

**HONOURING THE SACRED IN CHILDBIRTH:
A MIDWIFE'S STORIES OF WOMEN'S DEVELOPING SENSE OF SELF**

by

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ABSTRACT

Thirty years of midwifery practice has shown me the beauty of birthing. After spending time working with a homebirth midwife I had an awakening which affected me deeply, both personally and professionally. I looked on birth in a different light and started recognising new possibilities. I learned new skills and understandings working in a variety of settings during a time of major change for New Zealand midwifery.

This experience has led me to this study the aim of which was to explore the relationship between the woman and myself the midwife as I experienced it and understood it in practice. I use an auto/biographical method: reflecting on my own story and on both factual and fictionalised exemplars from my practice.

My research led me to the following conclusions. As women prepare for and reflect on their births they often tell stories about themselves based on a mix of recent events interspersed with their ideas and hopes. Telling stories helps women learn about aspects of themselves that reconstruct their identity, leading to a greater integration of their sense of self. Woman-centred midwifery care takes on new meaning when midwives practice midwifery by engaging with women's narratives.

Each woman and her birthing reinforce the sacredness of childbirth. By combining an awareness of sacred possibilities with scientific understandings, midwives offer a bridge so that through childbirth experiences, women can enhance and reconstruct their inner lives. This study

indicates that further research on the familiar but undeveloped aspects of 'everydayness' in midwifery practice is necessary. In particular, the emotional and spiritual aspects of midwifery deserve greater attention.

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‘To honour the sacred is to create conditions in which nourishment, knowledge, freedom, and beauty can thrive. To honour the sacred is to make love possible’ (Starhawk, 1997).

I dedicate this thesis to Joan Donley, O.B.E. for her friendship, midwifery knowledge and humour.

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CHAPTER ONE: INTRODUCTION TO THE PROJECT

The phone rings. “He says he’s leaving me and I’m scared,” says a woman who is 32 weeks through her pregnancy.

Later in the day two pager messages read “Urgent, Leila says she feels like pushing” and next “I have not felt the baby move all day, please ring Jenny”.

The following day a woman says, “I have this feeling my baby or I are going to die during the birth”.

What do midwives do with all these situations; how do they respond? Some responses are straightforwardly attending to physical problems. But what else is entailed? The ‘everydayness’ of practice demands different responses and ways of thinking and feeling. How do midwives integrate these responses into their practice? Is day-to-day practice concerned with physical events or with stories that carry meaning – or both? Do midwives each carry different stories about what it is they call midwifery?

From my experience in practice, particularly since offering continuity of care I believe that I absorbed these situations into everyday practice and into my being. My responses become a part of the art of my practice: some days more colourful than others. I have a collage of memories of women, of birthing, and of my own reactions.

Stories are spiritual forces, like prayers. They can heal us and heal others. Our stories go out from us in widening circles. Those of us

who live in white skins have been conditioned to discount the power of story (Krysl, 1991, p.37).

What this thesis is about

This thesis is about stories of what transpires between a midwife and a woman. In it I use narrative inquiry to explore my midwifery practice. It is an auto/biography: a combination of autobiographical and biographical accounts of my midwifery experience and those of birthing women. Remembering stories and creating a space for thinking, writing and collating fragments of women's stories and my own provide the data from which the findings of this thesis are derived.

My story in Chapter 3 is about how I discovered the spirit of midwifery by a journey that started with my being disassociated from women during childbirth to being engaged with women with whom I share experiences of joy, sadness, self-development, shame and transcendence. It includes retelling parts of my life history: identifying as a woman, revaluing women's childbirth experiences and developing midwifery relationships between women and myself. A pivotal moment in my life occurred when I attended homebirths in the 1970s and saw a midwife providing women-centred care. At that time I had an awakening in my understanding and saw that the midwifery role was one of being a guardian: a guardian of normal birth.

Normal birth plays quite a large part in thesis. From my experience as a midwife and as a mother, I am convinced that, once the short-term pain is past, natural

birth can be the least traumatic way for the body to give birth and for a baby to be born. A week after the birth most skin tears are healed, the breasts have softened again, and apart from sleep deprivation, most women are proudly recuperating from a natural birth. Moreover, as Jakobsen (1990) says, following a satisfying natural birth, women are empowered in subtle and in obvious ways for years to come; the converse is also true. In this thesis I have assumed that when the birth is expected to be normal and the woman wants a natural birth then that is the least traumatic and most empowering way for her to deliver her baby.

In this thesis I have also assumed that midwives are best placed to be the guardians of normal birth; they are the most qualified to assist women giving birth naturally. To do so they must not only understand the physiology and the scientific evidence about birth but also understand how to make relationships that promote and encourage women to trust their bodies. Hunter (2001) states that there is evidence that the quality of the childbirth experience is significantly affected by the quality of the relationship between the mother and the midwife. For example, midwives have been shown to be skilled at 'being there' for women (Halldorsdottir & Kalrsdottir, 1993) and this has been related to their ability at "keeping birth special" for women (Hunter, 2001, p.441). In considering the relationship between a midwife and a woman Pairman (1998, ; 1999) finds midwives become professional friends. Although there is a sense in which that seems an accurate description, the aim and purpose of midwifery is not about being a friend even though, because of the intimacy and trust involved,

friendship may be a result. For Hunter, an important part of the relationship is the commitment that the midwife gives to an individual woman (Hunter, 2001).

Strid (2000) was one of the primary instigators of the political organisation *Save the Midwives* who lobbied successfully to change the legislation (New Zealand Government, 1990) enabling midwives to practise independently. She contends that it was this commitment to normal birth that led to midwifery practice in New Zealand attaining statutory autonomy in 1990 with the passage of the Nurses Amendment Act (1990). The legislative change she says was won by those women and midwives, who had,

a commitment to women to protect the birth process from medicalisation and to restore to women the confidence in birth and confidence in the role of the midwife to provide the best support without intervention unless needed. (Strid, 2000, p.2)

Midwives commitment to women has been written about in New Zealand as a model of midwifery based on partnership between the woman and the midwife (Daellenbach, 1999, ; Guilliland & Pairman, 1995, ; Pairman, 1998, , 1999, ; Skinner, 1999). “This model of midwifery as a partnership provides an opportunity for the development of new knowledge of self, of midwifery and of childbirth which is emancipatory and equalises power relations within maternity services” (Guilliland & Pairman, 1995, p.9). This statement is one of hope. It talks of the opportunities for new approaches and knowledge when midwives and women work together – knowledge in areas that I discuss further in this

thesis. The last part of the quotation about partnership being “emancipatory and equalising power relations within maternity services” is about politics and power relations. It is mainly addressed to how services have been delivered and organised in New Zealand since the 1990 legislative changes. Although these aspects are inevitably part of the context of my recent practice I do not address them directly. Others have written much that is relevant to the history and effects of the 1990 change in legislation (Banks, 2000, ; Daellenbach, 1999, , 2003, ; Donley, 1986, , 1992, ; Guilliland & Pairman, 1995, ; McLaughlan, 1997, ; Pairman, 1999, ; Skinner, 1999, , 2002).

Just how do we marry our responsibilities to women, the profession, the community and ourselves? I believe midwifery holds the key to both short and long term improvements in the health of mothers and their babies. By connecting with individual women in their own context, midwifery mediates between the generality of professional health knowledge and the particularity of individual circumstances – making sense of both. Midwives need to be continually updating their knowledge in, for example, normal physiology, nutrition, breast-feeding, sudden-infant death syndrome, infant attachment theories and postnatal depression. Knowledge of such issues is an accepted and integral part of ongoing professional development but is also accepted that midwives should learn to communicate that professional knowing when they connect with women? What is involved with connecting with women? Does having a relationship make a difference or is it merely being nice?

Strid refers to the importance of midwives being women-centred. She believes in New Zealand a focus on women has been lost in recent years and says that a key to the way forward for midwifery is to “unearth the women-centred vision we shared which currently feels well buried” (2000, p.1). My thesis is about the idea that, while midwifery as a whole needs to have a women-centred vision, to be effectively connected with an individual woman a midwife needs to be woman-centred and, particularly, to be aware and awakened to the importance of the story that this woman carries.

Stories, their meaning and importance, are the focus of this thesis. Stories of birthing are frequently shared between women and between midwives but they are generally not considered a significant part of professional conversations. Although I did not start with a full literature review (because, by its nature, my inquiry was broad and undefined) during the course of the project I have read much about midwifery theory but, again, I find that stories and their importance barely feature. This means that often my frames of reference have had to be drawn from outside midwifery.

The stories in this thesis include parts of my own life and developing confidence in practice (Chapter 4) as well as factual and fictionalised examples I have written of the sorts of stories that women told me. These accounts are the ones I have chosen and written to illustrate various themes that arose as I worked through my auto/biographical inquiry. Some of the stories are narrative accounts of events during the childbirth process (from positive pregnancy test to

six weeks postpartum) and the issues that arose for women and for me. The stories in Chapter Five, which I have called 'Looking Out', are mainly of this sort. Chapter Six is called 'Looking In.' It contains a number of examples where over the childbirth process women reflect on and develop the stories they carry about their own life. My thesis is that such stories can be very powerful and midwives need to be attuned to women and the importance of their narratives (Hagell, 1989).

Well-attuned midwifery practised with a vision of women as strong and able, promotes the woman's well being and supports her in turn to be a well-attuned mother with strong attachment to her baby. Attachment theory is relevant to the outcomes for women as well as for their babies. If midwives recognise this in practice they can begin to break the intergenerational effects of insecure attachment. Home birthing models natural birthing and gives examples of individual well being which fosters understandings that will assist midwives empower women who are insecurely attached. This work demands a depth of understanding about birthing, responsibility and relationships.

Although midwifery students learn that the psychosocial aspects of midwifery care are important, Hunter (2001, p.439,) says "No midwifery literature deals explicitly with the emotional aspects of midwifery work". This project is my contribution to that literature. I use stories derived from the everydayness of practice to recount and reflect on the emotional labour that is often involved in birthing – and my understanding of its worth.

My own story and its relevance

I realised there was a connection between my work and my life story. I realised I was going to have to look back over my story and write down how my life story and midwifery were connected.

(Journal, June 2002)[#]

It was only after I understood what had meaning for me in my own life that I saw the importance of midwives maintaining the integrity of a woman's sense of the significance of the details around birthing. As a result, the way I saw the midwife's role changed from one model of practice, which had the baby's safe delivery as the primary outcome, to a more complex one, which saw this safe delivery as the minimum outcome. What changed my views is both personal and professional.

The ability and the desire to ascribe meaning to my life only happened after a transformative experience in my late twenties. I learned that being connected to life is a function of ascribing meaning to people, experiences and events (Johnstone, 1999b). This turning point opened up the birthing world for me as a place of deep learning and a potential source of love, fear or sometimes both for everyone involved.

I knew that the better women felt about themselves the more likely both they and their babies would benefit. I had two main

[#] Quotes from my Journal are inset in 12 pt *italics*.

assumptions emerging, which I needed to take account of and defend. These were that natural birth is inherently safer and better for a mother and baby than surgical or instrumental alternatives. And the other was that by attending to or being aware of women's stories in pregnancy women are able to birth well and be open and available to their babies after birth. When a woman expresses a coherent sense of her life she is showing that she is in touch with her inner life, which may be expressed in a number of ways: by stories, by comments and questions, or by her body language and posture but which give a midwife insight into how she is processing her life.

(Journal, September 2002)

Writing about experience, the natural and the spiritual

The arguments I develop in this thesis are from inside my midwifery practice. They are therefore individual, subjective and interpretive.

I began my research journey intending to write about my experience of independent midwifery focusing on things other than the physical dimensions of concerns for safety. What is at the heart of midwifery is attending to the women during the normal life event of birthing (Banks, 2000, ; Davis, 1987, ; Donley, 1986, ; Gaskin, 1977). Whether the birth is without intervention (thereby a natural event) or not, birthing is of itself a normal event in the life of a woman (Read, 1948).

The term 'natural childbirth' has emerged in response to medicated and

medicalised experiences of childbirth (Arms, 1975, ; Read, 1948). In the 1950s natural childbirth became synonymous with psychoprophylaxis or prevention of pain by psychological and physical means (Wright, 1966). For example, according to Bing (1977), the French physician Lamaze brought psychoprophylaxis to France in 1951. The Lamaze technique, a technique for controlling pain in labour first used in Russia in 1948, subsequently became popular in the United States.

Read, (1948) an English obstetrician began a revolution in approaches to childbirth in England whereby women were encouraged to become familiar with the process of childbirth in order that they might reduce their fear and as a result not suffer so much pain. Read (1948) believed that pain was as a result of becoming civilised:

It is not without interest that the more civilised a people becomes, the more intensified this pain appears to be; and since merciful relief of suffering is considered one of the greatest duties that physicians can perform, it has become easier to utilise the pain-relieving discoveries of science than to investigate its complicated causes. (p.1)

The nature of the complicated causes of pain in labour is not part of this study although the difference in pain for the women I saw at home in the 1970s in comparison to those in hospital was marked. This difference is discussed in Chapter Three. When I use the term natural childbirth I am referring to an unmedicated labour. Although I have on rare occasions witnessed women for

whom the pain is of little concern, I have found when the labour is normal that most women are able to manage well. Most say, "I didn't think about asking for pain relief because it was not part of my plan," but this is not because the pain was irrelevant. When the labour is abnormal so too is the pain (Bender, 1968).

When during her pregnancy a woman makes a decision not to use pain relief she generally accompanies it with a process of learning about childbirth, choosing an appropriate place of birth and a birth attendant. Her decision and subsequent learning often reduces the level of fear associated with the process (Kitzinger, 1991). The physiology of a normal birth supports women's endeavours (Newton, 1990, ; Pert, 1997).

In my experience, a midwife can make a critical difference to a woman's choosing and achieving a natural birth. There is a great deal of learning associated with planning a natural birth. For example, although the usual response in our society is to treat labour pain with analgesia (pain relieving drugs), there are many studies, which show the importance of not disrupting the finely tuned endocrine system (designed for both pain and pleasure), thereby disturbing otherwise normal labours (Jowitt, 1993b, Odent, 1993). The role that stress and emotions plays need to be understood. "Once the hormonal regulation of labour by stress hormones is understood then professionals will have a vastly different attitude to labour" (Jowitt, 1993b, p.4). Changing attitudes of professionals takes time and in my case it was a significant professional experience that helped me make that change.

The advantages of a natural birth approach have been shown in several studies. For example Enkin (2000) describes some studies of small teams of midwives providing continuity of care for women and using less intrapartum medical interventions. These women “felt more in control during labor, perceived the labor staff as more supportive, and felt more prepared for child care. They had fewer babies who required resuscitation at birth” (Enkin et al., 2000, p.22).

In this thesis I do not discuss in detail, ways to help women prepare for natural birthing. What I do discuss is an approach to midwifery that entails hearing and seeing how women present their dreams and hopes about this birth and how it fits into their lives. Birthing is but one part of the whole experience of childbirth and is a normal life event for women. As a midwife becomes experienced, her* knowledge, skills and attitudes about women and normal physiology are absorbed into a consciously competent practice that daily carries an awareness of the significance of this event.

When offering continuity of care from pregnancy test through until six weeks post partum most of a midwife’s contact with women is before and after labour, and this affords much time in conversation. Everyday practice provides midwives with a collage of events, women and stories and learning is never-ending. The challenge I faced in this project was opening up a conversation about the self and spirituality that emerge from women’s stories within the ‘everydayness’ of practice. My particular interest is the shift many women make

* I refer to the midwife as if she were female respecting that men may also be registered as midwives.

within themselves over the childbirth continuum. This shift manifests in many different ways: truth telling, observing, resolving and understanding their own mothering or lack of mothering or connecting with bloodline stores, addressing buried sexual abuse or making natural birth a successful project. I have observed and shared these experiences with many women. The stories I present have a quality that I understand as spiritual and I am hoping to encourage more stories about how midwifery helps women re-member themselves as whole and strong and able. Women with these qualities are able to look after themselves and their children fearlessly. Midwives are in a perfect position to use their knowledge to act as guardian of natural birthing and use their understanding as a therapeutic tool for women journeying through a normal but significant life event.

Is there a place within our midwifery knowledge base for addressing the spiritual aspects of practice? What does spiritual mean? According to the Venerable Lama Karma Samten (2002) “Spiritual means that you have a good understanding, you have compassion and are tolerant or open” (p.3). How is this related to childbirth? Here he is talking about a way of being whereas Gaskin (1977) describes both midwifery and childbirth as spiritual experiences that inevitably entail universal values. She writes: “The knowledge that each and every childbirth is a spiritual experience has been forgotten by too many people today, especially in countries with high levels of technology” (Gaskin, 1977, p.14). She says spirituality is more than a description of an experience: “This complex of values that attends each birth is so profound and universal that I use the term ‘spiritual’ when I talk about midwifery” (p.9). Gaskin’s book was first published

in 1977 and has been used widely by women and midwives. Despite its very practical suggestions it is not a mainstream book because its language and beliefs marks it as different and unconventional.

Moore (1994), a lecturer in archetypal psychology, mythology and the imagination adds to this discussion, and speaks both to the 'everydayness' and to spirituality. By paraphrasing the 15th Century philosopher Marsilio Ficino. Moore (1994, p.xiii-xiv) says:

The mind tends to go off on its own so it seems to have no relevance to the physical world. At the same time, the materialistic life can be so absorbing that we get caught in it and forget about spirituality. What we need, he said, is soul, in the middle, holding together mind and body, ideas and life, spirituality and the world. (p.xiii-xiv)

My exploration of practice is about my contact with the spiritual within the everydayness of practice, and how I might act as a bridge connecting and supporting the woman's journey from the physical to spiritual dimensions in her life over childbirth continuum. The physical dimension is most clearly manifest in the work I do by taking the women's blood pressure, checking her urine, listening to the baby's heart beat and feeling her pregnant belly. This 'doing' is the context within which we make a relationship and through which I hear how she is and what concerns her today. It is of course how I fulfil my professional clinical responsibilities both by doing and being in relationship *with* women (Powell Kennedy, 1995).

Her decision to have a natural birth may sometimes have been made early in the pregnancy though often I find as a woman progress through the pregnancy, she becomes more confident about birthing naturally: an unmedicated labour during a normal birth. In order to deliver naturally a woman's decision is often accompanied by a shift in focus of becoming aware of whom she is and what it is she needs to learn (Estes, 1993). It is at this point she begins what I consider her personal project, a process of turning in and tuning inside herself that finally leads her to the spiritual dimension of her experience or what I understand to be a process of connecting with her soul (Moore, 1994).

Overview of forthcoming chapters

Chapter One: *Introduction to the Project* is a discussion of aspects of the auto/biographical methodology. This methodology falls under the umbrella of Narrative Inquiry, a research methodology where the narrator reconceptualises familiar experiences. A brief history of auto/biography is followed by a consideration of questions about rigour and about the importance of reflection both in practice and in research. I then discuss how I proceeded to use auto/biography in my project including writing a journal, reading widely and writing fictionalised exemplars from practice memories. I outline limitations of this method, such as the dangers of generalising or producing theories from findings based on one person's experience. I finish with some of the ethical considerations of conducting auto/biographical research.

Chapter Two: *Methodology: Working with auto/biography* starts with a brief

overview of my life up until I began my midwifery training in 1971. It continues to describe the beginning of my journey of training to become a midwife pointing out that my lack of interest in birthing women fitted me perfectly as an assistant in a medicalised system known as the 'New Obstetrics' (Chard & Richards, 1977). Then five years later in New Zealand in 1976 I had an awakening experience that transformed the meaning of my life and my subsequent journey with midwifery. See Appendix 1 for clarifying the chronology of events.

In Chapter Three: *Training and Early Work (1968-1977)* I continue the story of my midwifery at a time when I began to actively seek out particular experiences that would add to my confidence in practising independently. I outline my understanding of the importance of the postnatal period in a section marked the 'golden orb of the babymoon'. I describe how I began a private planned early discharge scheme that included accepting some women who were discharged into my care following the loss of a baby, whether by death or by adoption – and I talk of some of the insights I gained from that experience. I also include brief personal accounts of having my two babies, one at home and the second by caesarean section. The first birth confirmed what I had observed about homebirths but my experience in the second birth marked the end of a previously easy association with obstetricians as my identification with women and a woman-centred view of birthing became uncompromising.

Chapter Four: *Reshaping and growing inside and out (1978-1986)* presents

changes in my life, my practice and the way that midwifery was organised and practised in New Zealand. I reflect on two stories from my practice, both of which were under the title of 'looking out' because they both were reacting to events beyond the women's own making. These stories talk of the value of scientific and technical aspects of care but also that sometimes it is inappropriate to try to solve problems when what is needed is for the midwife just to be present. In this period the changes in the legislation governing midwifery practice (1990) helped establish midwifery as an autonomous profession in New Zealand and I consider some impacts on my practice and that of other colleagues. I conclude with a discussion of what I was learning about my own needs for support to allow me to practise effectively with growing confidence.

Chapter Five: *Growing Understanding: Looking Out (1986-2001)* moves from the social interface to stories of the interior lives of women. I talk about the emotional relationship between mothers and midwives. I discuss Spiritual Intelligence, which, in my experience, seems an apt description for homebirth women and their partners. I also discuss recent findings about attachment theories and ask whether it is possible that those who deliver at home represent that group in our culture who were securely attached as infants.

Chapter Six: *Growing Understanding: Looking In (1986-2001)* concerns the most recent years of my active clinical work. That was a time when I made several important changes in the way I worked. I became that I had come a long

way in my life and work and that it was time for a shift in my life's adventure.

Chapter Eight: *Conclusions* summarises my most important conclusions. Women's stories hold transformative potential and the midwife-woman relationship may be a key to unlocking that potential – for the benefit of the woman and her children. If a midwife has knowledge and skills and a secure sense of her own self she is in a strong position to be able to hear the importance of the stories that women tell and, by listening, help women to realise the transformative and spiritual power of birthing. More research is needed to explore these ideas further: do women commonly experience the transformative power I speak of and what can midwives do in support? I also identify several other areas for further research and finally reflect on the research process I undertook.

CHAPTER TWO: METHODOLOGY: WORKING WITH AUTO/BIOGRAPHY

This thesis uses writing as inquiry as its methodology – specifically auto/biography – a combination of autobiography and biography. In this chapter I discuss aspects of the auto/biographical methodology and then the decisions I made in applying it as the method of inquiry for this study.

Auto/biography as research falls under the generic title of narrative theory which according to Ricoeur (1984) is “the activity that produces plots” and is different from the plot itself. Narrative theory has not yet made its mark in producing midwifery theory though it has been used in nursing (Gully, 1998, Johnstone, 1999b, Koch, 1998, Krysl, 1991, McEldowney, 2002). Narratives seem a perfect tool for midwives to rework their experience of practice and by doing so create new meanings and new connections not previously seen. Midwives tell abbreviated stories to one another and mothers tell us stories midst the everydayness of practice so much so that we perhaps overlook the value of this familiar knowledge. What follows is first a consideration of the history and theoretical under-pinning of auto/biography and then something of my experience of using it as a method.

History of Auto/biography

Autobiography and biography have in the past mostly focussed on famous people although there are some stories of ordinary men and women. Professor Jill Ker Conway (1998) recounts a tale from the book about an ordinary woman in *Narrative of the Capture and Subsequent Sufferings of Mrs. Rachel*

Plummer by Mrs Plummer (1836) about her capture by the Comanche Indians in Texas. Mrs Plummer watched the brutal killing of her newborn baby following her capture and, despairing, she wrote how she invited a similar fate to that of her baby. Conway says, "Such stories were riveting for readers in North America and Europe, because their narrators were seen as reporting on experiences which challenged social and racial hierarchies" (p.42).

Conway (1998) states that autobiographies at this time provided insights into the life and times of a particular period rather than being about their author's own ability as agents to affect changes to their lives (p.107). Addams (1910) a socially conscious urban reformer and though a contemporary of Pankhurst's, disapproved of her methods, preferring instead a 'feminine' approach and passive voice in *Twenty Years at Hull-House*. Her writing seems as if "she were a romantic heroine to whom things happen, and suppressed any reference to a desire for power to do good that she avowed openly in her most private correspondence" (p.108). Though Addams was skilled and insightful, achieving much for urban reform work in the late 1800s, she portrayed herself as "all feminine heart and intuition, without the faintest hint of executive talent" (Conway, p.108). Conway goes on to suggest that the suppression of her voice meant Addams artfully created the archetypal feminist reformer and that this challenged the efforts of later feminist reformers because it denied so much of Addams' own willpower, motives and management skills. Later authors did wittingly expose the life of their times in their life-story writings. For example, Virginia Woolf in her autobiography published posthumously with the title

“Moments of Being” (1976) shows:

The injustice of patriarchal domination of women, the horrors of incest, the consequences of a social system which places no value on educating women and the astonishing liberation of moving from the acceptance of a Victorian sentimental notion of marriage to Bloomsbury’s easy and tolerant attitude toward sexuality. (Conway, 1998, p.109)

Life history as research

Life history is used to denote a reflection or reporting on a life (life history method) as research rather than life story which is when the life is told as a story (Roberts, 2002). Life history both as biography and autobiography began being used as a method of research by sociologists in the 1920s (Johnstone, 1999b). In these biographical accounts, sociology located social structure in the stories of people’s lives (Stanley, 1992).

However, after World War Two, a new paradigm was emerging which meant biographical accounts became trivialised when put alongside scientific approaches to understanding the social world. Stanley (1992) reports that changes in the nature and understandings about the role of the state and the provision of scientific evidence altered the nature of acceptable evidence following the Second World War. She cites Bauman (1988) as believing the state wanted evidence with which to coerce its citizens and autobiography and biography were not able to provide the necessary scientific validity. Johnstone

(1999b, p.26) says of autobiography that:

Its popularity as a research method declined, however, as social researchers became distracted by the problems of 'measurement, validity, reliability, responses to attitude questionnaires, survey methodologies, laboratory experiments, theory development, and conceptual indicators' and, indeed, the quest generally to improve the scientific credibility of social inquiry.

Although autobiographies and biographies were not being used as a research method after World War Two, in the late 1950s according to Johnstone (1999b) mental health consumers were writing their stories down. Apparently mental health professionals saw them as "the richest source of information regarding mental illness and its treatment" (p.26).

According to Stanley (1992) autobiography and biography only slowly regained acceptance in the last third of the twentieth century as a research methodology. She outlines how this happened firstly in anthropology (Kessing, 1978, 1985, 1987, Young, 1983) and later in sociology, in the journal *Life Stories/Recits de vie* (Gully, 1998).

In recent years life history as a method of research inquiry has been used by health professionals, for example in a thesis: *Getting it Right: An Exploration of Compulsive Caregiving and Helping Profession Syndrome* by Thompson (2000). Thompson uses her own history to illustrate how particular childhood experiences might create the need to care for others. Koch (1998) recounts her

experiences of working as a nurse and researcher in a ward for older patients in the United Kingdom. Although she uses biographical data she is also recounting her own responses to the care she observes. Gully (1998) describes nursing a woman with cancer alongside her own story of being a nun, later marrying and having children and of finding that words had power beyond the story's content where associations and intentions are displayed.

Biography and autobiography in midwifery

In midwifery there are have only a few examples of autobiographies or biographies by or about midwives. *Listen to Me Good. The Life Story of an Alabama Midwife* artfully combines the story of a 91-year-old midwife, Margaret Charles Smith, within an historical context provided by Linda Janet Holmes, an historian and friend of the Alabama midwives (Smith & Holmes, 1996). This book is a story of Smith's work and what it meant to be black, female and a rural midwife in the American South of the Twentieth Century. Smith worked as a midwife through the civil rights movement of the 1950s and 60s. Holmes adds a broader historical context to the words of Smith. Many midwives were prevented from practising after the civil rights movement emerged and Smith recounts the experiences of black women of white doctors since this time:

When comparing past home births with contemporary hospital births, Mrs Smith is militant in her criticism of doctors who are too busy to spend time with women. Mrs. Smith reminds her audience that midwives stayed with women for as long as they were needed. (Smith

& Holmes, 1996, p.12)

The only other published oral history is of an Alabama midwife, Mrs. Onnie Lee Logan in *Motherwit* (1989) as told to Katherine Clark so it does not involve the storyteller as co-author; and tells the story of an aging midwife forced from practice in the 1970s.

At least two midwives, Caroline Flint (2003) and Hulda Thorey (2003), have internet 'blogs.' These blogs are diaries published to the internet. They can be accessed freely and conversations with the authors are encouraged.

Penfield Chester, herself a midwife, interviewed 27 midwifery colleagues about their reliance on intuition, their spirituality and their emphasis in the normalcy of birth in *Sisters on a Journey: Portrait of American Midwives* which she closes with a commentary about the future of midwifery (Chester, 1997).

An autobiographical journal article appeared in 2002 about a New Zealand midwife, Elizabeth Fletcher (2002) who trained in Britain in 1950 and the story follows her career until retirement in 1988. A midwife during her training wrote an assignment on breastfeeding, which included her own breastfeeding experience in some depth and which has since appeared in the journal of the New Zealand College of Midwives (Rountree, 2003). There are also biographies of midwives who have participated in the development of the New Zealand College of Midwives such as: Mina Timu Timu and Glenda Stimpson's life stories in *Midwifery News* (Cassie, 2003), (Cassie, 2002). Midwives have written and researched midwives' relationships and experiences in practice (Pairman, 1998)

(Smythe, 1998). I know of no other midwife who has written her autobiography as part of her research into midwifery practices.

What follows is an exploration of the value of auto/biography as a method of inquiry. How are we to read such work? What is gained by reading someone's story of practice?

Auto/biography – Considerations of Rigour

Qualitative research such as auto/biographical research and other forms of narrative inquiry encourages divergent thinking and creativity (Smith, 1994). As a qualitative method of inquiry, auto/biography is becoming more acceptable (Clandinin, 2000). Under the umbrella of narrative inquiry as research, auto/biography sits with reflective topical autobiography, biography, life story and life history writing (McEldowney, 2002). As a research tool the findings are valuable if they speak to the understandings of those sharing the same experiences (Clandinin, 2000, Garrison, 1989, Johnstone, 1999b). They may also be valuable to those who have not yet had those experiences such as student or novice midwives. As the researcher I have found it useful to have an opportunity to reflect on my practice and strengthen my understanding of the therapeutic value of midwifery. "New tales of the field will now be written, and they will reflect the researcher's direct and personal engagement with this historical period" (Denzin & Lincoln, 1994, p.7).

Although the particularity of the research limits its generalisability and the possibilities for generating theory, auto/biography can open the way for

reconstructing our worldview based on seeing new conceptual possibilities arising from the writing – and these may be useful in practice. Denzin (1994) states that the exploratory focus of auto/biography can add to a pool of research from which hypotheses may be derived and verified.

Auto/biography is very much a practitioner research methodology. Practitioners with practical knowledge of their field do not necessarily have ready access or desire to embark on scientific research therefore methods which encourage their experiences to be recorded and reflected upon may be of more interest to themselves and other practitioners (Hartsock, 1989). As a practitioner I am interested in the work of practicing midwives because they are close to the concerns of everyday practice.

How trustworthy are such approaches? Garrison (1989) maintains “practitioner research tends to distort reality less often than expert research because the practitioner is closer to the purposes, cares, everyday concerns, and interests of work” (p.149).

Roberts (2002) reports Denzin’s belief that the personality of the researcher can interfere with internal validity “due to the reactive effects and the surrounding changes that take place as the subject reappraises life experiences” (p.39). However, Richardson (1994) suggests that it is just that insight into the subjective and individual perspective – giving life and interest and, maybe more importantly, knowledge of others’ lives – which makes writing as inquiry worthwhile.

Writing this thesis was initially a naïve attempt to ‘write down my experience’ – something I have since discovered to be unworkable because as McLaren (1992) says experience never speaks for itself. My lack of awareness of this made for ‘turning point’ experiences for me in the thesis journey. As the interpreter in and about the world of my practice and the people in that world, my faith in being able to write about practice experiences diminished. This is a difficulty of auto/biographical inquiry. Instead of being a truth-telling exercise, the author, according to Pritchett (1977, p.3), “In a sense, ... is a stripper; the suspense of his story lies in guessing how far he will undress. Or, of course – if he is writing about his career – we see him putting more and more clothes on”. In contrast to the idea of stripping or dressing up, I have tried to examine metaphorically the clothes I was wearing – to find a design in them, perhaps, and, by using my story as an exemplar, make that design available for myself and others. Johnstone (1999b, p.27) captures the sense of my design that is not a didactic story of how others should practice but instead:

the life story that is ultimately presented is written not from an idea, but from the deep involvement of the storyteller in his or (her) own state of being in a given and particular experience or set of experiences—not least, of those involving ‘existential moments’ of life discovery (Moustakas 1973). In other words, the life-story is written from the perspective of a storyteller who has plunged deeply ‘into an intensive and timeless experience of self’ (Moustakas 1961 pxi).

I had not intended to write so much of myself into this work but as I tried to tell stories from practice it became obvious that my passion for midwifery evolved out of my life history. I wrote my story as I recollected it, a story that entails parts of my life from my training days to the present. This is a story 'told as true': it is to be believed because it is my life, as I have understood it and yet, of course, it is my reconstruction. Indeed, my life history took a different shape in my understanding as I reviewed, remembered, reflected on and wrote about the events. Stanley (1992) shows how auto/biography about ordinary people challenges the stereotype of writing about exemplary lives. It is still referential of that archetype but invites the reader to see all lives as connected and therefore the value is not so much in truth finding as it is in finding resonance in the reader's experiences. Have others had similar occurrences?

Stanley (1992) describes two currents of auto/biographies of ordinary people; one of which are writings of groups, such as the stories of groups of unionists writing down their experiences of strikes. In New Zealand a book about women's experiences of farming during the Second World War tells of their extraordinary/ ordinary 'war' stories (Rogers, 1989). The other current of writings of ordinary people are those of feminists who experiment with the boundaries between self and others cited by Stanley(1992) are Oakley's (1984) *Taking It Like a Woman* and Steedman's *Landscape For A Good Woman* (1986). Oakley (1984) blurs the line between fact and fiction and structurally alters the chronology, emotions, events and ideas. Steedman (1986) merges boundaries between self and other as she explores the relationships between

daughters and parents and how class affects the relationship, particularly when that relationship is outside the dominant discourse. The auto/biographical conventions are being altered by the awareness now that 'truth' is partial and perspective is highly complex (Stanley, 1992). I believe midwifery works across the public/private divide where awareness of self and other is highly complex and although the model of midwifery in New Zealand is based on partnership and relationship, conversations about the self have not yet emerged. This research hopes to generate some of those conversations.

Auto/biography is a means by which I can explore my self and my relationships with others and between others. My autobiography is topical and reflective as it addresses only those particular parts of my life history, which impact on being a midwife (Johnstone, 1999b, ;Roberts, 2002). I narrate from at least two if not three positions. It is my story of a person (me) transformed by an experience, which affects my professional relationships with women becoming mothers. It is also the story of those mothers as experienced, understood and rewritten by me as exemplars. There is also a letter written by a woman addressed to me given with signed permission to use it as I wished, the use of which I have discussed in ethical considerations later in this chapter. I have reflected on my recounted story that has provided some of the insights and use of theory throughout such as that concerned with attachment. I have been true to my memories, which is, however, different from claiming those are completely factual accounts.

Auto/biography is associated with memory and reconstructions of experiences

(Connelly & Clandinin, 1998). At each telling we reconstruct the verifiable facts with the knowledge and understanding of our life in the present. Some memories perhaps remain rich, consistent and coherent throughout our lives, but some of the fragments that have split off are reintegrated in the process of reconstructing an autobiography (Norman-Jones, 1985). Other fragments are lost to memory. I will return to ideas about the self in Chapter Six and to recent neurobiological findings (Damasio, 1994). Postmodernism has had difficulty with the notion of a continuous self preferring instead the idea of having a particular perspective which changes over time and my story bares some credence to this idea (Stanley, 1992). However the construction of the self of a baby as it develops into young child in relationship generally with its mother establishes the basis upon which the later life is lived more or less fearfully or lovingly or securely is also implied in this work and I think both these positions can be claimed (Karen, 1994). The construction of the self and the possibility of changing perspectives over time seem congruent to me.

Auto/biography is inherently value-laden. The author's point of view and the assumptions that underlie it inevitably affect what is written – and what is written about – and leads the audience and, to an extent, the author herself, to question and argue its value (Stanley, 1992): “That is, these autobiographical selves are both whole or struggling to become so and deeply and irresolvably fractured” (p.14). The point of writing this is ultimately as Johnstone (1999b) says a “search for meaning and increasing understanding of the commonality of

existential human experience” (p.24).

Justification for the validity of the method is based on the importance of the individual's experience and how the validity of the method gives meaning to that experience. This is a thesis about the use of stories in practice: by the midwife to herself, by the women to the midwife and by the midwife to women. As such it is also an insider story conversing with midwives in practice. I have written down my experience by telling it through my own stories and those of my clients.

Placing the narrative in its historical, social, political and cultural context is necessary to ground the study and is an important part of auto/biography. Although this study is inward looking, the methodology necessitates placing it in time and place. It is an interpretation from a certain time and in a certain place and needs to be understood as such by the reader.

In this thesis I use my story as data from which to extract the connection between midwifery and women's lives. My autobiography is both data and findings. Although I am the narrator I also use it as an audience might: to understand how the midwife was affected by what happened in her self-story and her practice-story. I have used my “internal” theorising in the sense of using the ‘everydayness’ of practice as my means of interpretation rather than “external” or grand theory such as Marxism or Post-Structuralism (Johnstone, 1999b). Similarly, I use the biographical part – the fictionalised exemplars from my practice – as data on which to reflect. This brings me to consideration of reflection: reflexivity in practice and in the auto/biographical process.

Reflection in Practice

Reflection in practice is a process that has been used by midwives for years (Davis, 1987, Kirkham, 2000, Oakley & Houd, 1990, Page, 2000, Pairman, 1998, Skinner, 2002, Smythe, 1998). After a study by midwives on reflective practice, Taylor (1995) made the observation that “Reflection is perceived by some professionals as one way to bridge the theory-practice gap, based on the potential of reflection to uncover knowledge in action” (p.27).

Donald Schon (1983), who conceived the concept of reflexivity in practice, says:

Many practitioners, locked into a view of themselves as technical experts, find nothing in the world of practice to occasion reflection. They have become too skilful at techniques of selective inattention, junk categories, and situational control, techniques which they use to preserve the constancy of their knowledge-in-practice. For them, uncertainty is a threat; its admission a sign of weakness. Others, more inclined toward and adept at reflection-in-action, nevertheless feel profoundly uneasy because they cannot say what they know how to do, cannot justify its quality or rigor. (p.69)

Reflexivity is about the experience of diffidence in the field, both practically and morally, that practitioners of all backgrounds experience. Problems in practice that lead to these feelings of diffidence are not solved by technical solutions, but through reflection (Schon, 1983).

Auto/biography involves a similar process of reflection – though it is reflection *on* practice rather than *in* practice and it carries reflection further with analysis and illumination (Garrison, 1989). It opens a space for offering an alternative or previously unspoken observation about practice knowledge (Denzin & Lincoln, 1994). Undertaking the work for this thesis made connections for me between observations about the meanings that women attached to their own lives, and their subsequent satisfaction with themselves and with their birthing.

The process of writing, rewriting and reflecting is one of making sense at many levels of reality. “Narratives make sense of reality by linking the outward world of actions and events to the inner world of human intention and motivation” (Mattingly, 1991, p.999). Auto/biography encourages critical reflection of inter- and intra-subjective knowledge, knowing which is generally not readily available.

Subjectivity is now legitimate within research methodologies (Denzin & Lincoln, 2000). It is finally the acceptance and awareness of enmeshed lives. This acceptance of the point of view of individual selves is correlated with both the demise of the power of a single answer or position and the acknowledgement that we are finally socially constructed (Clandinin & Connelly, 1994). My thesis is based on that premise because, for example, the meanings I had accepted about birthing as a young inexperienced midwife changed as I was exposed to different meanings women and midwives gave birthing. My subjectivity has been altered by experiences in practice, most profoundly by seeing my first

homebirths and also more recently by writing about that experience.

Johnstone (1999b) positively endorses an auto/biographical approach as advancing knowledge and research in the 'relatively new sociology of emotions' (p.24). Her justifications resonate for me as she supports making subjectivity more visible thereby allowing for multiple voices and decentering the notion of the detached and privileged observer (Stanley, 1992). Johnstone's other point, and the one most pertinent for my project, is "the search for meaning and increasing understanding of the commonality of existential human experience" (p.24).

Writing subjectively has some interesting associated theoretical dilemmas. The best one can claim is that from a particular position in a particular context at a particular time these were recurrent themes or emerging plotlines for this or that author. Richardson (cited in Denzin, 1994) is supportive of writing as a way of knowing and that the subjectivity which results allows us to know something without claiming to know everything. She also sees the risks and asks: "How do we put ourselves in our own texts and with what consequences? How do we nurture our own individuality and at the same time lay claim to "knowing" something? These are both philosophically and practically difficult problems" (p.517).

Having considered aspects of auto/biography as methodology the remainder of this chapter discusses the methods I used during my inquiry. As the research unfolded four overlapping processes emerged: journaling, reading, the drawing

together and writing of fictionalised exemplars from my practice records and memories, and writing my own life story. The last of these processes, writing my own life story, began as writing my practice story. As the thesis processes became crystallised, instead of covering a period of eleven years of practice as originally intended my inquiry covered the last thirty years as the period of greatest relevance to my reflection on midwifery.

Initial Plans

My initial plan was to write stories from my practice that would illustrate the effect and importance of mindful midwifery. However, there were many stories from practice that I could choose and they would each illustrate different points. Deciding which ones to include provided a challenge. To address this challenge I used writing a journal as an inquiry process and continued this throughout my research.

In a hermeneutic inquiry the journal serves to locate the self in the research process. Whilst researchers can be accused of self-indulgence, by returning to our personal history we can raise our situation to consciousness and monitor the way in which we deal with the research process, the story and traditions. Such reflexivity is the critical gaze turned toward the self in the making of the story. (Koch, 1997)

Richardson (1994) states “Writing is also a way of ‘knowing’ – a method of discovery and analysis. By writing in different ways, we discover new aspects of

our topic and our relationship to it” (p.516). Journal writing very quickly reshaped my ideas about mindful midwifery into exploring the dynamic between the midwife and the woman. I have included sections of my journal writing that seemed pertinent in the body of this thesis. I found journal writing invaluable: sometimes for showing the way and sometimes for simply exposing the fact that I had reached another dead end. I had a few dead ends. Journaling became an essential part of collecting data and identifying the way forward, sideways or at times backwards into the labyrinth.

I began to read books and articles related to matters that arose as I progressed further for example, I explored case study methodology (Hammersley, 1995, Rolfe, 1998, Stake, 1995, Yin, 1994). I also explored about some approaches to women’s bodies, history and life processes (Archterberg, 1990, Gully, 1998, Ignatieff, 1992, Northrop, 1995, Shorter, 1983). Some books were consciously spiritual as I was searching to find an approach that supported my understanding of the value of the birthing experience to women (Frankl, 2000, ; Hall, 2001, Moore, 1994, , 2001, Northrop, 1995, Zohar, 1990, Zohar, 2001). I have been interested in attachment theory since the 1970s but finding that recent neurobiological research into the brain supporting earlier psychoanalytical theories including attachment theory was of great interest to me (Bevan-Brown, 1948, Bowlby, 1967, Damasio, 1994, Deacon, 1997, Jung, 1964, Karen, 1994, Shore, 2001, Siegel, 1999, Siegel, 2001, Singer, 1999, Winnicott, 1973). Others provided a more philosophical interest, particularly toward the separation of mind and body, (Damasio, 1994, Descartes, 1970, Flax,

1983, Gilligan, 1987, Johnstone, 1999a, Ruddick, 1984).

As I focused more on what seemed to be happening for women during the birthing process, the connection between mind and body became important and I found a number of writers, particularly scientists, for whom the organic connection between mind and body was common knowledge (Capra, 1989, Chopra, 1989, Damasio, 1994, Deacon, 1997, Pert, 1997). Theories connecting mind and body abound and I read the work of Pert, a biochemist. Pert (1997), wrote that the nature of our understandings about the physical world often initiated changes in our understandings in the human sciences. She believes, as a result of her work, that we have reached an exciting new place from which to understand human experience:

And since information in the form of biochemicals of emotion is running every system of the body, then our emotions must also come from some realm beyond the physical. Information theory seems to be converging with Eastern philosophy to suggest the mind, the consciousness, consisting of information, exists first, prior to the physical realm, which is secondary, merely an out-picturing of consciousness. (p.257)

I looked at the mind-body literature searching for a way into writing about birthing that gave scientific credence to the idea that when women were birthing a baby they often also gave birth to themselves. Women discover themselves in a new way, more attached to their bodies, more whole. Although mind-body

connections are accepted now (Pert, 1997), what I was searching for was found in the psychoanalytical views of the self (Siegel, 2001). There is a quality about women who birth at home that resists the culture of fear that pervades discussions about birth in our culture. "To give birth is the psychic equivalent of becoming oneself, one self, meaning an undivided psyche" (Estes, 1993).

Some of my reading helped to bolster and shape my inquiry such as the psychoanalytical literature and the neurological research but other reading particularly about case study methodology turned out to be more of a dead end.

A book called *Spiritual Intelligence* sounded a certain resonance with the conclusions I was gradually forming because the model of the self presented was active, unifying and made sense of the process of giving meaning to our experiences (Zohar, 2001). The authors cite the recent findings of neurologists such as Deacon (1997) and Singer (1999) who have written about the changes in understandings about the brain that has taken place since 1990. Knowledge of brain structure and function has vastly expanded in the last decade.

Where previously scientists recognised serial neural connections (typical of linear and logical thinking) and the neural network organisation (associated with pattern recognition), a third mode of thinking was identified. This newly discovered neural process in the brain was devoted to unifying and giving meaning to our experience. Singer (1999) identified neurotransmitters, which oscillated between the intellectual and emotional centres unifying data and facilitating a dialogue between reason and emotion. This discovery meant that

the giving of meaning to experience was a function not only of psychology but in fact a part of neurophysiology and could be described as a superior intelligence combining both emotion and intellect.

Zohar and Marshall (2001) have called it spiritual intelligence. Jung (1964) called this human capacity the transcendent function of the psyche but at the time he called it a function it was not accepted as having any structural place in the brain. “In other words, they concern man’s release from—or transcendence of—any confining pattern of existence, as he moves toward a superior or more mature stage in his development” (Jung, 1964, p.149). I read research that linked those psychoanalytic theories of Jung and Winnicott with recent findings in neuro-physiology (Karen, 1994, Shore, 2001, Siegel, 2001, Stern, 1985). I also found the often-disputed theories of Winnicott (1973) and Bowlby (1967) particularly interesting with respect to their theories about attachment. The implications of their work were that babies needed mothers at home. This has been hotly debated, as women felt trapped and oppressed by research that seemed to insist that for the good of their children mothers should remain at home and out of the paid workforce (Kedgley, 1996). These recent findings sustain an argument that children perhaps need mothers at least early on and/or significant others with whom they create bonds over time, years rather than months (Siegel, 2001). The mother and/or significant other needs to have the capacity to feed back to the child a reflection of her/his feelings so that the child can develop the necessary neurological networks from which to form a secure

sense of self (Siegel, 1999).

Choosing and writing fictionalised exemplars

The exemplars in this thesis (the biographical rather than autobiographical part) are created out of a collage of practice memories. These fictionalised exemplars blur the line between fact and fiction because they are recollections of actual experiences that I have merged, so one story is in fact the stories of three or four women. The story of Phillipa (Chapter Six) is a story that I have seen repeated over countless times by women following the harrowing experience of being told she cannot expect to deliver naturally with a future pregnancy. Women have thanked me long after their discharge from my care for being there and enabling her to follow her hopes of delivering normally. Phillipa is a story that blurs the line between fact and fiction, as she is not one person but a fictionalised exemplar merging women who appeared to me to share a similar story of reaching out of their previously negative experience toward the hope of an empowering and joyful one which they frequently attained.

I reviewed my clinical records to see whether they contained traces of the stories of practice I wanted to tell but they were surprisingly unhelpful. This is an example of the invisibility of the sharing of stories within my work. I write my records as if I am a medical clinician. The personal references were clipped and sanitised. My records did not expose anything of the sorrows, hurts, joys and laughter I had shared but merely recorded the clinical details. On reflection I realise that I wrote records in this way to maintain the woman's privacy and

because I was aware at the time of making the records that they could be used as a part of our annual voluntary standards review process. They could also be used as evidence in cases of mandatory investigation for misadventure or malpractice. However, the records did help to remind me of my experiences with the many women I came into contact with in my years of midwifery practice.

Recollecting stories and fictionalising them involved looking for what seemed an interesting aspect of an often more complex story. The parts of stories used in the exemplars illustrate divergent themes. They were interesting but not necessarily unusual aspects that were part of everyday midwifery – examples of the milieu of stories in which midwives work – but which are generally invisible in our professional discussions and writings. Medical dramas would take the reader out of the world of everydayness and, in general, I avoided them. I mean by medical dramas stories of women who have bled excessively, had retained placentas (afterbirth) at home or a shoulder dystocia (situation where the baby's shoulder becomes trapped behind the pubic bone making delivery difficult) because although they are interesting I wanted to focus on the psycho/spiritual aspects of birthing women and to add these medical emergencies would be distracting to this aim. They (medical emergencies) are a reality of being in practice but not the focus of my inquiry. Choosing exemplars of women's emotional lives was deliberate. So too were the exemplars that featured midwifery as a profession which integrates our archaic and our modern role in the lives of women and in birthing. This everydayness may make our work seem trivial to those who want to see us as women-centred technicians. I wanted to

generate conversations about how midwives work and how conscious they need to be about the effects of particular points of view on the women they attend. These are the conversations I apprehensively intended.

My aim in presenting some of these particular stories was to highlight how having relationships with women over time create the possibility of a depth of practice not experienced when care was fragmented for example in the stories of Florence, Phillipa and Martha. I also wanted to expose the patchwork of a day in the life of an ordinary midwife aside from the physical demands of our work. I found it difficult to fictionalise a known story and it felt almost disrespectful to do so. Often it was difficult to take out interesting detail but, if such detail made the story identifiable or distracting, then it was removed.

Bloodline stories like Simone's are understood through one experience of being baffled as I had been with her. The idea of bloodline stories I had accepted as a normal part of midwifery but for some reason it just did not occur to me or to Simone in this scenario. Her story as I outline under ethical considerations was a true story and one that I sought approval from the woman to include in the research. Some like Beryl were about the sometimes-tentative nature of the midwifery relationship with women. They show a midwife's developing relationships with women over time as she became more experienced. Alice's story was given to me by Alice (not her name) however I included it as an example of what amazing skills women have when they have access to information about their body from a brief encounter with a midwife who is

experienced enough not to try and fix every problem. They are examples of practising as if birthing were a normal event of significance in relation to the past, the present and the future of those individual woman and their babies.

Limitations of the approach

This research is how I interpret recollections of women's stories and my own practice. It is necessarily limited both as the researcher's interpretation of the women's worlds and by a lack of critical comment about the social environment in which the stories are set. The social environment has not been described or analysed in any detail in order to stay focused within the inner worlds of women and their experiences during childbearing.

However, this should in no way be seen as denying that this inner world is intimately connected and affected by the outside world of politics, policies, laws and mores. This study is only one small thread in a larger weave towards enhancing well-being of mothers, babies and their families that needs a multidimensional and extended problem-solving approach (Wilson, 2002).

The subjective approach I have adopted clearly raises questions about generalisability. It is clear that my journal writing, the readings I choose to study, the practice stories I have used as exemplars, and even the way I have written about my own life are particular to my own experiences and perspectives. I make no apology for this and claim instead it offers an important dimension to the study of midwifery and the possibility of stimulating further research. As Martin (1983) claims, "Personal experience is real enough, but it is

a neglected dimension, that in due course is simply lost” (p.17).

Writing about a passion for midwifery as I have done, naturally evokes reservations about the usefulness of such an enterprise. However some authors such as Achterberg (1990) positively seek to understand the feelings one might have for midwifery.

The midwives’ story, like that of all women, is filtered through a distorted glass of words. What we know about them comes from the few midwife manuals that were handed down. What these books relate are ideal techniques, not what they actually did or their feelings about their work. (Achterberg, 1990, p.120)

Leaving feelings aside, how can one person’s stories have any relevance for anyone else? A distinction might usefully be made here between “postmodernism as an intellectual stance, and postmodernity as a claimed condition of the social order” (Stanley, 1992, p.6). Using the former position one is able to explore the understanding of a lifetime of work from a single subject’s viewpoint but include as data, stories of contact with the inner worlds of others. This view recognises the limitations of the researcher’s context and accepts it as “subjectivities engaged in knowing/telling about the world as they perceive it” (Richardson, 1994, p.516).

From that standpoint I believe that my auto/biographical approach has validity. Postmodernism raises doubts about the generalisability of all methods of research: “Postmodernism suspects all truth claims of masking and serving

particular interests in local, cultural, and political struggles” (Richardson, 1994, p.517).

Ethical Considerations

I planned to only use fictionalised exemplars put together by using a collage of bits and pieces of practice stories. Most of the stories are just as I had planned – a product of memory and imagination. They are reconstructed but they have the same power as a story ‘told as true’ if in their telling they are recognised as bearing the mark of practice experience. Two stories, one of which is factual and has been shared with the woman concerned and another story is in a letter written by a woman for me with permission to use should it help the thesis. Both women have signed letters giving ethical approval for inclusion of their stories in this work. All names in the story apart from my own are pseudonyms. I contacted the Human Ethics Committee at Victoria University of Wellington explaining the use of these stories and included the women’s letters of consent all of which I have included as Appendix 2.

The autobiography, another reconstruction, was written as it is remembered and imagined and creates a sense of internal coherence for me. Johnstone (1999b) addresses the ethical concern for oneself through being placed at risk by self-disclosure. I found this at times an almost paralysing experience. I was compelled to write my experiences down and much more than I have included and have continued despite my reservations. I believe that this ‘inside of the practitioner’s’ head research is important for a variety of reasons. It creates the

basis for conversations about practice boundaries, social and political agendas and a variety of important issues for the future of midwifery. These include but not exclusively those, which address the moral and aesthetic value of midwifery as an artful practice.

Johnstone (1999b, p.27) says reflective topical autobiography is risky:

...honest self-disclosure of the nature required of the reflective topical autobiographical method could prove to be a threatening experience and, depending on the topic chosen, could render the self-researcher vulnerable in the absence of appropriate support mechanisms.

I agree wholeheartedly with her reservations and the related ethical concerns of vulnerability. Recalling my past experiences meant that to some extent at least I spent time recalling old memories some of which were happy but not others. Discerning the relevance of some stories and the appropriateness or usefulness of others was not always straightforward. Any likeness in my fictionalisations to real events and persons is unintended and no offence or injury is wished or intended.

Revisiting a period of thirty years meant many possibilities were canvassed and I think perhaps the period of immersion was too long before finding the stimulus to analyse and reconstruct my experience of practice. The need to return to an academic purpose following this exploration of the past was more difficult than I imagined. It was with the same tentativeness I felt about becoming a homebirth midwife that I preceded with writing my stories of practice and self. As I began

to analyse and reflect on the reconstruction of my journey I found new pathways of understanding from practice to my personal worldview and from practice to theory and from theory back to practice.

CHAPTER THREE: TRAINING AND EARLY WORK (1968-77)

Introduction

This chapter is the start of my autobiography. It begins with a brief scene-setting account of my childhood followed by a discussion of how, despite some feminist awareness of women's place in society, in my midwifery training and early experiences as a midwife I accepted the standard medical views of birth and the role of the midwife. Then, at a time in my early years as a midwife when I was beginning to question the status quo, I saw a different way of birthing and of being a midwife and this significant experience was an awakening for me about being a woman. This changed the meanings I gave to ideas about health and sickness, to women's relationship to nature and to feminism, and, more profoundly, the nature and origins of love. I have a timeline in the appendices to assist keeping track of the chronology of my story (see Appendix 1).

Scene setting: family background and childhood

I was born in Australia at the midpoint of the twentieth century. I was the eldest and only daughter of a family of five children. My first two and a half years were marked by two spells in hospital and the birth of a new brother. In the next two and a half years, I had two further spells of hospitalisation and another brother. I was hospitalised for eye operations, an umbilical hernia and broken limbs. I believe these experiences combined with a sense of being less loved than the boys and contributed to my being a 'difficult' child at primary school. Between nine years old and my confirmation at twelve or thirteen I remember also

feeling disillusioned with religion and thinking God was not proving personally a very useful concept. By the time I was at secondary school I became more docile but mainly because I had decided to 'do time' until I could be free, leave home and travel.

At eighteen I left home to go to a different state to train in nursing because it offered accommodation, freedom and the skills I needed to travel. A few months after registration as a nurse, I travelled again – to another state of Australia for my midwifery training. For ten years travelling sustained me until I discovered a new concept of 'being free'.

Midwifery Training (1971-1972)

Although I had no particular interest in maternity work I thought of midwifery as an extra skill to add to my nursing training. I sought out the 'best' hospital because I assumed it would provide me with higher quality training and prepare me well for overseas travel and work. The hospital I chose was considered good since it was technically advanced and had low perinatal mortality figures: one was assumed to correlate with the other. The midwifery training in Australia took a year, as nursing graduates had no maternity experience in the general nursing training.

Turnbull, an obstetrician writing about the 'new obstetrics' of the early seventies, quotes Professor Melville Kerr's analogy between hospitals and football league clubs:

in which it is assumed that spending large sums of money on expensive facilities and talent inevitably improves position in the league table. In obstetrics, the 'position in the league' has tended to be judged on perinatal mortality figures; therefore, because the national rate fell steadily over the period when the use of new techniques was increasing, a cause-and-effect relationship was assumed which may well have engendered a false sense of security about the value of obstetric intervention. (Chard & Richards, 1977, p.viii)

At the technologically advanced hospital where I trained, I learned that birth was potentially dangerous, suctioning of babies at birth was normal and lifesaving, and feeding babies bottled dextrose (sugar solution) was important for their brain development. I did not seriously question the knowledge base from which I was taught at all although I did question the attitudes that accompanied the teaching. I felt very patronised at times. For example, in the medical lectures on contraception being told only about barrier methods and the new Lippes Loops (an intrauterine contraceptive device). Many of us were unmarried and taking the pill but were not being given information. Control over their own fertility was a major issue for unmarried as well as married women in the early seventies. In 1977 Chard wrote "Childbearing is no longer an inevitable consequence of marriage; parents can now choose when their children will be born, and the provision of contraceptives, sterilisation and legal abortion allows them to exercise more or less complete control" (p.161). However, the idea of women being in control of their reproduction was anathema to many people in the early

1970s and seen as heralding the end of morality. I remember being offended by the assumption that student midwives or unmarried women would not need information about oral contraception.

In the early 1970s I was strongly affected by the second wave of feminism, which was marked by concerns about fertility, particularly the availability of contraception and abortion, but little interested in childbearing (Morgan, 1970). I, along with many feminists of the time, was dismissive of marriage and childbearing (Oakley, 1982). It seems to me now that this position was a strange contradiction for someone training in midwifery. The effect was a detachment from my work, which fitted well with the type of midwifery being practised at that time: very task and rule driven.

One entry in my student midwife case notes leads me to wonder whether I ever connected with any of the women I came across at the time. The entry concerned a nineteen-year-old unmarried mother having her first baby. After charting all the criteria from family history, medical disorders, surgical history, menstrual history, present pregnancy, obstetrical examination, abdominal palpation, laboratory findings, and education, I made a general comment that “Mrs. M. appears to have a good, healthy attitude to this pregnancy. She appeared clean and tidy, suitably dressed and had a typical pregnancy gait” (Lennox, 1971).

I got a good mark for this assessment even though it served no purpose other than to provide me with a ‘case’ from which to make judgements about the patient’s attitudes, her cleanliness, her outfit and her posture. The purpose of

care was merely to mark physical signs and record the patient's compliance rather than considering their emotional or psychological needs. How would this maternity system have served this nineteen year old's experience of pregnancy? Was she in fact adopting her baby out?

Late teens and early twenties was a very confusing time for me. In many ways it was a carefree existence but there was a sense in which I was quite dislocated from any purpose in the world. I didn't feel a great passion for anything much though I reacted against gendered attitudes towards others and myself. I was very keen to be independent and autonomous. At twenty-one I was involved in the Women's Electoral Lobby. Avoiding marriage and children was important; I never felt an ounce of regret when friends married. I thought nursing would give me the means to travel and midwifery an extra qualification should I need it but one of my recurrent themes was finding a satisfying occupation. (Journal, June 2002)

I was an efficient and conscientious nurse (I did not identify myself as a midwife) and had no difficulty with understanding the knowledge base, performing the tasks or having a cheery disposition. I resented only that it took so many hours out of my week of being able to live and have fun. I believed my life, like my patients' lives, went on hold whilst incarcerated in the hospital and I simply made the best of it until I could go back to the real world. In fact my experience of midwifery was that it was boring to me. To me, it was merely

another qualification – nothing more.

I thought that being professional entailed being disinterested. Anyone similarly trained could offer the same service and was capable of doing the same things. We were trained to do things, not to offer our understanding or learn to listen or share our experiences. Being kind was who we were so those personal attitudes needed no further exploration. I fitted beautifully into the scheme of things.

Denying one's own feelings and denying other's experiences was a part of my upbringing and matched the mechanistic approach of medicine towards all illnesses the definition of which extended to birthing! (Journal, July 2002)

I did not appreciate that natural birth had any value. I had little experience of spontaneous onset of labour since, during my training, I saw women induced almost routinely. Most of my time in delivery suite was spent sitting with women attached to intravenous oxytocin drips that artificially stimulate labour. We needed to monitor the number of drips of oxytocin entering the mother's system via the intravenous infusion because overdose could lead to strong tonic contractions causing hypoxia (reduced oxygen to the tissues) and brain damage or death for the baby. Oxytocin, I was told, was the new wonder drug used in the most advanced institutions saving women hours of unnecessary labour.

In Chard (1977, p.viii) A.C. Turnbull writes that:

Between 1962 and 1964, I and Dr. Anne Anderson developed more

effective means of using oxytocin for inducing labour or for accelerating slow, 'dysfunctional' labour; between 1964 and 1966 we showed that induction of labour need rarely fail, and that prolonged, 'dysfunctional' labour could largely be prevented. As soon as the results were published, in a series of papers dating from 1967, the incidence of induction began to increase.

The increase in induction also affected the more frequent need for analgesia in labour(Kitzinger, 1975). We used injectable opiates or an anaesthetic agent, trilene (Trichlorethylene), via a mask for pain relief. This gas is combined with air for pain relief but I regularly saw the trilene increased to 100 percent as the baby crowned (sighting of the vertex or top of the baby's head) just before delivery. These women were anaesthetized – temporarily unconscious – whilst their babies were born. Neither they nor I was aware of the feelings of ecstasy that women have after birthing their babies undisturbed (Brinsmead, 1985, ; Odent, 1993). Women rarely challenged the care offered; they were largely docile and grateful. Nor did my peers or I seriously question the medical knowledge or the philosophy from which we practised.

A small group in Britain were questioning routine birth interventions but I was largely unaware of this in Australia. Oakley says "the central idea in the natural childbirth movement is that women should not have analgesic or anaesthetic drugs when they have babies" (1979, p.20). Even in Britain, however, such views were not encouraged. Riley (1977) quotes Kitzinger who, in reporting to the

British Department of Health and Social Security in 1975, said “one woman who queried a routine non-medical induction was immediately branded as a nervous one who had been reading too much or watching too many TV programmes” (p.67).

I remember during my training that one woman arrived at the hospital wanting a ‘natural birth.’ Our tutor thought it would be good for all thirty-student midwives to watch. This heroic woman managed even in such exposed circumstances to deliver normally. Emotionally I was affected by the sight and went hot and cold because I thought it looked so beautiful. However I thought, as did the other students, that she was a crank! I did not see that birthing well was a result of her effort or that the effort itself was desirable; only that she was lucky to be allowed to do what she wanted to do. I was holding a strange mix of understandings. I believed being married and having children was oppressive; that contraception and abortion should be freely available to all women; and I did not identify with women who were having babies.

Robin Morgan (1970), a feminist writer and poet, describes how women become ‘the oppressor’ until they identify themselves as a woman. I definitely did not identify with these powerless pregnant or birthing women. Staying single and motherless was my way out of female entrapment in the institution of the family. I understood that women were oppressed in general; though I had not identified myself as oppressed and as a consequence did not identify with childbearing women. Morgan (1970) wrote “it isn’t until you begin to fight your own cause

that you a) become really committed to winning, and b) become a genuine ally of other people struggling for their freedom” (p.xiv). Becoming a genuine ally for women happened for Morgan after having a baby.

Although I had little sense that women were disappointed or horrified by their birthing experiences I do carry some memories of uncomfortable and disagreeable feelings. One is of a woman standing on her bed terrified and screaming as she had her baby. As we caught the baby we were also trying to pull her to lie down. She fought and screamed until, finally, when she wept she made herself soft enough to allow us to put her into her bed. I can't remember what we did with the baby but I assume it was tucked into a cot and perhaps even taken to the nursery. Babies were never tucked up with the mother. I remember thinking that this woman's horror was self-inflicted because she hadn't come in early enough for pain relief.

I was part of the machinery that knew what was best for women; I followed the protocols without question. When admitting women to hospital in labour, I followed a detailed chart on the wall that told me the particular doctor's standing orders. Virtually all doctors wanted 'their women' given an enema on admission in labour before 'doing an internal' (vaginal examination) to decide whether the woman needed pain relief. We decided whether or not to give pain relief according to how dilated the cervix was – not what the woman wished or preferred. We would check the chart 'on the wall' for the doctor's preferences about shaving. Did he want 'his women' to be completely shaved or half shaved

leaving the hair over the symphysis pubis? This was despite the fact that already in 1971 studies had reported that shaving had the same or an increased risk of infection compared to not shaving (Burchell, 1964, Johnston & Sidall, 1922, Kantor, Rember, Tabio, & Buchanon, 1965). I was taught about shaving but not about any research that challenged or supported the practice. Nevertheless, 'rituals' like these continued into the late 1980s.

In a training hospital these procedures were generally performed by the registered midwives and by the students. The women assumed that I would know the best time for pain relief and I too believed this was appropriate. Looking back, I seemed to have nowhere within myself to make a connection with the women's needs and respond. On reflection I wonder whether the hospital culture would have permitted such 'intimacy' or acts of autonomy.

Women were belittled and infantilised and this was very much a part of the culture inside and outside of hospital. Although I was aware of women's unequal treatment in general in society, I did not see that this also translated into the hospital system. The idea that medicine was supporting an insidious form of discrimination within which I was participating was beyond my understanding.

I believed we could change our social system by changing the individual lives of the next generation. My individual solution was to avoid the basis of the discrimination by avoiding marriage and children. My sense of self was as limited as my political understanding and I imagine this is the case for many twenty-one year olds.

Starting to question

In 1976, some three years after my midwifery training, having travelled around the world I was working as a nurse in a small provincial New Zealand hospital when a shortage of midwives meant I had to work in the delivery suite. At that time I much preferred coronary care unit and intensive care nursing. Nevertheless, after about six months practising midwifery I began finding a point of view arising out of the experience. I was dissatisfied with routinely giving injections to women for pain in labour when they were actually doing well without it. I realised that midwives were often the active agents in suggesting pain relief. I had no problem with giving pethidine (a painkiller) if women wanted it, but I did notice they became less connected with their labour once the drug took over. I was also developing personal connections with women having babies. Some I knew and others sought me out at the university (where I was studying part-time) to come with them for their labours. I was becoming aware of a dimension of the birth experience that involved the patient having a position on their care and my responding.

Also at this time I had my own experience of being a patient, which sharpened and shaped my views about patient's rights and interests. I had what was supposed to be the last operation to finish off 'straightening my eyes' from the squint I was born with. I had been told to have a final operation in my twenties. It never occurred to me, nor was I warned that, after my four previous eye operations, there could be problems associated with scar tissue. In the event, my

appearance after the operation was considerably worse than before. I complained vociferously but was cautioned by a nurse not to be rude to the doctor. Two weeks later, following a second operation, my eyes were not quite as good as they had been before the first operation but my view on patient's rights was a lot clearer: my right to have a position about the outcome was something about which I was very clear.

Looking back over these years, I think I believed medicine and science always had the most advanced understanding on any topic (Bender, 1968). Medical and scientific knowledge was value-free and accessible to those who were interested. I accepted that the knowledge base of medicine made it the authority on anything to do with the body. My role was to support the medical approach. I saw my training as simply practical – allowing me to play my part in the more knowledgeable medical system that was solely concerned with people's best interests. Over the four years after my training when I worked in midwifery, intensive care, and coronary care I did not change my position on the superiority of medical knowledge. The patients were not our primary consideration but were rather the passive receivers of medical and nursing care for which they should be grateful.

This, of course, is simplifying a more complex set of beliefs. I did have some slivers of political and social insight and I was open to hearing new ideas. For example, I questioned the teaching that babies did not really feel pain in the same way that adults and children did and that this justified ignoring babies'

crying during circumcision.

It is a common practice to perform circumcision on young babies without an anaesthetic. This is a cruel practice. More than a third of circumcisions are performed in the first month of life at a time when faults or diseases of the prepuce itself are practically non-existent. (Illingworth, 1975, p.90)

Separating mothers and babies for four hours at a time seemed to me inhumane (Montagu, 1978). I did not shrink from challenging such unnecessary or cruel practices, but I did not challenge the medical model of health care (Gaskin, 1977, Leboyer, 1974). I understood that women were oppressed in our society and I could accept women's rights arguments for allowing choice about abortion (Greer, 1970, Mitchell, 1971). However I understood that birthing, as with all human suffering, was rightly the province of medicine (Bender, 1968).

Taking an independent questioning position about the culture within which I worked would have needed at least an association with people who questioned the status quo as well as a reflective sense of myself (Illich, 1977). At this time I had neither. I don't believe I had a coherent sense of myself from which reflection could take place (Siegel, 1999). I was therefore unable to ask the simple questions; questions such as how we had survived as a species prior to the interventions that were now believed necessary like routine episiotomies (cutting the skin and muscle below the vagina but keeping the cut well above the anus as the baby's head was born), lying on one's back to deliver, analgesia in

labour and giving babies bottled milk (Kitzinger, 1980, Oakley, 1979). My answer would surely have been that many women and babies did not in fact survive. The notion that women could and perhaps should deliver in their own environment without being medically observed and monitored was completely outside my range of thinking. The idea that each woman has the power to give birth naturally and so enhance her sense of autonomy I would have found laughable.

An Awakening

In 1976, my first year in New Zealand when I was exploring the country and its maternity services, I spent time with a homebirth midwife whom I had heard about during a meeting of the midwives section of the New Zealand Nurses Association. At that meeting I first recognised midwives as being independent and opinionated individuals. I found them interesting and committed women. I imagine it was at this meeting someone talked about a homebirth midwife and I became interested in meeting her.

So at twenty-six years old, between holidays of diving and horse riding in a beautiful part of New Zealand by the sea, I visited this 'old' woman who was working as a homebirth midwife. She was, in fact, probably in her early fifties. Her house was a place of treasures: books, posters of China, a wall covered in photos of babies and mothers, and a huge vegetable garden. She had me stay with her and accompany her on her daily visits and go with her to births for about six weeks. People would visit. They talked about women coming from all over New Zealand to deliver in this area where they could have their babies the

way they wanted to without being told how to deliver. The house was a busy political environment with links to similar midwives and women in other parts of the world. News came from France that a hospital there was allowing women to birth naturally and one woman who was having twins decided to fly over there (Odent, 1976).

As I watched and listened to this midwife and attended births, antenatal and postnatal checks with her, I became perplexed. Everything I saw and heard ran counter to any of my previous experience in the developed world. Up until this time my experience of being a midwife in Britain, Australia and New Zealand was predicated on the assumption that midwives were assistants to doctors. Doctors were the experts in anything medical and birth was a part of medicine. Women were the bearers of the babies but the important people were the doctors because they would save people from illness and death.

But now I had a strange sense of having found in this 'old' midwife a haven or outpost and that sense was reinforced daily by the women we visited and those who constantly contacted her for advice. It was as if I had entered another culture where what was important had changed around; a new world built on a different logic.

Women in labour met us smiling at their door and yet after being examined it was determined they were half way through their labour. I saw women delivering babies with seeming ease and it made no sense to me. Women treated their pain differently, not necessarily with any less dread but with a

determination to meet it and deal with it as if it were a part of them. Pain was something that it was possible to deal with, not something hard edged and wounding. This was quite different to my experience of women in hospital who seemed to me like any other injured person in pain. From my nurse's perspective they were in pain and that was an awful experience.

It seemed as if the attitude of these women was that the purpose of the pain was physiological therefore 'let's get that over' so we can enjoy the gift of the experience – the baby. The baby was the focus for these women and it seemed they would challenge anyone or any system to provide a gentle, quiet, and, according to them, appropriate environment for the new being. The mother held and breastfed her baby immediately after it was born. Then the baby was wrapped in or covered by a warm towel, which had been heated around a hot water bottle. Checking and dressing the baby did not happen for at least an hour. This approach was absolutely at odds with my training. The baby's interest in breastfeeding was treated as a sign of good health and therefore we could wait for a thorough examination. The family gathered around and generally the midwife and doctor stepped out of the way.

Many important traditions learned in my training were abandoned. Bathing did not happen at all for days; the explanation was that it would wash off the vernix caseosa – “the fatty covering on the skin of the foetus during the last months of pregnancy. It consists of cells and sebaceous material” (Cape, 1964, p.346). The explanation for this change in 'mothercraft' was that the babies suffered less in

the way of skin infections by leaving on the vernix. Having a baby at home meant there was little chance of cross infection anyway.

Seeing women at home being in charge of their own experience and involved in every decision was a very different experience from hospital management. I was fascinated by the trust and respect this midwife showed and felt toward these women. Observing how confident she was that birthing at home was perfectly safe was initially confusing for me. Everyone appeared comfortable and there was little fear or anxiety. It was the first time I had seen birthing and associated care managed in a relaxed way. In the hospital birthing, even if it was normal, seemed to be a drama with a lot of associated anxiety. Hospital staff appeared to be most admired when they worked with adrenalin.

Now I had been introduced to another point of view. It was a view perhaps only held by one percent of the birthing population but it had managed to lift up the veil that separated me from seeing myself as a woman connected with other women. By identifying with institutional and oppressive behaviours I had effectively been blind to how women commonly experienced hospital birth. Even for Phillida Bunkle, someone already committed to women's rights and knowledgeable about the misuse of power, birthing in hospital provided a source of surprise and horror. Of her first birth (in 1975) Bunkle says it "was my first experience of total powerlessness. I simply assumed there were laws against this sort of thing" (p.iv). I had known women in the hospital who were not happy with their care but until now I had not known there was a different way to have a

baby. I did not know that having babies could be a powerful positive experience.

During homebirths these women and their partners seemed to possess qualities I had not been aware of previously either personally or professionally. People who chose homebirths seemed to have a solid and consistent quality that I can best describe as a 'sense of integration.' They showed huge commitment to birthing naturally and afterwards recognised the importance of the mother/baby dyad. It is a quality that appears in very different shapes but is characterised by having wider horizons and a sense of connection with the natural world. These parents were serious about participating in their life experiences, which included taking responsibility for their health and birthing naturally in a loving environment.

I was exhilarated by the joy of midwifery in this setting and the integrity of those women and their families who happily allowed me into their homes. This was work where everyone could stay in touch with their own lives – their real lives. We were able to be real and so were the women. The midwife at a homebirth was a part of what was happening but not central to it, and the doctor even less so. This turned the usual power dynamics on their head. Even the fact that one could safely and responsibly deliver outside of hospital was a huge lesson for me.

Home birthing after this experience did not seem dangerous to me although initially I was not convinced that it was a safe option. When women were transferred, we were treated in a hostile manner. But none of that hostility any longer seemed very important because I knew they had only limited notions of

what home birth was about.

I also saw both that I had accepted unquestioningly my midwifery training and had been brainwashed about medicalised birth. That realisation brought with it a great deal of questioning. I suddenly saw that birth was part of both the natural and socio-political worlds, and I saw how the misuse of medicine in birth disempowered women. For me attending homebirths provided an overwhelming sense of liberation from rules that served no one but a hierarchy that had forgotten its purpose. I saw women deliver through their own efforts. Even if transferred to hospital women were knowledgeable and 'in control' in a way I had not experienced before.

I found the place of the midwife as helper and not in charge very liberating. It meant the midwife actually did assist rather than direct and I found this approach far more comfortable. It was comfortable because, as midwives although we carry generic knowledge we do not know individual women's personal experience. By this I mean I had to watch and understand the woman's signs and read these rather than working from some rule-based notion of the best time to do a vaginal examination or give pain relief. I began to realise that individual labours taught me important detail. This was detail that I was hungry to understand as it had relevance – in contrast to my training, which had very little value for women. The exchange between an individual woman and her midwife creates new knowledge that can be used in the labour. I began to know in a completely new way. My new knowledge changed me from being closed and

dictating to becoming open and responsive.

The midwife I accompanied had her own particular attitude towards birth, which I found refreshing and informative. Rules were not the order of any day but researching and questioning were a way of life for her. For example, when a woman who was in intermittent labour over a number of days was subsequently discovered to have meconium around the baby, she saw the delay as the body's way of keeping the baby safe. The medical/hospital approach would be to rupture the membranes and, once the meconium was sighted, to chemically stimulate the labour to deliver the baby as soon as possible. She would wait and watch letting the woman's body protect her baby in its own way. The idea of the body as a responsive system, which might be trusted on occasions, was certainly a new idea.

In 1976 I recognised at some level that midwifery was not merely a job or profession but held the possibility of deep knowing about life. Seeing midwifery in a community setting where natural birth was being sought and achieved sparked an enormous change in my understanding about the world. My experience so completely altered my way of being in the world that I can only accurately describe it as an awakening followed by a long period of transformation over the following years.

I recognised something authentic about the experience and the people who chose to have their babies at home. It seemed these women knew in themselves that they could have babies straightforwardly. They were mostly well educated

and were interested in more than simply having the baby. They believed in caring for the baby very gently and kindly and that their baby was fully sensate and not the small, unfeeling bundle that my training and subsequent experience had led me to believe.

I experienced the recognition of authenticity as a gate opening up in my heart to being in the world in a different way. I was uneducated in understanding selfhood and seeing people planning and living their lives around their values and beliefs. This was a level of identity I knew nothing about. I was uneducated and inexperienced about taking other people's lives or myself seriously.

Looking back, although I was unaware of it at the time, the effects of seeing births proceed naturally at home reconnected me to the presence of good in the world. It connected me with a deep spiritual knowing – and renewed my faith in God. As a nine-year-old girl after the birth of my fourth brother I began giving up on God and I completed that process at the time of my confirmation. I think my disillusioned child now re-emerged with a rekindled faith that something good actually existed in the world. I know I was deeply heartened and inspired by meeting these people and seeing undisturbed birthing. It was not that I was downhearted as an adult, but I believe I had been disconnected from any feeling of having purpose in my life.

I had found something in the world in which I was inspired to participate with my whole being. Zornberg's writing about the relationship between Exodus and the possibility of redemption recalls the quality of my experience:

The tension between God-inside and God-outside is associated in the midrash with the sin of the Golden Calf. To be asleep is to be stupefied by the fantasy of density, of rigidity containing God. To be awake, pulses beating, is to be aware of distance, difference, to yearn to open at the right moment. That is, God cannot be inside if he is not outside, if the heart cannot imagine its emptiness. (Zornberg, 2001, p.336)

My overwhelming sense was that I had tapped into something very special and precious. It was exciting learning that this natural process empowered women, though, in fact, it was these women's beliefs that created the possibility of their birthing being natural. A gate opened for me and since then over twenty-five years I have followed a path trying to put together what I saw and felt so that I can understand and explain its significance. This thesis is my coming to terms with that awakening, transformation and journey so far. All my preconceptions about social and political power, health and sickness, women's relationship to nature and to feminism, the origins and nature of love and my place in the world were turned upside down.

Working with this midwife over Christmas and New Year of 1976/77, was the most significant personal and professional experience I had had as an adult. I needed time to incorporate it into my psyche. Following this I had a period of readjustment that was described by one of the professors at the university I attended as an existential crisis. I needed time to accommodate the significance

of the experience into my life. Instead of simply being drawn along and reacting to people and events because I felt no driver of my own I needed time to reflect. Now my curiosity was stimulated and I felt I had discovered something interesting to me. I also knew I was not ready to be a home birth midwife yet. I felt I didn't know enough and I had to work out what this discovery meant about institutions, obstetrical as well as universities and even my own schooling. What other possible worlds had been complicated and dehumanised. I had finally identified myself as a woman and not as a traveller looking on. I realised I needed time to 'make my story':

Stories move in circles,

They don't go in straight lines. So it helps if you listen in circles. There are stories inside stories and stories between stories, and finding your way through them is as easy and as hard as finding your way home.

And part of the finding is getting lost

And when you're lost, you start to look around and to listen. (Bender, 1995, p.10)

By listening and looking around I began to reshape my practice as a midwife.

CHAPTER FOUR: RESHAPING AND GROWING INSIDE AND OUT (1978-1986)

Starting again as a midwife

My experiences of watching women birthing at home altered my worldview and the impact reverberated through my life for the next two decades. The immediate personal impact was that I cancelled marriage plans, revisited my birthplace and family, and began a new journey of learning to become a midwife. Of course I had been registered as a midwife for six years but that training was about preparing me for medical beliefs about birthing and practising to fulfil institutionalised and patriarchal purposes. With my new understanding of that role I was enraged with feelings Morgan (1970) describes so well as “deep down and way back, something like a five-thousand-year-buried anger” (p.xv). I now wanted to work with women but to do that I needed to learn a great deal and become more self-confident. Over the following four years, instead of travelling around the world, I stayed in one place and explored my new understanding about midwifery. I began listening to women’s views and observing normal processes.

The unlearning and relearning process took time. In late 1978 I began work as a charge nurse in a small New Zealand maternity unit. Working in a small unit provided me with the experience to ground the understanding I had gained during my homebirth experience. I realised now that women had their own knowing about birthing and as a result I was more trusting of them and of the

birth process. Meeting women on their own terms showed me how labours worked both individually and as a pattern over many labours. The staff of the unit saw me as very radical because I approved of getting women out of bed after a normal, unsedated delivery and encouraging women to feed babies on demand.

Building confidence: Post-natal care

In 1981, four years after my homebirth experience, I initiated a scheme where I worked in the community visiting women at home who had planned to leave hospital early. At that time, discharge from hospital after a baby was unacceptable earlier than five days after the birth and many women stayed in hospital much longer. If you wanted to go home you needed to sign yourself out, taking responsibility for whatever the consequence.

The scheme that I set up differed from any previous system in New Zealand. It was organised on a small private basis under contract to the Department of Health. It was specifically set up so women would be visited antenatally and this forward planning I believe improved the outcomes. It was based on women making the choice antenatally to go home in the first 48 hours after their birth. I was happy for the mothers and babies to come home at any time from immediately after the birth until some time on the second day. Amusing, as it now seems, this was at the time treated as risky. Of course in America early discharge was routine – often with no follow up at home. A study of my scheme undertaken by a student studying in a post-graduate nursing education

programme (Advanced Diploma of Nursing) showed that the main reason women chose a planned early discharge was that they had previously had a negative experience with hospitals (Martis, Mosely, & Kaoma, 1982). These women did not want a homebirth but were keen to be home once they had had their baby and they appreciated having support at home from a midwife. I loved my connection with these independent women. They taught me much about being at home with a baby. Neither my midwifery training nor my experience as a hospital midwife had provided experience of postnatal care at home and until I had attended homebirths I had no insight or interest about what happened when women left hospital.

In 1981 some of my peers saw early discharge as potentially unsafe. They seemed to be waiting for a problem with a client to undermine the service and for me to get my 'comeuppance'. Of course, few women or babies had any problems and the next year "early discharge was officially recognised as an option for postnatal care in a 1982 report by the New Zealand Board of Health Maternity Services Committee" (Kilgour, 1990, p.23).

When I started the scheme I was well supported by obstetricians whom I rang freely about anything from sticky cords to unusual discharges. I was completely unabashed about ringing for advice and I am grateful that the obstetricians were very supportive. I think my lack of confidence made me acceptable in their eyes; I was very tentative in these early days and it took me time to become confident.

My confidence developed as I began recognising patterns of normal processes in

the postnatal period. Much of my early focus was on learning about normal breastfeeding issues, learning when bleeding commonly changed from heavy to light, and how women coped, for example, with babies who cried all night. The way I was working meant that I could learn a lot from women in contrast to the situation as a midwife in hospital. I found postnatal wards infantilising and frustrating for women and for the midwife working on shifts. Caring for any particular woman was unusual as it was rare to follow a woman for more than a day or two and therefore the midwife's knowledge of patterns of postnatal adjustment was fragmentary. In contrast visiting regularly over two weeks at home was a new experience and I could see the effects of my input. This natural feedback loop meant it became obvious which suggestions helped and which did not. I read and researched because I felt connected and motivated to help where I could (Jolly, 1981, La Leche League International, 1988, Stanaway & Stanaway, 1978). The experience of home visiting also showed me how women solved many of their own problems between my visits.

The golden orb of the babymoon

Over time I became an expert on the first few weeks after birth. I was aware of the term 'babymoon' before reading it in Kitzinger's *Homebirth* book (1991, p.183) and it describes the potentially rich first few weeks after the birth if families are encouraged to support the mother appropriately. I came to understand the physical patterns and recognise deviations and my place in the scheme of things. I also became aware of, and developed awe for another more

important and interesting process. This process is that of mother's giving which Dowrick (1997) has described as a "celebration of sufficiency" and through which "babies feel the generosity of the world" (p.188). Dowrick's description of the mother matches with my experience.

When things go well after the birth, or well enough, the intensity of feeling she has for her baby unites her temporarily within herself, and, differently, within the mother-baby dyad. Often this unification within herself, and within her relationship with her baby, is more intense and more satisfying than anything else she has ever experienced, even though she is simultaneously tired, uncertain, fraught, frazzled. If she is lucky she will know that she is free to say, 'Now I am beginning to understand what love is'. (p.188)

This is an extraordinarily important time that is exquisitely tuned to promote and enhance great loving of mothers for their babies, and of fathers and other children for mothers and babies. When the mother is well cared for she feels that her special state of vulnerability is strength instead of weakness. She is high on love and an altered state of consciousness for at least two days and sometimes longer. "Through her innumerable daily acts of generosity to her infant child, she draws on and lives out the archetype of the good mother. She has never been less 'herself'; she has never been more herself" (Dowrick, 1997, p.189). This enables her to feed the baby for hours, sleep only in snatches, and be patient with other small children and often all of this despite a sore bottom and

emerging breast engorgement. Everything is slow and done with a slight smile.

The other members of the family, partners, siblings, grandparents, other relatives and friends express gratitude and show love to the mother and baby in abundance. Of course the midwife is blessed by this outpouring too, which is very heartening if not necessarily always deserved.

My image of the week following birth is of a golden orb with family and baby inside it. Naturally the detail in this picture alters for each individual woman and her family. The depth and width of the golden orb varies but, if it is fostered, the special properties of the time can be made more conscious and enjoyable. Working, as a midwife at this time and for the following weeks requires an appreciation of this special space or place that families live in after a birth.

For some women in some cases this time may not be such a joy because they need to recover from a birth that has been wounding. This can result from a caesarean or forceps birth or it can be because of attitudes of those around the woman. Some women are fragmented by their lives and the baby is yet one more demand. For such women giving anything is impossible. They may still be very young (not necessarily chronologically) and need a good deal of mothering themselves. In my experience these women are needy though they may not be poor financially. I believe their babies are often at enormous risk. Dowrick (1997) has written of such mothers.

If there is no husband, woman lover, close women friends or her own mother to hold her emotionally and keep her feeling safe, then the

new mother's abundant, passionate generosity towards her baby may be curtailed. The archetype of the good mother may fail to take hold. Perhaps the archetype of the wounded child takes its place. Then the mother may feel compelled to search much too soon for some generosity from the baby itself. (p.189)

This social deprivation of immature parents is compounded with the arrival of a baby and they more urgently need skilled management and good long term support which is currently only offered in my experience in local initiatives (Wilson, 2002). This situation contrasts with that of the parents who are mature but find they are facing the grief and loss of a newborn either as a stillbirth or a neonatal death.

Grief and Loss

Another group who did not experience the joy of the postnatal 'golden orb' were women who suffered a stillbirth, neonatal death or adoption. Since I was running the early discharge scheme the local hospital asked me to visit women who had suffered stillbirths. I was also working in delivery suite twice a week and I was sometimes called in to look after a woman with an inter-uterine death so that I could be with her during her labour and for the birth of her stillborn baby. I was moved by these women's experiences. The pattern of grief was similar to that of women who gave up their babies for adoption. Staying with women for an hour or more each day for two weeks afterwards gave me some insight into the varieties of ways families deal with grief and loss. Although I did

not have any experience of their pain I learned about the sequence of physical and psychological changes that seemed to characterise the experience. Two weeks was too short a follow-up time, but perhaps better than none as existed in most parts of the country.

I learnt a lot from listening to women letting go of their dreams for their child. Sometimes they felt sorrow or guilt because they had not initially wanted their baby. Often their grief initiated a process of delving into other life crises they had experienced. Again the significance of birthing as a major life event was underlined. They would talk because I was seen as a person 'doing something' but in my own mind the more important function was listening to the pain.

Even without the experience of nurturing a newborn infant, you are capable of deep love for your baby. With the death of the baby your sorrow, disappointment and feeling of loss are real and must be resolved. Even after delivery the hormones that sustain an attachment between mother and child are still present as are the physical signs and discomforts that a delivery has occurred. (Prendergast, 1982, p.1)

Helping these mothers with engorged breasts by using suppressing binders and checking the involution of the uterus (womb returning to its normal size) enabled a contact that was safe for them and their grieving families. Learning to be silent and comfortable with my own helplessness in this situation was a major leap forward in my practice. A few years later I heard about a woman who chose

to have her dead baby at home and found it healed a previously awful birth experience despite the grief she had over the loss of this baby.

In 1983, I stopped working in the area of planned early discharge because I was having my first baby. I collected my data from two years of the Early Discharge Scheme and sent the results in a submission to the Area Health Board (Lennox, 1983). The data showed bookings doubled in the second year as more women became aware of the service. I wrote the submission outlining the need for Hospital Board employed community midwives to continue this service and the outcomes from my experience. I was leaving work because I was pregnant with my first baby.

The birth of my own babies

Naturally, I wanted to have my baby at home. There were no midwives attending births at home at this time in my area, but a friend and a midwife who had previously attended homebirths agreed to support my choice. To be able legally to have a baby at home in 1983 we needed a doctor for my antenatal care and to attend in labour. Although not a homebirth enthusiast, a local doctor and friend agreed to attend the birth. The birth was an ecstatic experience that reinforced all my understandings since my 'awakening' some seven years before. The beta-endorphins "switches on learning mechanisms (most women remember their labour in uncanny detail) and leads to a feeling of euphoria" (Jowitt, 1993b). The homebirth was wonderful and I was unsurprised by the labour.

I had another baby 15 months later. I had planned a homebirth again but this

was quite a different experience: my daughter came prematurely, was a shoulder presentation and was delivered by caesarean. Later, the sense of disappointment that I needed a caesarean with my second baby took some time to resolve aided by my friend the 'old' homebirth midwife. She allowed me my story and listened for hours until I settled the experience into a place that made sense.

In hospital before the birth one midwife told me that, as the baby was only thirty-four weeks gestation, I must realise I wouldn't be able to provide enough milk for it. I was shocked and became uncertain but the Le Leche League mothers reassured me I could breastfeed my premature baby and agreed to provide milk if that became a problem. I now know that all women have milk designed for a premature baby. I refused to leave my baby in the neonatal unit there for more than an hour or two since I wanted to fully breastfeed her when and as often as she wished (Nissen, 1996). This was considered quite unusual; and sadly still is. Happily our responsive and somewhat eccentric consultant paediatrician found it all merely amusing and agreed to go along with my wishes. I noticed the rest of the paediatric team 'eyeballing' me from the door of my room curious but cynical just as I had been in my training. My daughter thrived.

Becoming an outsider with unacceptable beliefs

A few years after the births of my babies I tried working in the hospital system again but found it was difficult since the previously supportive obstetricians now

seemed to be punishing women for my 'unorthodox' beliefs.

One awful memory when I was working in delivery suite was of meeting a woman to whom I had taught antenatal classes. She told her obstetrician how pleased she was that I was looking after her. She was 'his patient' and when I called him for the delivery the baby's head was stretching the perineum beautifully but the obstetrician picked up the scissors to cut an episiotomy. I couldn't stop myself protesting. He smiled and very politely asked for lignocaine, which I needed to go out of the room and get. Meanwhile he cut the episiotomy with me out of the room. (Journal July 2002)

He did not cut episiotomies routinely but he was showing me how power works. In hospital, practices were very much dependent on the opinion of the specialist on duty for the day. The culture was unresponsive to women's beliefs and wishes but very responsive to obstetricians' opinions – mostly based on convention and habit rather than good evidence. Marsden Wagner who started working for the World Health Organisation in 1979 set up a perinatal study group to evaluate maternity and neonatal services in Europe.

We started by reviewing the scientific literature and soon came across the gap between science and practice. To confirm this observation, we recruited a scientist not in the group to survey routine obstetrical procedures. We were shocked when the report from this scientist concluded that approximately 10 percent of all routine obstetrical

procedures had an adequate scientific basis. (Wagner, 1997, p.369)

This culture supported the idea that the knowledge bearers were incontestably the obstetricians and not the women or midwives. I no longer believed in that received wisdom.

Another memory was of a woman who wanted to lie on her side to deliver. I called her doctor for the birth and who on arrival said “just roll on your back” and when I said she particularly wanted to lie on her side he responded with: “well that’s just psychological”. Furious I said that I thought his need to have her lie on her back was possibly also psychological. She stayed on her side and delivered straightforwardly. I believed that this would be my last shift because he would complain about me but in fact he said nothing at the time or since. At times it seems truth and anger triumph. (Journal, October 2002)

These experiences within the hospital I found infuriating and ridiculous. I enjoyed working with the women but it was tiring when despite doing all their effort women were infantilised, cut and patronised and yet afterwards found effusively thanking the doctors;

The idea of maternal power has been domesticated. In transfiguring and enslaving woman, the womb—the ultimate source of this power—has historically been turned against us and itself made into a source

of powerlessness. (Rich, 1986, p.68)

Rarely were women congratulated for their birthing abilities although they often were for the prize of the baby that was treated as if it arrived by magic. I was ready for a change from hospital midwifery. This readiness to be in what I perceived as an adult rather than an infantilising world and develop my own practice was a very powerful motivating influence in the following story covering a period of fifteen years of practice as an independent midwife.

CHAPTER FIVE: GROWING UNDERSTANDING: LOOKING OUT (1986-2001)

This chapter and the next cover the changes in my understandings about midwifery that took place for me over a period of fifteen years. The formation of the New Zealand College of Midwives in 1999 meant midwives had a voice for the first time as a separate profession from nursing. The face of the maternity system altered with the passing of *1990 The Nurses Amendment Act*. In 1990 legislation was passed enabling midwives to practise autonomously by admitting to hospital under our own authority (1990). This significance of this law change on my practice will be expanded in this chapter. This is my story of developing a practice during this time of optimism and idealism.

From 1986 until 1990 I worked as a homebirth midwife and an antenatal educator on the fringe of the maternity system. My children, who were two and three respectively in 1986, grew up with my disappearing at times for births, or on the phone talking to clients, or going to bed hearing my simulated 'birthing sounds' and the accompanying laughter coming from our lounge room when I ran antenatal classes. Over these next few years, I consolidated my midwifery practice. I was becoming an experienced homebirth midwife: having participated in transferring women to hospital, major haemorrhages at home, shoulder dystocia (a baby stuck behind the pubic bone during the course of delivery), and a face presentation (a birth where the face is coming first instead of the top of the head). All these major events once dealt with, added to my sense

of being able to cope with physical emergencies. Major events, however, are often not simply physical but can entail shared memories of problems and fears. It was during this period and as a result of these and many more day to day experiences that I began to develop the understandings that I have today – the ones that are the main subject of this thesis.

Most of the chapter involves descriptions of particular exemplars from events in my practice and my reflections arising from those experiences. I focus on the social context in which I worked initially. In Chapter 6 I will turn inward and focus on the psycho-spiritual aspects of midwifery elaborated by using mostly fictionalised biographical exemplars.

Joining the homebirth midwives of the 1980s

In 1985, a year after my daughter was born, I was asked by a midwife friend to care for her when she had a homebirth. I knew that homebirth midwifery was what I wanted to do eventually but with two very little children I was not sure this was the time to start. Nevertheless, I agreed, and by supporting and working with the homebirth midwife already in practice, I developed the confidence to care for my friend.

Now I had the opportunity to look after a woman ‘of my own’ and so began my next learning curve. Actually, the women who chose homebirths were very much their own people, very clear about the choices they were making and not mine in any sense other than that I had agreed to be their midwife. What was mine was learning about the practice of working with these women and continuing to

unlearn my very medicalised background.

What attracted me to be a homebirth midwife was an inner knowing about how precious the event of birthing was in my own and other women's lives as well as the achievement of having a baby. I believed that women in general were missing out on experiencing a great event over which they had enormous power. Those who were conscious of the power of birth were unusual and they sought out homebirths often against great odds. They represented perhaps two percent of the birthing population in New Zealand (Gulbransen, Hilton, McKay, & Cox, 1997). These were women who had a strong connection to birthing naturally. In contrast, many women in the 1980s were finding motherhood was not central to their identities, some choosing not to have babies at all (Kedgley, 1996). The maternal culture was changing and less women were 'at home' but living instead between the public and private worlds.

“...increasingly women approach birth and the initial tasks of motherhood in a business-like spirit, determined to do it well, but concerned to get back to the situation, both in working and their private and social lives, that existed before the baby was born.
(Kitzinger, 1992, p.3)

Where previously unconscious connections to the natural world meant pregnant women expected both that they could birth and bear pain, women were in an era of questioning their ability, capacity and desire to birth naturally. Some women who liked the idea of birthing naturally had to relearn this connection with their

bodies by making their ability to birth conscious. A change was occurring in western culture, which put birthing outside of normal life; it had become a clinical condition requiring a medical response for most women (Davis-Floyd & Sargent, 1997, Kitzinger, 1992)Murphy-Lawless, 1998 #122].

Homebirth was outside the normal experience of most women in the late 1980s but came to represent the only place where natural birthing was valued (Banks, 2000). It was not simply that women wanted to be at home in their own setting but being at home ensured that they had the opportunity of birthing naturally (Donley, 1992, McLaughlan, 1997).

Prior to 1990 and for some time afterwards there was little separation between homebirth women and their midwives. We shared being on the fringe of the 'normal practice' of 98 percent of the population. Our organisational focus was the Homebirth Association (Daellenbach, 1999, Donley, 1992). When the law changed in 1990, midwives who were working independently as domiciliary (homebirth) midwives shared a common understanding. We worked from a very woman-centred focus.

This informal 'partnership' involved a small group of consumers who were highly committed to the birthing option offered by a handful of domiciliary midwives who worked long hours for relatively little financial reward. Both midwives and consumers needed and respected each other and were united in their resistance to medicalised childbirth. (Tully & Mortlock, 1997, p.6)

Homebirth felt as if it was a cottage industry. Homebirth midwives mostly knew each other and helped one another as needed. There was opposition and claims of dangerous practice (Donley, 1986). Homebirth midwives knew that the overseas statistics for place of birth (O'Brien, 1978) supported our own experience about the safety of our practice (Donley, 1992) and some of the more rational of our medical colleagues supported us in practice (Donley, 1986). But homebirth is much more than just a safe option.

Homebirth midwife – apprehensive but learning

Learning to understand natural birth took time. Despite the evidence on safety I was an apprehensive homebirth midwife; not someone who 'just knew' everything would turn out fine. I was very vigilant about taking observations such as the fetal heart and maternal pulse. I actually learned a great deal by reassuring myself with these observations and still believe there are times a maternal pulse is an invaluable assessment tool. The length of a labour did not, by itself, worry me, but I was not happy to stay at home if the condition of the woman or her baby deteriorated. The new obstetrics had changed the length of time acceptable for a normal labour and soon there were set times for each labour stage (Chard & Richards, 1977). As I was trained and familiar with the new obstetrics my trusting the process of a normal birth created conflict and discomfort for me as I resolved this mismatch in ideas about what constituted best practice. I was not anti medicine or anti scientific knowledge however natural birth appeared safer than unnecessary intervention (Bing, 1977, Leboyer,

1974, Odent, 1976).

Midwives like myself and women similarly committed to natural birth found that in hospital they needed to work covertly to be protected from these labour time rules. This created a dual time schedule where, for example; full dilatation was not confirmed by internal examination (Curtis, 1991). Once the head was seen to be descending the full dilatation status was confirmed allowing women the time it takes to deliver (Kitzinger, Green, & Coupland, 1990). One hour in second stage is a ridiculously short time for a women having her first baby and rather long for one having her second or subsequent but the one hour rule for all was enforced in hospital. In hospital it was also routine to rupture membranes (the two membranes enveloping the baby in the uterus), and have the women on a bed for the whole labour with routine internal examinations (usually 4 hourly) and most had pain relief (also 4 hourly) (Kitzinger, 1980).

I had no hesitation in transferring women to hospital when it seemed appropriate. As an example of my apprehension I once got up at 4 a.m. to visit a woman I was concerned about because for one or two days she had had pre-labour ruptured membranes at term. I had my critics in the homebirth movement because of my tentative approach and at times I struggled with this criticism.

My practice was slow to become confident because I needed to develop what Schein (in Schon, 1983) says is the hallmark of a professional: the ability to “take a knowledge base and convert it into professional services that are tailored to the

unique requirements of the client system” (p.45). I needed a range of experiences for me to begin to trust my ‘hands-on’ knowledge and my intuition and to value the knowledge that women brought to a decision. I needed time to develop a sort of tacit knowledge from practice – and as I gradually learnt this knowledge my way of being in the world changed. I began to carry my learning and the associated confidence inside me in a new way. Understanding natural birth and mapping its shape is essential to good midwifery care. We homebirth midwives learned by using our skills of observation and listening. We learnt about what constituted ‘natural’ – something we had no way of learning in the hospital environment because of the amount of intervention.

“Homebirth midwives and families had a powerful sense of ‘rediscovering’ normal childbirth and ‘recreating the relationship between midwives and birthing women. It was like an ‘underground laboratory’ where new ideas and forms of midwifery practice could be tried out – away from the eyes of authorities and medical ‘experts’”.

(Daellenbach, 2003, p.8)

I was also helped to learn about natural labours by books such as *Spiritual Midwifery* (Gaskin, 1977) and later *Heart and Hands* (Davis, 1987).

Learning about breastfeeding was another area – a real passion of mine about which I read everything I could find. The standard text was *The Womanly Art of Breastfeeding* first published in 1958 (la Leche League International, 1988). This reassuring reference book for women provided knowledge about women’s

experience. It also provided midwives like myself with another place to source answers for problems with baby's who were slow to gain weight but being described by doctors as babies who 'failed to thrive', a naming which represented a further impediment to relaxed mothering and feeding. Another useful and well-researched book that I used a good deal was *Breast-Feeding a guide for the medical profession* that was helpful because it was both informative and insightful about the process and the experience (Lawrence, 1980). Having gained a sense of the essential 'need to know' technical aspects of breastfeeding and the usual range of problems my interests in mothering changed. As Alice's story illustrates, learning about life at home after the birth led me into a realm outside of discussions about physical safety, outside of the 'doing'.

Alice: breastfeeding 'problems'

I received the following story from Alice whilst writing my thesis. I asked her if I could use her letter and she gave me permission to use it and a copy of this letter is in the appendices. It was an episode I had forgotten but one that I think illustrates the importance of the issues that often come up from simply attending to the normal range of happenings around birthing. This 'simply attending' at some point becomes an attunement to the nuances and the soft signs of what is within the normal range and what is not – and a preparedness on the midwife's part to voice her feelings, ask naïve questions or just to allow space. It is in this space that magic happens.

Alice wrote:

“I expected breastfeeding to be a breeze. I had breastfed my first child well and did not expect any problems...however I found it difficult to latch Erika and called Sue out one night because I couldn’t get it right. Sue came and said, “Is there anything bothering you?”

“What came to me was my Father who I was really cross with. I had had what was the most successful experience of my life – I planned a homebirth and had a homebirth, the people I wanted with me were with me, and my Father had rung me up hardly acknowledging my achievement as he was bitterly disappointed that 1) I never went to hospital (where it is supposed to be safe!); 2) he couldn’t bear to be in the same room as me when I breastfed; 3) he rang and complained about my brother and his present relationship.

“I believe to achieve a homebirth one becomes very focussed on you, or I did. It was my husband who had to say please give your first child some attention. My focus slowly unravelled from the baby and myself, to my first-born and then to my husband. It was 5 – 7 days before I walked to the letterbox, and nearly 2 weeks before I got into my car which I felt was too early.

“Hence my Father coming down about his own worries really was a shock to my body and I really couldn’t deal with it and which Erika was very sensitive to ... so ... Sue’s simple question opened this huge

can of worms. What I realised was I never used to talk about what was bothering me. I would just keep it to myself and deal with it with a 'pantry attack'. Erika latched on and breastfed like a dream after telling Sue what bothered me.

"So what eventuated basically was if Erika wouldn't latch on, you could bet it was because someone, or something had upset me, she could sense it and unless I talked about it then she wouldn't feed!! Quite a challenge for me; I had to start talking.

"Erika and Sue were actually the beginning of me dealing with the grief of my sister, Amy. She had died when I was ten. At the age of ten I was not allowed to go to the funeral and never discussed her death with my parents because I could see it would upset them. So I developed my own little theory that I had to be careful what I said to people as I may upset them so I wouldn't say what I wanted. This little theory has caused a lot of grief in itself and now getting close to forty I am finally saying what I want to say (not all the time) but LOTS more than ever before and there is a huge sense of freedom from this. So thanks Sue for freedom."

I had forgotten this story although I imagine I knew something of it at the time I was visiting Alice. This sort of midwifery situation is not unusual (stress presenting as a breastfeeding or other problem) in my experience and, since I don't remember all the events that have happened during my practice, I would

have no reason to remember whatever comments Alice made to me about her father. Why did I include her story? Although her individual story is unique and complex her difficulty at the time and my actual midwifery response was not unusual because I have found that breastfeeding problems in practice are often of this order.

Alice had already had a good deal of practical experience of breastfeeding: essentially a perfectly normal process. When she asked for help because the baby wouldn't feed I knew there was a reasonable chance that something had upset her. I find some sort of personal upset is more often the problem than that the equipment (mothers' nipples or baby's mouth) is faulty. Her looking out for help may have been satisfied by assistance with latching the baby on and I am sure I have done this for other women unaware just as she would have been unaware that her body provides a good deal of information about her actual state of mind.

The important thing is that Alice has moved herself on by taking up the challenge this experience offered for looking in but this was not my work this was her understanding the significance of Erika's refusal of the breast. When I read her story I was interested that she used a capital 'F' when spelling 'Father' – perhaps an indication of the importance she still attaches to her father.

I have found understanding techniques very useful for my practice but there are also limitations to this approach. Suzanne Colson (1998) writes about the introduction of technical terminology, even the term “successful breastfeeding” to the breastfeeding literature of the 1970s. She claims the term was first used by

Appelbaum, one of the first medical advisors to La Leche League, who wrote an article which although 'a marvellous resource' was the beginning of a process of turning an art into a series of techniques.

Just like many things medical, the exception soon became the routine and breastfeeding management became a priority for all mothers. Appelbaum's terminology and style typified the fatherly or patronising approach of the times, paving the way for a patriarchal, controlling approach to breastfeeding. (Colson, 1998, p.34)

To illustrate the point, Colson reverses roles in this sweet parody: "Mabel Midwife, a professional woman, teaches an incompetent man how to hold his penis and be successful at a specifically masculine thing – peeing standing up" (Colson, 1998, p.34).

Had I tried to force Alice's baby on to the breast or extolled the virtues of the 'rugby hold' or teased the baby's mouth with her nipple, perhaps Alice's baby would have had a 'successful' feed but would this have continued into the next feed? Would she have simply learned that I knew about breastfeeding and she didn't? Another option would be for me to say on the phone "you know how to feed babies as well as I do." This would be respecting her skill and, by encouraging independence, some might say I would have avoided creating dependence. I have found my technical skills are not always or even often needed. Rather it is my ability to be present and pay attention that the woman actually needs. Attempts to foster a breastfeeding culture are developed in

Breastfeeding in New Zealand: Practice, Problems and Policy as follows:

Health professionals and healthcare workers may therefore have the correct information about lactation but have little experience in translating the information into practical help for women who wish to breastfeed successfully within the conditions and demands of their daily lives. (Beasley & Trlin, 1998, p.20)

I know that when women call me it is often because they need me to act as a sounding board. When I confuse this knowing with my technical knowledge I can do a disservice to women.

However, sometimes the converse is also true. The next story, Beatrice's story, speaks to a different knowing in practice – how technical knowledge and the appreciation of safety are important – but they too must be seen in the context of knowing about this particular woman, her baby and family. Elizabeth Smythe, a New Zealand midwifery lecturer, writes about safety and her appreciation of the complexity of safety in practice:

The doing brings to light the concerned mindfulness of practice that is focussed on what is happening right now, without ever forgetting what may have already happened, and always anticipating what might be about to happen next. (Smythe, 2000, p.19)

Baby Beatrice: The complexity of safety

About the time of the law change that reinstated a midwife's right to practise

independently (1990) Baby Beatrice was born at home. I commented on how purple Beatrice's nail beds appeared to my colleague but her Apgar* scores were fine. She breastfed from her mother without a problem and I left the house two or three hours after the birth, planning to return next day for a postnatal visit. The next day I decided I would visit Beatrice and her mother, Beryl, before the other women I was caring for since it was twelve hours since Beatrice's birth.

I laughed when the parents commented on how much the baby had interrupted their night's sleep and I took the baby's part in her need for sustenance. No, they hadn't fed the baby, since "she didn't seem to want to feed but was quite noisy and grunting a lot". I was alerted at this point and, though the baby was apparently sleeping normally, I lifted her gown to find rapid, paroxysmal breathing. After taking her observations, which were markedly abnormal, I arranged admission to the neonatal unit. On admission the baby's blood gases were seriously abnormal and some cyanosis was evident.

Beatrice had an overwhelming streptococcal infection and I was horrified by the speed with which she deteriorated. If I had decided to visit the other family first it might have been too late by the time I arrived at Beatrice's house. The parents were perfectly sensible and caring but it had not been at all obvious to them that anything was wrong with their baby. Beatrice was lucky – she recovered – babies who suffer streptococcal infections can die very quickly. They can die at home or lying in a cot beside their mother in hospital.

* Apgar scores are a measure of a newborn baby's physical condition at one and five minutes after birth (developed in 1952 by anaesthetist Virginia Apgar)

My learning here was huge. I wondered whether it was intuition that had me visit Beatrice before my other postnatal family? What made me lift the gown on this baby, as I was not normally someone who woke sleeping babies? Is this what is called “subjective knowing”, that fallible gut feeling of which White (1996) speaks?

It is a deep point of inner strength on a journey of knowing, but it is a private knowing and as such has the limitations of ‘small sample size and limited generalisability’, and suffers the inevitable influences of potency of an experience and recency of experience. (p.10)

I have found intuition an important tool to carry along with me though it is impossible to teach because it is part of an individual's neural network of recognising patterns based on our experience.

When Beryl became pregnant again we talked about the increased risks of infection this time and discussed what a reasonable plan of care might be. I advised her that a vaginal swab might be the way to decide whether she was a carrier or not. In those days researched evidence about best management was not as clear as it is today (Minkoff & Mead, 1986).

Beryl wanted a homebirth and did not believe the infection would happen again – although she accepted she was at greater risk. I found the prospect of having another baby get sick so quickly very daunting. I didn't think birthing in hospital was necessarily the answer unless Beryl was shown to be carrying group B streptococcus vaginally. She was very adamant that she was not taking

antibiotics without evidence of infection. The vaginal swab was negative at 36 weeks gestation, encouraging us all to relax.

The baby was born without a problem and until day ten we were all pleased to be following a normal process. On the tenth postpartum day Beryl rang to say Baby Graham was flushed and had a temperature. After visiting them, I recommended he should be transferred to hospital, something I have seldom done in fifteen years. The hospital staff were as concerned as I was and were not reassured by the earlier negative streptococcal vaginal swab. A lumbar puncture, blood and urine tests taken from Graham were all negative. He recovered very quickly and was discharged without a definite diagnosis ever being confirmed.

Beryl found this experience far more stressful than Beatrice's admission. Both parents wanted the baby to have the best care – but only what was necessary. They thought the lumbar puncture was cruel and unnecessary and driven by an element of overreaction because of the previous history. The parents were unsure whether to make the hospital the target of their horror at the invasive diagnostic techniques or was it I who had been too quick to admit the baby? They were in a difficult position – questioning the need for intervention and wanting to protect their baby but at the same time grateful for any necessary care. However, they were soon home again with their baby and carried on as before in a very relaxed way.

On reflection, the story of Baby Graham raises a number of issues for me. I was relieved that nothing serious was found with this baby but I felt quite

uncomfortable about my role in admitting him. I had already decided this situation was outside my comfort zone and expertise and admission was probably the safest thing to do – I would certainly have thought so had the baby not recovered so well – but I am also sure I would not have admitted him so quickly without his sister's prior history. The parents' distress and their questioning of the need for invasive procedures left me unsure of whether my management was appropriate. Should I have waited a little longer? Would I have been better to contact the general practitioner first? Perhaps this would have been a good option because general practitioners are in this position with children and babies regularly, assessing their patients from a medical standpoint but in a primary care setting.

But it did not occur to me to contact the general practitioner. In 1990 the Act giving midwives autonomy had only just been passed and most other health professionals did not recognise midwives as having any particular knowledge base. There was very little respect and quite a deal of disdain toward midwives who practised independently. Midwives were seen to be taking over general practice obstetrics though the issue was most often portrayed as a question of safety. I have had good relationships with one local general practice since it was started in 1992, and that has encouraged good contact but, in general, the tone of relationships with general practitioners has been one of suspicion. I tried (as did many midwives) to keep channels of communication open by contacting general practitioners and communicating about women who were transferring back to their care at six weeks – but the effort was rarely reciprocated. This backdrop

then did not incline me to contact the general practitioner before transferring baby Graham to hospital.

As in this case, birthing was not always the difficult part. There were considerable challenges dealing with people who would only accept interventions if they were absolutely necessary, kept to a minimum and fully discussed prior to their enactment. The need, or at least the perceived need, to act quickly for the baby's safety, especially given my frightening experience with her sister, may have lead me to recommend actions more forcefully than I would otherwise have done. For similar reasons the hospital staff may have gone further than was absolutely needed. Perhaps more importantly, these parents felt redundant and as if they were of no importance while invasive procedures were being performed on their baby – and that may have led to later feelings on their part that they had unnecessarily exposed their baby to interventions. As a midwife how should I reconcile my fears and knowledge of dangers with the rights and concerns of the parents?

In such situations and such settings it is challenging to advocate from powerlessness either as parents or as a midwife. Midwives often refer to specialist services because a situation is outside their expertise, but they have an ongoing interest and engagement with the family. However, they are often treated as redundant in the hospital setting because they are no longer managing the physical care and they have little power to influence the care that is given or to advocate on their clients' behalf.

I found that working in the community left me in a difficult position in respect to hospitals. When midwives (or other primary care workers) transfer babies from home to hospital they often generate disrespect within the hospital environment. Almost by definition in these circumstances hospital staff see midwives and their clients at a time when problems arise but rarely is there recognition of midwives' good judgements or knowledge in recognising the need to transfer or in giving care to the great majority of mothers and babies that never need to be transferred. This is a very tiring and stressful part of my work, when it should be straightforward, seamless and respectful.

Homebirth midwives had always been in this situation in relation to hospital staff but there was some hope, that after the change in legislation (1990) improving our status, that because we provided continuity as legally autonomous midwives that the staff would acknowledge the importance of our engagement and on-going interest with the women (1990). In the next section I consider some of the changes experienced by me in my practice as a result of the new Act.

After the Nurses Amendment Act 1990: Work and identity

At the time of midwifery autonomy (August 1990) I had been an enthusiastic homebirth midwife for some four years. The understanding and map of natural birth I was developing from my experiences meant that when a woman wanted to birth naturally, I clearly encouraged her to do so. I was building a client

base from the women I had taught in antenatal classes over the previous decade, from those who had previously had home-births and from people I had followed up postnatally in my early discharge scheme.

After the change in legislation (1990) midwives who had always been independent in their thinking were the first to leave the hospitals and set up various arrangements for independent practice. Two colleagues and I formed the first midwifery group in our area. We met regularly and shared a pager system so that we could support each other when needed but we did not share our individual client loads. Everyone received all the pager messages so we could be aware of who was busy or if a call repeated it might mean that we needed to check the call. We had no regular days off, and apart from holidays, were on call twenty-four hours a day, seven days a week. When I became tired my colleagues backed me up. This was my working pattern for most of the next decade.

There was an 18-month period in the late 1990s when I completely shared my practice with another midwife – working one week on and one week off – though still part of the larger group that met perhaps once every six weeks. That system worked very well for us and will remain the best working arrangement I have ever enjoyed. I usually relied on one of the other midwives to attend as the second person at births and generally the women had met this midwife during the pregnancy. Only once did I share work with a general practitioner for a hospital birth, However, on occasions women having a repeat homebirth wanted the doctor who had been involved in the previous births to be present again and

I enjoyed some fine collaboration with such doctors early in the 1990s.

There were many other midwives happy to work with doctors attending hospital births within the shared care framework but, although I believe women should be able to choose their caregivers, I chose not to work that way. I found that being able to function effectively as a midwife I needed to establish a relationship with the women based on respect for my skill and the level of responsibility I was taking. That was difficult in a shared care situation in the hospital since my experience of working with doctors in hospital was that they mostly behaved in a hierarchical manner and were focussed on the potential pathology inherent in birthing rather than on wellness and relationships. At times I missed out on caring for women because they wanted their doctor involved but I never felt a conflict about not working in shared care and it was worth it for my peace of mind and autonomy of practice. Women who wanted their care to be shared between midwife and doctor were often insecure about trusting midwives and, though I could respect their need to feel safe, I did not want to work in this way – I wanted to work with women who wanted a midwife to work with them.

When the law changed in 1990 the word 'midwife' was barely understood in everyday parlance. Now nearly twelve years later I would be surprised if someone didn't understand what was meant. Sometimes people, believing I would feel pleased to be called a doctor call me a 'baby doctor'! I find the easiest thing is just to smile in these situations. It takes a long time to shift established

patterns and expectations. However this brings up the larger question of identity: why would I not want to be called a doctor? Surely this is one of the positions of great status in our technological world. I am not anti-medical and believe obstetrics has an important place and could dovetail well with midwifery but instead when midwifery tries to work with medicine it risks losing its identity to the more powerful and dominant group – as it has in the past. Our identity is unimportant I would contend unless we are intimately connected to our purpose of being guardians of normal birth.

Maintaining a midwifery identity is important for women, because without strong support for birth as a normal life event women will, I believe, eventually lose confidence in natural birthing (Schmidt, 2003). Perhaps this has already happened, with out rates of intervention having reached a point where 22 percent of women nationally are having caesarean sections (Ministry of Health, 2003). As I discuss later, my experience suggests to me that birthing is one important way for women to achieve the maturation necessary to deepen her life experience and find the resilience to mother well. A satisfying birth is also a sustaining experience of oneself as capable, strong and womanly (Greer, 1999, Kirkham, 2000). Birthing is a unique experience in a woman's life if she is the central player.

In any culture birthing sits on the interfaces between the natural and the social worlds, and between the social and the medical models of care. Because of the diverse views about power and control around the birthing processes even whilst

claiming women are at the centre of care she needs to be well supported to achieve any sense of empowerment. How can midwives help?

Birth models are similar to models of sickness and health in that they are made up of beliefs and expectations that are part of a person's cultural experience and cognitive being. Arthur Kleinman (1980) points out that the models of sickness and health are often ambiguous and inconsistent. It may be more useful to focus on knowledge that people bring to an experience and to factor in issues of power and social class. (Lazarus, 1997, p.138)

Flax (1983) envisions a society of self-critical, self-reflecting individuals coming together developing concepts based on experience and knowledge providing the basis for a theory of individual and social liberation transcending the ideas of the past. Feminists have argued for a fundamental change in thinking about women and society (Chodorow, 1978). Sara Ruddick writes that the aim of having a feminist political commitment is

“...to eliminate all restriction of power, pleasure and mastery arising from biological sex or social construction of gender, so that women will have as much (and as little) control as men over their collective and individual lives”. (Ruddick, 1984, p.234)

Midwifery is acknowledged in New Zealand and appreciated in the public realm. Mothering too has that capacity according to Ruddick (1984) who believes it can be transformed into being understood as a public good. This vision of mothering

in our culture is at present a long-term aim. Midwifery may be one means to its achievement.

I take pride in midwifery and being a midwife because my position affords me responsibility and I enact this responsibility through my knowing about normal physiology rather than drugs and instruments (Davis, 1987). I work within the world of the individual woman and with an understanding about the range of normal variations within birthing. Midwives are fundamentally feminist: knowing well that in shedding the social self during birthing, women find a form of liberation of Self (Kirkham, 2000).

Childbirth can be utterly empowering; it can transform a woman, renew her, strengthen her faith and deepen her identity. Her ensuing change in perspective enables her to mother in a fiercely independent fashion and with new-found inner certainty. (Davis, 1987, p.5)

The women that midwives attend often share their midwives' beliefs about the midwives' role – but this is not always the case. I remember one woman that I attended who was very well groomed and socially conscious; she could not understand why I would encourage her to make her own choices. She never did understand it despite birthing well. She felt let down that I would not assume responsibility for her. When I met her some time later she reported being bemused at hearing people talk about midwifery as a healing art (Archterberg, 1990).

I wrote about this empowering quality around birthing and mothering in 2000

for a Master's paper in an essay called "Exploring the construction of childbirth in New Zealand and its relationship to sacredness and love".

What I and other midwives experience and know convinces me that if women are sensitively prepared for birth and supported throughout labour they feel better about themselves, are physically less traumatised and are able to source the capacity to love well. (Lennox, 2000)

Learning about midwifery was for me a complex experience because once I changed my perspective five years after my training I needed to gain a sense of competence. To effectively trust birthing, women and myself I needed a range of challenges to feel a sense of confidence that I knew about natural birthing. Ten years after first seeing homebirths I tentatively began attending women at home. The following years my sense of what is 'normal' for natural birthing is held more comfortably. Within four years the Nurses Amendment Act 1990 allowed midwives hospital privileges and the right in law to deliver babies without medical oversight. Over the following eight years I took the opportunity for caring for women who chose to deliver in hospital as well as homebirth women. The opportunity to participate in maternity care as an autonomous health professional changed the ground of my practice along with the benefits of pay equity came a change in accountability.

Clarifying my practice life and home life

This increasing responsibility and independence following the changes in

legislation in 1990 meant I had to think about and plan my practice and work and I also often faced situations that raised new issues. To help cope with these challenges I contacted a supervisor and worked with her every month to establish how I wanted to practise and gain clarification about issues at either a collegial or client level. Supervision worked well to develop a separation between my work life and my home life. The supervisor is a person who had been trained to work with a range of health professionals such as doctors, social workers, counsellors and psychologists. It is essentially a consciousness raising exercise where I become aware of my practice concerns and s/he acts to disabuse me of beliefs that are clouding my understanding. Often in practice midwives have little time for reflection unless they consciously make time for it. I paid for sessions myself as a part of my practice management and a part of the support system I had in place to care for my health.

I managed the three most significant complaints about my practice and me by having regular supervision. I had to learn in a deep way that I was not always going to suit even the people who thought they wanted me to care for them and I also learned that I would not necessarily know about incompatibilities with women before the birth. I learned about women and about myself from such complaints. For example, my first complaint was from a woman who felt unsupported by me and complained about my style of practice. I felt misunderstood and abused by her.

I realised "being nice and helpful" was not enough; I needed to have better

understanding of my symbolic role for women. I became aware that some women who had problems with their mother struggled with their relationship with their midwives and some suffered from feelings of insecurity. This was not, of course universal, but was something that I observed. I learned quite painfully to respect that I couldn't 'fix' what had happened by saying "sorry" or just listening for long enough. Sometimes it isn't about me at all but, because I am there, I am the person put in the frame. I learned to respect how I worked, to understand that I could only do my best and that sometimes that wouldn't be enough for some people.

This meant I became clearer about who I was and it followed that this clarity would extend to how I practised. I learned to be very clear about how I worked and the regulations and specifications I worked with, including the College of Midwives complaint and the annual review processes. The change in my confidence, which resulted from the years of experience, coupled with coping with emergencies, complaints and having supervision added enormously to my understanding about my work and myself.

I find that by combining an appreciation of the women's sense of what is important for herself alongside my knowledge of normal physiology of birthing creates a 'practical consequentialist' modus operandi. Instead of operating as if there are rules by which I work I can as a midwife give people some insight into my own particular view of a situation, and explain the limitations of our bias and work with the parents own views to achieve as closely as possible the most

desireable outcome without causing any harm. Working with women and families by sharing the current evidence on a particular issue enables comprehensive discussion to take place and for decisions to be arrived at through the conversation.

I have called Chapter 5, 'Looking Out' because it was a story of fifteen years of learning about what constituted normal in childbirth and becoming confident in a field of work which as is challenging as it is changeable from literally one minute to the next (Baby Beatrice). Law changes meant increasing accountability however the dynamics in the field between practitioners did not always support our level of responsibility. The story of Baby Graham is an example of the complexity of attending a woman when her baby's care has been transferred to a neonatal unit. This is also a woman's (parents) story but it is about reactions to events rather than reflections on her life as in Chapter 6, which is called 'Looking In'. Alice was looking out for help with a physical problem. Her letter is about two processes one of which I was involved in by drawing her attention to the reaction of her body to stress and another where she later attends to this new information by looking in, reflecting on her life and finding her own treasures. My focus in chapter 5 on 'looking out' is about finding ways to manage my practice, forming a solid base of experiences and developing confidence over a time in midwifery which was exciting and challenging but a time in which I learned to also value looking in, which I develop in Chapter 6.

CHAPTER SIX: GROWING UNDERSTANDING: LOOKING IN (1986-2001)

In the previous chapter I discussed changes in my life, my practice and the way that midwifery was organised and practised in New Zealand. I also reflected on two stories from my practice, both of which raised issues concerning relationships outside of but impacting on the nuclear family. In this chapter I focus more on the internal world of women during the birthing process.

When I started to think what I had learned during practice I used the phrase mindful midwifery to denote the need for alertness, awareness or wakefulness to women's changing perceptions during childbirth. I seemed to have evolved an intuition about what was normal and what not normal. Being relaxed, having confidence, listening to and trusting women and their stories all seem to be landmarks on my map of mindful midwifery.

Elizabeth Smythe (1998) wrote her doctoral thesis on “*Being Safe' in Childbirth: A hermeneutic interpretation of the narratives of women and practitioners*” and in it she used the concept of mindfulness. Smythe (2000) speaks of mindfulness by saying, “The spirit of safe practice is seen most clearly in engaged doing” (p.19).

She says that doing includes watching and anticipating and this approach to practice is, she says, what makes a practice safe. She illustrates the depth that this form of practice plumbs saying, “Gathering together the knowledge and skills to become a safe practitioner is a complex process. ... It quickly goes beyond the simplistic notion that the practice reality can be neatly divided into

what is safe, and what is unsafe” (Smythe, 1998, p.144).

Mindfulness of concern in Smythe’s sense is for me the essence of good practice. However, when Smythe writes about mindful midwifery her focus is on being and acting safely. For me, mindfulness of concern allowed me to go further than being safe and describes a concept I term ‘attunement’.

In the course of writing this thesis my ideas about ‘mindful’ midwifery changed becoming instead an attunement by a midwife to deeper processes and internal journeys observed in women transitioning from pregnancy through to six weeks postpartum.

(Journal, October 2002)

Such attunement adds a further dimension to safe practice by leaving the woman intact spiritually and/or emotionally. I believe this individual attunement enables women to enhance the value they give to themselves, their babies and ultimately to our community.

As I became more experienced in practice and gradually more attuned to what was happening internally for women I frequently observed that many women make internal journeys over the course of the childbirth continuum in preparation for mothering. There seems to be a common ‘drive’ to look inside that has multiple presentations but inevitably included the woman reflecting about her life up to this point. I interpreted this as a drive toward integration. I think these inner journeys are a healthy sign of pregnancy processing and are generally resolved before the birth. This aspect of childbirth is rarely spoken of

in midwifery and is virtually invisible in our writings. I have a sense that many midwives will recognise the exemplars of women who, during their pregnancies, search for lost threads in the story they bring to us about their lives. Simone's story is one example.

Simone's fear of death story: Building bridges to the soul

Simone's story is a simple and perhaps unremarkable tale, but for me it is a tale that illustrates how midwives live in a practice world of both knowing and not knowing. I have written Simone's story (not her real name) about an actual client; she has read it and agrees it is a true account.

Simone rang me up just before she was due to have her baby. She said, "I am worried I might die or my baby might die. I don't know what it's all about or why I have suddenly felt like this, and I'm not sure what to do about it. What do you think?"

Simone had had three babies before and had never had a problem with any of her births although she had had a miscarriage between her first and second babies. In the pregnancy that followed the miscarriage she had been concerned that her baby would die but at a much earlier stage in the pregnancy than this time. There was nothing in Simone's medical history or in this pregnancy that was at all unusual or abnormal.

We got together and, after I checked her physically, she talked about her family relationships, her friendships and various aspects of her life that were worrying

her. She appeared to me to be processing issues that she had not before had time to do in her busy life as a mother. Women often talk in detail about their lives before having a baby. I had been visiting her with a student midwife for most of the latter part of the pregnancy so this urgent visit gave us a chance to have a more private, one-on-one conversation. We discussed in depth why she might be feeling apprehensive and, although I was fairly sure her anxieties were unfounded, we decided between us that she would book into hospital for the birth and she would see an obstetrician the next day.

When addressing concerns that do not have any obvious solution I tend to begin by looking at the range of possible decisions to check what the person might want to do. In this case the range went from doing nothing (which can often give the time to allow concerns to resolve) to going to hospital and seeing a specialist. Discussing possible choices I see as an important part of encouraging women to participate and take responsibility.

In order to canvas all the possible options the midwife needs to know about relevant evidence or how to find it and she must also be open and honest about her experience with a specific issue. This is also the place for the midwife to be clear about her biases and the reasons for them. There are always going to be limits, flaws and biases in our knowledge and practice. The range of choices and ways forward then becomes the point of negotiation between midwife and woman.

With Simone my thinking was that, although I did not think there was any

physical pathology, I could not place her concerns within any framework that I had previously used in similar situations. Often when women have concerns, there are physical problems or the women themselves are anxious or unsure. Simone was neither. She was also a strong advocate for homebirth and would not have agreed to see an obstetrician or gone to hospital to birth without feeling she had good reasons.

She rang me the next morning and said, "I don't think I will go to the hospital or see the obstetrician today, as planned, unless, of course, you want me to." I felt no need for her to go to hospital unless she wanted to because she was in all other respects a well woman. I respected her change in thinking and trusted she was able to discriminate between a realistic fear and a measure of internal processing before birthing her baby.

There were many different possible responses to Simone's concerns. Some midwives would have spent less time; others may have found the 'story behind the anxiety' without 'risking' a medical check. I say 'risking' because referral to an obstetrician without any obvious pathology can create a dilemma. The specialist may simply say, "There is nothing to be concerned about" or equally "As your Lead Maternity Carer is sufficiently concerned to refer you perhaps we should induce you". So referral carries potential risks of unnecessary intervention. Nevertheless, I believe it is legitimate to use secondary services in times of uncertainty like this. I agree with well-known obstetrician Wendy Savage who, at a public lecture at Victoria University of Wellington in the 1988's,

described obstetricians as 'risk assessors'. Another reasonable response might have been to downplay the concern as a common fear, to reinforce Simone's choice of a homebirth and reassure her that if, I were at all worried, I would certainly transfer her to hospital.

I judged Simone as someone who was generally very thoughtful about making the right choices. She was very capable of making good decisions whether about birthplace, support people or whatever. For me to suggest a hospital visit and have her accept the idea showed me how concerned she was about these fears.

My role was one of an active listener and I did not try to influence how she should respond throughout her deliberations. So, although I listened actively, my response was passive. After listening for some time the suggestion for visiting an obstetrician was also a part of showing I heard that she thought her concerns were worth taking seriously. Equally, if she chose not to go to hospital I was also satisfied because I could find nothing of any clinical concern.

I knew this woman well and I respected her apprehension although, until later, neither she nor I realised what her fears were based on. The common wisdom that "you must be careful because there are times when people are aware of quite justified forebodings" is sometimes true.

Simone didn't go to hospital. Two days later she rang me and asked, "what are you doing right now?" I was intending to go out so she said "Don't go yet because I may want you here," and sure enough half an hour later or perhaps less she rang and I went to see her. She was almost ready to start pushing her baby out

and in a short time did so very ably.

So why had she wanted to have her baby in hospital a few days before? Was it fear and if so, was it the same fear that many women have, that they or their baby might die? Certainly many women think about death. I am aware that often women have fearful concerns that never come to fruition. However, when something does go wrong women often say they knew something was going to happen.

How can we as midwives know when someone's fear demands that we must act? Acting might mean referring onto hospital and secondary care. Alternatively, instead of a referral, such fears may mean that we have to understand that, in preparing for birth, some women have to follow certain internal processes in order to help them feel safe for the birth.

Much later I discovered that Simone had had an older sibling who died at two weeks of age. The grief of the loss of this baby is still talked about by her mother, forty years later. I believe, as she does, that this was what triggered that fear that she or her baby might die. There are times when, dealing with the concerns of the day, we are actually connected to the past through intergenerational memory some of which is unconscious. The memories of stillbirths and neonatal deaths are carried on through generations of women. Simone had no idea that this event in her mother's life was something she might carry as her own fear. Intergenerational memory might also explain some of the frequency with which midwives and women discuss death. Death has become a taboo subject in an age

when it is often considered someone's failure if a death occurs.

Such concerns of women if discussed when they surface, provide a means by which the woman anchors herself in her world. I think hearing them is a part of what being woman-centred means. It is part of what I mean by attunement. This is an attunement to the mother's 'way of being' in the world, which may be through the stories she tells, or by the ways she presents herself. In various ways the woman reconnects with her self and perhaps with her soul. Once she has reconnected she begins to tell her story. Or maybe, she tells the story and by this means she reconnects.

Thomas Moore exposed a difference between soul and self, which I found useful for separating some of the mix of ideas I associate with what happens for women.

Soul is nothing like ego. Soul is connected to fate, and the turns of fate almost always go counter to the expectations and often to the desires of the ego. Even the Jungian idea of Self, carefully defined as a blend of conscious understanding and unconscious influences, is still very personal and too human in contrast to the idea of soul. Soul is the font of who we are, and yet it is far beyond our capacity to devise and control. (Moore, 1994, p.xviii)

When thinking about the relationship between midwives and women, one image that emerged for me was that of the midwife acting as a bridge that enables a woman to make connections with her self and soul. Later, I found this notion of

a bridge in the work of Raphael-Leff:

Recognising pregnancy as a highly volatile period, most traditional societies provide a female guide to act as an intermediary between society and the woman, between internal forces and external demands. This 'mid' woman shelters her and acts as a bridge during this turbulent time of transition between the pregnant woman's familiar previous life and the monumental changes to come. (Raphael-Leff, 1998, p.20)

I know for some women, once they understand that I am interested to hear about their world and how they see it I begin to see a change in their respect for their own reality. However, what I understand or hear is not as important as being open to hearing or seeing. Their own horizon changes as they begin to deal with their bloodline story, their demons and their hopes. What matters is that through telling her stories or being true to herself the woman can help shape 'the place' from which she gives birth, lives her life and parents. Alongside being heard by someone, the woman has an opportunity to reconstruct her life history. My experience is that during midwifery visits women share significant parts of themselves.

There are important gains from this sharing other than building a relationship between the midwife and the woman. For example: there is new evidence in neurophysiology that reinforces a psychoanalytical view of child development. Working at the Department of Psychiatry and Biobehavioral Sciences at the

University of California, Shore (2001) says

I integrate current interdisciplinary data from attachment studies on dyadic affective communications, neuroscience on the early developing right brain, psychophysiology on stress systems, and psychiatry on psychopathogenesis to provide a deeper understanding of the psychoneurobiological mechanisms that underlie infant mental health. (p.7)

As I explored the literature there is indeed evidence of a connection between a secure sense of self as an adult, and the quality of the attachment experienced as a young child. Many psychoanalysts and therapists have written convincingly about this connection (Bevan-Brown, 1948, Bowlby, 1967, Jung, 1964, Winnicott, 1973). “The most successful mother is one whose own infancy was satisfying and secure” (Bevan-Brown, 1948, p.117). Winnicott is at pains to make it clear that all that is required is what he terms ‘good-enough mothering’ and not sentimentality; “A mother’s love is a pretty crude affair. There’s possessiveness in it, appetite, even a ‘drat the kid’ element; there’s generosity in it, and power, as well as humility” (Winnicott, 1973, p.17).

Siegel (2001), a neuropsychiatrist when referring to the work of Hesse, (1990) says “Attachment research has established that one of the most powerful predictors of an infant’s attachment to the parent is the parent’s autobiographical narrative coherence” (p.77). It seems that the ability to tell a coherent story about one’s life is a marker of the ability of the brain to integrate

its right and left hemispheres and allows the person to 'tell self stories' and it is this ability which creates the environment for understanding children's experiences. Siegel (2001, p.77) asserts that this capacity in the parents is what the baby needs as it grows "In essence the infant's brain needs to "feel felt" by the caregiver". Unless the mother has a secure sense of self whether from her own infancy or later from conscious effort she will find this ability to be present for a baby by accurately reflecting back to the baby his expressed emotion. This is how the baby learns about feelings and finding congruence between internal sensation and external events. The more congruent the parent's emotions and awareness the more able they are to provide this responsive care for their child/ren.

I find that midwifery provides a safe environment for women to talk about their lives, be heard and discuss their relationships, parents and parenting. As a woman talks about her life she is too making a story about who she is and what she values. A woman's life story may become more coherent to herself as she tells it – but sometimes that only happens after she births. At times it is in retelling her birthing that a woman makes her life more coherent and herself more whole (Barwell, 1999). And also it seems that by being more aware of herself, she is also more available for a responsive relationship with her baby. Sometimes a woman talks about her life before the birth, sometimes through birthing and its retelling she is able to pull together unconnected pieces of herself and her life history.

This story that follows is just such a tale where a woman made herself whole again through birthing and in its retelling her life story became more coherent.

Emotional relationships between women and midwives

I heard this story at the New Zealand College of Midwives Biennial conference in Dunedin in 2002 in an address by Dutch midwife, Beatrijs Smulder promoting a normal birth culture.

Mareika, a pregnant woman in Holland wanted a caesarean not a natural birth. In fact it seemed the important thing for her was not to be seen naked. She made a deal with her midwife not to make a decision about a caesarean until she was in labour. The midwife reassured her “If you still want a caesarean then, it’s ok!”

The call came that Mareika was in labour and the midwife arrived only to find that no one was allowed into the room where she laboured. Finally, in desperation, the midwife saw a scarf hanging with the coats in the corridor and tied it around her eyes and, blinded in this way, she was admitted to the room. The baby was delivered vaginally attended by the blinded midwife. The following day the woman called the midwife into her room throwing back her bedcovers to expose her nakedness.

“For years I have had psychotherapy for child abuse and nothing changed until yesterday and through delivering my baby myself I can feel whole again.”

This is the most extreme of the transformational stories I have heard or witnessed but there are many other less dramatic stories. I have known sexual

abuse to be a cause of obstructed labours and inability to push in second stage – and I think it is more common than is recognized.

Memories of sexual abuse may be vague, fragmented, or come and go over time. For this reason the sexual abuse victim may have difficulty making conscious connections between the abuse and her responses to life events such as childbirth (Rhodes, 1994, p.215).

I once waited for hours with a woman who would not give permission for the obstetrician to apply forceps. I asked her whether she had suffered any sexual abuse. At the time she denied this but very much later admitted that she had been abused but had 'forgotten' and it only came back to her much later. I have also attended women who have resolved their loss of bodily autonomy from sexual abuse by giving birth naturally.

I am aware of meeting women who have suffered in their childhoods or at other times and there is a fracture in a woman's story even when it is not precisely acknowledged. When talking with another midwife after sharing or covering for her and having met one of her birthing women I have had the experience of both of us discussing being aware of something not being quite coherent about that woman's presence or her story. Midwives can often provide a bridge for such a woman to connect with her self. But the midwife is an observer; because the connecting journey is not her journey the midwife can never know for certain whether the woman has crossed the bridge or not. Sometimes the midwife can provide a dependable place for the woman to rest on her journey but she must be

careful to ensure this is not the same as creating dependence or operating from a sort of compulsion. Thompson, (2000) a psychotherapist and nurse writes about compulsive care-giving in nursing and develops a case that those caregivers who operate from compulsion may have suffered from anxious/insecure attachment in their own childhoods.

The association between the woman's and the midwife's emotional history is frequently important and yet is largely ignored in professional conversation.

We are all vulnerable on our journey and need the hospitality and understanding of others. But it takes an awakened heart to identify with others through our own needs and experiences. When the heart goes numb, as it does when a culture loses its soul in a generic way, we can no longer feel empathy based on our own emotions. (Moore, 2001, p.23).

How to remain empathetic with a sense of clear boundaries is a part of the learning about being in practice that seems largely lacking from discussion in midwifery. McCrea and Crute (1991) identify four issues in their paper on midwifery/client relationships: "the nature and value of the midwives' role; recognition of authority/autonomy in practising this role; emotional involvement with clients; and maintaining personal integrity" (p.183). The last two are of particular interest to me as I explore the emotional relationship between women and their midwives. My experience would support the evidence presented by McCrea and Crute who suggest that, when we are aware of our own

needs and our own history, we are able to make relationships that are both special and therapeutic. Supervision is one way we can take responsibility for ensuring we maintain the boundaries between the personal and the professional concerns and improve the quality of professional relationships.

Supervision also enables midwives to support women while they take time to work out their story. Martha needed support to do some quite deep work on her bloodline story and this was managed more easily by using supervision in a safe professional setting.

Martha's Mothering

Women's stories are not always clear. The story that follows concerns the midwife's sensing and development of a 'feel' for what is happening for a woman and hearing things the woman didn't know she said. Smythe (Smythe, 2000) cites Heidegger (1927/1962) who says caring in its positive mode, falls within two extremes: to leap in and to leap ahead. This is one of those experiences where the midwife leaps ahead in a way that "is to go ahead of the other, not to take away their care, but to give it back to them" (Smythe, 2000, p.19). Martha's story is an example of caring.

Martha was neatly dressed, softly spoken, self-contained and, although she was terrified by her last birth, she was very excited by the prospect of delivering naturally and bonding well this time. She had bled quite significantly after the last baby and, as a result, had not had immediate contact with her baby. She went home shortly after the birth with very little support since her boyfriend had

abandoned her and her relatives lived overseas. I believe she probably ate poorly and was iron deficient from haemorrhaging. She told me she didn't bond with her last baby for almost a year. She had been depressed but hid it from her Plunket nurse and went back to work.

I feel confident about caring for frightened people who want normal births because they are ready to do the work. I am confident I understand natural birthing well enough to support them to achieve their goal.

Her interests were diverse and she read a lot. We talked about her interests for a few visits and then unexpectedly her 'real story' emerged. Martha was a woman who needed to make some connections with her own life history.

Her mother had died when she was nine and, although her father was keen to be a good parent, until she met her partner, Martha felt that she had not been heard by anyone since her mother died. Still, even her partner got sick of her relentlessly going back over her life story. Usually she didn't much like sharing the story of her life with other people but now it seemed she needed to talk about it again. Every visit would take a long time as she revisited aspects of her journey through the last pregnancy and touched her childhood bit by bit.

What should a midwife do when women want to share in this way? I remember one midwife recounting her horror when, after the physical checks, a woman 'dumped her story on the table' and wanted the midwife to pick it up and do something with it. This midwife felt the woman's problems had nothing to do with her job as a midwife. Each individual midwife must work out for herself and

with each woman how she will deal with such sharing.

At some point I wondered if a counsellor would help Martha but I was dubious about whether she would agree. She began to admit shortfalls in her mothering and questioned the connection with her own gaps in being mothered. At that point I told her about a well-qualified counsellor and she agreed to a referral.

I continued to offer guidance about birthing but withdrew from hearing about her family background because she had someone better qualified to address that part of her history. We didn't ever discuss the change of focus in our meetings, which, from being usually more than one and a half hours, were now half an hour or at most an hour.

Midwives are not really paid for such frequent and extended meetings but I think it is sometimes important to give time since the depth of contact enables more work to be done by the woman in preparation for parenting. Not every woman or midwife shares this point of view. I remember one woman who thought it was nice that I chatted with her but she had no idea that there was any purpose in my mind.

With Martha my midwife role became clarified and she was beginning to develop a firm birth plan. I was looking forward to what I imagined would be a very good birth but I was still having some niggling doubts about her delivering at home. This was her husband's first child and he had a very romantic vision of having a baby. Both wanted very little input from people other than myself and were not keen on a second practitioner at the birth. The older child was not yet at school

and there were no plans for childcare. This was a woman who expected she should do everything about the household and childcare herself. My warning bells started to ring so I decided to talk about my concerns with Martha and her husband. They were fascinated that I was delving into their plans for postnatal and birth care because as far as they were concerned once the baby was born it was all going to be fine.

Martha delivered at home but was very anxious throughout the birth and never really relaxed into the experience. However her response once the baby was born was pure delight with her achievement. This happiness lasted just three days: the length of time that her husband was able to sustain untarnished admiration coupled with childminding, food preparation and cleaning.

Then Martha started to find things wrong with the baby or herself at almost every visit. At this point, while checking carefully on all the concerns about both mother and baby, it was important for me to recognise what was really happening. I have experience of woman somatising their mental anguish in many different ways: as abdominal pain, wrist pain or perineal changes. I began to realise that we were not going to get through six weeks without confronting what were probably signs of depression.

The Edinburgh Post Natal Depression Scale (EPNDS), was introduced to New Zealand and some midwives use routinely (Cox, 1987). The scale consists of ten statements that the woman responds to by stating which of four possible responses is closest to how she has felt in the last week. Validation studies have

shown that above a certain score there is a high probability that the woman is depressed. I have found the EPNDS to be a very useful adjunct to my clinical findings and routinely use it at six weeks after the birth – sometimes being surprised by a positive result. I also use it earlier when someone shows signs of depression prior to this.

Evidence from Britain suggests that responding effectively to postnatal depression with suitable referrals has had a positive influence on the attachment outcomes of women and their infants. Follow up with effective counselling by a trained health visitor was shown to be effective in reducing the rate of insecure attachment in infants immediately after maternal counselling, at 4 or 5 months and again at 18 months old (Cooper, 1998). This shows a very significant effect of early intervention.

Early identification is the key and using the EPNDS improved the detection rates. Cooper (1998) reports a sensitivity of 88 percent and a specificity of 92.5 percent. I think that as a result of an already established relationship, midwives in New Zealand are able to detect postnatal depression very easily using this scale alongside their own clinical judgement. I find it simple to use and find it provides a sense of the degree of the problem. I have found that women who are recognized as being depressed like to reassure themselves by retesting for a comparison a week or two later.

After confirming Martha's depression using the EPNDS I was able to discuss the possibility of her revisiting her counsellor. The scale provided an assessment she

could see and understand rather than being a referral based only on my opinion. Her prenatal counselling meant that she already had insight into the connections between her own past and her mothering. Mills (2000) has reported the results of attachment research by Grossman and Fremer-Bombik Health (1988): “The authors concluded that it was not just the mother’s experience as a child that was important, but also the parent’s conscious awareness and insight into her experience of being parented” (p.230). Martha was aware now of her need to take care of herself so that her baby would also be receiving her best mothering. The birthing at home gave her the opportunity to achieve something she wanted but she realised in the process it was but one part of a larger project to do with her life.

Florence finds fragments

Often I think the women we look after choose us for particular characteristics that will help them do their own inner work. Again the idea of the bridge also emerges for me with Florence who seemed like a trapped dragon fly – very elegant but hemmed in and unable to fly.

Florence’s life had its fair share of demons. Both she and her partner had children to other partners. They were quite suspicious of me, as they were of any outsider, and they had asked every local homebirth midwife to visit them so that they could decide whom to choose. For my part, I was unconcerned about whether or not they chose me since they lived far away and I had enough work. After a first meeting at her house with her partner Darren, Florence visited me

again at my house where I have a consulting room. I knew that Darren didn't much like me; he liked a much younger midwife but Florence wasn't sure. Weeks later she rang back with the news I had been chosen; news that I greeted with mixed feelings.

I have a belief that we are meant to meet some of the clients who come our way. I was somewhat apprehensive about Florence and her partner mainly because I did not completely trust their sense of reality. Florence had birthed well in the past but she was unusual and had quite a 'fragmented' story. I have found that people who choose to deliver at home in general have a clear and consistent life story. I would generally describe them as intelligent and compassionate, not risk-takers. This couple did not fit the general picture. I describe Florence's story as fragmented or lacking a sense of coherence – not because she told me things that did not make sense but because from one visit to the next the concerns never seemed to add up to a life being expressed openly. When women express a sense of coherence it fosters a free flow of conversation backwards and forwards but when missing there is instead a rather awkward and uncomfortable relationship.

A secure sense of self is a product of attachment and expressed by the stories people tell about themselves (Stern, 1985). I believe making conscious life choices such as birthing at home instead of hospital may also be evidence of a coherent sense of self. This coherence may be a product of a woman's secure attachment. However, it may also be evidenced by "her relationship with other

important adults in her life and her adult relationship history” (Mills, 2000, p.231). According to Mills, consciousness of one’s own early experiences can also alter the intergenerational effects of insecure attachment. Mills describes previously held views on attachment as based on simplistic assumptions and as being replaced by; “a more dynamic interpretation in which change through insight, external variables and significant other relationships can facilitate a conscious reworking and alteration of early experience” (p.230).

Florence had previously delivered at home but with another partner. She had delivered quickly and easily according to the records but she said she remembered the experience as horrifying. I was not reassured even though Florence and I had some rich and enjoyable antenatal visits. I met with their children who were excited at the prospect of a sibling who would bind both parents in their reconstituted family.

She birthed with another midwife because I was unavailable and at another woman’s birth. Florence and Darren had previously met this midwife as a normal part of ensuring that good cover was in place. However Darren was at work and missed the birth. He was apparently cross with the midwife for some confusion over contact arrangements. A neighbour supported Florence instead of him during the very straightforward birth. Florence was however very pleased with the speed and efficiency with which she gave birth.

Then out of the blue I was excluded from visiting – they left a message asking me not to visit. I rang and after a number of calls leaving messages I offered them

another midwife. I found the experience of being excluded very difficult since it was so unusual. However, Florence and her baby appeared to be doing fine and I had a sense that this was one of those times that maintaining my professional relationship with them was more important than my dignity or loss of pride. About a week later they called to have me come and weigh the baby and, although a little uncomfortably, we gradually resumed our relationship.

Florence never apologised or in any direct way explained her behaviour in the immediate postnatal time but gradually there was an easing in our relationship. She began to talk about her own family and feelings of lack of support from them. She had previously never mentioned these feelings, instead speaking in glowing terms of her parents and siblings. She later told me she never knew whom to trust. Her sense of judgement about people seemed to her quite unreliable. As we talked it gradually emerged that this was because of her experience of her own childhood with her mother.

Despite being generally caring toward her children, Florence's mother used to beat them quite regularly. Florence had watched her enraged mother regularly beat her older brother. I had heard a lot about her childhood that was colourful, worldly and interesting but, until this time well after the birth, I had heard none of this darker side.

Then on my second to last visit came the bombshell I never expected to hear: Florence found it very difficult not to hit her own children and had had episodes when she had hit them. She had recently done so again and hated both herself

and the fact that she had repeated a family pattern. She understood that this behaviour was related to her childhood but found the pattern too hard to break when she too became enraged.

Florence acknowledged that she found it bewildering to know whom she could trust to tell about this horror of her own behaviour. Her relationship with me was the first time she had been in a position in her adult life to have a relationship that was both intimate and professional. She had been testing my trustworthiness and commitment when she excluded me both literally and figuratively.

Although I had not been completely convinced by the persona she presented to me during the pregnancy, I had trusted in her ability to birth. Now, at last, I had found out why I was caring for her. I had stayed in contact with Florence despite being shut out a week after the birth and I had continued to care for her for some weeks. I now believe she had needed to have conflict with me and to find me consistent and caring. It must have seemed safe for Florence to talk to me when she did – perhaps partly because our professional relationship was ending. I referred her on to an appropriate health professional, whom she accepted, to find ways to deal with her violence toward her children and resolve some of her needs – and in many ways this was a perfect conclusion to our professional relationship.

Interestingly, I believe had I become defensive about Florence and Darren's earlier rejection, she would not have spoken about her very deep concerns about

herself and her mothering. I believe she recognised me as someone to whom she could entrust her secret. I wonder too if that was what the sorting out of midwives was about early on in the pregnancy – she finally and unconsciously found the person she somehow knew she needed.

The effects of Florence's 'telling' will depend both on her and the services available to assist her and her family. There is now considerable evidence that the importance of resolving the issues that led to her violent behaviour are crucial to the future of her children and avoiding the possibilities of further intergenerational effects. Insecure attachment as a child impacts on nurturing behaviours as an adult (Mills, 2000). Mills quotes from studies by Van Ijzendoorn (1992) on intergenerational transfer of attachment, which found a 75 percent correlation between the parents' Adult Attachment Interview (AAI) results and their infant's as five year olds using the Strange Situation Procedure (SSP) (Mills, 2000). She further states that this was confirmed by studies carried out in Europe by Grossman & Fremer-Bombik (1988) with an 88 percent correlation between the parents' AAI classification and the infants' patterns of attachment using the SSP (Mills, 2000).

The effect of early childhood abuse or lack of attunement between the mother and the child are literally wired into the brain according to recent studies (Karen, 1994). This basic circuitry is being established in the first years of life. Siegal (1999) does not argue there is no possibility of reversing an insecurely attached child after the 'critical' period has passed. What he proposes in *The*

Developing Mind is that integrating components of mind is a core process and fundamental to the development of the nervous system (Siegel, 1999). The evidence seems very convincing now that insecure attachment is passed on from one generation to another. To change these intergenerational effects is complex but there is a part midwives can play simply by listening to women and by providing woman-centred care.

The connection I make between midwifery attunement and women's sense of self is perhaps my most significant claim. Should the woman progress in understanding herself and birth to her satisfaction then she is far more available to mother. In a sense the midwife's attunement to the woman's way of being allows the woman to make sense of herself for herself.

I found this the most rewarding aspect of midwifery once my experience allowed for enough confidence to use my 'life-knowing' effectively. Woman-centered care is one of the philosophical underpinnings of the model of midwifery as partnership (Guilliland & Pairman, 1995).

Midwifery theory is developing in New Zealand and the focus has been on such issues as partnership, continuity of care and lead maternity carer concepts (Guilliland & Pairman, 1995, Lybrand, 1993, Pairman, 1998, 1999). All of these concepts have been a part of the development of a client-sensitive model of care. The lead maternity carer concept was initiated to limit maternity spending and clarify individual practitioner responsibility. Although the lead maternity concept enflamed the conflict between medicine and midwifery, it reinforced the

partnership model in practice, between the midwife and the woman.

By being 'woman-centred' according to Guilliland (1995) midwives accept and work with the woman's own context that for me implies an acceptance of her social and relational world. This is made more individualised by providing continuity of care as independent practitioners who understand birth as a normal life event (Guilliland & Pairman, 1995). This social model for maternity care returns birthing to women and the community. Guilliland and Pairman (1995) quote Eisenstein as saying that the idea of being 'woman-centred' has a number of features relating to woman's relationships, values and community and it "celebrates the centrality and value of women's experience and culture" (p. 41). Women-centeredness according to the authors goes further so that "midwifery exists only to facilitate the optimal experience of birth for pregnant women and their babies" (p.41).

Achieving the optimal outcome in any situation requires not only being woman-centred but also that the midwife be aware of herself too – for without this self-reflection the understanding of what being woman-centred means, changes. To achieve this Ramsden calls for each midwife to "understand and acknowledge her own cultural bias and position in order to work safely with women from other cultures " (p.43). Woman-centred care is dependent on the degree to which the midwife has the ability to reflect on her own life. This plays a large part in her capacity to hear what a woman might be meaning rather than what she might be saying or not saying – it is on this level that the midwife helps the

woman understand the profound nature of the birthing journey. The midwife can do this by listening for that understanding that the woman holds and imaginatively using it to explore with the woman the meaning the birthing journey has for her. What happens sometimes is that the woman fulfils previously unrecognised desires for wholeness.

I contend that translating what being woman-centred means as a practitioner as simply doing what women say they want may be fine in some situations but it may also fall short of showing interest in that woman's welfare. Women may want a lot of things (natural birth, epidurals, caesareans and induction) when they do or do not understand or have not had time to discuss the nature of birthing – for some women birthing is a journey of self-discovery. There is a line between m/paternalism and 'mindful' concern that I would like to draw.

Sometimes the need for a guide or mid-woman is all she needs to begin the journey; often she needs merely to be attended with respect and concern. Comments made by women in a study exploring the midwife/woman relationship show women respond very positively to being the centre of the care: "they were interested solely in you when they came"..."made me feel special" and how it was "nice to actually sit down and have some attention paid to you" (Pairman, 1998, p.183). Jean Davies (2000) says,

"The aim should be that women will be enabled to birth well and see themselves as 'women who can'. This is especially important for women whose experience of much around them is that they cannot".

(p.140)

I imagine many midwives have stories about women who transformed themselves after finding they were now what Kirkham (2000) describes as “women who can” and this is a part of the joy of enabling in midwifery which is not about being a therapist but is certainly about being available to support women making a new and empowering story about who they are. This does not make up for insecure attachment as a child but it does create healthy and successful new bedrock.

My interest is in well-being and I see homebirth women as a group who need to be studied because they can offer insights into health and wellness. A midwifery lecturer Douche (Douche, 1997) found having an internal locus of control was a critical feature of women who delivered at home. Kirkham suggests midwives need to study this group because of their differences so we might deliver more appropriate services to them (Kirkham, 2000). I suggest we may be able to deliver more appropriate services to all women because of knowledge gained about birthing and wellness from homebirth parents and midwives.

Spiritual Intelligence

I assert that the women I cared for at home mostly had what I would describe as ‘spiritual intelligence’ according to the description outlined in *Spiritual Intelligence the Ultimate Intelligence*, (Zohar, 2001). Spiritual Intelligence is described as a mix of three intelligences, spiritual, intellectual and emotional by

which is meant:

the intelligence with which we address and solve problems of meaning and value, the intelligence with which we can place our actions and our lives in a wider, richer, meaning-giving context, the intelligence with which we can assess one course of action or one life-path is more meaningful than another. (Zohar, 2001, p.3-4)

The notion of spiritual intelligence gave me a name for my experience of those qualities I found in the homebirth women and their families in 1976. Since then when I work with women I have had a sense of working across a range of values and desires, which I am now tempted to call spiritual intelligence. It was this quality in women's 'ways of being' and 'ways of knowing' with which I work with when our relationship is established. This is when as a midwife I am truly working with "what the woman seeks and defines, rather than what the midwife defines as being best for her" (Kirkham, 2000, p.240).

I contend that often unwittingly health professionals show their level of interest and women can be turned on or off by how you listen and respond – and by what you know. I recall sitting in a general medical practice listening to a consultation during which the pregnant woman spoke of weird dreams. This was joked about and then they moved on to do the 'real' business. The woman seemed accepting of that but I have found that talking about dreams can sometimes be a way to let a woman air anxieties and concerns that, unless there is a willing ear, may never be addressed (Clerc-Jude, 1997).

I am sure midwives are not taught to be aware of dreams but some midwives will be sensitive to such cues or openings for talk that may be very useful. I think the main point is to be ready and expect that many women have a 'story' to tell before they give birth. Knowing this and being ready beforehand helps the midwife give individualised care. Listening to the story, whether it is from dreams or conflicts or happenings in daily life is an important part of being a midwife. The meaning and value of the story is for the clients to decide.

Phillipa

So how does this work in practice? Phillipa came to see me having her third baby. She had previously had a caesarean and a high forceps and wanted a natural birth this time. She decided to try with a midwife rather than an obstetrician this time around but she would have an amniocentesis with her previous obstetrician rather than with someone she didn't already know. He followed up her appointment by sending a letter strongly dissuading her from attempting a natural birth citing her past births as proof of her obviously diminished pelvic size. It was a formidable and emphatic letter.

Despite the obstetrician's admonishments Phillipa persisted with her plan. She was seen by an osteopath to check her skeletal structure particularly the sacrum (Power, 2002). Phillipa and I talked a good deal antenatally about how she would like to birth and also about her relationship with her kindly, hard working, often absent partner. We became quite focussed on discussions

about her relationship and the importance of being cared for post-partum – something I feel quite strongly about. I believe if all women can have ten days without responsibility for cleaning, cooking and childcare (apart from the baby) it allows her a good ‘baby-moon’ to feast off for months of sleep deprivation. She initially spent her time with me talking about how she could suggest it, and then later she became completely determined to be cared for afterwards. He agreed but was concerned she would try and correct his way of doing things. This too was discussed so the scene was set for her first normal birth followed by a period of caring from him for which she never thought she should ask.

Her birth was normal but by this time that was not a surprise – she already assumed it would be a natural birth. The weeks that followed were a busy but very rich time for her. Her partner stayed at home caring for the children and struggling with it all but managing to do it with good grace even if less efficiently than Phillipa herself might have.

Phillipa was transformed, partly I think by the normal birth but also by the change in her family dynamics as a result of her partner’s great involvement. I know I watched a very anxious woman transform her life story through her efforts to birth naturally. She has since spoken with me about the difference it made to her life.

Birth can be a healing event of the spirit that requires a leap of faith for the mother. She must trust her carers but primarily she must trust herself. The strength and the vulnerability that Joseph Campbell talks about make her a

hero. An ordinary hero: “Giving birth is definitely a heroic deed, in that it is the giving over of oneself to the life of another” (Flowers, 1988, p.125).

The mother’s leap of faith is a curious one. Some women have faith that they are physically healthy and able to deliver normally. Who are these women and why does it seem that their choice of homebirth improves the likelihood that they will deliver normally?

Our research has shown that, for women with low-risk pregnancies in the Netherlands, choosing to give birth at home is a safe choice with an outcome that is at least as good as that of planned hospital birth. We also found indications that there is some self-selection among women who can decide for themselves where to have their baby, and that this preordains outcome, albeit to a limited extent. (Wiegers, 1996)

A woman’s decision on homebirth is important to me as a midwife because it tells me something about her and her partner right from the start. It means they believe in the normalcy of the enterprise. They may well have concerns and matters that they want to discuss and negotiate but I know we are starting a journey of utmost importance – and I feel honoured since, from my point of view, this is a very sacred journey.

The minimum objective in a normal birth is having a baby safely. I expect that to happen and if there is a problem I will refer as needed to achieve that minimum objective. Maintaining safety, health and wholeness on a physical level also helps

maintain it at the spiritual level and visa versa – but in many ways the spiritual level is the more important. A normal satisfying birth is far more than good for the baby – it is particularly sustaining for the women and this naturally enhances the baby's life too.

Being spiritually intelligent in a spiritually ignorant culture means honouring the importance of birthing – and acknowledging that it is not a purely physical event. Sometimes the physical side can seem terrible but the spiritual result is very positive. I have had people say, “Oh, I was expecting to love having this baby and it was disgustingly painful” – but by the third day post-partum the memory of the pain has faded and they couldn't be happier with the experience.

Women value the presence of their partner, the setting, the support and being in their own space, which if the midwife realistically prepares them all contribute to a good experience postpartum. These women happily give over their lives to their baby in the short term - or if they are not so happy at least they know the value of what they are doing when they wake hourly to feed. Women develop compassion as a result of pain and ecstasy and of reflecting on their acts of heroism (Flowers, 1988, Read, 1948).

This is for me the 'so-what' of a natural birth. The 'so-what' is about women developing compassion through the process of meeting the pain of labour or meeting themselves as women and finding that they mother with connection and delight (Hunter, 2001, Kirkham, 2000). This style of mothering seems rare in our culture now but is always associated with the woman's sense of integration

as a person. Women who mother in this way are of many different sorts but are characterised in my view by having wide horizons and a sense of connection with the natural world.

Spiritual intelligence acquisition is an important project for birthing women, and also for midwives, to understand. The contrast when people are fearful is so disheartening. The midwife's efforts to 'fill the void' or find a touchstone are met only with curiosity and confusion. I saw this often in hospital and feel like Banks (2000) a certain disgust with the unnecessary culture of birth that I saw there. Women in hospital don't seem to know what to do with their pain yet when they are encouraged to maintain their own space they know very well what they need to do. I suspect Young was referring to this knowledge when she wrote:

Midwives and women have lost confidence in women's ability to birth babies without the encroachment of intervention. Because midwives work in partnership with women they can honour women's power in birth. But midwives must remain vigilant about aligning themselves with the true spirit of midwifery, or there is a danger that midwives will become the new medical managers of childbirth. (Young, 2003, p.27)

Unnecessary intervention or overly mechanistic care destroys a woman's sense of her ability to birth. As a midwife I find holding an image of birthing as a spiritual events as well as a physical events captures women's imagination where before there was only fear. This image making happens more easily if this

experience of natural birthing is regularly a part of your midwifery experience. Familiarity with natural birthing and respect for the women's truth changes the potential of the experience for the mother (Jakobsen, 1990).

The internal journeys women make are significant opportunities for development of her internal self in preparation for this new baby. This processing of her life I contend enables her to make herself available for a baby in a uniquely demanding way not expected of any person in any other situation. There is an increasing literature in philosophy, psychiatry, or neurology supporting the idea that our sense of self is co-created with another being: in other words we only develop our sense of self in relationship. As a midwife I felt a responsibility to the women I cared for to assist in her process of preparing for the intensity of this mother-baby experience. I believe midwives develop relationships that are both special and therapeutic acting at times as a bridge for women to find themselves. Midwives are also on their own journey and the next chapter speaks of my most recent clinical work as an end to my autobiographical tale.

CHAPTER SEVEN: CLOSING THE CIRCLE (1998 – PRESENT)

This chapter of my study concerns the most recent of my active clinical work. That was a time when I made several important changes in the way I worked. I gradually became aware that I had come a long way in my life and work and that it was time for a shift in my life's adventure. My sense of this is captured by Mahy's lovely tale.

New Zealand writer, Mahy writing about what an adventurous life means to her, says:

We were being told about the prenatal development of a human baby. I listened, increasingly moved and astonished at something so marvellous yet commonplace, at something dictated in a realm beyond invention, and felt myself becoming determined some day to take a conscious role in this drama. It seems peculiar to think that the idea of having a child should be reinforced by the image of Alan Quartermain struggling through the desert, but that image has become my touchstone for adventure. And have I had an adventurous life? I think so, but it has been a matter of internal declaration.

(Mahy, 2003, p.30-31)

I call my last few years of practice “merging self and work,” which alludes to a connection I made between midwifery as my profession and my own journey into consciousness. I was amazed in 1976 when I saw homebirth parents showing such great concern for their babies. I realised then that these were

people who cared about the quality of the experience of being alive and that they were not simply being intense. I had never seen such care taken over what babies experienced whether it was about the roughness of clothes on their skin, the brightness of the sun in their eyes or the level of noise they heard. These parents were so concerned with the fragility of their babies' senses. The family and friends also cared for these new mothers with the same attention to the detail.

This contrasted with my nursing and midwifery and personal experiences. I had learned to desensitise myself to my own interior reality and look outside of myself to find the value in my life. Discovering people who took their own experience of being alive seriously was of profound significance for me. I identified this approach to living in the world as the real adventure of my life.

I saw that women were able to more deeply connect with their own power and their ability to love in a place literally and figuratively of their own making. I am acutely aware of how intact women are who consciously birth through their own efforts.

I have experienced that sense of elation that is not only about the awe of delivering a baby but also participating in the line of women through the ages that have delivered naturally. This experience is transcendent and one that I know is quite different from feeling elated at having a baby by caesarean.

What I had seen at homebirths all those years ago were women who trusted in their bodies' ability to birth. They believed that birthing at home was in the best

interests of themselves and their babies. I was impressed by their determination and now I too share that sense of commitment to a new line of women becoming mothers consciously. In becoming mothers so consciously they are already hugely committed to parenting well. The bigger picture is about learning to trust and to love in a world where the project of mothering and parenting are treated as irrelevant.

I have an instinctive dislike for reductionism and my tendency to expand meaning outside valid connection is laughed at by my family who are not convinced by the connections I make. In the same vein I used to read self-help books with a passion because if it were possible to change the course of destiny with our own efforts why wouldn't we try? I saw homebirth as a quest for freedom from social determinism and a trust both in individual effort and in the natural world. When sometimes this quest was unfulfilled and mothers transferred to hospital I still felt that these people had invested meaning in their plans and whether they achieved a homebirth or not was irrelevant or, at least, not crucial.

My preoccupation with homebirth was about finding one's own freedom through investing meaning in a significant life event. Of course women who have decided to have a homebirth may not be so intense or introspective about their choices. I told a homebirth client that my hypothesis was that women who chose homebirths were more spiritually intelligent than those who chose to birth in hospital and she laughed saying she simply felt it was easier than going to

hospital in labour in a car. To imagine one can birth safely at home is unusual in our culture and that is the step in thinking that I invest with notions of spiritual intelligence.

The questions and confusion I felt after seeing homebirths in 1976 are now mostly answered for me. I found a wonderful vocation exploring the realms of giving birth naturally. The experience of being responsible for my own midwifery practice meant I learned to trust my own decision-making and found the limits of my practice.

Taking complete and sole responsibility for a practice is, however, very demanding. For a time I found a way of working with a colleague that enhanced my life in practice. Sharing the same client load with that colleague meant that for the first time I felt well supported because the arrangement was based on caring for us as well as the women. Sharing clients is a challenge unless both partners match each other's style but, with a colleague I trusted implicitly and admired enormously, for eighteen months I enjoyed the situation and found the shared practice was delightful. Interestingly I think having days off over this time was the beginning of my recognising how tired I actually felt.

In 1998, three years before I finished in clinical practice, I attended a Homebirth Association conference and realised I needed to go back into working solely with homebirths. The conference reminded me why I had become interested in birthing and that the gift for me was working with women who valued and trusted the birthing experience. After that, I stopped attending hospital births to

work again exclusively with woman who chose to birth at home. I was back where I had first started in terms of my real soul interest in the work. It was wonderful! I felt in tune with what women wanted and what I had to offer.

However something new was emerging out of this very satisfying work for me and I needed time to explore ideas about midwifery practice. My postgraduate study and this thesis arose out of the need to reflect on thirty years of practice and understand what it was that was so compelling for me about midwifery.

Midwives make a difference by attending to women with the realisation that the woman's experience, and any crisis and/or opportunity that arises is a significant addition to the woman's sense of self. No matter the type of birth a woman eventually experiences, if she is attended with respect there is a chance it will enhance rather than detract from her life story and her sense of self. To leave a woman satisfied with her experience is the greatest reward of being a midwife and is one that, as Kirkham acknowledges, requires 'emotional labour' (Kirkham, 2000, p.244).

I do this emotional labour because I have identified myself with the nature of the enterprise of being women and our responsibility both into the future and to the past. Both midwives and mothers share powerlessness socially, economically and politically. I like the image Greer presents of the persistence of women to survive by supporting one another.

The principle of sisterhood is power sharing, which is another name for powerlessness. In a society constructed of self-perpetuating elites

a grass roots movement exists to be walked on. Elites tumble down
but the grass survives to spring again through the thickest pavement.
(Greer, 1999, p.294)

I identify mothering as a social good and one that, if supported, holds the hope of a more peaceful and loving world (Ruddick, 1984). Birthing and mothering is challenging whether the mother was well attached or not as a child. Midwives have a privileged place in relation to birthing women becoming mothers. Debates about birthing and mothering have challenged feminist thinkers particularly since the seventies (Chodorow, 1978, Ruddick, 1984) (Flax, 1983, Gilligan, 1987). Greer maintains that “female is essence and feminine social construct” (Greer, 1999, p.294). She maintains our embodiment marks our essential difference. I would agree though Oakley (2000) argues that approaching woman’s reactions to childbirth as reactions of people rather than women would make understanding easier. Women’s lives seem to me especially demanding of appreciating difference.

There is no doubt that women need supportive environments for birthing. This environment may simply be a listening ear through the pregnancy, a supportive presence during the birth and an informed, discerning presence postnatally. The beauty of midwifery is in the enhancement of women’s sense of themselves.

Through this exploration of my life and practice story I discovered that for me birthing was the evidence that good existed in the world. Each woman and her birthing reinforced for me that giving birth was sacred. “Spirituality does not

exist only in ancient times or in books. It exists – it emerges into existence – through our own encounters with the sacred” (Noble, 1993, p.115).

I want to resist the silence around spiritual issues that exists among midwives. Childbirth is inherently spiritual and it is important that midwives are comfortable addressing spiritual ideas in practice. If there is a continuum of spiritual intelligence and if describing, exploring and naming it increases understanding about the meanings and value of childbirth then it may enhance the experience for all.

I assert through this study that caring for women with respect for their whole person demands spiritual development in the midwife and for many of us that happens within the work itself. It is one of the features of practice that at times drains and at others sustains us in our role. Once our spirituality is recognised as strength and reinforced in practice, a place of resistance to defensive approaches to practice will have been articulated in midwifery theory. Chapter eight draws my project to a close by clarifying my most significant findings.

CHAPTER EIGHT: CONCLUSIONS

In the previous chapters I have enquired into my personal background, my early learning and approach to midwifery, a transformational encounter with homebirthers, and then my years of experience as a practising midwife. I have reflected on what I learned from these experiences and from the stories of women I met along the way. This chapter is about the most important conclusions that I have reached as a result of my inquiry.

Midwifery knowledge and skills complemented by a sense of self

All midwives carry skills and knowledge acquired from study, research, and contact with women and with colleagues, and from their reflective experience. These midwifery skills and knowledge fulfil the needs of the mother and the family over the childbearing continuum for safety, self-determination and congruence (Borrmann, 2002). Midwives add to the woman and the family's own resources by providing a reference point outside the immediate family as a resource for maintaining well-being. By offering a conversational and supportive place between medicine and mothering where birthing is made relevant to parenting, midwives act out an important social role. In this world of mothering in which trusting and loving play such central roles, midwives may also act as lightning rods for the processes of birthing and mothering (Noble, 1993). I assert that we are able to facilitate her grounding herself by being aware of her story and by carrying knowledge of birthing.

As I reconstructed my story in this thesis I came to terms with the complexity of my knowing about my practice and about my self. I understand how my knowledge is shaped by my way of being in the world. Realising gaps existed in my own understanding led to a strengthening of my own selfhood and an exploration of the process of developing an autobiographical self. Having a coherent life story is important for a midwife. It creates a place in our knowing as midwives that allows us to hear the importance of the stories that women tell us and to recognise them, not as wasted time, but instead as stories that enable the woman to prepare for birth, to trust and know that what she decides to do is understood and supported.

Transformative power of birth

By telling stories, even patchwork stories, people construct their selves (Barwell, 1999). Pregnancy offers a unique opportunity for women to tell stories about themselves during consultation with midwives. Sometimes these are mere fragments that form part of the chitchat of the day but at other times they are a rare opportunity for significant stories to be heard.

Transformative possibilities exist which may be extreme and profound because women find they are strong and powerful giving birth. Transformations also happen because mothers share hidden aspects of their lives and by doing so enable a reintegration of a more authentic self. Almost always women learn about aspects of themselves about which they knew nothing. Frightened women find a self capable of birthing and a commitment to parenting of which they were

previously unaware. Strong determined women find themselves coming to terms with completely unexpected outcomes and their own vulnerability.

I had my first glimmer of these transformative possibilities when I first saw homebirths in Auckland in 1976. The homebirth women with whom I subsequently spent much of my working life seem to me to offer the most perfect example of women with integrated life stories who demonstrate undisturbed birthing and intentional mothering. Perhaps these women, their partners and families have spiritual intelligence and give meaning to their own life projects from a more secure place. Is it possible that they are able to do this because they were bonded and well attached as infants?

However, stories such as Martha's and Florence's persuade me that, even when a woman has herself had a difficult childhood she can, during the childbirth process, develop her sense of self and strengthen her capability as a mother.

My particular assertion as a result of this study is in the possibility that either through expressing herself antenatally or by birthing or by telling the story of her birthing afterwards, the woman's story becomes more integrated. She completes her contact with midwifery services feeling and being more in control of her world. This world creates the emotional and spiritual environment for the attachment processes. Klaus and Kennell wrote about attachment from their observations as paediatricians:

Our observations force us to ask the question, "What is the normal process by which a father and a mother become attached to a healthy

infant?” Recently, we developed an even greater respect for some of the complexities of the process by which this occurs. At the same time we have felt a new excitement as we have appreciated both the opportunities parents have for major psychological growth with the birth of a new infant and the neat orchestration of the many biological systems in both parents and infants that are integrated into the attachment sequence much like a jigsaw puzzle. (Klaus, 1982, p.3)

Conducting this research has confirmed for me that mothering is a sacred process – starting at conception, moving through birthing, and including the woman’s learning of how to be a mother in a way that honours this particular baby.

This thesis proposes that midwives recognise and hold a space for the spiritual and for transformative possibilities within their relationships with women as a part of their work. It is important to talk about these possibilities for transformation and sacredness within birthing as another key to safe midwifery wherever it is practised.

My recent practice has been with women birthing at home and it is largely in this context that I have developed the ideas in this thesis. However, I think it is likely that, by being aware of the potential in stories, a midwife on a single shift in hospital may open possibilities for transformation if she has time to hear the significance of what she is being told, The change may sometimes be quite small; she may, for example, help the woman solve a breastfeeding problem or change

her ability to resolve a disappointment. By listening carefully to women and their stories midwives can discriminate and choose appropriate responses. Hearing what a woman is really saying may change rates of intervention because midwives will be combining their professional knowledge of what is generally best practice with understanding the particularities of this individual woman.

Writing about the spiritual in the daily world of midwifery and mothering is to some extent an act of resistance to an approach to childbirth that acknowledges only the physical parameters of care. When women and midwives begin to tell and hear the full patchwork of the woman's life then they will begin to attend to the whole woman and her family and be able to positively affect women's stories and their babies' lives. They will be encouraging loving parenting and more securely attached children. As mid-women they can act as bridges for women to discover parts of themselves and for families to reintegrate absorbing a new life as a joy rather than another burden. Wanting to enhance women's lives inspires many midwives. For me my soul awakened seeing homebirths and the joy of participating in the sacred world of birthing inspires me still and my gratitude to the hundreds of women and their families is unbounded.

Relevance of this Research

It is dangerous to generalise from one person's subjective experiences and there is a risk of reading too much into fictionalised stories. Qualitative research of this type derives its validity from the extent to which it makes sense and rings true for others who have been through similar experiences. I hope at least some

mothers and midwives who read this will say 'yes, I recognise that.'

The importance of the research depends upon the extent to which it offers new insights on a worthwhile subject. There has so far been little work in the area of emotional connections between women and their midwives and even less attention paid to the importance and potential in the stories of birthing women. My experience has lead me to conclude that women's stories hold transformative potential and that the midwife-woman relationship may be a key to unlocking that potential – for the benefit of the woman and her children.

It is easy to dismiss stories and miss the importance of a woman's narrative. It is difficult to know what is important and what amounts to little more than chit-chat. However, it seems to me to make inherent sense that, when birthing women have a continuity of relationship with one (or preferably two) midwives lasting over many months there will be many opportunities for the sorts of sharing of significant stories that I have described. In New Zealand our system of midwifery provides exactly this opportunity for continuity and I believe it is important that midwives are aware of and able to respond to the great potential that this provides. But to realise that potential midwives will need to be well supported in practice.

Further research

More research is needed into many of the areas I have discussed. Both qualitative and quantitative research approaches might be utilised for questions

such as the following that have arisen for me throughout this project.

Women might be researched about what it was they learned about themselves during the childbirth experience, how they thought this happened and in what respects the learning has been significant for them.

Research that would interest me in the future is how midwives can most appropriately attend to women's stories and use them to support women. Surveying or running focus groups with midwives to look at the value of practice stories could begin a process of acknowledging the depth of what woman-centred care might mean for midwives.

I only briefly touched on relationships between primary and secondary care (in my story of Baby Graham) but this is an interesting area for research. What effect does transferring babies to neonatal units have on the family and on the primary care midwife? Action research in the area of transfers may well work to ameliorate the common discomforts and misunderstandings.

A narrow question I would be interested to research is my proposition that parents who choose homebirth were more securely attached as children than an equally matched cohort of parents choosing hospital births.

Because of the significance for midwifery, research is needed into how midwives can understand and apply recent findings about infant attachment and its importance for establishing a sense of self. A full understanding of the long-term significance of good attachment can have major impacts on the way midwives

provide care for women and how that in turn may affect the way women respond to their babies. It would also be interesting to research if such knowledge affects midwives' understanding of themselves.

Many implications for midwives arise from my research that could form other research questions. Midwives' work is emotional labour (Hunter, 2001); how commonly do midwives experience it as challenging and deeply satisfying? How do we find the appropriate models of midwifery that can sustain practice over the long-term without losing the gains from close midwife-woman relationships? In the New Zealand model of independent care are midwives themselves as well supported as the women they care for? The lack of a clear answer to such questions may be a sign of what Hunter (2001) describes as a system that lacks "careful implementation and evaluation." (2001, p.440) Surveying New Zealand midwives who have been independent midwives since the law change may start to provide answers to such questions.

Midwifery is such a potent force for good in our community that funding for research and education, which improves the knowledge base from which we work, is mandatory. A good deal of knowledge has accumulated particularly in the field of attachment and storying which has not yet been assimilated into midwifery practice and ways of disseminating this have to be found both by educating and researching for knowledge gaps.

Reflections on the Research Process

The research process has been a long, seemingly endless and iterative journey

with many dead ends. My understanding that childbirth provided deep learning about life was correct but putting that experience into words has proved rather ambitious. In my next life I would choose painting. However, with a good deal of satisfaction I complete this story of an ordinary midwife learning the joys of midwifery.

APPENDIX 1: TIMELINE

1950	<i>Born in Australia.</i>
1968 – 71	<i>General nurse training (3 years).</i>
1971 – 72	<i>Midwifery training (1 year).</i>
1971	Amendment to the Nurses Act ended autonomous midwifery in New Zealand and doctor's support mandatory.
1972 – 76	<i>Travelling</i>
1976	<i>Working as midwife, in a regional hospital.</i> First New Zealand Homebirth Association formed.
1976 – 77	<i>Six weeks with a homebirth midwife.</i>
1977 – 80	<i>Working as hospital midwife, Australia & New Zealand.</i>
1978	Auckland Homebirth Association formed.
1983	1983 Nurses Amendment Act passed followed by the formation of a consumer group in opposition to the new amendment "Save the Midwives". The amendment enabled all nurses to supervise maternity care-actually reinforcing obstetrical care for mothers.
1980 – 83	<i>Established planned early discharge scheme, and a part-time delivery suite midwife.</i>
1983 – 85	<i>Two babies, teaching ante-natal classes</i>
1986 – 90	<i>Domiciliary midwife</i>
1987	Sandra Coney and Phillida Bunkle's story of the <i>Unfortunate Experiment</i> (unethical research on women at largest Maternity Unit in N.Z.) in <i>Metro magazine</i> .
1988	Sandra Coney publishes the book <i>The Unfortunate Experiment</i> .
1988	Midwifery Conference with Caroline Flint as the inspirational keynote speaker. Joan Donley's lecture " <i>Moas or Midwives?</i> " challenged midwives to defend their profession. This lecture was the rallying call that stimulated the process of establishing the New Zealand College of Midwives (1989).
1990	The Nurses Amendment Act passed (Midwifery autonomy)
1990 – 1998	<i>Independent midwife hospital and homebirths (Mentoring new midwives and midwifery practice supervisor for student midwives).</i>
1998 – 2001	<i>Homebirth midwife (Mentoring and practice supervisor for student midwives).</i>
2000 – now	<i>Teaching associate, Graduate School of Nursing and Midwifery, Victoria University of Wellington</i>

APPENDIX 2: LETTERS CONCERNING TWO PRACTICE STORIES

The letters on the three following pages concern the two practice stories I have used that are based on true accounts rather than being fictionalized.

The first is a letter to the chairperson of the Human Ethics Committee at Victoria University of Wellington concerning ethical approval to include the stories covered by the following two letters.

The next letter (name and signature removed) is from a woman whose story I have used without changing the details other than the names.

The third letter is a handwritten letter from the woman I have called 'Alice' giving me her permission to include her story.

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