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### **Paper:**

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## **Title**

**Coping, Help and Coherence: a non-dichotomous theory for childbirth.**

## **Aim**

In this paper I propose a new theory, which may be useful when seeking to explain childbirth from the perspective of women and their midwives.

## **Approach**

The proposed theory builds on previous research and follows a previous discussion paper, which was published earlier this year. It draws on my extensive experience in midwifery, findings from my PhD research study and an in-depth review of models of midwifery and childbearing.

## **Implications**

The proposed theory avoids considering childbirth and through dichotomous ways of thinking. I propose that an integration of Sociologist Aaron Antonovsky's theory of a Sense of Coherence (Antonovsky, 1979, 1987) and Nurse/Midwife Ernestine Wiedenbach's Need for Help Theory (1964, 1967) may be a starting point for a more suitable explanatory framework through which to understand birth from the perspective of new mothers and their midwives.

I consider that combining these two theories avoids the drawbacks of a dichotomous structure; it does not rely on dubious definitions of what is 'normal' in birth and integrates the perspectives of both the woman and her midwife. It reflects the high value placed by women and their midwives on 'coping' and self-reliance. It takes account of women's desire to cope with labour and midwives' role to offer help in this desire. It provides a sense of coherence regarding the uniqueness of each and every birth for both the woman and her midwife, set in context of with one's own and others' experiences. It recognises that the woman and her body can be trusted to express any need for help, if necessary, along with the vital nature of the midwife's skills to recognise when help is needed, and what that 'help' might be. Finally it places at the centre of the model the supreme right of the woman to validate the help she may need.

**Keywords:**

Midwifery; childbirth; normal birth; conceptual framework; model; theory

**Background**

My previous paper (Darra, 2018) provided an in-depth critique of dichotomous models of midwifery and childbearing, which I characterised as being 'false' dichotomies, since they separate the woman from the midwife and perpetuate the oppositional concepts of 'normal' vs 'abnormal', 'natural' vs 'medical', and 'pain relief' vs 'working with pain'. I discussed how I used my PhD findings and an analysis of midwifery literature to conclude that separating 'normal' from 'abnormal' and 'natural' from 'medical' are of little use. I focussed particularly on how women and midwives 'cope' with labour, largely seeking to avoid interventions and analgesia while at the same time using them.

In this paper I discuss further my consideration of a more nuanced view of what goes on in a birthing room from the perspective of women, and their midwives. The discussion reflects the inclusive nature of the framework for quality maternal and newborn care: maternal and newborn health (Renfrew et al. 2014), this time including the woman who is giving birth and the midwife who is caring for her. I focus on perceptions of what is 'normal' in birth and seek to reflect the high value placed by women and their midwives on 'coping' and self-reliance. I seek to recognise the importance of a sense of coherence regarding the uniqueness of each and every birth for both the woman and her midwife, set in context of one's own and others' experiences. I demonstrate a recognition that the woman and her body can be trusted to express a need for help, if necessary, along with the vital nature of the midwife's skills to recognise whether and/or when help is needed, and what that 'help' might be. The proposed theory may be useful when considering the experiences of all women who experience labour and the midwives who care for them but it is not intended to explain experiences around elective caesarean. It can however help to inform care in labours which result in instrumental intervention or non-elective caesarean birth.

I touch upon some very complex ideas but it should be noted that the discussion reflects what might be characterized as a 'western-centric' nature of the midwife/mother relationship. It doesn't examine competing inter-cultural and historical perspectives

and while it intentionally includes the voices of women and their midwives it does not analyse all aspects of the influence of 'power' in all its forms on childbirth and midwifery practice. In particular it does not seek to identify exactly what 'help' would comprise and indeed it does not suppose that all women would recognise that 'help' is needed at all. Finally it does not contribute greatly to current debates around place of birth, since it is proposed that the theory discussed here would be applicable in any situation where a woman and midwife are 'working' together during labour. Instead the discussion is proposed as a potential starting point for further professional, philosophical and practical discussions in which these issues and challenges may be debated at greater length.

### **A new theory**

In this paper I propose a new theory, which emerged from my PhD thesis and reflects how the women and midwives in my study identified that 'normal' birth is a complex, widely used yet not easily identifiable defining concept (Darra, 2008). The women and midwives did not appear to take great account of potential 'risks' in the pregnancies, instead the women appeared to understand their pregnancies in the context of their own wider understanding of birth as an event that women wanted to cope with, with the help of knowledgeable midwives. The women sought to achieve this by relying on themselves and 'breathing' during labour whilst also accepting (and even requesting) analgesia and some birth interventions. The midwives also appeared to aiming to achieve 'normality' in birth but they commonly also utilised birth interventions. I was therefore able to conclude that current dichotomous models and theories of birth and midwifery separating the normal from the abnormal and non-intervention from intervention do not fully explain the perspectives of women or their midwives.

My proposed theory (Figure 1) demonstrates how giving birth generally requires a helping process, which is triggered by a woman's behaviour that is perceived and interpreted by the midwife. This takes place in relation to both parties' expectations and/or hopes.

The midwife does this by:

(1) observing inconsistencies during the labour and acquiring information about how women mean any cues that are given by the woman,

(2) determining the cause of any discomfort or need for help, and

(3) determining whether the need for help can be met by the woman or whether assistance is required.

Once needs for help are identified, ministrations are achieved and validation that help was given is recognised.

Help may be having the midwife present to encourage the woman's ability to cope or anything else; up to and including pharmacological means or help from other professionals (this might include medical or instrumental intervention).

This theory resulted from merging a model of nurse/midwifery from the 1960's and a 1970's sociological theory

### **Key components of the new theory**

The two key components of the new theory are drawn from Nurse-Midwife Ernestine Wiedenbach's 'Need for Help Theory' and Sociologist Aaron Antonovsky's concept of a 'Sense of Coherence'.

#### *Component one: Ernestine Wiedenbach's 'Need for Help' Theory*

Wiedenbach's theory was developed inductively through observing practice and from her own working experience as a nurse-midwife (Wiedenbach, 1967). She stated that the goal or purpose of the midwife is to meet a woman's need-for-help. Her definition of a need-for-help is "Any measure or action required and desired by the individual and which has potential for restoring or extending her ability to cope with the demands implicit in her situation" (p.6). She went on:

...Whenever a need-for-help exists, its presence may usually be suspected by behaviour – physical, emotional or psychological – which is different from the normal or usual pattern. The nurse (midwife) who is perceptive will be aware of it. Perceptiveness thus is an attribute of [] nursing (midwifery). The fact that a need is perceived, however, does not mean that it is met. First it must be identified. To do this requires skilled use of

eyes, ears, hands and mind – eyes through which to perceive or look intently; ears with which to listen expectantly; hands with which to feel, touch or palpate sensitively; and a mind with which to understand and interpret the observation. Once the need is recognised and has been validated by the one whose need it is, appropriate action can be taken to meet it. (Wiedenbach, 1967 pp 353-354).

Wiedenbach appeared to be ahead of her time in many ways; for example in the 1940's she recommended that babies be cared for beside their mothers instead of being sent to a central nursery between feeds (Bennett & Coldwell Foster, 1995). She also published a very early journal paper entitled 'Childbirth as mothers say they like it' in 1949. Marriner-Tomey (2002) reflected on this paper and noted that the needs-for-help that were identified by Wiedenbach in her paper were not met until the 1970s. Also, by the 1980's health authorities were developing the 'unique' idea of family centred care, which was actually proposed by Wiedenbach over 20 years earlier.

Wiedenbach was amongst the first nurse-theorists who proposed that the needs and the input of the patient are essential components of nursing (and midwifery) (Bennett & Coldwell Foster, 1995). Her prescriptive theory was strongly influenced by the behavioural paradigm, which assumes that people seek to meet their own needs (McKenna, 1997) going through several iterations throughout the 1960's and 70's (Bennett & Coldwell Foster, 1995; Gordon, Touhy, Gesse, Dombro, & Birnbach, 2010; Marriner-Tomey, 2002; Raleigh, 1989). Wiedenbach defined all the major concepts that contributed to her theory including the idea of the '*patient*', which she defined as "any individual who is receiving help of some kind, be it care, instruction or advice, from a member of the health professions or from a worker in the field of health" (Wiedenbach, 1964, p.3). She also provided definitions of the nurse, the nurse's purpose and set out her philosophy and all other components of her theory (see Appendix 19). Key components are: "identification of a need-for-help" (Wiedenbach, 1964, p.60), the "ministration of help" (Wiedenbach, 1964, p.61) and "validation that a need-for-help was met" (Wiedenbach, 1964, p.62). In short, her theory is made up of the nurse observing that a need-for-help exists, provision of the help that is needed, potentially looking outside of her own skills and capabilities to provide the required help and then validation that the help provided was indeed helpful to the patient (Bennett & Coldwell Foster, 1995).

In Wiedenbach's theory one can see that the nurse (midwife) comes to the situation with four properties or components: philosophy, purpose, art and practice. Using Wiedenbach's theory I considered that the findings of my study in which I analysed 'normal' birth stories from 21 women and their midwives within 6 weeks of the birth (Darra, 2016, 2018; Darra & Murphy, 2016) would look like this:

**Table A:**

	Wiedenbach's 'Need for Help' Theory (1964, 1967)	Component one of the new theory
<b>Philosophy</b>	A personal stance of the nurse that embodies attitudes toward reality.	A personal stance of the midwife that embodies attitudes toward reality in labour and birth.
<b>Purpose</b>	The overall goal. The purpose of clinical nursing is 'to facilitate efforts of individuals to overcome obstacles which interfere with abilities to respond capably to demands made by the condition, environment, situation or time' (Wiedenbach, 1964, p.15) Purpose is the embodiment of meeting needs for help.	Normal birth is desirable; intervention should be avoided if necessary but may be used judiciously if thought to be potentially helpful.
<b>Art</b>	The art of clinical nursing requires using individualized interpretations of behaviour in meeting needs for help.	Pain in labour is normal but some women may need help with it.
<b>Practice</b>	Meeting needs for help implies goal-directed, deliberate, patient-centered practice actions that require (1) knowledge (factual, speculative and practice), (2) judgment, and (3) skills (procedural and communication).	The overall goal. The purpose of midwifery is to facilitate efforts of women to cope with labour and birth overcoming obstacles which interfere with their abilities to respond capably to demands made by the condition, environment, situation or time.

Chinn and Kramer (1991) explain that "the helping process is triggered by patient behaviour that is perceived and interpreted and in relation to which the nurse reacts. In interpreting behaviour the nurse compares the perception to an expectation or hope. [] Identification of needs for help involves: (1) observing inconsistencies and acquiring information about how patients mean the cue given or determining the basis for an observed inconsistency, (2) determining the cause of the discomfort or need for help, and (3) determining whether the need for help can be met by the patient or

whether assistance is required. Once needs for help are identified, ministrations and validation that help was given follow.” (Chinn & Kramer, 1991, p. 179).

As suggested by Wiedenbach (1964) and explained by Chinn and Kramer (1991) midwives need to observe a woman’s behaviour looking for clues, which seem inconsistent with her continuing to cope with what she is experiencing in labour (whether the labour appears to be ‘normal’ or not). S/he would need to firstly determine whether the need for help can be met by the woman (through self-help methods of coping) and then, using her/his knowledge and judgment to apply the necessary skills to help the woman. In my study help was either: (1) ‘keeping the woman going’ through self-help methods, water immersion, distraction and/or encouragement as seen in several of the stories, and in particular in those relating to Rhiannon and Claire; (2) offering Entonox as was apparent in all the stories in my study; or (3) offering and administering further analgesia as is evident in almost half of the stories.

A vital question remains as to how the midwife can reliably work out whether a woman needs help and what help she might need. The birthing women and their midwives were in the same place at the same time with the women aiming to have a birth that they could cope with and the midwives aiming to achieve as ‘normal’ a birth as possible.

#### *Component Two: Aaron Antonovsky’s theory of Salutogenesis and ‘Sense of Coherence’*

Apart from considering Wiedenbach’s theory of the nurse identifying a ‘need for help’ I was led to wonder how the midwife can give the *right* help to each woman at the *right* time. When thinking about this I was led to consider Antonovsky’s theory of salutogenesis (Antonovsky, 1979, 1987; Downe, 2004; Schmid, 2011). This rose out of my reading of UK Midwifery Professor Soo Downe’s (2004) and Italian Midwife-researcher Verena Schmid’s (2011) work on salutogenesis. Salutogenesis refers to both the woman and her midwife understanding the concept of risk factors but also utilising the concept of salutary factors, which are those factors that promote good health and coping.



The women and midwives in my study were apparently able to take into account risk factors but put these into context of their aim to achieve normal birth. This was evident as a number of the women referred to antenatal factors that may have involved increased maternal or fetal risks and which might have affected their ability to achieve a normal birth (See Appendix 20). Anwen was under shared care (De Vries et al., 2001) with her midwife and an obstetric consultant because of her low serum ferritin levels in pregnancy, which is linked with anaemia. N.B. all names used throughout my study were pseudonyms.

Anwen (woman): *'I had to go to (Name of the town where the hospital is situated) because I was consultant-care-led because of my ferritin. That was the only reason why I had to go over there.'*

And Denise (midwife): *'everything had been fine antenatally apart from as you know the low ferritin, so she was, you know, for a normal delivery in the low risk room.'*

Jo had previously been diagnosed with a bicornuate uterus:

Me: *'So, you know you said you were under the care of the consultant? So was there reason for that then?'*

Jo: *'Yeah when I was having my first daughter umm they discovered, cos we were on, we were having tests to find out why I wasn't conceiving properly and we waited seven years to have my first daughter. So they done a umm scan with dye of my uterus inside and they found out that I had a bi-cornuate uterus so they kept an eye on me, when they found out then I was pregnant, they wanted to keep an eye just in case the, empty side then would interfere then with the baby on the other side. They just wanted to keep an eye, so because of that they put me under consultant care again, but I only went into hospital twice to see the consultant. Twelve weeks and I think it was thirty-five weeks.'*

Me: *'And it all progressed normally?'*

Jo: *'Yeah it was all normal and fine yeah.'*

And Alison (midwife): *'Jo had gas and air I think that was the only pain relief she had....and..... well, she progressed really well. Jo had a bi-cornuate uterus and I listened in*

*cos she was on the normal care pathway, oh no....she was on the obstetric pathway, but I just listened in because she was so normal.'*

Bethan had polyhydramnios and had previously experienced a precipitate (very rapid) birth

Bethan: *'So and cos I'd got polyhydramnios as well, excess fluid, they said, you know any niggles you think, you know to come in straight away'*

(Bethan's midwife Nicky is extremely likely to have known about her medical history but she didn't even mention it)

Penny had a low lying placenta

Penny: *'But ahh, it was a lovely room and the midwife was fab... but umm, because my placenta was low, ummm and they weren't...I'm not sure what it was, exactly, ummm'*

Penny's Mother- *'They couldn't find it on the scan they said, cos umm .. it was so low'*

Penny: *'Yeah.'*

Penny's Mother: *'There was problems from the very beginning.. you know.'*

Penny: *'They couldn't find out exactly how far it was from the exit, then.. so they were a little bit worried, so they felt than that umm I needed to be monitored, so they took me down to a normal labour room, then and I went down and they put me on the monitor then...'*

And Tina (midwife): *'She did have a low lying placenta antenatally I think, it just wasn't flagged up, it was just, and that was probably why she had a bit of a bleed... at the early labour...'*

Isabelle had previously experienced a forceps delivery and a shoulder dystocia when giving birth to her first two children.

Isabelle: *'Emma was about 27 hours and ended up in a forceps delivery and I lost a lot of blood ... umm I had epidural with her and it just slowed everything up and then in the end I couldn't feel anything so I was pushing against nothing umm and then it ended up in forceps delivery... she was born, we were living in (Place) at the time, so she was born in*

*(Place) umm. Thomas was to all intents and purposes a normal delivery but he was 10lb 4 so he was quite big... and his shoulders got stuck so I had a midwife kind of diving on me at the last minute and because of that I think y'know birth weight and there was a little bit of a problem at the end... but he was only sort just under 4 hours so it was a different experience to Emma. I know he was big but again it was fairly normal...'*

And Carolyn (midwife): *'she'd had a shoulder dystocia, quite a nasty one, but this baby was no problem.'*

None of the women had referred to these issues when I telephoned them to check their inclusion criteria and to arrange the interviews. During the phone calls I asked them if they had any identified risks prior to the birth and they all stated that they did not. I was keen to recruit women to my study and I tried not to appear to be too searching in my discussions with them during our first telephone encounter. I was also aware that I should not appear to be looking for reasons to not interview them; they were therefore included in the study.

I had also received no information from the community midwives who recruited the women for the study about these potentially serious risk factors prior to the interviews and only learnt about them when they were mentioned by the women during the interviews. This clearly brings into question the consideration of the definition of normal birth being "low risk at the start of labour" (WHO, 1997). This apparent indifference towards risk factors by both the women and their community midwives was unexpected when one considers the current ubiquitous perception of risk and fear in childbirth (Boyd, 2006; Dahlen, 2010; Eriksson et al., 2006a, b; Gamble et al., 2007; Kitzinger, 2006; Lavender et al., 2012; Nilsson et al., 2012; Thompson, 2006; Walsh, 2002; Wolf, 2001). It appears that the community midwives did not think that the risks involved would affect the definition of normal birth. They and the women also did not seem to consider these factors to be risks at the time of recruitment to the study.

I considered whether this might have been different if I had asked them about it prior to the birth, at a time when the risk might have been more keenly felt by them. When I contacted them they had just had what they felt was a normal birth, so the risks that had been identified before the birth had turned out to be not problematic; this might account for the apparent underestimation of these risk factors, on the part of the

women and perhaps the midwives. However, it might equally have been the situation that both the midwives and the women were seeking to emphasise salutary factors instead of risk factors, as suggested by Antonovsky (1979), Downe (2008) and Schmid (2011).

Downe (2004, p.19) identified the key salutary factor in childbirth to be a “sense of coherence” in which the experience of birth may be positively affected by it being “meaningful”, “manageable”, and “comprehensible”. The women in my study also expressed their understanding of birth in a way that expressed such a “sense of coherence”. The women in my study exhibited commonality in their stories, which was similar across the range of ages and backgrounds. The stories pointed to virtual emotional connections with other women. The women seemed to care particularly about the advice they were offering to others (as well as what they wanted to avoid telling them) with Isabelle referring to pregnant women as being in a ‘club’:

*Isabelle: ‘I think you can’t really and you don’t know what to expect. My sister in law is pregnant now for the first time and I know there’s things that I’m not telling her... y’know there’s things that you don’t say and I guess that why they call it a club and things like that.. you know you don’t want to scare people.’ [Lines 229-232]*

This led me to conclude that they were demonstrating “empathy across different social locations” as suggested by Riessman, (2002, p.696) when she referred to how storytelling bridges policy discourse and fosters development of constituencies through the language of women’s life worlds.

The women’s stories are also reminiscent of the work of Robbie Davis-Floyd (1992) who set out to study American rituals in birth by interviewing over a hundred pregnant women, mothers and health care professionals. She described the rites of passage around birth as “transformation in the peer domain” (p. 34). She described how the women talked about being part of an “underground network” and a “secret sisterhood” (p.34) Davis-Floyd characterised the transformation as a unique bond within which first-time mothers seek ways to help them cope with their pregnancy and birth. They are initiated into what Davis-Floyd called the common culture of pregnancy in which knowledge is passed on in story, symbol, and example.

An explanation of how an understanding of a sense of coherence in childbirth fits within Antonovsky's theory is set out in Table C:

**Table B:**

	Antonovsky's Sense of Coherence Theory (1979, 1987)	Component two of the new theory
<b>Meaningfulness</b>	The deep feeling that life makes sense emotionally; that life's demands are worthy of commitment. It is essentially seeing coping as desirable.	The deep feeling that the experiences of child birth makes sense emotionally; that its demands are worthy of commitment. It is essentially seeing coping in childbirth as desirable.
<b>Manageability</b>	The extent to which people feel they have the resources to meet the demands, or feeling that they know where to get help.	The extent to which women feel they have the resources to meet the demands of childbirth, or feeling that they know where to get help.
<b>Comprehensibility</b>	The extent to which a person finds structures of their world to be understandable, meaningful, orderly and consistent instead of chaotic, random and unpredictable.	The extent to which a woman finds what goes on during childbirth to be understandable, meaningful, orderly and consistent instead of chaotic, random and unpredictable.

I propose that the stories told by the women and their midwives in my study reflect aspects of Wiedenbach's Need-for-Help theory and Antonovsky's Sense of Coherence as seen in the following three aspects of the stories I heard:

- 1) COPING - The women and the midwives seemed to express the deep feeling that the demands inherent in birth are worthy of commitment and that coping with them is desirable.
  - The woman copes with the personal, psychological, social & physical aspects of birth.
  - The midwife copes with the legal, professional, ethical and personal aspects of being with a woman in labour.

2) HELP - A belief that they each have the resources to meet the demands of labour and birth but feel that they know where to get help. In a birth attended by a midwife, the woman seeks and can expect to receive that help from the midwife.

- 'Help' may be simply having the midwife present to encourage the woman's ability to cope or it may be anything else, up to and including a request for help that may only be obtained by pharmacological means or from other professionals.
- Any need for midwifery, obstetric or other medical help must be recognised by the midwife and be validated by the one whose need it is. Then it is the role of the midwife to take appropriate action to meet the need.

3) COHERENCE – An expectation that what happens in labour and birth will be understandable, meaningful, orderly and consistent instead of chaotic, random and unpredictable.

- The woman does this by considering her birth story in the context of her own previous stories and/or other people's stories that she is aware of.
- The midwife does this by trusting and relying on her legal, professional, ethical and personal understanding of birth and of the demands of midwifery practice.

## **Conclusion**

In this paper I have explained how the stories I heard in my study provided insights into current perceptions of 'normal' birth. I have also criticised how midwifery knowledge and practice has for many years been analysed through and subject to dichotomous ways of thinking and have proposed that an integration of Antonovsky's Sense of Coherence (Antonovsky, 1979, 1987; Downe, 2004; Schmid, 2011) and Wiedenbach's Need for Help Theory (1964, 1967) is a more suitable explanatory framework through which to understand the stories told by new mothers and their midwives in my study, and potentially more widely.

I consider that combining these two theories avoids the drawbacks of a dichotomous structure; it does not rely on dubious definitions of what is 'normal' in birth and integrates the perspectives of both the woman and her midwife. It reflects my findings regarding the high value placed by both the woman and her midwife on 'coping' and self-reliance. It takes account of women's desire to cope with labour through not panicking and the midwives' role to offer help in this desire. It provides a sense of coherence regarding the uniqueness of each and every birth for both the woman and her midwife, set in context of with one's own and others' experiences. It recognises that the woman and her body can be trusted to express a need for help, if necessary, along with the vital nature of the midwife's skills to recognise when help is needed, and what that 'help' might be. Finally it places at the centre of the model the supreme right of the woman to validate the help she needs.

The theory proposed within this discussion paper may provide a new and useful explanatory route through which to understand the experiences of some new mothers and their midwives in Western cultures where medical models are currently the dominant paradigm and continue powerfully to inform many societal values, views and norms for care in childbirth. It may be used by researchers to seek explanations for their findings in relation to labour, birth and midwifery practice research. It may also inform debates in other areas of practice that are explained by appeals to dichotomous models and it may influence educators and service providers to develop people and services that seek not to separate considerations of people's experiences from those of their carers.

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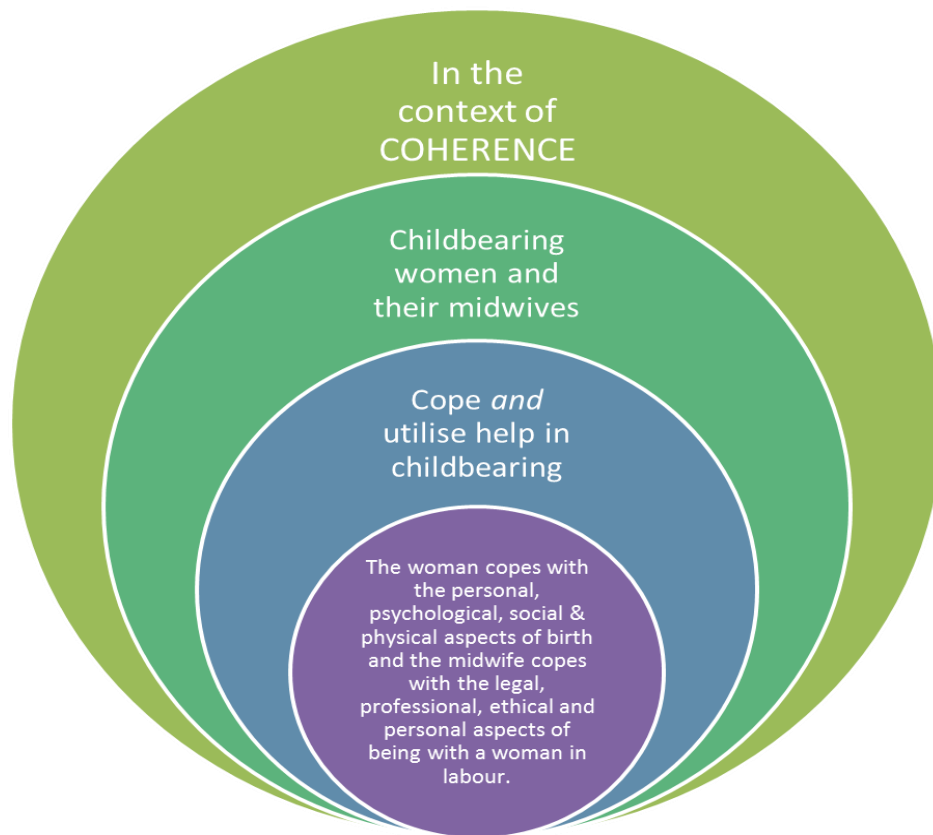
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**Figure 1:** Diagrammatic representation of Coping, Help and Coherence: a non-dichotomous theory for childbirth.



The Coping Help and Coherence theory (Figure 1) demonstrates how giving birth may require a helping process, which is triggered by a woman's behaviour that is perceived and interpreted by the midwife. This takes place in relation to both parties' expectations and/or hopes.

The midwife does this by:

- (1) observing inconsistencies during the labour and acquiring information about how women mean any cues that are given by the woman,
- (2) determining the cause of any discomfort or need for help, and
- (3) determining whether the need for help can be met by the woman or whether assistance is required.

Once needs for help are identified, ministrations are achieved and validation that help was given is recognised.

Help may be having the midwife present to encourage the woman's ability to cope or anything else; up to and including pharmacological means or help from other professionals (this might include medical or instrumental intervention).