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Midwives' experience of delivering a counselling intervention to distressed postnatal women

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature _____

Date _____

Acknowledgments

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This thesis is dedicated to my beloved father

Barry Chandler

Who always had faith in my ability, supported my dreams and was there to guide me whenever I faltered.

You are much loved and sadly missed.

Abstract

'Promoting resilience in mothers' emotions' (PRIME) was a large, team-based NHMRC funded randomised control trial (RCT) aimed at determining the effectiveness of a midwife-led counselling intervention in minimising psychological distress in childbearing women. Midwives were employed as research assistants and trained to deliver a counselling intervention to distressed postnatal women. This present study made use of an opportunity to explore and describe these midwives' experiences.

The purpose of this qualitative descriptive exploratory study was to explore and describe midwives' (n=18) experiences of working as research assistants in the PRIME project as well as their experiences of learning and delivering a midwife-led counselling intervention to distressed postnatal women. In-depth interviews, midwife diary entries and their postings on the PRIME midwifery forum were the methods of data collection employed for this study. Data was analysed using manual thematic analysis techniques. There were two distinct findings elicited from the midwives' descriptions.

The first related to the challenging but worthwhile nature of their role as research assistants. Midwives in this study considered their preparation for and work as a research assistant in the RCT a challenging experience. In part, they attributed this to learning the counselling intervention, having their practice critiqued and being daunted by the level of commitment the research role required of them. The support of the collegial team members of the project was therefore fundamental to the midwives perceiving this experience positively. Despite these challenges, midwives expressed that overall PRIME was a worthwhile experience that enhanced their knowledge of the research process.

The second finding was the level of confrontation midwives experienced as they came to appreciate the level of emotional distress some women suffered as a consequence of their birth experience. A desire to improve the emotional care provided to women in the postpartum was the midwives' primary motivation to contribute to the PRIME project. Midwives wanted to be more actively involved in the care of women distressed by their

birthing events, however it was evident that prior to PRIME many were not confident in their ability to perform this role. For the most part, they attributed this lack of confidence on insufficient counselling education received in their midwifery training, limited opportunity to impart emotional care in practice and the subsequent delegation of women's emotional care to other health professionals. Although considered challenging for most of the midwives to learn, the advanced counselling skills they acquired in PRIME provided them the confidence to care for women distressed by their birthing experience and to personally deal with any stressful situations they may encounter in practice. The findings of this study contribute to developing a better understanding of midwives' experiences of participating in research and working with distressed women in practice.

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Chapter 1

A travel guide

Introduction

There is a general perception that pregnancy and the transition to parenthood are a natural and joyous event for all women. During this period, women face many changes both physiologically and psychologically and most will successfully adapt to any challenges these changes may present. Unfortunately, however, this will not be true for all women. There is an extensive body of both Australian and international evidence that has identified significant rates of perinatal mental health disorders in childbearing women (Austin et al., 2010; Buist et al., 2008; Gavin et al., 2005). The consequences of which can have a detrimental impact on the health and well-being of the woman, her partner and the newborn infant (Perinatal Mental Health Consortium, 2008).

Gamble and associates identified a need for further research that investigates, develops and tests postpartum counselling strategies to inform midwifery practice and improve the emotional outcomes of women who have experienced a traumatic birth (Gamble & Creedy, 2009). Furthermore, these authors suggest midwives are well placed to understand and respond to childbearing women who have experienced a distressing birth and have the potential to play a pivotal role in facilitating their emotional recovery at this important time in their lives (Gamble & Creedy, 2009). As a result, Gamble and associates developed a midwife-led postpartum counselling intervention for women distressed by their birthing experience which demonstrated positive results when previously pilot tested by a single midwife (Gamble et al., 2005). On the back of these results, funding was sought and successfully obtained from the National Health and Medical Research Council (NHMRC) to conduct a larger randomised control trial to determine the effectiveness of this midwife-led counselling intervention.

The PRIME project: Following in the wake

PRIME is an acronym for 'Promoting resilience in mothers' emotions', a NHMRC funded randomised control trial (RCT) that was conducted in the states of Queensland and Western Australia between 2008 and 2009 by Prof. Jenny Gamble and associates. The study's aim was to determine the effectiveness of a midwife-led counselling intervention in minimising psychological distress in childbearing women. Some 1000 women were recruited in the third trimester of pregnancy and screened within 24-72 hours of birth to determine if they met Criterion A of the American Psychiatric Association, Diagnosis and Statistical Manual of mental health disorders (DSM IV-TR) for posttraumatic stress disorder (American Psychiatric Association, 2000). DSM IV-TR Criterion A for post-traumatic stress disorder seeks information about perceived exposure to a traumatic event and the woman's initial emotional response. Women were asked if during labour or birth they had been fearful for their life or their baby's life, or feared serious injury or permanent damage. Mothers screening positive were randomly allocated to receive the counselling intervention or parenting support (active control). Both groups of women (intervention and control) received the same level of contact from the research midwives.

Clinically-based current midwives (n=20) with an interest in perinatal mental distress and in developing their counselling skills were recruited as research assistants. Research midwives were expected to recruit women, provide consenting women with two questionnaires (the first when obtaining consent antenatally and the second within 72 hours of birth), screen for a distressing birth experience, randomise distressed women into the control or intervention groups and telephone them in four to six weeks time and implement the counselling intervention/parenting support depending on group allocation. A detailed description of the development and key elements of the counselling intervention are provided in chapter two of this thesis.

For their role in PRIME, the midwives received training which consisted of three, four-hour workshops, written manuals and digitally recorded counselling skill vignettes related to the counselling framework. Research midwives were required to demonstrate

competence by completing at least one digitally recorded counselling interview with a volunteer who self-identified that she had experienced a distressing birth. Supportive supervision to gain competence prior to commencing recruitment, and ongoing supervision to assure adherence to the counselling framework, was provided to the research midwives for the duration of the project. A tool was developed to determine integrity of the counselling intervention and to trigger remedial training and supervision if needed (scores below 7 out of 10). A clinical psychologist developed and implemented the training protocol and supervision of the research midwives under direction of the chief investigators. To assist with the team cohesiveness, confidentiality and accessibility, a PRIME website was created for the midwives to access project information and interact with other members of the PRIME team via the online 'midwifery forum'. The study presented in this thesis took the opportunity to explore and describe these midwives' experiences.

This thesis presents the experiences of 18 midwives who sought and successfully obtained a position as a research assistant in the PRIME project. The primary aim of this study was to develop a better understanding of two phenomena. Firstly, what it was like for midwives to participate in a large team-based research project and secondly, what it was like for them to learn and deliver a midwife-led postpartum counselling intervention for distressed women. Both of which are inadequately reported on in the literature.

The study presented in this thesis was conducted during a 17 month period from August 2008 to December 2009 and used a qualitative descriptive exploratory research design. Descriptive approaches to research are considered an appropriate choice if the phenomenon is inadequately defined or conceptualised. Furthermore, the exploratory component of this approach allowed for the full nature of the phenomena and other factors to which they were related to be investigated and described (Polit & Beck, 2010). Purposive sampling was used to recruit the participants for this study. Open invitations and consent to participate were posted to the 20 midwives along with the confirmation of their appointment as a research assistant in the PRIME project. It was

made clear to the midwives that the researcher in this study had no affiliation with the PRIME project. In keeping with the qualitative approach to research, multiple methods of data collection were used to ensure sufficient density and multiple perspectives of the phenomena of interest were obtained. These methods included prospective semi-structured in-depth interviews conducted at four time points throughout the participants' journey in the PRIME project; participant diary entries and participants' postings on the PRIME web-based forum. Thematic analysis and constant comparison techniques were used to analyse the data set and closely resembled the method described by Taylor and associates referred to as 'The concise version of the manual thematic method' (Taylor, Kermode, & Roberts, 2006, p. 464).

Background and justification of the study

As a midwife and novice researcher I wanted to develop a better understanding of two phenomena of which little is known or reported on in the literature. The first relates to how midwives could use their skills to improve the care they offer distressed postnatal women. The second relates to the need to enhance research capacity within midwifery and how successful, if at all, collaborative team-based approaches to research are in negating barriers commonly associated with research and engaging midwives participation.

Women have consistently reported feeling less than satisfied with the postnatal aspects of their childbirth experience (Brown, Davey, & Bruinsma, 2005; Cooke & Stacey, 2003; Rudman & Waldenström, 2007). Furthermore, there is a line of inquiry that questions midwives' ability and confidence to provide distressed women effective emotional care at this time (Jones, Creedy, & Gamble, 2012). As a registered nurse and midwife with extensive experience of caring for women exposed to potentially traumatic life events, I am acutely aware of the important role staff can play in assisting their emotional recovery. The majority of my 27 years in clinical practice have been devoted to women's health. In my early career working as a clinical nurse in gynaecology/ oncology, I witnessed the devastating effect traumatic news such as a diagnosis of cancer or loss of a much wanted baby had on women. During this period I

developed an awareness of the important role staff can play in assisting women and their families to get through this difficult time. My last 17 years of practice have been as a registered midwife working at King Edward Memorial Hospital (KEMH) in Western Australia which specialises in obstetrics, psychiatrics, gynaecology and neonatology. As the largest public maternity hospital in the state and only referral centre for complex pregnancies, KEMH staff oversees in excess of 6000 births a year many of which are complicated, high risk cases. Although many births are uneventful and happy occasions for women, there are unfortunately a significant number of women for whom this is not the case. As previously discussed and cited, perinatal mental health disorders are prevalent and considered a major health priority worldwide. My interest in the provision of women's emotional care in the early postpartum was thus borne from a desire to enhance this aspect of midwifery practice and ensure the health and wellbeing of women and their families in their transition to parenthood.

As stated above there are two phenomena that I am interested in. The second is related to enhancing research capacity within the midwifery profession. There is a dearth of literature reporting the significance of developing research capacity in midwifery to enhance practice and professional standing (Fahy, 2005). Furthermore, there is significant body of work that has identified research barriers to nurses undertaking research activities (Carlson & Plonczynski, 2008). What is not common is inquiry focused specifically on the midwifery professional undertaking research or the potential benefits collaborative team-based approaches to research may provide as a potential solution to enhancing capacity in the profession. As a novice researcher conducting this study in pursuit of a Masters degree, I am acutely aware of the level of commitment required when undertaking independent research. Although I believe this experience has enhanced my level of understanding of the research process, I appreciate this is not a path that all midwives would choose to take to achieve this goal. My interest in investigating the potential benefits of collaborative, team-based approaches to research in engaging and sustaining midwives activity is based on a desire to identify other potential pathways in which midwives can become actively involved in clinical research and contribute to health promotion and policy.

Overview of the thesis

The analogy between travel and the titles chosen for the chapters in this thesis, reflect the journey undertaken to explore and describe the experiences of the 18 midwives who worked as research assistants in a large, randomised control trial and delivered a counselling intervention to distressed postnatal women. This chapter, 'A travel guide', is the first of six chapters, and sets the scene by providing the reader with a detailed description of the PRIME project in which the midwives worked as research assistants, an overview of the study design for this present inquiry, a rationale for the investigation and the researcher's personal and professional background. Outlines of the remaining five chapters within this journey are now presented.

Chapter two, 'Sign posts in the journey: A literature review', is divided into two sections and presents two distinct bodies of knowledge that underpinned the conceptualisation of this study and the dual roles undertaken by the midwives in PRIME. The first presents literature on research capacity building in the midwifery and nursing professions. A difficulty encountered in this study was the paucity of inquiry on the midwifery professional undertaking research and thus discussions on this topic had to draw heavily on literature from her 'sister' profession of nursing. A synopsis of the extensive body of work that relates to and has identified numerous barriers to clinicians undertaking research is presented. Following on, a discussion on collaborative, team-based approaches to research is provided and puts forward the argument that projects such as PRIME may not only address some of the barriers commonly associated with research but may also provide a solution to enhancing research capacity in midwifery.

The second section of chapter two presents contemporary literature pertaining to perinatal mental health and women's postpartum emotional wellbeing. This includes outlining the consequences of mood disorders for new mothers and their families and the role midwives play in supporting women's emotional wellbeing after birth. The increasing rates of distress after birth and midwives inability to adequately work and emulate women's birth distress provided the rationale for the development of the midwife-led PRIME intervention; and a detailed description of the developmental

process and key elements of this intervention are presented in this chapter (Gamble & Creedy, 2009).

Chapter three, 'Finding the way: exploring and describing midwives' experiences', outlines the research design and how this study was conducted. The discussion commences by providing an overview of the naturalistic and positivist paradigms and rationale for the qualitative approach employed. This is followed by an explication of the researcher's attitudes and beliefs prior to data collection. The research objectives are then identified and the approach is outlined under the conventional headings of study setting, participant sampling and recruitment, data collection and data analysis. Explanations of the multiple methods of data collection used in this study are provided and include; in-depth interviews, participant diary entries and participants' postings on the online PRIME midwifery forum. Thematic analysis was used to analyse the data set and an explanation and examples of this technique are provided. Finally, chapter three concludes with a description of the measures taken to ensure trustworthiness and the ethical procedures and considerations that were undertaken.

Chapters four and five of this thesis contain the findings of the research. Chapter four, 'A challenging journey: working in research', presents five themes that relate to the midwives' experience of working in research and participating as research assistants in the PRIME project. The first theme labeled 'Research is important but not something I know much about', sets the scene by providing insight into the midwives' previous experience in and expectations of research, prior to undertaking their role in PRIME. The second theme, 'Opening new doors', describes the reasons why the midwives sought the opportunity to work in the randomised control trial. Finally the themes, 'Being challenged and finding a way forward', 'Clinical supervision: a new and confronting experience' and 'The research project: a mighty undertaking' reflect the midwives descriptions of preparing for and working as research assistants in the PRIME project.

Chapter five, 'The low road: working with distressed women' provides an additional four themes that relate to the midwives' experiences of caring for distressed women and

implementing the PRIME counselling intervention. The first two themes within this chapter, 'Women out there on their own' and 'Dilution of the midwives' role', set the scene by describing midwives' perceptions of current postnatal care and their experiences of providing emotional care to women during this important time in their lives. The third and final themes 'Brushing so closely next to women' and 'Making a difference', reflect the midwives' descriptions of caring for distressed women in practice and implementing the PRIME counselling intervention. Throughout these two findings chapters, participants' quotes and excerpts are used to illuminate and support a theme or sub-theme and provide a rich source of description of the phenomena of interest.

The sixth and final chapter of this thesis, 'Dual highway: two distinct stories', is once again divided into two distinct sections. Discussion in the first section relates to the midwives' research experience and in particular their challenging but worthwhile experience as research assistants in the PRIME project. The discussion commences with 'Midwives and nurses: data collectors for others', and provides a comparison between the participants' research experiences with that of other midwives and nurses recorded within the literature. Following on, the section titled 'Barriers to research persist for clinicians', examines factors the midwives in this study perceived hindered their research involvement to determine what, if any, commonalities exist within the literature on this topic. Finally, in the section titled 'PRIME: A collaborative approach to research', the discussion focuses on the findings related to the midwives involvement in the PRIME project and examines them in relation to contemporary literature, specifically, what motivated their participation, whether the collaborative approach provided any solutions to the barriers commonly associated with research and how, if at all, their experience in the project influenced their views on clinical research.

The second key finding identified in this study was the level of confrontation midwives experienced as they came to appreciate the level of emotional distress some women suffered as a consequence of their birth experience. The discussion in this section begins with the section titled 'Out of their comfort zone: Learning to work with

distressed postnatal women', and looks at factors the midwives in this study perceived influenced their confidence and ability to care for distressed postnatal women in practice. Following on, the section titled 'Confronted by the reality of distressed women', examines how being with women and implementing the PRIME intervention shaped their views on how a perceived negative birthing experience may impact on women. Finally, in the section titled 'Gaining confidence to unwrap women's birth stories', the discussion focuses on how the participants' experience in PRIME influenced not only their confidence to care for women who were identified as traumatised by their birthing experience but also their views on the provision of emotional care they provided to women in practice. The chapter concludes outlining the strengths and limitations of the study as well as implications and recommendations for practice, education and future research.

The challenging and at times confronting journey experienced by the midwives learning the intervention and developing the confidence to care for distressed women in PRIME were echoed throughout their descriptions in this study. The following excerpt by Olive (fp4) depicting herself as a *"tourist on a guided tour"*, poignantly describes what this experience was like for her and provides the reader with some insight into this phenomenon:

Her first child's birth 18 years ago and she was retelling it as if it was yesterday. All she needed was permission and off she went. I mimicked her posture at times to encourage her to talk but mostly I gave her my full attention. It wasn't so much technique, although I was aware I was using the skills…taught, it was about focusing on her and wanting to share the experience. It was a bit like being on a guided tour; I had never visited this place and I was visiting it with this woman. She was the inside expert. Along the way I asked questions, listened to her descriptions, asked her how she felt about this place and explored the sub stories; that 'made up the whole' and gave it definition and texture. During the interview kids trailed in and out and the phone rang a few times, my internal dialogue threatened to explode into major critique mode. Breathe I heard myself say just like coaching the laboring woman; nearly there now keep

breathing, just relax. The story/journey deepens as we brushed past some deep feelings of betrayal. Like all good tourists on a guided tour, I hang back to stroke the feeling and get a sense of it myself. "Tell me more about this" I ask her I want to know more about this one. She stops and ponders and becomes reflective, nursing it tenderly. Tears well up in her eyes, she drops her eyes for a moment, not sure if it is safe to talk about this betrayal. It has never been on display before. She looks up at me, my eyes are waiting softly. I offer a gentle smile that says "it's ok I'm not frightened you can tell me." She begins and the hurt tumbles out, connections are being made. The journey has changed me, it has changed her. After 18 years she finally connected the fact that nearly dying when her heart stopped was traumatic and that fleeing to France to find better care, alone and unable to speak the language had an impact on her experience…What she discovered was not pleasant or pretty but had been neatly packaged with pink ribbon as 'a good birth with no complications'. I don't know if any of my experience is helpful but I am just a midwife... this time I listened with my heart and my eyes. I let one woman tell her story and boldly shook the box with pretty wrapping saying "tell me more I want to see what is inside this one".

Summary

This first chapter has provided the reader with a 'travel guide' and overview of what to expect in the remaining five chapters of this thesis. To prepare them for the journey ahead a detailed description of the PRIME project in which the midwives worked as research assistants, an overview of the study design for this present inquiry, a rationale for the investigation and the researcher's personal and professional background were all provided.

Chapter 2

Signposts in the journey: Literature review

Introduction

The study presented in this thesis seeks to explore midwives' experiences of being research assistants who not only recruited participants but also randomised and delivered a newly learned counselling intervention to distressed postnatal women. The dual roles undertaken by the midwives mean that there are two distinct bodies of knowledge that underpin the conceptualisation of this study. The purpose of this chapter is to provide an overview of this knowledge. Therefore, in the first section of the chapter the contemporary literature on research capacity building in both the midwifery and nursing professions is presented. This includes a synopsis of the extensive body of work that relates to and has identified numerous barriers to clinicians undertaking research in these two professions. The section concludes with a discussion on collaborative, team-based approaches to research. Here the evidence is used to argue that team-based approaches to research may not only address some of the barriers commonly associated with research but may also provide a solution to enhancing research capacity in both disciplines.

In section two of the chapter the contemporary literature pertaining to perinatal mental health and women's postpartum emotional wellbeing is canvassed. This includes outlining the consequences of mood disorders for new mothers and their families and the role midwives play in supporting women's emotional wellbeing after birth. The increasing rates of distress after birth and midwives inability to adequately work and emulate women's birth distress provide the rationale for the development of the PRIME intervention; the midwife-led telephone intervention delivered by the midwives.

Building Research Capacity

Research capacity-building in midwifery and nursing is recognised as a priority worldwide, a crucial element in the advancement of the disciplines and the enhancement of health promotion and policy development (Australian Health Ministers Advisory Council, 2006; Green, Segrott, & Hewitt, 2006; McCance, Fitzsimons, Keeney, Hasson, & McKenna, 2007). Yet there is a considerable body of evidence that suggests this goal may not be easily achieved, in the most part, this is a result of identified barriers for midwives and nurses undertaking and implementing research (Bonner & Sando, 2008; Funk, Champagne, Wiese, & Tornquist, 1991b). However, within this literature there is a preoccupation to identify barriers and significantly less inquiry into how to overcome these challenges. Some argue that collaborative, team-based approaches to research have the potential to negate some of the barriers commonly associated with research and enhance capacity within these disciplines (Borbasi, Emden, & Jackson, 2005; Gillibrand, Burton, & Watkins, 2002).

Given the paucity of research relating specifically to midwives and the propensity for authors to combine midwifery with nursing in their discussions/ reviews of this subject (see Australian Health Ministers Advisory Council, 2006; Cooke & Green, 2000; Green, et al., 2006; McCance, et al., 2007), it is important to note that this discussion draws heavily on literature from the nursing profession.

Research capacity building in midwifery and nursing

A difficulty in discussing this subject is that there is no universally accepted definition of the term 'research capacity building'. Rather, there is a constellation of inquiry acknowledging the differences in opinion and the difficulty defining a concept that encompasses several strategies and continues to evolve (Condell & Begley, 2007; Segrott, McIvor, & Green, 2006). Finch's (2003) earlier commentary on building research capacity in nursing simply defines the term as "enhancing the ability within a discipline or professional group to undertake more high quality research" (p. 427). Condell and Begley's (2007) more recent concept analysis of research capacity building

in nursing, medicine, education and health service research (HSR) acknowledged the lack of clarity in defining this term. These authors provide a more comprehensive description of research capacity stating it is "a funded, dynamic intervention operationalised through a range of foci and levels to augment ability to achieve objectives in the research field over the long-term, with aspects of social change as an ultimate outcome" (p. 268). They however caution that in view of the evolutionary nature of the concept, this definition can only be considered as an interim statement.

Despite disparity in opinion over the definition, there is a general consensus that developing research capacity within the midwifery and nursing professions is imperative if they are to positively contribute to future health promotion and policy development (Condell & Begley, 2007; Cooke & Green, 2000; Grange, Herne, Casey, & Wordsworth, 2005; Green, et al., 2006; McCance, et al., 2007). In the United Kingdom (UK) for example, McCance et al.'s (2007) nominal group technique sought to identify strategic priorities for research capacity from experts (n=105) in the fields of midwifery and nursing research. Their findings revealed that capacity building was highlighted as a central component by the participants with the following three areas identified as priorities for future development; 1) strong and visible leadership 2) enhance research expertise to develop programmes of research and 3) increase the capacity of individuals and organisations to engage in development activity (p. 57). Likewise, nationally the importance of enhancing research capacity in midwifery and nursing has been similarly reported by the National Nursing and Nursing Education taskforce (N^3ET) publication Priorities for Nursing and Midwifery Research in Australia (Australian Health Ministers Advisory Council, 2006). The overall objective of this report was to provide researchers and organisations with strategies to enhance the quality and direction of research so they could contribute to the development of a sustainable healthcare system in Australia. The N^3ET report suggests that this goal could be achieved by researchers and organisations if they focused on team-based, collaborative research inquiries into identified health priorities (p. 9).

Discussion on the need to enhance research productivity within the midwifery and nursing professions commenced over two decades ago and coincides with the transfer of their education from hospitals' skills-based training to the academic sector in the 1980s. This merger between two different approaches to education increased the importance of establishing a strong research base in the disciplines. However, it was also the precursor to concerns being raised about the ability of hospital-based educators to contribute to academic research (Borbasi, Hawes, Wilkes, Stewart, & May, 2002; Dunn & Yates, 2001; Sellers & Deans, 1999), research productivity in midwifery and nursing (Fahy, 2005; Wilkes, Borbasi, Hawes, Stewart, & May, 2001) and the quality of publications being generated (Fahy, 2005). The significance of these three issues in relation to developing research capacity in midwifery and nursing necessitates the need for further discussion.

Integrating hospital-based educators into academia

Research is a fundamental requirement of the academic sector. During the initial transfer of midwifery and nursing to the academic setting, there was some trepidation about the ability of departments to work collaboratively due to lack of research knowledge and experience of many hospital-based educators (Clare & Hawes, 2001; Cooke & Green, 2000; Sellers & Deans, 1999). In the UK Cooke and Green (2000) conducted a meta-analysis of the literature to identify factors that might affect the research capacity of midwifery and nursing departments in higher education. In particular, they focused on the impact on nurse educators' integration into the academic sector and the subsequent effects on academic research. Cooke and Green reported that factors affecting research capacity development were numerous, complex and required consideration at not only a national and organisational level but also by individual academics. Their recommendations included the assessment of the pros and cons of developing a nursing research council at a national level, the implementation of strategies to develop a research-orientated culture within organisations and the provision of opportunities for educators to develop their research skills and pursue individual academic qualifications (p. 63).

In Australia, similar findings have also been reported. Clare and Hawes (2001) scholarly paper on creating a research culture at an Adelaide School of Nursing for example, identified that a conflict existed between the educators research and teaching orientations. Clare and Hawes reported that many hospital-based educators were expected to obtain higher education qualifications to enhance their academic standing and research capabilities whilst simultaneously maintaining their teaching and research commitments. To successfully integrate hospital-based educators into academia they suggest structural changes and transformative leadership was required in order for them to assimilate into the university research culture (2001, p. 35). Likewise, around this time Sellers and Deans (1999) nationwide survey of nursing academics (n=369) working at universities, identified that nurse educators predicted they would need to not only contribute more time and effort to future research but to also acquire a higher education degree to advance professionally in academia (p. 55).

Within the Australian literature there was also a perception that tensions developed between nursing academia and clinicians when these two different approaches to education merged into one (Dunn & Yates, 2001). One action taken in an attempt to address this matter was to create the position of clinical chairs. Clinical chairs have been described as "joint appointments at the professional level with links to both the academic and clinical settings" (Dunn & Yates, 2001, p. 166). The objective of this position was to strengthen relations between hospitals and universities, enhance a collaborative partnership and promote further research and development (Dunn & Yates, 2001; Retsas, 2000). Dunn and Yates (2001) qualitative exploration of the experiences of eight Australian professors holding clinical chairs for example, reported that these positions helped to link professionals in academia and the health care sector by emphasising the common purpose of enhancing health care delivery. Dunn and Yates found that all but one of the professors in their study believed that initiating clinically relevant research that impacts positively on client outcomes was the primary focus of their positions. Likewise, Retsas (2000) considered a significant objective of his position as Chair of Clinical Nursing at an Australian hospital, was to enhance evidenced-based practice within the nursing division. Retsas (2000) conducted a mixed

method analysis of barriers to utilising research in practice for 400 registered nurses working at the tertiary centre where he was appointed. He reported that staff had a high level of research readiness and valued the contribution research had to improving practice. Although midwives and nurses have been reported to value the contribution research can make towards practice, increasing their research productivity has been the subject of much discussion within the literature and is considered a key element in enhancing research capacity within these professions (Australian Health Ministers Advisory Council, 2006).

Research productivity in midwifery and nursing

The amount of research being published globally by midwives and nurses is significantly less than other health disciplines such as medicine (Rafferty, Traynor, Thompson, Ilott, & White, 2003; Wilkes, et al., 2001). Rafferty and associates (2003) editorial on research productivity of midwives, nurses and allied health professionals in the UK for example, reported that significantly less research was being generated by these professions compared to that of medicine. In the most part, Rafferty et al. attributed this to midwifery, nursing and allied health research being significantly underfunded. The authors raised the pertinent point, that this group of health professionals accounted for two thirds of the staff directly responsible for patient care and yet little was known of their clinical or cost effectiveness (p. 833). Furthermore, they suggest that additional investment was required within these professions in the areas of training and preparation of research leaders at more senior levels in order to provide sustainable programmes of clinical research in the future.

Nationally the Australian Institute of Health and Welfare publication Nursing and Midwifery Labour Force 2009 reported that there were only 2,213 researchers to the estimated 276,751 midwives/nurses employed in 2009 (Australian Institute of Health & Welfare, 2011, p. 3). This was slightly higher than the 1879 researchers to the estimated 294,764 of midwives/nurses employed in 2005 that was reported in the previous publication (Australian Institute of Health & Welfare, 2008, p. 5). Nonetheless, it is not surprising that focus on enhancing research productivity in the Australian midwifery

and nursing sectors has also been a topic of ongoing discussion within the literature. Wilkes and associates (2001) for example, conducted a review of research published by Australian authors in the fields of midwifery, nursing and allied health in 11 journals based in Australia, UK and America between 1995 and 2000. The authors identified that the 509 articles analysed represented only 12.5% of the total 4062 published (p. 17). Nursing was the most common discipline citing first author, with 403 articles representing 83.6% compared to that of midwifery with six (1.2%) (p. 18). However, research papers accounted for only 12.5%, leading Wilkes et al. to conclude that "few nurses publish research papers in the refereed general nursing journals we focused on" (2001, p. 15). Considering the brevity in the shift to a research base in education at this time, these results should not overshadow the progress made to date. Indeed, in Wilkes and Jackson's (2011) more recent comparative publication analysing Australian nurse researcher output in journals with a high ranking within the Institute for Scientific Information (ISI) or Excellence in Research for Australia (ERA) between 2004 and 2008 for example, identified some positive trends in research productivity. The authors reported that of the articles analysed, a total of 652 papers of a total 1182 were by Australian-based authors in Australian journals and 254 papers of a total of 3481 in international journals (p. 127). Wilkes and Jackson reported an increase in volume of research articles (n=276) and concluded there had been an increase in research productivity since the earlier analysis conducted in 2000 (p. 125). Unfortunately, unlike Wilkes et al. (2001) earlier publication, this review categorised participants as either nurses, nursing students, consumers of care or other health professionals, making it difficult to correlate these findings to research capacity of midwifery professionals.

Quality and significance of midwifery and nursing publications

In addition to enhancing research productivity, the standard of publications being generated by midwifery and nursing professionals has also been a topic of discussion within the literature on research capacity building. Concerns have been raised in relation to the quality of publications, the choice of topics and their relevance to health promotion and policy (Borbasi, et al., 2002; Cooke & Green, 2000; Fahy, 2005; Green,

et al., 2006; Mc Vicar & Caan, 2005; Peacock, Pirkis, & Cumming, 2004; Wilkes, et al., 2001).

Cooke and Green's (2000) previously cited UK review of developing research capacity in departments of midwifery and nursing higher education criticised the quality of research being generated from nursing academic departments stating "the quality of the research performed by nursing was judged (by the Research Assessment Exercise) to be the lowest of all the disciplines assessed" (p. 58). However, in a later publication by McVicar and Caan (2005) on the research capability of UK doctoral nursing students, the authors argued that nurses' research capabilities were in fact improving. McVicar and Caan evaluated abstracts of 204 nursing doctoral theses obtained from a database between the years 1983 to 2002. The authors' review of these abstracts led them to concur that the breadth of nursing research skills had increased with research designs frequently employing multiple methods (p. 644). However, a limitation of this paper is that McVicar and Caan (2005) neglect to report how many, if any, of the doctoral students sought and were successful in publishing their research. A disappointing oversight, as evidence of publication would indeed have provided strength to their assumption of improvement in research skills and quality of nursing publications.

Australian midwifery and nursing research has not been immune from such scrutiny. Concern has been raised that Australian midwifery and nursing research is generally considered too low a standard to be considered fit for practice and neglects to address the major health issues of the broader community (Borbasi, et al., 2002; Fahy, 2005; Peacock, et al., 2004). Fahy (2005) evaluated the quality and significance of Australian midwifery research published in the Australian Midwifery Journal between 2002 and 2004 and declared the research was not of a high enough standard to be used for evidenced-based practice (p. 8). In the most part she attributed this to the individualistic, unplanned and uncoordinated approaches to research and advocated the adoption of team-based, multi-site, programmatic research. Furthermore, Fahy advised that midwives must consider and defend the nature of their research in terms of significance to practice. The recommendation that research needs to focus on identified priorities in

health has been similarly directed at the nursing profession. Borbasi et al. (2002) quantitative review of Australian nursing research published between 1995 and 2000 for example, identified a 'shortfall' in the 509 articles published as not focusing on clinically relevant topics that address the health priorities of the Australian community (p. 496).

To generate research fit to influence health promotion and policy in Australia will require a collaborative approach to research. This assumption is supported by Peacock and associates (2004) editorial on papers presented at the Health Services Research Association conference in Melbourne 2003. Peacock et al. reported that although the culture of health services research has improved immeasurably in Australia and New Zealand there was still an element of competitiveness for funding and hoarding of information by individual organisations (p. 1). The authors believe that continuation of such traits would be to the detriment of establishing productive research departments. Apart from the need to work collaboratively in research, the identification of a consistent relationship between perceived research barriers and midwives and nurses' limited research involvement necessitates the need for further discussion.

Research barriers for midwives and nurses

As highlighted in the previous section of this chapter, there is an ongoing need to address the issue of research capacity-building in the disciplines. There is however a considerable body of evidence that suggests this goal may not be easily achieved. While the midwifery literature provides limited evidence to support this claim, nursing studies have generated a significant body of evidence that suggests in the most part this is a result of identified research barriers. Although a significant amount of this evidence has been generated overseas (see Fineout-Overholt, Levin, & Mazurek Melnyk, 2005; Funk, et al., 1991; Gerrish & Clayton, 2004; Glacken & Chaney, 2004; Grange, et al., 2005; Green, et al., 2006; McNicholl, Coates, & Dunne, 2008) similar findings have been confirmed from a smaller sample of published studies in Australia (see Bonner & Sando, 2008; Hancock, Emden, Schubert, & Haller, 2000; Henderson, Winch, Henney, McCoy, & Grugan, 2005; Kerr, Woodruff, & Kelly, 2004; Reid, O'Reilly, Beale,

Gillies, & Connell, 2007; Retsas, 2000). The following section will outline some of these barriers and discuss their significance in relation to research development in midwifery and nursing.

Lack of time

Lack of time has been highlighted as a major challenge for midwives and nurses undertaking and implementing research into practice. Increasing workloads, staffing shortages, insufficient funding and a perception that research is not a valuable use of time have all been cited as contributing factors within the literature (Fineout-Overholt, et al., 2005; Gerrish & Clayton, 2004; Glacken & Chaney, 2004; Green, et al., 2006; McNicholl, et al., 2008; Reid, et al., 2007; Retsas, 2000). Glacken and Chaney (2004) for example, acknowledged that although nurses recognise the positive impact research has over practice; their actual application of research findings into practice was not consistent. In their cross-sectional survey to identify perceived barriers for 169 Irish nurses to implement research, Glacken and Chaney identified that in order to achieve this goal the nurses reported that they needed protected time. Likewise, McNicholl and associates (2008) conducted a comparative survey of midwives and nurses to examine the research and development culture in the UK and elicited similar findings. In their survey of 379 midwives and nurses employed within the Trust, McNicholl et al. identified a total of 21 barriers that the participants perceived inhibited their research participation of which 'insufficient time' was the second most cited barrier only being surpassed by the equally ranked 'lack of opportunity' and 'lack of skills'.

Working in a culture that places high demands on midwives and nurses to meet physical aspects of care over research activities can result in research being perceived as less valued. This assumption is supported by the work conducted by Fineout-Overholt and associates (2005) in America. Fineout-Overholt et al. reported on a pilot study testing a 'mentor model' developed to assist nurses to implement evidenced-based practice (EBP) in the clinical setting and identified that nurses did not often have the time necessary to complete the intervention due to competing priorities such as compulsory

education. The authors put forward the view that like educational activities, EBP needs to be supported by administrators through the investment of time and money (p. 31).

In Australia, lack of time has been similarly identified as a significant factor for midwives and nurses limited research involvement (Reid, et al., 2007; Retsas, 2000). The Australian Institute of Health and Welfare publication Nursing and Midwifery Labour Force 2009 (Australian Institute of Health & Welfare, 2011) confirms that midwives and nurses are indeed working longer hours with the reported average weekly hours increasing slightly from 33 hours in 2005 to 33.3 hours in 2009 (p. 1). In the clinical setting, increasing workload demands impact on midwives and nurses' ability to conduct research and may also inhibit them being granted protected time in order to engage in research activities. This claim is supported by the earlier work conducted by Retsas (2000) exploring nurses' perceptions of barriers to implementing research into practice. Retsas quantitative factor analysis of 400 nurses' opinions working in a medical centre identified that although staff demonstrated a high level of research readiness and shared a strong sense of valuing the contribution that research can make to practice, they needed paid release from work in order to participate in research activities. Likewise, the importance of providing protected time for research has been similarly reported by Australian midwives (Reid, et al., 2007). Reid and associates conducted a quantitative survey of 213 midwives to identify priorities in research and found that participants considered lack of time related to excessive workloads, professional and personal responsibilities inhibited them from accessing or participating in research. Apart from insufficient time, evidence suggests that lack of funding and financial support have also been identified as significant barriers in enhancing research capacity in midwifery and nursing.

Financial support for research

Financial support offered to midwives and nurses conducting research has come under scrutiny worldwide. Evidence suggests there is a disproportion in the allocation of funds amongst health disciplines and insufficient financial support to sustain research capacity in midwifery and nursing (Gerrish & Clayton, 2004; Haas, 2004; Pirkis et al., 2005;

Rafferty, et al., 2003; Segrott, et al., 2006). Despite the health disciplines as a whole receiving dedicated government funding in the UK for example, Rafferty and associates (2003) reported an inequity in the allocation of these funds amongst the health disciplines. In their editorial on research in midwifery, nursing and allied health professionals, Rafferty et al. assert that the "United Kingdom invests almost $5.5bn in medical research…nursing receives only 20% of that allocated to a national programme" (p. 833). Furthermore, they purport that a significant proportion of the nursing research conducted in the UK at the time of this report was unfunded (73%). Interestingly, others would argue that it is not insufficient funding but a lack of knowledge of how to access available monies that resulted in a significant percentage of UK nursing research being unfunded (Gerrish & Clayton, 2004). Gerrish and Clayton's (2004) report on the status of research and development in the nursing profession in the UK, argued that sufficient funding is provided by the Department of Health for nursing research and that nurses have failed to access and capitalise on such opportunities (p. 15).

In Australia, unlike the UK, there is no dedicated funding from the government to enhance midwifery and nursing research capacity, and researchers are required to seek financial support through competitive sources (Australian Health Ministers Advisory Council, 2006). Lack of dedicated funding for midwifery and nursing research in Australia has had a significant impact on enhancing research capacity. This assumption is supported by the early work conducted by Haas (2004). Haas conducted a content analysis of 21 journals to ascertain the status of health services research (HSR) in Australia over a ten year period. She reported that despite financial support from the National Health and Medical Research Council (NHMRC) and Australian Research Council (ARC), funding was insufficient with only 482 HSR articles being published over the ten year period. Comparable findings were also reported by Pirkis and associates (2005) web-based survey of the HSR community in Australia and New Zealand. In their survey, Pirkis et al. identified that HSR researchers (n=191) relied heavily on external funding to conduct and sustain their research activities. Unfortunately, the authors in this report were ambiguous surrounding the professions of

the HSR respondents making it difficult to relate these findings specifically to either the midwifery or nursing professions. However, it is unlikely that the provision of adequate time and funding alone will guarantee increased research capacity in midwifery and nursing. Leadership, support, education and training are also seemingly necessary contributory elements that have been identified by midwives and nurses (Fahy, 2005; Fawcett, Aber, & Weiss, 2003).

Research skills and training

In discussion on research capacity building within the literature, midwives and nurses lack of research skills and training have also been identified as factors contributing to their limited research involvement. Green and associates (2006) UK case study into enhancing research capacity in midwifery and nursing university departments for example, identified that neophyte researchers lacked the confidence and ability to conduct research. The authors recommended the need to implement additional research training sessions as well as the formation of alliances between novice and experienced researchers as a means of developing their skills and enhancing overall research productivity of the departments. In the clinical setting similar reports of insufficient research skills of nurses have been elicited. Roxburgh (2006) qualitative exploration of factors which hindered UK nurses (n=7) participation in research for example, identified that although receptive to participating in research activities nurses felt constrained due to a lack of time, insufficient support and limited knowledge/skills of the research process. Participants referred to their research skills as being basic, with most reporting they had no formal educational preparation in research methods. Roxburgh suggests that nurses' educational preparation needs to be assessed to ensure they are educated on how to access and interpret research findings. Likewise, Grange et al.'s (2005) literature review on research capacity in UK midwifery and nursing, reported that for midwives and nurses to contribute to healthcare research they must first be provided with opportunities to enhance their skills in this area.

Nationally, similar concerns in relation to midwives and nurses research skills have been reported. Nagy and associates quantitative study for example (Nagy, Lumby,

McKinley, & Macfarlane, 2001), sought to identify what nurses' (n=816) believed supported or hindered the development of evidenced-based nursing and they found four major obstacles. These obstacles were firstly, nurses did not regard the research as relevant to practice. Secondly, they lacked confidence in their ability to locate, comprehend and evaluate research. Thirdly, they lacked protected time to implement research. Fourth and finally, they doubted the willingness of their organisation to support evidenced-based practice (p. 319). Likewise, a later survey to elicit perceived barriers/facilitators to research utilisation for 317 Australian nurses, found nurses believed factors such as time constraints, lack of awareness of available literature, insufficient authority to change practice, inadequate skills and lack of support to implement research findings all hindered their research utilisation (Hutchinson & Johnston, 2004). These findings were again echoed in a more recent comparative survey conducted by Bonner and Sando (2008). These researchers surveyed 347 registered Australian nurses to identify their attitudes and use of research and concluded that although the participants had a positive view of research they acknowledged that they lacked confidence in their ability to conduct and implement research into practice.

Some published literature suggests that midwives and nurses require higher education qualifications to enhance their ability to conduct and implement research (Kajermo et al., 2007; Michel & Sneed, 1995; Whyte, Lugton, & Fawcett, 2000). In South Carolina, Michel and Sneed (1995), utilised the Nurse Practice Questionnaire to gauge the relationship of masters prepared nurses (n=167) and their use of research findings. The authors reported masters prepared nurses revealed a higher utilisation of research compared to those with a bachelor degree and thus able to disseminate research findings into the practice setting (p. 306). Likewise, similar assertions were reported in the work by Whyte and associates (2000) in their UK questionnaire to determine the impact a master degree had on 109 nurses' professional development over the subsequent ten year period. Whyte et al. reported that respondents attributed their higher degree to opening up job opportunities, enhancing their clinical practice and increasing their personal sense of satisfaction and achievement in relation to the acquisition of academic skills. Likewise, Kajermo and associates (2007) more recent questionnaire seeking to

identify barriers for 833 Swedish nurses to use research in clinical practice reported that participants who had no academic degree were more likely to perceive barriers to utilising research in clinical practice.

Conversely, there is some published literature that argues little benefit has been demonstrated with attainment of tertiary qualifications on overall research capacity in the discipline (Bonner & Sando, 2008; Kerr, et al., 2004). In the earlier work by Kerr and associates (2004) for example, the authors surveyed 178 Australian nurses to ascertain their research attitudes and activity and concluded that tertiary qualifications for these participants had little impact on either their attitudes or enthusiasm for research. These findings were echoed in the later study conducted by Bonner and Sando (2008) of Australian nurses, where the authors found tertiary research preparation did not adequately prepare these nurses to evaluate or implement research into clinical practice (p. 340). Certainly there is a significant body of evidence that suggests apart from the acquisition of skills, individuals require ongoing support and leadership if they are to be successful in their research pursuits.

Leadership and support

The need for leadership and a definitive career pathway for midwifery and nursing research have been highlighted as fundamental in the development of research capacity within these professions (Bonner & Sando, 2008; Fitzsimons, McCance, & Armstrong, 2006; Fowler Byers & Bellack, 2001; Gerrish & Clayton, 2004; Grange, et al., 2005; Hill, 2002). Equally, the need to support midwives and nurses in their research activities has also been identified as instrumental to them achieving success (Fineout-Overholt, et al., 2005; Gerrish & Clayton, 2004; Grange, et al., 2005). However, there is evidence to suggest that midwifery and nursing leaders at all levels need to be more proactive in establishing a career pathway and fostering a positive culture for midwifery and nursing research (Fitzsimons, et al., 2006; Henderson, et al., 2005; Hill, 2002).

Hill's (2002) commentary on transformational leadership in nursing education suggested that the leadership challenge begins with nurse educators. She purports that

educators are the pivotal force behind preparing nurses to "meet society's demands for increased access, increased quality, and decreased cost of healthcare" (p. 162). However, she implies that in order to achieve this task, educators need to constantly adapt curriculum and teaching methods to ensure students have the requisite knowledge and skills to meet these future healthcare demands. A similar viewpoint was reported in the work conducted by Fitzsimons and associates (Fitzsimons, et al., 2006). Following a comprehensive review of the literature, these authors conducted structured interviews with 32 organisational leaders in nursing and midwifery in Northern Ireland. Fitzsimons et al. reported that despite a general recognition of the value of research, only a minority of organisations had an up-to-date corporate strategy that included research and development. In order to advance the research and development agenda in midwifery and nursing, Fitzsimons et al. suggest organisations need to forge effective partnerships through the development of a clear vision and enhanced leadership (p. 753). The need for definitive leadership to facilitate the implementation of research in the clinical setting, was a factor identified in the more recent study conducted by Kajermo and associates (2007). Kajermo et al. questionnaire to elicit Swedish nurses (n=833) perceptions of barriers to research utilisation, found that participants were dissatisfied with the support received from immediate superiors in regards to research. The authors recommended that leaders within the organisation should not only develop strategies for supporting nurses' professional development but also strategies to implement research into clinical practice.

In Australia, similar views were reported in Henderson et al.'s (2005) theoretical review into creating a sustainable nursing infrastructure to support nursing research and education at a tertiary referral centre. In this paper the authors describe changes made by senior management within the tertiary centre to enhance research and development. Henderson et al. reported that the goal of enhancing the provision of services was achieved when the clinical area, education and research division all worked in unison with one another (p. 106).

In addition to providing leadership in the field of midwifery and nursing research and development, evidence suggests individuals also require support when undertaking research activities (Bonner & Sando, 2008; Fawcett, et al., 2003; Fineout-Overholt, et al., 2005; Kerr, et al., 2004; Retsas, 2000). In the USA, Fineout-Overholt and associates (2005) trial of a mentorship programme to assist nurses implement evidenced-based practice for example, reported positive results from using 'champions' to provide skills, support and mentorship in translating research into practice. These authors reported that administrative champions were instrumental in achieving staff participation in research (p. 30). Another innovative measure in supporting neophyte researchers in the clinical setting also came from research conducted in the America (Fawcett, et al., 2003). Fawcett and associates' (2003) paper discussed integrating teaching, practice and research with undergraduate maternity students in the clinical setting. Under the supervision of academics, undergraduate students were utilised to assess women's perceptions and responses to their caesarean births. The authors believed this approach enhanced student's awareness of research whilst simultaneously assisting them to implement research into practice.

Nationally, similar reports of the importance of supporting midwives and nurses in research activities have also been raised (Bonner & Sando, 2008; Kerr, et al., 2004). In the earlier questionnaire conducted by Kerr and associates (2004) to investigate clinical nurses' (n=178) research attitudes and activity for example, the authors found that although participants attitudes towards research were positive their enthusiasm to actually participate was variable. Kerr et al. concluded that this lack of enthusiasm may reflect the level of support, leadership and resources provided by the organisation. Likewise, the more recent comparative study by Bonner and Sando (2008), found that nurses (n=347) believed senior personnel with an inherent positive attitude had the potential to permeate the organisation and foster a positive research culture.

It is evident from the discussion thus far that enhancing research capacity in midwifery and nursing is an ongoing concern and one which is faced with many challenges. There is evidence to suggest however that collaborative approaches to research may be a way

to not only enhance research productivity but also negate some of the barriers commonly associated with research. The next section of this chapter will present some of the literature that supports collaborative, team-based research.

Collaborative, team-based research: A way to negate barriers?

Recapitulating the discussion thus far, the midwifery and nursing professions have a responsibility to generate quality research that can positively impact upon practice and contribute to the body of evidence addressing national health priorities (Australian Health Ministers Advisory Council, 2006). However, the quality of midwifery and nursing research has been criticised as generally being too low to create evidence that can be confidently used for practice (Fahy, 2005). Publications have drawn negative censure for being individualistic in nature, not focusing on identified health priorities and for having too small a sample to draw any meaningful conclusions (Fahy, 2005). These criticisms, in the most part, are related to identified research barriers and the general lack of research ideology that exists within these professions. Building research capacity in midwifery and nursing therefore requires implementing strategies that can negate identified research barriers and promote research within these disciplines. Collaborative, team-based projects may be one way to negate some of the barriers commonly associated with research and enhance research productivity.

Collaborative approaches to research have been identified as a way to consolidate research knowledge, experience and valuable resources to conduct large scale inquiries that focus on priorities in health (Australian Health Ministers Advisory Council, 2006; Borbasi, et al., 2005; Emden & Borbasi, 2000; Fahy, 2005). Research projects are generally governed by an experienced researcher who coordinates and supervises novice researchers and/or clinicians in the research process. Formation of alliances need not be restricted to within a single research unit, in fact multi-site, national, even international connections have the potential to generate more meaningful results that accurately reflect the general population (Borbasi, et al., 2005). The importance of establishing an infrastructure that supports research within the nursing discipline was initially raised by Emden and Borbasi (2000) in their discussion paper on

'programmatic research' which they define as a "planned and purposeful strategy" (p. 32). In their experience as researchers and supervisors of research students, Emden and Borbasi reported that the problems often encountered by lone researchers could be negated by team-based research projects. Likewise, Gillibrand and associates (2002) UK discussion on the collaborative approach of 'clinical networks' to enhance research capacity in nursing, acknowledged the difficulties faced by nurses to individually conduct research that can impact on practice. They believe it is naïve to suggest that over-worked clinicians with limited researcher training and supervision could undertake such research inquiries. Gillibrand et al. similarly proposed collaborative research as a potential solution to this problem.

Nationally the debate for midwives to work collaboratively in research was raised by Fahy (2005) in her evaluation of the quality and significance of Australian midwifery research. Fahy expressed concern about the structure and focus of research projects by Australian midwives stating "currently, we are developing as researchers but largely in ways that are individualistic, unplanned and uncoordinated" (p. 14). Like the authors previously cited, she also advocated the implementation of collaborative, team-based research as a potential solution to address the issue of inferior quality in publications and to make the most of the limited resources available for midwifery research in Australia. Although team-based research projects are still faced with such challenges as securing much needed financial assistance, compared to individual inquiries, the large scale structure of such projects has the potential to generate more meaningful findings and thus be considered a more attractive option by funding sources (Australian Health Ministers Advisory Council, 2006; Fahy, 2005).

Summary

The importance of developing research capacity in midwifery and nursing is evident and recognised as a priority worldwide for the advancement of both professions. Midwifery has a responsibility to generate quality research that can positively impact on practice and contribute to the body of evidence addressing national health priorities. Although there is an exhaustive body of work focused on the nursing profession, it is

evident that there is a paucity of research specifically related to midwifery in this area. Furthermore, qualitative inquiries exploring the benefits of collaborative midwifery research as a means to negate barriers commonly associated with research are scarce within the literature. The evidence gained from the study presented in this thesis will form the basis of a programme of work aimed at developing, implementing and evaluating initiatives to more successfully and sustainably engage midwifery practitioners in midwifery research.

Emotional care in midwifery practice

In this section of chapter two, contemporary literature relating to the emotional care of women in the perinatal period will be presented. Firstly an overview of the literature focusing on perinatal mental health disorders and their consequences for women and their families is discussed. Following on, literature that relates to the provision of women's emotional care by midwives in the postnatal period is provided. This work provides the rationale for the development of the PRIME counselling intervention and an overview of the strategies employed to create this counselling model is provided.

Women's perinatal emotional health: An overview of the literature

There is a general perception that pregnancy and the transition to parenthood are a natural and joyous event for all women. During this period, women face many changes both physiologically and psychologically and most will successfully adapt to any challenges these changes may present. Unfortunately, however, this will not be true for all women. There is an extensive body of both Australian and international evidence that has identified significant rates of perinatal mental health disorders in childbearing women (Austin, et al., 2010; Buist, et al., 2008; Gavin, et al., 2005; Valdimarsdottir, Hultman, Harlow, Cnattingius, & Sparen, 2009). The consequences of which, can have a detrimental impact on the health and well-being of the woman, her partner and the newborn infant (beyondblue, 2012; Perinatal Mental Health Consortium, 2008).

Postnatal depressive symptoms affect a significant number of women giving birth in Australia. Buist and associates (2008), nationwide survey of postnatal women (n=12,361) found that between 5.6% to 10.2% scored more than 12 on the Edinburgh Postnatal Depression Scale (EPDS) which was indicative of a high likelihood of depression. The rates varied between States and Territory and between the public or private health care sector. Women in the public sector were identified as more likely to have a higher EPDS and associated lower incomes and educational levels (p. 66). More recently Austin et al. (2010) have confirmed these findings, indicating that depressive and anxiety disorders are prevalent amongst Australian postnatal women. In their study, antenatal women (n=1549) were recruited from the Royal Hospital for Women in New South Wales and underwent assessment for depressive and anxiety disorders in late pregnancy and again at two, four and six-eight months after birth. Assessment measures implemented were the EPDS, an 'interval symptom question' to detect feelings of sadness and the psychiatric assessment tool, Composite International Diagnostic Interview (CIDI), for women who scored an EPDS of more than 12 and/or a positive response for the 'interval question'. Austin et al. reported that 20.4% of these women had an anxiety disorder (approximately two thirds with comorbid depression) and almost 38% of women with a major depressive episode had a comorbid anxiety disorder (2010, p. 395).

Studies conducted internationally have similarly reported significant rates of mental health disorders in women in the perinatal period. The meta-analysis of 28 international studies undertaken by Gavin et al. (2005) indicates that minor and major depression are prevalent both antenatally and postnatally in developed countries. Gavin et al. reviewed 28 studies that assessed women for depression during pregnancy or the first year postpartum and reported that the combined point prevalence estimates from the meta-analysis ranged from 6.5% to 12.9% (1.0% to 5.6% for major depression alone) at different trimesters of pregnancy and in the first year after birth. The combined period prevalence showed that as many as 19.2% of women had a depressive episode during the first 3 months postpartum (2005, p. 1071).

Contrary to previous thinking on this subject, pregnancy does not protect women against distress, mental illness or suicide (Cohen et al., 2006; Giardinelli et al., 2012; Priest & Barnett, 2008). In America, Cohen et al. (2006) naturalistic inquiry followed 201 women with a pre-existing history of major depression through their pregnancy to determine the risk of relapse in those who elected to stop antidepressant medication. Amongst this cohort, of the 82 women who maintained their medication, 21 (26%) relapsed compared with 44 (68%) of the 65 women who discontinued medication (p. 499). Cohen et al. found that women who discontinued medication were significantly more at risk of relapsing more frequently over the course of their pregnancy. These authors concluded that pregnancy was not a protective factor against a major depression relapse. Likewise in Italy, 590 women between 28th and the 32nd gestational weeks were recruited and submitted to a socio-demographic, obstetric and psychological review to determine the prevalence and risk factors for perinatal depression and anxiety. Antenatal depressive and anxiety symptoms were found to be as common as postnatal symptoms. In summing up Giardinelli et al. (2012) argued strongly that early identification and treatment of perinatal affective disorders was critical in preventing the escalation of more serious consequences for both mothers and their children (p. 21).

Anxiety disorders in pregnancy have been reported to be as common as depressive disorders (Matthey, Barnett, Howie, & Kavanagh, 2003; Miller, Pallant, & Negri, 2006). Results from the Australian study conducted by Matthey et al. (2003), suggest that there is a need to assess for both depression and anxiety in new and expectant parents to avoid perinatal mental health disorders being undetected/untreated. In their survey of first time parents (women n=408, men n=356), women were recruited antenatally and both the woman and her partner were interviewed six weeks postpartum using the Diagnostic Interview Schedule, to determine the presence of depression, panic disorder, acute adjustment disorder with anxiety and phobia. The inclusion of the diagnostic assessment for panic disorder and acute adjustment disorder with anxiety as an adjunct to self-report measures such as EPDS increased the rates of detection for minor depression between 57-100% for women and 31-130% for men (p. 139). Matthey et al. concluded from these results that new and expectant parents should be assessed

for both depression and anxiety disorders in order to more accurately reflect the significant adjustment difficulties they encounter in the perinatal period. Some three years later similar results were elicited by Miller et al. (2006). In their cross-sectional study, the EPDS and Depression Anxiety Stress Scales (DASS-21) were used to assess the prevalence of depression and anxiety disorders in 325 Australian primiparous mothers between six weeks to six months postpartum. Miller et al. (2006) reported that the inclusion of the DASS-21 to broaden the criteria for distress resulted in a further 33 (10%) women being identified with symptoms of anxiety and stress without depression. Forty-one (13%) had symptoms of anxiety either in isolation or in combination with depression and 7% of the sample were identified as being both anxious and depressed. The prevalence of anxiety and stress in this sample, points to the importance of assessing postnatal women for broader indications of psychological morbidity than that of depression alone.

Poor maternal mental health can have significant ramifications for the health and well-being of the woman her infant and her family (beyondblue, 2012). The following section of this chapter will discuss some of these consequences in relation to maternal morbidity and mortality and the impact on her partner and newborn infant.

Consequences of poor mental health outcomes

Undetected and/or untreated emotional disorders in the perinatal period can have devastating and long-term effect on the health and well-being of women and their families. Consequences of depression and related disorders during this time have been the topic of much discussion in the literature and have some bearing on the morbidity and mortality of the women in the perinatal period (Austin, Kildea, & Sullivan, 2007; Lewis, 2007), the decisions made about future pregnancies (Nerum, Halvorsen, Sørlie, & Øian, 2006; Söderquist, Wijma, & Wijma, 2006), the likelihood of paternal mood disorders (Matthey, et al., 2003; Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006) and some adverse effects on infant development (Cornish et al., 2005; Milgrom, Westley, & Gemmill, 2004). The association of perinatal emotional disorders with such significant health related outcomes necessitates the need for further discussion.

Morbidity and mortality

Mental health disorders have been identified as a leading cause of maternal morbidity and mortality in the United Kingdom (UK) (Lewis, 2007) and as one of the leading causes of indirect maternal mortality in Australia (Austin, et al., 2007). In the UK a public enquiry into the causes of maternal deaths during 2003 to 2005, identified that out of more than two million women who gave birth during this period, 295 died from causes directly or indirectly related to their pregnancy. Of these over half, 163 (55%), died of underlying medical or psychiatric causes such as heart disease or severe depression aggravated by their pregnancy (Lewis, 2007, p. 3). Likewise, Austin et al. (2007) Australian assessment of maternal deaths relating to psychiatric morbidity in the perinatal period (1997 to 2002) identified maternal mental illness as one of the leading causes of indirect maternal death in the perinatal period, with the majority of deaths occurring by violent means (p. 366).

Concerns for the mortality of women with perinatal mental health disorders have been similarly reported in discussions on puerperal psychosis (Posmontier, 2010; Valdimarsdottir, et al., 2009). According to Priest and Barnett (2008) puerperal psychosis, although rare, constitutes a psychiatric emergency. This mental illness is often florid, acute, usually occurs in the first three weeks postpartum if not prior to birth and carries a high risk of survival for both mother and infant (p. 30). Likewise the Swedish study conducted by Valdimarsdottir et al. (2009) reported that puerperal psychosis can have enormous negative implications for the mother and her newborn infant such as repeated episodes of psychoses and subsequent hospitalisation, increased risk of self-harm or suicide and infanticide. In their study using proportional hazard regression models, Valdimarsdottir et al. sought to identify the incidence of puerperal psychosis in first-time mothers (n=745,596) who had no previous history of psychiatric hospitalisation. They reported that within the first 90 days after delivery 1.2 per 1000 births were hospitalised due to psychoses and of these 0.6 per 1000 births had not previously been hospitalised for any psychiatric disorder (2009, p. 194).

Other studies on mental health disorders have suggested that the presence of anxiety and agitation may serve as a marker or risk factor for suicide in depressed patients. In America for example, Rivas-Vazquez and associates (Rivas-Vazquez, Saffa-Biller, Ruiz, Blais, & Rivas-Vazquez, 2004) discussion on anxiety and depressive disorders, reported that comorbid depression and anxiety tend to manifest more severe symptoms, exhibit less favourable treatment responses and are at increased risk of suicide (p. 77).

Impact on future pregnancies

Poor mental health outcomes following a perceived traumatic birth experience can result in women expressing fear of childbirth and avoiding vaginal births in the future. Studies have identified that women experiencing such events may be at risk of developing posttraumatic stress disorder (PTSD) (Beck, 2004; Fenwick, Gamble, & Hauck, 2006; Nerum, et al., 2006; Söderquist, et al., 2006). Posttraumatic stress disorder is an anxiety problem that may develop in some people following exposure to an extremely traumatic event. People with PTSD may relive the event via intrusive memories, flashbacks and nightmares; avoid anything that reminds them of the trauma; and have anxious feelings they didn't have before that are so intense their lives are disrupted (American Psychological Association, 2012).

Beck (2004) descriptive phenomenology study involving 40 mothers who had perceived their birth as traumatic, found that women believed their traumatic births were often viewed as routine by clinicians. She reported that the prevalence of PTSD after childbirth ranges from 1.5% to 6% (p. 28), that birth trauma lies in the eye of the beholder and clinicians should treat every woman as though she were a survivor of a previous traumatic experience. Likewise, Söderquist (2006) questionnaire to assess the presence of PTSD in 1224 Swedish women in pregnancy and again at one, four, seven and eleven months postpartum, reported that 37 (3%) had PTSD at least once in one to eleven months postpartum, of these 24 (65%) also developed depression. They identified that women with severe fear of childbirth, previous counselling or history of self-reported psychological problems related to pregnancy were considered at risk of developing PTSD postpartum (p. 113).

The work of Nerum and associates (2006) in Norway indicates that impending birth can activate previous traumatic experiences, psychiatric disorders and may give rise to fear of vaginal birth. In their survey of 86 women with a fear of childbirth and planned caesarean delivery, they reported that women's fear of vaginal birth was accompanied by extensive psychosocial problems. Nerum et al. (2006) identified that 90% of the women had experienced anxiety or depression, 43% had eating disturbances, 63% had been subjected to abuse and 24% of those with a psychiatric condition had previously been in treatment (p. 221). In Australia, Fenwick et al.'s (2006) qualitative review to describe the childbirth expectations of 49 women who had experienced an unplanned caesarean section and planned a caesarean for their subsequent delivery, identified that after having a caesarean birth women reframed vaginal birth as uncertain, unsafe and unachievable. The authors suggest that acknowledging and validating women's childbirth fears may decrease the risk of future negative consequences of caesarean birth (p. 128).

Impact on partners

Mental health disorders in the perinatal period are not confined solely to women. A small sample of studies have identified that women's partners are also susceptible to developing mental health disorders following the birth of their child (Matthey, et al., 2003; Munk-Olsen, et al., 2006). In their previously cited assessment for both depression and anxiety in new and expectant parents in Australia, Matthey et al. (2003) noted that the inclusion of the diagnostic assessment for panic disorder and acute adjustment disorder with anxiety, increased the rates of detection for minor depression for men (n=356) in their study. Likewise, the international report by Munk-Olsen et al. (2006) on postpartum mental disorders necessitating hospital or outpatient admissions for Danish parents during the first year postpartum, found that 658 men in their sample (n=547,432) were admitted with a mental disorder to a psychiatric hospital during the first 12 months of parenthood. The corresponding prevalence of severe mental disorders for the male participants through the first three months after childbirth was reported as 0.37 per 1000 births (p. 2582).

Impact on infants

Maternal perinatal mental health disorders are reported to have adverse consequences for their infants, including impaired cognitive and psychomotor development (Cornish, et al., 2005; Grace, Evindar, & Stewart, 2003; Halligan, Murray, Martins, & Cooper, 2007; Milgrom, et al., 2004). Priest and Barnett's discussion on infants of parents with mental illness, reported that adaptive brain development, including buffering of stress responses, is promoted by secure attachment based around sharing of positive emotional states, regulation of arousal and attunement between mother and infant (2008, p. 31). This opinion supports the earlier work conducted in Australia by Milgrom et al. (2004). In their investigation into the effects of maternal depression (n=40 depressed, n=48 non-depressed) on infant interactions and development over a 42 month period postpartum, Milgrom et al. (2004) identified mother-infant interactions were impaired at six months in the depressed group. For these children, subsequent cognitive deficits were also identified at 42 months. The authors concluded from these results that early disturbances of mother-infant interaction will mediate some developmental deficits in children of depressed mothers (p. 443). Similarly, a study examining the impact of brief and chronic depression in mothers (n=112) on their child's development at 12 and 15 months of age, identified that chronic maternal depression lasting throughout the first 12 months and beyond was associated with lower infant cognitive and psychomotor development (Cornish, et al., 2005, p. 407).

Studies conducted internationally have similarly reported adverse effects of maternal depression on children's development. In Canada, Grace et al. (2003) literature review of studies conducted on postpartum depression (PPD) and associated child cognitive behaviour and development between 1990 and 2003 (n=7 cognitive, n=6 behavioural), identified that the strongest effects of PPD appear to be on cognitive development such as language, intelligence and Piaget's object concept tasks (p. 274). Likewise, in the UK, Halligan et al. (2007) 13 year longitudinal study investigating maternal depression and psychiatric outcomes in adolescent offspring, found adolescents exposed to maternal postnatal depression (PND) showed elevated rates of affective disorder by 13

years of age. In their study comparing adolescents exposed to PND (n=53) with those who were not exposed (n=41), they identified maternal depression was only associated with increased risk of depression in offspring if there had been later episodes of maternal depression. In contrast, anxiety disorders in offspring were elevated in the maternal depressed group regardless of the occurrence of subsequent maternal depression (p. 145).

As a result of the significant body of evidence identifying and acknowledging the risk, prevalence and subsequent consequences of perinatal mental health disorders for women, inquiry into the care they receive at this time has drawn much attention in the literature.

Postnatal care: Not always a satisfying experience for women

The puerperium or postnatal period is defined as a period of six weeks which begins after the expulsion of the placenta at birth (Bennett & Brown, 1993, p. 233). In Australia, like many other resource rich countries, the majority of postnatal care is generally provided by registered midwives. Contemporary postnatal care within the Australian hospital context is characterised by a short length of stay and information intense content for women (McLachlan, Forster, Yelland, Rayner, & Lumley, 2008; Rayner, Forster, McLachlan, Yelland, & Davey, 2008). Following an uncomplicated delivery, women will typically remain in hospital for a period of one to two days post vaginal birth and four days following a caesarean section. McLachlan et al. (2008) reported that despite the length of hospital stay for postnatal women steadily declining over the years, care providers still attempt to deliver a large amount in relation to information, advice and observations during this time. In their Australian survey of the postnatal services provided at 71 public hospitals in Victoria, McLachlan et al. (2008) identified that care was often provided in busy, at times chaotic environments with limited continuity of care making it difficult for staff to provide effective practice. Another Victorian study conducted around this time confirmed these findings and reported that clinical midwives and managers (n=33) perceived limited time, shorter hospitalisation time, busyness of postnatal wards and inadequate midwife-woman ratios

as factors that impacted on their ability to provide women effective postnatal care (Rayner, et al., 2008).

Women consistently report feeling less satisfied with this aspect of their childbirth experience. Nationally, a large retrospective survey of women's views and experiences of postnatal care (n=1616) reported that only 51% of women rated their postnatal care in hospital as 'very good'. The factors that most contributed to a good experience for these women were interactions with caregivers that were perceived as sensitive, understanding, helpful and not hurried (Brown, et al., 2005). In a comparative, albeit smaller (n=365) self-report questionnaire evaluating the differences in postnatal support of Australian multiparous and primiparous women two weeks after birth, found that there was room for improvement in all areas of midwifery practice for both groups of women during the postnatal period. The factors identified as needing to improve by these women were in relation to the health and well being of mothers, the provision of emotional support and the provision of an environment that is conducive to rest (Cooke & Stacey, 2003).

Reports of women's dissatisfaction with postnatal care are not confined to Australia, with similar findings being reported in studies conducted internationally. In Sweden for example, a large longitudinal survey of women (n=2783) conducted at three time points; early pregnancy, two months and one year postpartum sought to identify women with negative opinions of their postnatal care. Altogether 150 women reported negative comments about their postpartum experience which included lack of opportunity to rest and recover, and difficulty obtaining individualised information and breastfeeding support (Rudman & Waldenström, 2007). Some four years later on and the work by Hildingsson and Sandin-Bojö (2011) reported that Swedish women were more likely to be satisfied with intrapartum than postpartum care. They surveyed 1240 women who were recruited in mid-pregnancy and followed up two months after childbirth. These authors identified that women in the traditional postnatal wards, 'hotel ward' (family suites for uncomplicated births) and those who had co-care on neonatal wards reported

deficient care in all studied variables and overall indicated a lack of satisfaction with the postnatal aspects of the care provided.

Women have an expectation that midwives will assist their transition into motherhood in the postpartum. In the Netherlands, qualitative work exploring 21 pregnant women's preferences for psychosocial support identified that postnatally women explicitly expressed a need for professional, informational and emotional support from midwives in their transition to motherhood. Women in this study had an expectation that midwives would provide reassurance, companionship and take a real interest in their needs and wishes, but found that this was not always the case (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). Likewise, Bayes and associates (2008) qualitative study of 141 women's accounts of labour and birth in Western Australia, identified three elements of equal importance in women's ability to reach a sense of resolution after a disappointing or traumatic birth experience in the postpartum. These were; one, time to assimilate unexpected events as they occurred; two, being vindicated or absolved of any sense of responsibility for what happened by people they respected; and three having the opportunity to talk about their experience postpartum. All three were considered priorities by these WA women (p. 59).

Despite these expectations, the emotional care of women during their early transition to motherhood has been singled out for improvement (Rowan, Bick, & Bastos, 2007; Yelland, McLachlan, Forster, Rayner, & Lumley, 2007). There is an increasing body of evidence that consistently reports deficiencies in the provision of women's emotional care postpartum. UK researchers Rowan and associates (2007) suggest that the physical aspects of midwifery care (activities and tasks) have taken precedence over emotional care in the postpartum. After exploring the gap between evidence and UK policy and practice these authors argue strongly that the extent and persistence of women's postnatal mental health issues should be a major public health concern. Likewise, 1474 Swedish parents completed a questionnaire evaluating their level of satisfaction with the postnatal care provided (Ellberg, Högberg, & Lindh, 2010). A key finding of this study was that the emotional bond between parents was not always supported by staff, with

fathers reporting being treated as an outsider. Ellberg et al. (2010) proposed that organisational shortcomings and lack of attention to postnatal care resulted in the importance of emotional attachment between new parents being neglected.

Similar trends have also been identified in Australia. Yelland and associates (2007) survey evaluating how 66 publicly funded maternity units assessed and promoted women's psychosocial health postpartum, identified that there was diversity in assessment practices with care being neither individualized nor woman-centered. The authors reported that physical checks were more common than enquiring about how women felt. In addition they noted there was a reliance on women with psychosocial issues being detected and managed in the antenatal period, resulting in this aspect of care being less of a priority in the postpartum. A large cross-sectional survey undertaken in Western Australia has highlighted similar issues (Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010). Some 2699 women were asked their perceptions of midwifery care in the early postnatal period. While women were generally happy with the practical aspects of in hospital care they were less satisfied with the emotional support they received (p. 11).

One of the landmark studies that alerted maternity services providers to the extent of the problem was the work of Creedy and associates (2000). These researchers were the first to explore and determine the incidence of acute trauma symptoms in a population of Australian postnatal women (n=499). They identified that women who perceived their support person to be disappointed and/or not wanting to talk about the birth were more likely to be dissatisfied with childbirth and report distress. Alarmingly, Creedy et al. also found that one in three women (33%) identified birth as traumatic and reported the presence of at least three trauma symptoms. In her more recently published work with Gamble these authors have been highly critical of the emotional care provided by midwives to women stating that "postpartum women are rarely afforded opportunities to work through feelings associated with childbirth experiences" (2009, p. 23).

As a result of the identified deficiencies in the emotional care provided to postnatal women, Gamble, in collaboration with Creedy and others, developed a midwife-led

counselling intervention to minimise psychological distress in childbearing women (Gamble & Creedy, 2009). This counselling intervention forms the basis of the NHMRC funded randomised control trial PRIME of which a full description is provided in chapter one of this thesis. In the following section, the development of and pilot test that preceded the NHMRC backed trialling of this counselling intervention is described.

The development of a postpartum counselling model

Gamble and associates identified a need for further research that investigates, develops and tests postpartum counselling strategies to inform midwifery practice and improve the emotional outcomes of women who have experienced a traumatic birth (2009). Studies to date have indicated that some women report trauma symptoms and may develop PTSD following childbirth (Creedy, et al., 2000). Indeed, these authors suggest that the experience of birthing trauma carries the potential risk of intensifying into PTSD unless early and effective measures are implemented (Gamble & Creedy, 2009). Despite midwives being criticised for providing ineffective emotional support to women in the postpartum, Gamble and Creedy suggest midwives are indeed well placed to understand and respond to childbearing women who have experienced a distressing birth and have the potential to play a pivotal role in facilitating their emotional recovery (2009).

In their earlier work investigating debriefing or non-directive postpartum counselling, Gamble and others identified that there was little systematic research into early interventions to reduce acute stress response disorders in women who had experienced a distressing birth (Gamble, Creedy, Webster, & Moyle, 2002). These authors were highly critical of the studies conducted to date on postpartum counselling interventions to ameliorate acute stress disorders in women. In their evaluation, they reported that the results of the investigations reviewed were inconclusive, should be regarded with caution and lacked sufficient detail to replicate. Further, they suggest that despite debriefing being intended to prevent acute stress reactions and PTSD, no study had screened for trauma responses in women as an inclusion criteria and several had cited depression as the main outcome measure (Gamble, et al., 2002).

Gamble et al. suggest early psychological intervention using two or more sessions to reduce symptoms of psychological trauma may result in more positive emotional outcomes for postnatal women (Gamble & Creedy, 2009). With this in mind, they developed and trialled a midwife-led counselling intervention for women reporting a traumatic birth experience. As part of developing this intervention they conducted focus group interveiws (with postpartum women and midwives), a critical literature review of postpartum counselling strategies and pilot test of the model in a randomised control trial. A brief description of the strategies employed in the development of this intervention and the key elements involved to implement this model will now be provided.

Focus group interviews with women and midwives

In the development of the midwife-led counselling intervention, focus group interviews were conducted with both women and midwives to identify and compare their views of counselling strategies that may facilitate women's recovery following a traumatic birth.

In their focus group interviews with women, Gamble and associates recruited six English speaking participants who had given birth within three years preceding the time of the study, were over 18 years of age and identified they had experienced a traumatic birth (Gamble, Creedy, & Moyle, 2004b). The authors reported that the women's experience of trauma was related to a sense of loss, feelings of failure and self-blame, anxiety and fear, lack of control, and feeling betrayed by those in whom they had placed their confidence during their birthing experience. Four main themes were identifed in this study as helpful for the women's emotional recovery following their traumatic expeirence. These themes were; opportunities to talk about the birth, developing an understanding of events, reviewing the labour management and discussing future childbearing to alleviate their sense of fear (Gamble, et al., 2004b, p. 14).

Two focus group sessions with midwives (n=16) were then organised and conducted one month apart (Gamble, Creedy, & Moyle, 2004a). In the first group, midwives were provided with a brief summary of factors contributing to and symptoms of

psychological trauma following childbirth. In addition, they were provided with a copy of the American Psychiatric Association diagnostic criteria for PTSD (Appendix A). Participants were then asked to identify strategies they believed would reduce women's emotional distress. Midwives in the second focus group session, were provided with the opinions obtained from the six women interviewed in the previously cited study (2004b). Gamble et al. suggest that this allowed the midwives in this group to reflect and expand on the discussion and confirm the themes previously identified by the women.

The findings reported in this qualitative inquiry indicate that midwives in both groups unequivocally supported debriefing for women following a traumatic birthing experience. Furthermore, three main themes were identified as strategies that may help women to recover from such events. These themes were; opportunities to talk about the birth, developing an understanding of events and minimise women's feelings of guilt (Gamble, et al., 2004a, p. 18). In light of these results, Gamble and Creedy then conducted a critical review of the literature to identify 'best practice' in postpartum counselling strategies (Gamble & Creedy, 2004).

Gamble and Creedy's critical literature review of postpartum counselling techniques

In a critical review of the literature, Gamble and Creedy sought to identify and examine common content and processes of postpartum counselling interventions that addressed women's trauma symptoms following childbirth (Gamble & Creedy, 2004). Nineteen publications that described postpartum counselling strategies to improve symptoms of psychological trauma in women were retrieved and evaluated. The authors identified several common strategies inherent within these publications. These counselling strategies were; providing women an opportunity to talk about their birth experience; allowing them to express feelings about what happened; have their questions answered; address gaps in their knowledge or understanding of events; connect the event with emotions and behaviour; talk about future pregnancies; and explore existential issues (2004, p. 213). Gamble and Creedy however were critical of the fact that many of the interventions reviewed were untested and lacked sufficient detail in the descriptions

provided to allow replication. Furthermore, they were of the opinion that some interventions may require providers to have psychotherapeutic training and therefore be unsuitable for use in the midwifery context. In light of these results, they concluded that additional research was required to develop counselling models for the use of health professionals caring for women who identify a distressing birth experience (2004, p. 213).

The postpartum counselling intervention

In the development of the midwife-led counselling intervention Kendall-Tackett and Kaufman-Kantor's conceptual model for understanding women's negative birth experiences was adapted (Kendall-Tackett & Kaufman-Kantor, 1993). Gamble and Creedy suggest this conceptual framework, unlike others, helps to explain possible triggers in the perinatal experience leading to women's perceptions of childbirth as traumatic. Understanding the cognitive processes that link events with trauma reactions, they suggest is fundamental in the development of any counselling intervention. These authors believed Kendall-Tackett and Kaufman-Kantor's model offered "an interpretive lens through which women's negative or traumatic birth experiences can be understood" (2004, p. 214). This conceptual model underpinned the development of the midwife-led counselling intervention presented in Figure 2.1 (on page 56). Following on, a brief description of the key elements in this counselling intervention are provided and were sourced from Gamble and Creedy (2009, pp. 24-28);

Key elements of counselling intervetion.	
Strategy	*Key elements of counselling intervention*
Therapeutic connection between midwife and woman.	Show kindness, affirm competence of the woman, simple non-threatening open questions about the birth, attentive listening and acceptance of the woman's perspective.
Accept and work with women's perceptions.	Prompt the woman to tell her own story, listen with encouragement but not interruption.
Support the expression of feelings.	Encourage expressions of feeling by open questions, actively listening, reflecting back the woman's concerns.
Filling in the missing pieces.	Clarify misunderstandings, offer information, answer questions realistically and factually, ask questions about key aspects to check understanding. Do not defend or justify care provided.
Connect the event with emotions and behaviours.	Ask questions to determine if the woman is connecting current emtoions and behaviours with the traumatic event(s). Acknowledge and validate grief and loss. Gently challenge and counter distorted thinking such as self-blame and a sense of inadequacy. Encourage the woman to see that inappropriate or hasty decisions may be a reaction to the birth.
Review the labour management.	Ask if the woman felt anything should have been done differently during labour. Offer new or more generous or accurate perceptions of the event. Realistically postulate how certain courses of action may have resulted in a more positive outcome. Acknowledge uncertainty.
Enhance social support.	Initiate discussion about exisitng support networks. Talk about ways to receive additional emotional support. Help the woman understand that her usual support people may be struggling with their own issues.
Reinforce positive approaches to coping.	Reinforce comments by women that reflect a clearer understanding of the situation, plan for the way forward or outline positive action to overcome distress. Counter oblique defeatist statements.
Explore solutions.	Support women to explore and decide upon potential solutions, e.g., support group(s), further one-to-one counselling, seeking specific information, accessing the complaint system.

Figure 2.1: Key elements of a postpartum counselling intervention (Gamble & Creedy, 2009, p. 25)

Therapeutic connection between midwife and woman

Prior to any direct questioning or discussion about the birth, midwives should display gestures of kindness and understanding. This is believed to help women feel less isolated and demonstrates that assistance is available and willingly offered.

Accept and work with women's perceptions

A woman's perception of what has gone wrong is at the core of her distress. Midwives should allow women to tell their story without interruption and demonstrate interest in their account of events.

Support the expression of feelings

Midwives are encouraged to ask women open questions that allow them to express their feelings. Helping women to verbalise their feelings to a supportive and knowledgeable listener is believed to facilitate emotional catharsis and reveals the depth and breadth of her emotional response to events surrounding birth.

Filling in the missing pieces

Telling the birth story provides opportunities to clarify misunderstandings, offer information and answer women's questions. Clarifying aspects of the birth for women is considered crucial for them to move on as opposed to them searching memories in attempt to make sense of what went wrong. Midwives should answer women's questions realistically, factually and not defend or justify the care provided.

Connect the event with emotions and behaviours

Helping women to connect emotions and behaviours with the events that occurred during the birth is considered an important task for midwives in the counselling process. Acknowledging and validating grief and loss is considered difficult for women in a society that devalues the birth experience. Open enquiring questions will help to determine if the woman in connecting current emotions and behaviours with a traumatic event. Midwives should gently challenge and counter any distorted thinking such as

self-blame or sense of inadequacy and help women gain a more manageable perspective of what has occurred. Encouraging woman to see that inappropriate or hasty decisions may be a reaction to the birth is another aspect of this intervention and midwives should support women to work through other possible alternatives.

Review the labour management

Distressed women need to gain a rational understanding of events in order to progress from a point where they can recount their experiences and feelings to a more fully informed or broader perspective of the birth. Many women have clear insights about their birth experience. Midwives should ask if there is anything the staff could have done differently to indicate to the woman that she is competent and her assessment of the experience is valued. Women should be encouraged to realistically postulate how other certain courses of action may have resulted in a more positive outcome. This is considered essential to women maintaining a sense of control and faith that the world is manageable and predictable enough to plan, especially in relation to future pregnancies.

Enhance social support

Regaining usual competence following a crisis is enhanced by the availability of interpersonal and social support. Midwives are encouraged to initiate discussion with women about their existing support networks and how they may receive additional emotional support. It is important to help women to understand that her usual support people may be similarly struggling with their own issues.

Reinforce positive approaches to coping

Postpartum counselling builds on the assumption of client competence by reinforcing comments that reflect a clearer understanding of the situation, plan for the way forward, or outline positive action to overcome distress. Midwives are encouraged to counter oblique defeatist statements made by women.

Explore solutions

Long-term solutions to restore self-confidence, reduce anxiety and facilitate healing lie with the women. Midwives need to encourage women to explore and decide upon potential solutions that may consist of further counselling, seeking specific information or accessing the complaint system available where they birthed.

Pilot testing the counselling intervention

Gamble and associates conducted a randomised control trial to evaluate the effectiveness of the midwife-led counselling intervention (Gamble, et al., 2005). Women were recruited in the last trimester of their pregnancy from antenatal clinics of three maternity hospitals in Australia between April 2001 and February 2002. Some 348 women were screened for trauma symptoms 72 hours following birth using Criterion A of DSM-IV-TR for posttraumatic stress disorder (American Psychiatric Association, 2000) and those who met this criterion were randomised for this trial (intervention n=50, control n=53). The intervention group received face-to-face counselling within 72 hours of birth and again via telephone at four to six weeks postpartum. At the three month follow up, PTSD total symptom scores were reduced for women in the intervention group, as were stress symptoms. All women in the intervention group reported high or very high satisfaction with the counselling intervention. Furthermore, confidence about future pregnancies was higher for these women than for those in the control group. The authors also identified that women in this study were more able to process events surrounding the birth at four to six weeks postpartum rather than immediately after birth (2005, p. 11). These promising results led the authors to seek and successfully obtain NHMRC funding to trial this midwife-led counselling intervention in the larger randomised control trial PRIME.

Summary

It is evident from the body of work presented that perinatal mental health disorders are considered a health priority worldwide. Midwifery research investigating ways to positively impact on practice in this area and improve the health outcomes for women, their newborn infants and family is therefore imperative. The study presented in this thesis took the opportunity to follow the midwives involved in implementing the midwife-led counselling intervention in a large NHMRC funded randomised control trial. The evidence gained from this study will contribute to a programme of work aimed at identifying and implementing initiatives to improve the emotional health outcomes of women in the perinatal period and enhance the standard of midwifery services provided.

In the following chapter, the research paradigm and methodology employed to explore and describe midwives' experiences of being research assistants who not only recruited participants but also randomised and delivered a newly learned counselling intervention to distressed postnatal women in the NHMRC backed PRIME project is presented.

Chapter 3

Finding the way: Exploring and describing midwives' experiences

Introduction

This chapter presents how a study of 18 midwives' experience of participating in a randomised control trial and delivering a counselling intervention to distressed postnatal women was conducted using a qualitative descriptive exploratory methodology. The discussion commences by providing an overview of the naturalistic and positivist paradigms and rationale for the qualitative approach used in this study. This is followed by an explication of the researcher's attitudes and beliefs. The research objectives are then identified and the approach is outlined under the conventional headings of study setting, participant sampling and recruitment, data collection and data analysis. Finally, the chapter concludes with a description of the measures taken to ensure trustworthiness and the ethical procedures and considerations undertaken.

Naturalistic and positivist paradigms

Naturalistic investigations are deeply rooted in the descriptive modes of science and focus on the understanding of human experiences as they perceive them (Hesse-Biber & Leavy, 2006; Polit & Beck, 2010; Streubert Speziale & Carpenter, 2007). Naturalistic inquiry however has not always been embraced by the scientific community. Originally, human scientists relied upon applying an objective reality to describe human thought and behaviour. If objective measurement could not be assigned to a phenomenon the importance and thus the existence of the phenomenon was questioned by empirical scientists. In particular, Descartes view that cause and effect could explain all things in science was long regarded as the only approach to new knowledge (Streubert Speziale & Carpenter, 2007). In the 18th-century however, Kant put forward the idea that

perception was more than an act of observation and that reality could not simply be explained by Descartes rationale of 'cause and effect'. Kant's philosophical view point emancipated science, with later existentialists advancing to explore reality as it is perceived rather than simply as an observed phenomenon. As a consequence the foundations of the qualitative paradigm were established (Streubert Speziale & Carpenter, 2007). An overview of these two research paradigms is now provided.

Positivist paradigm

A fundamental assumption of the positivist paradigm is that nature is ordered, regular and exists independent of human observation (Polit & Beck, 2006). In their pursuit of empirical knowledge, supporters of the positivist paradigm strive for objectivity and typically conduct quantitative inquiries to investigate phenomenon of interest. Quantitative research generally imposes tight controls to protect objectivity of the study, minimise biases and maximise precision and validity. Empiricists believe studies void of controls to protect objectivity lack rigor and are unable to generate results that can be generalised. This approach to acquiring knowledge has been fundamental in the field of biological sciences for example, and has resulted in the generation of evidence that has improved the medical management of many human physical conditions (Hesse-Biber & Leavy, 2006; Polit & Beck, 2010; Streubert Speziale & Carpenter, 2007).

When investigating psychological human phenomena however subjectivity comes into play and there is much debate about the relative value of information that is derived from a purely objective standpoint. Streubert Speziale and Carpenter (2007) suggest the problem with this position is that researchers as well as those being studied think and act based on their subjective interpretations of the world. With this in mind, a naturalistic approach to inquiry is therefore important for researchers who want to gain insight into what people think and why they behave in the ways that they do (Minichiello, Aroni, Timewell, & Alexander, 1995).

Naturalistic paradigm

In contrast to the positivist approach, followers of the naturalistic paradigm believe that there are multiple realities (perspectives) to consider when seeking an understanding of a human phenomenon (Polit & Beck, 2010). In their pursuit of knowledge, researchers typically conduct qualitative inquiries and embrace the idea of subjectivity. They recognise that humans are incapable of total objectivity and are indeed influenced by their subjective experiences (Streubert Speziale & Carpenter, 2007). Qualitative inquiries therefore attempt to understand the human experience by collecting and analysing data that are usually narrative and subjective in nature (Hesse-Biber & Leavy, 2006; Polit & Beck, 2010; Streubert Speziale & Carpenter, 2007). Unlike the positivist approach that aims to minimise contamination of data through personal involvement with participants, 'researcher as instrument' is often a characteristic of the qualitative approach. The participants' experiences are the study's findings and are often reported in a rich literary style. Streubert Speziale and Carpenter (2007) suggest that qualitative researchers emphasise six significant characteristics in their research. These characteristics are reported as (1) a belief in multiple realities; (2) a commitment to identifying an approach to understanding that supports the phenomenon studied; (3) a commitment to the participant's viewpoint; (4) the conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest; (5) acknowledged participation of the researcher in the research process; (6) the reporting of the data in a literary style rich with participant commentaries (p. 21).

In summing up, both qualitative and quantitative research is important in the development of knowledge in relation to human phenomena. Streubert Speziale and Carpenter (2007) suggest that it is up to the researcher to clearly identify the focus of their inquiry and then choose the method that will most effectively answer the question. These authors offer a comparison of qualitative and quantitative research methods which is provided in Figure 3.1 (on page 64).

Comparison of Quantitative and Qualitative Research Methods	
Quantitative	*Qualitative*
Objective	Subjectivity valued
One reality	Multiple realities
Reduction, control, prediction	Discovery, description, understanding
Measurable	Interpretative
Mechanistic	Organismic
Parts equal the whole	Whole is greater than the parts
Report statistical analysis	Report rich narrative
Researcher separate	Researcher part of the research process
Subjects	Participants
Context free	Context dependent

Figure 3.1: A comparison of quantitative and qualitative research methods: In Streubert Speziale and Carpenter (2007, p. 20).

In the study outlined in this thesis, careful consideration of the intended objectives led the researcher to choose a qualitative descriptive exploratory design. A rationale for using this approach will now be presented.

Choosing a qualitative descriptive exploratory approach

The researcher in this study was interested in developing a better understanding of two phenomena. Firstly, what it was like for midwives to participate in a large team-based research project and secondly, what it was like for them to learn and deliver a midwife-led counselling intervention to distressed postnatal women. Both of which are inadequately reported on in the literature. Polit and Beck (2006) suggest descriptive approaches to research are chosen if the phenomenon is inadequately defined or conceptualised. Furthermore, these authors recommend researchers employ an exploratory approach if the full nature of the phenomenon and other factors to which it is related is the aim of the inquiry (p. 21). With this in mind, the researcher in this study elected to use a qualitative descriptive exploratory methodology to seek information on the phenomena of interest.

Qualitative descriptive exploratory methodology has its foundations in the naturalistic paradigm. This approach was chosen because it is regarded as the method of choice when straight description of phenomenon is desired (Sandelowski, 2000). As its name suggests, the purpose of qualitative descriptive exploratory methodology is to explore and describe a phenomenon of interest. Qualitative researchers use in-depth methods to describe the dimensions, variations and importance of phenomenon (Polit & Beck, 2010). According to Sandelowski (2000), qualitative descriptive designs are arguably the least 'theoretical' of all the qualitative approaches to research and typically incorporate an eclectic combination of methods in the design (p. 337). However, this freedom to carefully select methods of data collection and analysis provides the researcher with an opportunity to gain a rich description of how the participants perceive events within their social context (Sandelowski, 2000). Through description, relationships between behaviours, individuals or events can be seen and relationships between variables better understood (Burns & Grove, 2003). The exploratory nature of this approach provided the researcher with an opportunity to explore the full nature of the phenomena and other factors to which it is related rather than simply observing and describing events (Polit & Beck, 2010).

It is recommended that before commencing qualitative research it is in the researcher's best interest to make clear their thoughts, ideas, suppositions, or presuppositions about the topic, as well as any personal biases (Streubert Speziale & Carpenter, 2007). With this in mind, the process undertaken by the researcher to explicate her beliefs prior to undertaking the qualitative inquiry will now be provided.

Explicating the researcher's beliefs

A detailed description of the researcher and her reasons for undertaking this study are provided in chapter 1 of this thesis. Prior to commencing data collection however, she attempted to identify any preconceived ideas that may hinder this process. Pausing and reflecting on one's own personal beliefs of the phenomenon under study is recommended if the researcher is to approach the topic honestly and openly (Streubert Speziale & Carpenter, 2007). Taking this on board, the researcher reflected on and

wrote down all that she thought, felt and assumed as a midwife employed as a research assistant to learn and implement a counselling intervention for distressed postnatal women.

As a midwife herself for example, she thought about her experiences of caring for distressed women in practice. That she often felt a sense of inadequacy and inability to effectively care for such women and assumed they were often better referred on to other health professionals such as clinical psychologists. The thought of facing distressed women and implementing the counselling intervention therefore conjured up feelings of uncertainty, inadequacy and trepidation, knowing full well the responsibility that you have to women to 'get it right'. With this in mind, she was careful not to convey her personal thoughts/beliefs when interviewing participants for the study nor allow her opinions to influence the data analysis process and present the findings as they were described. Indeed, as a midwife with no association with the PRIME project proved to be beneficial rather than a hindrance for the researcher, for it allowed her to develop a strong rapport with the participants who openly discussed their experiences knowing she could relate to them within the midwifery context.

In the role of a research assistant working in a large randomised control trial, she assumed she would feel safe and confident knowing that the research process was being conducted by highly respected midwifery researchers. Working alongside such experienced personnel she believed would provide insight and understanding into the research process without any of the concerns in relation to setting it all up. She imagined she would feel proud to be contributing to a project that had the potential to improve the care provided to women in midwifery practice. Overall, this process of introspection to identify personal thoughts and beliefs enabled the researcher to put her assumptions aside prior to collecting data and describe the findings of the midwives' experiences openly and honestly.

Research design

The purpose of this qualitative descriptive exploratory study was to explore and describe midwives' experiences of working as research assistants in a randomised control trial as well as their experiences of learning and delivering a midwife-led counselling intervention to distressed postnatal women.

Study setting

The study was conducted in the Australian states of Queensland (QLD) and Western Australia (WA) during a 17 month period, from August 2008 to December 2009. In their role as research assistants, midwives recruited antenatal women for the PRIME randomised control trial at two hospital sites. These sites were the Gold Coast Hospital Queensland, and King Edward Memorial Hospital in Western Australia. Descriptions of these two hospitals are now provided.

The Gold Coast Hospital is located in Southport, QLD. This large public hospital has a bed capacity in excess of 500 and provides a wide range of healthcare services including coronary care, intensive care unit, dialysis, elective surgery, geriatric care, hospice, rehabilitation, psychiatrics, obstetrics and paediatrics. The maternity unit consists of 38 beds with an average of 3100 births each year. In addition to the provision of healthcare services, this hospital is also a teaching centre for both undergraduate and postgraduate midwifery students as well as undergraduate medical students.

Across the country in Subiaco WA, King Edward Memorial Hospital (KEMH) is a part of 'Women and Newborn Health Services' (WNHS) and specialises in obstetrics, psychiatrics, gynaecology and neonatology. This hospital's facilities include a 260 bed capacity and 80 cot special care nursery. As the largest public maternity hospital in the state and only referral centre for complex pregnancies, KEMH staff oversees in excess of 6000 births a year many of which are complicated, high risk cases. The hospital is also a tertiary training centre for allied health professionals, midwifery and nursing

students and undergraduate medical students. To protect the confidentiality of participants in this study the state in which they were located will be referred to as Site A or Site B.

Participant sampling and recruitment

Purposive sampling was used to recruit participants for this study. The method allowed the researcher to select individuals who had knowledge of the phenomenon of interest and could provide information rich data by reflecting and articulating their individual experiences (Patton, 1990; Polit & Beck, 2010; Streubert Speziale & Carpenter, 2007).

As the phenomena of interest were midwives' experience of working as part of a large research team and delivering a midwife-led counselling intervention to distressed women in practice, midwives employed as research assistants in PRIME were an obvious source for information.

Recruitment of midwives

All midwives employed as research assistants in the randomised control trial PRIME, were intentionally targeted for this study. Open invitations and consent to participate (Appendix B & C) were posted to the 20 midwives along with the confirmation of their appointment as a research assistant in the PRIME project. An additional open invitation and consent to participate was also sent to one midwife who planned to observe the training sessions but not work in the PRIME project (n=21). It was made clear to the midwives that participation was entirely voluntary and they could consent or withdraw from this study at any time. Moreover, all midwives were assured that their confidentiality would be maintained and their participation or non-participation would not affect their employment as a research assistant in the trial. Midwives who agreed to participate were asked to complete the written consent provided prior to the researcher telephoning/or emailing them to arrange an interview.

Participant profile

All twenty-one midwives that were approached consented to participate in this study. Of these midwives, 10 were located at site A and 11 at site B. One midwife located at site B, withdrew her participation from this study prior to being interviewed citing "lack of time" but continued on in the randomised control trial. Two midwives from site A did not respond to the researchers' telephone or email requests for an interview and also withdrew their participation from the PRIME project. The remaining eighteen midwives contributed to this study in varying degrees.

All the midwives were female, aging from 26 to 59 years with a mean of 13 years clinical experience in midwifery. Seven midwives were trained in the tertiary sector while the remaining eleven were educated in a hospital-based midwifery programme.

Of the eight midwives located at Site A, one was an observer only at the training sessions and did not work as a research assistant in the PRIME project. Three withdrew their participation from PRIME (one withdrew by three months and a further two by eight months) and four remained until the end of the randomised control trial. Of the ten midwives located at Site B: One withdrew from PRIME before training commenced. Eight withdrew their participation from PRIME (six by five months and a further one by ten months) and two midwives remained until the end of the PRIME project.

A summary of the participant profile of the 18 midwives that contributed to this study is provided in Figure 3.2 (on page 70). Included in this participant profile is information on the midwives location in Australia (Site A or Site B), their source of midwifery education (hospital-based 'H' or tertiary 'T'), history of previous experience in a research project (□), age and years of midwifery clinical experience (CE). The shaded area represents the length of time these 18 midwives participated in the randomized control trial PRIME.

						PRIME training/ obtaining counselling competency			Recruiting for PRIME & implementing telephone counselling/ parenting advice										End of PRIME project	
						Project month														
				Age	CE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Midwives: Site B Midwifery education: **H** = Hospital based, **T** = Tertiary based **CE** = Years of midwifery clinical experience	Ann		H	47	16																
	Beth		T	30	2																
	Carol	□	H	46	12																
	Dana	□	T	26	4																
	Elaine	□	T	38	3																
	Fran		H	59	8																
	Gill		H	54	32																
	Helen	□	H	57	37																
	Joan	□	T	43	10																
	Violet	□	T	30	6																
Midwives: Site A Midwifery education: **H** = Hospital based, **T** = Tertiary based **CE** = Years of midwifery clinical experience	Lucy		H	48	15																
	Mary		T	43	3																
	Nicole		H	38	15																
	Olive	□	H	44	12																
	Pam		T	-	8																
	Quinn		H	40	16																
	Rachel		H	43	16																
	Tania		H	41	17																

Figure 3.2: Participant profile.

Midwives site location, previous experience in a research study (□), source of midwifery education, age, years of midwifery clinical experience and timeline of their participation in the PRIME project (shaded area) at the time of this study

Justification of sample size

There are no established rules for sample size in qualitative research. It is generally accepted however that qualitative studies typically tend to use small samples that are studied intensively to generate large amounts of information (Curtis, Gesler, Smith, & Westburn, 2000; Patton, 1990; Polit & Beck, 2010). Polit and Beck (2006) suggest that data saturation is used as a guiding principle in qualitative sampling and redundancy can be achieved in small samples if there is sufficient depth in the information (p. 273). The researcher expected some midwives would withdraw their participation from the PRIME project along the way. However she also anticipated that data quality would be enhanced by the proficiency of midwives to reflect on their experiences and communicate effectively. Moreover, the longitudinal methods of data collection employed provided the potential to generate rich detailed descriptions of their individual experiences. These data collection methods will now be described.

Data collection

Multiple methods of data collection were used in this study to ensure sufficient density and multiple perspectives of the phenomena of interest were obtained from the participants (Fitzpatrick & Wallace, 2006). These methods were multiple semi-structured interviews, participants' diary entries and participants' postings on the PRIME web-based forum. A record of the data collected from participants in this study is provided in Figure 3.3 (on page 72).

			Participants: Site B										Participants: Site A						
			Ann	Beth	Carol	Dana	Elaine	Fran	Gill	Helen	Joan	Violet	Lucy	Mary	Nicole	Olive	Quinn	Rachel	Tania
Data Collection methods	Interviews	Pre PRIME training	□	□	□	□	□		□										
		Post PRIME training	□	□	□	□	□			□	□		□	□	□	□	□	□	
		Recruiting for PRIME			□		□		□				□		□	□	□		
		Completion of PRIME			□										□	□	□		
		Withdrawn from PRIME	□			□	□	□	□	□	□		□	□				□	
		'One off'										□							□
	PRIME Web-based forum				□		□			□		□	□	□	□	□	□	□	□
	Participant diary entries		□		□	□	□		□	□			□		□	□	□		

Figure 3.3: Record of data collected from participants

Interviews

Semi-structured in-depth interviews were conducted with midwives either face-to-face or over the telephone at four time points across the randomised control trial. In-depth interviewing is one of the most frequently used data collection strategies in qualitative research as it allows the researcher to gain access to and understanding of events and experiences which they are unable to observe directly (Minichiello, et al., 1995; Streubert Speziale & Carpenter, 2007). Taylor and associates suggest participants interviewed in this manner can provide rich accounts of their experiences and lead researchers into a deeper understanding of those events (Taylor, et al., 2006). Indeed in this study, the repeated in-depth interviews provided the researcher an opportunity to develop a strong rapport with the participants who openly shared their experiences and provided insight into the phenomena under investigation.

Face-to-face interviews were conducted with the WA midwives first. Given that the more comfortable the informant, the more likely they would share important information; participants were encouraged to elect a time and location convenient for them to be interviewed (Streubert Speziale & Carpenter, 2007). In most situations, this was at the participant's home. Other locations included the participant's hospital of employment or on rare occasions at a local café which proved challenging from the perspective of the researcher maintaining focus and obtaining an audible recording of the conversation in a busy, noisy environment. It was anticipated that the initial interviews with WA participants would not only yield quality information but also provide an opportunity for the researcher to refine her interviewing skills before conducting telephone interviews with the QLD participants.

Although it is generally accepted that qualitative interviews are conducted face-to-face, it is also appreciated that this is not always possible to achieve (Polit & Beck, 2006). Telephone in-depth interviews were conducted with the QLD midwives due to the tyranny of distance and on occasion with WA midwives when their family and work commitments did not support the face-to-face approach. Telephone interviews provide researchers the opportunity to explore topics with otherwise unavailable populations and have been effectively used by others. Studies conducted by Fenwick and associates (Fenwick, Hauck, Downie, & Butt, 2005) and Hauck and Reinbold (1996) for example, demonstrated the successful implementation of telephone interviewing in qualitative studies involving childbearing women. Likewise, Beck's (2005) inquiry of women's experience of birth trauma collected a rich source of descriptive data from participants via the internet which led her to report that "participation in qualitative interviews, be they face-to-face or over the internet, can be a beneficial and powerful experience" (p. 421). In line with these cited studies, this present inquiry similarly found that interviews conducted via the telephone yielded a rich source of data that was comparative to the data collected in the face-to-face interviews.

All interviews (n=42) for this study were conducted by the researcher, digitally recorded and transcribed verbatim. Reconfirmation of the midwives' consent to participate and permission to record the conversation preceded the interviews. Semi-structured in-depth interviews enabled the researcher to encourage the free flow of words and ideas while keeping the midwives relatively on track of the phenomena being explored. In the initial interviews for example, the researcher began by asking midwives to tell her about their experiences in research and how they felt about their role in PRIME. Later on when participants had had an opportunity to implement the counselling intervention with distressed postnatal women, they were asked to talk about what these experiences were like for them. Coming to know the midwives in the study made the interview process easier for the researcher. In later interviews, the researcher noted that conversations with the midwives flowed and needed little prompting or guidance for them to remain focused on the phenomena of interest. A simple question posed by the researcher such as "What's been happening for you in PRIME?" prompted midwives to pick up from where they left off in their conversation and chat away comfortably relaying their expectations, concerns and experiences.

As previously stated, interviews were conducted with the midwives at four points in time in this study. The first interview was attended prior to the midwives receiving training for their role in the randomised control trial. Only midwives from Site B were interviewed at this time, as the Site A midwives had already completed their training programme when this study commenced. The second interview was on completion of their training. The third interview was conducted whilst midwives were simultaneously recruiting antenatal women and implementing the counselling intervention to distressed postnatal women in the trial. The fourth and final interview occurred on the completion of their participation in the randomised control trial. The repeated interviews afforded the researcher a greater length of time with each participant, enhanced rapport and provided her greater understanding of the midwives' perspective of events (Minichiello, et al., 1995).

A total of 42 interviews were conducted for this study. This equated to 31 hours and 44 minutes of interview data collected. The researcher had originally anticipated that each interview would last approximately 60 minutes, however on average the length of each interview was only 45 minutes and may in part be related to the opportunity to participate in a number of interviews to share their experiences. Length of interviews ranged anywhere from as little as 8 minutes, when the researcher interviewed Fran to ask why she had decided not to participate in PRIME for example, to a 1 hour and 45 minute telephone interview with Olive describing her experiences implementing the counselling intervention with distressed postnatal women. The complete researchers' interview log is provided in Appendix D.

Participant diary entries

Midwives participating in the study were also requested to complete reflective diary entries of their experiences in the randomised control trial. In ethnography, the practice of journal/diary entries is commonly used as the data generated can illuminate a variety of aspects of social life (Tuckett & Stewart, 2003). In this study it was anticipated that this method would provide participants with another means of expressing their individual experiences thus enhancing the researcher's insights into how they perceived these events. In an attempt to make it easier for the participants, there were no particular time demands of when to attend this task and they were simply encouraged to reflect on their experiences and write what they felt in emails that were then forwarded on to the researcher (Streubert Speziale & Carpenter, 2007).

Difficulties with this approach to data collection are not uncommon and were not exempt from this study. Participant diary entries required the midwives to be willing, able and eager to write reflectively (Maloney, Dietrich, Strickland, & Myerburg, 2003; Taylor, et al., 2006). The researcher anticipated midwives would be proficient at this task and able to reflect on their experiences and express their feelings and opinions with relative ease. Unfortunately however, the number of participants in this study who actively engaged in this form of reflective practice on a regular basis was limited. Ten of the eighteen midwives provided reflective diary entries. Of these midwives, the

majority were sporadic entries with only one midwife, Olive, writing on a regular basis. A total of 18 A4 pages of data were collected using this method. Although this was less than anticipated, this was a rich source of data, particularly from Olive, that provided the researcher with further clarity around the emerging themes.

Participants' postings on the PRIME web-based forum

A website for the PRIME randomised control trial was created for all members of the research team to use. Midwives accessed project information at this site and interacted with other members of the research team via the online midwifery forum. Permission was sought from and granted by the chief investigator, midwives and all other members of the PRIME randomised control trial for the researcher in this study to access the discussions posted on the midwifery forum. A total of 169 A4 pages of data were collected using this method. The midwifery forum provided a particularly rich source of data that provided insight into how individuals' perceptions of events developed over time through their interactions with other members of the team. In combination with the other methods of data collection in this study, the forum entries helped the researcher to develop a better understanding and appreciation of the phenomena of interest and enhanced data triangulation, credibility and dependability in this study.

Data analysis

Thematic analysis and constant comparison techniques were used to analyse the data in this study. Taylor and associates describe thematic analysis as an overarching approach that identifies answers to research questions embedded in the data (2006, p. 459). Researchers with exploratory and descriptive intentions employ thematic analysis strategies and immerse themselves in the data to identify common themes or patterns within the text. Themes are simply defined by Streubert Speziale and Carpenter as "structural meaning units of data" that capture and unify the nature of the experience into a meaningful whole (2007, p. 47).

The technique of constant comparative analysis was originally developed for the use in the grounded theory methodology of Glaser and Strauss (1967). However, methods

such as thematic analysis depend on constant comparison techniques to develop ways of understanding human phenomena within the context in which they are experienced (Thorne, 2000). As its name suggests, constant comparative technique is a continuous process whereby researchers take a single piece of data and compare it to all others to identify commonalities and variations. Through the process of induction and deduction, data is grouped together to form themes that conceptualise the potential relations between various pieces of information. The process continues until no new themes are generated at which point data saturation is achieved (Polit & Beck, 2010; Thorne, 2000).

Although the researcher was aware of computer software programmes available that analyse qualitative data, such as NVIVO, she preferred to attend analysis manually using Microsoft Word to manage the data. It was anticipated this experience would not only provide an opportunity to refine her qualitative analysis skills but also place her 'closer' to the data and the participants' 'voice.' The process of analysis employed in this study closely resembled the method described by Taylor and associates 'The concise version of the manual thematic method' and began with the commencement of data collection (2006, p. 464). The steps undertaken analysing the data in this study will now be described. Although written in a linear fashion it should be noted that analysis was in fact a continuous, cyclic process of comparing and reducing data until the limits of reduction had been reached.

Analysing the study data using a manual thematic method

Interviews were transcribed verbatim into a Microsoft Word table with three columns. Raw interview data was typed into the left hand column leaving the other columns free for the researcher to transfer words/phrases and make notes in the next step in the analysis process. Transcripts were de-identified by replacing participant's names with their allocated pseudonym. Copies were made of all interview/diary/and forum transcripts and the originals were securely stored in either a password protected computer file or locked filing cabinet (hard copies and computer discs). Copied interview transcripts were then reviewed whilst simultaneously listening to the

participant's interview again. Superfluous words that added no meaning to what the midwife was discussing such as 'umm and hmm' were removed as well as any unrelated text such as her having to collect sick children from school for example. Once editing was completed, the process of open coding began.

Keeping the objectives of the research in mind, each transcript was re-read line by line. Unlike Taylor et al.'s (2006, p. 464) suggestion to cut out sections of text that may be related to a theme, the researcher preferred to use coloured highlighters to trace what appeared to be common threads woven throughout the midwives descriptions. Data collected from the participant diary entries and web-based forum were similarly reviewed and colour coded. In the initial stages of analysis the researcher found it easier to grasp the potential interlaced themes within the text by reviewing all transcripts in hardcopy format. In later stages of the analysis process and when more confident she was on the right path, this process was attended using the computer software Microsoft Office. Once this stage was completed, the researcher read each transcript again and selected data to be placed in the open coding column. An example of open coding from this study is provided in Figure 3.4 (on page 79).

Source: First interview with Rachel page 4	
Data from transcript	**Open coding**
What were you hoping to get from the training sessions in PRIME? The PRIME study I was more interested in the counselling, learning to counsel, learning to. Lots of nurses and midwives always say I wish I knew the right things to say and I thought yeah I don't want to be someone's bad memory. You know I kind of want someone to think oh she said that, wasn't that terrible or that was the wrong thing to say or and those, those times when you feel quite uncomfortable not knowing, you feel like you're out of your depth. And that goes for lots of things not just midwifery I guess that's nursing all, you know across a broad scale that's nursing. But that's why I was interested…	Interested in the counselling Learning to counsel I wish I knew the right thing to say Don't want to be someone's bad memory That was the wrong thing to say Times when you feel quite uncomfortable not knowing You feel out of your depth

Figure 3.4: Example of open coding

Following on in the process, sections that appeared to be related in the open coding were then grouped together. When 'cut and pasting' sections of text from the main transcript, the researcher was mindful not to misconstrue the meaning or use excerpts out of context. If there was any doubt, she would listen to the participant's interview again and re-read sections of the surrounding text within the transcript to ensure she was accurately describing events. Text removed from the main body of transcripts were assigned a code to identify who had made the comment (used the first letter of their pseudonym) and from what source it was obtained (interview number, forum = f, diary = d and page number = p). This made it easier for the researcher to quickly locate the

source and for others who may wish to conduct an audit trail. An example of how excerpts were labelled in this study is provided in Figure 3.5.

Source: First interview with Rachel page 4		
Data from transcript	**Code**	**Group**
We have little time to even talk to women	Little time to even talk	Little time to talk **R1p4**

Figure 3.5: Coding excerpts for audit trail

This was a time consuming and all encompassing process for the researcher. It wasn't difficult to spend hours on end immersed in the words of the participants. However, the careful listening, questioning and verifying data in this cyclic manner were recognised by the researcher as important steps in the analysis technique. Groups of words and phrases were then reviewed and reduced into sub-themes displaying commonalities. An example of part of the data analysis process that identified the sub-theme 'Little time to talk' is provided in Figure 3.6 (on page 81).

Data from transcript	Code	Sub-theme
We do need to provide a lot more opportunities for women to talk	Opportunities for women to talk **J1p4**	Little time to talk
Women do want to talk about their experiences and that we're not actually providing the service	Women want to talk. We're not providing this service **C2p4**	
We have little time to even talk to women	Little time to even talk **R1p4**	
In the clinical area…you see your lady for a very short period of time so you don't really get the chance to really talk	Don't get the chance to talk in clinical setting **N1p5**	
You can't sit there and talk to people for too long because you're letting the team down	You can't sit and talk **M1p2**	

Figure 3.6: Example of data analysis technique to identify a sub-theme

The researcher was mindful to include her supervisors in every stage of the data analysis process but particularly at this time when data was being reduced to reveal sub-themes and potential themes. Informal presentations and discussions helped the researcher to clarify and validate how ideas had been merged into respective groupings. These meeting occurred on a regular basis throughout the analysis process. Relationships between themes were further explored and reviewed until ideas could no longer be moved without losing meaning in relation to the research. At this point the five themes related to the midwives' experience of research were identified. Four

themes emerged to describe the midwives experience of learning and delivering the PRIME counselling intervention.

Trustworthiness

In qualitative research the goal of trustworthiness or rigor is to accurately represent the study participants' experiences (Streubert Speziale & Carpenter, 2007). Concerns of rigor in naturalistic inquiry such as reliability and validity translate as issues of credibility, dependability, confirmability and transferability. These four criteria are therefore important when evaluating the trustworthiness of qualitative research (Denzin & Lincoln, 2005; Guba & Lincoln, 1994). With this in mind, measures employed in this study in pursuit of trustworthiness will now be described.

Streubert Speziale and Carpenter suggest credibility is the confidence that the findings accurately reflect the data and dependability is a criterion met when researchers demonstrate their findings to be credible (2007, p. 49). Activities such as prolonged engagement and triangulation can increase the likelihood of achieving this goal in qualitative research. In this study, the prolonged engagement of collecting data over a 17 month period not only assisted the researcher to establish rapport with participants but also increased the likelihood of producing credible data. Triangulation, or the use of multiple sources, was sought by employing multiple methods of data collection (interviews, participant diary entries and postings on the web-based forum) and obtaining the perspectives of others in interpreting this data. Data interpretation in this study involved the input from supervisors and peers (midwifery HDR students) which occurred at regular meetings throughout the course of this investigation. In relation to confirmability, Streubert Speziale and Carpenter suggest researchers document confirmability of findings by leaving an audit trail (2007, p. 49). As previously discussed, Figure 3.5 provided an example of a method employed (coding excerpts) to illustrate as clearly as possible the evidence and thought processes that led to the conclusions made in the analysis of data in this study. Finally, transferability, or whether the findings can be applied to others in similar situations, is considered an

expectation that rests with those who chose to use the findings and not with the researcher (Streubert Speziale & Carpenter, 2007).

Ethical considerations

Full ethical clearance processes preceded the commencement of this study. Permission to conduct this inquiry was sought from and granted by the Human Research Ethics Committee at Curtin University, Bentley Campus Western Australia. The project approval number for this study was SON&M 11-2008.

An information sheet was provided to participants (Appendix B) that outlined the purpose of the study, use of information and an assurance of confidentiality. Participants were assured of the voluntary nature of their participation in the research and that they were free to withdraw from the project at any time without penalty. All participants completed a consent form (Appendix C) prior to their commencement in the study. Participants were assigned a pseudonym known only to the researcher to ensure their confidentiality. The investigators' contact details were provided should the participants wish to seek clarification on any aspect of the study.

Data storage

All data were stored in accordance with the National Health and Medical Research Council's guidelines (National Health & Medical Research Council, 2007). Computer files created in Microsoft Office for the storage of data and participants' personal details were password protected and known only to the researcher. Sources of raw data including consent forms and hard copies of transcripts and data analysis were secured in a locked filing cabinet at KEMH. The master list containing personal details of the participants was not kept in the same location as the de-identified data. The researcher was the only person with access to this material. All data will remain securely stored for a period of no less than five years. Participants were given assurances that no information identifying them would be used in any written reports, presentations or publications.

Summary

This chapter has presented how a study of 18 midwives' experience of participating in a randomised control trial and delivering a counselling intervention to distressed postnatal women was conducted using a qualitative descriptive explorative methodology. The background and origins of qualitative descriptive inquiry were described and a rationale for the use of this approach was provided. Principles of this methodology were used in the design of this study and the methods employed in sampling, data collection and analysis were provided. Measures taken in pursuit of trustworthiness were outlined as well as the ethical considerations undertaken. The findings elicited from the midwives in relation to their experiences will now be presented. Given the very specific themes identified in this study, two findings chapters are put forward. Firstly, in chapter four, the midwives' experiences of working as a research assistant in a randomised control trial are described. Following on, chapter five presents the findings that relate to their experiences of caring for distressed women in midwifery practice.

Chapter 4

A challenging journey: Working in research

Being a researcher in PRIME it's been a lifestyle change it's not just work…I've had a whole paradigm shift in terms of accommodating my activities and my schedule and my new time frames and my learning and all of that and maintaining the momentum, it's not something where I can walk away from it for three days and come back…it really does require intense focus in maintaining that finger on the pulse.

(Olive 3p9, on completion of the PRIME project)

Introduction

The thematic analysis of 18 midwives' experiences of participating in a randomised control trial (RCT) and delivering a counselling intervention to distressed postnatal women identified two divergent themes within the findings. Given that these themes are quite distinct, the findings are presented in two chapters. Firstly, this chapter presents five themes that relate to the midwives' experiences of working in research and participating as research assistants in a randomised control trial. Following on, chapter five provides an additional four themes that describe their experiences of caring for distressed women in practice and implementing a counselling intervention.

When quotes are used to illuminate and support a theme or subtheme in these findings chapters, the identity of the midwife is protected by the use of a pseudonym. Likewise, any references made to names of people in these quotations have been removed. Quotes are presented in italics with the pseudonym of the participant, source (diary-'d'/forum-'f'/or interview number) and page number of the transcript cited. Where words have been omitted from quotations … is used to indicate this.

The research journey

In this chapter, five themes are presented that relate to the midwives' experience of working in research and participating as research assistants in the PRIME project. The first theme labeled 'Research is important but not something I know much about', sets the scene by providing insight into the midwives' previous experience in and expectations of research, prior to undertaking their role in PRIME. The second theme, 'Opening new doors', describes the reasons why the midwives sought the opportunity to work in the randomised control trial. Finally the themes, 'Being challenged and finding a way forward', 'Clinical supervision: a new and confronting experience' and 'The research project: a mighty undertaking' reflect the midwives descriptions of preparing for and working as research assistants in the PRIME project. A diagrammatic overview of the themes and sub-themes discussed in this chapter are provided in Table 4.1.

Table 4.1: Five themes and sub-themes under 'A challenging journey: Working in research'

Research is important but not something I know much about
Opening new doors
Being challenged and finding a way forward
Training: An overwhelming experience
The counselling intervention: Learning a new skill
Being technological savvy
Clinical supervision: A new and confronting experience
The research project: A mighty undertaking
Being daunted by recruiting and changing expectations
Teamwork
Not a money making venture
Hard work but a worthwhile experience

Research is important but not something I know much about

This theme groups together a number of concepts that relate to the midwives previous experiences in and expectations of research prior to PRIME. Analysis of the data identified that the midwives were aware of the importance research plays in guiding midwifery practice and advancing the profession. However, they also acknowledged that their actual involvement in research was limited and attributed this to insufficient training, lack of comprehension, and not enough support or time.

All the midwives agreed with the importance of research in guiding midwifery practice. They were familiar with evidenced-based practice and the influence research has over initiating change to improve midwifery care and education. Participants articulated that research was used *"everyday"* and was a *"daily necessity"* in providing quality care. Whilst midwives experiences and knowledge may have varied they all acknowledged that research was *"incorporated in all aspects"* of midwifery practice. Rachel for example explained that she couldn't see improvements in *"midwifery and services without research"*. Although the midwives identified research as a *"huge component"* of midwifery practice, their participation in research prior to PRIME had been limited. They used phrases such as *"very little"*, *"non-existent"* or *"a little bit"* when describing their actual involvement in research and expressed a lack of training, comprehension, support and time as contributing factors.

For midwives educated in a hospital-based midwifery course, research was not a component of their study. For these midwives phrases such as *"didn't enter into it"* or *"wasn't even covered"* were common. These midwives openly admitted to not *"knowing much about it"* and considered their tertiary based counterparts as more adept and at ease with the concept of research. For example, Ann described recently qualified midwives as *"a step ahead of me"* (1p1) in understanding research and Lucy felt intimidated when discussing evidenced based practice with a midwifery colleague stating *"they start spouting all these things at you"* (1p2). Surprisingly, of those midwives educated in the tertiary sector many described their research educational experiences unfavorably using words and phrases such as *"very basic", "less than*

great" and *"disappointing"*. Expectations of developing a better understanding of research at university was denied them as it was *"all on paper"* and commonly focused on terminology without, as Violet put it, getting to the *"roots of it"* (1p24). Elaine explained that her disappointment was related to *"losing"* the research knowledge she had gained because she was unable to go on and *"consolidate what I learned"* (1p1).

Given the midwives perceived inadequate educational preparation it's not surprising that they expressed some difficulties comprehending research when exposed to it in the clinical areas or in research study days. A few of these difficulties were perceived to be because research from their perspective was *"a completely different language"* which was often *"presented in a very detailed manner"* and required *"a whole different way of thinking"*. Most midwives interviewed described being *"overwhelmed"* by the *"challenge"* of understanding research and described the process as *"difficult to grasp"*. As Beth explained:

> *You get these huge reading packages and off you go and you get emails about submitting. You get your dates to submit your assessment so I found it all very overwhelming and I always was looking for a book that broke it down to much more simplistic information.* (1p3)

Yet at the same time many of the midwives also expressed that they found research stimulating. Ann for example said it *"opened my eyes"*; Elaine commented that it *"sparked my interest"* and Carol described her previous experiences of research as *"thought provoking".*

The midwives also talked about the importance of being supported when undertaking training or participating in research. Those who felt supported described their previous experiences in a positive light as *"fun", "all good"* and *"really enjoyed it"*. Working with others provided them with an opportunity to bounce ideas off each other which was considered beneficial. As Gill explained *"it was good to have a buddy to do that research with"* (1p5) when discussing her experience of being 'paired up' at a tertiary research study day. In contrast, midwives who felt unsupported in previous research

endeavors, particularly where a self-directed approach was used as a learning strategy, perceived it as a *"frightening"* experience and felt *"isolated"* as this was not their preferred way to learn.

When midwives were asked to talk about why their research involvement was often limited in their clinical practice, *"lack of time"* resounded prominently in their replies. With increasing workloads, staffing shortages and decreased length of hospital stay for women, research was considered as *"extra work"*. Midwives described their daily clinical environments as ones where they felt *"overwhelmed"* by their workloads and continually *"pressured"* to complete basic care. Being *"so short on time"* was frequently cited as a reason why 'doing research' was almost impossible. Rachel described it as *"fighting a losing battle"*. She went on to explain that although midwives were well aware of the important role research plays in enhancing practice, they had no time to contribute or participate in research activities in the clinical setting.

Opening new doors

Midwives considered PRIME as "*a vehicle to change"* not only the provision of emotional support provided to women in their care but also to advance their own personal and professional development. This theme describes their reasons for exploring the opportunity to participate in the PRIME project.

All the midwives expected their participation in PRIME to be an opportunity to *"branch out"* and do *"something different".* Some midwives, like Olive and Mary, perceived their participation as *"injecting meaning"* into their work, described as *"stifled and stagnant"* and lacking in *"job satisfaction"*. For Ann and others, it was about *"opening up opportunities and new experiences".* Dana for example considered PRIME an opportunity to *"put a foot in the door to research"* (1p1). Likewise, Olive explained *"I always wanted to go into either research or teaching but I never quite found the right pathway"* (1p9). Many of the midwives also expressed a genuine desire to learn more about and *"be involved"* in the research process. Working as part of a large research team inspired midwives such as Helen who looked forward to the

opportunity to work with revered midwifery researchers she described as *"amazing women".* Furthermore, some midwives such as Quinn, were of the opinion that their participation would enhance their personal and professional development and her following comment highlights this expectation well;

> *It's not just a brief research that will end and then we will have nothing. We definitely have the prospect of using our experiences to extend ourselves professionally…it was mentioned today that all of what we're doing could lead us to well towards having half the requirements for a counselling qualification.* (1p5)

Although inspired by an opportunity to *"get involved"* in research, it was evident in the data analysis that midwives primary motivator to participate in PRIME was to improve the provision of women's emotional care in practice. Elaine for example, expressed that although she was interested in *"doing research"* she didn't want to *"do research for research sake"* (1p4). Likewise, Ann spoke of not being *"focused"* on the research aspect of the study and went on to explain that midwives are interested in *"the women and their needs because…midwives that's where their passion is"* (1p8). The midwives were *"excited"* about the opportunity to *"make a difference"* in the emotional support provided to women in their care. They all believed PRIME had the potential to generate evidence that would enhance midwifery practice in this area. Elaine and Ann's comments are reminiscent of the majority of midwives explanations of why they sought participation in PRIME, but were best encapsulated in the following comment made by Gill:

> *The PRIME study interested me because of the emotional involvement for the women and to have the best care for the women because sometimes I look at our practice and wonder whether we are doing the best care and I'm sure that there's improvement that can be made.* (1p1)

As part of improving the emotional support provided to women in their care, the midwives articulated their desire to reclaim the role of counsellor which they perceived

as *"taken away"* by other health professionals. One midwife, Joan, phrased her concern like this; *"Traditionally we've handed over to other professionals when it really is an integral part* [of] *midwifery…we are the ones that are at the birth and we need to take more ownership over the broader aspects of that care*" (1p4). Perhaps not surprisingly while midwives were excited about their role in PRIME, they expressed a sense of trepidation at having to step outside what they considered their *"normal scope"* of practice and venture into something *"all very new"*.

Being challenged and finding a way forward

Preparing for their role in PRIME was considered a *"challenging"* task for all midwives in this study. In their role as a research assistant they were expected to recruit women, provide those who consented with two questionnaires (the first when obtaining consent antenatally and the second within 72 hours of birth), screen for a distressing birth experience and randomise distressed women into the control or intervention groups. Moreover, they were also responsible for telephoning these women four to six weeks postpartum and implement the counselling intervention/parenting support depending on which group the woman had been allocated to.

In preparation for this role, midwives received face-to-face training which consisted of three, four-hour workshops, written manuals and digitally recorded counselling skill vignettes related to the counselling framework. A portion of this educational experience also incorporated an element of self-directed learning in the form of additional readings, 'take home tasks' and self-assessment of their digitally recorded counselling interviews. As part of this training programme, midwives were required to demonstrate competence by completing at least one digitally recorded counselling interview with a volunteer who self-indentified experiencing a distressing birth. Supportive clinical supervision to gain initial competency in the advanced counselling skills and assure adherence to the counselling framework throughout the duration of the project was provided by the clinical psychologist/project manager. All members of the research team had access to a PRIME website where they could obtain project information and interact with other

team members via an online midwifery forum. This theme thus describes what it was like for the midwives preparing for their role in PRIME.

Training: An overwhelming experience

Training was conducted at Site A first and at Site B four weeks later. Sessions were conducted by a chief investigator and project manager based at one site and a chief investigator and site coordinator based at the other. Teaching strategies included audio-visual examples of counselling techniques, written manuals, small group or paired practice activities and self-directed 'take home tasks'. Digitally recorded interviews and a self-assessment of technique and skills were employed to build on and further develop midwives skills and assess competence in delivering the counselling intervention. Evaluation and feedback of each training session was incorporated into the subsequent session.

Several midwives, such as Helen and Quinn, spoke positively about the training sessions describing the experience as *"exciting"* and of being *"thrilled with it all"*. Another midwife, Elaine, stated the combination of teaching methods was *"excellent"*. However, it was evident from the analysis that the midwives found the pace of learning challenging believing the workshops were overly compacted in an attempt to cover all the content. Rachel explained that she felt there was *"a lot to take in, in a short amount of time"* (1p6). Similarly, others described the scene as *"skimming through"* the theory in attempt to cover it all in the allocated time, which resulted in many midwives feeling as though important information was *"skipped over"* too quickly. This resulted in midwives describing the sessions as *"rushed"* and *"very short"*. Olive's description highlights this well;

> *I felt the sessions skimmed the surface and really just gave us an overview of the programme and how we fitted. Considering that the programme success is hinged on us getting it right, not enough time is allowed for me to up skill with the computer and the counselling techniques. I would have liked to have twice the time to get my head around the project and the new skills.* (dp2)

Midwives also expressed a desire to have *"more time"* devoted to learning the counselling techniques in the workshops. Although counselling vignettes were included in their training many midwives spoke of wanting to view longer examples in order to better understand the complexity of the counselling technique. As Lucy said *"it didn't give me the right idea that it would be a very extensive thing…they only explored a little…hard to pick up what was going on"* (2p12). Carol reiterated this by saying, *"it's like just skimming over the top of it and yet each part of it is actually really quite important"* (2p2). In addition to more visual examples the midwives also spoke of wanting more opportunity to *"role play"* the counselling techniques in order to develop the concepts being taught. Mary's comment highlights this well; *"it's one thing to say this is active listening and this is what you do but it's actually a bit of a skill you develop with practice"* (2p9).

Not surprisingly then, when the midwives were asked at the end of the workshops how the training and practice opportunities impacted upon their experience they used words such as *"overwhelmed"* and *"stressed"* to describe their feelings. When interviewed at this point in time, none of the midwives were adverse to the suggestion of a longer training period as they were all committed to the project and wanted to master the new skills. As Elaine explained *"I don't think the length of time training would have bothered me, I would have been quite happy to devote a couple of months doing this because…I believe very strongly in it"* (3p33).

The counselling intervention: Learning a new skill

The PRIME counselling intervention consisted of six key elements and was an integral part of the midwives training programme. These key elements were (1) Hearing the birth story and filling in the missing pieces, (2) Connecting events with emotions and behaviours, (3) Reviewing of labour management, (4) Enhancing social support, (5) Promoting positive approaches to coping and (6) Exploring solutions. When implementing the intervention, midwives were trained to utilise their interpersonal skills to elicit a distressed woman's birth narrative, help her fill in any missing gaps in her story and assist her to connect emotions with events passed. Furthermore, they had to

identify those women who needed support to engage in or create social networks and encourage them to identify positive coping strategies and solutions to facilitate the healing process. A detailed description of the development of and the key elements in this counselling intervention are provided in chapter three of this thesis.

Midwives found learning the counselling intervention *"challenging"*. In the most part, this was because they perceived the *"directive"* counselling style as a *"new skill"* which was *"quite foreign"* and difficult for them to master in the designated timeframe. Many midwives expressed feeling a sense of pressure to learn the skills quickly. Their perception of the "*unrealistic*" time frames left many feeling frustrated. Ann for example stated *"they thought they'd make us into counsellors overnight and that's not happening"* (2p1). Joan reiterated these sentiments by saying, "*how realistic that was in expecting midwives to be able to pick that up and run with it with a few short of half day training sessions I think was a lot to ask"* (2p16).

The midwives also spoke about a perceived lack of preparation in the training workshops and some believed *"changes"* were made to the counselling intervention being taught. Gill for example expressed she felt as though she was always *"missing something"* in the workshops and believed it was because the sessions weren't *"clearly set out"*. Helen reiterated her comments and felt the lack of clarity in the training sessions lead to a sense of *"confusion"* amongst the midwives stating *"it wasn't all that clear about the actual intervention…and the process…I think they sort of worked that out as they went"* (2p10). Some midwives perceived the intervention had "*changed or evolved*" over the course of the training programme. Tania for example stated, *"I don't think that when we started off we're doing the same things as we're doing now"* (1p13). Another midwife, Joan, phrased her concerns like this;

> *quite of lot of things had changed from when we first did some of the training to that point of counselling, different things that I wasn't really aware of that we were supposed to be doing…the actual intervention or I guess the methodology had changed.* (2p1)

It was evident from the analysis that the methods used to assess the midwives ability to implement the counselling intervention also influenced their learning experience. As previously discussed, digitally recorded interviews and a self critique of skills were employed to assess the midwives' competency delivering the counselling intervention. Midwives were expected to not only locate and attend a one hour digital recording of them delivering the intervention to a woman who had experienced a previous traumatic birth but also set up the recording equipment.

Physically having to arrange and set up equipment for the interviews caused a level of distress among the midwives. Rather than seeing it as a potential powerful learning experience it became fraught with anxiety with midwives using words such as "*stressful", "exhausting"* and *"really difficult".* Beth poignantly described the experience as, *"a nightmare".* Some midwives articulated that during the interviews, they were more focused on the recording equipment than listening intently to the woman and implementing the counselling techniques. The majority of midwives had to repeat the digital recordings of the interviews two or three times before obtaining competency and able to move on to the recruitment phase of the project. One midwife Helen, described the midwives as *"traumatised by the process"* and recommended *"the team"* organise the women and recording equipment for them, which they did. As a consequence, many midwives reported that the subsequent assessment interviews were *"a lot easier"*. Furthermore, some midwives described feeling *"intimidated"* being in front of a camera and questioned the emphasis on face-to-face techniques when they were expected to deliver the intervention over the telephone in PRIME. As one midwife explained the, "*DVD process for all of us was incredibly intimidating…being exposed, having it watched…was quite confronting"* (Violet, 1p6). Olive reiterated Violet's comment and said the "*DVD isn't appropriate because we don't do face-to-face interviews, largely it's phone…so if anything it should just be a phone interview because a lot of them were losing confidence being in front of a camera*" (3p31).

Midwives were also expected to self-assess their own interview in 30 second increments; a reflective exercise to ensure they had initiated all the components of the

counselling intervention. While considered a *"useful"* exercise by some midwives, most stated the process took *"hours of work"* to complete and expressed a level of 'annoyance' with the expectation this task would be completed in their own time. Ann for example stated *"I gained very little out of it both professionally and financially and they'd used up a lot of my time"* (3p6). Another midwife suggested, "*the assessment* [should be] *done in class and then there would be an equal division of time and resources because it would take up their time and ours and not just be put all onto our shoulders*" (Olive, 1p15). For one midwife, Lucy, the self-assessment task was a "*struggle*" because she was yet to fully comprehend the counselling technique and explained; *"I'd spent hours…reviewing* [the] *DVD of yourself what you did or didn't do when you had no clue about what it was you really meant to have done"* (2p2).

Techniques and processes put in place to ensure the integrity of the different components of the PRIME intervention also caused some level of stress and frustration for the midwives. Having to maintain a consistent approach was interpreted as not being able to express oneself. Ann for example explained *"there was just no scope for who you are or what you were…you had to be this stereotyped counselling midwife"* (3p10). Another midwife reiterated these comments and said *"they want the approach and the questions and everything to be the same…but everyone's got their own little bit of personality as well so it can't be completely mirrored to somebody else"* (Nicole, 1p12). For others, it was the expected standard delivering the intervention that was challenging. As Lucy explained there was a *"high expectation that you find everything out about this woman"* (2p6). Likewise, Quinn's comment following a supervised interview with the project manager highlighted this well;

> *I knew I was achieving each of these areas that I was being asked. However, as I was looking at it from that angle I think she was expecting me to be delivering it at a psychologist level…if she only heard the fifteen minutes she couldn't possibly have seen that I eventually got there so I felt frustrated, betrayed and angry.* (Quinn, 2p16)

When their experience of learning the counselling intervention was different to what they originally anticipated, some midwives came to the assumption that the chief investigators and project manager *"hadn't been upfront about the role"*. Midwives spoke of PRIME being *"pitched as an extension of midwifery skills"* and some became disillusioned when told to put their midwifery experience to *"one side"* when learning the intervention. As Elaine explained, *"If the object was to turn me into a counsellor I should have been informed"* (3p5). Another midwife commented that her *"main criteria for being on this project is because I'm a midwife, because it's midwifery intervention and she would say… 'forget your 35 years of midwifery experience', why would I do that"* (Helen, 2p4).

While one midwife felt prepared to implement the counselling intervention at the end of training, she attributed this to *"the fact I'd had prior training* [in counselling]*"* (Olive, 3p29). The majority confessed to feeling *"unprepared"* for their counselling role in the randomised control trial. Joan for example stated *"I don't think we were prepared enough"* (2p8). Similarly, Rachel commented that she was *"feeling unprepared or under qualified"* (2p21) when interviewed at the end of training (prior to recruiting women). Many midwives spoke of feeling *"nervous"* and *"not confident"* in their ability to counsel women effectively and were "*daunted"* by the prospect of going from the classroom to the client. As Mary explained *"it's not just a matter of getting the DVD right it's actually a matter of when you're out there doing it and getting it right"* (2p7).

The midwives lack of confidence was further compounded by the delay between their training and opportunity to implement the intervention in the project. As one midwife explained, *"I was nervous, really nervous…that feeling of I just want to get this over because from the DVD to that first intervention was quite a while"* (Tania, 1p8). In the most part, this delay was attributed to the time it took to get all the midwives assessed as competent in the counselling intervention. However, midwives also spoke of a perceived *"slow down"* over the festive season and believed this also impacted not only on their confidence but also the project's *"momentum".* Quinn's statement poignantly

described the situation at that time; *"three month gap between me doing the DVD and actually delivering the skills and I found that a little staggered…I felt quite rusty because of the timeframe"* (2p1).

Being technological savvy

The PRIME project used the latest web-based technology to not only store data but also in an effort to enhance communication between research sites and midwives. While this was a clearly articulated to the midwives at the commencement of the project the reality of having to use these different techniques was a challenge for some. Using computers in order to access and download online information, communicate via email and post online discussions on the project's website again provoked a level of stress. Many midwives confessed they were initially less than confident in their computer skills describing their abilities as *"challenged"*, *"hopeless"* and *"not that crash hot".* As a consequence, some spoke of *"being frightened to open things up"* and found the PRIME website *"difficult to use"*. As one midwife explained, *"I was worried about computers mostly, I thought I'm hopeless on the computer"* (Rachel, 1p6). However, despite these initial challenges the midwives reported developing confidence using the computer with practice. As Rachel explained, *"get on your computer and play and get in there and not be frightened to open things up and post comments and use the website and I made a big effort"* (1p9). Similarly, Quinn was pleased with her improved computer skills and stated *"I've surprised myself"* (1p6).

Clinical supervision: A new and confronting experience

Clinical supervision, a process largely associated with psychology, was used to help midwives learn the counselling skills and maintain integrity of the counselling intervention throughout the course of the randomised control trial. The supervision and feedback was provided by the clinical psychologist managing the project. Many of the midwives interviewed found this process confronting. At times they described feeling undervalued and considered the feedback to be *"abrasive"*, *"harsh"* and *"critical"*. Ann for example explained, *"I came out of that feeling so humiliated and so small and*

questioned my whole midwifery practice" (3p2). Helen reiterated these comments and stated *"just in the way she gave feedback was just really very negative. Very patronizing, very demeaning"* (2p4). As a consequence, many doubted their ability to implement the intervention stating they felt *"incompetent"* or *"well below standard"*. As one midwife explained, *"I'd been quite confident in interviewing people before that. So I felt a bit incompetent…felt like I was missing the whole point of this intervention"* (Helen, 2p5).

While many midwives found this form of practice evaluation difficult, others accepted clinical supervision as part of the process of learning counselling techniques. Elaine for example, acknowledged that even though she perceived the feedback to be difficult to hear at times she did not take it personally stating *"I take it as what we need to do"* (3p41). Another midwife agreed and said, *"It's not to critique in a bad sense it's only to critique to improve"* (Violet, 1p8). However, it was evident from the analysis that the majority of midwives interviewed were taken by surprise at the level of assessment and therapeutic monitoring entailed in this form of clinical supervision. Being made aware of and engaging in more active discussion about this process may have better prepared them for the experience. One midwife with previous counselling experience described this effectively in the following quote;

> *Criticism is not a personal attack it's actually a learning thing…if you're not in a place where you realise that from the beginning and actually willing to be able to be in a place where you're going to be criticised it could be really, really difficult…maybe that's something they could have talked about more.* (Carol, 3p7)

The Research project: A mighty undertaking

As previously discussed, the PRIME project was a large randomised control trial that used midwives to recruit, screen and implement a counselling intervention for women reporting that their birth experience was traumatic. Many aspects of the project exposed midwives to new and challenging experiences not the least being their increased awareness of just how many women were traumatised after birth. Similarly, and perhaps not surprisingly given the midwives limited exposure to research, they expressed being unaware of the level of commitment the research role would require of them. This theme thus groups together a number of concepts that relate to their descriptions of their research 'journey' in PRIME such as being daunted by recruiting and changing expectations, limited financial remuneration, developing an awareness of the level of commitment required when participating in research and relying on support from the 'team'.

Being daunted by recruiting and changing expectations

In their role as research assistants in PRIME, twenty midwives recruited around 1000 women for the randomised control trial. Midwives employed for the project were educated about the recruitment process and independently recruited antenatal women in their last trimester of pregnancy from clinics of the participating hospitals. As part of the recruitment process they were expected to provide women who consented with two questionnaires (the first when obtaining consent antenatally and the second within 72 hours of birth). When visiting women at 72 hours postpartum, the midwives screened them for a distressing birth experience and randomised distressed women into the control or intervention groups. Midwives were then responsible for telephoning the women they had recruited at four to six weeks postpartum and implement the counselling intervention/parenting support depending on which group the woman had been allocated to.

One of the 42 interviews conducted with the midwives for this study was scheduled as they began recruiting women into the PRIME project. Despite having been prepared for

the recruitment process the reality and enormity of such a task soon became apparent. While some midwives with previous research experience, such as Violet and Quinn, commented that recruiting women for the project *"wasn't difficult"* and *"quite easy"* they did acknowledge that *"a lot have found it challenging"* (Quinn, 2p5). Many midwives described their recruiting experiences as a *"big learning curve"*, *"difficult"* and *"hard work".* For example, one midwife explained, *"it was a bit daunting…the big thing for me was getting this skill in my head initially and then finding a process of what to do"* (Carol, 3p9). Another put it like this; *"it's been slow and tortuous and some days you just get one or two and you've gone to all that effort"* (Tania, 1p20).

Many midwives expressed being surprised by the competitiveness of recruiting women in the antenatal clinics of the tertiary hospitals. For most, it was adjusting to the *"chaotic"* nature that often ensues in the clinic environment where doctors, midwives, students and researchers are often all competing for the same women. As Carol explained, *"trying to keep out of the staff's way at the same time as doing your job… it's actually quite chaotic and quite exhausting"* (3p11-12). Elaine, poignantly described the clinic scene like this, *"A file comes in and then it is like throwing a chip to a seagull"* (3p15). For others such as Tania, it was coming to terms with the realisation that they were expected to compete with other research groups targeting the same women, she explained *"when we encountered it for the first time we were all shocked and that somebody else was targeting our women"* (1p22).

For some midwives, the reality of conducting an antenatal questionnaire with such a large number of women one-to-one in the clinic setting and again just after birth prior to discharge became an *"unrealistic"* expectation and something they considered was not *"practical"*. As Helen explained, *"there's a very small window when a midwife can get in there and have a woman that's got a spare hour to sit and talk to without interruption"* (2p16). Following consultation with the chief investigators and project manager, the recruitment process was improvised to allow midwives the option to not only hand out the antenatal questionnaires for the women to complete themselves but also attend the postnatal questionnaires over the telephone. Midwives also problem

solved themselves. As Olive explained, *"there's no way we could get the numbers that we need doing it only that way (one to one) so we're doing it more of a team effort"* (2p7). Despite these initial difficulties one midwife believed the recruiting process eventually became *"second nature when you've done eighty or ninety recruitments"* (Quinn, 2p15) and in subsequent interviews the midwives spoke more about the changing expectations in the number of women they were expected to recruit for the project.

Contributing significantly to the midwives' experience in PRIME was the changing expectations around the number of women individual midwives were expected to recruit, screen and deliver the intervention to. At the outset of the project recruitment time had been predicted to require a six month commitment from each midwife. The need for extended training timeframes, recruiting across the Christmas period and attrition of midwives resulted in a slower recruitment rate which in effect meant the recruitment timelines were considerably extended. As none of the midwives had expected their role to last longer than six months this caused some level of distress amongst them. Midwives spoke of feeling irritated when the timelines for recruitment and their participation were both extended. As Violet, explained *"we were told recruiting would start here, it would finish here and that has changed markedly…that side of things has been frustrating"* (1p17). Likewise, Tania stated, "*It can get frustrating when they keep moving the goal posts and when there's pressure applied to recruit…I gave this six month commitment and its well and truly surpassed that"* (1p11). This inevitably led to those midwives who remained in the project feeling under "*pressure*" to recruit and ultimately to a sense of "*exhaustion*" for some. As one midwife said, *"There had been a lot of pressure … to get our recruits and to get the numbers up"* (Violet, 1p18). Quinn articulated this in the following way, *"a smaller base of midwives to pull this project through has taken its toll on everyone…we actually put a lot more effort into keeping these figures rolling"* (3p6). Lucy simply said, *"I wanted it done and dusted"* (3p18).

Teamwork

Feeling part of a *"cohesive group"* was pivotal not only to the midwives learning experience but also how supported they felt in the PRIME project. Many midwives spoke of the benefit of not only working alongside other PRIME midwives but also of being able to discuss, compare and share experiences following the often challenging counselling sessions they conducted as part of their research role. They talked about benefits such as *"peer support"*, being able to *"bounce ideas off each other"* and developing a sense of *"connectedness"* when asked to discuss their experiences working alongside others in the project. For example, Tania stated *"we debrief and that's been very supportive"* (1p5). Another midwife explained that they would *"help each other and steer each other on the right track"* (Ann, 3p1). Working in close proximity to one another and reconnecting at the fortnightly team meetings was considered beneficial by the majority midwives. As Rachel explained, *"We were lucky we all worked together. ...I had a lot of support off the girls because I would see them"* (2p15). Similarly, Ann highlighted the importance of, *"regrouping and knowing, yes we are still a part of this, yes we are all still here"* (2p3). The importance of being physically close to each other and thus being able to support one another in person was born out by Lucy's experiences. Lucy did not live near or work at the same hospital as her state colleagues. As a result she expressed a sense of alienation when asked to describe her sources of support in PRIME and explained;

> *I didn't think it would make any difference not being in the area but it made a lot of difference. I think if you were in the one group…if you can stick with your group you can do a lot of support things but I think the fact that I wasn't there at the hospital, I think that made a big difference.* (3p30)

Another potential source of support for the midwives was the online PRIME midwifery forum. The online forum provided not only an opportunity for the midwives to interact between the project sites by posting discussions of their experiences but also to seek or offer support and guidance. Midwives were encouraged by the project manager to actively participate and contribute to the discussions posted. Having said this, however,

there were mixed messages in the midwives descriptions of how supportive they perceived this mode of interaction. For midwives such as Quinn, it was considered a great opportunity to connect and share experiences with other midwives who were often at different stages in the project and explained that, *"we all communicate with each other…put up little recipes how to achieve something"* (1p3). Nicole reiterated these comments and said *"if you have a problem…someone will reply"* (1p6). In contrast some midwives openly acknowledged they were not comfortable posting their thoughts and opinions online. In the most part, as previously discussed, this was related to midwives lack of confidence with using this type of computer generated communication medium. For a small few however there were also lingering concerns that their disclosures or postings may be reviewed as part of the clinical supervision process and attract censure. Lucy explained how the project manager had encouraged her to engage with the medium however her statement, *"how am I to know what type of person you are or what you think if you're not been posting and contributing to the whole thing"* left Lucy feeling uneasy stating *"that gave me a bit of a big brother feel…I became very guarded*" (3p14-15). Similarly, Elaine commented:

> *You've got to be careful the way you word things because it can be taken out of context. You might mean it in a nice or happy or jovial way but because you can't portray that in email or in forum in text it gets taken out of context and can be felt as criticism. So even though everybody I'm sure was very well meaning of it, unfortunately for me…I found myself reluctant to disclose too much on that forum 'cause it felt not hostile but not as supportive.* (4p21)

As previously discussed, learning the counselling intervention was a challenging task for the majority of midwives and as such they relied heavily on the support of the project manager and site coordinator. Many midwives spoke appraisingly of these team members and used such terms as *"helpful", "incredibly supportive"* and *"fantastic role model"* to describe them. As one midwife explained, *"having those people on board from the beginning that were part of the training process and having their support has been quite invaluable"* (Violet, 1p6). Another midwife commented, *"if I couldn't see*

her [project manager] *for another three weeks I'd probably be panicking"* (Rachel, 1p10).

There was however some confusion around the roles of the chief investigators. Most midwives initially expected to work alongside the project's midwifery chief investigators, who they described as *"awesome", "inspirational"* and *"dynamic".* As one midwife explained, *"I was excited to be part of such a distinguished peer group"* (Olive, dp1). While the two chief investigators were heavily involved in the midwives' training programme, like most large research projects, the day to day management of the project was the responsibility of the project managers and site coordinator. Over the course of the first few interviews it became clear that this was something that some of the midwives had not expected or realised. Many anticipated the chief investigators would be more available to clarify the components of the intervention and relate the counselling techniques to their midwifery practice. Not surprising then some midwives expressed disappointment when the chief investigators were not as available on a regular basis to provide individual support. Interestingly, Quinn, when discussing this issue referred to herself as a "*student"* which may provide some insight into why this phenomena occurred: "*not as available as a student would like but at the same time we did a workshop…and to have her sort of undivided attention for the day was very helpful and our team felt we needed that a lot earlier"* (2p4).

While generally midwives expressed feeling supported throughout the project there was a sense in the data that the level of support could have been greater. Most midwives articulated that overall there was *"not enough"* or that they *"needed more"* support in the project. For example one midwife stated, *"It's been a lot of hard work and a lot of anxiety…and pretty much being left to do it ourselves without supervision"* (Olive, 2p4). Another midwife reiterated Olive's comment and stated, *"they'd sort of done a lot of preparation already as far as it goes for themselves and the study and perhaps hadn't anticipated that we were going to need more support"* (Mary, 2p6).

Not a money making venture

As previously discussed, midwives were trained in the project free of charge but unpaid. Once competent and recruiting they were paid at the same rate as a registered midwife. While none of the midwives expected PRIME to be a *"money making scheme",* the analysis also clearly revealed that several were disappointed when their financial remuneration wasn't perceived as equitable for the time they committed to the project. In the initial interviews midwives spoke of not being paid for project meetings, posting online discussions or travel expenses that were incurred when they recruited for PRIME. As a result some midwives questioned if they could financially afford to sustain the level of commitment required. As one midwife explained, *"I put in, it may not have been up to sixty hours training but I was up to over sixty hours work with the project and I think I'd earned forty seven dollars"* (Helen, 2p8). Another midwife said: *"it was never about making the money but I didn't, I wasn't able to do this if it was costing me money…I don't think I'm going to continue"* (Rachel, 2p9). Midwives expressed their concerns to the project manager and site coordinator and changes were made that enabled the midwives to claim time spent attending the online discussions and travel expenses incurred for the project. For midwives such as Carol, this was enough incentive to continue her participation in the trial and she explained; "*I get paid for travel so that is fantastic. In fact the day that come through I had actually, I was thinking of packing it in…that really made a huge difference to me…I'm going to keep doing this"* (3p16-17). For others, it was 'too little too late' to encourage them to remain in the PRIME project. For example, when Rachel discussed her reasons for withdrawing from the randomised control trial she stated a contributing factor was "*Time and money basically, unfortunately money had to come into it but that's a fact of life isn't it*" (2p21).

Hard work but a worthwhile experience

It is obvious from the analysis that not one of the midwives interviewed anticipated the level of commitment their role in PRIME required. Many described their research experience as *"hard work", "hard yakka"* or relegated it to the *"too hard basket".* As

one midwife explained, *"I didn't comprehend how much time it would take out of our lives…I really wasn't prepared to compromise my lifestyle"* (Gill, 2p3). Similarly, Rachel stated, *"this is much harder than what we thought it would be"* (2p24). Many midwives expressed feeling *"overwhelmed", "pressured"* or *"burnt out"* keeping up with the demands of the role as well as other personal and professional commitments. For example, Mary explained, *"I just felt like I was spreading myself too thin"* (2p1) fitting PRIME into an already busy schedule. Similarly, Carol commented that "*this is what I felt like when I was an independent midwife, I was beginning to feel a bit overwhelmed…putting myself out over and above myself and the hours outside normal time"* (3p15). Some midwives believed the research team was aware of the level of commitment required but elected not to openly disclose this information. As one midwife explained, *"I suspect the national project coordinators knew but didn't disclose. I felt ripped off because of the level of commitment you can afford is not enough"* (Elaine, 3p5). Similarly, Olive agreed with Elaine's suspicion and stated;

> *I think they were afraid that it would put people off. That they maybe wouldn't get the commitment from the midwives so therefore they said ok everybody, everybody on board, all casual, jump on we'll give you the basic training and then you know we know there's going to be a natural attrition rate and I just think that they went too wide, too wide and too thin and definitely needed to be told that there was more involved than there was. More realistic, it wasn't realistic.* (2p32)

Having said this, however, it is also interesting that although PRIME was considered hard work for all the midwives, many were still of the opinion that it was overall a worthwhile experience. Midwives spoke of *"gaining insight"* into midwifery research, of developing a *"far greater respect"* for the process and of not being *"so naïve"* to the level of commitment required. For midwives such as Violet and Carol their experience was described as *"overall it's been positive"* and *"given me an interest in research*". Being "*involved"* not only enhanced the midwives understanding of the research process but also their confidence to engage in other research activities. Elaine for

example stated, *"I've got exposure to this any other research that I want to do or be involved in I'm going to feel more confident in doing and getting involved"* (2p9). Likewise, Rachel commented, *"I've learned so much by being involved in PRIME. So for me even though I didn't get paid and I didn't stick it out to the end I've learned a lot…I wouldn't rule out doing it again"* (2p20). For others such as Quinn, PRIME was the precursor to conducting her own research and she explained, *"I am quite confident if I can fit in the time that I will* [do research]*…I actually put forward a proposal"* (3p18).

In contrast, this newfound knowledge prompted some midwives to be *"wary", "careful"* and *"more selective"* when considering participating in future research projects. Several midwives doubted they would ever consider undertaking individual research pursuits now knowing the level of commitment required. As one midwife stated, *"it's fantastic it's just not me"* (Helen, 2p29). Another midwife commented, *"It's not my cup of tea"* (Violet, 1p24). Yet at the same time none of the midwives interviewed were averse to participate in other collaborative research studies in the future.

Summary

In this chapter, the reader has been introduced to the midwives' experiences of working in research and participating as research assistants in the randomised control trial PRIME. It was explained how the midwives' limited research activity prior to working in the PRIME project was related to their perceived insufficiencies in their training, comprehension, support and time available. The PRIME project presented them an opportunity to not only advance their own personal and professional development but to also get involved in research. Midwives in this study considered their preparation for and work as a research assistant in the RCT a challenging experience. In part, they attributed this to learning the counselling intervention, having their practice critiqued and being daunted by the level of commitment the research role required of them. The support of the collegial team members of the project was therefore fundamental to the midwives perceiving this experience positively. However, despite these challenges midwives expressed that overall PRIME was a worthwhile experience that enhanced

their knowledge of the research process. The findings elicited from the midwives in relation to their experiences of caring for distressed women in practice and delivering the counselling intervention will now be presented in chapter five.

Chapter 5

The low road: Working with distressed women

You hear other women's birth stories and some women are just obviously so traumatised by it and you think 'God what are we doing wrong?'…fifteen years further on from that birth that she was talking about, and within the first thirty seconds of the interview she was in tears…we've got to do better than this…for me it was a huge motivator…we have to get this right, the implications are just too far reaching

(Violet 1p15, twelve months into the PRIME project)

Introduction

Chapter five is the second of two findings chapters in a thematic analysis of 18 midwives' experiences of participating in a randomised control trial (RCT) and delivering a counselling intervention to distressed postnatal women. Chapter four presented five themes in relation to the midwives' experiences of working in research. This chapter provides an additional four themes that describe the midwives' experiences of caring for distressed women in practice and implementing a newly learned counselling intervention in the PRIME project.

When quotes are used to illuminate and support a theme or subtheme in these findings chapters, the identity of the midwife is protected by the use of a pseudonym. Likewise, any references made to names of people in these quotations have been removed. Quotes are presented in italics with the pseudonym of the participant, source (diary-'d'/forum-'f'/or interview number) and page number of the transcript cited. Where words have been omitted from quotations … is used to indicate this.

Caring for distressed women

As stated above, in this chapter four themes are presented that relate to the midwives' experience of caring for distressed women and implementing the PRIME counselling intervention. The first two themes labeled 'Women out there on their own' and 'Dilution of the midwives' role', set the scene by describing midwives' perceptions of current postnatal care and providing emotional care to women during this important time in their lives. The third and final themes 'Brushing so closely next to women' and 'Making a difference', reflect the midwives' descriptions of caring for distressed women in practice and implementing the PRIME counselling intervention. A diagrammatic overview of the themes and sub-themes discussed in this chapter are provided in Table 5.1.

Table 5.1: Four themes and sub-themes under 'The low road: Working with distressed women'

Women out there on their own
Dilution of the midwives' role
A small cog in the big wheel
Little time to talk
Role taken over by others
Brushing so closely next to women
Working at the forefront
Brave to look at ourselves
Making a difference
It meant something to the women
A tool for midwives
More mindful, more skilled

Women out there on their own

The theme 'Women out there on their own' reflects the midwives' perceptions of the limited emotional care offered to women in the postnatal period and that they are left to fend for themselves. In essence this theme sets the scene by putting into context the reasons midwives were motivated to seek the opportunity to participate in PRIME.

The midwives interviewed for this study considered the postnatal period to be a very important time for women in their changeover into motherhood. While they considered that midwifery care was integral to assisting women make a healthy transition, they simultaneously acknowledged that the emotional support provided to postnatal women was often inadequate. There was a general sense that in the hospital setting midwives frequently prioritised the practical and educational aspects of midwifery practice over providing emotional care. Phrases such as *"I don't think we're offering enough"* and *"it's something that's really needed"* were common to the data set. As Violet explained *"emotional psychosocial side of things is just so valuable and gets overlooked to a large degree"* (1p23). Elaine reiterated this by saying, *"the psychological family health is the poor sister that tends to get ignored in birth"* (2p7). Although these midwives expressed a strong desire to play a more active role in women's emotional care, they spoke of their efforts often being hindered by factors such as the length of hospital stay for women in the postpartum.

Midwives articulated that with the ever decreasing length of hospital stay, they had limited opportunities to elicit and listen to postnatal women's stories or provide them with effective emotional care before discharge. On average, midwives reported women were sent home from hospital 2-4 days after birth and referred on to other health service providers such as the child health nurse and general practitioner for ongoing care. Many midwives expressed concern that this was *"not enough"* and believed more should be done to support women during this time. Rachel for example expressed concern that women referred on to child health services could not *"see anyone for more than a couple of months which is not nearly enough…there's not a lot of support out there"* (1p15). Likewise, Dana commented *"the time they're kept in hospital is cut down even*

more…it's even more important that we need to start to have a resource for these women postnatally" (1p1). Some midwives with experience of working in the community setting spoke of witnessing the *"fall-out effects"* of postnatal women they perceived had received insufficient emotional support. Pam for example commented that, "*all too many times I have witnessed women so traumatised by a birthing experience that it has profoundly affected them to the degree that they cannot function as part of their own family let alone society*" (dp13). Another midwife explained "*I've sat on the other side of child health and watched the fall-out effects of these women…if they* (babies) *have a more sound environment and a more confident mother emotionally they will do better*" she went on to express concern that *"I don't know that midwives generally speaking understand that"* (Quinn, 2p13).

As a result midwives expressed a strong desire to play a more active role in *"helping"* support women emotionally. The majority of midwives were therefore "*interested*" in contributing to the PRIME study. Midwives hoped PRIME would provide the evidence required to improve practice. Most thus anticipated that their participation in the project would enhance their own counselling abilities and better equip them to provide women emotional support in practice. For some of the midwives, like Carol and Olive, PRIME was considered an opportunity to *"refresh"* and utilise counselling skills they had previously acquired. For Beth and others it was about learning how to counsel women effectively, a skill she believed would be a *"huge asset"* for her midwifery practice. Dana expressed the view that women needed to *"debrief following even the most normal of birth experiences"* and believed her participation in PRIME was an opportunity to *"learn how"* to do this properly. Similarly, Ann hoped that the knowledge she obtained in the project, would prepare her to know *"what you say"* to women distressed by their birthing experience.

Midwives also hoped PRIME would improve resources for women to access. Ann, for example, anticipated that participating in PRIME would improve her knowledge and understanding of what women needed both in hospital and the community. She considered women to be "*out there on their own*" with little access to appropriate

resources and/or supports. The following quote by Quinn was reminiscent of the majority of the midwives' opinions of the PRIME project, "*it was something I believed in, that I have learnt to be completely passionate* (about)*…this is something that should be happening now*" (2p5).

Dilution of the midwives' role

When discussing their thoughts on postnatal care and their own practice in this area, many midwives perceived their role and sphere of practice within the hospital setting was becoming increasingly eroded. As a consequence, many believed this impacted on the emotional support they provided to women in their care. 'Dilution of the midwives' role' clusters together three sub-themes. The first labeled, 'A small cog in the big wheel', describes the midwives' perceptions of their position or place with the hospital hierarchy. The second sub-theme 'Little time to talk', presents the midwives' descriptions of the difficulties they encountered trying to impart emotional care in a time poor environment. Finally, the sub-theme 'Role taken over by others', highlights the midwives' sense that their role is becoming increasingly fragmented as a result of the multiple referral pathways to other health care professionals in the postnatal period.

A small cog in the big wheel

The sub-theme 'a small cog in the big wheel' describes how the midwives felt they were positioned in the hospital organisation and the subsequent impact they believe this had on their practice. All of the midwives interviewed had experience of practicing in what they commonly referred to as the *"the system"* and the majority were employed by a maternity hospital at the time of this study. It was evident from their descriptions that although many believed their role within these organisations was necessary, they also felt that the 'woman centered' ideology to which they aspired was considered of minor significance in the overall scheme of things. Midwives expressed a sense of despondency and conflict with their role, realising that although taught to provide 'woman centered care' this was difficult to achieve working within the confines of a *"system"* governed by strict guidelines and policies. When they were asked to talk

about their midwifery role in hospital, some articulated that they felt they were working for a *"failing health system"*. Midwives spoke of how organisational issues such as increasing workloads, limited time and lack of continuity of care impacted not only on their ability to provide holistic care to women but also on their level of job satisfaction. As one midwife explained, *"I have noticed that the system that offers maternity care to the majority of birthing women is inadequate to say the least"* (Pam, dp12). Rachel reiterated Pam's comments and articulated that for her it was *"awful working for a failing health system*" (1p1). It was evident from their descriptions as well as others that many were disheartened working in the hospital setting. Olive for example explained she *"felt lost in a big system that said you're insignificant you're just part of a cog in the world. Turn up, do your bit and bugger off home"* (3p15). Similarly Carol commented that for her *"working in the system that we're in at the moment is crap"* (4p11). One midwife was of the opinion that part of the problem was related to midwives having to conform to unstated expectations of the institution and *"learn to deal with"* women in their care stating rather than meeting women's individual needs and preferences commenting:

> *They* (midwives) *know the preferred method that the hospital would like, you know the way that they would like women to do things…I've seen some midwives who've become quite developed in channeling women into birthing the way that they would like them to…I see what appears to me like a dance that goes on from the midwives to create a situation where their job can be easier and it can fit in with the system that they've become part of.* (Mary, 2p14)

When the midwives were then asked to discuss the emotional support they provided to women in hospital, some articulated that in the *"age of litigation"* their practice was often *"inhibited"*. Midwives such as Elaine and Violet used words such as *"restricted"* and *"guarded"* to describe their practice. These midwives, like others, felt they were unable to candidly critique the care of women in labour or openly discuss their birthing experience when called upon to talk through their experiences postnatally. As Mary explained, *"I kind of avoided saying anything bad about things that people had done*

like agreeing with them 'cause…you're not supposed to go against the hospital system" (2p16). Similarly, Tania stated, *"to deliberately challenge the systems in place and to openly admit we've made mistakes…usually you're scared of litigation and that would never come out of your mouth"* (1p24).

As a result several midwives expressed a desire to practice with a degree of independence from an organisation which is what they anticipated PRIME could provide. As one midwife explained, *"I've wanted to reconnect with the ability to relate to people on a deeper level and not just be part of the big industry"* (Olive, 2p33). Many of the midwives were therefore *"excited"* at the prospect of participating in the PRIME study and of having what they perceived as the "*freedom"* to practice with a level of autonomy. Violet for example, explained that in PRIME she believed she would be able to have a *"completely honest conversation"* with women about their birth experiences. Likewise Elaine commented, that instead of being an *"ambassador of the institution"* the PRIME project would allow her *"to be a midwife in its pure sense…you're not protecting anybody…that gives you an amount of autonomy for you to be able to practice as you should be in being the advocate for the woman"* (2p1). In addition to a degree of autonomy in practice, the midwives also anticipated that PRIME would provide them with an opportunity to talk to women without being encumbered with the multiple tasks that often ensued in their hospital position.

Little time to talk

'Little time to talk' is the second sub-theme that presents the midwives' descriptions of how they perceived the chaotic postnatal environment provided little opportunity for them to spend time with women in their care. When midwives were asked to elaborate on factors that they believed influenced their ability to impart emotional care to women in the early postnatal period, 'limited time' resounded prominently in their replies. As previously discussed in chapter four, midwives articulated that they were working in a time poor environment that left them with *"little time to even talk to women".* As Nicole explained, *"it's gone from where you had a chance to really know the family to where you feel like they're in and out so quickly that you don't get a chance"* (1p8).

Midwives described their work environment as *"task orientated"* and acknowledged that the care women received was not woman centered and could be likened to being on a *"conveyor belt".* With increasing demands on their time, all expressed feeling pressured to impart basic education to women prior to discharge and of having little opportunity to discuss their birthing experience. As one midwife explained, *"We are having less time with our mums, yet expected to churn out more and more, losing intimacy and relationships for robotic chaotic duplication of non essential chores"* (Tania, fp66). Similarly, Dana commented *"we are sending women home within twenty four hours…the chance of trying to get through all the general education let alone sitting down for an hour or so and talking through a birth experience… it just couldn't be done"* (2p7). Furthermore, some midwives admitted that when they spoke to women they were not as supportive as they would have liked to have been. As one midwife explained, *"You can't sit there and talk to people for too long because you're letting the team down"* (Mary, 1p2). Another stated *"you're so preoccupied about the next thing that you probably are not as supportive as you could be"* (Lucy, 1p12). Rachel believed that the time constraints also influenced midwives' expectations of the women they cared for and explained, "*we expect women to talk a lot in a short amount of time and I think our expectations of women are higher than what they should be"* (1p4). When women were then referred on to other health professions for ongoing emotional support postnatally, several midwives expressed the view that their role was being increasingly eroded.

Role taken over by others

The third and final sub-theme that signals how midwives felt their role was being diluted, relates to the increasing number of women being referred on to other allied health care professionals for emotional care. Assessment of a woman's emotional status is incorporated into routine prenatal visits. Women identified at risk for depression are offered referral to services such as psychiatry, clinical psychology and/or social work depending on the level of support required. In addition to prenatal screening, postnatal

women identified as emotionally vulnerable by their attending midwife or doctor, are also offered referral to such support services.

Although midwives expressed a desire to be more actively involved in women's postpartum emotional care, they simultaneously acknowledged that many women were instead referred on to other allied health care professionals for ongoing emotional support. In their discussions many midwives expressed this was because they often had insufficient time working in the chaotic postnatal wards. Others suggest midwives doubted their ability and lacked the confidence to counsel distressed women. Furthermore, some midwives were of the opinion that health care professionals such as psychologists and social workers were better equipped to give women the emotional care they required following a distressing birth experience.

Working in a time poor environment with increasing demands to complete practical tasks resulted in the emotional aspects of women's care often being referred on to others. As one midwife explained, *"because of the time constraints and the business of the wards we're a little too quick to hand over to the clinical psychologist…we don't venture into the birth experience as much as I think we could"* (Dana, 1p1). Dana was of the opinion that distressed postnatal women were being *"too easily"* referred on to other allied health professionals for postpartum counselling rather than midwives addressing this issue themselves. One midwife believed her colleagues may not *"feel they have the skills"* to counsel women effectively. While several others *"assumed"* professions such as clinical psychology and social work were better prepared to provide emotional support to women following a distressing birth experience. As Quinn for example explained she *"assumed social workers and psychologists would have a better understanding of women's health issues and potential traumatic* (birth) *experiences"* (2p21). Likewise, Violet commented that,

> *You tend not to tackle a lot of that issue because you kind of go 'oh that's not my scope of practice that's the clin psychs* (clinical psychology) *it's not for us as a midwife'. Like you assume there's that professional person…clin psych's sold to*

> *you as if they've got all the answers they're the ones that deal with that side of things leave it alone.* (1p25)

However, it was evident from their descriptions that when the midwives commenced PRIME and were exposed to the knowledge of preparation clinical psychologists received, how it varied considerably and often did not include common women's health issues and trauma as it related to birth, they began to question this referral process. Midwives felt they were in fact better positioned to provide emotional support to women postnatally. As one midwife explained, *"potentially I think midwives are in a really good place and probably better than most professions to be able to you know talk through those stories"* (Joan, 2p8). Another midwife commented *"this is our bread and butter, this is what we do, dare I say it's kind of been taken away from us"* (Elaine, 2p10).

Several midwives voiced a desire to reclaim the role of counselor in their midwifery practice, using phrases such as we *"know what to expect"* and *"we have the knowledge"* to justify their position. Midwives were of the opinion that when women sought clarification of events that occurred during their birth experience that they were indeed best suited to provide them such information and support. As Carol explained *"only somebody like midwives who know the process of birthing and what goes on…are able to fill in the missing pieces for the women"* (4p4). Likewise Quinn stated, *"I get quite frustrated now when a social worker stands on my territory…I actually do know how to speak to the woman about a post traumatic birth. You don't deliver babies and I have"* (2p21). Carol and Quinn's comments are reminiscent of the majority of the midwives' comments but were best encapsulated in Violet's following statement:

> *I've assumed all these years that they are the people that …should be dealing with this and they are the person that has the skills and the knowledge…They're not midwives, they don't understand it, they've not been with women who've birthed…they don't get what happens behind those closed doors.* (1p26)

When the midwives reflected on practice events perceived as distressing, it was evident from their descriptions that they too were affected by what they had witnessed. The next theme 'Brushing so closely next to women', provides insight into what it's like for midwives to work in situations they considered stressful and to provide care to women distressed by such events.

Brushing so closely next to women

When the participants spoke of their role as a midwife, it was evident that they believed a close bond existed between themselves and the women in their care. Many acknowledged that when women became distressed this closeness made their work even more *"challenging"*, a factor that was also evident when they later described their experiences of implementing the PRIME counselling intervention. Midwives articulated that they found it difficult not only practicing in situations they perceived as stressful but also providing care to women distressed by such events. The theme, 'Brushing so closely next to women' thus encompasses two sub-themes that describe what it was like for midwives practicing in situations they considered stressful. The first sub-theme, 'Working at the forefront', describes how prior to PRIME midwives felt they were ill prepared and unsupported in their role caring for women in stressful situations. The second sub-theme 'Brave to look at ourselves', describes the midwives' experiences of reflecting on their performance in PRIME and of developing confidence to counsel distressed postnatal women.

Working at the forefront

This first sub-theme, 'Working at the forefront', describes how the midwives believed they were positioned in their practice working alongside distressed women *"day in day out"* feeling ill prepared and unsupported. Many believed their midwifery training did not adequately prepare them to cope with stressful practice situations or provide them with counselling skills to support women distressed by birthing events. It was evident in their descriptions that frequent exposure to perceived stressful practice events had a

negative impact on the midwives which was further compounded by a perceived lack of support offered from their colleagues and the organisation in which they worked.

As previously alluded to in Chapter 4, several midwives interviewed for this study openly acknowledged that prior to PRIME they felt unprepared for events they had perceived as *"traumatic"* in practice and most articulated that they were not confident to counsel distressed women. As one midwife explained, *"it's just assumed that you will do it because inevitably you're that close to women in a time of great emotional vulnerability"* (Fran, 1p4). For the most part, midwives attributed this perceived lack of preparation to their midwifery education which many believed only focused on the *"physical side of midwifery".* Quinn for example commented that, *"I was hospital trained…traumatic situations were never a taught process"* (2p6). Another midwife stated that *"no one really goes into the trauma part…we weren't given any preparation"* (Lucy, 2p27).

While one midwife was of the opinion that midwives were "*counsellors in our own right*", the majority expressed the view that their midwifery education did not prepare them for this role. As Gill explained "*any skills that we have, we've picked up and learnt along the way from our experiences*" (2p12). Similarly Carol, disputed the view that midwives possess innate counselling abilities stating, *"I don't think midwives are natural counsellors"*. She went on to explain that although she believed midwives generally had good interpersonal skills, most would benefit from learning *"basic counselling"* (3p22). Given the midwives perceived poor counselling preparation, it's not surprising they expressed a sense of difficulty caring for distressed women in practice. Rachel, for example stated, "*Lots of nurses and midwives say 'I wish I knew the right things to say…I don't want to be someone's bad memory'…those times where you feel quite uncomfortable not knowing, you feel like you're out of your depth*" (1p4). Likewise, Lucy explained that prior to PRIME *"I didn't want to go there you know like if they got really emotional…probably wasn't ready to compartmentalize or have the skills to deal with it properly"* (2p27). Interestingly, when the midwives spoke of their experiences working alongside women in stressful situations, it was apparent from their

descriptions that they expressed a sense of wanting/needing more support from their colleagues and the organisation in which they worked.

When discussing events they had perceived as stressful in their practice, midwives used words and phrases such as *"frightened", "distressing"* and *"it affects you"* to describe how they felt. Many articulated that at such times they believed they were unsupported in their role. As Lucy explained *"if something went bad, there wasn't anyone you could go to and debrief with"* (2p28). Similarly, Carol stated *"all the trauma situations that midwives go through and you just kind of shove it to the back of your mind"* (4p15). Elaine was of the opinion that it was inevitable that midwives would be affected by such experiences because they were *"brushing so closely next to women"* in practice and explained her point of view like this;

> *If you were feeling trauma say you had something happen to you and you're feeling anxious and alone and desperate and desolate and angry and… I'm walking close to you and I start feeling the anger and desperation, they are not nice emotions to feel.* (3p28)

As a consequence of feeling unsupported in their position, midwives used terms such as *"falling apart", "burnt out"* and *"hardened"* to describe the impact these experiences had on them. Quinn commented that she had *"no doubt that midwives are being traumatised by their work. You only have to sit in some of my handovers at work to know"* (3p17). Elaine was of the opinion that midwives would *"distance themselves"* from the women in their care in order to cope in such situations and explained *"If you're copping that all day at work and then you're not getting supported by your peers…your soul, your emotions get sucked dry… older midwives who've been doing it for years…have atrophy of the sympathy gland"* (3p21). One midwife with previous counselling experience was of the opinion that midwives would benefit from clinical supervision, a process regularly used in psychology and other disciplines to provide therapists with feedback and stated, *"it's one of the professions that don't have supervision and they're dealing with people and relationships all the time and you know traumatic experiences…they never really have a thing in place where you can actually*

go and talk" (Carol, 2p4). When the midwives commenced work for the PRIME project, they spoke of changing their approach to practice and of developing skills that not only assisted them to implement the PRIME intervention but also to cope with stressful situations they encountered in their role.

Brave to look at ourselves

'Brave to look at ourselves' is the second sub-theme under the main theme of Brushing so closely next to women that presents the midwives' descriptions of their *"challenging"* journey learning to implement the PRIME counselling intervention and develop confidence to counsel distressed women in practice. When describing their experiences of learning the counselling skills taught in PRIME, midwives spoke of reflecting on their performance and of the *"difficult"* task of *"learning to change"*.

As previously discussed, prior to PRIME, midwives expressed a sense of difficulty caring for distressed women in practice within the context of having limited understanding of the nature of trauma and its relationship to the care received. When they were asked to talk more about these experiences they used phrases such as *"I didn't want to go there"* and *"I didn't want to mess her up"* to describe how they felt. The majority openly acknowledged that they were neither confident nor comfortable in the counselling role. As one midwife explained, *"before PRIME I would have run away from it, I wouldn't have gone there"* (Elaine, 4p17). Some midwives, such as Nicole, felt they were protecting the woman by *"not making her explore her feelings"*. For others like Violet, it was a sense of *"fear"* that they would only *"make it worse"* for the women in their care. However, as Elaine poignantly explained *"It's the thing that we've got to get right. So we've got to be brave to look at ourselves objectively"* (2p10).

Midwives articulated that changing the way they interacted with women when implementing the intervention was a huge learning curve that was not easy. Some midwives described themselves as "*problem solvers",* keen to provide women with an answer and *"make it right"*. However, PRIME focused on supporting women to explore and identify their own solutions. As a result several midwives expressed the need to re-evaluate their usual approach to practice. For example, Tania explained *"you're taking*

on a different mindset, you're looking at things more objectively and you're trying to get to the bottom of things" (1p15). Likewise, Quinn commented that midwives are generally focused on "*fixing a problem, hearing a problem and then giving an answer and that is not what PRIME is about, it takes a completely different approach for a midwife to walk down a bit of reprogramming in our heads"* (3p9). Not surprisingly then, many midwives struggled to adapt and expressed finding this new way of working and interacting with women *"uncomfortable".* As one midwife explained it was like *"stepping out of my normal comfort zone"* (Nicole, 2p17). Similarly, Quinn commented that *"like anything new…when you're changing who you are and what you do it's quite an uncomfortable time and I guess that's not to be underestimated because you're learning a new technique…you're learning to change"* (3p19).

Most midwives agreed that part of the learning process was to *"listen to women",* of *"not being afraid of the silence"* in their conversations and of developing confidence to *"let women talk"* about their experiences. For Violet, it was about *"really listening to what's being said…not reading things into it"* (1p1). For others such as Lucy and Nicole, it was a matter of not attempting to fix women's problems but to *"shut up and listen"*. When the midwives gained experience implementing the techniques taught in PRIME, it was evident from their descriptions that they became more comfortable listening to distressed women's narratives. Lucy for example explained that since participating in PRIME, *"instead of fobbing it off,* (I'm) *more prepared to sit and listen"* (3p27). Similarly Nicole stated:

> *I just want to make their world feel better but it might not actually be about just making their world better it might be just letting them talk about their experiences…letting them reflect…come up with their solutions and their coping mechanisms and their support.* (2p16)

One of the most challenging aspects of the PRIME intervention for the midwives was learning how to *"unpick"* and *"tease more out"* of the women's narratives whilst listening intently to her story. As one midwife explained *"your brain is in all different angles…you become this omniscient midwife emotionally looking at every angle of*

everything that you've said" (Elaine, 3p29). Likewise, Tania commented, *"there's so many unknowns and so many elements that you might have the opportunity to touch on and it becomes overwhelming sometimes"* (1p9). Some midwives also spoke of women's propensity to *"package"* up their emotions and the difficulties they encountered trying to get them to explore their feelings. For example Olive stated *"how do we open the carefully wrapped package when the woman is insisting we see how beautifully she has wrapped it and she needs it to stay that way"* (fp68). Similarly, Nicole commented that she learned *"not to let the lady just wrap up her story but to really unpick all aspects of the pain, physical but mostly the emotional pain"* (fp3).

While all the midwives considered learning to implement the intervention was *"difficult"*, those that continued on for several months or completed the intervention stage articulated that they became more confident to counsel distressed women over time. Midwives spoke of becoming *"comfortable with her* (the woman's) *crying",* of developing the *"courage really to talk about sensitive issues"* and of learning *"to listen and be more present"* when describing their counselling experiences in the project. Olive for example explained she had gained an *"increasing confidence with dealing with and supporting women who have experienced trauma"* (fp45). Another midwife commented that, *"It's definitely been beneficial for me, I've definitely grown from it and I've definitely altered my practice. My skill level has improved…I'm better at honing in on things"* (Tania, 1p24). Olive and Tania's comments are reminiscent of the majority of these midwives but were best encapsulated in Quinn's posting on the midwifery forum:

> *I now have the knowledge to be confident to not let her trivialize the trauma, I give her permission to tell me how she feels as that is where the pain is and I do have the experience to walk that journey with her and explain a misunderstood event and connecting the emotions to this is a very challenging but also the most exciting moment of the process.* (fp5)

While some midwives learned to be comfortable working with distressed women in PRIME, others expressed that they were never confident in their ability to implement

the intervention. One such midwife who worked in PRIME for 9 months stated *"I don't think I was ever great at it…because it's completely different to the way we normally would do things"* (Lucy, 3p3). Likewise, Rachel with 5 months experience in the project declared she may *"never be comfortable doing it"* and explained *"I don't think it's something that we are used to doing pulling apart a story or letting people get emotional"* (2p2). For others midwives such as Ann, who completed the initial training and DVD competency and then withdrew, stated *"I didn't feel that I was capable of delivering this midwifery intervention"* (3p15). While Ann attributed her lack of confidence to the training she received in PRIME, others openly acknowledged they were not *"comfortable"* listening to and managing women's emotional responses. Beth for example, explained she was *"fearful of…interviewing them and bringing up some things that I couldn't handle"* (2p1) and withdrew from the study after 2 months. Joan, who participated for 3 months, doubted her ability to implement the intervention stating *"I felt a bit blind you know thinking what, I'm not really sure here what I'm supposed to be doing"* (1p8). When then asked to discuss why some doubted their ability to implement the intervention, midwives spoke of PRIME being *"translatable"* but *"not to every midwife"*. One midwife believed that *"maybe some people are cut out for this and other people just aren't"* (Rachel, 2p2). Similarly, Elaine commented that *"a lot of the success of this intervention and this tool is…to do with a person's ability to get insight; to be in tune with their insight and instinct. Some people have just got that and some people haven't"* (4p28).

Although some midwives lacked confidence in their ability to deliver the PRIME intervention, all those that stayed in the project past the initial training phase expressed gaining a sense of self-satisfaction from their counselling experiences. These midwives spoke of their counselling experiences positively using words such as *"rewarding"*, *"empowering"* and *"validated"* to describe how they felt. For Elaine and Olive, it was about feeling validated as midwives. As Elaine explained, *"I feel more like a midwife now"* and went on to declare she'd been *"empowered with a tool that is going to benefit me for the rest of my midwifery career"* (3p34). Similarly Olive stated *"I feel like I am giving back and my midwifery again has meaning and value"* (fp65). For Tania and

others, it was believing they had made a difference in the women's lives that was satisfying; "*There was definitely some trauma in her birth experience and…it all just came bubbling out…I was enjoying the interaction and I felt like I was making a difference"* (1p14). Likewise, Nicole commented *"she said to me at the end of the counselling 'thank you ever so, ever so much' so it was very satisfying for us both!!"* (fp77). Not surprisingly then, when their role in PRIME was completed one midwife expressed a sense of disappointment at the prospect of having to return to work in the hospital setting and stated *"the curse of prime is of course forever feeling dissatisfied at our work place"* (Tania, fp66). In part this disappointment was related to the fact that many felt they had made a difference in women's emotional recovery but they doubted they would have the opportunity to do so in a hectic clinical environment.

Making a difference

When the midwives discussed their experiences of implementing the PRIME counselling intervention, it was evident that they believed the skills they had acquired could be used to assist not only women distressed by their birthing experience but also others. This theme "Making a difference" groups together three sub-themes that present the midwives' descriptions of how they believed the techniques taught in PRIME were not only *"making a difference"* for the women in the project but also enabled them to help themselves, their colleagues and others outside of the profession to cope in stressful situations. The first sub-theme, 'It meant something to the women' presents the midwives' descriptions of how they believed the distressed women in PRIME benefited from the counselling intervention. The second sub-theme, 'A tool for midwives' describes how the midwives used the skills they had learned in PRIME to assist themselves, their colleagues and family members to cope in situations they considered distressing. Finally, the sub-theme 'More mindful, more skilled' provides the descriptions of the midwives who over time gained confidence in their ability to work with distressed women.

It meant something to the women

This sub-theme 'It meant something to the women' describes how the midwives believed the distressed women in the study benefited from the implementation of the PRIME counselling intervention. When the midwives were asked to talk about their counselling role in PRIME, it was evident from their descriptions that they believed the intervention would provide them with the necessary skills to help distressed women in their care. Gill for example stated, *"I was really excited to think we were going to be doing something to help women…that always drove me to think that it was going to be making a difference"* (2p2). Similarly, Carol explained she was motivated to contribute to the project because *"I want to be helpful…I want to be beneficial to women"* (3p32). When then asked to talk more about their individual counselling experiences in the project, midwives expressed the view that the intervention had made a difference for the distressed postnatal women they had encountered.

Midwives described the postnatal women they had met in PRIME as *"very grateful"* and that some had expressed a sense of *"relief"* following the counselling sessions. Beth explained that one woman stated on completion of the counselling intervention that *"it was one of the best things that happened between her and her husband 'cause it's the first time they'd discussed things…brought them closer"* (2p3). The midwives came to understand and appreciate how each aspect of the PRIME intervention worked to assist and emulate distress. Carol for example commented, on assisting women to understand all aspects of their birthing experience saying that for several women *"the missing pieces of their birth story had been filled in and they were clear in their mind…they would say 'oh yeah that makes sense'…you could tell that it had meant something to them"* (4p1).

For midwives such as Quinn and Olive, part of the benefit of the intervention was providing women with the opportunity to talk through their labour and birth experience and put the sequence of events into perspective. As Quinn explained, *"The relief that occurred after my intervention for her was obvious and I had the honor of watching her and her husband discuss parts of the events that they had never reviewed. She*

had...never discussed" (fp5). Likewise, Olive commented that one woman "*began to cry and said that it was difficult to revisit but helpful to understand some aspects that had not made sense to her before"* (fp49). For other midwives such as Violet, it was about providing continuity of care by a *"known and trusted person"* in PRIME that they believed was most beneficial for the women. Violet was of the opinion that all women would benefit from having someone available to listen and support them throughout the perinatal period and explained that in PRIME the *"feedback from the women 'thanks so much for ringing, it was just nice to talk to you'* (was) *across both groups, the randomised…or counselling group…that comment is quite resounding"* (1p28). An opinion that was reiterated by Elaine when she stated, *"isn't this all about communication…I guess I was the first person in their entire experience with pregnancy and birth and parenting that acknowledged to them you should have had continuity…you should have felt protected…you should have felt supported"* (3p31). Apart from the perceived benefits for the women in the project, it was evident from their descriptions that midwives believed the advanced counselling skills taught in PRIME provided them with a *"tool"* that could also be used to help themselves, their colleagues and others to cope when involved in stressful situations.

A tool for midwives

The PRIME intervention was developed to assist and improve the emotional health of women identified as traumatised after birth. However several of the midwives interviewed described using these advanced counselling skills in other situations as well. 'A tool for midwives' is the second sub-theme under the theme 'Making a difference' that presents the midwives' descriptions of how they believed the techniques taught in PRIME not only made a difference for the women in the project but also provided them with the skills to help themselves, their colleagues and family members to cope when confronted by stressful situations.

When the midwives discussed events they had considered distressing in their practice, it was evident from their descriptions that they too were affected by what they had witnessed. Midwives spoke of the *"emotional intensity"* often involved when they were

caught up in stressful situations in practice and used phrases such as *"that does hit home with you"* or *"shove it to the back of your mind"* to describe how they coped in such circumstances. Some midwives articulated that they believed the techniques taught in PRIME could be used to enable midwives confronted by such events not to *"take it on board"*. Elaine for example referred to PRIME as a *"double edged weapon"* and explained that when she was involved in a delivery she considered distressing she applied what she had learned to manage her own emotions stating "*I was shocked and traumatised by what was happening but I recognised it and was able to deal with it"* (4p8). Violet spoke of the need to seek counselling from the project manager following a particularly difficult intervention with a distressed woman and explained *"we are talking to women day in day out who've had traumatic births, so to be able to have someone else to debrief and bounce that off has been really necessary"* (1p6). Likewise, Olive commented that in the project *"we were thrust into paying more attention to the distressing parts of women's stories and there is no back up for us…project manager…has helped me to apply PRIME to myself"* (3p25). As well as a tool midwives could use to assist themselves when involved in stressful practice situations, others also spoke of applying these techniques to help their colleagues and family members exposed to a distressing event.

As previously discussed, the midwives interviewed felt they were often unsupported working in stressful practice situations and many believed midwives in general were being affected by exposure to such events. Midwives such as Carol and Lucy, articulated that the skills they had acquired in PRIME could be used to assist midwives in practice. Carol, for example, described a scenario of using the advanced counselling skills on a colleague who was the accoucher at a delivery where the baby died and stated, *"she was quite distressed and I actually used the PRIME on her and she said…'you've no idea how helpful that conversation was for me'"* (4p15). Similarly Lucy came to the aid of a student midwife and explained, *"I was doing, not my midwife counselling hat to a woman but to a student who has just been through a traumatic situation with her first shoulder dystocia…we talked it through…it did help"* (3p22). Furthermore, some midwives believed that by educating all midwives with the PRIME

techniques they would not only be better prepared to cope with the stressful situations they encountered in practice but also more able to support their colleagues distressed by these events. Quinn for example commented that *"you actually need another midwife to be able to debrief with, who understands the emotions and the adrenalin that are involved"* (3p17). Likewise, Elaine believed that PRIME may provide a solution to what she referred to as the *"emotional fallout"* in midwifery, where midwives are inevitably affected by what they witness in practice and explained:

> *It's something you could teach to either student midwives or graduate midwives. You're empowering the women and you're empowering the midwives…so all the emotional fallout that happens with being a midwife, here's a tool to be able to deal with that as well.* (4p16)

Furthermore, some midwives were of the opinion that PRIME was a tool that could be applied to distress in most situations. For example, Olive commented that *"as a midwife in a general hospital I'm already seeing that I can apply PRIME to most distress"* (3p16). Another midwife described a scene where she used the skills she learned in PRIME to assist her son deal with the death of a friend and explained, "*I was able to support him through that and as terrible as it sounds it actually ended up being a very positive experience…he's actually quite at peace with the whole thing"* (Elaine, 4p22). Apart from the perceived benefit of providing midwives with a tool to cope and assist others in stressful situations, the PRIME counselling techniques also enhanced some midwives' confidence to effectively care for distressed women in practice.

More mindful, more skilled

This final sub-theme, under the theme 'Making a difference', describes how some midwives believed their participation in the PRIME project not only made them *"more aware"* of how the childbearing experience can impact on women but also provided them with the skills and the confidence to care for distressed women in practice.

Early interview data collected from midwives before they commenced the PRIME project, suggests that the extent of women's distress and possible trauma following

childbirth was not really appreciated. As previously stated, many of the midwives worked in the hospital setting where postnatal women are discharged in 1 to 4 days following birth. Only midwives with experience of caring for postnatal women in the community or those with a personal history of perinatal mental health issues such as postnatal depression (PND) used words such as *"distressed"* and *"traumatised"* when discussing postnatal women and their birth experiences. While one midwife mentioned the word *"traumatic"* when talking about her own birth experience in the initial interview, most gave no indication that they were aware of the extent to which some women may be affected by their birthing experience. Interestingly it was noted, that in subsequent interviews after having an opportunity to talk to women and deliver the intervention, the midwives language was noticeable different. The realisation that some women were being *"traumatised"* by the care they had received during their childbearing experience was clearly apparent. As one midwife explained, *"you hear other women's birth stories and some are just obviously so traumatised by it and you think God what are we doing wrong…we have to do better than this"* (Violet, 1p15). Another midwife stated "*The number of women that I've spoken to and they've had what every other midwife or obstetrician would say "you've had a really good outcome because you've got a spontaneous vaginal birth"…but these women are absolutely traumatised"* (Elaine, 4p37). Having gained the skills associated with PRIME, midwives were able to identify and better understand how some women suppressed their emotions. Midwives described being able to pinpoint women who were *"in denial"*, *"holding guilt"* or *"haven't faced"* their birthing experience. Violet explained that when one woman's birth experience was not what she had expected *"it was easier to blame herself rather than to lose all faith/trust in the medical profession"* (fp46). Likewise, Olive commented that when interviewing a woman who recounted the events of a distressing labour 18 years passed *"she was retelling it as if it was yesterday. All she needed was permission and off she went"* (fp4).

During the interviews midwives retold women's birth stories and came to the realisation that unresolved distress could resurface and impact not only on themselves but also on their subsequent pregnancies. Carol for example related a story on the midwifery forum

of a woman whose firstborn had a congenital abnormality and explained that following the birth of her second *"normal"* child *"It made it so much more real for her that her 1st child wasn't 'normal'. It seemed this child had triggered the grief and loss she had experienced with her first"* (fp14). Another midwife, Beth spoke of interviewing a woman after the birth of her second child who began discussing a previous medical termination stating *"she'd never really grieved for this baby and held a lot of grief and guilt because she'd chosen to terminate…this came up…tears came out"* (2p3). Carol and Beth's comments are reminiscent of the majority of midwives' descriptions of what they encountered when implementing the PRIME counselling intervention but were best encapsulated in Olive's powerful description of a woman's dispassionate account of the birth of her first child and the subsequent impact hearing this story had on Olive:

> *She proceeded to state, quite matter of fact that her first emergency c/section* (caesarean) *was one big rush, she did not get to hold her baby. She said that as she lay on the cold operating table in the air conditioned room she was seeing the birth as if she were at a Woolworths deli counter. It was cold, the deli server complete with cap (surgeon) peered over the counter (green op sheet) and asked what was she having…minutes later the little parcel of meat (baby) was held up for her to see. "There you go that about right?" (surgeon confirming baby ok). "We'll just wrap it for you" (take baby away and wrap in cotton sheet). Meat gets labeled and passed over the counter all wrapped ready to put in trolley (incubator). I was gob smacked.* (fp46)

Midwives articulated that by becoming *"more aware of the effects of traumatic birth"* through their experiences in PRIME, they were subsequently *"more empathetic"* to women's plight. Several midwives spoke of how this newfound knowledge had altered their opinions and approach to practice. As one midwife explained *"if I hadn't been involved with PRIME I probably wouldn't readily associate trauma and fear with birth"* (Carol, fp50). Another midwife stated, *"when I talk to the women postnatally it's made me think about things a little bit differently…trying to find out where they're really at"* (Lucy, 1p12). Some midwives expressed that they were now less likely to *"assume"* the

level of a woman's resilience or how they may perceive their birth experience. Olive, for example, described a scenario where she was *"expecting to hear a horror story"* but was surprised to find a woman was not distressed following her birth and explained, *"I've learnt then, that it is important not to pre judge, to allow for the possibility of pre existing resilience and if in doubt simply ask"* (fp36). Likewise, Tania stated that since her participation in PRIME she was less likely to go straight to the positive affirmations with a woman after her delivery because she may "*have to smile thru* [sic] *gritted teeth and be possibly unable to ever tell anyone if it was horrible because all the midwives think she should feel great! Look what we are learning!"* (fp25). Furthermore, over time several midwives expressed a sense of confidence in their ability to approach and work with women distressed by their birthing experience. As one midwife explained at the completion of PRIME, she was looking forward to being *"able to connect with women on that deeper level"* (Olive, 3p16). Another midwife felt that since her participation in the project she was better prepared to talk women through their birthing experience in the postnatal period and stated *"in the past I tended to give mothers opportunities to debrief but PRIME has certainly given far greater tools to be able to walk somebody through that in a concise manner"* (Quinn, 3p3). Similar accounts of learning and developing new skills from their experiences in PRIME are echoed throughout the descriptions of all those midwives who remained in the project.

Summary

In this chapter, the reader has been introduced to the midwives' experiences of caring for distressed women and delivering the PRIME counselling intervention. It was explained how midwives in this study perceived the provision of women's emotional care postpartum as inadequate and that this was a primary motivator for them to seek the opportunity to participate in the RCT. Although the midwives wanted to be more actively involved in the care of women distressed by their birthing events, it was evident that prior to PRIME many were not confident in their ability to perform this role. For the most part, they attributed this lack of confidence on insufficient counselling education received in their midwifery training, limited opportunity to

impart emotional care in practice and the subsequent delegation of women's emotional care to other health professionals. Although challenging for some to learn, the advanced counselling skills midwives acquired in PRIME were considered beneficial for the distressed women they encountered in the project. Many midwives believed these counselling skills better equipped them to not only confidently care for women distressed by their birthing events but also help them personally to cope with stressful situations they may encounter in practice. Chapter six will now provide a discussion of some of the key findings identified in these last two chapters situating them within the contemporary literature.

Chapter 6

Dual lane highway: Two distinct stories

Introduction

This qualitative, exploratory study of 18 midwives' experience of working as research assistants in a randomised control trial (RCT) and delivering a counselling intervention to distressed postnatal women identified two distinct findings. The first related to the challenging but worthwhile nature of their role as research assistants. The second was the level of confrontation midwives experienced as they came to appreciate the level of emotional distress some women suffered as a consequence of their birth experience. As a result, this chapter is divided into two sections that discuss the key aspects of these distinct findings situating them within the contemporary literature. Given the paucity of research relating specifically to the midwifery profession it is important to note that at times the discussion draws heavily on the extensive body of evidence related to midwifery's sister profession of nursing. The chapter concludes outlining the strengths and limitations of the study as well as implications and recommendations for practice, education and future research.

Research: Challenging but worthwhile

One of the objectives of this study was to describe the midwives' experiences of working in research and participating as research assistants in the large team-based PRIME project. In chapter four, five themes that described the midwives experiences in research were presented. To recapitulate these findings, this study found that prior to their involvement in PRIME; the midwives attributed their limited research activity to insufficiencies in training, comprehension, support and time. The PRIME project presented them an opportunity to not only advance their own personal and professional development but to also get involved in research. Participants in the study considered

their preparation for and work as a research assistant in the RCT a challenging experience. In part, they attributed this to learning the counselling intervention, having their practice critiqued and being daunted by the level of commitment the research role required of them. The support of the collegial team members of the project was therefore fundamental to the midwives perceiving this experience positively. However, despite these challenges midwives expressed that overall PRIME was a worthwhile experience that enhanced their knowledge of the research process.

In this first section of the chapter, some of the key findings identified in chapter four that relate to the midwives' experiences of working in research will be discussed. This discussion commences in the section titled 'Midwives and nurses: data collectors for others', and provides a comparison between the participants' research experiences with that of other midwives and nurses recorded within the literature. Following on, the section titled 'Barriers to research persist for clinicians', examines factors the midwives in this study perceived hindered their research involvement to determine what, if any, commonalities exist within the literature on this topic. Finally, in the section titled 'PRIME: A collaborative approach to research', the discussion focuses on the findings related to the midwives involvement in the PRIME project and examines them in relation to contemporary literature, specifically, what motivated their participation, whether the collaborative approach provided any solutions to the barriers commonly associated with research and how, if at all, their experience in the project influenced their views on clinical research.

Midwives and nurses: Data collectors for others

The expectation that midwives will incorporate research into practice is clearly articulated in the Australian Nursing and Midwifery Council's competency standards (Australian Nursing & Midwifery Council, 2006). All midwives in this study were aware of the importance research plays in guiding midwifery practice and overall their attitudes towards research were positive. This finding is not dissimilar to that reported in many other studies conducted within the midwifery and nursing disciplines worldwide (Corchon, Portillo, Watson, & Saracíbar, 2011; Darbyshire, 2008; Fahy,

2005; Fenwick, Butt, Downie, Monterosso, & Wood, 2006; Ravert & Merrill, 2008; Roxburgh, 2006). However, despite this positive attitude, midwives involvement in research prior to PRIME was primarily as a collector or provider of data for other health professionals, with only one reporting undertaking independent inquiry. This finding suggests that many clinicians are not actively engaged in research themselves and is consistent with findings reported by many nursing academics and researchers (Corchon, et al., 2011; Deave, 2005; Fox, Bagley, Day, Holleran, & Handrahan, 2011; Higgins et al., 2010). For example, Higgins et al. (2010) position paper on the challenges and benefits for Australian nurses undertaking clinical research, reported that nurses participation in research is often in the capacity of data collector, and research conducted with clinicians is often imposed on them rather than generated or commissioned by them. Similarly, in America, Fox et al. (2011) web-based survey of nurses' (n=280) experiences in research, found that almost half of the respondents had participated in research as either a participant or data collector but independent inquiry was rare and mostly confined to nurses working in academia.

The use of nurses as research data collectors by other health professionals is well documented in the literature and is at times encouraged. Yallop and McAvoy (2007) when discussing medical research for example suggested that general practitioners could lessen their load by using nurses to recruit patients for medical trials. Yet it is widely accepted that to enhance research capacity within these disciplines, midwives and nurses need to focus on independent inquiry into areas of relevance for their clinical practice (Darbyshire, 2008; Fahy, 2005; Higgins, et al., 2010). Less than one third of the participants in this study reported an interest in undertaking independent inquiry in the future. Part of the explanation they reported lies with the level of commitment and the skills required undertaking individual research pursuits. However, all midwives in this study actively sought the opportunity to participate in the collaborative PRIME project and reported that they were not averse to participating in other team-based projects in the future. This finding lends support to the line of thinking that collaborative, clinical-focused, interdisciplinary inquiries may provide a solution to engaging clinicians in clinical research (Darbyshire, 2008; Fahy, 2005).

Barriers to research persist for clinicians

All midwives in this study took the view that issues such as lack of time and insufficient training impeded their research involvement. Studies conducted globally over the past two decades have similarly identified these barriers for other midwives and nurses undertaking and utilising research (Bonner & Sando, 2008; Fox, et al., 2011; Funk, Champagne, Wiese, Tornquist, 1991a; McNicholl, et al., 2008; Meah, Luker, & Cullum, 1996). This finding clearly suggests that despite prolonged and thorough investigation into this area the same issues are still apparent for clinicians today. The earlier work of Bonner and Sando (2008) and more recently by Corchon et al. (2011) supports this assertion. Bonner and Sando's descriptive study examining the knowledge, attitudes and use of research by 347 Australian nurses, found that all nurses regardless of position indicated time constraints, skill, organisational support and perception of resources as barriers to them undertaking research. Likewise, Corchon et al., (2011) quasi-experimental evaluation of an intervention (control n=81, intervention n=89) to increase nursing research capacity in a Spanish hospital, identified that lack of time was the main inhibiting factor for nurses research development.

The recent work by Carlson and Plonczynski (2008) confirms that research barriers for clinicians have indeed remained consistent for well over a decade. These authors conducted a meta-analysis of 45 studies to identify perceived barriers for nurses' research utilisation. Carlson and Plonczynski identified that barriers have remained unchanged over the past 15 years with insufficiencies in the areas of time, authority to change practice, comprehension and awareness of research as common difficulties identified in the studies they reviewed (2008, p. 329). Although the nursing literature has informed this position, it is likely that part of the explanation why midwives are not more actively involved in research, lies in the fact that there have been consistent reports of no time spared for such activities working in the hectic clinical environment (Corchon, et al., 2011; Fox, et al., 2011; Hayes, 2006; McNicholl, et al., 2008; Ravert & Merrill, 2008; Roxburgh, 2006). The identification of a consistent relationship between clinicians' perceived lack of time and limited research involvement is therefore an issue

that necessitates the need for further discussion, ongoing attention and priority setting by the profession to facilitate our contribution to midwifery knowledge.

No time for research in an overwhelming clinical environment

Midwives in this study perceived lack of time as a major contributing factor to their limited research involvement. All participants reported they were overwhelmed by the demands of their clinical environments and pressured to complete basic care. The majority either worked on a part-time basis or had negotiated a decrease in contracted hours so they could participate in the PRIME project. The sole participant employed full time and unable to be released from clinical duties withdrew participation citing lack of time, competing demands and impact on lifestyle as reasons for her withdrawal from the trial. These findings add support to the argument proposed by others, that midwives and nurses require protected time to engage and sustain them in research activities (Corchon, et al., 2011; Fox, et al., 2011; Hayes, 2006; McNicholl, et al., 2008; Ravert & Merrill, 2008; Roxburgh, 2006). McNicholl, Coates and Dunne's (2008) survey to elicit midwives and nurses (n=379) research activity in Northern Ireland for example, identified that the most common barriers to research participation for clinicians were lack of opportunity, knowledge/skills and time. The authors concluded that clinicians required protected time to enhance research capacity within their disciplines.

For the midwives in this study, limited time at their disposal resulted in some participants taking the view that research was 'extra work'. The need to prioritise clinical duties over research related activities was also a finding elicited by Reed (2005). In her action research project undertaken in aged care in the UK, Reed reported that nurses (n=37) perceived the research was imposed on them, created extra work and provided no meaningful reward for their efforts. In Australia, it has been suggested that nurses' perceived imposition to do research when they have no time spared arises from a culture that prioritises practice (Higgins, et al., 2010). In their discussion of the challenges and benefits for nurses undertaking research, Higgins et al. (2010) suggests clinical work is the core business for clinicians who are expected to address immediate

and short term goals in patient/client care in an environment that demands rapid client turnover.

Educated to be a consumer of research, not a researcher

In addition to lack of time, participants in this study also identified insufficient research training as a major contributing factor to their limited research involvement. Irrespective of whether the midwives were trained in a hospital-based programme or at university, they all acknowledged some comprehension difficulties and lacked confidence in their research abilities. This finding suggests that undergraduate education may at best prepare midwives to be consumers of research but not researchers. It is generally accepted that midwives and nurses need to complete honours, masters or doctoral studies to acquire the skills of a researcher. This lends support to the premise put forward in the nursing literature, that clinicians may not be suitably equipped for clinical research (Deave, 2005; Kuuppelomäki & Tuomi, 2005; Woodward, 2007).

For the eleven midwives educated in a hospital-based course in this study, there was no research component included in their training. As a result it is not surprising that they acknowledged deficiencies in understanding the research process. Similar difficulties encountered by other nurses educated in a hospital-based programme have been elicited by others. Kuuppelomäki and Tuomi's (2005) quantitative investigation of 400 Finnish nurses' attitudes towards research for example, found that hospital trained nurses were disappointed in their research educational experience and believed that their relationship to nursing science was quite distant. The authors reported that the respondents did not regard 'doing' research as an integral part of nursing practice.

Although the seven tertiary trained midwives in this study were enthusiastic and amenable to participating in research, like their hospital trained counterparts they too admitted to limitations in their knowledge of the research process. In the most part they attributed this to the fact that their tertiary research education focused primarily on terminology, preparing them to understand and critique journal articles but only

providing a *"basic"* understanding of the research process. Of these midwives, only two expressed a desire to pursue independent research in the future with the majority acknowledging they were not confident to do so. While the midwifery literature provides limited support for these findings, nursing studies conducted in Australia, America and the UK have found that nursing educational preparation did not offer a significant difference in nurses' confidence to undertake independent inquiry (Kerr, et al., 2004; Smirnoff, Ramirez, Kooplimae, Gibney, & McEvoy, 2007; Woodward, 2007). Kerr, Woodruff and Kelly's (2004) earlier quantitative review of Australian nurses' (n=178) research attitudes and activity, reported that tertiary qualifications had little impact on not only nurses' ability to do research but also on their attitudes and enthusiasm for research. A more recent comparative study of 470 American nurses' research attitudes, reported that despite respondents being more highly educated compared with the national averages, their actual involvement in research was primarily as data collectors for others (Smirnoff, et al., 2007). Likewise in the UK, Woodward, Webb and Prowse's (2007) qualitative review of research-active nurses (n=48) found that despite their sample consisting predominantly of nurses with higher degrees, they lacked confidence in their ability to undertake or understand research and had difficulty with the research process. Part of the explanation has been reported to lie in the fact that the amount and standard of training in research methods received by nurses can be misleading and may undermine the complexity involved in undertaking research independently (Deave, 2005). Furthermore, it has been suggested that collaborative, clinical-focused, interdisciplinary approaches to research may provide a potential solution to this problem and bridge the perceived divide between academy, research and practice (Darbyshire, 2008; Higgins, et al., 2010).

PRIME: A collaborative approach to research

As outlined above, collaborative multidisciplinary research projects have been mooted as providing contexts within which midwives and nurses might best engage with the research process (Fahy, 2005; Gillibrand, et al., 2002). PRIME was a large, collaborative randomised control trial that sought to determine the effectiveness of a

midwife-led counselling intervention in minimising psychological distress in childbearing women. The intervention incorporated advanced counselling skills that demonstrated positive results when pilot tested by a single midwife (Gamble, et al., 2005). Thus one of the objectives of the RCT was to test whether the intervention could be successfully taught to a large number of midwives. Midwives (n=20) were employed as research assistants and trained to deliver the counselling intervention to distressed postnatal women. This present study made use of an opportunity to explore and describe these midwives' experiences. One specific objectives of this study was to find out what it was like for the midwives working as research assistants as part of this large research team. It was anticipated their experiences would shed some light on whether the collaborative approach provided any solutions to the barriers commonly associated with research and how, if at all, their experience in the project influenced their views on clinical research.

Literature on midwives' experience of undertaking research in practice was difficult to locate, but several publications from the nursing discipline have argued that the following factors should be considered when seeking clinicians' involvement in research activities. Factors for consideration included: select topics of clinical relevance (Corchon, et al., 2011; Darbyshire, 2008; Ling et al., 2010; Spilsbury et al., 2008), provide protected time (Corchon, et al., 2011; Fox, et al., 2011) and ensure adequate training and support (Fink, Thompson, & Bonnes, 2005; Higgins, et al., 2010; Smirnoff, et al., 2007).

Postnatal emotional care: A topic of relevance for midwives

Midwives in this study sought the opportunity to participate in PRIME because they wanted to improve the emotional care provided to women in the early postnatal period. Historically postnatal care has been considered a low priority and the "poor cousin" of maternity services, often under resourced and receiving limited research attention (Yelland, et al., 2007, p. 291). Although there is now a growing body of work in this area, the midwives in this study believed improvements in the provision of emotional care to postnatal women could still be made. This finding supports the notion that if

clinicians believe the research topic is of clinical relevance to them, they are more likely to participate. Similar findings have been reported in nursing studies conducted in Australia as well as internationally. Corchon et al. (2011) previously discussed quasi-experimental study, found that to engage Spanish nurses to participate in a journal club it was important to select articles relevant to their clinical practice. In Australia, Ling et al. (2010) action research study on care of older people at risk of delirium, reported nurses (n=8) were able to engage other staff members in the medical ward to participate because they could see the value in the project. Likewise, a qualitative exploration of the potential contribution of Clinical Research Nurses (CRN, n=9) made to research in the UK, found that CRNs were keen to participate when research topics focused on improving the quality of care for their patients (Spilsbury, et al., 2008).

In addition to a topic of clinical relevance, some midwives expressed their perceived *"stifled and stagnant work environments"* and subsequent lack in job satisfaction motivated them to seek participation in PRIME. Participants reported dissatisfaction working in the clinical setting, where they felt pressured to focus primarily upon providing basic 'tick box' care. The disenchantment felt by these midwives was similarly found by Parker, Giles and Higgins (2009). Parker et al. mixed-method review of challenges confronting Australian multidisciplinary healthcare professionals (n=20) working in acute care settings, reported that having the time to be with people was part of the enjoyment of work and without rewarding relationships these healthcare professionals considered coming to work a *"chore"*. Midwives in this present study wanted more out of work than simply being part of a production line. This finding is in line with the work of Parker et al. and supports the views expressed by Darbyshire (2008). In his position paper on Australian nurses' research involvement, Darbyshire suggested that clinicians demand more from their working lives than simply walking the clinical "hamster-wheel" and he advocated they engage in clinical research (2008, p. 3243). Indeed the midwives in this study reported they were excited by the opportunities PRIME presented and looked forward to enhancing their research knowledge and participating in research they considered relevant to their clinical practice.

Working together: Support of the research team

Midwives working in PRIME reported obtaining support from sources such as the other team members, the online forum and in the form of paid time. Overall their attitudes towards the support provided in the randomised control trial were positive. The support derived from the other team members was considered particularly significant. Working alongside the other midwives and catching up at scheduled meetings, provided them with the peer support and sense of camaraderie they required. This finding lends support to the notion that collaborative, team-based research projects may negate the issue of clinicians feeling unsupported in research activities (Woodward, 2007). The importance of having someone to share the challenges and difficulties encountered in research support the findings of others. Spilsbury et al. (2008) previously discussed qualitative review for example, reported that Clinical Research Nurses emphasised the importance of having someone with whom they could share their challenges and difficulties encountered in their research role. In contrast the negative consequences of not having support were highlighted by UK researchers Boase, Kim, Craven and Cohn (2011). When exploring practice nurses' perceptions of the research role (n=14) in an RCT implementing a diabetic intervention, Boase et al., found that the research nurses not only felt isolated from the other members of their clinical team but also resented by them.

In the study outlined in this thesis, cohesiveness between all members of the PRIME team was further enhanced through the use of the online midwifery forum. The online forum provided opportunities for team members located in Queensland and Western Australia to interact and share experiences and the majority expressed this mode of interaction was supportive. This finding suggests that online forums may be a way to connect and support members of a team-based project when they are not all located in the same area. The benefits of utilising online sources to support and connect individuals have also been reported by Vesley, Bloom and Sherlock (2007). In their survey exploring American university students and faculty members (n=62) opinions of an online learning community, these researchers reported that students achieved more

through the collaborative efforts of the online group. Likewise in the UK, Brooks and Scott's (2006) case study, found that an online communication forum provided a mechanism for midwives (n=15) to access personal and professional support from their colleagues and create a positive working culture.

Midwives working in PRIME were also provided support in the form of paid time. Participants were paid at the equivalent hourly rate of a registered midwife in the trial. Several midwives acknowledged the financial remuneration they obtained working for the project enabled them to decrease their clinical duties. This finding suggests that remunerating clinicians at industrial award rates for their work in research may enable them to negotiate protected time from clinical duties and encourage their active involvement. The potential benefit of supporting clinicians' involvement in research in the form of paid time was similarly reported by Fox et al. (2011). As previously discussed, Fox et al. quantitative review of American nurses' experience in research, reported that nurses research productivity was low and could be increased with the provision of resources such as paid/protected time.

External critique of practice: A challenging and potentially confronting experience

As previously discussed, the PRIME training sessions consisted of three workshops each of four hours duration and incorporated a mix of teaching and learning strategies, specifically, face-to-face sessions, audio-visual examples of counselling techniques, written manuals, small group or paired practice activities, role play and self-directed learning tasks. Assessment strategies of midwives' counselling abilities included a video recording of them implementing the counselling intervention with a volunteer. Learning the PRIME counselling intervention was a challenging experience for all midwives in this study. In part this can be explained by the midwives own admission that they found watching themselves and having their practice critiqued on video confronting and at times intimidating. This finding suggests that midwives are not accustomed to having their practice observed and assessed in this manner. Similar findings were also reported by Hayes (2006). In her predictive correlational study to promote American nurse practitioner's (n=3500) practice through research, Hayes

found that only a small proportion of the nurses invited to participate were willing to have their communication with patients video-taped (n=30). She concluded that videotaping was considered emotionally risky and the nurse practitioners may have felt less vulnerable entrusting themselves and their patients to researchers with whom they were more familiar.

In addition to achieving competence through the use of video the technique of clinical supervision, largely associated with psychology, was used to help midwives learn the counselling skills and maintain integrity of the PRIME intervention. Supervision and feedback was provided by the psychologist managing the project. The use of clinical supervision in health professions such as psychology is a well established process and one that is supported by a large body of work (Gross, 2005; Lennox, 2008; Tracey, 2006). The aim is to provide constant critique and feedback enabling students and/or beginning level therapists to develop as successful counsellors (Tracey, 2006). The process is ongoing and conceptualised as a fundamental component of delivering quality care. However, midwives in this study were confronted by the feedback received and some perceived the comments as a personal attack. This finding suggests that unlike psychology students, not all midwives are accustomed to their practice being critiqued in this manner. Similar findings were elicited in the previously cited work of Boase et al. (2011). In their UK trial of practice nurses delivering a diabetic intervention, the researchers reported that it was rare for the nurses, opting to undertake the researcher role, to have ever recorded and/or have examined their communication with patients. As a result they reported feeling uncomfortable and judged.

Apart from the midwives unfamiliarity with this form of assessment, mismatch between supervisor and trainees may also explain why several midwives in this study reported feeling undermined and unsupported in these sessions. The importance of avoiding mismatch between supervisors and trainees in clinical supervision has been raised in the psychology literature. Gross's (2005) mixed method study of 321 doctoral psychology students' perspectives on clinical and counselling psychology experiences in practicum, reported that the second most frequent area of mismatch in the study, and one which

was identified as a critical issue, was related to supervision and the 'fit' between supervisor and trainee. It is therefore important to consider potential differences that may exist in health professionals' education and training when conducting interdisciplinary inquiries to avoid similar issues identified in this study from occurring.

Gaining new insight: Developing awareness of the research process

Although the midwives reported that participating in PRIME was a worthwhile experience, initially they expressed surprise at the amount of work that was required. This finding can partly be explained by the midwives lack of understanding and/or anticipation of the level of commitment their research role would require and of the research process in general. This may explain why they regarded: 1) competitiveness to recruit women, 2) increased recruitment demands to counteract attrition of midwives and 3) extended project timelines as unexpected events. Once again underestimating the level of commitment required when participating in research was also a finding elicited by Boase and associates (2011). The nurses in their study similarly expressed that they initially had no idea of what they were taking on and felt overwhelmed by the scale of what was required of them. This finding also explains in part why only six of the eighteen midwives in this present study remained until the completion of the PRIME project.

However, most midwives believed their participation in PRIME enhanced their level of understanding and knowledge of the research process. Many expressed they were more confident in their research abilities and all reported they would consider participating in other collaborative projects in the future. Developing clinicians understanding of the research process through active participation has been similarly reported by others (Ling, et al., 2010; Spilsbury, et al., 2008). Ling et al. previously outlined action research study on patients with delirium for example, found that nurses involved in the project reported their participation not only demystified the academic process of research but also encouraged a few to get more involved in research projects. In the qualitative work by Spilsbury et al., the authors reported that the nine clinical research nurses perceived a long term benefit of their research role was developing a better

understanding of the research process. Furthermore, it has been suggested that through hands on experience health care clinicians, can gain not only a greater knowledge and understanding of the research process but also skills that will better prepare them for future research endeavours (Higgins, et al., 2010). These findings lend further support to the argument that collaborative, clinical research projects may provide a solution to engaging clinicians in research activities and enhancing research productivity in the discipline.

In the next section of this chapter, discussion moves on to explore midwives experiences of working with women who identified as traumatised after their childbirth experience.

Caring for distressed women in the early postpartum

Midwives experiences of working with distressed women featured prominently in the data collected for this study. As previously discussed, midwives were recruited and trained in the PRIME project to implement a counselling intervention for distressed postnatal women. Analysis of the data, presented in chapter five, identified four themes that described their experience of providing emotional care to women and of delivering the PRIME counselling intervention. To reiterate these findings, this study found that the midwives believed postnatal women's emotional care was often overlooked for the practical and educational aspects of practice in the hospital setting. In part, they attributed this to organisational constraints such as lack of time to talk with women, shorter hospitalisation time and lack of continuity of care. However, most midwives also acknowledged they were not confident in their ability to care for women distressed by their birthing experience and many questioned their educational preparation in this area. Many midwives perceived that working with distressed women in practice also had negative connotations for themselves, with participants reporting feeling 'distressed' and 'burnout' by such experiences. Learning the PRIME counselling intervention was cited as a challenging experience for all the participants. In part, they attributed this to being unfamiliar with the counselling techniques taught and of learning to change their approach to practice. What was also evident in the analysis was that

many midwives were surprised at the extent to which some women were affected by a perceived negative childbirth experience. However, despite these reported challenges, many midwives expressed that their participation in PRIME provided them with the necessary skills to not only confidently provide emotional care to distressed postnatal women but also to personally cope with stressful situations they may encounter in their practice.

In this second section of the discussion chapter, some of the key findings identified in chapter five that relate to the midwives' experiences of working with distressed women will be discussed. The discussion begins with the section titled 'Out of their comfort zone: Learning to work with distressed postnatal women', and looks at factors the midwives in this study perceived influenced their confidence and ability to care for distressed postnatal women in practice. Following on, the section titled 'Confronted by the reality of distressed women', examines how being with women and implementing the PRIME intervention shaped their views on how a perceived negative birthing experience may impact on women. Finally, in the section titled 'Gaining confidence to unwrap women's birth stories', the discussion focuses on how the participants' experience in PRIME influenced not only their confidence to care for women who were identified as traumatised by their birthing experience but also their views on the provision of emotional care they provided to women in practice.

Out of their comfort zone: Learning to work with distressed postnatal women

Midwives in this study acknowledged the importance of providing women an opportunity to discuss and explore the meaning of their birthing experience as part of facilitating their emotional recovery postpartum. Indeed their desire to be part of the PRIME project was based on their experiences that women were not receiving the type of care they deserved. Participants reported they often had no time to sit and listen to women's recounts of their birthing experience. In their early interviews, midwives expressed the belief that this, for the most part, was a result of busy and chaotic postnatal wards where time was at a premium. Factors such as increasing workload

demands, shorter hospitalisation time for women and lack of continuity of care featured heavily. This finding suggests that the model of practice in mainstream midwifery may inhibit the provision of holistic care by midwives and is in line with the earlier work by (Brodie, 2002). Brodie's exploration of 376 midwives' perceptions of maternity care in Australia, found that the midwives believed their role and practice was constrained. In the most part, the participants attributed this to a system of care which they believed was dominated by medicine, restrictive of women's choices and lacking in autonomy for midwives. It has also been suggested that conflicting ideologies between meeting the needs of the institution and the needs of the woman are a key source of midwives perceiving their work as emotionally difficult (Hunter, 2004). The notion of conflicting ideologies in midwifery proposed by Hunter was certainly supported by the findings of this study in the subtheme 'a small cog in the big wheel', where midwives noted how working for a perceived failing hospital system impacted not only on their ability to provide holistic care but also on their level of job satisfaction.

However, data from their earlier interviews also indicated that some midwives felt 'out of their depth' and reported they were reluctant to engage distressed postnatal women in discussion about the birth. One of the striking features of the findings was that several midwives acknowledged they were not comfortable or confident in their ability to care for women who identified as traumatised after their childbirth experience. Indeed, other researchers have suggested midwives perceived inability to provide emotional care to distressed women in practice relates to an issue of competence in ability rather than organisational constraints. Elliot et al. (2007) study evaluating the impact training had on UK midwives' (n=187) ability to detect mental health problems in women for example, found that one month post training, midwives' perceived inability to detect mental health issues had decreased with fewer midwives (60% compared to the pre training 84%) reporting they did not have the time, skills or knowledge to provide good psychological care. Similarly in Australia, Jones, Creedy and Gamble (2012) quantitative survey of 815 midwives' attitudes towards care for women with emotional distress, reported that over half the participants did not perceive systematic problems such as workload, organisational priorities and time as an issue when caring for women

with emotional distress. On the contrary, Jones et al. found that emotional care of women in practice was impeded by midwives' perceived lack of competency in this area.

Part of the explanation why midwives in this study lacked confidence to care for distressed women perhaps lies in the fact that their midwifery education focused primarily on the physical aspects of care. This assumption is supported by Ross-Davie et al. (2006) quantitative inquiry of the confidence, attitudes and perinatal mental health knowledge of 187 UK midwives. These researchers found that most midwives felt inadequately prepared in mental health issues and were less confident in their knowledge and abilities in relation to mental health than in relation to the physical problems in childbearing. Likewise a comparative quantitative evaluation of a counselling training programme for 660 Spanish nurses, suggested that healthcare professionals are not always equipped to deal with the psychological suffering they encounter in practice (Arranz, Ulla, Ramos, del Rincón, & López-Fando, 2005). These findings highlight how this issue is not confined to a particular health care professional, setting or country and may explain why midwives have been reported as lacking competence to provide emotional support to women in practice (Jones, et al., 2012). In this context it is perhaps not surprising that several midwives in this study identified that their work with distressed women was considered personally overwhelming and emotionally intense and may in part account for their high attrition rate from the PRIME study.

Dealing with distress: The impact on midwives

Midwives in this study acknowledged that their work with distressed women both in the RCT and in practice was emotionally taxing. Participants reported that they often felt overwhelmed in such encounters and expressed a need for support and ongoing supervision in this role. A Canadian review of 72 papers that focused on the concept of emotional labour in healthcare practice, argued that in most clinical cases nurses and midwives can perform independent of patient factors such as emotional distress (Huynh, Alderson, & Thompson, 2008). However this was not supported by the findings of this

study, where in the subtheme ‘brave to look at ourselves’ midwives acknowledged that prior to PRIME they would ‘fob off’ and ‘run away from’ distressed women in practice. Indeed, it is more commonly accepted in the literature that such work can be extraordinarily stressful for midwives and can influence not only their personal sense of wellbeing but also their sense of job satisfaction. Midwives have been described as possessing a spiritual strength that allows them to share their humanity, be fully present with women and give of themselves for the sake of helping others (Posmontier, 2010, p. 433). The recent Australian literature review conducted by Leinweber and Rowe (2010), provides some insight into how this close connection of ‘being with women’ may impact on midwives. Leinweber and Rowe reported that the high degree of empathic identification which characterises the midwife-woman relationship in midwifery practice places midwives at risk of experiencing secondary traumatic stress when caring for women experiencing a traumatic birth. Likewise, the recent qualitative work by Halperin and associates (2011) exploring how Israeli midwives (n=18) coped with stressful childbirth experiences, cautioned that there may be long-term consequences on midwives emotional well-being in such situations. The authors postulate that these situations could lead to stress-related disease such as ‘Burnout syndrome’ (p.388). Indeed, in line with the work by Halperin et al., the findings outlined in this thesis similarly found that midwives empathy was further intensified by their strong identification with the women in their care.

Confronted by the reality of distressed women

In PRIME the midwives were confronted with literature on women’s postnatal experiences and the high number of women that reported their birth as traumatic. Consequently, they began to reflect more closely on their own practice in terms of working with distressed women. Another significant feature of the findings was that not all midwives appreciated the extent of women’s distress and possible trauma following childbirth. Unless the midwife had experience of either working with women in the community or a personal history of postnatal depression, they did not fully comprehend the impact a perceived negative birth experience had on women and were ‘gob

smacked' listening to their narratives in PRIME. This may be a result of the limited longitudinal experiences midwives have with postpartum women in the Australian maternity health care context.

In Australia, access for midwives to work in models of care that provide community placement and/or continuity of care is limited and consequently may inhibit the formation of positive relationships with women. Jones et al. (2012) previously cited survey of Australian midwives attitudes towards care of women with emotional distress for example, reported that for midwives to be effective and supportive of the delivery of emotional care to childbearing women they need to have the necessary time, resources and continuity of relationship with them. Similarly, the earlier qualitative work by Fenwick and associates (2007) on Australian midwives' (n=83) experiences and attitudes caring for women who experience the death of a baby, found that when afforded the opportunity to provide continuity of care, midwives felt they were able to provide skilled midwifery care that they considered had made a difference to the women.

When midwives in this study were provided with the opportunity to talk with postnatal women at 72 hours and again at 4 to 6 weeks later, they began to appreciate the extent unresolved birth distress may have on women. Midwives expressed that some women had a propensity to conceal or 'package up' their emotions following a perceived negative birthing experience. In part, this might be attributed to fact that births regarded as normal from an obstetric point of view may in fact be perceived as traumatic by some women, resulting in them feeling the need to conceal their emotions. Disparity in perceptions of a birth outcome between that of the healthcare professional and the woman have been similarly elicited by others. Nyberg, Lindberg and Öhrling (2010) qualitative study of Swedish midwives (n=8) experiences of working with women with posttraumatic stress symptoms following childbirth for example, found that a seemingly normal birth resulted in strong, negative emotional experience for some women. Women reported that they had felt abandoned and lacked support from health care staff during their childbirth experience. In line with the work by Nyberg et al., the realisation

that women may be traumatised by the care provided during their childbirth experience occurred for several midwives in this study and altered their views in relation to how to better support women emotionally in the postpartum period.

Gaining confidence to unwrap women's birth stories

Subsequently to the realisation of just how emotionally distressed some women were after birth, midwives started to reflect on their own practice when caring for women. The findings indicate that they started to recognise their hesitation in engaging distressed women in discussions about their birthing experience. Participants reported they were initially confronted by women's distress and acknowledged a lack in confidence to counsel them effectively. Like others have found (see for Elliot et al., 2007; Ross-Davie et al., 2006), concerns of letting women get emotional and of not being able to handle what they may disclose were at the forefront of their minds. Elliot et al. previously cited UK study evaluating the impact training had on midwives ability to detect mental health problems in women provides some insight into this phenomenon. They found that midwives did not have the time, skills or knowledge to provide good psychological care. Despite midwives seeing themselves as providers of holistic care many perceived their training in mental health issues was inadequate, some were unsure of what to do if women disclosed a history of mental health problems and many were not confident to care for women with mental health issues. Likewise, in their previously cited quantitative inquiry of the confidence, attitudes and perinatal mental health knowledge of UK midwives by Ross-Davie et al., the authors found that midwives were less confident caring for women with depression than caring for women with rarer and complex physical health problems. In this context it is perhaps not surprising that all the midwives in this study identified that learning and implementing the PRIME counselling intervention was a challenging experience.

To facilitate women's emotional recovery following a traumatic birth experience, midwives in this study came to the realisation that they needed to change their approach to practice. Like others have suggested (Gamble, et al., 2004a), they were initially unsure of the best counselling approach to instigate in the aftermath of a negative or

distressing birth experience. In their later interviews however, the findings indicate that several midwives came to the understanding that it was not about fixing the problem for women but to be more present, demonstrate a willingness to listen to their perceptions of birth and assist them to restore their self-confidence and sense of control following a negative birthing experience. Participants reported this required taking on a completely different mindset to their usual approach to practice. The difficulties encountered by the midwives in this study may be explained in part by the work of Wilkinson and Whitehead (2009) and their exploration of the concept of self-care in models of practice. They suggest a person-centered model of practice may require a conceptual shift for some health care professionals from feeling responsible *for* patients to feeling responsible *to* patients (p.1146). Indeed, in line with their work, midwives in this study realised they needed to change their approach from that of problem solver (responsible *for* women) to facilitator (responsible *to* women) when working with distressed women in practice.

Over time participants initial hesitancy to 'pull a story apart' and let women get emotional dissipated as they gained confidence in their ability to handle what women may disclose. Midwives increase in confidence in part may be attributed to the fact that they expressed developing a better understanding of the nature of trauma and its relationship to the care received. This finding suggests that midwives may not realise the importance of listening to women and accepting their perceptions of the birth without defensiveness or professional distance and is in line with the earlier work by Gamble and associates (2004a). Gamble et al. qualitative exploration of 16 Australian midwives views on counselling women following a traumatic birth found that differences existed between what women want and what midwives provided in relation to the depth of exploration of a traumatic birthing event. They reported that although women wanted full disclosure of events, fear of litigation and anxiety about legal processes may result in healthcare professionals avoiding open and in-depth discussion surrounding the birth.

Although several of the midwives in this study developed the confidence to hone in and gently unfold the layers of women's recounts of their birthing experiences, others doubted their ability to effectively counsel distressed postnatal women. This finding supports the need for midwives to receive ongoing education and training in this area and confirms the previously cited work by Jones et al. (2012). These authors suggest that to enhance midwives' self-efficacy in the provision of emotional care, they require ongoing clinical support and reassurance to address their concerns of exacerbating women's distress when engaging them in dialogue about their birth.

Strengths and limitations

These findings apply to an Australian context only but hopefully with the rich description provided, readers can then determine if the findings are transferable to their context. A limitation of this study was that the findings are context specific, concentrating on the midwives' opinions only and did not seek the views of the other team members of the PRIME project or the postnatal women. Despite this limitation, the multiple forms of data collection used to ensure sufficient density and multiple perspectives of the midwives experiences were a methodological strength as they provided a rich description of the phenomena of interest (Fitzpatrick and Wallace, 2006). Furthermore, these findings contribute to understanding the phenomena of midwives' experience of working in research and of caring for distressed women in practice and may resonate with other midwifery contexts.

Implications and recommendations

This study is significant for several reasons. Firstly, although literature from the nursing profession is plentiful, there is a scarcity of literature focused specifically on the midwifery professional in research. The findings of this study contribute to developing an understanding of midwives' experiences of working in research and in particular as part of a large collaborative team and may resonate with other midwifery contexts. Furthermore, these findings indicate that undergraduate education provides midwives with a basic understanding of the research process only and not all wish to pursue a

higher degree in order to advance their knowledge and skills in this area. Other options are required for midwives interested in research that allow them to explore and develop these skills. Some tertiary hospital research and development centers have already identified this priority and offer graduate midwives an opportunity to work as research assistants under the guidance and supervision of experienced midwifery researchers which is certainly a step in the right direction. Furthermore, the appointment of clinical chairs has also promoted the collaboration between academics and clinicians in research.

Secondly but most importantly, there is an ever growing body of work focused on the emotional care of women in the perinatal period, however little is known on how best to prepare midwives to step up and take a more active role in caring for distressed women in practice. The findings of this study indicate that some midwives may lack the confidence and ability to effectively care for women traumatised by their birthing experience. Midwives in this study believed the advanced counselling skills taught gave them the confidence to take a more active role in this area of practice. Further educational opportunities should be provided for all midwives, irrespective of whether they received tertiary or hospital-based education, to enhance their knowledge and skills in caring for women distressed by their birthing experience.

Another finding of this study was the perceived negative impact caring for distressed women can have on midwives. The implications for their personal health and practice thus necessitates the need for supervision (in the mental health sense of the word) for midwives undertaking complex postnatal work and further investigation into how to best prepare and support them in such stressful practice situations. Finally, the findings of this study also contribute to the literature focused on continuity of care models whereby midwives have an opportunity to get to know the women in their care and are better positioned to recognise and address their emotional distress. Further research is required in relation to continuity of care models and the impact such models have on women's emotional health and midwives' job satisfaction and wellbeing.

Conclusion

This study explored and described 18 midwives' experiences of working as research assistants in a randomised control trial and delivering a newly learned counselling intervention to distressed postnatal women. Qualitative data was collected via semi-structured in-depth interviews, participant diary entries and participant entries from an online forum. The process of thematic analysis was used to analyse the data obtained.

There were two distinct findings that were identified in the analysis process. The first related to midwives challenging but worthwhile experience of working as research assistants in a large randomised control trial PRIME. Midwives were motivated to participate in the RCT because they believed improvements in the provision of women's postnatal emotional care were needed and believed the PRIME study would generate knowledge that could further enhance midwifery practice in this domain. Their research experience in the project was at times considered a challenging ordeal. In part they attributed this to the fact that they were unprepared for the level of commitment the research role required, others acknowledged that they found learning the counselling intervention and clinical supervision process a new and challenging experience. Despite these issues, overall the midwives believed this experience enhanced their knowledge of the research process and none were averse to participating in future collaborative approaches to clinical research.

The second was the level of confrontation midwives experienced when they came to appreciate the level of emotional distress some women suffered as a consequence of the birth experience. Initially midwives acknowledged feeling a little out of their depth when first learning the advanced counselling skills and delivering the counselling intervention to distressed postnatal women in the trial. However, it was evident over the course of the RCT that they gained confidence in their ability to 'hone in' and not only identify women at risk but also confidently handle whatever they may disclose. An interesting finding was the impact dealing with distress had on the midwives themselves. Many believed lack of preparation in dealing with traumatic situations and distressed women in practice impacted negatively on midwives, resulting in them

becoming stressed and despondent in their practice. The advanced counselling skills taught in the trial, they believed, have the potential to assist midwives to process difficult situations at work and alleviate some of the stress and angst they may be exposed to in their daily practice.

The findings of this study contribute to understanding factors that support and engage midwives in clinical research of which there is a scarcity within the literature. Moreover, it contributes to a body of work investigating ways of improving the provision of women's emotional care in midwifery practice.

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Appendix A

Table 1 Diagnostic criteria for post-traumatic stress disorder

A. *The person has been exposed to a traumatic event in which both of the following were present:*
   (1) The person experienced, witnessed or was confronted with an event or events that involve actual or threatened death or serious injury, or threat to the physical integrity of self or others
   (2) The person's response involved intense fear, helplessness or horror

B. *The traumatic event is persistently re-experienced in one (or more) of the following ways:*
   (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions
   (2) Recurrent distressing dreams of the event
   (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on wakening or when intoxicated)
   (4) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
   (5) Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic events

C. *Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:*
   (1) Efforts to avoid thoughts, feelings or conversations associated with the trauma
   (2) Efforts to avoid activities, places or people that arouse recollections of the trauma
   (3) Inability to recall an important aspect of the trauma
   (4) Markedly diminished interest or participation in significant activities
   (5) Feeling of detachment or estrangement from others
   (6) Restricted range of affection (e.g., unable to have loving feelings)
   (7) Sense of foreshortened future (e.g., does not expect to have a career, marriage, children or a normal lifespan

D. *Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:*
   (1) Difficulty falling or staying asleep
   (2) Irritability or outbursts of anger
   (3) Difficulty concentrating
   (4) Hypervigilance
   (5) Exaggerated startle response

E. *Duration of the disturbance is more than 1 month*
F. *The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning*

Source: American Psychiatric Association (2000).

American Psychiatric Association Diagnostic Criteria for Posttraumatic Stress Disorder (2000): In Gamble, J., & Creedy, D.K. (2009). A counselling model for postpartum women after distressing birth experiences. *Midwifery*, 25(2), p22.

Appendix B

PARTICIPANT INFORMATION SHEET FOR MIDWIFE RESEARCH ASSISTANTS

MIDWIVES' EXPERIENCE AS RESEARCHERS IN A

PROGRAMMATIC RESEARCH STUDY

Introduction

Building research capacity in nursing and midwifery is recognised as a priority worldwide. It is considered crucial for the advancement of the professions, and essential for the enhancement of health promotion and policy. There is, however, a lot of evidence that suggests this goal may not be easily achieved, because of a number of identified barriers to midwives and nurses conducting and implementing research. Identification of these research inhibitors, and of ways in which to overcome the challenges, is necessary. Collaborative approaches, such as programmatic research, have the potential to negate identified research barriers and enhance capacity, although the use and efficacy of such integrative approaches to enhance midwifery and nursing research capacity has yet to be explored. This study aims to describe midwives' experience as researchers in one such programmatic research study, specifically their experience of working on a NHMRC-funded RCT of a midwifery-led telephone counselling intervention. The study also aims to describe how participants perceived the training, leadership and support provided to them, as well as how this integrative approach impacted upon translation of research into practice. Findings from the study will form the basis of a program of work aimed at developing, implementing and evaluating initiatives to more successfully and sustainably engage midwifery practitioners in midwifery research.

Who is carrying out the research?

Researchers from Curtin University of Technology are undertaking the investigation. The research team comprises Associate Professor Yvonne Hauck, Dr. Jenny Gamble and Ms Maree Reed.

What is expected if I decide to participate?

If you consent to participate we would like to interview you on four separate occasions (prior to training for the RCT, at the completion of the training, after commencing recruitment of participants, and on completion of their participation in the NHMRC RCT research study). The interviews will be tape recorded and last for about 60 minutes. We will do them at a time that suits you, at a convenient location. During the interviews we will ask you questions about your feeling, attitudes and expectations of your participation in the RCT. In the last interview we will ask you to reflect on the experience of being involved in the RCT. We would also like you to keep a diary for the duration of your involvement in the RCT. The diary would require you to make regular entries describing your thoughts and feelings about being involved in the RCT. E-mail reminders will sent to you to facilitate this process. The diary will then be collected at the end of your time on the RCT.

Do I have to take part?

Your participation in the study is voluntary. If you do not wish to be involved or wish to withdraw at any time you are free to do so. May we reassure you that this will not affect, in any manner, the support given to you during your employment on the RCT.

Will my privacy be protected?

The recorded interviews and transcripts will have all identifying material removed. We will then code them for the purpose of data tracking. The information you provide will be kept separate from your personal details. Please feel reassured that you will not be able to be identified by anyone outside of the research team. Results published in professional journals will be reported as a summary of the whole group not as anyone individually.

Where is the data kept?

Sources of raw data, including interview recordings, diaries and computer storage devices will be stored in a secure location in a locked filing cabinet at King Edward for a period of five years. No name related information will be used in written reports or presentations, as only group data will be recorded.

Who has approved the study?

Ethical approval to conduct this research project has been granted by the Human Research Ethics committee at Curtin University of Technology (Approval number SONM&11 2008).

Who can I contact if I have any questions about the study?

Please feel free to contact the Project Manager Ms Maree Reed on 0412 738181, or Associate Professor Yvonne Hauck on xxxx xxxxxx.

Who can I contact if I am concerned and/or would like to clarify any issues pertaining to the way the study has been conducted?

If you have any concerns or complaints regarding this study, you can contact the secretary of the Human Research Ethics Committee at Curtin University on (08) 9266 2784. Your concerns will be drawn to the attention of the Committee who is monitoring the study.

What do I do now if I want to be part of this study?

- Read all the information provided and make sure you get any questions or queries clarified (please do not hesitate to phone us).
- Contact us on the numbers provided above OR
    - Sign the attached consent form and make sure we have your contact details

Thank you for considering taking part in this study.

Appendix C

PARTICIPANT CONSENT FORM

MIDWIVES' EXPERIENCE AS RESEARCHERS IN A

PROGRAMMATIC RESEARCH STUDY

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND SUBJECTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE.

.....

Given Names Surname

I have read and understood this Information and Consent Form, and I freely and voluntarily agree to take part in the research study called **Midwives' experience as researchers in a programmatic research study**

I have received an explanation of the purpose and duration of the study, and I have been given an opportunity to ask questions related to this research.

I am free to withdraw from the study at any time, for any reason, and without prejudice.

I agree to take part in this research study and for the data obtained to be published provided my name or other identifying information is not used.

I understand that I will not receive any payment for participating in this study.

I understand the trial investigator(s) will adhere to usual standards of confidentiality in the collection and handling of my personal information and that the provisions of the Privacy Act 1988 will apply to the way my information is handled.

Dated ..... day of ..... 20.....

Signature .....

Address: _____

Home Telephone number: _____

Mobile telephone number: _____

E-mail: _____

Appendix D

Interview time log (Page 1 of 2)

Participant [Pseudonym]	Telephone/ Face-to-face	Date	Time of interview [WA time]	Length of interview [min]	Purpose of interview	Location of interview & Notes
Ann	Face-to-face	20/08/08	1130	35	Pre training	Hospital
Beth	Face-to-face	30/08/08	1530	13	Pre training	Hospital
Carol	Face-to-face	26/08/08	1430	18	Pre training	Cafe
Dana	Face-to-face	27/08/08	1130	21	Pre training	Hospital
Elaine	Face-to-face	30/08/08	1620	25	Pre training	Hospital
Gill	Face-to-face	1/09/08	1130	17	Pre training	Hospital
Ann	Face-to-face	28/10/08	1130	31	Post training	Hospital
Beth	Telephone	16/10/08	0900	18	Post training	
Carol	Face-to-face	23/09/08	1300	21	Post training	Outside area Hospital
Helen	Telephone	25/10/08	0930	34	Post training	
Joan	Face-to-face	21/10/08	0930	31	Post training	Library Hospital
Elaine	Face-to-face	23/09/08	1400	31	Post training	Outside area Hospital
Lucy	Telephone	10/09/08	0900	48	Post training	
Nicole	Telephone	10/09/08	1230	39	Post training	
Quinn	Telephone	11/09/08	1400	23	Post training	
Mary	Telephone	12/09/08	1215	31	Post training	
Olive	Telephone	25/09/08	1200	58	Post training	
Rachel	Telephone	11/09/08	1100	41	Post training	
Dana	Face-to-face	17/4/09	1100	17	Withdrawn PRIME	Hospital
Fran	Face-to-face	21/4/09	1500	8	Participant enrolled but didn't commence PRIME	Hospital
Gill	Face-to-face	22/4/09	1330	42	Withdrawn PRIME	Participant's home
Ann	Face-to-face	29/4/09	1200	39	Withdrawn PRIME	Hospital

Interview time log (Page 2 of 2)

Participant [Pseudonym]	Telephone/ Face-to-face	Date	Time of interview [WA time]	Length of interview [min]	Purpose of interview	Location of interview & Notes
Helen	Face-to-face	01/05/09	1230	57	Withdrawn PRIME	Participant's home
Elaine	Face-to-face	05/05/09	1300	9	Recruiting	Participant's home: Rescheduled by participant
Carol	Face-to-face	07/05/09	1230	68	Recruiting	Cafe
Olive	Telephone	12/05/09	1200	105	Recruiting	
Elaine	Face-to-face	13/05/09	1600	100	Recruiting	Participant's home
Mary	Telephone	18/05/09	1000	68	Withdrawn PRIME	
Rachel	Telephone	19/05/09	1100	57	Withdrawn PRIME	
Quinn	Telephone	19/05/09	1600	52	Recruiting	
Nicole	Telephone	21.05.09	1800	58	Recruiting	
Lucy	Telephone	22.05.09	1100	82	Recruiting	
Joan	Telephone	3.07.09	1100	47	Withdrawn PRIME	
Tania	Telephone	16.07.09	1100	52	Recruiting	Consented to a 'one off interview'
Violet	Telephone	11.08.09	1930	71	Recruiting	Consented to a 'one off interview'
Elaine	Face-to-face	04.12.09	0900	100	Completed PRIME	
Carol	Telephone	07.12.09	1000	51	Completed PRIME	
Olive	Telephone	08.12.09	1515	107	Completed PRIME	
Quinn	Telephone	14.12.09	1700	58	Completed PRIME	
Lucy	Telephone	17.12.09	1200	105	Completed PRIME	Malfunction voice recorder: Data lost uploading to PC
Lucy	Telephone	21.12.09	1200	85	Completed PRIME	Second interview
Nicole	Telephone	21.12.09	0900	85	Completed PRIME	
TOTAL				**[1904min] 31 hours 44 minutes**		