easier.

R: Did it make a difference as well when she came round afterwards; what difference did it make that she'd been there... did you talk it through or did it deepen the relationship...?
M: Yes, it did. I think also as well when I came home with him he had a problem with his cord because it was incredibly thick... it took a long time to heal up and it was nice to have her reassurance, you know, the person that has actually delivered him and everything that he was going to be alright.... But again it was an important part of the bond I suppose because you've seen where the baby's grown and everything... It's difficult to isolate. I think it was just the reassurance of having Anna coming back every day; and not losing her, not letting go of her.

R: [Did you talk over the birth?]
M: I kept on saying what an experience it was and I mean it was Anna who said that it was what every woman should experience and that was how they saw their role, but it was just a question really of manpower/womanpower and of the actual logistics of it all... But the interesting
thing that also came up, and this was when Suzy visited was: a) Anna had obviously talked over the delivery with her. Suzy came and said, 'Oh I've heard it was lovely delivery'; and also what an importance they attach to each other...

R: Did you like the fact that Anna had spoken to Suzy about the birth?
M: Yes because it brought up to me that she felt that it had been a positive experience. I mean I would have shared it with anybody. A friend of mine who's expecting in June who I know is very apprehensive about it, she had a bad experience ...I mean if I could sell it to her that it needn't be like that — Gosh, yes, if you could bottle it and sell it you'd make a fortune. But I mean that is how it actually feels... It made me want to go and tell everybody, it really did. [Amanda]
Notes

1. This is not to suggest that the service could not be improved, that all women experience midwifery this way, or that such a service can arise only with professionals.

2. Of course, a formally defined relationship also has a personal element deriving from the psychosocial role of the community midwife but the distinction is nonetheless helpful.

3. 'Don't knows' have been counted affirmatively and so this is a positive presentation of the data.

4. There is no data on this point from Linda and Alexandra.

5. Interestingly, this interpretation is consistent with my recollection of the way gender was elaborated by the mothers in the interviews rather than from an abstracted reading of the tables, which would tend me to interpret in the opposite direction.

6. It is interesting to note too that a lot of the early development of the relationship occurred in hospital settings, indicating the importance of emotional orientations over social setting: 'The time I actually got a bit of a bond with her was when I was in labour, and she gave me pethidine, which was the best thing on earth at the time.' That said, she enjoyed a degree of continuity unusual in hospital settings; and the emotional bond of labour was consolidated by the more naturalistic setting of casual conversation on the night shift. Note too that the relationship acquired its friendship aspect in the community setting.

7. This does not follow inevitably from such an experience, as noted earlier, but it provides a basis from which relationships may deepen.

8. First time mothers are not offered a community delivery in this district health authority; domino deliveries were usually only practicable in the midwife's off duty hours; she then typically went on to do a full day's work; there was no relief midwife to relieve her, so she had to improvise and call on other midwives to relieve her before she could attend a delivery.

9. Data was unavailable on this point from the 24th mother.

10. And not all friendships are the same.

11. Although Vera construes it simply as different kinds of help. 'Theirs is professional help.' Family help is where you can just say, 'Take her.' This is a valid distinction but reflects too a clinical orientation.

12. There are women who cannot accept the supportive aspect of midwifery care but these tend to confide vulnerability to very narrow circles indeed, eg. their spouse.
Chapter Fifteen

A Psychosocial Role
Chapter 14 suggested that women seek an emotionally supportive personal relationship with their community midwife. This chapter considers how the role of the community midwife makes this possible, compared to the GP and health visitor. I suggest that the community midwife's role is empathically woman centred. Her role is to be 'with woman'; the original meaning of the noun 'midwife'. She therefore takes on the concerns of the woman; and it is this which gives her role its distinctive psychosocial orientation. The roles of GPs and health visitors, on the other hand, are not defined in such terms. The GP's role is objective and medically oriented; the health visitor's bureaucratic, advisory and interventionist. This places both GP and health visitor in a different plane of being to the mother and precludes an empathic, supportive, woman centred role orientation. This is not to deny that GPs and health visitors can be supportive, or that community midwives can be unsupportive. Individuals may have a role orientation or personal disposition which departs from this, just as there was variability between midwives, identified in Chapter 10. But it does identify an important source of difference in the respective roles. These differences make it more difficult for a GP, for example, to be as socially supportive as a community midwife, whatever her/his personal outlook.

This chapter highlights these differences by comparing and contrasting women's experiences of community midwives, GPs and health visitors. I suggest that they experience the role of GP and health visitor as operative within a professional, and the midwife's within the personal, paradigm.
Being a Professional

Asked to identify what the phrase 'a professional' conjured up, respondents identified four aspects. Firstly, professionals are formally trained. Secondly, they are experts; that is, they have appropriate skills and knowledge. Thirdly, the client trusts and relies on them. Finally, it dissociates them; that is, a professional is different to a client. This is its negative characteristic. Respondents did not, on the whole, explicitly refer to the unequal power relations concealed beneath professional rhetoric. The extract below illustrates each aspect. A professional is

Somebody who sits behind a desk. I suppose really it has to be somebody who knows what they're talking about. I think quite often if something goes into the bracket of being professional, or under a professional's concern, then it also becomes tied up in a package of vocabulary that attaches to that profession. It then has its own mystique sort of tagged on to it... I've found that in the work I do... a therapist would use certain terms about the clinical, diagnostic side of the patient... and we I think deliberately try and not use those terms but to use everyday language that the student can understand... [Therapists] then think that they are the professional and we are the lay person, which to some extent we are because we don't know about the clinical details, but there's also a value judgment attached to that... [Valerie, my emphasis]

When mothers are asked to consider additional qualities needed to be a good community midwife they emphasise those aspects obscured by the professional paradigm but visible within the personal paradigm. These are essentially human qualities; specifically relational, emotional, empathic and sociable qualities. They also define it as corrective to the negative characteristics of professionalism. The only characteristic referred to in both sets of responses was that of feeling safe.

Midwives' responses had a different emphasis. The emphasis was predominantly on
doing the job well, meaning having expertise and maintaining high standards. This reflects the practical priorities of the practitioner. Carol mentioned formal training. The negative characteristics identified by the mothers, such as detachment and coldness, were also mentioned. With Elizabeth this was more of a caveat. Veronica contrasted professionalism with personal feelings and preferred the former. So the midwives recognised professionalism as emotionally remote and personally detached; but their responses also contained a personal commitment to expertise and professional standards.

They also differed from mothers when asked for the additional qualities required of a good community midwife. Elizabeth and Carol explicitly mentioned the professional aspects of the role. Again this is a marked variation on the mothers' replies, which opened up the relational and emotional dimensions; some of which, however, were identified by Joanna. Overall, the midwives' replies do not reflect or capture the emotional and relational needs of the mother when discussing professionalism. This distinction between mothers' and midwives' responses was not evident when discussing the community midwife's role; and suggests that the concept of 'professionalism' accentuates difference between mother and midwife.

What is the Community Midwife's Role?

Women depict a role founded on a personal paradigm. They see the community midwife as caring, approachable and accessible; supportive; sincere and invested; emotionally and relationally attuned; and intimate.
They're both so excellent at being approachable that you feel you can ask them anything... It's treated as important: it matters to you and therefore it matters to them because they want you to be relaxed and have peace of mind and not be anxious... [Baby had been breech but turned,]... I opened the door to her [Carol] and she said, 'The baby's turned hasn't it; I can see it on your face.' And she looked really pleased about it. And I think again that created a bonding...I think that is what community midwifery is all about; because you really do feel that this other person cares as much as you do about your body and the baby that's growing inside and a safe delivery. And aftercare – I just wish it lasted longer. Day 10 is ever so hard! [Camilla, my emphasis]

You just want to feel that somebody's actually interested in you, not just part of the job, they're interested in you; and that they want to deliver the baby and that's really friendly and at ease, somebody that you feel you can talk to. It's no good having somebody that's not very friendly; it's something that's very intimate and it's... a really special thing that is shared by your other half and the midwife and you really want to like that person don't you. [Lydia, my emphasis]

But we had a terrible evening yesterday and just thought, 'Oh God, who the hell can I phone?' Of course it was out of hours so you can't phone people like health visitors or anything like that. Of course with the midwives you could just phone them up anytime... Last night as I say I was thinking, 'Oh God, where's my midwife, what can I do without my midwife?' Everyone, especially in America, they talk about their shrinks: I want my midwife, my own personal midwife! [Christine, my emphasis]

It's more professional than a friendship but nevertheless I think there's an element of it there as well... there's a certain sense of trust there really; that they're there for you and don't hesitate to ring them....I think it's almost unique. I mean even in the teaching profession you have certain lines over which parents and teachers don't step. I mean you wouldn't expect to be contacted at home by a parent...whereas I think there's a certain overlapping with a midwife... you know that you can call them at home; and by the very nature of childbirth that call might actually be in very unsociable hours. [Amanda, my emphasis]

Midwives' responses were congruent with those of the mothers, in contrast to the responses to the concept of a professional noted above.

I think it's quite important, I think you've got to like women too. You've got to like women. [Veronica]
I cannot be detached and I think my practice would suffer greatly if I tried to be like that; I would lose far more, or the women I look after would lose far more than they'd gain, if I did it from a distance and tried to do it 9-5. [Elizabeth, my emphasis]

R: [Would you say it is better to be detached or involved overall?]
Mw: Oh involved...What's the trigger that gets two women involved? It is like friends in a way. I suppose if you want to give in any relationship you're getting involved aren't you?... Some people feel you shouldn't get really involved. Some people are quick, very very quick. I know one particular midwife ...who can do 12 visits before lunchtime. If I'd got 12 visits I'd die. I can't do what I want to do, whizzing in and out ...it's not how I want to work. [Anna]

R: [Observed that midwifery was earthy sort of work.]
Mw: I think it's the earthiest don't you, apart from prostitution. It is though, isn't it, it's really fundamental. And this is why my friends sometimes say, oh I'm so basic, at dinner parties when I come out with all sorts. It's just because life is so normal and natural that you don't [have airs and graces] any more. [Anna]

I think on the whole in nearly all cases it's just for someone who will be alongside them and who will listen to them, that's actually got time for them....very few people have the time just to sit down and to actually listen to what someone is really saying. [Laura, my emphasis]

So the concept of professionalism carves differences between mothers and midwives which from another perspective, the concept of role, is redundant.¹ When discussing the role of the midwife mothers and midwives are entertaining the concept of intimacy, not the idea of standards or training. The kernel of the role is emotional support through sharing. The mother's need for this arises from her unusual degree of openness and vulnerability during childbearing. Paradoxically, the midwife's ability to meet this need comes from the formal nature of the relationship, which permits the mother to have needs and, as noted in Chapter 14, relieves her of reciprocal obligation.
Comparison of the Roles of Community Midwife and General Practitioner in the Provision of Maternity Care

A midwife, do you see, they're in a category of their own. They're not a GP and you don't talk to them like a GP because a GP, they don't come down to your level. They're more than a nurse for the simple reason that although you can chat to nurses, it's more personalised isn't it, person to person. Friend? No, they're more professional; you look at them in a more professional light than you would a friend. But you'd still talk to them as you would your friend...Because of the uniform you look at them at a professional level but you can chat to them as well, not just talk but chat...It's not just politeness... you know them well enough to ask them. [Christine, my emphasis]

You're in there in about two seconds flat with a GP...No they [midwives] have more time; I don't know whether they have more time but they make more time for you. And they always ask how you are... It's just more friendly really, they're just more approachable. And you can ask them things you wouldn't ask a doctor... I think if you're worried about something you just think, 'Oh the doctor will think I'm just making a fuss.'... Just to be reassured really. I think you have more confidence because you think they must see more than the GPs do anyway, so they have more experience... Yes I don't know what it is but I think you definitely have a much better relationship with the midwife. I think also because you actually see them when you're healthy as well; I mean you also see the GP when you're not feeling very well... [Caroline, my emphasis]

I think a midwife – her role is deeper. An obstetrician's perhaps more of a clinician; and they [the mothers] rely on us for other things like counselling. And we have a bit more time because our role is more defined if you like. And it's just about midwifery and isn't about all the other stuff. I suspect that they're [GPs] not really interested in getting to the bottom of things; they want to be able to put their observations down, and weights and they may say, 'Are you alright?' but they don't really want to know about it. And I think a midwife offers much more support for a woman. It's more about her emotional welfare. [Elizabeth, my emphasis]

This subsection compares women's maternity care experiences of GPs and community midwives. At the antenatal stage all but one of the surgeries taking part in the research offer 'alternate' care; in which GPs and midwives see women alternately at the antenatal clinic and offer identical clinical care. This provides a good comparative
basis to assess differences in role, although women's comments are not confined to antenatal care.

All the mothers provided data on this question. In essence, they found midwives more approachable than GPs, the relationship more relaxed and intimate, their attitude more direct and involved, their practice style more informative, appropriate and attentive, and the midwives more expert and culturally qualified. GPs, on the other hand, were experienced as more clinically, medically and abnormality oriented, less psychosocially oriented, and socially more remote. Some women mentioned they found the GP nice, pleasant, and socially open.

This suggests that there are four distinguishing features of the midwife's role compared to the GPs. Firstly, the relationship is more personal and subjectively oriented. Women refer to the relationship with the community midwife as more supportive, personal, intimate, friendly, informal, enjoyable and continuous. Secondly, the role is psychosocially oriented. Her role involves greater intimaey between mother and midwife; in particular, a more personal, caring, intimate and supportive orientation; more extensive and intimate contact with her body and more contact with her in her own home. The lines of communication are more open between mothers and midwives. In particular, they feel more able to confide and to ask about 'little things' they may feel are too trivial to mention to the doctor.

Thirdly, the midwife is seen as the more appropriate professional; associated with childbearing in a way medical practitioners are not. Midwives make more time, there is greater continuity of care. The midwife 'sees you through' the whole experience,
antenatally, intranatally and postnatally in a way the GP does not. These relational and role differences give rise to concrete differences of practice style. Women refer to midwives as better informed, more thorough in the care they provide, and as providing better explanations. The style of consultation is more informal, the seating arrangements less confrontational. Midwives and mothers are connected in a way mothers and doctors are not. This is graphically illustrated by the use of the sonicaid. When monitoring the fetal heart beat midwives use a sonicaid, which enables the mother to hear the baby's heart beat; whereas most GPs continue to use the ear trumpet which makes the fetal heart beat audible only to them. Many mothers commented on this difference; in particular the importance to them of hearing the baby's heartbeat and their gratitude to midwives for appreciating its significance and searching for the fetal heart from the earliest possible stage.

GPs, on the other hand, have a more clinical orientation. Their frame of reference is objective and medical. Their wider caseload is medical: women have visited them in the past in connection with illness. They feel defined as a 'patient' when they go for maternity care. GPs are felt to have an 'abnormal' orientation to maternity care consistent with their medical training.

I'm trying to get as many GPs in our practice comfortable with them... Dr Smith tends to chat [during labour. Anna says,] 'Please don't talk, especially during contractions... I think Peter was scared to death, the first one he came to; came with all this resuscitation equipment, antique stuff he'd found somewhere. You could see him visibly sweating. Whereas now he doesn't. I've got it all there anyway. [Anna]

Moreover women do not believe GPs to be as expert or specialist in maternity care as midwives.
I know Elizabeth and I think I have more faith in her than the GP to be quite honest. It's not their fault, but I mean I dread to think when the last time they delivered a baby was - you might as well have your husband doing it. I mean, he's probably been at a birth more recently. [Emily]

Visits to GPs have an instrumental character; the GP is monitoring for abnormality. If the clinical signs are normal the purpose of the visit has been achieved. Only medical expertise is recognised in the professional paradigm; and women's beliefs, experience and expertise can be dismissed because their knowledge base is not recognised.

When I went to see my GP, I went a bit early because I had thrush, I was only a week overdue, it was my second, I was fairly certain I was pregnant. I'd done a test and it was positive. And I just mentioned it to him. I just said, 'I think I am pregnant,' and he just about pooh poohed me out of that surgery... He obviously didn't realise I was a biologist or he might not have said the things he did about home pregnancy tests. He said they were unreliable, they go off quickly; he said, 'There's lots of reasons why you might be late,'; and I thought, 'Well yeah, but look the most obvious one is that I'm pregnant' and on top of that I had thrush. He gave me pessaries and cream. The next GP that I saw was the woman in the medical practice; she said, 'Pessaries...shouldn't give you pessaries when you're pregnant, it's best not do anything like that.' And I was so put out about that doctor, but basically didn't see anyone then until I was about 12 weeks. [Elizabeth]

This instrumental and clinical orientation defeats the expressive and psychosocial aspects which are such a crucial part of the midwifery relationship. The relationship is described as professional rather than personal. Essentially the GP is felt to be out of touch with women. Notwithstanding the need to foster a relationship for the purposes of subsequent contacts after the pregnancy, the GP is felt to be less interested in, and less sympathetic to, 'minor' or emotional aspects of care, and to have less understanding of women's needs and concerns. There is less personal interest in the women themselves; and where interest is expressed it is somehow less attuned to women's own feelings.
I will spend more time with them. They say he'll say how pretty they look; where they're feeling absolutely grotty and want to tell him so. But that's excluded now any conversation about how grotty they feel because he's just said how lovely they look. [Anna]

GPs may fail to remember who the woman is, her personal details and, in one case, failed to spot whether she was still pregnant or not!

That was probably the famous occasion when I went to see him [at 38 weeks]. I think he was a bit harassed and he said to me, 'So you're here for your postnatal checkup.' [Emily]

He was meant to come out and see the pair of us but he never turned up. We sat in all week. [Vivien]

They resort to the notes, or the computer, or midwives, to avail themselves of details community midwives grasp and retain informally.

Finally, women describe ways in which doctors are socially more remote than midwives. At one level, this reflects class and status differences. But the distinctions they describe are sown into the fabric of the relationship in subtle ways which reinforce the dissociations inherent in the professional paradigm. The use of titles rather than first names reinforces social distance. Status distinctions underwrite social distance when women are called by their first name and doctors by their title. Doctors are very much 'that side of the desk' and women are summoned to consult them by a buzzer; in contrast to the practice of most midwives of going to greet and accompany the mother from the waiting room. There is less time, the GP is more busy (or mothers feel them to be), they are conscious of the queues of people waiting behind them. The atmosphere is less relaxed and more formal. It is not an environment conducive to sharing and support.
Midwives' Clinics

Within this context, it is no surprise to discover that these mothers would, almost without exception, prefer to eliminate the GP from routine antenatal care altogether and be seen by midwives alone in a midwives' clinic. The data suggest that women vastly prefer their encounters with community midwives over general practitioners. Not only do they receive a service more sensitive and oriented to their emotional and psychosocial needs; they also feel they receive more expert, informative and appropriate care. There were no negative responses and few equivocal ones. This is so despite the variability in relationships demonstrated in Chapter 11 and holds even in the case of those who have good relationships with their GP, who were deferential to their GPs, who had disappointing relationships with their midwives and who marginally preferred seeing the GP.

The reasons given are by now familiar. The midwife is seen as the expert and specialist with greater familiarity and experience of childbearing women. The relationship is a more informal and satisfying one and there is better communication within it. The GP is seen as the less appropriate professional to consult, both because of their medical and abnormal orientations and because their organisational practices and psychosocial skills are less well developed. Some women gave equivocal replies; these were either sceptical (there is not much anyone can do anyway) or indicated a wish for medical contact at some stage. Some women mentioned caveats; that the existing quality of care (especially continuity of care and sufficient time) must be retained otherwise there would be no advantage; that a consultant should be seen at least once; that at the moment the doctor is known better than the midwife; and that
it all depends upon characters: the best organisation can be thwarted by the wrong approach.

R: And how do you get on with Carol?
M: She's really nice...my doctor, he's not really worth asking anything.
R: Really. Why's that?
M: He's - I don't know. He never - if you want to know a question, whereas Carol would explain everything; whereas my doctor just gives out 'yeah' or 'no' and it's never enough.
R: [If you could choose who to see when you go to appointments, would you choose your midwife or GP?]
M: Midwife. My doctor don't do as much as what the midwife does. Whereas the midwife always feels how big it is and takes all the heart and blood pressure, but my doctor doesn't do it all... [Midwives use sonicaid which she 'much prefers to hear.'] I think they know more what mums expect... I mean my doctor he's like so busy, you know, he's not really got much time. When I go there he's always got loads of people to see... The midwives tell you more, much much more; they're always asking how you feel and what's going on, whereas he just - it's as if he just wants to get on with his job... I always feel more comfortable with my midwife than the doctor. [Celia]

There are echoes in this passage of all that has been discussed; the importance of the relationship, of open communication from mother to midwife, of explanation, of a known caregiver; of the quality of maternity care; of sincerity and commitment. It is not simply a matter of knowing the caregiver, for she also knows her GP. It is the quality of the relationship they establish and the care delivered within its embrace. The possessive pronoun in the final sentence speaks of the difference. She feels more comfortable with 'my' midwife than 'the' doctor.
Comparison of the Role of the Community Midwife and Health Visitor in relation to Maternity Care

Mothers are usually signed off from the midwife's care on the tenth postnatal day. Thereafter they are visited in their home once a week by the health visitor, until the end of the puerperium 6 weeks after delivery. Thereafter mothers take the babies to baby clinics. Mothers have usually met the health visitor antenatally and can expect to have regular though infrequent contact with her during the child's preschool years.

There are superficial similarities between midwives and health visitors. Each is a health professional; and almost invariably female. Each has contact with the mother in her own home. Each is concerned with facilitating the wellbeing of the family unit. Each is (almost invariably) a trained nurse. Each has an advisory aspect to her role. Each is involved in a key life event; with the midwife centred around childbirth, and the health visitor centred on the baby's wellbeing.

But the two roles are very different and mark something of a culture shock. Replies from 23 respondents indicate five key differences in their roles, which in turn affect the relationships which are typically formed. Firstly, the health visitor has a more advisory role. Secondly, this lacks the supportive and intimate orientation of the community midwife. The relationship is less personal, less satisfying, less involved and less easy. Often mothers say there is no sense of a relationship at all. Thirdly health visitor's remit is seen as the baby not the woman, and the woman may feel on trial as a mother. Fourthly, it is a more dissociated, bureaucratised relationship;
marked by the mores of formal knowledge including clinical measurement and
textbook advice. Correspondingly, there is less emphasis, investment and immersion
in experiential knowledge. Finally, mothers perceive a potential conflict of interest
between themselves and the health visitor. The alliance between mother and
community midwife is gone, replaced by the advisory, surveillance role of the health
visitor.

With the exception of one health visitor, who was popular, the mothers painted a
picture of mild antagonism towards the health visitor, who was variously perceived
as unhelpful, out of touch or an inconvenience; there to instruct or test rather than
support and befriend the mother.

M: I think the health visitor you feel is more for the child...I mean Joan
would be much more hesitant about weighing Janie if she was asleep;
whereas the health visitor would always want to weigh the child
naked, even if she's fast asleep and just been put down, and your
routine goes out the window... Midwives are more interested in us...
She put Jason on the scales and things but he already had his clothes
on...he'd only just gone off to sleep, so she didn't bother to do any of
that. I don't really feel that I need a midwife (sic) particularly, they're
not — I mean she's nice enough... I'd be very happy to go to her if I
feel that I needed her but I don't actually feel that I need her... Oh
it's more, she's a further distance away, she's more distanced to
me, whereas Joanna is much more intimate... And also I think
you're more vulnerable in those first days, aren't you, I think you
probably need the moral support in those first days but by the time the
health visitor comes —. I hadn't seen the health visitor before in my life,
so that's the first thing, and also I tend to think — it sounds awful —
they always come over as being a bit scatty, they're ....like a
combination of roles ...a bit wishy washy... no chance for a
relationship really to build up. I felt that with my last health visitor,
I thought well why are you bothering, I'm perfectly alright, but I'm sure
if I wasn't then I would actually have more of a rapport with them...
It's more of an intrusion than a midwife was. A midwife is a
welcome visitor... I've always treated midwives as friends more...

R: [Mentioned surveillance.]
M: Yeah, I think that's the other thing, you do tend to feel that they're
watching you. That doesn't actually bother me too much because I don't care if she is, I still do things my own way. They're also often middle aged people who are ...like social workers as well... [Judy, my emphasis]

M: The difference has been that I've found the midwives incredibly supportive, very encouraging, very positive... and views you as an individual... I've found the health visitor: a) doesn't seem to have the same amount of knowledge; certainly has no knowledge when it comes to problems and difficulties, and tends to do everything by the textbook... My health visitor certainly is obviously much happier with a bottlefeeding mum... It gave me a lot of negative, depressed, anxious feelings... [With Katy, the relief midwife]... just with a bit of patience and care... I don't know how long she was here that first morning, it felt like all the morning really, but it was what I needed. The next day when she called I said, 'It's been going great...' And she said, 'Yeah, throw those nipple shields away!' [Camilla, my emphasis]

M: I don't even think I had that relationship with the health visitor... It's a definitely more detached role. Although they take over at day 11... Plus you don't really see them... I suppose your relationship with them isn't so close because they're not actually doing anything personal to you, just coming round –. I don't know, health visitors, there's always this element of 'Are they going to take them away; am I an unfit mother?' You're always worried about that or whether the house is clean enough...It's not so much of an intimate relationship I suppose because you're not – basically with your midwife you have to expose all don't you really. You can't really hide anything. And I suppose they see you for quite a long time... plus it's very baby motivated and they talk to you but it's not the same; whereas a midwife is interested in you and the baby comes second really and I suppose that emphasis changes... Also she hasn't got children. Because I know with Anna I kept saying, 'Oh they get on your nerves don't they?'; which probably makes a difference... and she's actually likely to agree with you... [With health visitor]... there's always that element of 'how much should you say?'; and you know they actually record things... [A friend of hers was 'crawling underneath the window ledge' so that the health visitor wouldn't see that they were in – the house was in a tip, they had only just got up, on so on.] [Caroline, my emphasis]

Some women made positive comments about their health visitor; for example, that she was involved, highly trained, gave good advice, was practical, involved and so on.

Another woman whose child was handicapped had major needs of the health visitor,
was emotionally more invested, and so developed a stronger relationship. One health visitor in particular had a supportive orientation and was well integrated into the community. She tended to be appreciated in terms similar to those used for community midwives; but there was no suggestion of the special relationship identified in Chapter 13. Nonetheless even some of these appreciative women still clearly distinguished the role of community midwife and health visitor along the lines indicated above.

M: Yeah, she played quite an important part. She was brilliant...She just knows everything. Yes, she was very good, very helpful, very positive person and I just think you need somebody like that...
R: [Were there any differences to the midwife's role?]
M: Well yeah you know that the midwife is there to support you and help you through your labour, and there again it's attention on you; whereas the health visitor I used to think was just looking at the baby, she was just making sure that he was ok, nothing really about myself, whereas the midwife is as concerned for me as she is for my baby. [Lydia]

In these ways, the roles of both GP and health visitor operate within the confines of the professional rather than the personal paradigm. In addition the specific role of GP and health visitor differs significantly from that of community midwife; in a way which detracts from the supportive, intimate, woman centred relationship mothers themselves value. This purpose of these comparisons is not to critique the roles of GP and health visitor, but to highlight by contrast the distinctive contribution of the community midwife. The analysis should be understood in the light of this objective. In Chapter 16 I consider the third of the '3Rs', the 'real' social context within which the midwife's role and relationships are enacted.
Notes

1. The distinctions do however speak of real differences of position and orientation.

2. This is from 22 respondents. Data on Amanda and Virginia are missing but given these were special relationships it is reasonable to infer that these would not object to midwives' clinics.

3. Vivien preferred it despite having known and liked her GP for 20 years; Jill despite having known her GP all her life; Lesley and Louise despite deferential orientations towards their GP; Vera and Lesley despite disappointing relationships with their midwives; and Abigail despite a marginal preference for seeing her GP.

4. Emily was emotionally reliant upon her health visitor; but this appeared to be an appreciative rather than a special relationship.

5. It may be suggested for example that the analysis unfairly favours community midwives because the postnatal interviews were held early in the postnatal period, before the relationship with the health visitor was fully established. Whilst accepting this does health visitors no favours, it remains the case that only 25% of the mothers were first time mothers. 75% of them can therefore speak from previous experience.
Chapter Sixteen

The Real Social Context
R: [What have you learned in the community?]
Mw: So much, learning so much all the time about how different it is once they're home; how unrealistic a lot of the care is that we give in hospital; how maybe we should know more about their home situation in order to give them the right advice in the hospital... I've learnt about myself, I've learnt about loads of different problems about babies that you'd never know about in hospital because they're never in long enough; the healing process; normal postnatal expectations and watching people who don't reach those and do have other problems. [Eg. Bleeding doesn't always stop, women get mastitis and sore perineums.]. I've learnt about accepting more responsibility and how I cope with that and how I cope with stress and how to speak with other professionals. I've learnt how to swear a lot at other drivers... I've also learnt a lot about just what sort of situations people do live in and how lucky I am... and they are normal human beings underneath it all. It just looks like they're someone's mummy all the time, but they're not, they're still that person... [Joanna, my emphasis]

I have suggested that the distinctive aspects of the mother/community midwife relationship hinge on three key features: the Relationship, the Role and the Real social context. The Relationship is an intimate, personal one. The Role is a psychosocial one, supportive and centred on the mother. This chapter looks at the third aspect, the Real social context. I shall suggest that the context of care fundamentally affects its character, creating some possibilities, precluding others. The community is the appropriate context of midwifery care, complementary to both Role and Relationship. It enables the personal and psychosocial aspects of midwifery care to be realised more fully. It does this by anchoring midwifery within the mother's social context; making visible and emphasising her psychosocial needs and concerns.

This has four consequences for midwifery. Firstly, it improves empathic understanding, which facilitates both Role and Relationship. The midwife has access at an existential level to feelings, knowledge, relationships, environments and priorities.
which would not be apparent in the hospital. Secondly, it enhances the psychosocial dimension of midwifery care, which is central to the community midwife's role. Childbearing is as much a psychosocial as a biological event and it is lived in the community. This is therefore the most appropriate site for the provision of psychosocial support. Mother and midwife experience the vivid realities of motherhood at the centre of the appropriate stage. Thirdly, it enables the midwife to give more appropriate practical advice because, as noted, she has more direct access and exposure to the mother's environment. Conversely, the hospital setting is culturally discontinuous with the real social and domestic context within which mothering occurs. This diminishes its practical utility. Finally, the community context facilitates the intimate and personal relationship. In the home context women typically feel more relaxed and more powerful and this means the relationship is more equal and open.

Both mothers and midwives indicate that it is easier to know and understand women in the community context. Their circumstances and viewpoint become more visible. It is more their domain. The hospital is more the domain of professional experts. These are not absolute distinctions; the comments about GPs indicate it is perfectly possible to practice in the community yet not engage with the mother's perspective. But it is nonetheless a key distinction for midwifery because it makes possible information, experiences and understanding which would be unavailable to even the most sensitive hospital midwife. Compared to the hospital setting, women feel they enjoy better care and better relationships; and midwives a better understanding and appreciation in the community setting. It is more personal, more relaxed, more humane. It is less clinical, less medicalised, less rushed and more individualised.
Midwives get a better appreciation of the realities of women's situations, and thus greater understanding and ability to engage and support.

... I think it's a very personal thing... it seems like because we are creating a family then the natural place to be is where that will happen. But also I'm not keen on hospitals generally and I'm suspicious of hospitals because I think you feel powerless and when you're on your own territory I think you feel more in control. [Valerie]

I guess it was different [to hospital] because in the end I think both of us were quite pleased it happened at home, it was something a bit different, it made it nice, it was relaxed; whereas in hospital you're under the glare of the lights. I remember sitting there while it was going on looking out at the trees: it was fairly different to a hospital. I remember last time people popping in and out. Looking back I wouldn't have changed it... I remember speaking to my sister later in the day and she was in hospital; and she said, 'I'm standing by the phone' and I could hear all these babies crying in the background and she said, 'Oh, I'm not too sure if that is David, I'd better go.'... I'm glad that I didn't have the pethidine and gas and air and all that palava; if I had gone into hospital... I'd probably have had it ... and I didn't really need it... It was just that much more natural and that much more calmer really... I didn't even say who I was, I just said, 'Is that Elizabeth?'; she just recognised my voice and she said, 'What's happening?' Just so sort of calm. As soon as I'd spoken to her I felt better. [Emily]

Well it's different in that you're alongside them in that you know that they're having difficulties with their mortgage repayments or that you know that the husband didn't want this baby — you know quite a bit about them. [Laura]

These distinctions are at their most pronounced when comparing clinical contexts, whether the hospital or the GP's surgery, with meetings in the mother's own home. Asked to compare them, women almost unanimously preferred the home context, with varying degrees of emphasis. No one expressed a preference for a clinical context. They identified three key differences. Firstly, the home setting did not have the disadvantages of the clinical setting. Thus mothers felt there was more time in their own home and they were not concerned about others waiting in the waiting room. The clinical setting feels impersonal, the home setting less so and more convenient. The
home setting, and the organisation of care within it (visits are typically more leisurely, with no queues or sense of outside pressures, and with a greater social component), fosters an environment in which it is easier to confide and ask questions and in which there is a better exchange of relevant information.

I learned more about coming in here (hospital) from that one visit than I did at all the clinics. There isn't time at the clinics. [Extract from Anna's field notes]

Yeah, you're not hurried at all and it's relaxed and you tend to remember what you want to say. [Lydia]

Secondly, the home setting alters the balance of power within the relationship. The woman's home is 'her' territory, the midwife is a guest and so both less presumptuous and less controlling. The imbalances of power within a professional relationship are subtly altered, with the mother relatively more in control and so more confident and relaxed.

I think there's this, 'You're in my home now.' I prefer that though. I'd much rather be in their territory than mine... and I tread very carefully... Yeah, they are different at home. It's nice, I like it, it's a positive thing... They're more confident, they're much more relaxed. You take what you find... they're the boss. I like it, I don't like this putting the bracelet on the wrist; we're not on equal terms. I feel more equal when we're in their homes. [Joanna]

You are a guest in their home and basically you're working within their perimeters rather than your perimeters really. [Laura]

It's my home and if I want to walk round in my bare feet —... You want to try and make them feel welcome; whereas there you are just like a number and they just get you in and out. [Louise]

Thirdly, the relationship is more sociable. Although the professional purpose defines the encounter as more than sociability, nonetheless the concept, as noted in Chapter 14, does draw attention to precisely that mutual, affective space within which mother
and midwife distinctively interact in the home setting. And integral to sociability is intimacy (Bologh 1990:217), the hallmark of the mother/community midwife relationship.

Oh I think when they come to your house they're a lot different, because you're not going to them, they're coming to you... When you go there it was like me making conversation more... But when Carol come here she was more relaxed because she weren't at work... she sat down and watched a bit of telly with me... I showed her the cot. She's very easy to get on with... You know you haven't got to rush or anything... When they're here they've got time to sit down and speak to you. But like in the surgery you've got to hurry up because there's people there. But there's not really that much difference, once you're in the room with them. [Celia]

R: [Where would you like antenatal care ideally?]
M: Oh I think the home, definitely.... I think just because it is more relaxing. I mean, the first thing I always say to Anna and Suzy when they call in is, 'Do you want a cup of coffee?'... Yes so it's much more sociable in the home. They're no less professional but it feels less professional. [Camilla]

This more sociable environment is one in which the mother feels more confident, relaxed and better able to confide.

...it always surprises me; you think ones coming to clinic every week or whatever, and you go and see them at home and all sorts of other things come out. They will tell you more at home, definitely. [Veronica]

If a woman plans a home birth, these influences are at their strongest. In the DHA studied here, all midwifery antenatal care of mothers booked for a home birth is conducted in her home. So they have relatively longer per visit, in a more intimate setting and with the expectation that together they will share an intimate birth experience. In these circumstances the relationship achieves greater depth.

R: [Home births, all midwifery antenatal visits at home. Does the relationship differ in consequence?]
M: Yes.... Because a friendship does develop. There's no seven ways about
it. A friendship does actually develop. I think it's work on both parties because you know it's going to be a sp - well not everybody views it as a special event but I think a home delivery, I think with family and that you do tend to bond a bit... because you're actually spending more time with the person you're building a closer relationship with somebody... as a home visit it's more of a social thing as well as a professional thing; whereas in the clinic it tends to be - ok, you do have your social undertones but not to the same degree... [Carol]

The home context therefore enhances the personal relationship and psychosocial aspect of the midwife's role. It is also worth noting that this allows women greater scope to express their vulnerability; for they cannot voice it unless they feel relaxed. Anxiety confounds vulnerability and will not permit it expression. Only in an environment and relationship in which they feel secure will women confide vulnerability in all its emotional hues.

R: [How does a home visit normally differ from the clinical setting?]
Mw: Probably from the fact that you're sitting down having a cup of coffee. You don't launch straight into something; you tend to relax, you tend to sit down, you have your cup of coffee and relax. It depends what people want to say to you. If they've got a problem I think they feel as though you've got more time to sit and actually listen to that problem. I think if there is a problem people will actually tell you about it in their own home setup, not so much a problem physically but more the emotional aspects of it tends to come out at a home visit. [Carol]

R: [Could you have same relationship in hospital if you had continuity of care?]
Mw: No I think the home does it... People relax more at home... Oh it's different yes, a woman to woman. I think you just sit down and you talk about anything. You could talk about bringing up kids, fashion, the next door neighbour. They'll talk to you about their problems, whatever it is. I've noticed that they don't offer GPs a cup of tea; whereas I'll be sitting there with one, a mug in my hand. They're setting a barrier up: 'The doctor will be too busy...the doctor's here.' [Anna]

Home visit. The mother was concerned for the condition and state of the baby and her ability to cope. She had not mentioned this at the clinic or classes; she didn't want to upset the women who didn't have this concern. Elizabeth had not anticipated this set of issues. She says with some women you know that they are nervous and use the home visit to get at it. With some you didn't know.
This woman, for example, always seemed extremely confident and capable. [Extract from field notes.]

On the other hand, women experience the hospital as 'an institution'; cold, impersonal and clinical. They draw attention to three particular aspects of the hospital environment. Firstly, it depersonalises. Within such an environment mothers and midwives are dissociated, care is stripped of its emotional aspect, and women become tongue tied, anxious and angry. In hospital, you are 'just a number', anonymous, stripped of personal identity. You are redefined as a 'patient'; sanitised, passive and helpless.

What do we do? We bring you in, we put you in a white gown and we put...a label on you. You're a patient, I'm a nurse. It's terrible... I feel it, every time I put a bracelet on a patient, on one of the women; now you're a patient. And they're not really. They're just in there because the facilities are there for them to have a baby. They're no different to me. [Joanna]

This is spoken by a midwife who moved from hospital to community based practice. The cognitive dilemmas are apparent in the extract; the pivotal point of which is her refusal to categorise women as patients. She corrects herself: '...every time I put a bracelet on a patient, on one of the women.' She then goes on to place herself as a person with the women, in the same plane of being: 'they're no different to me.'

Secondly, the parties do not know each other, despite the existence of a team midwifery scheme. The interaction is more superficial, less grounded, less meaningful. In these circumstances,
I guess the answer you give is quite a stat answer. You just answer their question. It's not a meaningful one, it's not from the heart. You're a midwife telling somebody something they've asked; where is was Joanna telling somebody something when they asked a question [on community]. We did have some women that used to come up quite regularly and that was great: 'Oh a face I've seen before!'. And they would latch on to you too. But yes, it is different. You're just a midwife... there's not that personal contact.... I was still myself but I just didn't feel I knew the person... I was desperately missing my women. [Joanna]

When Joanna returned to the community after an absence of 3 years she had to reestablish the rebuilding of relationships with the women.

You just don't know any of the women... And I also feel it when they come in and say, 'Oh another face!'... there's nothing I like nicer than walking out into the waiting room and spotting the woman who's next on the list, calling her by her christian name and saying, 'Hi, how are you?' rather than going out there not knowing who's who and just going out there and calling their name... And I missed the hands on... And you're looking at the most non maternal person. [Joanna]

The community midwife aspect of it, what makes it special has just got to be this continuity of care, and the fact that you do get to know the woman that you're looking after; and if you manage to stay in the same job for a while and they start coming back the second time around, that is lovely. [Elizabeth]

Thirdly, hospital is seen by many as an irrelevance, a waste of time. For them, impersonal care is impoverished care. With the exception of the scan, the care offered is seen as similar, and the setting less congenial and considerably more inconvenient.

You... go into a hospital and it's just so impersonal. As I say, although it's in my notes I haven't even bothered to make an appointment to go up to the hospital because to me it's just a waste of time. I'm a number to them and they'll have my file but they won't know anything about me. Whereas I know at this stage if I've got a problem I'll go down to see Anna or Suzy or Dr Peters and be dealt with in a much better, more humane way. And it won't take two and a half hours... That's something else, they will come back to you if there's a problem... I really don't see the point of it. I mean they look after you so well; why go and sit up there and have exactly the same thing done to you that Anna can do? [Amanda]
You don't know people. You go into a room cold. You've got minutes to get a rapport with that person... You can do it but it's not as satisfying. I can't remember their names for instance. I can remember the incidents. It's not as satisfying as going into somebody's house that you know, is it? [Anna]

The extract from Anna tells its own story. In a hospital context, the midwife noted for her intimate orientation forgets the personal details, remembering simply the 'incidents', abstracted away from their contexts. She remembers incidents not people. Her recollection is fragmented, decontextualised and depersonalised.

It may be suggested that these distinctions reflect not the social setting per se but the organisation of care, which in the hospital setting is typically more fragmented. According to this argument if there were continuity in the hospital setting, the same relationships could be formed. But even if one could overcome the medicalised, bureaucratised and hierarchical culture of the hospital setting, and even if continuity, familiarity and sensitivity could be fostered, the relationships would differ for the reasons indicated earlier: the woman's social context would be invisible, the relationship would be less personal and less psychosocially oriented, and the possibilities for realistic social support would be severely diminished because it would be enacted within an inappropriate environment, that of the expert rather than the client. In the extract at the beginning of this chapter Joanna eloquently summarises some key differences between the two settings. She identifies how the community context makes midwifery more realistic and more appropriate to the realities of women's lives, how it facilitates a personal relationship, and how unrealistic hospital care can be.
Looking back on the time in hospital, when somebody comes in you put them in a nightie; that person's in a nightie. With the best will in the world, that person's still in a nightie. You've got no idea of their social background or their emotional needs... [Carol]

Jeanette's always sticking babies under the tap... that's brilliant because that's what people will do at home. And I got hauled up and questioned about my procedure on doing bath demonstrations. And I just said, 'Ok then, you tell me one person who's got all the gear that I've got in front of me now... And then I was actually invited to go on the procedure committee and we changed it... But I did upset a lot of people. This one particular midwife stomped out of the nursery straight up to the boss. [Joanna]

So the community provides a context within which midwives can most appropriately be 'with woman' and supportive; incorporated within a personal paradigm. The midwife becomes an aspect of the community, part of the social network and the family unit; not 'facilitating' or manipulating it but immersed in it, part of it, oriented to both in a way the hospital context prevents.

Out in the community. On the rounds we repeatedly bumped into people Anna knew. In a traffic queue a car pipped the horn - it was the father of a woman whom Anna had cared for. As we left the house of one woman on an estate she saw another woman whom she knew and went over to say hello. Then we pulled up and Anna got some petrol for the car. At the kiosk she bumped into another woman she knew. Then when walking back to the car after visiting another woman she met another woman. She said how lovely it was to see her. Anna said that she had thought of dropping in to see her but was worried about intruding. The woman said with feeling and emphasis that she would always be extremely welcome: 'You would never be intruding.' She said that she had lent numerous of her neurotic friends Anna's relaxation tape and that she if she saw women going onto the labour ward with a walkman she would know why. The woman explained they had just been to see a school for her daughter. Anna said she knew the school and had heard good reports of it. [Extracts from field notes]

Being part of the network means that midwives are in a better position to support women indirectly as well as directly. As Anna says, 'I'm part of that community I realise now. I'm known round the estate.'
... there are a group of women in parentcraft class who all know each other and whose babies are due at around the same time. And when you come home and one of them says, 'How is so and so getting on?' of course you can't say, 'I can't divulge that'; you say, 'Fine'. You say something very bland that doesn't mean anything. 'Why don't you give her a ring?' if she's having a rotten time and could do with some moral support. 'Why don't you give her a ring; I'm sure she'd be glad to hear from you.'; that sort of thing. There are ways round it. [Elizabeth]

You do have influence, and you can change things if you like, and have an impact on people's lives... And what you do, through the role of the midwife. Midwives are important, particularly community midwives because you get the continuity of care; they're coming back to the same face every now and again and they value that. [Elizabeth]

Being part of the community means being personally involved and committed; and this brings us back full circle to the importance of an emotionally committed personal relationship.

R: [What makes you want to get back out into the community?]
Mw: My women. You're not supposed to say that, you know, 'my', the possessiveness, you're not supposed to feel possessive about it but you do. Because you see them, you know, they come back again, this relationship builds, and you get to know them.
R: Who says you shouldn't?
Mw: Who says you shouldn't? My friend Agnes. My friend Agnes. Ticked me off once for referring to somebody that I knew. And at, yeah, a refresher course, the first refresher course that I did, we were talking about continuity of care and shared care and they were saying how it's not healthy and good for you to think of them as 'yours', to think that you're the only person. And it isn't, I do recognise that, and I see myself sliding into it, and I think 'No, come on, you know get back, other people can do it.'... But we're not supposed to think of them as ours, but we do. [Elizabeth]

This extract indicates how midwives as well as mothers gravitate towards specific emotional commitment. It is not a perspective identical to the mothers' (and indeed these perspectives vary) but it is one which complements the midwife's psychosocial role and the personal relationship women seek. It means that midwives are extended beyond themselves and into intimate social circles they would otherwise never
Normally inhabit.

Bringing me up to date about the mothers seen on the first day. Kate has asked Anna to be godmother to her baby daughter. Anna did not know what to say. She felt that they had made a bold public statement in asking her to the first child's christening [she had gone to it at the time when the suspected child abuse enquiry was proceeding - nothing proved]. 'It was important to go along then to support them when that was going on. Even if there had been abuse they would still need people to stick by them.' [Extract from field notes.]

[On estate] I go and see them. Because I've become godmother to some. You see it's a most peculiar situation. I'd almost not become that. You could never be friends really, can you see what I mean, because your backgrounds are so different. They would feel uncomfortable, they wouldn't fit in if you had dinner. But they're still very special. [Anna]

There's quite a lot of them, especially on [estate]...but they either make sure they come and see me in a clinic. It happens very frequently, you've got a group in there. Or I'm going through a street so often they just call you in, or I pop in for a cup of tea. Or they send you photos... and some can't afford it. Send you every Easter or Xmas, little presents. A bit embarrassing really, because you couldn't afford to do it for everybody. [Anna]

The community midwife becomes both part of the family and part of the community.

I think you just feel that she's done this so many times before and living round here she's delivered so many babies round here that she's sort of part of the whole – part of the area really. And you see all these people waving to her in the car. Everybody feels the same about community midwives I think; I mean, they're really part of their life really. They remember when their birthdays are and all that sort of thing... in a way I'd like to go and have these babies in a country where the midwife is really part of the village atmosphere, never far away... It's a very special job, very special... I don't know how emotionally they cope with being part of each little unit. Because I mean I almost cried when she left after 10 days... And I was thinking, 'I wish she could come every other day or something,'; it would be nice if it almost was weaned off. I think it's quite sad... I remember feeling, 'It's like losing a member of your family really,' as she was going... Do you know what I mean? She's gone... I'd have liked her to pop in... I really did feel very upset and bought her a present. [Virginia]

The following case illustrates many of the points made about the utility of the community context. It shows how it facilitates understanding and develops a
perspective lacking in the experience of hospital based colleagues, in this case medical practitioners. It concerns the case of a baby who 'failed to thrive'. Her mother was a 24 year old single parent of three children, regularly battered and abandoned by her partner but nonetheless keeping her family unit intact. The woman desperately wanted to breastfeed her baby but the baby had difficulty feeding. Doctors diagnosed maternal abuse. The midwives and the health visitor, with personal knowledge of the mother, suspected the baby had a physiological problem absorbing the milk. Thus were set the competing perspectives: one founded on abstract, circumstantial information, the other on personal conviction. The midwives turned out to be 'right'. Their insights and convictions were derived from close experience in the community; a combination of personal exposure on the one hand, and a woman centred understanding on the other.

Extracts from the field notes bring these conflicting interpretations to life.

The problem in this 'problem' case appeared to be that the midwives were convinced that this was not a breastfeeding problem; they had seen her express sufficient milk. The doctors wanted the baby in for test weighs etc. The mother wouldn't let the baby go to hospital and the midwives said they "had gone down that road" already and believed that was not the problem. The problem they felt was an absorption problem. A previous baby of this woman's had a similar problem and this had been sorted out by giving the baby Wysol. The midwives oscillated between two perspectives. On the one hand the difficulty was to convince the doctors of the absorption hypothesis... At several points Carol looked exasperated whilst on the phone to the doctors... On the other the problem was that the mother desperately wanted to breastfeed and Carol in particular felt it would do "enormous psychological damage" to insist she stop breastfeeding and use Wysol... the baby was losing weight to an alarming extent, but the mother, a single parent with four children under three... did not want the baby to go to hospital. Notwithstanding the fact that 'she almost had me in tears' as a result of 'blowing up' at Carol, Carol was committed to the needs and support of the woman. She said to me, impassioned: 'She's coping really well... She's holding in there really well: her place is immaculate, she hasn't got a bean, she's got four kids under three, they're always really well turned out, she's got nothing going for her, the last thing she needs is this.' Carol spent approximately an hour following up swabs, talking to paediatricians etc., trying to get a lead on the baby's problem. She called me at 9 o clock that night, saying that she was going to see her with the health
visitor at 9 the following morning so would be late picking me up. [Extract from field notes]

Carol had a grasp of the woman's social and emotional circumstances which made her sympathetic and supportive. She explained,

She's a single mother aged 22 with four children. She's pretty isolated up there. She hasn't got a car. You imagine when she has to do her shopping she has to get all four children on a bus to go into town to get it... Her partner... comes back every now and again and thumps her about and gets her pregnant and goes off again. She's quite an educated girl, she had ambitions for herself... She knows he's a bad lot - she'll never be married to him - but what can she do? She's fallen in love with him... She wants to be sterilized, she's no fool, she knows what's what; but the consultants say she's too young and won't do it. [Extract from field notes]

It also gave her a perspective unavailable to hospital based colleagues. She went on,

Mw: The hospital don't think it was the soya milk last time... they think it was just coincidence. Because it has happened again this time they suspect neglect. They think she isn't feeding them. But you only have to look at the others to see they are all right. They say she does very little with them in the hospital. [Extract from field notes]

I asked if the mother knew the doctors suspected neglect. Carol said yes. I said she could hardly be expected to behave normally in a strange environment where she is with people who suspect her of neglect. Carol glanced knowingly and said: 'She's also got the other children to think of. She can't stay there indefinitely because of them.'

This case illustrates starkly the different knowledge bases of the professional and personal paradigms, as well as the influence of social location. The medical practitioners disregard the social context in two respects; first in denying her a sterilisation operation and secondly in preferring their own, socially removed, subjectivity to that of the midwife and health visitor.
But the baby was eventually admitted to hospital. When the relief midwife went to see how she was getting on the nurse said, 'She loves her bottle.' But the mother managed to continue breastfeeding, even though the hospital had told her she must bottlefeed her. Subsequently, milk intolerance was diagnosed.

**Deliveries by Hospital Midwives**

I conclude this chapter by dealing briefly with the suggestion that what has been depicted as distinctive to community midwifery amounts in practice to 'being there' at a major emotional experience, childbirth. If this were true, mothers would feel similarly towards all principal caregivers at delivery. Certainly, when women describe their labours it is not unusual for them to speak of strong feelings of affection and gratitude for their immediate caregivers, whether or not they had prior contact with them. Moreover, Klaus et al (1986) refer to the socially supportive effects of 'doulas', or specialist lay attendants, who attend and support the mother during labour, with statistically significant reductions in perinatal complications in the general sample and a shorter labour in women requiring no intervention. There are two aspects to this enquiry: i) Is the community midwife just in the right place at the right time?; and ii) Would anybody do as long as they are supportive? This boils down to one basic question: 'Does a preexisting relationship with a community midwife add anything to a delivery?'

It is clear that 'just being there' in itself is not enough. Mothers often refer to the unimportance of general practitioners or students during labour. It is the principal
caregiver who is likely to have a major impact, be it positive or negative. It is also well established that women do benefit from continuous emotional support during labour, although the nature of their requirements may vary.

Beyond this, two points can be noted. The first is that women's depictions of the delivery experience differs where the midwife is unknown, or relatively unknown, compared to that with their principal community midwife, even if the experience with hospital midwives was emotionally intense and positive. As noted in Chapter 14, women may describe their hospital midwife as 'nice', 'friendly', 'lovely' and 'caring'. They may also describe social and biographical exchanges more typical of established relationships. But what is missing from their accounts is the relational element: the depth of relationship on the one hand and the sense of shared experience on the other. This manifests itself only in relation to community deliveries. Even if the most intense emotional attachment was with the unknown hospital midwife at delivery, the community midwife, as the one who 'knows you and has seen you through it' remains an enduring association. An emotionally intense relationship with the hospital midwife is more like a blend of 'appreciative' and 'special' relationships in the senses discussed earlier, rather than the straightforwardly 'special' relationship characteristic of community deliveries. Moreover, it is significantly less likely to have the emotional intensity of a community delivery, notwithstanding that the midwife was present at the delivery.

It should also be noted that over 40% of respondents described mixed or negative intranatal experiences with hospital midwives, although this is not confined to the
principal caregiver. So the picture of woman centred, personal approach from some midwives has to be counterbalanced by the more familiar scenario of depersonalised care within the hospital context.

I found it much more clinical. The midwife wasn't very good...She was going on about, 'Oh well let's hope they hurry up with the morning lists... because I want to go for my lunch. And I was thinking, 'Well I want to go in as well you know, I want to get it over and done with. I'd been sitting there with an epidural in my back for the last hour and was still waiting to go... she couldn't have children... [Judy]

There were rules and restrictions which defeated the mother's own needs.

[Of relative] She's the one who's been with me through the nine months. They wouldn't let her in to see me. They said I was too tired... but I was up and walking around that day... She was crying her eyes out because they wouldn't let her in and I was crying my eyes out, so my mum sneaked her in. [Jill]

And there were examples of insensitive midwifery.

...when I tried to feed him for the first time it was the horrible midwife - or the not so nice midwife - and I mean she was just so rough with me. And she just sort of grabbed my nipple and shoved it in his mouth. And I was trying to do it myself, I really wanted to try and do it myself. And she kept sort of hitting my hand saying, 'No no, he's going to get confused if there's two people pulling around with him. And she just sort of had hold of me and I didn't have a clue how she'd latched him on... he came off and I didn't really know how to put him back on because nobody had shown me... She was telling me that I'm not allowed to touch his mouth because I'm confusing him. [Ellen]

These considerations suggest that, whatever the merits of deliveries with unknown, hospital based midwives, the experience with a familiar, community based midwife with whom a woman has an established relationship is distinctively different and preferable.

In addition, the picture which emerges of medical care in hospital is the familiar one of a depersonalised, controlling service involving the elevation of the expert, and
expert knowledge, within the professional paradigm. The 'patient' is overlooked, her insights are dismissed, and her body is taken over. She becomes the object of professional practice; stripped of knowledge, emotional needs, social location and responsibilities, fragmented, dislocated and objectified. This echoes the difficulties women encountered in their dealings with their GPs. But in the hospital context, anonymity, fragmentation, and decontextualisation compound these difficulties. The best endeavours of a minority of practitioners cannot overcome the structural obstacles to open and equal communication.

The vignette presented below illustrates these difficulties. It concerns a woman who had an elective epidural caesarian delivery. There were two sets of difficulties. Firstly, the quality of communication from the surgeons was extremely poor. The mother felt depersonalised and dissociated. This had a significant impact on the whole birth experience and her initial contact with her baby.

M: The whole thing was a let down, compared to Michael. I mean I wasn't introduced to the bloke, I was wheeled in there, I was full of sinus, I couldn't breath and they put a mask over my face... It was just all - it wasn't as nice. [Judy]

She found the administration of the epidural extremely painful. She was worried that she had been paralysed. She felt isolated and alone in her pain. They seemed to take ages to stitch her up. She had to wait ages for the porter.

M: I had such a pain down my right leg, I thought she'd done something, I thought she'd paralysed me or something. And my leg went, it jumped. And the midwife went, 'Oh your leg jumped then.' And I'm thinking, 'Shut up. I think I'm paralysed, how about a bit of reassurance, you know, I'm feeling absolutely awful over here.' And John was just looking at me... just looking at me, and I couldn't even
say anything else. And his poor face... because all he could do was hold my hand. But it was painful. [Judy]

She goes on:

M: I didn't even remember anyone saying, 'It's a girl.'... He hadn't come to introduce himself. And I was halfway through the op and I said, 'Who's doing it John, I don't know who's doing it.' And he said, 'I don't know.' And I said, 'Well who is he?' I don't know.' And I'd asked the night before and in the morning, 'Could I just know who it is?' And they never came and said, 'Hello, I'll be doing -'... I don't know, but it was terrible PR, it really was... It's quite frightening though, not knowing who's tugging away at your bottom half.

R: So he didn't introduce himself at all?

M: No. No. I even asked the nurses there and they said it could be one of two people. So I never got a reply. I felt like a bit of meat, you know, a pregnant cow in the vets. And all it would have taken was for him to waddle over in his greens and say 'Hi, I'm such and such and I'm doing the operation today.' That's all I needed, just to know who it was and what his name was. That, if anything, that can cause you to feel miserable afterwards actually, because you feel totally deflated; and you almost lose, you do lose a bonding with the child through all that. Because when I saw her I just thought, there wasn't the instant love that there was with Michael... I just thought, 'Oh God, take her away.'... I could have given her away quite happily at that moment... I didn't know what was happening, I didn't know whether she was out, whether she was in, whether it was a boy or girl... No one told me what I'd had... They brought her over and gave her to John. John actually tried to give her to me; I didn't want her, whereas with Michael I did. I just wanted to get out of that theatre, I just felt totally butchered. John said, 'Shall I go?' I said, 'Go, and take her away.' And then when I came into a room and John was sitting there in his greens and his hat was still on all lopsided, and he had this baby and he was standing there with this big grin on his face. And that was when I fell in love with the baby, then, when we were on our own in the room afterwards. But just laying there I just felt like it was like a big intrusion into your body. It was almost like a rape. It sounds crazy but it was almost like you'd been assaulted, without knowing who it is. Somehow if they'd made it a bit more friendly... [Judy]

So the community context enhances the midwife's relationship with the mother and her psychosocial role. It is permissive of both Role and Relationship in a way the hospital context is not. These three characteristics, the Relationship, Role and Real social context, explain the distinctive contribution of community midwifery to
maternity care. The following, concluding, chapter summarises the main arguments and findings of the thesis.
Notes

1. 'Community' bears a variety of sociological meanings. Here I use it pragmatically, to refer to the provision of midwifery care within GP clinics and the mother's own home.

2. Although as noted in Chapter 12 a community delivery does not guarantee this experience. See for example Emily and Jenny.
Part Seven

Conclusion
Chapter Seventeen

Conclusion
This thesis has made four main suggestions. The first is that the professional paradigm which dominates the midwifery literature is incompatible with the insights generated from mothers' own experiences. The second is that the alternative metatheory developed in the thesis, the personal paradigm, accommodates those aspects obscured by the professional paradigm. The third is that a corresponding reconceptualisation of sociological methodology is required in order to locate the researcher in the research process. The fourth is that mothers seek a personal not a professional relationship with their community midwives.

I suggested that the professional paradigm structures experience in ways which confer exclusive capability, competence and control on the professional. Firstly, it imposes a set of epistemic preferences, which elevate certain sorts of knowledge (abstract, rational, objective, formal) over others (embedded, subjective, emotional, experiential), and invest the former exclusively in the professional. The professional knows and the client does not. Secondly, it dissociates professional and client; investing competence exclusively in the professional and emphasising their differences. This dissociation pivots on the epistemic preferences noted above and on the professional's formal training. But it also dissociates the professional from her/his emotional and social biography. According to this perspective the doctor's life experiences, social identity, attitudes and values are irrelevant to the work s/he does. Thirdly, it fractures the relationship between professional and client, and renders the client an object of the expert's professional activity. It views the client through the eyes of an omniscient knower, and in so doing removes the professional from scrutiny.

This is a paradigm which casts the professional as expert, which only recognises
objective knowledge, and which views mothers as objects. There is no subjectivity, emotionality or interpersonal relationship.

My own analysis, by contrast, has been couched within the personal paradigm; a synthetic, rather than dualistic, metatheory which conceptualises research, professional and 'lay' activity within the same frame of reference. I have drawn on the work of feminist philosophers, methodologists, psychoanalysts, a psychologist, and sociologists to construct a metatheory within which consciousness, experience, and knowledge, (which for heuristic purposes we may identify as the perceptual, biographical and epistemological aspects of existence respectively) can be seen in their mutual, multidimensional complexity. Thus emotion informs cognition, experience informs abstraction, and biography informs knowledge and understanding. Within this frame of reference, there are no hard and fast distinctions between the way experts and non experts know, experience or exist in the world. In particular, there is no absolute distinction between objective and subjective knowledge, although professionals and academics often behave as if there were. We each have a subjective relationship with, and experience of, the world and the people we encounter within it. We have to work with full awareness of these complexities.

Looked at in this way, mothers and midwives exist in the same plane of being as each other. Each exists personally, subjectively and in dynamic relation to the other. The relationship becomes visible. Moreover, midwives' personal skills, their emotional resources and their biographical experiences all become relevant to how they operate as a midwife. The personal aspect of professional practice becomes visible and crucial.
Finally, since they exist in the same plane of being, midwives become the hourglass of women's childbearing experiences, a medium for cultural transmission and exchange.

I have used this metatheory to achieve the two research objectives: to discover what characterises a 'special' relationship on the one hand and to identify what is distinctive about the role of the community midwife on the other. To achieve the first objective, I analysed 24 relationships from both points of view, based on the personal paradigm characteristic of the mother's perspective. This suggested that 'special' relationships are personal relationship with their community midwife; one which is emotionally committed, woman centred and supportive.

The second objective broadened the analysis out, considering from a sociocultural perspective the distinctive aspects of the community midwife's role. I divided the relationship into the '3 Rs': the Relationship, Role and Real social context. I suggested the role is distinctive because it constitutes an intimate, personal, psychosocially oriented relationship between women regarding a core life experience, childbirth, in an appropriate social environment, the community.  

So women are seeking a personal relationship, not a professional service. The relationship between mother and midwife is intimate, emotional and biographical, and draws on the midwife's own cultural qualifications as a woman and/or mother. At all levels, perceptual, biographical and epistemological, this clashes with the professional paradigm. At the perceptual level, it requires the midwife to engage emotionally and
authentically, not merely rationally and abstractly. At a biographical level, it incorporates rather than denies the midwife's own social identity and experience. At an epistemological level, it pitches mother and midwife in the same, not different, plane of being and prioritises those ways of knowing undervalued in the professional paradigm; including intuition, experience, emotion and touch. It redresses the powerful, object oriented, manipulative dynamics of the professional paradigm and conceptualises instead differentiated dynamic relations within the context of a shared experience centred around the mother.

This account resonates with the understanding of some midwives (Flint 1987; Cronk and Flint 1989; see also Oakley 1992). But it struggles to find a voice in the dissonant chorus of the professional paradigm which so dominates maternity services research. My research may be seen as an attempt to redress this balance and to highlight those aspects overlooked to date; particularly the emotional, relational and biographical elements.

The mother/ community midwife relationship thus understood bears some similarities to women's friendship relationships. But there are two key differences. Firstly, there is space for women to be vulnerable with their midwives in a way which is denied in many friendships. Secondly, there is no requirement of reciprocity. Women made it clear that in these respects the community midwife is preferable to a friend.

This speaks of the enormity of women's emotional labour in their personal relationships (Finch 1989; Graham 1983; James 1989). Emotional labour of the kind
women perform in many of their domestic relationships is incompatible with the emotional openness and vulnerability of childbirth. There is a tension between their personal needs and their ideological construction within friendship relationships; the only solution to which appears to be professional care.

The mother/community midwife relationship provides a safe haven within which women can be vulnerable and have needs; where they can let go and be supported. In this way, professional boundaries preserve a space for women. But this gives rise to a contradiction, because women also seek emotional connection. Those mothers who were emotionally engaged were most likely to have a special relationship. Moreover, emotionally profound experiences such as a community delivery draw the parties together, inclining the relationship to friendship.

So the professional boundaries which preserve a space for them inhibit personal relationships. There is therefore a tension between the need for emotional connection and the need for personal care. It can, and has been, negotiated through the construction of midwifery within a personal paradigm; but few have yet dared to believe it. When they do, when they move beyond anonymity of professionalism to the intimacy of personal care, the consequences are profound and enduring, and challenges social and emotional oppression in other intimate and personal relationships.
Notes

1. This conceptual framework leads one to appreciate difference and complexity since it creates the analytic space for uniqueness. By extension, it requires one to consider the value and utility of the research for the research subjects and others, in so far as one can know it. This self scrutiny is crucial to feminist analysis and research 'for' women. It is clear that our perspectives will differ. The practical urgency is missing from my experience; the extended reflection from theirs. Whether these differences are useful will remain to be seen.

2. It is the woman centredness which leads to the psychosocial orientation; because this echoes women's own realities. In practice, of course, relationships and preoccupations may differ. (See Chapter 12 and Oakley 1992).

3. It may be suggested that this reproduces dualistic thinking. I do not think that this is so, provided the metatheoretical framework of the personal paradigm is utilised. The emphasis is appropriate to the enquiry; although it needs to be borne in mind that women are not only seeking a personal relationship. No account is entirely complete or whole.
Appendix One

Data Collection Instruments
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<td>d. Midwives' interview schedule</td>
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</table>
Observation Sheet
OBSERVATION SHEET

Date: Time: Mw No: M No: Obs. No.
Tape Ref: Duration:

Type of visit:

Previous contacts:

Booking status:

Complications:

Details on presentation

-------------------------------------------------------------------------------------------------

Observation

Commenced: Completed:

Others present:

Opening remarks:

Examinations: communication 'on the body'.

Procedures: communication 'off the body'.

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Examination of baby (if appropriate): communication.

'Off the body' communication.
Assessment/Overview

Midwife's orientation:

Midwife's disposition:

Mother's orientation:

Mother's disposition:

Relationship type:

Relationship character:

Relationship pattern:

Ascertain and consider:

Mother's response to observation:

Midwife's response to observation:

Observer's response to observation session:
Mothers' Antenatal Interview Schedule
Mothers' Interview Schedule

MW No: M No:

Section One. Background details

Date: Occupation:

Date of birth: Occ. pre 1st Prg.

No of weeks pregnant: Employment/ed. since 16:

Baby's due date: Employment/ed plans:

Housing: Marital Status:

NCT: Use of Car: working day, night

List of who see: Telephone: Income:

Parity: Partner's occupation:

Midwives: Delivery booked:

GP: Complications:

No of times seen: Mw: OtherMw: GP: Hsp:

Duration of meeting: Duration of interview:

Previous pregnancies: Parity: Gravida:

Delivery Date(s)

Duration pregnancy (ics): Labs:sp/ind/ac

Length of labour(s) Analgesia used:

How effective

Delivery type: Perineum: Intact

Tear(mi/maj); Epis

Baby: Sex, condition, complications

B/f?: Y/N; Duration; experience

Postnatal complications: medical, social, psychological

GP(s)

Who delivered

Midwife(ves)

AN care pattern

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Days in hsp

Three further sections:

i) experiences/previous experiences of pregnancy
ii) you and your needs
iii) your experiences of midwifery care during this pregnancy

Section Two: Previous experiences

Mother's account of those experiences:

i) of pregnancy/childbirth/breastfeeding/motherhood
ii) of maternity care
iii) how different this time around

Try to cover:

Recollections
Division of labour Mw/GP
Feelings (good/bad) about AN care
How could be improved
How compares this time

How was the labour and delivery; detail
Was it better or worse than you expected; detail

Who was with you during labour and the birth
Did you know them; how well
Who was most important to you at that time

How did you feel you were treated
What was good/bad about the care you received
Did you feel in or out of control
Were your wishes respected
Did you have the contact you wanted with the baby
How could the care have been improved/how
would you like it to be different next time

What do you particularly remember about that time
What were your overall feelings

Woman's A/c

Antenatal

Labour/birth

Postnatal

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In hospital
Pattern/duration of postnatal care
Was your stay helpful in any way
What did you like/dislike about it
How could it be improved

Domiciliary care postnatally
No of days visited; by whom
What did she do
Did you have any problems; detail
Value of midwife, in general/overall/most helpful
Feelings: likes and dislikes
How could it be improved
How useful (and in what ways) was the midwife

Relationshi
ps

Did any Mw/GP have much of an impact on you; why/why not
Which one was most important; why
Relationship with one who delivered the baby; cf cmw

How do you remember your community midwife
Did you find it hard to say goodbye

How were the midwives different
What difference did it make which midwife visited
Which did you prefer; why
How did the GP visit compare

Motherhoo
d

What was 'motherhood' like; good/bad
Was it ever difficult to cope/ feel depressed/ feel resentful. Detail.
How did you feel in yourself
What practical help/emotional support did you get
Did you get enough help; detail

Impact

Influence of ch/b, motherhood experiences this time around
Worries, wants, anxieties; which
Who do you discuss it with
Do you discuss it with your midwife; why/why not.
If so, how does she respond
Impact of a "second" time around on wants/needs/relationship with caregivers
How do the experiences compare

Which pregnancy do you prefer/why
Which midwife do you prefer/why (if appropriate)
Section Three. You in relation to midwifery care

Section 3.1 The psychological context

Psychological disposition:
Character/role id
Character type
Gender: attitude, role id, self id, ch/b
Feelings/anxieties
Relationships, personal and bureaucratic

How would you describe yourself as a character:
Five 'I am ...' statements.

How would you describe your roles in life:
Five 'I am a ...' statements

Are you more:
  i) an extravert or an introvert
  ii) practical/down to earth or imaginative/creative
  iii) a thinker or a feeler

Do you have strong opinions/ are you decisive

Statements (attitude):
A woman should stay at home and look after her children
My husband is the head of our household

Statements: (id: feminine role)
I am the homemaker in our family
I feel responsible if the house isn't tidy
I need to work outside the home

Did you always want to:
  i) get married
  ii) have a baby
  iii) have a job/ career
Which parts of your life give you particular satisfaction

Gender Id: self

Statements:
I like being called feminine
Would you describe yourself as a person or a woman

Women intuitively understand each other in a way men do not

Gender Id: Reproductive

Statements:
Having a baby makes me feel special
Having a baby affirms my womanhood

Is pregnancy something to be got through or an experience to be treasured. Why. Detail.
Dreams about/during pregnancy/childbirth/babies

Have you liked being pregnant. Why/why not

Was the baby planned
Do you intend to have any more; why, why not.

Contact with babies

Meaning of Motherhood

Have you always wanted to have children
Was it having a baby/child/family which attracted you
How do you feel about being/becoming a mother
What is 'being a mother' like

Emotionalty

Do you find it easy to express your feelings

Anxiety/control
Do you organise people/situations
Do you like to be in control
Are you a worrier; egs.
Do you have any worries about the birth etc.

Do you like to spend time on your own
Are you a private person or quite outgoing
Would you like to see more of people
Do you ever feel cut off from people

Do you find it easy to get to know people
Is it easy for people to get to know you

Do you like to know a lot of people or just a few
When/with whom are you most 'yourself/held back'.
How would you describe your close friends
Are they your 'own' friends or joint/family friends
Gender/other divisions
Role(s) of women friends

Section 3.2. The Social Context

i) The Past

Detail family of origin
Who were you close to as a child: 3
Describe relationships with family members now.

How do you get on with your mother
How does that rel. differ from your mother in law for eg.

Would you like her at the birth; why/not
How involved has she been in this pregnancy

ii The present

Employment/lifestyle

Psychological distance

Friendships

Significant Others (1)

Rel with mother

Employment

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What do/did you do.
Maternity leave or full termination
What did you like/dislike about it: 3.
How do you feel about leaving
Will you keep in touch with others from work
Do you plan to return to work; why/ why not
When/why/f/t/p/t/ child care plans

Which feels more 'you', your new role or the old one
How important is it for you to work outside the home;

What other things would you like to do

How has/will the baby will affect your attitude/
ability to work

Social support

Detail 'family of procreation'/living arrangements

Domestic

Emotional support

Self depiction

Who comes to mind if you are asked who
you are close to
Who do you contact when something exciting happens
Who picks you up when you're down

Who comes to mind if you are asked who you
rely on, day to day:
  i) in practical ways
  ii) emotionally

Crunch

Obtain following details:
  i) Of the ones relied on day to day:
  ii) Of other supportive contacts/relationships:
      a) nature of reliance
         mainly practical
         mainly emotional
         integral
b) importance
   very
   not very
   other

c) type of support
   emotional:
      time to self
      reliance/relied/expertise
      confiding/understanding
      other
   social:
      friendship
      a laugh
      company
      other
   practical:
      childcare
      childminding
      school runs etc

      housework: type
      shopping
      other

d) frequency (aggregate and individual)
   daily
   twice weekly
   weekly
   monthly
   other

e) expectation
   high
   low
   other

f) any paid help

   ii) degree of reciprocity
   iii) If just left work link up to those feelings

   Belt and
   Braces

3 closest relationships

Close

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Closest family relationships: 3
Mode, function and frequency of contact

Closest friendships: 3
Mode, function and frequency of contact.
Are they 'your own' friends or joint/family friends

Who are you close to in local community: 3
Mode, function and frequency of contact

Are you a member of any local:
clubs etc
groups
church etc
coffee/babysitting/mother/baby groups
AN groups
other

Establish mode, function and frequency of contact;
degree of friendship and importance of group.

New relationships developing (eg. AN). Ditto

What do you like to do (hobbies etc)
Opportunity for 'gratification'; who with;
frequency, etc.

Do you ever feel cut off from other people
Do you feel part of your local community; why/why not.
Would you like more contact with others
Would you like more personal space
Would you like to do things you don't do now

Describe a typical day – chores, social contact,
time 'on own' (including with children),
places visited
Typical week
How much 'you' time, how much 'you' contact
Quality of social contacts
How much 'you' time/contact

How do you feel at the prospect of the
next six months re. social contact.
What are you looking forward/not looking forward to.

How does this compare with life 'before children'
Which do you prefer (allow for pregnancy)
Do you feel happy/unhappy/acceptant with that lifestyle

'Around the house'

Who has responsibility for: i) the home
ii) the children

Who does what around the house:
cooking/washing up,
washing/ironing
cleaning
shopping
household management
DIY/ decorating
gardening
car
other.

Re. the children. Who does:
feeding
changing
bathing
comforting
up in night/ in morning
looking after when sick
going to clinic
taking to school etc
playing
outings
'minding them.'

How would you describe your relationship with X?
Do you tend to do things together or separately:
household tasks; leisure.
How involved is he in the pregnancy/other children
Does he ever have the children to give you time to yourself

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How was it different when both at work f/t.
Who has more free time

Who gives you practical help with:
a) i) the house; ii) the children; iii) other
b) Who, how often, typicality
c) What about your family/friends.
d) Do you get enough help

Statements:
I feel mainly responsible for:
i) the running of the home
ii) the children

I enjoy:
i) running the home
ii) my level of responsibility for the children

How much help do you get:
i) More than I need
ii) As much as I need
iii) Less than I need
iv) Other
NB: How much is that

Are your needs being met? Detail.

Society expects too much of women

**iii) The future**

What help would you like
What will you get
Who from, how long etc.
What will they do

Do you want someone to stay with you.
Who, how long, why.

What positive feelings do you have
What reservations do you have
What about when they've all gone home
Who will you look forward to showing the baby off to.

How do you feel about the forthcoming weeks/months
Section Four: Midwifery care.

What is a professional
Egs in own life of professionals relied on
(eg. solicitor, doctor, teacher etc) Detail

Gender re. childbirth

Statements:
Men are on the periphery of childbirth
Pregnant women prefer to be cared for by:
i) other women
ii) women who are mothers
It wouldn't matter if my midwife was male

Orientation
: Ideal Role

What is a 'professional'?
What else do you need to be a good midwife – experience, biography etc
Is midwifery just a service or more than that
What personal qualities go into being a good midwife
Statement: 'It would have been nice to know her as a person but apparently that's unprofessional.'

What would you like your cmw to be like ideally:
character and role

What does a community midwife provide:
i) in practical terms
ii) in emotional terms

Is her role most like that of a:
i) friend
ii) mother
iii) GP
iv) other

This pregnancy

How do you feel about this pregnancy/labour/motherhood
What have you enjoyed/ not enjoyed
What 'discomforts' have there been

Easier or more difficult than you'd expected; how
How is it different to last (previous) time(s)?
Are you more or less:
i) anxious
ii) relaxed
iii) tired
iv) laid back
v) other
Why

Is the c/midwife:
i) more important
ii) less important
iii) no difference
iv) other
Why

Ideally, who would you like to deliver the baby:
Someone I know:
   i) Cmw
   ii) GP
   iii) other
Someone I don't know
   i) hsp mw
   ii) hsp doctor
   iii) other
Don't mind
Don't care

Why:
i) they know what I want
ii) they know my background
iii) I trust them
iv) they won't spring any surprises
v) she's a friend
vi) other

Arrangements for delivery: actual & ideal
Impact of domino/non domino
Prefer home or hospital.
Any disadvantages of location booked

Plans, if any, for:
pain relief

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birth position
breastfeeding
stay in hospital
other

Mentioned to the midwife/on birth plan?

How do you feel about the forthcoming birth:
i) worried
ii) resigned
iii) looking forward to it
iv) other
Why

What are you not looking forward to

Do you worry about being 'out of control'?
Are you worried about 'making a fool of yourself'.

Would it help to have your mw/gp around; why
Is it better to have someone you don't know too well at the birth. Why?

Previous contacts with midwives
Cmws seen: who, how often, alone?
Know all the same or one more than others
Who is 'your' midwife

Would you rather see:
i) the same mw each time
ii) different ones
iii) don't mind
iv) other
Why

How well did you know your midwife
What did you expect her to do
What did you hope she would be like
How has reality matched up
Which has been most valuable to you:
( monitoring, advice etc, support, help)

Elaborate:
i) physical checks (you and baby)
ii) advice about worries/answering questions
iii) information (what to do when, benefits etc)
iv) education (explaining things)
v) practical help (showing you how to do things)
vi) emotional support (reliance, confide, be understood)
vii) the personal relationship (friendship)

Go through relevant AN bits of schedule
How useful have you found antenatal care

Do you rely on the mw in any way; eg.
i) make mental notes to raise things (what)
ii) someone to talk to
iii) sense of bonding you/baby/her
iv) other

Has she been important; how
Have your needs of her changed over time; how.

Likes/dislikes of midwifery care to date
How could it be improved

Home visit. Detail.
Compared to clinic was there more:
i) time
ii) informal chat
iii) discussion of your wishes
iv) discussion of your feelings

Were you
i) more relaxed
ii) less relaxed
iii) no different
iv) felt spied upon
v) other

Was she different in any way, eg:
i) more relaxed
ii) more talkative
iii) more open
iv) more interested in you

Did you feel you knew her/she knew you more after the home visit?

How useful for getting to know each other:
i) very
ii) not very
iii) no different to the clinic
iv) already knew each other
v) other

Comm’ty vs Hospital

How does hospital and community based care differ
i) longer waiting/travelling for hospital. No extra benefit
ii) more impersonal care from hsp doctors
iii) more impersonal care from hsp midwives
iv) community based more of a social occasion
v) meet other mums in local community

Is it more appropriate to have AN care based in hospital or community. Why

Which do you prefer. Why.

How did you feel about the scan

Social context

Choose from:
i) AN classes
ii) books
iii) family
iv) friends
iv) partner
vii) midwife
v) other

Where would you find out about something (eg. stages of labour)
Do you do that very often
Do you attend AN classes
Where would you get advice about something (eg. sex during pregnancy; heartburn; piles)
Do you do that very often

Who has given you 'moral support' during pregnancy:

What about practical help

Who have you felt close(r) to during pregnancy:

Establish position and importance of midwife in the social network

Knowing your midwife

Does it matter whether:
   i) you know your midwife
   ii) your midwife knows you
Why/why not (likes, trust, rel., )

Do you feel your midwife knows you 'as a person'
Would you want that

Do you want to know her 'as a person'
Do you find yourself wondering:
   i) if she is a mother
   ii) other personal/professional details
   iii) about other women she cares for
Do you ask her

4.1 Midwives compared to GPs

Functions of GP. (3) Compare to mw (3) above
How are midwives different to doctors
What does the midwife offer that the GP doesn't

Who is the expert on pregnancy and childbirth
Who do you find most informative/knowledgable

What is your GP/meetings with GP like
What is you MW/meetings with MW like
How about the other mw

Who would you turn to for:
   i) advice about pregnancy etc.
   ii) information

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iii) explanations about pregnancy etc.
iv) worries
Try to get cgs in each case

Who do you find it most easy to:
   i) Ask clinical questions
   ii) Raise personal matters
   iii) Raise minor matters
   iv) Chat
   v) Contact
   vi) Rely on

How would you describe your relationship
   with your midwife/GP
Who do you have the better relationship with; why.
Would it make any difference if your GP was
female/sympathetic/a mother etc.

Who do you prefer seeing; why
Who is most important to you; why

Who do you most trust
Who do you feel closest to

Who do you know best
Who knows you best

Who can you chat most easily to
Is there anything you would raise with one
but not the other
Has your mw/gp ever done/said anything
you didn't like. egs.
Who gives you most time
Who do you wait longest to see

How does the midwife's role differ from the HV's.
Which do you prefer; why

How important has your midwife been to date:
   i) important
   ii) quite important
   iii) not very important
   iv) not at all important
Why. Elaborate
Has any health care professional been more important
How useful has your AN care been. In what ways.

Is it a 'special' relationship; why/why not

Ask for preliminary/open ended account of midwife:
  i) as a person
  ii) of the relationship
  iii) of 'ideals'.

Who offers help most similar among family and friends.

4.3 Ideals

How would AN care be organised: eg. alternate/ midwives' clinics
Where would it be located – hsp, home, GP etc.
Would it be 1:1 or team midwifery

Section Five. The mother/community midwife relationship:

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Type</th>
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<tbody>
<tr>
<td></td>
<td>Pattern</td>
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<tr>
<td></td>
<td>Intensity</td>
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</table>

<table>
<thead>
<tr>
<th>Provides:</th>
<th>Practical support</th>
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<tbody>
<tr>
<td></td>
<td>Emotional support</td>
</tr>
<tr>
<td></td>
<td>'Social'/relational support</td>
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</table>

Compare it to friendship

Is it ever easier to ask for help/confide things to your midwife than a friend. Why?
Is it because you don't have to 'give back'. Does it help that you won't see her after the 10 day period.

Relationship

How would you describe your relationship with your midwife
What is she like

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How do you get on with her
Do you most value:
i) the practical help (advice, demonstrations etc)
ii) the clinical service (monitoring, weighing etc)
ii) emotional support (reliance)
iii) the relationship itself (personal).
Why

What is unique about your relationship with her
Who does she remind you of
What does her role remind you of

How important is she to you
Has she become more/less important over
time or no change; why
Would you say it is a 'special' relationship;
why/not
What is 'special'/not special about it.
Which other relationships are 'special' to you
at the moment

Compare her with other cmws had contact with
How is your relationship with her different
Which relationship do you most enjoy; why?

Provides:

Intensity

When did you begin to feel that you knew her
What do you feel you have in common with her
What distances you from her

Liking

How do you feel towards your community midwife
What do you like about her
What do you like about her
What problems do you have with her if any
How much do you rely on her. What for?

Confiding

Things you feel you can raise with midwife
Things you would like to raise but feel you can't
Things you turn to the midwife for in preference
to others
Any problems you don't raise with the midwife
- eg. housing, money.
Do you ever make a mental note to tell your midwife something. Do you rely on her in any way. Do you look forward to her visits. What sort of things do you talk to her about?

Expand

Do you rely on her in practical ways? Egs. Do you make mental lists of questions etc. What sort.

Expand – mainly pn.

What is she like as a character

Do you feel you know her as a person Would you like to know her more as a person.

Detail of biographical knowledge
Husband
Children
Hobbies
Likes/etc

Importance of being a woman, being a mother. What difference does 'knowing her' make to the relationship/care How is it like, how unlike friendship. Other imp. aspects Is it easier to ask for help/confide things to your midwife than a friend. Why? Is it because you don't have to 'give back'.

Does it help that you won't see her after the 10 day period.
Is it better to have someone you don't know too well at the birth. Why?
Does it help that you won't see her after the 10 day period.

Practical help, emotional support anticipated from mw.
Compare it to that provided by others.
PN. How does it feel getting help/support from mw rather than family/friends.

This is an important dimension – how similar,
how different, both practically and emotionally
to help provided by family, friends.

The help the midwife provides. Who offers help most similar among family and
friends.
Mothers' Postnatal Interview Schedule
Mothers' Postnatal Interview Schedule

MW No: M No:

Section One. Birth details

Date interview
Born at: hsp/home/other
Domino?:

Domino booked:

Date baby born:
Weeks pregnant:
Baby's age at int'vw:

Went to hospital: cms
Caregivers: 1st stage:
Turnover hsp staff:
Who delivered:

Whose direction:
Know IN caregivers?:
Student present?:

Contact cmw?: 3rd stage:
Others present:

Stay booked:
Ward booked/got:

Stayed del suite:
Left hospital:

Stayed PN hsp:

First saw cmw:
PN domiciliary visits: MW:
Signed off: days

First saw GP:
Other MW:
HV visit?:

GP:

Duration of meeting: Duration of interview:

PN Obstetric details

Previous pregnancies: Parity: Gravida:

Duration of labour: 1st stage: 2nd stage: 3rd stage:
Labour: spontaneous/induced/accelerated
Analgesia used: When:
Effectiveness: Satisfaction:

Requested:

Delivery type: normal vag/forceps/ventouse/breech/caesarian/other

Perineum: Intact/tear (minor/major)/episiotomy Stitches:

Baby: Single/Sex/Apgar/SCBU
PN Trauma: (Perineum/ stitches/ breasts, nipples/ afterpains/constipation etc/ other)
Severity: PN Blues: Obstetric Complications:
Feeding: Breast/bottle; duration; experience; problems
IN feelings: Labour/birth: Baby: Self: Carers:
SECTION TWO: HAVING THE BABY

The antenatal period

Did you enjoy being pregnant; why/why not
Was it easier or more difficult than you expected
What worries/anxieties did you have

What did you want the birth to be like;
  i) quick
  ii) natural
  iii) free from pain
  iv) other

What were you dreading:
  i) pain
  ii) repeat bad experience
  iii) out of control
  iv) other

Did you talk about any concerns to:
  i) your midwife
  ii) anyone else
  With what effect

What were you looking forward to:
  i) hoping for good experience
  ii) holding the baby
  iii) getting labour over with
  iv) ending the pregnancy
  v) having X with me
  vi) other

Who ideally did you want to be there:
  i) partner
  ii) friend/family
  iii) cmw
  iv) other

Who ideally would you have liked to deliver the baby

Did you have practical arrangements on your mind (eg. who look after toddler).
What plans had you made
What happened in practice

**Labour and the birth**

What were the first signs of labour:

i) pre labour:
   - sickness
   - backache
   - spring cleaning
   - irritability
   - other

ii) labour itself
   - contractions
   - show
   - ruptured membranes
   - other

What did you do:
   - contact midwife
   - contact hospital
   - make arrangements for child
   - contact partner
   - bath
   - pack
   - other

Time of first contact with health professionals
( relative to onset of labour)

Contact with community midwife
   - yes, for advice
   - yes, to go in
   - tried but failed
   - didn't try to make contact

If yes,
   - Effect of contact established
     - advice – detail
     - advice and home visit
     - advice, home visit and went in
     - met at the hospital

Feelings about that contact/advice
admission
contact,
hsp

Pre admission contact with hsp
Advice given
Feelings about the contact/advice and labour

Feelings
about
labour

How were you feeling at that time
Who did you want with you:
i) midwife
ii) partner
iii) other

Going in

Did you want to go into hospital
straightaway
leave it as long as possible
follow whatever advice give
other

Why

Did you want your family to know you were in labour
yes, no, didn't mind, practicalities
Why

Admission
procedure

Procedures

How many cms dilated were you
Who did you see
Did you know them
What did they do/say

Did they (ask to) do a:
Shave/enema/suppository/gown/drip/arm/
monitoring (periodic, continuous)/internals/
other

Did you agree
How did you feel about it

How did they treat your partner?
Did they ask him/her to leave the room at all

Did they ask you about your preferences/wishes
What did you say

How did you feel you were treated on admission

Were there any disputes
Did they do anything you didn't like

Did you feel they would respect your wishes
Did you feel in control
Did you feel that they were 'on your side'
Did you trust them

Would you like to be admitted the same way next time
How did you feel overall about the admissions procedure

Labour
first stage

Obtain a chronology. Include:

Caregivers during labour
How she felt about each of them
Any change of shifts and how she felt about that

How long did it take contractions to get started
Any slowing or stopping
When, why
How got going again and with what consequence
Effectiveness

What was done to her, whether requested by woman or professional, and how she felt about it:
i) procedures, (monitoring (type), drip, episiotomy, VEs etc)
ii) mobility during labour
iii) birth position
iv) pain relief
v) other

Nature and timing of pain relief obtained
Whose suggestion
Effectiveness
Side effects

Did you feel inhibited about crying out:
yes
no
other

Why
Did you feel inhibited in any other way. 
Did you feel out of control at any time. Detail and reason

What did the midwife do/say which she found encouraging 
What discouraging 
What did she like/dislike about her 
Ditto other professionals present

How did you know it was time to push; 
felt urge to and mw said yes 
felt urge to and mw said no 
midwife examined and said yes 
other

Subjective account of transition

Chronology of second stage. 
Recollections of what midwife said and didn't say 
Who most important at that time 
Who standing where/doing what

Woman's account 
Birth position – who decided 
Baby, where delivered to. 
Any resuscitation etc 
3rd stage injection

Did the GP attend at all 
If so when did s/he arrive 
Did s/he do/say anything ( eg. the stitching) 
How did you feel about: 
  i) the timing 
  ii) the visit 
  iii) was it social/duty

Stitches

Did you have any stitches 
Who did it; what materials 
What position 
How did you feel about it 
How much did it hurt 
How much trouble subsequently

Labour:
second stage

The birth itself

GP

Stitches
How long, post delivery, were you in the delivery suite for

Which procedures etc did you want:
i) at the time
ii) in retrospect

Which would you rather not have had:
i) at the time
ii) in retrospect

Did you feel that your choices were explained to you and your wishes respected
Did staff explain what they were doing and why
Did you feel in control
Were you satisfied with the pain relief

What was the worst part of the whole thing:
i) going in
ii) transition
iii) stitches
iv) the birth
v) other

What was the worst aspect of care:
i) admission procedure
ii) rudeness/bad social skills
iii) insufficient information
iv) changing shifts
v) not being listened to
vi) other

Who were you most keyed into during labour:
i) from a practical point of view
ii) from an emotional point of view
What part did the others play

How did your partner cope

Post delivery, how did you feel about:
i) the labour/birth
dreadful
pleased
relieved

Overall feelings

Overall
shocked
glad it's over
euphoric
other

ii) the baby
loved it
hated it
didn't want it
thought it ugly	
tender
other

iii) self
proud
embarrassed
disappointed
euphoric
shocked
injured
exhausted
other

iv) other (partner, midwife, other)

Who cried at the birth (apart from baby!):
i) mother
ii) father
iii) midwife

What was your overall feeling post delivery
(exhausted, delighted)
What labour/birth better or worse than you expected

Feelings towards caregivers
team

Carers/deliverer:
i) when first met
ii) how felt about any absences
iii) how felt towards them
iv) how remember them

How do you feel about the person who delivered the baby
Is s/he 'special' to you. How and why.
Compare this to feelings for community midwife
Did knowing/not knowing her make any difference;

Knowing:
 i) trusted her
 ii) felt she knew me, my wishes
 iii) felt it would be alright
     if she was there
 iv) tried harder because I knew her
 v) didn't want to let her down
 vi) felt more in control with her there
 viii) would have preferred someone I didn't know
 ix) other

Not knowing:
 i) pleased not to see her again
 ii) thought I would want someone I knew
     but it was fine
 iii) she was so nice it was ok
 iv) didn't care who it was
 v) make relationship anyway
 vi) other

Were you glad it was someone you did/didn't know
Why

How caring did the staff seem

Marks out of 10

Who would you have liked to deliver the baby ideally

If community midwife delivered:
 How did you feel about having her there; why
 How did it affect the way you felt about it
 Did you talk to her about the birth; when, what
 Did you feel embarrassed after at all
 What did she say about it all

Effect of her being there on relationship:
 i) None
 ii) felt embarrassed
 iii) felt closer
 iv) cemented it
 v) made it 'special'
 vi) other

The hospital stay

Post birth

501
Did you see the person who delivered the baby again
Do you know her name
Detail. How felt.
Would you like to have seen/kept in touch with her
Did you give any gift. Did you feel an impulse
to do so

Caregivers

Did you know any of them
Did they introduce themselves before doing anything
Did you know who were drs./nurses/midwives
Who was your favourite caregiver
Good ones/Bad ones anecdotes
Contact with doctors, in, pn. Feelings about that
Contact with paed. Feelings about that

Contact with others. Eg. the auxiliary staff,
night staff, relationships with them

What they did

What did they do
to you
to the baby
How busy was it
How was care affected by the hospital move
Did they show you how to:
bath/ top and tail the baby
feed ( breast or bottle)
other (hold it, wrap it, etc)
Were any of them dictatorial. Detail
Did you feel they 'took over' the baby or not
Anecdotes about hospital care
Food

Problems

Difficulties in the immediate pn period
Help sought
Help given
Mother's feelings

Were there any restrictions:
i) on visiting
ii) on access to baby
iii) other
Feelings about them

Contact with

502
Did you know anyone else in there
How were the other mothers coping
Did they help each other out
Did you get to know any of them

What did you do/talk about:
i) birth experiences
ii) feeding
iii) 'discomfort'
iv) staff
v) borrow things
vi) find out things (eg. info. routines)
vii) babycare
viii) support each other
ix) other

How much did you feel you had in common
Did you feel cut off from them
How important were they
Will you keep in touch with any of them

Practical help in hospital
Emotional support in hospital

In each case: who from:

i) drs
ii) mws
iii) auxilliaries
iv) mothers
v) others

Did you enjoy your stay in hospital
Would you like to go there next time
What would you keep the same next time around
What would you change next time around
Overall feelings about it

New hospital: experiences
SECTION THREE: THE POSTNATAL PERIOD AT HOME

Feelings

How have you felt in the first 14 days
- tired
- elated
- weepy
- depressed
- peaceful
- relaxed
- happy
- hassled

How have you found 'being a mother' (again)
- easy
- easier than expected
- terrible
- more difficult than expected
- a shock
- hard work
- other

How do you feel you are coping
- day to day
- well
- just
- not very well
- awful
- other

How does it compare with previous experiences
Who do you turn to if you're desperate
i) named person
ii) no one
iii) other

How are you feeling in yourself
- happy
- worn out
- like life has stopped for me
- like a new lease of life
- desperate
- depressed

Problems

Postnatal problems:
- weepiness
- depression
- panic
- sore perineum
sore breasts/nipples
constipation/piles
afterpains
difficult establishing breastfeeding
passing water
painful intercourse
nerves/depression
backache
tired – feeding baby
tired – crying baby
bleeding
other

Remedies suggested:
   by whom
effectiveness

Raised with midwife? What effect

How's the baby:
   placid
cries a lot
won't sleep
windy
won't feed
other

How do you feel towards the baby
   could murder it
   besotted by it
   ambivalent
   fitting it in
   other

Breast or bottle feeding. Why
If changed to bottle feeding, why

Did you feel prepared for the baby
If so, where did the preparation come from;
i) classes
ii) own experience
iii) seeing others
iv) books etc
v) other

How useful were AN classes in preparing you
How have you found having visitors
  too many
  too few
  ok

Did you feel as if you had to put on a face
for them
(If appropriate) Did you feel ok about feeding
in front of them

Any family tensions with the visitors
Any other tensions with visitors

How has he responded:
  i) Doing a lot more
  ii) Back to normal
  iii) Doing little
  iv) other

Detail of pn help provided
  partner at home and what he did
  any family member who stayed and what did
  any friends who stayed and what they did
  any non resident help from family
  any non resident help from friends

Who did the
  cooking
  looking after you
  looking after the baby
  housework
  looking after the other children
How much/how long for

Duration of help

Establish when each of these bits of domestic help
terminated

Deviations from pre birth PN support plan
Feelings re. help rec'd

How did you feel about accepting this help
  felt guilty
  felt I had to supervise
  felt pressure to reciprocate
  enjoyed it
  felt it brought us closer

How 'helpful' was this help. Detail
Who did you find most helpful. How and why.
Did you get enough help. Detail.
Ask whether there were any helpers who 'did not have to be told'. Who, how helpful, egs.

Who did you get the most practical help from:
a) re the baby, b) re the home c) re other children
i) partner
ii) family
iii) friend
iv) midwife
v) other

Who did you get the most emotional support from:
i) partner
ii) family
iii) friend
iv) midwife
v) other

How did you feel when things 'got back to normal'
  relived - want to get into routine
  relieved - domestic hassles
  relieved - no one does it the way I want it
  missed the practical help
  missed the company
  missed the moral support
  didn't mind either way

What would you keep the same next time round
What would you change
What additional help/support would you have liked

Overall feelings

Was the labour easier or more difficult than you'd
expected. How.
How would you like it to be different next time
Has the postnatal period been easier or more difficult
than you'd expected. Why.
How would you like it to be different next time.
Did you feel like writing about your birth experiences

Compare with previous:
i) labours
ii) babies
iii) pn care
iv) pn 'adjustment'
How do you feel about labour/birth now
How would you like it to be different next time round

Overall impression of first 14 days

Who has been most important to you in the
last 2–3 weeks. (3)
Why. What have they done etc.

Who have you enjoyed showing the baby off to

Feelings (likes and dislikes) about forthcoming 6 months
Employment plans (if expressed AN)
How different now (if at all)
SECTION FOUR: MIDWIFERY CARE IN THE COMMUNITY

Detail of mws who visited
Who present at the meetings
Effect of others present on the meetings

Did you look forward to her visits (support) Detail.
Did you make lists of questions. Egs.

When did you first see your mw after the birth
What did the midwife do

Did you talk to your mw:
i) about any of the
   problems
   feelings
   referred to above or
ii) any other issues.
   With what consequence

Did she get you through any difficulties; eg:
i) the blues
ii) feeding problems
iii) perineal trauma
iv) coping
v) other

Did you raise any other issues with her
Were there any problems you did not feel able to raise.
Detail.

How important was she postnatally:
a lot
a little
not at all
other

How did you find her most useful postnatally:
i) practical help, demonstrations etc
ii) advice about worries – what on
iii) answering questions – which
iv) checks on the baby
v) checks on self
vi) someone who understands how I feel
vii) someone I can lean on (cf friends)

Did you get help re. these matters from anyone else (eg. mother)

Did you feel you needed help from her about; eg:
i) feeding
ii) your body
iii) the baby
iv) childcare
v) contraception/diet
vi) other

How does the help she offers differ from help from family and friends
i) she's an expert
ii) can be vulnerable with her, won't lose face/see her again
iii) feel you have to 'give back' with friends
iv) feel you have to appear competent etc with family/friends
v) it doesn't
vi) other

Did you feel she had a lot of experience. How important was that.

Any alternate day visiting. How did you feel about that;
i) indifferent
ii) relieved
iii) ok either way
iv) disappointed
v) panicky
vi) other

Did it matter whether you knew your mw; how.

Does it matter that you see the same mw each time:
i) yes
ii) no
iii) other
Why

Would you say you had continuity of care:
i) in the community
ii) in the hospital
ii) in the hospital

Aware of 'team midwifery'
How worked out in practice

Do you want a 1:1 relationship or is it enough just
to know them

Does having a cmw deliver you have any advantages over
a hsp mw, assuming that you know them both

What does 'knowing your midwife' mean:
i) you knowing them: familiarity
ii) them knowing you: needs and wishes
iii) each of you knowing each other as people (relational)
iv) other

What difference does 'knowing her' make to your
feelings about the midwifery care you receive

Did you get to know her better over time

If so, did you:
- trust her more
- like her more
- tell her more
- want to know more about her

Did she open up more. How

What was the most important element of 'knowing her'
at the time:
i) someone you trusted who knew you; trust
ii) someone who would give without you having
to give back: non reciprocal caring
iii) someone you knew who knew you: mutuality
iv) other

What difference does it make that she visits you
in your own home
How is it different to the clinic/hsp
Which location do you prefer:
i) hospital
ii) home
iii) gp surgery
iv) other

Why: Just convenience or more than that
Do you feel more in control in your own home; why, why not

Did you prepare for her visits in any way: eg,
i) Get up
ii) Tidy the house
iii) Dress the children
iv) Get special food/drink in
v) Other
Why.

Did you feel 'watched' at all
i) yes
ii) no
iii) other

Was it easier to develop a relationship with a cmw than a hsp mw. Why:
i) hospital too rushed
ii) community/home more relaxed (informal)
iii) com/home more appropriate (social vs medical)
iv) you have more control over things in community
v) other

Could the mw have given the same help in hsp or GP clinic:
(compare for eg. pn hsp mw)

Explore situationally appropriate to need.

Did your GP visit you PN
What did s/he do
How important was that visit to you
How did it differ from a visit from your mw
Does it make any difference that he's a man

Have you met your HV
Has she visited you
What do you think of her
How does her role differ from MW
Who do you feel closer to; why
Does it make any difference whether she's had children herself
Has she

Did you talk to her about the birth. What said.
What did you talk about:
   i) routine pn matters
   ii) small talk – subjects
   iii) chat – subjects
   iv) other

How well do you know her:
   i) very well
   ii) reasonably well
   iii) not very well
   iv) not at all

How would you describe her as a person

Did you want to know her more 'as a person'. Egs.

Did she talk about herself at all. Detail.

What do you know about her as a person

Do you know of:
   i) husband
   ii) children
   iii) hobbies
   iv) likes etc
   v) church
   vi) other prof. work
   vii) holidays
   viii) other

Do you know if she has children of her own

Did anything get in the way of knowing her better
( eg. own pre birth anxieties)

Did it matter whether your mw:
   i) was a woman
   ii) had children of their own
   iii) other

Why

Has the midwife had much impact

Was she important to you. Why/why not
   i) needed help and expertise
   ii) relied upon her support
iii) helped me through a difficult patch
iv) liked her
v) other

How close did you feel to your midwife
   very
   quite
   not very
   not at all

Why

How much was that because of:
i) your needs at the time
ii) her as a person
iii) her role
iv) other

How does it compare with any previous experiences
i) of mw
ii) of cmw
iii) of other systems of maternity care

Did it make any difference which mw visited.
How, why.

What hopes/expectations did you have of the relationship;
i) high
ii) low
iii) perfunctory
iv) other

What would it be like ideally:
i) Professional
ii) friendly
iii) friendship
iv) other

How has it matched up;
i) better than expected
ii) as expected
iii) worse than expected
iv) other
How and why

How would you describe her:
i) friendly
ii) special
iii) professional
iv) down to earth
v) remote
vi) other
Who/what would you have liked ideally

How would you describe your relationship with her
   distant
   professional
   friendly but not friends
   felt like a friend to me
   close
   other

When did you begin to feel that you knew her
What have you in common with her
What have you not got in common

Would you describe it as a 'special' relationship
   Yes
   No
Why, why not.
   special time of life
   she's a special person
   midwife has a special role
   just doing her job
   other
What is unique about it
What does is most remind you of (nurse, mother, friend etc)

Which are the 'special relationships' in your life at the moment

How did the relationship change in the PN period:
i) got to know each other better - more contact
ii) knew each other better - home surroundings
iii) arrival of baby changed needs of her
iv) arrival of baby made her more imp
v) other

How would you summarise;
i) the midwife
ii) your relationship with her
iii) an ideal m/mw relationship

Friendship
How is it like, how unlike a friendship
Is it easier to ask for help than with friends
Is it easier to be vulnerable than with friends
Is it easier because you do not have to 'give back'
Does it help that you won't see her again

How is it most unlike a friendship (eg. lack personal knowledge or lack reciprocity)
How is it most like friendship (eg. caring)

Did you find it hard to say goodbye. Why, why not
Would you have liked to keep in touch
Did you feel like giving her a gift. Did you
SECTION FIVE: EVALUATION

How useful did you find her visits overall
i) very, needed her knowledge and expertise
ii) very, needed the moral support
iii) enjoyed them more than needed them
iv) could have done without them
v) a waste of time

Could you happily have done without them

Was she more important:
  i) AN
  ii) IN
  iii) PN
How and why

Did you find the midwives useful. If so, how

How important were each of the following:
  i) showing you how to do things: practical help
  ii) answering questions/reassurance: advice
  iii) helping with problems: practical support
  iv) explaining things to you: information/education
  v) help with feeding: practical help/advice
  vi) emotional support/reliance: emotional support, personal
  vii) intimacy/friendship: emotional support, social
  viii) monitoring/checking etc.
  ix) other

What did you most value overall:

Which mw did you find most helpful
How would you like it to be different next time

Did you enjoy the visits. Why/why not

How would you describe the postnatal visits
  i) routine
  ii) important
  iii) a waste of time/nuisance
  iv) social occasions
  v) other
How important was 'knowing her'?
Would it matter if you'd seen a different midwife each time?

Was it a 'special relationship'
  i) yes
  ii) no
  iii) other

How does she compare with other midwives you've met:
  i) more friendly
  ii) less friendly
  iii) the same
  iv) other

How important was she to you
  i) very
  ii) not very
  iii) other

How did you feel towards her:
  i) very close
  ii) liking
  iii) nothing much
  iv) negative
  v) other

Who was the most important person overall out of:
  i) cmw
  ii) GP
  iii) one who delivered baby
  iv) HV
  v) other

How do you feel towards your mw compared to:
  i) the one who delivered the baby
  ii) the GP

How would you sum up your relationship with your
  c/midwife
What do you think were the significant factors
  affecting your relationship with your midwife

What would you like to be different next time
What would you like to keep about the service next time
What would you like to change next time

How does it compare with your previous experiences

SECTION SIX. TAKING PART

Did you and your midwife discuss the research
(If yes) What was said

Did taking part affect the relationship in any way
i) re you (eg. sensitised you)
ii) re. her (attentiveness etc)

What made you agree to take part?

How did you find taking part
i) interesting
ii) a nuisance
iii) didn't mind either way
iv) other

General

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Midwives' Interview Schedule
Summary Details: MW:

Date of qualification as a midwife: Age:
Post basic/direct entry:
Where trained: i) as a nurse
   ii) as a midwife

Years of practice as a hospital midwife: F/t: P/t:

Years of practice as a community midwife: F/t: P/t:

Marital status:
Children (ages):
Partner's occ:

GPs work with: Sample GP:
Division of labour:

Duration of meeting: Duration of interview:
Date:
Other:

Sample GP:
Duration of interview:
Date:
Other:
Midwives' Interview Schedule

Mention:  
- May cover old ground  
- Informal but lots of questions. Mw bring in what seems relevant to her  
- Tape on/off  
- Attend delivery  
- Three sections to interview

Three sections:  
1. Personal aspects of midwifery practice  
2. Professional Practice  
3. Mothers/relationships

Section One. Personal aspects of midwifery practice

1.1 Background

What made you decide to become a midwife  
What made you decide to become a community midwife  
What would you like to do ideally  
What do you enjoy about being a community midwife  
What are your strengths as a community midwife

1.2 Personal qualities

How would you describe yourself as a character:  
Five 'I am ...' statements.

How would you describe your roles in life:  
Five 'I am a ...' statements

Character/Role

M y e r s  
Briggs  
T y p e  
descrip.

Are you more:  
i) an extravert or an introvert  
ii) practical/down to earth or imaginative/creative  
iii) a thinker or a feeler

Do you have strong opinions/ are you decisive
Do you contain or express your emotions
e.g. hugging, anger.

Do you organise people/situations
Do you like to be in control
Do you like everything to be in its place
Are you a worrier; e.g.
Do you suffer stress related illnesses
/have trouble sleeping
Are you placid & easy going or active & assertive.

Are you shy or outgoing
Do you like to be at the centre of things
When/with whom do you feel you are 'yourself'
Who do you like to be with
Is it easy for people to get to know you
In what circumstances/situations do you
'hold back'; e.g.

Do you find it easy to get to know people
Do you ever feel lonely

Which parts of your life give you particular satisfaction
Think of parts of your life that you feel positive about: which images come to mind
Sources of positive self esteem in midwifery

Statements (attitude):
A woman should stay at home and look after her children
Women who want careers shouldn't have children
My husband is the head of our household
The social differences between men and women are biologically determined
Gender id: feminine role

I am the homemaker in our family. I feel responsible if the house isn't tidy.

Did you always want to:
   i) get married
   ii) have a baby
   iii) have a job/career

Gender id: self

Statements:
A woman's femininity is her greatest asset.

Women understand other women more.
I feel closer to women than men.

Orient bur rel

What is a 'professional'?
What does it mean to be 'professional'?

Choose a professional relationship important to you (solicitor, GP, bank manager).
How would you describe it?
How do you feel/what did you need?
Is it just a service or more than that?
How did you feel about saying goodbye/did you want to know them better?

Statement: 'it would have been nice to know her as a person but apparently that's unprofessional'.

1.3 Biography

Background: age, marital status, children, occ. sp.
Details of family of origin.

Who were you closest to as a child?
What were your aspirations as a child (career, marriage, baby)?

Have you had personal experience of:
i) pregnancy
ii) childbirth
iii) breastfeeding
iii) full time motherhood

Can you describe your recollections and feelings
How do you remember the professional care you received

Have you experienced such other major life events as:
i) depression/anxiety
ii) miscarriage
iii) infertility
iv) relationship breakup
v) bereavement

Can you describe your main recollections and feelings

How, if at all, have these experiences affected your approach in your work.

Social support

Domestic labour: home

Who is your house is responsible for:

the children - getting them up etc
- 'being with' them
- ferrying them around
cooking/washing up
washing/ironing
cleaning
shopping
household management
DIY/gardening
cars
other

Do you:
i) employ any professional help
ii) get any other help (eg. partner, children)

How would you describe your relationship with X?
Do you tend to do things together or separately:
i) household tasks
ii) leisure
iii) friends

What about the emotional wellbeing of the family
Do you do any 'emotional labour' for others — eg. relatives, parents, neighbours, friends etc.
What about practical care outside the family and work

How much 'personal space' do you get:
i) in the average day
ii) in the average week
How do you like to spend it

Outline of personal social contacts in the average week

Who picks you up when you're down
Who do you contact when you're excited
Who gives you day to day moral support

Which are your closest personal relationships:
How much contact do you have with them
How much in the last week/Is that typical
What if anything is 'special' about them

Do you like to know a lot of people or just a few
How would you describe your close friends
Do they tend to be:
i) women/men
ii) women with careers/in the home.
iii) colleagues/not colleagues
iv) like you/unlike you as a character
v) similar/dissimilar life circumstances to yours
vi) similar/dissimilar interests

Are they based around:
i) doing (eg. hobbies)
ii) talking (eg. confiding)
Are you a member of any:

i) organisations
ii) church
iii) community groups
iv) informal social groups (‘girls’ night out)
v) other

Do you ever feel you would like more practical/social/emotional support

Do you belong to any professional organisations (eg. RCM, ARM)

Who do you turn to for:

i) practical help
ii) emotional support
iii) social contact
in your professional work.

Egs (in the last month).
Is there much contact of that sort

Do you agree that cmws are quite isolated
Do you ever feel you would like more support/contact

What about mothers/ex mothers
What about the midwifery managers

1.4 Juggling work and home

Please describe a typical working week, indicating:

i) time spent on antenatal care
ii) postnatal care
iii) deliveries
iv) administration
v) other

Are you ever called on in your off duty hours
If so:
how often
by whom
for what reason
with what result

Formal

Profession
al

Public/prv'
te
How do you feel about these interruptions
How do your family feel:
i) about you being a midwife
ii) about the interruptions

Length of average working week

What is convenient about cmw from a family point of view
What is inconvenient
How do you manage the clashes

1.5 Personal orientation/disposition towards midwifery practice

Gender
re.c’birth
Disposition

Men are on the periphery of childbirth
Pregnant women prefer to be cared for by:
i) other women
ii) women who have had children of their own
A man could make a good midwife
A man could make a good mother

Meaning of childbirth
Disposition

Is pregnancy something to be got through or an experience to be treasured. Why. Detail.
What images come to mind when you think about:
i) a pregnant woman
ii) a woman in labour
iii) a newly delivered woman

Statements:
Being pregnant is an affirmation of womanhood
Pregnancy is a sensual/ erotic/sexual state

Professional

What is 'a professional'?
To what extent is a midwife 'a professional'
What else does she have to be?
Is it better to be detached or involved
(How does this differ from the medical profession )
Disposition

What do you need to be a good community midwife
What personal qualities do you need
What sorts of characters does midwifery attract
Would you say that midwives are: strong minded; organised.
How does this enter into your own work
What/who has particularly influenced you as a cmw

Do you find it helpful to have experienced some things yourself? Which – prompt if necessary.
How important is being a woman, being a mother.

Role orient: biography

How important is it to be: a woman,
a mother,
other

What does it add to cmw.
What has it added to your own practice
Is it appropriate to draw on your own experiences

Role orient: personal

To what extent can you be 'yourself' as a cmw
How are m/mw relationships like, how unlike, friendships.
What about relationships with colleagues

To what extent do you draw in aspects of your personal life:
i) own experiences of childbirth etc
ii) family
iii) hobbies
iv) other
Egs.

Section Two. Aspects of Professional Practice

2.1 The role of the community midwife

What does a (community) midwife do
How does her role differ from that of the GP
How does it differ from hospital midwifery

Orientation
How does her role change over time

2.2 Personal orientation to midwifery practice

How would you describe your approach to midwifery? What are the hallmarks of your practice? How do people (mothers) describe you?

What does it mean to 'practice midwifery as it should be practised'?

Would you agree that: most pregnancies/births are uncomplicated/complicated at some stage?

Are cmws more likely than doctors/hsp mw to see childbirth as normal rather than normal only in retrospect?

Are cmws/mws more likely to emphasize the psychological/social aspects of childbirth?

Do you approve of home births? Why/why not? Do you raise the possibility of it or only if the woman raises it? Do you discourage women who raise the possibility?

What do you get out of being a midwife? What gives you particular pleasure/satisfaction? What do you find stressful in your work? How do you cope/deal with it?

What do you like best about being a cmw? What do you like doing best (an, in, pn)? What did you like doing best in hospital? What do you like best about being in the community? One suggested advantage is 'being your own boss'. Can you elaborate on that?

What do you feel is the most important part of your job?

How many deliveries do you do a year on average?
How do you juggle this with your other commitments?
How do you select mothers for domino delivery?
What effect does you doing the delivery have on:
you, the mother, the relationship?

2.3 Practice Orientation/style

Which is the linchpin of cmwery:

The relationship (social)
The emotional support (emotional)
The clinical service (clinical)
The advice/information (information)
The Educative role (teaching)
The practical help (showing, helping)

Why
Which do the mothers most value

Rate the relative importance of:
Experience
Practice style
Personality
Biography
Formal Training.

How much of what you do is:
Common sense
Training
Skill
Experience
Intuition
Formal knowledge/research based

What part does:
friendship
intuition
feeling
play in midwifery
What about clinical skills

What atmosphere do you try to foster during your meetings
What sort of atmosphere do you try to foster during labour
How do the mothers etc describe you
Emotions in midwifery: Disposition

Which of the following emotions come up:

Pain
Fear/Anxiety
Dependence
Trust
Love
Empathy
Anger
Shock
Eroticism
Rivalry
Defensiveness
Hostility

How do you deal with these feelings:
i) in yourself
ii) in others

When do they tend to arise
Which of them are helpful/unhelpful
Which do you find you have to come to terms with

When do you feel most emotion
When do you have to control yourself most

2.4 Practice Issues

What has experience taught you about effective care re:

- pain relief/delivery positions
- perineal/wound trauma
- breastfeeding/babies
- other

Do you ever find yourself disagreeing with 'the experts'?

Procedures/practices you find helpful
Practices/practices you would like abandoned
eg. temperature taking, weighing mothers, guthrie
Policy prescriptions for procedures at clinics, home visits, home assessments. How useful.
Popular misconceptions about midwifery practice
What have you learnt from experience

What are the objectives of antenatal care
How effective is it
How valuable is it to the mothers

What are the objectives of postnatal care
How effective is it
How valuable is it to the mothers

2.5 Relationships within midwifery hierarchy

What explains the difficulties between 'management' and mws/cmws
How could things be improved
What made life so difficult for DMS
Would you like to be in management. Why/why not

Can you describe the relationships between hospital and community midwives

Relationships between community midwives
Who do you feel you work well with and why

Sources of difficulty

Relationships with other colleagues (eg. GPs, students)
Section Three: Relationships with Mothers

3.1 Mothers

Getting to know

What are the important things to know about a woman: (5)
How do you get to know a woman
How do you 'suss out' her situation and needs
How do you go about building a relationship

Which women do you find it easy to get to know. Why.
Which women is it hard to get to know. Why.

Which 'cases' are particularly satisfying for you
How do you deal with 'difficult' cases; eg. stillbirth

Women's priorities

What do mothers most value:

The relationship and emotional support
The clinical monitoring
The advice/information
The practical help

What does the mother most want from her cmw

Variability of need

Do women's needs of their midwives change over time

Mention the 'regulator' 'facilitator' concepts
Do different women have different needs and expectations:
i) about pregnancy etc
ii) about childbirth

Do primips and multips have differing needs; if so, how
Do working and middle class women have different needs
Other 'special need' groups: eg. teenage mothers

Are there some women you just know its going to be difficult with
Which women seem to 'adjust' well to motherhood
Which women find it more difficult
Are some women more suited to natural childbirth than others
Which women tend to have have difficulties breastfeeding
How is this linked to women's sexuality

What is the best time/way to get to know mothers
Do you prefer the clinics or the home visits. Why
Does booking at home have advantages over the clinic

What has being a midwife taught you about:
  i) women/variability
  ii) the experience of becoming a mother
  iii) pregnancy/childbirth etc
  iv) the role of the midwife

3.2 Mother/Midwife relationships

How would you describe the m/mw relationship
What about the m/cmw relationship:
  i) what's 'special' about it
  ii) what effect the community context has on it
  iii) what effect does the hospital context have
Establish whether this is community = appropriate or permissive

How does it differ from the relationships women develop with their GPs. Detail

What sort of relationship do you aim to establish
  ( 'friendly but not friends for eg."

How is it like, how unlike a friendship:
  i) for the woman
  ii) for the midwife

Do women develop/tend to develop one close relationship
or build up several.
Is it more likely to be with:
  i) the GP
  ii) the community midwife
  iii) the person who delivers the baby
Do you and your team partner tend to build closer relationships with different types
of people – ie. specialise.
Do they build 1:1 relationships or is it enough just to 'know' the midwife
Do they try to get to know you 'as a person'.

How much do mothers ask about your personal life:
  i) own experiences of childbirth etc
  ii) family
iii) hobbies
iv) other
Egs.

What are the most important stages of:
i) the relationship
ii) the care

What would you say makes a relationship 'tick'
What cements them
When is the midwife most important to the mother
When is the closest time
What difference does it make if you already know them

Can you give an eg. of relationships which went really well
What about ones which didn't
Does the 'talk' vary
Do you feel more involved/yourself/satisfied
What do women complain about in relation to maternity care

What effect do others have on the interaction
i) students
ii) fathers
iii) grandmothers

How do the fathers and grandmothers relate to you

3.3 Miscellaneous

- saying goodbye, keeping in touch
- when do you find it difficult to say goodbye
- uniform, apron, badge, blazer, hat etc.
- delivering friends, good idea, what difference
- feminism

3.4 The future of midwifery

What do you think of team midwifery: in theory, in practice
How would midwifery care be organised ideally
Do mothers like it
Practical steps to improve women's experiences of midwifery

How do you feel about the increased emphasis on research and training

How would you like to see midwifery develop
What threatens that development
How will midwives be affected if the local hospital goes self governing.

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Appendix Two
Letters of Introduction
and Explanatory Notes
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Letter to Mothers in Observational Study
THE MOTHER/COMMUNITY MIDWIFE RELATIONSHIP

Thank you for allowing me to attend your meeting with your midwife.

The relationship between a mother and her midwife is often described as 'special' but surprisingly little is known about it. The purpose of this research is to identify what is 'special' about it in the community setting.

The research is divided into two main phases. In the first phase I accompany a number of midwives on their 'rounds' and at clinics, in order to observe them at work. This is the part of the research you have been involved in. The second phase of the research involves interviewing both mothers and midwives. You have not been involved in this part of the research.

The research is registered as a PhD at the University of Surrey and is funded for three years from October 1989 by the Economic and Social Research Council (ESRC). The identities of all those taking part will be protected. If you have any queries relating to any aspect of the research, please do not hesitate to contact me. My home telephone number is Guildford 66466.

Thank you once again for your help.

Yours sincerely

RUTH WILKINS
Letter to Mothers in Interview Based Study
THE MOTHER/COMMUNITY MIDWIFE RELATIONSHIP

Thank you for the interest you have expressed in this research.

The relationship between a mother and her midwife is often described as 'special' but surprisingly little is known about it. The purpose of this research is to identify what is 'special' about it in the community setting.

The research is divided into two main phases. In the first phase I accompany a number of midwives at work in the community. You have not been involved in this phase of the research. In the second phase I talk (on an individual basis) to a number of mothers and midwives about their relationships. This is the phase of the research you have been asked to take part in. It does not matter how well you know your midwife.

If you would like to take part, your midwife will let me know and I will contact you with further details. Participation is purely voluntary and does not affect the maternity care you receive. The research is registered as a PhD at the University of Surrey and is funded for three years from October 1989 by the Economic and Social Research Council (ESRC). The identities of all those taking part will be protected.

If you have any queries relating to any aspect of the research, please feel free to contact me at any time. My home telephone number is Guildford 66466.

Thank you very much for your help.

Yours sincerely

RUTH WILKINS

543
Explanatory Notes for Mothers
Notes for Mothers

Thank you for the interest you have expressed in this research. The purpose of these notes is to explain the aims of the research and the part you can play in it.

About the research

The relationship between a mother and her midwife is often described as 'special', but surprisingly little is known about it. The basic aim of the research is to identify what is 'special' about it in the community setting. (Of course it may not always be 'special' but this is one of the things to explore.) It will explore women's experiences of community midwifery and the distinctive contribution of the community midwife to maternity care. In these ways, the research may help ensure that women receive midwifery care appropriate to their needs and wishes.

The research is registered as a PhD at the University of Surrey's Department of Sociology and is funded for three years from October 1989 by the Economic and Social Research Council (ESRC).

Organisation of the research

The research is organised into two main phases. The first is an interview based and the second an observational study. A self completion questionnaire may also be distributed.

The Interview based study

This is the main part of the study and will look at a number of relationships from both points of view. It is divided into two phases. The first phase consists of brief interviews with approximately 12 mothers (and their midwives) at the booking clinic stage, followed up by either a brief questionnaire or discussion after the baby's birth.

The second phase involves approximately 24 relationships. These will be followed from late in the mother's pregnancy onwards. This will involve two in-depth interviews with each mother; once in late pregnancy and again a few weeks after the baby is born. Her midwife will also be interviewed briefly regarding each relationship and in more detail regarding her own experiences as a community midwife. The 'interviews' will be informal discussions on an individual basis, reflecting on the themes of the research, rather than formal question and answer sessions.

Mothers and midwives may also be asked to complete a questionnaire.

The observational study

The focus of attention in this part of the study is on how the midwife practises in the community. For a short fixed period (about 2 days) I shall accompany each midwife as she goes about her work. If you are taking part in the main study, you may also be involved briefly in this phase of the study (see below).
Summary of your involvement

If you are taking part in the interview based study, your involvement depends on which stage of pregnancy you are at:

i) If you are in early pregnancy your involvement will consist of a short initial meeting plus brief follow up contact after the baby's birth, (either a short questionnaire or a brief conversation). The initial meeting should take place on the day you book or shortly afterwards.

ii) If you are in late pregnancy, you will be involved for about 3 months (so that your relationship with your community midwife can be followed to its conclusion.) During that time I will 'interview' (ie. talk with you) twice. The interviews will take place at your convenience, but I expect that in most cases this will be in your own home. These meetings will take about one and a half to two hours each. I may also ask you to complete a questionnaire after the baby is born and to allow me to attend one or two of your meetings with your midwife.

How the research will affect you

The research is being conducted to help improve our understanding of the mother/community midwife relationship and to help ensure that women receive the sort of care they most want and value.

In this way the research may benefit both mothers and midwives in future. The benefits for you personally are less easy to identify, apart from the satisfaction of knowing that you are directly contributing your knowledge and experience in a much needed way. One possible benefit is that you may find it enjoyable to talk through your experiences and feelings with someone who is interested in exactly those matters. I am myself the mother of two young children and the research arose from my own experiences of midwifery care.

The research is about your feelings and experiences and those of your midwife. I shall ask your midwife and you to reflect upon your relationship (although nothing you say will be disclosed to your midwife and vice versa). As the research progresses it will become clear how the different themes link together. However, if you have strong reservations about the central theme of the research (relationships), or the fact that I shall also be talking to your midwife, it may be better for you not to participate.

You can at any stage refuse to answer any question put to you in the course of the research, or indeed withdraw from the research as it is being conducted. I can be contacted at the address given below.

It is also important to stress that this research is completely independent of the maternity care you receive. Nothing you say will be passed on to your caregivers. Your identity will be protected in any public references (see below). Participation in this research project is entirely voluntary and there is no cost to you if you do not participate or if you withdraw. This is a piece of social science research with no
formal connection with any organisation other than the University of Surrey.

Anonymity

The research is being conducted to improve our understanding of the mother/midwife relationship in the community and to make that knowledge available to a wider audience. I hope to publish the research findings in due course, possibly as a book or a series of articles. Any information obtained will be used for the purposes of the research and I may refer to it directly or indirectly in research reports, papers, talks, publications and so on. In all such cases I shall protect the identities of those taking part by changing names (and other details if necessary). Where possible, all data collection and analysis will use numbers or pseudonyms rather than original names; where this is not possible (for example in the transcription of tapes) access will be strictly limited (for example to the researcher and transcriber).

Finally, I should point out: 1) that some people will of necessity know that you are taking part (e.g., your midwife and some of her colleagues); and 2) the possibility (however remote) that someone may try identify 'who said what' in the research. I mention this simply so that you are aware of such a possibility and for no other reason.

I am extremely grateful for the interest you have shown in this research and hope that you will consider it yours as well as mine. I look forward to getting to know you personally; and to understanding how you feel about the care you receive. Please keep me in touch with your feelings and observations as the research progresses. I shall be 'around' in person for much of the next year; alternatively you can contact me at the university or at home in the ways listed below.

Note: This research is subject to the provisions of the British Sociological Association's 'Statement of ethical principles and their application to sociological practice' (as amended, May 1982), the Social Research Association's 'Ethical guidelines' (1988/89) and the University of Surrey's 'Ethical guidelines for research and training' (October, 1980, currently being revised).
I hope that these notes have given you a good idea of what the research entails and of the contribution you can make. If, having read it, you have any queries of any kind, please do not hesitate to contact me. I shall also be available throughout the research project to answer any other queries and/or hear any other observations you may have.

My details are set out below:

Name : Ruth Wilkins
Contact
Address : Department of Sociology
          University of Surrey,
          Guildford,
          Surrey, GU2 5XH
Work Tel. : G't 571281, Ext. 2809
Home Tel. : G't 66466
If you would like to take part, please complete and return this form in the stamped addressed envelope provided.

THE MOTHER/COMMUNITY MIDWIFE RELATIONSHIP

Name : 
Address : 
Tel. : 

Midwife : 1. 2. 
GP : 
GP's Surgery Address : 

I have read the 'Notes for Mothers' and agree to participate in the research referred to therein.

Signed ...................... Date..............
Explanatory Notes for Midwives
THE MOTHER/COMMUNITY MIDWIFE RELATIONSHIP

Notes for Midwives

Thank you for the interest you have expressed in this research. The research is to be based in the Guildford area and I hope that you will be able to participate. These notes will explain the nature and purpose of the research and the part you can play in it. If you have any queries of any kind, please do not hesitate to contact me at any time. My details are set out at the end of these notes.

I hope that you are able to take part. To do so, please complete the form enclosed with this letter and return it to me in the stamped addressed envelope provided. I will then send you further details.

About the research

The relationship between a mother and her midwife is often described as 'special'. However the nature and importance of the relationship has been virtually overlooked in research terms (except as an incidental part of the 'midwifery process'). This research attempts to remedy this deficiency. It will attempt to identify what is 'special' about the relationship and to draw out the practical implications of the research findings. (Of course, it may be that it is not 'special' to some people, but that is one of the things to explore.) In this way it is hoped that the research will help to ensure proper recognition of the community midwife's distinctive contribution to maternity care.

The research is registered as an MPhil/PhD at the University of Surrey's Department of Sociology and is funded for three years from October 1989 by the Economic and Social Research Council (ESRC).

Organisation of the research

The research is organised in three sections. The first is an interview based study, the second is an observational study and the third is based on self-completion questionnaires.

The interview based study

This is the main phase of the study. The idea is see how relationships develop over time. About 20-25 relationships will be followed from start to finish, looking at them from both points of view. This will be done by a series of informal in-depth interviews with the mothers and midwives concerned. Each mother will be interviewed briefly at the outset and again in more detail a few weeks before the baby is due and about 6 weeks after the baby is born.

There will be about 6 teams of community midwives participating in this part of the study. Each participating team will have about 4 clients involved in this phase of the research. Each midwife will take part in two brief interviews regarding each specific
relationship. She will also be interviewed in more detail regarding her own experiences as a community midwife.

The observational study

The focus of attention in this part of the study is on how the midwife establishes and maintains the relationship with her client. For a short fixed period (about 2 days) the researcher will accompany each midwife participating in the main study as she practices, subject to agreement with the parties concerned. Mothers in the main study may also be featured in the observational study.

The self completion questionnaires

The purpose of this phase of the study is to situate the in-depth studies described above within a wider context. Two self completion questionnaires will be distributed, one to about 100 mothers and the other to about 100 midwives. All mothers and midwives participating in the main study will be asked to complete a questionnaire. In addition, each team of midwives from the main study will be asked to distribute questionnaires to approximately 20 additional clients meeting specified sample criteria (subject to agreement). Community midwives from other DHAs will also complete the questionnaire.

Summary of your commitment

Your involvement will span about one year (so that specific relationships can be followed from start to finish.) During that time you will be interviewed briefly about 8 times (twice for each client), lasting about 30 minutes each. (In practice your commitment may be less than this). You will also be interviewed in detail once. This will take about one and a half to two hours. You will also be asked to complete a fairly detailed questionnaire.

Therefore, in the course of a year, the research will involve a commitment of about 7 hours. In addition the researcher will follow you 'at work' for about 2 days, but this should not require a commitment of time in and of itself.

How the research will affect you

As stated above, the research is being conducted to improve our understanding of what uniquely characterises the mother/community midwife relationship. I believe it to be an important piece of research which should help ensure better recognition of the role of the midwife in the community and in so doing improve the maternity services available to women in the medium to long term.

In this way the research may benefit both midwives and mothers in the medium term. It is less easy to say what benefit you personally will derive from participation, apart
from the satisfaction of knowing that you are directly contributing your knowledge and experience in a much needed way. One possible benefit is that you may find it enjoyable to talk through your experiences with someone who is interested in exactly those matters.

At times you will be asked about yourself as a person, since your role demands personal as well as professional qualities and experiences. At other times you will, with the informed consent of your client, be reflecting upon specific relationships; your client will be asked to do likewise. The relevance of these themes will be clear once the research is underway. However, if you have strong reservations about the central theme of the research (relationships), or the fact that I shall also be interviewing/questioning some of your clients, it may be better for you not to participate.

You can at any stage refuse to answer any question put to you in the course of the research, or indeed withdraw from the research as it is being conducted, without having to give any reason to me. I can be contacted at the address given below.

It should be emphasised that this research is independent of your employers, colleagues and professional organisations (although it may in different ways involve them all). Nothing you say will be passed on to them. Nothing you say will be attributable to you. Your identity will be protected. This is is a piece of social science research with no formal connection with any organisation other than the University of Surrey.

Anonymity

The research is being conducted firstly to improve understanding of the mother/midwife relationship in the community and secondly to make that knowledge available to a wider audience. I hope to publish the research findings, possibly as a book or a series of articles. Any information obtained will be used for the purposes of the research and I may refer to it directly or indirectly in research reports, papers, talks, publications and so on. The anonymity of participants and their responses will be preserved at all times by changing names (and other details if necessary). No one other than the researcher will have access to research records or material identifying those involved in the research. Where possible, all data collection and analysis will use numbers or pseudonyms rather than original names.

Finally, I should point out: 1) that some people will of necessity know that you are taking part (e.g., some clients and colleagues); and 2) the possibility (however remote) that someone may try identify 'who said what' in the research (even though for the reasons given above they will have no way of knowing). I mention this simply so that you are aware of such a possibility and for no other reason.

I am extremely grateful for the interest you have shown in this research and hope that you will consider it yours as well as mine. I look forward to the chance to get to know you as a professional and as a person; and to understanding the challenges of
your professional role. Please keep me in touch with your feelings and observations as the research progresses. I shall be 'around' in person for much of the next year; alternatively you can contact me at the university or at home in the ways listed below.

Note: This research is subject to the provisions of the British Sociological Association's 'Statement of ethical principles and their application to sociological practice' (as amended, May 1982), the Social Research Association's 'Ethical guidelines' (1988/89) and the University of Surrey's 'Ethical guidelines for research and training' (October, 1980, currently being revised).

General

I hope that these notes have given you a good idea of what the research entails and of the contribution you can make. If, having read it, you have any queries of any kind, please do not hesitate to contact me. I shall also be available throughout the research project to answer any other queries and/or hear any other observations you may have.

My details are set out below:

Name : Ruth Wilkins
Contact Address : Department of Sociology, University of Surrey, Guildford, Surrey, GU2 5XH
Work Tel. : G't 571281, Ext. 2809
Home Tel. : G't 66466

If you are willing to participate, please complete the form enclosed with these notes and return it to me in the stamped addressed envelope provided. I will then contact you with further details.
'THE MOTHER/COMMUNITY MIDWIFE RELATIONSHIP'

Please return this form in the stamped addressed envelope provided.

Name : 

Contact address : 

Contact tel. no. : 

Surgeries attached to : 1. 2. 

I have read the 'Notes for Midwives' and agree to participate in the research referred to therein.

Signed......................... Date.............
Bibliography

Ackerman B. (1986) 'Midwives – Past, Present and Future' in Claxton (ed.).


Allen J. (1989) 'Women Who Beget Women Must Thwart Major Sophisms' in Garry & Pearsall (eds.).


Anderson J. (1986) 'Medical Knowledge – Its Relationship to Medical Information and Information Systems' in Kohout & Bandler (eds.).


Arluke A. (1977) 'Social Control Rituals in Medicine' in Dingwall, Heath, Reid & Stacey (eds.).


Association of Radical Midwives (1986) The Vision Ormskirk The Association of Radical Midwives


Averill J. (1986) 'Acquisition of Emotions in Adulthood' in Harre (ed.).

557


Ball J. (1989) 'Postnatal Care and Adjustment to Motherhood' in Robinson & Thomson (eds.).


Beinart J. (1990) 'Obstetric Analgesia and the Control of Childbirth in Twentieth-Century Britain' in Garcia et al (eds.).


Bell C. (1978) 'Studying the Locally Powerful: personal reflections on a research career' in Bell & Encel (eds.).

Bell C. & Encel S. (1978) 'Introduction' in Bell & Encel (eds.).


Benney M. & Hughes E. (1977) 'Of Sociology and the Interview' in Bulmer (ed.).

Bierstadt R. (1977) 'A Critique of Empiricism in Sociology' in Bulmer (ed.).


Blum H.P. (1986) 'Psychoanalysis' in Kutash & Wolf (eds.).


Bulmer M. (1977) 'Introduction Parts 1, 5, and 6' in Bulmer (ed.).


Cass B. et al (1978) 'Working it out together' in Bell & Encel (eds.).


Clark C. (1989) 'Studying Sympathy: Methodological Confessions' in Franks & McCarthy (eds.).


Clarke M. (1978) 'Getting through the Work' in Dingwall & McIntosh (eds.).

Claxton R. (1986) 'Introduction' in Claxton (ed.).


Cooper C. (1990) 'Psychodynamic Therapy: the Kleinian approach' in Dryden (ed.).


Coulter J. (1986) 'Affect and Social Context: Emotion Definition as a Social Task.' in Harre (ed.).


Davies J. (1991) 'The Newcastle Community Care Project Part 1. The Project in Action.' (pre pubn.copy) in Robinson & Thomson (eds.).

Davis A. & Horobin G. (eds.) Medical Encounters London Croom Helm.

Delmar R. (1986) 'What is Feminism' in Mitchell & Oakley (eds.).


Deutscher I. (1977) 'Asking Questions (and listening to answers): a review of some sociological precedents and problems' in Bulmer (ed.).


Dingwall R. & McIntosh J. (1978) 'Introduction' in Dingwall & McIntosh (eds.).


Duelli Klein R. (1980) 'How to do what we want to do: Thoughts about Feminist Methodology' in Bowles & Duelli-Klein (eds.).

Ehrenreich B. & English D. (1979) For Her Own Good. 150 Years of the Experts' Advice to Women London Pluto Press.


Evans F. (1991) 'The Newcastle Community Midwifery Care Project; evaluation of a social intervention. Part Two' (pre.pubn.copy.) in Robinson & Thomson (eds.)


Figlio K. (1987) 'The Lost Subject of Medical Sociology' in Scambler (ed.).

Finch J. (1984) 'It's Great to have Somebody to Talk To: the ethics and politics of interviewing women' in Bell & Roberts (eds.).


Finch J. & Groves D. (1983) 'Introduction' in Finch & Groves (eds.).


Frank J. (1986) 'Foreword' in Kutash & Wolf (eds).

Frank J. (1986) 'What is Psychotherapy?' in Bloch (ed.).


Fraser C. (1976) 'An analysis of face–to–face communication' in Bennett (ed.).


Gamarnikow E. (1978) 'Sexual Division of Labour: the Case of Nursing' in Kuhn and Wolpe (eds.).


Garcia J. (1982) 'Women's Views of Antenatal Care' in Enkin & Chalmers (eds.).


Garrett S. (1989) 'Friendship and the Social Order' in Porter & Tomaselli (eds.).

565


Goffman E. (1978) 'Make – Do's' in Denzin (ed.).


Graham H. (1983) 'Caring: a labour of love' in Finch & Groves (eds.).

Graham H. (1983) 'Do Her Answers Fit His Questions?' in Gamarnikow et al (eds.).


Greed C. (1990a) 'The Same But Different' Paper presented at British Sociological Association Conference, 2–5th April, University of Surrey.

Greed C. (1990b) 'The Professional and the Personal: a study of women quantity surveyors' in Stanley (ed.).


Greer S. (1977) 'On the Selection of Problems' in Bulmer (ed.).


Harding S. (1987a) 'Conclusion. Epistemological Questions' in Harding (ed.).

Harding S. (1987b) 'Introduction: Is there a Feminist Method?' in Harding (ed.).


Harstock N. (1987) 'The Feminist Standpoint: developing the ground for a specifically feminist historical materialism' in Harding (ed.).

Hart N. (1977) 'Parenthood and Patiengthood: A Dialectical Autobiography' in Davis & Horobin (eds.).


Kemper T. (1989) 'Love and Like and Love and Love' in Franks & McCarthy (eds.).


Kirkham M. (1989) 'Midwives and Information-giving During Labour' in Robinson & Thomson (eds.).


Kitzinger S. (1988) 'Why Women Need Midwives' in Kitzinger (ed.).


Kreuger C. (1978) 'Good Girls – Bad Nurses' in Dingwall & McIntosh (eds.).


569

Laryea M. (1989) 'Midwives' and Mothers' Perceptions of Motherhood' in Robinson & Thomson (eds.).


Lewis J. (1990) 'Mothers and Maternity Policies in the Twentieth Century' in Garcia et al (eds.).


Limb S. (1989) 'Female Friendship' in Porter & Tomaselli (eds.).


Lloyd (1989) 'The Man of Reason' in Garry & Pearsall (eds.).


Lomas P. (1973) True and False Experience London Allen Lane


570

McCarthy E. (1989) 'Emotions are Social Things: an essay in the sociology of emotions' in Franks & McCarthy (eds.).


McIntosh J. (1989) 'Models of Childbirth and Social Class: a study of 80 working class primigravidae' in Robinson & Thomson (eds.).

McIntosh J. & Dingwall R. (1978) 'Teamwork in Theory and Practice' in Dingwall & McIntosh (eds.).


Maguire P. & Rutter D. (1976) 'Training Medical Students to Communicate' in Bennett (ed.).


Mitchell J. (1986) 'Reflections on 20 Years of Feminism' in Mitchell & Oakley (eds.).


Moulton J. (1989) 'A Paradigm of Philosophy: the adversary method' in Garry & Pearsall (eds.).


572


Oakley A. (1977a) 'Cross Cultural Practice' in Chard & Richards (eds.).


Oakley A. (1983) 'Relations between Feminism and the Consumer Movement in Maternity Care' in Dennerstein & de Sennarclens (eds.).


Oakley A. (1984c) 'The Consumer's Role: adversary or partner' in Zander & Chamberlain (eds.).


Oakley A. (1986a) 'Feminism, Motherhood and Medicine – Who Cares?' in Mitchell & Oakley (eds.).

Oakley A. (1986b) 'Feminist Sociology – is it Possible?' in Oakley (1986g).


Oakley A. (1986e) 'On the Importance of Being a Nurse' in Oakley (1986g).

Oakley A. (1986f) 'Social Support and Perinatal Outcome' in Phaff (ed).

Oakley A. (1986g) *Taking It Like a Woman* London Flamingo.


Odent M. (1986) 'Creating a New World' in Claxton (ed.).


Pilgrim D. (1990) 'British Psychotherapy in Context' in Dryden (ed.).


Porter M. & MacIntyre S. (1989) 'Psychosocial Effectiveness of Antenatal Care' in Robinson & Thomson (eds.).


Posner T. (1977) 'Magical Elements in Orthodox Medicine' in Dingwall et al (eds.).


Rajan L. & Oakley A. (1990) 'Low Birth Weight Babies: the mother's point of view' 
Midwifery 6 pp.73–85.

empowerment' Sociology Vol.26 No.2 pp.207–212.

Raphael-Leff J. (1986) 'Facilitators and Regulators: conscious and unconscious 
processes in pregnancy and early motherhood' British Journal of Medical 

and Perinatal Studies pp.79–89.

and Hall.


Redmond M.V. (1989) 'The Functioning of Empathy (Decentering) in Human 
Relations' Human Relations Vol.42 No.7 pp.593–605.

Report of the Briggs Committee on Nursing (1984) 'Nurses, Midwives and the Public: 
images and reality' in Black et al (eds.).

Oakley' Sociology of Health And Illness Vol.5 pp.83–94.

Reid M. & McIlwaine (1980) 'Consumer Opinion of a Hospital Antenatal Clinic' 

Ribbens J. (1989) 'Interviewing: an 'unnatural situation'? Women's Studies 

Ribbens J. et. al. (1991) 'The Personal and the Professional' Social Studies Department 
Oxford Polytechnic.

Practice – How have things changed over the last 10 years' New Generation 
March pp.6–8.

Richman J. & Goldthorp W.O. (1977) 'When was your Last Period?' in Dingwall et 
al (eds.).

of labour' in Chard & Richards (eds.).


576


Robinson S. (1989a) 'Caring for Childbearing Women: the interrelationship between midwifery and medical responsibilities' in Robinson & Thomson (eds.).


Robinson S. (1990) 'Maintaining the Independence of the Midwifery Profession' in Garcia et al (eds.).

Robinson S. & Thomson A.M. (1989) 'Research and Midwifery' in Robinson & Thomson (eds.).


577


Royal College of Midwives (1987) Towards a Healthy Nation. A policy for the Maternity Services London Royal College of Midwives.


Scambler G. (1987a) 'Habermas and the Power of Medical Knowledge' in Scambler (ed.).

Scambler G. (1987b) 'Introduction' in Scambler (ed.).


Scott M.V. (1989) 'Sociology encounters Psychoanalysis' in Franks & McCarthy (eds.).


Sherwin S. (1989) 'Philosophical Methodology and Feminist Methodology: are they compatible?' in Garry & Pearsall (eds.).


Sieber S. (1978) 'The Integration of Fieldwork and Survey Methods' in Denzin (ed.).


Smail D. (1987) *Taking Care* J.M.Dent & Sons Ltd.


Smith D. (1990) 'Psychodynamic Therapy; the Freudian approach' in Dryden (ed.).


Spender D. (1986) 'What is Feminism? A personal answer' in Mitchell & Oakley (eds.).


Stanworth M. (1987) 'Editor's Introduction' in Stanworth (ed.).


Stein L. (1978) 'The Doctor-Nurse Game' in Dingwall & McIntosh (eds.).

Stewart N. (1986) 'Obstetric Drugs and Technology' in Claxton (ed.).

Stockley S. (1986) 'Psychic and Spiritual Aspects of Pregnancy, Birth and Life' in Claxton (ed.).


Swanson S. (1989) 'On the Motives and Motivation of Selves' in Franks & McCarthy (eds.).


The University of Surrey Advisory Committee on Ethics (1980) *Ethical Guidelines for Research and Teaching* The University of Surrey.


Thomson A. & Robinson S. (1985) 'Dissemination of Midwifery Research: how this has been facilitated in the UK' *Midwifery* Vol.1 No.1 pp.52–53.


Ward C. (1986) 'Meditations on Uncertainty' in Kohout & Bandler (eds.).

Weigert A. & Franks D. (1989) 'Ambivalence; a touchstone of the modern temper' in Franks & McCarthy (eds.).

Whitbeck C. (1989) 'A Different Reality: feminist ontology' in Garry & Pearsall (eds.).

Whittaker E. & Olesen V. (1978) 'The Faces of Florence Nightingale: functions of the heroine legend in an occupational sub–culture' in Dingwall & McIntosh (eds.).


Wilkinson S. (1986a) 'Introduction' in Wilkinson (ed.).

Wilkinson S. (1986b) 'Sighting Possibilities: diversity and commonality in feminist research' in Wilkinson (ed.).


Williams A. (1990) 'Reading Feminism in Field Notes' in Stanley (ed).

Williams K. (1978) 'Ideologies of Nursing: their meanings and implications' in Dingwall & McIntosh (eds.).

Wise S. (1990a) 'Becoming a Feminist Social Worker' in Stanley (ed).

Wiseman J. (1979) 'The Research Web' in Bynner & Stribley (eds.).


