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Antenatal education in the transition to motherhood

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Antenatal Education in the Transition to Motherhood

Suzanne Elizabeth Burley

**A thesis submitted to the University of Plymouth in partial
fulfilment for the degree of**

DOCTOR OF PHILOSOPHY

**School of Sociology, Politics and Law
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Suzanne Elizabeth Burley

Antenatal Education in the Transition to Motherhood

Abstract

This thesis explores the relationship between antenatal education and the transition to motherhood, focusing on the pre-natal expectations and postnatal experiences of a small sample of first-time mothers in Plymouth. The aims of the study were 1) to investigate the style and content of statutory and voluntary sector antenatal classes in the Plymouth area. 2) To investigate factors affecting non-attendance, including non-attenders' perceptions of them. 3) To examine the role of lay systems of knowledge and support in the transition to motherhood and 4) to investigate the differential impact of different patterns of knowledge and support on the experiences of new parents, with particular attention to the three key areas of maternal wellbeing, parenting skills and parental relationships. A combination of qualitative and quantitative methods was used to obtain relevant data. The findings suggested that antenatal classes in both sectors focused mainly on labour and birth. Coverage of infant care skills and other important postnatal issues like parental relationships and maternal wellbeing were virtually non-existent. The style of antenatal classes was perceived as overly-prescriptive and directive. Information about labour and birth often duplicated what women already knew. The greatest benefit of attending classes was social, rather than informational. Many women found the classes did not provide them with realistic expectations of new motherhood. Non-attenders were found *not* to be disadvantaged by not attending classes, despite the common concerns of health professionals. Instead, they drew extensively on lay information and support. In light of these findings, it is argued that formal antenatal classes should have a broader curriculum that is also *realistic*.

This study is implicitly critical of the biomedical framework in which maternity services are couched. It contributes to the field by broadening the definition of antenatal education to include informal and lay sources, engaging with users' (rather than just providers') views, to help evaluate antenatal education services. Importantly, it does this by evaluating them in the *context* of new motherhood.

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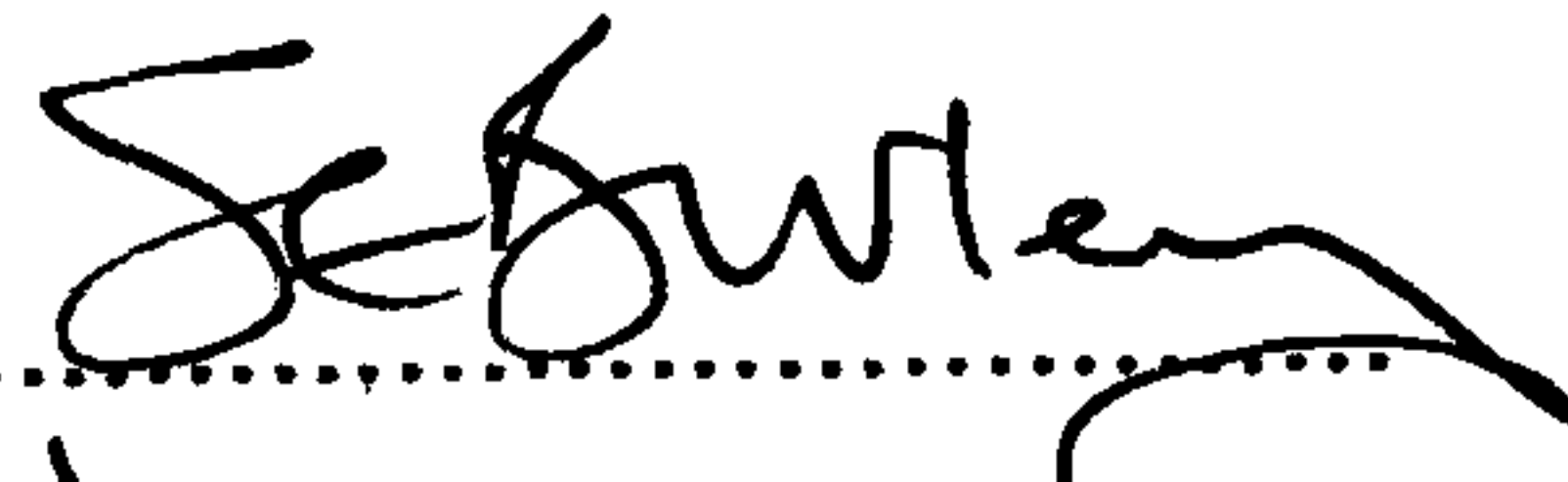
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Author's Declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award.

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Signed.....
Date.....8 March 2005

Chapter 1 Introduction

This thesis has its origins in the field of social policy but takes an interdisciplinary approach that embraces a number of disciplines including psychology and sociology. Its theoretical orientation is implicitly critical of the biomedical framework underpinning health policy and practice in the west including the UK. The study itself focuses on users' perceptions of policy and practice in the field of maternity care and - specifically - antenatal education. In particular, it seeks to evaluate *the role of antenatal education in the transition to motherhood*. It does so by exploring first-time mothers' perceptions of various aspects of that transition in light of the preparation they received for it. The primary research setting is Plymouth - a city with a population of around 240, 000 in the south west of England. Local, national and international secondary data were used to inform the central themes and issues of the research.

'Antenatal education' is a rather ambiguous term that tends to be thought of as 'childbirth preparation.' Indeed, this general perception has had a two-way influence on existing policy; both service providers and users have in recent decades come to expect a physiological emphasis on preparation for the birth itself. While clinical antenatal care is quite explicit about this, antenatal education is not. However, preparation for the social, emotional and psychological changes that motherhood brings have never been effectively integrated into antenatal classes organized and run by the National Health Service (NHS) in clinics nationwide. In the voluntary sector, organizations like the National Childbirth Trust (NCT) have endeavoured to address this shortcoming, with limited success. The role of the lay sector remains largely overlooked, but may represent an important information source for expectant and new mothers. Despite the

fact that these three sectors - public, voluntary and lay - are considered separately for methodological purposes they do, in fact, overlap considerably in reality. This study has therefore adopted an epistemological approach that effectively broadens the popular definition of antenatal education.

The thesis begins with a review of the literature (Chapter Two) relevant to maternity services in Britain. Developments and trends in antenatal, perinatal and postnatal care are seen to have incorporated a strong biomedical emphasis, and that emphasis is critiqued explicitly here (e.g. Foucault, 1993; Oakley, 1994). Additionally, we see that the 'softer' services of antenatal education (antenatal classes, usually) and community-based professional support (e.g. midwifery and health visiting services) have themselves integrated a biomedical approach - one that focuses principally, though not exclusively - upon the absence of illness in the new mother and child (Miles, 1991). The biomedical discourse can also be seen to spill over into other sectors, e.g. voluntary and lay, albeit in a somewhat diluted form (Williams and Calnan, 1996). The role of the lay sector in providing information and support for new parents is particularly under-researched; this study seeks to redress that.

The essentially reductionist approach in public sector antenatal education is evident from the way in which classes are seen to focus almost exclusively on preparation for the birth itself. Little or no account is taken of the further social and emotional ramifications of becoming a first-time mother. Parental relationships, infant care skills and maternal well being are marginalised, despite considerable evidence (e.g. Combes and Schonveld, 1992; Kelly, 1998) to suggest that expectant parents are concerned about these issues. Furthermore, the prescriptive ethos of NHS antenatal classes

(Underdown, 1998) renders them conceptually - as well as practically - problematic (Nolan, 1997). It is hard to reconcile recent practice in this area with wider imperatives to elevate the role of consumerism in health care, including maternity services (Department of Health, 1993) and a preventive, inclusive approach within health services generally. A raft of initiatives aimed at promoting the health and wellbeing of families with young children has been launched since 1999, including the Sure Start programme and, more recently, the National Service Framework for Children (Department of Health, 2001). These policy developments (many of which have emerged since this study began) are outlined in Chapter Two and revisited in Chapter Eight.

The take-up rate for antenatal class attendance in the public sector has long been a cause for concern among service providers. In particular, a two-tier system seems to have emerged, in which older, married, middle-class women represent the main client group, while their younger, unmarried counterparts tend to stay away (Cliff and Deery, 1997). Whether this represents a problem in itself is questioned at length in this thesis. The role of the lay sector in supporting first-time mothers across the transition to parenthood is explored in some depth, along with valuable insights provided by women choosing not to attend antenatal classes. This hard-to-reach group may have a voice that remains unheard within the somewhat middle-class discourse inherent in maternity services.

Justification for the research, based on the issues outlined above, is presented in Chapter Three, along with the research methods and instruments employed. The main objectives of the research were:

- To explore the range, accessibility and content of statutory and voluntary antenatal education services in the Plymouth area.
- To investigate factors affecting attendance and non-attendance for such services, including non-attenders' perceptions of such services.
- To examine the role of lay systems of knowledge / support in the transition to parenthood.
- To investigate the differential impact of different patterns of knowledge / support on the experiences of new mothers, with particular attention to the key areas of infant care, parental relationships and maternal wellbeing.

Because of the preponderance of research based around service providers' views and experiences (e.g. Kelly, 1998), it was particularly important to focus on women's own perceptions and experiences *across* the transition to motherhood. With this in mind, a longitudinal case-study approach was adopted, in which a small sample of expectant first-time mothers was interviewed once prenatally and twice postnatally. Both attenders and non-attenders of antenatal classes were included, in order to provide the necessary contrast. This qualitative phase yielded numerous insights into the key areas as identified above. Not only were the data richly informative in their own right, they also helped to inform the design of the principally quantitative - questionnaire - phase that followed. The latter involved the distribution of in-depth questionnaires to recent first-time mothers across the city, yielding retrospective data to augment those already obtained from the case-study participants. Additionally, a selection of relevant health professionals was interviewed for their views on the issues under consideration. In

summary, despite the small sample sizes (and Chapter Three explains the difficulties experienced in recruiting participants to the study), the findings were useful in highlighting - and often reinforcing - the main questions raised about the efficacy and relevance of formal antenatal education in the transition to motherhood.

Chapters Four to Seven contain the results elicited via the methods described above. Throughout the presentation of results, the published literature is integrated together with discussion as appropriate. Broadly, the case-study data precede the questionnaire data. This is consistent with an approach that endeavours to compare and contrast *expectations* of impending new motherhood with the *experience* of new motherhood. Results are presented chronologically and thematically across the transition.

Chapter Four engages explicitly with the central topic of antenatal education. It addresses the types of provision available in the local research setting, together with participants' attendance patterns and perceptions of both style and content. The three key themes of infant care, parental relationships and maternal wellbeing are highlighted as crucially important to expectant mothers, despite being markedly out of step with the physiological emphasis reported in classes within both the public and the voluntary sectors. The middle-class bias that is also apparent within both begins to shed light on the potential social (peer) support role afforded by attending such classes. Indeed, this emerges as something of an unexpected bonus for those participants. By contrast, the informational support role of antenatal classes largely disappoints, as the published literature suggests. The chapter goes on to present the non-attenders' perceptions of antenatal classes, together with the reasons that they gave for choosing not to attend. Their alternative (usually 'lay') information and support sources are then explored

before ending the chapter with a consideration of the role of the lay sector for *all* of the expectant mothers in the study.

Chapter Five deals with the case study participants' *expectations* of motherhood - from the birth itself to the early weeks and months, including the main themes of infant care, parental relationships (where relevant) and anticipated effects on personal wellbeing. All of these issues are considered against a backdrop of the type of education / preparation received. At this stage, the diversity and complexity of both practical and emotional elements of the transition to motherhood become apparent.

Chapter Six presents the *experiences* of the early postnatal period (including the birth) for all of the participants in the study. This is a lengthy chapter that details results from across the range of themes and issues. Following on from the hospital experience (which applied to all participants), this chapter addresses infant feeding experiences by comparison with prior expectations, together with women's accounts of general infant care tasks. The role of previous expectations, cultural influences and social support from a variety of sources are examined in conjunction these and other elements of the transition - for example, more general adjustments and lifestyle changes, as well as effects on the couple relationship where appropriate. It can be seen from these results and the associated discussion that the emphasis on labour and birth preparation favoured within antenatal classes has extremely limited relevance for the majority of first-time mothers. Indeed, it becomes increasingly apparent that those women exposed principally to *lay* information and support fared rather better in terms of realistic preparation for new motherhood than their antenatal class counterparts.

The results are concluded in Chapter Seven, which examines the impact of all of the above factors on maternal wellbeing. Here, the participants themselves report their feelings since the birth, using terminology of their own choosing. The latter was encouraged in order to avoid promoting the dominant biomedical discourse in which postnatal depression seems to represent 'illness', yet other states of mood / wellness are inadequately defined or quite simply ignored. The chapter that a *diversity* of feelings characterise the transition to motherhood. Many of these are perceived as negative, rather than positive, yet accurately reflect the reality of the ups and downs that the transition encompasses. Indeed the evidence suggests that a social, rather than a medical model of psychosocial wellbeing (Nicolson, 1998) is both preferable and more realistic.

While social support seems to be beneficial in promoting maternal wellbeing, the relationship between women's expectations and their subsequent experiences of new motherhood appears to be pivotal. The closer the match, it seems, the smoother the transition. For these reasons, formal antenatal education may not be delivering the type of support that expectant and new mothers require. These fundamental issues are revisited in Chapter Eight, which discusses the results in relation to both pre-existing and emergent themes. The thesis concludes with an evaluation of the study's methodological strengths and weaknesses together with its relevant policy recommendations.

Chapter 2: Literature Review

2.1. Introduction

The transition to motherhood encompasses a range of social and physiological changes. Pregnancy, birth and the early postnatal period constitute the three main stages of this transition. In this chapter, these stages are used to provide a framework for a review of the literature. The chapter begins with an outline of the twentieth century context of maternity care, together with its ideological underpinnings and subsequent critiques. Thereafter, antenatal services – both clinical and educational – are examined on similar grounds. The final focus in this chapter is upon postnatal issues. These range from infant care decisions such as feeding methods, through to broader psychosocial issues like social support and the impact of a first baby on the parental relationship. Ultimately, this chapter serves to provide a broad justification for the main focus of the study.

2.2. British maternity services in the twentieth century: trends and critiques

Medical involvement in maternity care increased markedly through the twentieth century. This was evidenced by growing levels of hospitalisation of women in labour, from fifteen per cent in 1927 to ninety-eight per cent by 1999 (Oakley, 1980; ONS Birth Statistics, 1999). Explanations for this have ranged from the alleged self-interest of the medical profession (e.g. Towler and Brammall, 1986; Donnison, 1977) to the demands of women themselves (Lewis, 1990). The technologisation of birth increased concurrently: by the 1970s the routine use of ARM (artificial rupture of membranes), episiotomy, for example, were (and still are) attracting criticism (e.g. Foster, 1995).

While many erstwhile standard procedures such as shaving and enemas were discredited and largely abandoned in practice, other interventions such as electronic foetal monitoring (EFM) have become more widespread since the 1970s (Wheble, 1989, cited in Foster, 1995). This has prompted concern among those who claim that misinterpretation of data generated by such procedures leads to 'cascades of intervention' (e.g. Robertson, 1994) culminating in the increased incidence of forceps-assisted and caesarean section deliveries. The latter, for example, now stands at 22% in England (NHS Maternity Statistics, England: 2001-2002).

Feminist critiques of the pathologisation of childbirth - and of women's reproductive functions generally - abounded from the 1970s onward. Particular attention had been paid to the expropriation of women's health care for financial profit (e.g. Foster, 1995; Greer, 1991) and the diminution of women's own care-giving role in the sphere of childbirth (e.g. Kitzinger, 1988; Towler and Brammall, 1986). The latter applies in particular to the medicalization of midwifery and the concurrent devaluation of the lay skills inherent in women's traditional networks (Donnison, 1977; Ehrenreich and English, 1979; Oakley, 1980; Miles, 1991). Indeed, medicine acts as a powerful institution of (patriarchal) social control, according to some feminist critics (e.g. Doyal, 1994; Lupton, 1994).

Many of the feminist critiques outlined above were influenced by the 'medicalization thesis' - a body of work in which it is argued that biomedical ideology powerfully and pervasively dominates most spheres of life, irrespective of whether 'illness' is present. Proponents include Irving Zola (1971, 1975), Michel Foucault (1973) and Ivan Illich (1977). They argue that doctors subordinate a whole range of human activities to the

control of the medical profession, partly through what Foucault (1973) calls the 'medical discourse'. Here, the exclusivity of clinical language - or 'jargon' - is said to help prevent lay challenges to medical professional 'expertise' (Fox, 1993).

Such expertise has extended beyond the sphere of labour and childbirth to include the mothering role, according to Ann Oakley (1994). Indeed, professional guidance is now actively sought and freely given in this area, as it has been since the beginning of the twentieth century. The key difference between then and now revolves around social class; originally, only poorer working-class women were targeted for 'instruction', whereas now it is perceived as deviant for any new mother to fail to engage with statutory maternal and child health services. As Miles (1991) has suggested, such services are seen to be, "backed by the prestige of scientific medicine" and designed to promote "good health" (Miles, 1991: 201). According to a Foucauldian analysis, this might be an example of institutional - medical and state - power working together to affect mothers' behaviour through persuasion and coercion.

The medicalization thesis is now seen as somewhat outdated, in the light of so-called 'demedicalization' and consumerism in health services over the past twenty or so years. The advent of Giddens' (1991) and Beck's (1992) postmodern theories of 'risk' and 'uncertainty' have also been influential in this respect. Williams and Calnan (1996) suggest that:

The structure of lay thought and perceptions of modern medicine is complex, subtle and sophisticated, and individuals are not simply passive consumers who are duped by medical ideology. Rather, they are critical, reflexive agents who are active in the face of modern medicine and technological developments (Williams and Calnan, 1996: 1613).

This highlights the complexity of the relationships between diverse models of health and patient/consumer approaches to contemporary health care. However, the extent of medicalization (whether explicit or implicit) within the statutory maternity services in England and Wales remains quite substantial, with hospital births accounting for around ninety-eight per cent of all births and a caesarean section rate of twenty-two per cent – a figure comparable to that of the USA (Department of Health, 2003). Such figures suggest that it may be premature to dismiss the relevance of the medicalization thesis entirely; its legacy still frames current childbirth practices (Cahill, 2001; Kitzinger, 2003).

2.2.1. Recent policy developments

A raft of initiatives designed to improve maternal and child health services over the last decade suggest a continued (though perhaps diminishing) emphasis on clinical outcomes by comparison with more holistic approaches. Table 2.1 outlines the most relevant policy developments in this area. These begin with the Changing Childbirth Report (Department of Health, 1993) and move through the measures proposed to date. Following discussion of these initiatives, the chapter continues by focusing on clinical antenatal care and then antenatal education in its various forms.

The 'Changing Childbirth' Report (Department of Health, 1993) recommended in particular an enhanced role for midwives, teamed with greater continuity of care for women, as well as more information and choice. The report also included recommendations for change in clinical antenatal care, but only the briefest consideration of antenatal education, with an example of good practice in Part 2 of the report. Clinical antenatal care is picked up by NICE as part of its remit to evaluate

Table 2.1. Key Policy Initiatives 1993 - 2003

Date/s	Initiative	Target Population	Objectives	Relevance to antenatal education
1993	Changing Childbirth	Maternity service providers and childbearing women.	Women to be focus of maternity services. Enhance choice and continuity of care.	Limited. Principally physiological focus on pregnancy, intrapartum and postnatal care.
1999 <i>Including: In progress</i>	National Institute for Clinical Excellence (NICE) Antenatal care: routine antenatal care.	The NHS and its patients Pregnant women; their carers; clinical managers.	To provide guidance on clinical 'best practice'. To produce evidence-based guidance for the routine antenatal care of all pregnant women.	Very limited. Principally clinical, although guideline will aim to "offer advice on the optimal methods for providing antenatal education".
1999	Sure Start	Families (especially but not exclusively disadvantaged) and children before and from birth	Community based. Tackle child poverty. Health Promotion through social, emotional and educational development.	Prenatal as well as postnatal and childhood emphasis. Considers range of social / health issues for families and communities.
1999	Teenage Pregnancy Unit (TPU)	Teenagers and those involved in education, health promotion and youth work.	To reduce teenage conception rates and encourage education, work and training for teenage mothers.	Specialist advice on contraception and parenting skills through schemes such as Sure Start Plus.

2000	NHS Plan <i>Includes The Children's Taskforce</i>	NHS and Social Services – users and providers Children and their families	Radical programme of reform including ten taskforces for different areas of service To ensure the NHS plan delivers improvements	Unclear.
Announced 2001 – still in development April 2003	National Service Framework for Children Emerging findings of External Working Group (Maternity)	Children, their carers and professionals within health and social services Women, babies and their families	To drive up standards (including setting national standards), reduce inequalities and forge partnerships 'To define the standards that will enable childbearing women and babies to achieve optimum health and wellbeing'	Not yet known, but early consultation papers suggest greater attention to social / emotional as well as physiological issues. Breastfeeding promotion, postnatal support and parenting education all mentioned.

clinical effectiveness and produce recommendations for change. However, its second draft for consultation (June 2003) has little to say on the topic of antenatal education, despite part of its original scope to “offer advice on the optimal methods for providing antenatal education” (NICE website, 28.01.2003). By contrast, the The Children’s Taskforce, which oversees the development of the emerging National Service Framework for Children, appears to be more holistic in its approach. Its Chair – the National Clinical Director for Children – has stated clearly that:

Not just physical health, but psychological health is also programmed by early experiences. So, there is an emotional reason for children being important, there is

a societal reason for children being important and there is a health economic reason for children being important (Aynsley-Green, 2003: 3).

Essentially, the emerging National Service Framework for Children is intended to drive up standards of care for all children and their families / carers. A nationwide consultation exercise has been undertaken with all relevant agencies, including clients, to try to establish the principles, values and scope of the Children's NSF. These are – broadly – ‘to improve the lives and health of children and young people through the delivery of appropriate, integrated, effective and needs-led services’ (Aynsley-Green, 2003: 9). Within this, six external working groups have been set up to identify services needs in particular spheres. The Maternity External Working Group (EWG) deals with the issues most relevant to this study. It includes five sub-groups; ‘Pre-birth’, ‘Birth’, ‘Post-Birth and the Baby’, ‘User Involvement’ and ‘Inequalities/Access’. These sub-groups comprise both professional and lay members.

In April 2003 the Maternity EWG produced its ‘emerging findings’ document, the main thrust of which is that services need to be better integrated, co-ordinated and accessible to all. At this stage, the extent of attention to antenatal education *per se* is unclear, although the document does suggest much greater recognition of the ‘continuous process’ that the transition to motherhood may represent (Smale, 1998). Thus, more explicit links are being made from pre- to post-birth to try and ‘join up’ the various stages that impact on the wellbeing of parents and their infants. In particular,

Postnatal services include building on the support and information to the woman and her family already given in the antenatal period; supplemented as necessary, by tailor-made plans to meet the individual needs of women and babies. (Maternity EWG Emerging Findings Document: DoH, June 2003: 1).

Greater flexibility of services, improved accessibility and targets to reduce smoking / improve breastfeeding rates are also mentioned. Additionally, the document highlights the need to improve the ‘diagnosis’ and ‘treatment’ of postnatal depression – an honourable endeavour that nevertheless remains couched explicitly in a biomedical discourse. On balance, there appears to be little that is new or innovative, even at the planning stages. However, there are clear links with the Government’s recent commitment to tackle poverty and social exclusion by driving up standards across a range of health, education and social services.

The Sure Start initiative, launched in 1999 sought to address these issues through its stated aim:

To work with parents-to-be, parents and children to promote the physical, intellectual and social development of babies and young children – particularly those who are disadvantaged – so that they can flourish at home and when they get to school, and thereby break the cycle of disadvantage for the current generation of school children. (Teenage Pregnancy Unit website, 2003).

Initially, just a handful of pilot programmes were set up in particularly deprived areas of the UK. Following five successive waves of its implementation, several hundred schemes now operate with a remit to offer family support from both health and educational perspectives. The Sure Start programme is one example of a multi-agency approach involving a wide range of clients and services providers, with strong emphasis on a ‘bottom-up’, local needs-based approach.

‘Sure Start Plus’ was launched in 2000 as a new service for teenagers. It has the dual aim of supporting teenage parents and preventing teenage pregnancy through its network of locally-based teenage pregnancy co-ordinators. Sure Start Plus, like the

Teenage Pregnancy Unit (TPU) – also launched in 1999 – has its policy origins in the Government’s ongoing commitment to tackling social exclusion (TPU website Press Release, February 2000). Plymouth was one of the first twenty pilot areas for this scheme, receiving funding from April 2001 to help tackle its relatively high rate of teenage pregnancy – the second highest in the south west of England (Plymouth Health Action Zone, 2001).

In summary, it appears that the initiatives outlined above are focused on reducing social exclusion by tackling what are seen to be the most pressing areas and groups. Much of this emphasis may be linked to government targets reflecting public opinion around perceived ‘problems’ like teenage pregnancy (Arai, 2003). Little or no attention has been given to antenatal education, although the Maternity EWG of the Children’s NSF may yet come up with something prior to the publication of the finalized NSF. Clinical antenatal care has, by contrast, received greater attention. The review proceeds below with the background to this area of maternity service provision.

2.3. Clinical antenatal care

The impetus for antenatal care in the UK derived from the Boer War-era revelations about the poor state of the nation’s health. Initial improvement measures were focused on maternal and infant health. Maternal mortality at the time (the beginning of the twentieth century) was in the region of four deaths per thousand live births in England and Wales (OPCS mortality statistics, cited in Campbell and Macfarlane, 1994). The gravity of this figure is revealed by comparison with the current maternal mortality rate of 0.2 per thousand live births.

The first antenatal clinic to be opened in the UK was in Edinburgh, in 1915. By 1932, around seven hundred were in operation throughout Britain and, by 1948 – the inaugural year of the NHS, free antenatal care was available to all pregnant women (Himmelweit, 1988). Despite the significant decline in maternal mortality, a causal relationship between this and routine clinical antenatal care has never been established. Rather, a number of factors such as better general health and hygiene, falling rates of poverty and the trend towards smaller families may all have played a part. Nevertheless, the prevailing medical view that maternal ignorance in matters of hygiene and nutrition needed addressing continued to inform developments in this area (Tew, 1990).

Antenatal care for women in Britain (as in other western states) has been couched in terms of *prevention* – of both infant and maternal morbidity and mortality. Therefore, traditional checks on the pregnant woman have tended to be focused on blood pressure, diet and, more recently, on other aspects of health behaviour such as smoking cessation and alcohol limitation in pregnancy. Routine tests since the 1970s include ultrasound screening for all women and specific tests (such as amniocentesis) for those women deemed to be most at risk of producing an infant with Down's syndrome or Spina Bifida, for example (Foster, 1995). However, the medicalized nature of western antenatal care has been criticised for distancing women from their own maternal instincts (Vincent Priya, 1992), as well as for introducing tests which have no proven effectiveness (Thomas et al, 1991). Furthermore, the standardised nature of the post-1920s pattern of care - originally instigated by the Ministry of Health in 1929 (Battersby and Thomson, 1997) - attracted criticism from various quarters. In their classic critique of antenatal care, Enkin and Chalmers (1982) asserted that:

Common-sense tells us that it is better to prevent disease than to cure it, and antenatal care has been described as the perfect example of preventive medicine. The aims of universal antenatal care – to prevent the complication of pregnancy and to ensure the well-being of mother and child – are self-evidently desirable. One could easily fall into the trap of assuming that any steps taken in the hope of achieving these aims would be eminently desirable as well (Enkin & Chalmers, 1982:268)

They went on to claim that antenatal care should reflect more closely the specific needs of individuals and communities. This view was later echoed in the Winterton Report (House of Commons, 1992) and the *Changing Childbirth* report (Department of Health, 1993). Until this time, women had been encouraged to attend regular appointments in a hospital setting, often with an obstetrician, as well as community-based checks with GPs and midwives. The frequency of visits tended to be monthly until the final trimester of pregnancy, whereupon weekly visits were required. However, *Changing Childbirth*'s emphasis on continuity of care, together with existent criticism of the current system precipitated research into the effectiveness of such frequent routine antenatal checks. In particular, questions were raised about the appropriateness of one system for all pregnant women, irrespective of parity or level of risk, for example. Such research findings indicate that while many women felt reassured by frequent antenatal checks, no discernible difference was found, in preventive terms, between a higher or lower frequency of check ups (e.g. Sanders et al, 1999; Sikorski et al, 1996). Hence, the subsequent recommendations were for revised patterns of antenatal care for first-time mothers with uncomplicated pregnancies – a reduction from thirteen checks in the traditional pattern to nine in the reduced pattern (Audit Commission, 1997). More recently, the National Institute for Clinical Excellence (NICE) has suggested a reduction to between six and ten visits (NICE, 2003).

As well as reduced visits for those with apparently 'normal' pregnancies, there has also been a move away from hospital based obstetric care, to community based care provided by GPs and midwives. This is consistent with Changing Childbirth's 'continuity of care' recommendations. 'Shared care', in which hospital and community based services are provided in combination, is now the most common form (Green et al, 1998). According to one of the Audit Commission's own surveys, over half (52%) of expectant mothers receive this form of antenatal care, while 42% receive community care and just 6% receive care just in the hospital setting. Take-up for clinical antenatal services is generally high – around 96% nationally (Audit Commission, 1997) and, according to local community midwives, about 98% in Plymouth.

These high rates of attendance for clinical antenatal care are significant for a number of reasons. First, they suggest that the majority of pregnant women accept the need for additional health care vigilance in pregnancy (e.g. Young, (1994, NICE, 2003). Most want to be reassured that their pregnancy is progressing well, and this may often be confirmed by technologies such as ultrasound imaging. However, these data may also be interpreted as evidence in support of the medicalization thesis; Illich's (1977) concept of cultural iatrogenesis could easily apply to this phenomenon, for example. Indeed, the fact that most pregnant women equate pregnancy confirmation with a visit to their GP and subsequently go on to give birth in a hospital setting is not a coincidence. Once in the biomedical 'system', that is where most women remain throughout the transition to motherhood.

Feminist critics of modern maternity services, such as Sheila Kitzinger (1978, 1988) and Ann Oakley (1979, 1980, 1982, 1984) have repeatedly suggested that women's

dependence in this respect has been actively encouraged by the medical profession itself. Angela Phillips echoes this view in relation to pregnancy care, asserting that, 'The antenatal period should lay the foundations for what is not primarily a medical but a social experience' (Phillips, 1990: 361). However, it may be both: we should beware of assuming that all health care providers endorse a heavily medicalized experience for women. This leads to the second area of significance - the role of clinical antenatal care as an information base as well as a gateway to other services.

As indicated above, initial entry into statutory maternity services tends to begin within the primary care sector. Therefore, pregnant women can expect not only routine clinical checks at this point, but also advice and guidance about other services. Booking in for a hospital (or, less frequently, a domiciliary) delivery, takes place at the primary care interface as part of the popular 'shared care' approach (Audit Commission, 1997). Additionally, it is at this stage - usually at the 'booking in' appointment that community midwives offer invitations to expectant mothers to attend antenatal classes. Such invitations invariably appertain to the NHS antenatal classes, but may also involve a mention of alternative services, such as the National Childbirth Trust or Active Birth classes. While the availability of local services may vary, the role of the community midwife in disseminating information to pregnant women is not disputed (Department of Health, 1993; Green *et al*, 1998). Within this context, it may also be suggested that midwives themselves are sources of antenatal education on a one-to one basis, as are GPs and other primary care workers. A recent study indicated that women cared for principally by midwives particularly value this aspect of their care, preferring their involvement to that of obstetricians (Spurgeon *et al*, 2001). The third and final point to

make about the high take-up rate for clinical antenatal care by comparison with statutory antenatal *education* services (detailed below) is that, given the holistic role of the community midwife in particular, this contact might satisfy all of the perceived prenatal needs of many pregnant women.

2.4. Antenatal education

2.4.1. Background and development

Formal antenatal education in the UK is generally considered to date from the 1930s (e.g. Nolan and Hicks, 1997). Prior to this, a few prenatal classes existed around Infant Welfare Centres, which arose from concerns about maternal/infant health issues as indicated above. They were one of the earliest initiatives based on the Maternity and Infant Care Act of 1918 (Abbott and Sapsford, 1988). Spring Rice (1939) has described the rather haphazard nature of provision at that time. From the exercise classes developed by the Women's League of Health and Beauty in the 1930s, however, came the basis of antenatal classes in their present form. Importantly, breathing and relaxation techniques were introduced as a means of helping to cope with the upcoming labour. This type of antenatal preparation stemmed from the collaboration of a London obstetrician Dr J.S. Fairbairn, with a Miss Randall, a trained midwife and physiotherapist (Williams and Booth, 1980).

By the late 1940s, 'mothercraft' classes had been introduced nationwide as part of the universal services offered through the NHS. Although these had initially been focused on the quality of mothering, they soon began to incorporate preparation for childbirth as well. Grantley Dick-Read's (1942) *Childbirth Without Fear* was especially instrumental

in adding to the trend for relaxation techniques to be incorporated for use in the first stage of labour. Hence, the model for statutory antenatal education in the UK was instigated in the 1940s and combines breathing and relaxation techniques with early postnatal parenting issues.

2.4.2. Modern NHS antenatal classes

From the 1940s onward, then, the NHS service developed, in which all expectant mothers are routinely invited to attend prenatal classes. These have, in the past, been termed 'relaxation' classes, but are now often referred to as 'parentcraft classes' or simply antenatal classes. Here, the latter will be used to reflect both elements of their general content, as well as the term most widely used in the literature. Local and regional variations in the provision of antenatal classes prevent a definitive description of content, duration or style. However, it is possible to outline the main features as evidenced in relevant research publications.

NHS antenatal classes are normally run by community midwives in collaboration with other health professionals, such as physiotherapists and health visitors (Combes and Schonveld, 1992; Nolan, 1997; Underdown, 1998). The setting may be a local hospital, GP surgery/clinic, or a church hall, for example. Classes may run during the day or in the evening. Often, a daytime series of classes will include at least one evening session to encourage the attendance of fathers who may be working during the day (Underdown, 1998). However, it has been suggested that low levels of attendance for classes generally may be due in part to the fact that expectant mothers who are still in employment feel unable to take time off for such classes, despite their statutory right to do so (Kelly, 1998).

While the number of sessions offered varies between six and eight (or more), a study of 3000 midwives nationally found that the average number offered is six (Kelly, 1998). Two hour sessions appear to be fairly standard (Underdown, 1998). In Plymouth, for example, the community midwife would normally cover the first hour, with the second facilitated by a physiotherapist or health visitor (Local community midwife, personal communication: October 1998). In this way, both pre- and postnatal issues may be covered by the relevant health professional. So, what are the topics covered in antenatal classes?

As stated above, considerable variation exists in terms of content. However, a number of core topics emerge as standard. A survey conducted by the Royal College of Midwives (Kelly, 1998) found that little had changed since the 1960s.

The **most** common topics are, in order:

- Stages of labour
- Infant feeding
- Pain relief in labour
- Difficult births/episiotomy/operative delivery
- Tests and scans
- Hygiene
- Bathing baby
- Health and safety in the home
- Fetal development

The **least** common topics are, in order:

- Sexual problems
- Incontinence
- Household management issues

- Postnatal depression
- Adapting to changing relationships with partner
- Emotional and psychological effects of childbirth
- Coping with stress and responsibilities of new baby
- Coping with fatigue and lack of sleep
- Physical effects on mother's body

Source: Kelly, 1998.

These findings - based on midwives' own reports of their coverage - illustrate a number of criticisms of antenatal class content cited in the literature. For example, it has often been claimed that classes pay undue attention to labour and birth at the cost of postnatal issues (e.g. McIntosh, 1993; Nolan, 1995, 1997). Additionally, the way in which preparation for labour is often presented by those running NHS classes has been deemed inappropriate and unrealistic by some researchers (e.g. McKay et al, 1990; Combes and Schonveld, 1992). On the other hand, there is some evidence to suggest that attendance at such classes can increase women's optimism and promote realistic expectations of the birth by comparison with non-attenders (Slade et al, 1990). Further, it is suggested by Nolan and Hicks (1997) that childbirth educators in the NHS are bound by its biomedical model of care, 'and that parentcraft classes operate not within a framework of adult education, but conform to this medical model' (Nolan and Hicks, 1997: 181). Thus, they effectively reiterate claims that midwives may account to the prescribed needs of the NHS before those of the pregnant women they encounter in classes (e.g. Rees, 1996).

Angela Underdown's research into the teaching and learning techniques used in NHS antenatal classes suggests that 'directive' rather than 'facilitative' techniques are

dominant. Indeed, she found, in the majority of the classes she observed, 'a high level of teacher input, a low level of broad, open-ended questions and a low level of acceptance of ideas, behaviours and feelings' (Underdown, 1998: 66). She concluded that midwives running antenatal classes appeared to need more training in facilitation techniques, in order to encourage a more participative learning environment. Findings from the RCM survey reported by Kelly (1998) suggest that a large proportion of midwives feel ill prepared for their role as childbirth educators. Indeed, many felt that they had been inadequately trained for the role which, combined with a personnel shortage and other resource issues, led them to feel quite negative overall. Nolan (1997) has been particularly outspoken on the issue of midwives' suitability - as things stand - for 'childbirth education':

Most childbirth educators are midwives; they are trained as clinicians and not as teachers. Although new diplomate and degree courses emphasize the role of the midwife as communicator, advocate and health educator, constraints of time make it difficult for those who do not choose to specialize in childbirth education to become fully conversant with the principles of adult education (Nolan, 1997: 1200).

In terms of the language used, there is something of an inconsistency between Nolan's use of 'childbirth education' as a generic term for antenatal preparation, and her frequent criticism of the lack of attention to postnatal issues in NHS classes in particular. However, in a field where literature is thin on the ground (especially by comparison with that on clinical antenatal care) her contributions are interesting and original. Indeed, she has raised some very important issues about the effectiveness, ethos and take-up of NHS antenatal classes, as considered below.

2.4.3. Effectiveness of antenatal classes

Measuring effectiveness is both important (in terms of assessing the usefulness of services) and - in the current climate of accountability and performance measurement - consistent with national government policy. Indeed, the establishment of agencies such as the National Institute for Clinical Effectiveness (NICE) in 1999 reflects this tendency. However, measuring the effectiveness of antenatal classes is problematic, for many reasons.

First, as alluded to above, are such classes clinical, or educational? There appear to be elements of both. For example, if one accepts the dominance of a medical model of childbirth (and given the figures for hospital birth rates and clinical interventions, it is hard not to), then antenatal classes aim to prepare expectant mothers for a clinical experience, in most cases. In fact, Mary Nolan insists that the NHS culture prompts midwives (in their 'childbirth educator' capacity), to encourage women to '...accommodate themselves to the system of hospital managed birth...' (Nolan, 1997a: 1200). Indeed, it has been suggested that classes prepare women for what to expect when they get to the maternity hospital for delivery. When Nolan and Hicks (1997) interviewed some NHS childbirth educators, they found that:

The Midwives valued the transmission of information in a way that suggests they incorporate a medical model of diagnosis and prescription into the educational arena. Their language during the interviews implied that they adopt a parental role towards their clients, offering expert advice, giving information and 'telling' them what to expect. High levels of attendance at classes provided by the two hospitals where the Parentcraft Sisters work suggest that the parents who attend are not dissatisfied with this model, or at least expect no different' (Nolan and Hicks, 1997: 186).

Yet, the authors found that none of the participants in their study (educators from both statutory and voluntary sectors) assessed their effectiveness according to clinical

criteria. This, they suggest, makes any kind of audit very difficult in the light of market-driven health care. On the other hand, given the aforementioned failure of the NHS to conceptualise antenatal classes as 'educational', rather than as medical/clinical, there may be a situation in which measures of their effectiveness fall between two stools. Despite this, there have been numerous studies in which antenatal classes have been assessed, both in terms of client satisfaction, and in terms of how effective any information received in classes may be for reducing anxiety in childbirth, for example.

Hiller and Slade (1989) found that, despite a significant increase in knowledge and confidence displayed by women attending antenatal classes, there was no significant reduction in their anxiety during pregnancy. By contrast, Salmon and Drew (1982) found that women's postnatal assessment of their birth experience indicated reduced anxiety and distress during labour if they had attended antenatal classes; the level of obstetric intervention was not reduced by having attended, but women were better able to cope with it. The authors expressed surprise at their findings, in view of the fact that NHS antenatal classes purport to help women in labour. Indeed, their findings led them to claim that, "...it is possible that antenatal preparation is inappropriately targeted or ineffectively executed" (Salmon and Drew, 1992: 325). Nolan (1997b) alleges that there is no evidence for fewer interventions or a reduction in the need for analgesia for labouring women who have attended NHS classes. Spiby and Henderson (1999) concluded that the 'relaxation' component of antenatal classes is not effective in labour because women had inadequate time to practice within NHS classes and their birth companions were not adequately supported in the labour ward setting.

Niven (1992) is one of many authors on this topic to suggest that antenatal classes need to provide women with realistic expectations of labour and birth. Indeed, on the rather inconclusive results about the effectiveness of antenatal classes, she claims that "They do not tell us whether or not this knowledge and confidence affect the women's experience once they are in labour" (Niven, 1992: 58). Combes and Schonveld (1992) made similar assertions, claiming in their review of the literature that classes may not only promote unrealistic expectations, but also fail to dispel any existing ones. The issue of realistic expectations has also been taken up by Slade et al (1990) who suggest that antenatal class attenders *do* display more optimistic and realistic expectations of birth than those who do not attend classes. On the basis of such evidence, it would seem that, while attendance at classes may have little or no effect on labour and birth outcomes, it may be beneficial for women in other ways. Gaining knowledge and information - even if that information simply prescribes the hospital birth experience, as Nolan claims - appears to be useful to some extent in enabling women to cope.

It is important to note that the majority of studies into antenatal education do not involve clients. As a result, the literature in this area is dominated by the views of providers. Indeed, Rees (1996) makes a regretful mention of this in his review of the shortcomings apparently inherent in statutory antenatal education provision. When clients' views have been sought, they have tended to be less than favourable; Nolan (1997a) has gone so far as to suggest that, "Women have repeatedly criticized their antenatal preparation whenever asked by researchers for their opinion" (Nolan, 1997: 1200). The main elements with which women appear to be dissatisfied are the failure of antenatal classes to address psychological and emotional issues (e.g. Combes and

Schonveld, 1992); postnatal issues (Hiller and Slade, 1989) and the ethos of the classes themselves. In fact, one of the rare studies in which clients themselves were surveyed suggested that classes are 'too much like school' (Cliff and Deery, 1997). This applies especially to younger women from lower socio-economic groups, who dislike the classroom-style approach that Underdown (1998) found to be dominant within antenatal classes when she investigated the style and teaching techniques used by NHS midwives.

Given the issues raised above, it may be suggested that NHS antenatal classes are of limited value in terms of labour preparation and birth outcomes, yet valuable to some extent for their apparent ability to promote confidence among expect mothers. Given also that only around half of those women who utilise clinical antenatal care avail themselves of NHS antenatal classes (Hancock, 1994), we need next to ask who they are, and why they do - or do not - choose to attend.

2.4.4. Social profile of NHS antenatal class attenders and non-attenders

The paucity of research into the topic of antenatal education generally is offset to some extent by growing attention to this particular issue. This appears to stem from concerns that fewer women than might be expected are presenting for this service. The above section indicates some possible reasons, but how can this account for the absence of first-time mothers-to-be without previous experience of attending such classes?

Mary Nolan's (1995) study of those attending antenatal classes in both the statutory and voluntary sectors reveals that the principal attenders of NHS classes are white, married, middle-class and relatively well-educated women. These findings reflected those of Jacoby, (1988), who found similar social characteristics (Murphy-Black, 1990). Indeed,

Nolan found that certain characteristics, such as women's age, were of particular significance:

When the national figures for the ages of women giving birth in the UK are related to the study figures, it is apparent that none of the classes surveyed attracted younger women in the proportion in which they are represented in the childbearing population (Nolan, 1994:143).

Nolan questioned the validity of responses indicating 'married' status among attenders, wondering whether a certain amount of stigmatisation still exists in NHS maternity units concerning unmarried mothers. None of the NHS attenders in her sample were planning for a home birth. This she felt was a reflection of their decision to attend hospital-based classes in the first place. The same study found that women attended five sessions each, on average. However, uptake is low by comparison with clinical antenatal care, as indicated above. Combes and Schonveld (1992) examined a selection of studies on attendance rates (in Bath, Sunderland and Belfast) and concluded that while non-attendance could be as high as 78% (McKnight and Merrett, 1986), the figures are confused by issues of whether or not women knew about the classes. In other words, those who had no knowledge were not making an active choice *not* to attend.

The social profile of women attending classes led Nolan to suggest that, "...socially advantaged women take a slice of the antenatal education cake out of all proportion to their numbers and obstetric risk..." (Nolan, 1995: 144). However, she also concluded that the attendance of these women in such high numbers suggests the classes do offer them a service that they both need and want. Despite her criticisms of the content and style of NHS classes, both here and in subsequent publications (Nolan, 1997a, 1997b, 1998), she asserts that the issue of non-attendance could be tackled in a number of ways. Focusing on community-based classes, perhaps run by representatives from their

own social or ethnic groups or even offering financial incentives to attend are just some of the suggestions offered. The latter has actually been instituted effectively in Finland, where 'family training' is a necessary condition for the receipt of family allowances. Unlike antenatal education in the UK, however, the Finnish model seeks to integrate postnatal issues more effectively, in order to support the transition to parenthood for first-time mothers and fathers in particular (Vehvilainen-Julkunen, 1995).

On the social-class issue - which is clearly a significant one in the UK - there is some evidence to suggest that initiatives designed to attract younger women from lower class groups have been successful (e.g. Department of Health, 1993). However, such initiatives have tended to be piecemeal, rather than mainstream. In Plymouth, a local community-based project set up to provide just such a service was still not well attended, and subsequently closed down (Community psychologist; personal communication, 1997). More recently, national strategies designed to tackle social exclusion have prompted initiatives like Sure Start Plus, as described in section 2.2.1. Hence, in Plymouth for example, local co-ordinators now work specifically with teenagers to help *prevent* teenage pregnancy and also to help facilitate *support* for teenage parents. Politically and ideologically, teenage pregnancy and motherhood continue to be tense and emotive issues. As Lisa Arai (2003) has argued, there is a (perhaps irresolvable) conflict between the discourse of social exclusion – as used by the government in its commitment to initiatives such as the TPU and Sure Start Plus – and that of individual responsibility / irresponsibility in which teenage motherhood is both demonized and pathologised. A key part of the latter relates to explicitly to social policy areas like education, employment and housing. Indeed, there appears to be a

distinct mismatch between the values held and choices made within certain communities to elect to have children at an early age, and their middle-class critics. This, claims Arai, overlooks the fact that very young mothers may have educational and work opportunities later, rather than earlier in life, when their children have grown up. Furthermore, she argues, “A compassionate society would facilitate this sequence of events and not condemn it” (Arai, 2003: 213). However, Arai’s research into the choices and experiences of teenage mothers indicates that they are all too aware of the prevailing social view. This is important because it has implications for the choices they make about whether or not to attend for mainstream services, including antenatal classes.

Non attendance for formal antenatal education does appear to be based on the characteristics outlined above. In other words, younger, poorer, single and less educated women are least likely to attend. As most research on this issue uses antenatal classes as a starting point for the recruitment of participants, questions about non-attenders and non-attendance have received very few answers. Indeed, this population and its views is under-researched. This may be due to difficulties of access.

Cliff and Deery (1997) produced a rare article addressing both attenders' and - importantly - non-attenders' views about antenatal classes. Access was gained via maternity wards, thereby circumventing problems of accessing only *attenders* through antenatal classes. They found that those who attended NHS classes bore similar characteristics to those in Nolan's (1995) study; non-attenders were overwhelmingly young, unmarried, working-class women. When interviewed about their perceptions of antenatal classes and their reasons for choosing not to attend, the following emerged:

- Classes were felt to be 'for other people', not for 'people like me' - based on social class, age and marital status.
- Classes were perceived to be technical, directive and 'too much like school'.
- Midwives running the classes were believed to be 'like teachers' - summoning negative associations with mainstream school experiences.

Source: Cliff and Deery, (1997: 143).

While social class was a key variable, it was overridden to some extent by age; working-class women who were older and married were actually more likely to attend. Material factors were felt to be partly responsible for this, as was the passage of time; the authors believed that the older women might have come to terms with any negative memories of mainstream education.

Additionally, the criticisms generated by those women who *did* attend NHS antenatal classes echoed many of those already examined. For example, it was found that the classes did not adequately address emotional and psychological issues. As this study engaged to some extent with women's postnatal experiences, this criticism has particular resonance. Most of the published literature in this field does not contextualise antenatal education within the transition to motherhood, and hence its effectiveness for women *as new mothers* is even harder to gauge. While Cliff and Deery's study involved a very small sample - a limitation that they acknowledge - it does, nevertheless, raise further questions. One of these is based on a concluding comment from their paper, echoing an issue already identified by Nolan (1995). They question

...whether older married middle class mothers are actually the preferred clientele of midwives and whether young, single working class women are viewed as problematic and non-conforming. In other words, midwives may actually perceive these women as 'awkward'. This in turn may be sensed by these women on initial contact with the

midwife and as a result, this may reinforce the negative image young single women have of antenatal classes (Cliff and Deery, 1997: 144).

They go on to suggest that crucial peer support opportunities for non-attenders may be forgone as a result of this alleged social divisiveness. Another question yielded by this, then, is the type and extent of *alternatives* to formal - statutory - antenatal education accessed by non-attenders. For the latter with social characteristics identified in Cliff and Deery's research, for example, very little is known in this respect. Indeed, it is a topic meriting particular investigation. For others, principally at the opposite end of the socio-economic continuum, considerably more is known. Informal or voluntary bodies such as the National Childbirth Trust (NCT) and the Active Birth Movement organise and run antenatal classes that complement or challenge those run by the NHS. It is to this sector that the review now turns.

2.4.5. Antenatal education in the voluntary sector

A variety of voluntary sector organisations exist to provide information and support to expectant and new parents. The most relevant to the provision of antenatal education are, however, the National Childbirth Trust and the Active Birth movement. Here, their development, aims and practices are outlined. As with the statutory sector, perceived strengths and weaknesses of their respective approaches will be examined as well.

2.4.5.1. The National Childbirth Trust

The National Childbirth Trust was established (originally as the Natural Childbirth Association) in the UK in 1956. Its founder, Prunella Briance, believed that childbirth preparation classes were too scarce at that time. Additionally, she felt that those classes that were available placed too little emphasis on the psychological aspects of childbirth

preparation - a shortcoming already seen to continue to exist. The main aim, therefore, was to encourage women to "approach labour free from ignorance and fear" (Kitzinger, 1990: 92). This was to be done by teaching Grantley Dick-Read's method of childbirth preparation (Dick-Read, 1942).

Later, the NCT shifted its approach from this to the psychoprophylactic method of Dr Fernand Lamaze. Later to be known simply as 'the Lamaze method', this bore similarities to the relaxation techniques of Dick-Read, but incorporated a more active approach to blocking out or alleviating responses to pain. Linked with Pavlov's work on conditioning, women were taught to disassociate various stimuli in labour with the sensation of pain (Williams and Booth, 1980). Therefore, the NCT based its classes on these relaxation techniques, but added value by producing information sheets for women, as well as for health care professionals. It differed from the statutory sector in that its educators were mothers themselves; in fact, the experience of having given birth was an important qualification (Nolan, 1998b). By the late 1960s, the Trust was employing teachers trained in its own methods to facilitate classes nationwide. By 1986, the Trust had 320 branches nationally, with around 40,000 members in total (Kitzinger, 1990).

As a consumer group as well, the NCT has carved itself a distinctive niche, representing the interests of expectant and new parents across a range of maternity service issues. For example, its members made a significant contribution to the Changing Childbirth report in the early 1990s (Department of Health, 1993). Its ethos since inception has included empowering women to challenge the medical model of childbirth through, for example, questioning the need for 'standard' procedures, especially in the hospital

setting. The NCT is well known too for its commitment to the promotion of breastfeeding and in providing postnatal support for breastfeeding women. Indeed, as Mary Nolan describes,

The organization was founded on an ethos of support for women who were embarking on motherhood from women who were experienced mothers. The interplay, sometimes creative and sometimes hostile, between antenatal classes offered by midwives and those provided by the NCT fostered the development of antenatal education. The women who came to classes, whether at the hospital or in the home of an NCT teacher, were the descendants of those middle-class women who, in the late eighteenth century, had begun to find themselves cut off from traditional sources of wisdom about birth and early parenting (Nolan, 1998b: 4-5).

Indeed, the National Childbirth Trust's website describes its antenatal classes as follows:

NCT antenatal classes are small, friendly groups for parents expecting babies at about the same time. In these classes you will be given practical information and have a chance to talk through your feelings about labour, birth and life with a new baby (NCT Web page, November 2001).

The topics outlined as usually being covered in these classes are:

- Pregnancy, what happens in labour and how the baby is born
- Choosing where to have your baby
- Body awareness, relaxation, breathing and massage
- Positions for labour and birth
- What is available for pain relief - natural and medical methods
- What complications might arise - Caesarean birth, for example
- What your partner can do to help
- What happens if your baby is early, or ill
- Looking after a newborn and feeding your baby
- What it might be like when you become a parent and form your own family

Source: The National Childbirth Trust, 2001

This list suggests that expectant parents will be encouraged to discuss options concerning, for example, the place of birth - something that does not emerge from NHS

class descriptions. Otherwise, the topics outlined appear to represent a broad range of issues relating not only to the birth itself, but to postnatal issues as well. Indeed, the NCT emphasises that reunions of group members are encouraged, and mutual postnatal support among members is a particular strength of its organisation. It also has volunteer postnatal support workers who can be a point of contact for new mothers.

Like NHS classes, six to eight two-hour sessions are usual with the NCT. However, the classes are more commonly held in the evenings, rather than during the day like the majority of NHS classes. This is because the NCT encourages not just expectant mothers, but expectant *couples*. In fact, its reference to the role of partners - above - may be construed as off-putting to expectant mothers *without* partners. Another feature of NCT class attendance is that a charge is made for the series of sessions attended. While these rates vary nationally, the charge levied in the Plymouth area at the time of the primary data collection – 1997 - was £42. This may be a factor in making such classes inaccessible to those on low incomes.

NCT class attenders are indeed likely to come from higher socio-economic groups, to be well educated and to be married. As Nolan's (1995) study showed, the social profile of those attending classes in the voluntary sector is an accentuated version of that already seen to be prevalent in the statutory sector. She found that 94% of women attending NCT classes were from social classes 1 and 2. For younger, poorer, unmarried mothers-to-be, NCT classes do not appear to be attractive. This, Nolan (1998b) ascribes in part to a belief that such women already belong to a women's network through closer kinship ties and other such community links. Others, however,

have suggested that the NCT's ethos, including widespread perceptions of an emphasis on 'natural' childbirth may not appeal to working class women.

One of the earliest tenets of the National Childbirth Trust was that childbirth could be "an experience *in itself*, not just a means to an end" (Kitzinger, 1990: 98). Indeed, the NCT's commitment to teaching relaxation techniques for labour and its encouragement of women to question the need for analgesia probably adds to this belief. Margaret Nelson (1983) found that middle-class women espoused these values to a greater extent than working-class women. The latter, she found, preferred "more passive birth experiences with more medical intervention", while middle-class women generally wanted "active, involved births free from medical interventions" (Nelson, 1983: 284). Linked to these preferences, she found that middle-class women attending childbirth preparation classes were hoping for a pleasurable and 'natural' birth experience, whilst the others just wanted a shorter labour - focusing on the end product - i.e. the baby, rather than on the 'experience' of childbirth. McIntosh's (1989) study yielded similar results, with working-class women perceiving childbirth merely as a 'hurdle to be surmounted', rather than as a positive experience in itself.

Deborah Lupton (1994) has suggested that while the natural childbirth movement has sought to increase women's control over childbirth, this clearly pertains more to middle-class women for whom articulating demands is more of an issue. Indeed, the NCT has been criticised for being run by and *for* middle-class women, yet its place in the voluntary sector - traditionally a 'middle-class sector' - perhaps goes some way to explain that bias. Additionally, as noted above, its emphasis on helping new mothers to establish support networks and to prepare for the type of birth that they want may not,

in itself, disadvantage others with different needs and circumstances. That aside, the NCT's approach has attracted criticism from those who argue that its preparation for birth is unrealistic. Kate Figes, for example, has described the NCT's approach as a "quasi-spiritual natural birth dogma" to which many pregnant women subscribe, only to feel that they have 'failed' when the more medicalised reality of childbirth sets in. Further, she asserts that, "The purpose of childbirth is to have a baby rather than to experience labour, but the NCT ignores that - preparation for parenthood in its classes is almost non-existent" (Figes, 2000). One NCT teacher in Nolan and Hicks' (1997) study of statutory and voluntary sector childbirth educators claimed that, while postnatal issues are always on the agenda:

Parenting is a constantly changing process as the babies grow older and their needs change...So I think in terms of preparation for parenthood, maybe I can prepare them for the first week or so, but I can't actually get beyond that until they've actually had the experience of that first week or so and are ready to build on that (NCT Teacher 1, cited in Nolan and Hicks, 1998: 184).

Nolan herself has criticised the view held by many childbirth educators who claim that expectant mothers cannot see beyond the birth itself to a postnatal situation in which they have never found themselves. This is not justified, she asserts, in view of the fact that first-time mothers have not been through childbirth either, and yet that situation *is* prepared for in classes (Nolan, 1998b). On the issue of 'prepared childbirth', and particularly the Lamaze method on which NCT classes are based, there is little evidence either to suggest effectiveness once women are actually in labour. In a study conducted by Mackey (1990), the Lamaze method was met with difficulty by 61% of women trained in its use. Many such women go on to feel that they have 'failed', as Figes (2000) suggests. They may subsequently describe themselves as 'performing inadequately' (Lederman, 1995).

Given the points already raised about expectations and reality in the context of NHS antenatal classes and, in particular, their alleged failure to address adequately the postnatal aspects of the transition to motherhood, it may be that such issues are even more pronounced among NCT class attenders. However, there is a dearth of research-based evidence that contextualises any such issues within the experience of the transition to motherhood overall. What little there is tends to focus on the immediate postpartum period, when women are still in hospital following the birth, and are feeling 'grateful' and relieved about having their new babies (Green et al, 1998). Measured views, in the context of being new mothers, are, it seems, harder to establish, yet very important in terms of providing any kind of realistic evaluation of the social impacts of antenatal education.

2.4.5.2. The Active Birth Movement

The Active Birth Movement was spearheaded in the early 1980s by Janet Balaskas, whose impetus was a deep dissatisfaction with the active management of childbirth by clinicians (Robertson, 1994). Her intention was to empower women to understand their bodies through yoga-based exercises and gentle stretching. This would enhance the physical experience of pregnancy and help to prepare them both spiritually and physically for the process of childbirth. In fact, the Active Birth approach focuses less on 'teaching' relaxation exercises and more on 'body awareness' than either the NCT or the NHS:

This is very different from learning control through breathing techniques, such as the Lamaze method for example. Spontaneous breath awareness enables you to be uninhibited, to let go of control, in a focused and deeply relaxed way (Active Birth web site, January 2002).

The Active Birth Manifesto emphasises the importance of an upright or squatting position for women in labour, particularly in the second stage. This, it claims, is historically universal for women in childbirth and corresponds with a primeval instinct that modern hospital procedures have tried to eradicate by encouraging women to labour in a horizontal position. Thus, it claims, "birth in our modern hospitals becomes daily more complicated and passive, turning a perfectly natural process into a medical event and the labouring woman into a passive patient" (Balaskas J and Balaskas A, 1982).

Hence, it is clear that the Active Birth movement differs markedly from the approaches adopted by the NHS and the NCT. The controversial childbirth 'guru', Michel Odent, concurs with the Active Birth movement's philosophy. He states that logic and intellect have no place in a woman's experience of labour; instead, he asserts, a woman needs only to listen to what her body is telling her at the time (Odent, M., cited in Boseley, 2000). Mary Nolan - herself an NCT childbirth educator - accepts that:

Michel Odent is certainly of the opinion that techniques of prepared childbirth are unhelpful because they invite the woman to control her labour from the higher cognitive centres of the brain, centres that should be quiescent if the lower centres that stimulate the release of labour hormones are to work to maximum effect (Nolan, 1998b: 6).

In the words of two Active Birth teachers interviewed by Nolan and Hicks (1998):

You're teaching women to breathe properly and spontaneously, to turn inwards and focus on what they're feeling in their bodies, to become more aware of the baby and, of course, as the body relaxes, emotions are released (Active Birth Teacher 1)

I work with the model pelvis and get them really feeling and thinking about their bodies so by the end of six weeks, they've really got an idea of how the baby is going to come out and what's possible for them. Yes, I do give them information, but it's not heavily factual. It's more about getting them to experience (Active Birth Teacher 2, cited in Nolan and Hicks, 1998: 183).

Given this emphasis on helping women to 'get in touch' with their own bodies and yield to their primal instincts in labour, it is clear that Active Birth represents a form of antenatal education which is very different from either the NCT or the NHS. It does, however, share similarities with the NCT in that it actively encourages women to question and challenge modern obstetric procedures. Additionally, Active Birth endeavours to support women and their babies beyond the birth itself, offering all sorts of postnatal activities such as baby massage and baby gymnastics. To what extent other postnatal issues are covered in Active Birth classes remains questionable: the Active Birth teachers interviewed by Nolan and Hicks (1998) had little to say on this. However, the organisation does appear to promise shared learning in classes:

...about the huge variation of what can really happen, and what life is really like after the baby comes. It is the best way for you to learn about the realities and challenges, the difficulties along the way (Active Birth Centre web site, January 2002).

Indeed, it is quite explicit about its role as a modern equivalent of "the tribal society or extended family groups" (Active Birth Centre, *op cit.*). Therefore, is its claim to be the 'best' way to learn perhaps just a compromise for those who find themselves unable to access such information and support in their day-to-day lives? As with NCT classes, there is a charge for attending Active Birth sessions; also, the social profile of attenders is quite similar (Nolan, 1995).

2.4.6. Summary

This section has outlined the three main types of antenatal classes currently available. It has been seen that in both the statutory and voluntary sectors, attendance at classes is strongly influenced by social characteristics such as maternal age, marital status and social class or educational level. It has been suggested that such classes may, however,

represent formalised alternatives to more traditional community-based learning experiences. These may still be more relevant and accessible to expectant mothers who fall into the category of 'non-attenders'. While the literature pertaining to non-attenders and non-attendance is scarce, it may be that any definition of what constitutes 'antenatal education' might be widened to include lay alternatives.

In terms of the style, ethos, content and delivery of antenatal classes themselves, a number of similarities and differences emerge. First, there is a strong emphasis on labour preparation across all three of the types examined. While the approaches vary from 'directive' (NHS) to 'enabling' (Active Birth), the birth itself still appears to be the main focus in all types of classes. Postnatal issues, by contrast, appear to be less widely discussed. This is a particular criticism of NHS classes - and significant in that most women who attend *any* type of antenatal classes attend those run by the NHS in their local community. Further, if it is accepted that women attend antenatal classes as modern alternatives to the traditional women's network, then it must also be accepted that they expect to learn about important elements of the transition to motherhood in the very same setting. The following sections address these issues and topics.

2.5. Social aspects of the transition to motherhood

2.5.1. Introduction

While the process of childbirth is a social - as well as a physiological and emotional experience, there are many other important, and longer-lasting, social aspects of the transition to motherhood. For example, the numerous lifestyle changes associated with becoming a mother demand considerable adjustment for most women (e.g. Rogan et al,

1997). Such adjustment involves changes in personal identity, additional responsibilities - principally those of caring for another human being - and relationship changes, particularly with partners, as the 'couple' becomes a 'family' (Raphael-Leff, 1991). Indeed, in the context of the transition to parenthood overall, childbirth itself is a short-lived event which nevertheless appears to command most of the attention in both clinical and educational antenatal care settings. As Enkin and Chalmers claimed, "The psychological and social dimensions of health are as vitally important to the wellbeing of a woman and her family as the physical dimensions which current patterns of care have tended to emphasise" (Enkin and Chalmers, 1982: 283). Although this claim predates the most recent changes in maternity and family-centred policies (see section 2.2.1.), there still appears to be an overemphasis on physiological issues at the expense of social issues. In antenatal education, there is little evidence of any significant move to encompass ongoing postnatal issues such as those outlined above. Evaluation still tends to focus on labour and birth outcomes, particularly in terms of the efficacy of breathing exercises, rather than on how useful the classes are for preparing women for the realities of motherhood. Indeed,

Pregnancy, labour, birth, breastfeeding and the postnatal period are sometimes seen as separate in research and in the organization of maternity services, but women's lives may feel more continuous, despite the drama of birth (Smale, 1998: 192).

Maternal psychological wellbeing, infant care skills and parental relationships emerge as the three areas most in need of exploration, given their central role in the transition to motherhood overall.

2.5.2. Maternal wellbeing

Maternal wellbeing is basically about how the expectant and new mother *feels* about herself and what is going on around her during this important phase in her life. 'Wellbeing' is a difficult concept to operationalise, however. There have been attempts to develop measures of wellbeing (e.g. Bowling, 1991), but these are usually medical rather than social in orientation. As pregnancy, birth and parenthood are physiological, social and emotional processes, engagement with all three facets may be preferable to the medical model in which health is seen as an absence of illness (Clement, 1998; Nicolson, 1998, Oakley, 1993). Indeed, an holistic approach helps not only to engage with these different elements, but also to recognise that women conceptualise their own wellbeing in ways which do not fit into a medical model (Nicolson, 1998).

Despite this, the literature on wellbeing in the transition to parenthood - and motherhood in particular - is laced with research that focuses on the negative side of 'wellbeing'. Postnatal 'blues' and postnatal depression fall into this category. Indeed, women who are not 'diagnosed' as suffering from either of these 'conditions' are apparently of less interest in research terms, perhaps because of the recent historical dominance of medical labelling and the search for causes and cures that this engenders (e.g. Brown, 1995). Therefore, it has usually been assumed that women who are not 'ill' during the transition to motherhood are 'well'. Far less research has been undertaken on the states in between, although an increasing acceptance - both in theory and in practice - of a social model of wellbeing (e.g. Ussher, 1991; Nicolson, 1998) has begun to challenge this. Nevertheless, attention to psychological disorders dominates the literature in this area, so these are considered below.

2.5.2.1. Postnatal 'blues'

Often known as 'baby blues', this transient period of low mood is said to affect around 50 - 70% of new mothers in the week following the birth (Riley, 1995). Characterised by tearfulness or anxiety, the postnatal blues may be upsetting for new mothers, but in most cases the effects are temporary; indeed, the fact that so many women experience this may suggest that it is a normal condition, rather than a 'disorder'. Hormonal changes following the birth are often thought to be responsible (e.g. Felski et al, 1994), but this may be questioned in light of the fact that the condition is not experienced by all women. Wilkie and Shapiro (1992) examined the relationship between sleep deprivation and postnatal blues, and concluded that women who gave birth during the night suffered more distress at three to five days postpartum than women who had delivered during the day. Duration and quality of sleep in the nights following the birth was not found to have a significant effect, however. Anxiety during pregnancy and fear of the birth itself has been found to increase both incidence and severity of the blues (Knight and Thirkettle, 1987), and yet for women to feel anxious about a first-time birth is deemed to be quite normal (Raphael-Leff, 1991).

The quality of social support available to women in the immediate postnatal period may also be highly influential. Social support in the context of the transition to motherhood has been defined as, " Factors that buffer an individual from physiological or psychological consequences that are often present as the individual makes the transition from not being a mother to the maternal role" (Majewski, 1987: 400). It is often suggested (e.g. Ball, 1997; Tarkka and Paunonen, 1996b) that the role of midwives on the postnatal ward is especially important in terms of giving women flexible and

sensitive support as they make this transition. Learning to breastfeed, for example, is often more difficult than women anticipate (e.g. Buckell and Thompson, 1995), so the attitude of maternity staff at this time is important. However, the reduced length of postnatal hospital stay in Britain - now often less than three days even for first time mothers (Dowswell et al, 1997; Audit Commission, 1997) may be a cause for concern. Podkolinski (1998), for example, rues the fact that new mothers are now often discharged before they have had a chance to recover adequately from the birth, and cites the demise of the traditional 'lying-in period' as problematic in terms of helping women to adjust at this time.

Paula Nicolson (1998) suggests that the hospital setting and staff attitudes may help to contribute to the postpartum 'blues'. While the women in her study expressed awareness of the link between hormonal changes and the 'blues', they did not feel that hormones were responsible in their own cases. Instead, a variety of causes, from the stresses of labour and early breastfeeding to the attitudes of the midwives were all cited. Indeed, Nicolson suggests that:

Having a baby and being in hospital are both socially and psychologically stressful experiences during which the women having the baby experiences pain and uncertainty. Any emotional responses need to be considered as rational, whether or not hormones make the individual more vulnerable to depression (Nicolson, 1998: 55).

This excerpt demonstrates the way in which the holistic approach engages with the main dimensions of women's experiences at this time - social, emotional, physiological and practical. It accepts that while hormones may play a part in depressed mood, there are many other causes which women themselves see as influential. However, for the majority of women, 'the blues' turns out to be a brief and temporary state. For others, a

longer lasting and more debilitating postnatal depression may ensue. The following section explores the social and medical perspectives on this condition.

2.5.2.2. Postnatal depression

Postnatal depression (PND) is less common but more serious than 'the blues'. It is characterised by a range of negative emotional experiences such as tearfulness, irritability, fatigue, anxiety or panic. One participant in McIntosh's (1993) study, for example, described her feeling of postnatal depression as follows:

I felt depressed, fed up and tired. I just wanted to go into a little corner and cry. I just couldn't stop crying. I couldn't be bothered with anybody or anything and I couldn't be bothered with the baby. I felt exhausted all the time (McIntosh, 1993: 179).

While this woman described herself as experiencing 'depression', many women describe their feelings differently, using alternative terminology that describes their negative feelings without recourse to the medical/clinical discourse of 'depression' *per se* (Nicolson, 1998). Indeed, self-reporting of postnatal depression is both qualitatively and quantitatively different from psychiatric measures. This has important implications for the way in which PND is perceived and handled both personally and socially.

There is no real consensus on the incidence of PND, mainly because of differences in definition and measurement. For example, the use of psychiatric instruments such as the Edinburgh Postnatal Depression Scale (Cox et al, 1987) and the Beck Depression Inventory indicate levels of around 10 - 20% (e.g. Beck, 2001). Self-report measures, by contrast, indicate a much higher rate of between 50 and 70% (e.g. Oakley, 1980; McIntosh, 1993). Nicolson (1998) maintains that what has become termed 'postnatal depression' is a normal reaction to the changes experienced by women in the transition to motherhood and therefore should not count as 'illness' requiring 'treatment'. However,

the vast array of research into the causes and treatments of PND suggests that a medical model of PND is still dominant.

The medical model treats postnatal depression as a psychiatric disorder, thereby reducing the likely causes to individual personality traits or predisposition to depression. It follows from this that 'treatment' for the condition is also individualised, and the routine use of psychotropic drugs such as Prozac to treat postnatal depression is widespread (e.g. Greer, 1999). In the absence of previous psychiatric illness, the focus of attention turns (as with the postnatal 'blues') to hormonal changes which occur perinatally (Nicolson, 1990). This has led to numerous clinical studies of the effectiveness of hormone injections to combat PND - with mixed results (e.g. Smith et al, 1990; Gregoire et al, 1996). Indeed, the labelling of PND as a mental illness and the subsequent prescribing of drugs to treat it has led many women to fear that they might be seen as weak or incompetent; therefore they will avoid seeking help as a result (Riley, 1995). Additionally, if women perceive their problems to be social rather than medical, they are unlikely to seek a medical solution (McIntosh, 1993; Nicolson, 1998; Mauthner, 1998).

The social model of PND locates any causes and possible solutions in a social, rather than an individual context. Therefore, factors such as economic disadvantage, inadequate social support and the general stresses and strains of new motherhood are of greater consequence (Oakley, 1980; Cramer, 1993; Sheppard, 1997; Lee, 1997). It follows from this that medical solutions are seen as inappropriate by contrast with social solutions such as greater support for new mothers (Langer et al, 1993, Sheppard, 1994,

1997; Lee, 1997; Mauthner, 1997). The following section outlines the role of different types of social support and its relevance in the transition to motherhood.

2.5.2.3. Social support and its role in promoting maternal wellbeing

Social support has been categorised into three basic types: *informal*, covering issues like advice, guidance and feedback, *instrumental*, which involves practical aid or support - e.g. babysitting, shopping, etc. - and *emotional* support, which includes intimacy and reassurance, affection, and a feeling of being cared about (Collins et al, 1993; Sheppard, 1994). Such support may come from a wide range of sources, from midwives and health visitors to partner, family and friends. The most important indicator of the effectiveness of social support has been found to be its *appropriateness* for the woman concerned, as well as her ability to mobilise (or tap into) the right sort of support when she needs it (Cutrona, 1984, 1986). Of the three types of support mentioned above, emotional support, particularly from partners, is seen to be especially beneficial for the wellbeing of new mothers (Sheppard, 1994; Priel and Besser, 2000). This has been found to apply throughout the transition to motherhood - in pregnancy (Collins et al, 1993), in labour (Tarkka and Paunonen, 1996) and during the early postnatal period (Small et al, 1994). Oakley (1992), however, warns against the 'maritalist' assumption that a woman's psychosocial assets may be deemed adequate merely on the basis of having a partner. Indeed, inadequate partner support, especially of the emotional kind, is likely to have a deleterious effect on new mothers which support from other sources does not really compensate for (Levitt et al, 1996; Collins et al, 1993).

Given the growing acceptance of the relationship between maternal wellbeing and social support, a number of studies have attempted to evaluate the effectiveness of

formal support interventions for expectant and new mothers. A preventive approach to postnatal depression is implicit in such research, as it has repeatedly been found that prenatal depression is a strong predictor of postnatal depression (Beck, 2001, Evans et al, 2001). Clement (1995) suggests that 'listening visits' by midwives through pregnancy and the early postnatal period may be beneficial for such women. The timing of such interventions may be justified by claims that health visitors using the Edinburgh Postnatal Depression Scale (EPDS) in one study (Holden, 1994) had previously been unaware of depressive symptoms in up to sixty per cent of their clients. In view of the fact that so many women are reluctant to admit to feelings of depression, this implies that a significant proportion of them might miss out on formal support, despite feeling depressed. However, more recent research has found that health visitors are more accurate than the EPDS at spotting signs of depression or low mood among new mothers in the first two months (Leverson and Elliott, 2000). Indeed, the same authors reported some success in terms of prevention of postnatal depression in a controlled trial where 'vulnerable' first time mothers attended antenatal classes and postnatal support groups (Elliott et al, 2000).

Other studies have shown that enhanced formal postnatal support for mothers is beneficial in both the short term and the longer (7 year) term (Oakley et al, 1996). Nevertheless, a recent randomised controlled trial which evaluated the costs and benefits of community support funded by the NHS found no significant health benefits at six weeks or six months (Morrell et al, 2000). These examples seem to illustrate some of Oakley's (1992) assertions about the enduring problems inherent in establishing *how* social support benefits health. While it is generally accepted that it does, the problems

of quantification (highlighted by Morrell et al, 2000, among others) and hence positive evaluation, continue to persist. Ann Oakley stresses the incongruity between measures of quantity and perceptions of *quality* in citing that, "The study of sociable relations has been dominated by quantification: contact rates are regarded as the prime measure of sociability and taken as indicators of quality" (Allan, 1979 cited in Oakley, 1992: 23). In policy terms, valuable intervention measures may not be instituted simply because quantification strategies have not been established.

2.5.2.4. Antenatal education and social support

The problems identified above may be just as relevant to antenatal education. The already complex relationship between social support, maternal wellbeing and postnatal depression may be complicated further by the issue of self-selection. It is known, for example, that women who choose to attend antenatal classes are generally less disadvantaged in socio-economic terms than those who do not (Nolan, 1995). Does this perhaps imply that such women consciously (or unconsciously) seek the sort of support through antenatal classes that Nolan (1998b) suggests is now missing from their mainstream lives? The NCT is explicit about its role in trying to promote supportive relationships between expectant parents attending its classes (NCT, 2001), and the Active Birth Movement echoes this aim. NHS classes, which may be more informational and directive (Kelly, 1998; Underdown, 1998), do not appear to promote informal support explicitly, although such support may follow from attending the classes, as well as existing to some extent within them. Combes and Schonveld (1992), for example, claim that 'meeting other women' has been cited as one of the top three reasons for expectant parents attending such classes. They go on to note, however, that

"There appears to have been no systematic research to date on the impact of parent education on building up support networks for women" (Combes and Schonveld, 1992: 92).

This may be another shortcoming associated with the clinical/educational dichotomy in antenatal education. While evaluation has tended to focus on labour and birth outcomes, the social implications of attending the classes might be as - or more - important to expectant and new parents. While 'informational' support is clearly accessible by virtue of *attending* classes in both sectors, it remains unclear whether, and to what extent, further support in the postnatal period may be accessed between attenders as peer support. It is known, however, that the NCT employs volunteer postnatal support workers who act as 'friendly contacts' for new mothers postnatally, as well as an extensive network of breastfeeding counsellors (Nolan, 1998b). These services exist alongside the statutory midwife and health visitor support to which all new mothers are in any case entitled. Jean Ball (1994), on a similar note to that of Nolan (1997a) suggests that the growth of organisations such as the NCT "may be indications of the failure of family or professional helpers to provide appropriate support" (Ball, 1994: 10).

For those women who choose not to attend antenatal classes, only a little more is known about their general social support sources than about the sources of information that they access in relation to the transition to motherhood. Therefore, while many women with social characteristics of 'non-attenders' might be assumed to have closer kinship ties and greater access to informal support (e.g. Young and Willmott, 1957) there is little to draw on from the literature in this particular field. It has been asserted, however,

that it is *untrue* that very young mothers are especially lacking in social support. One study of British sixteen year-old first-time mothers found that they were:

Likely to be living with or near their family, gaining social support and practical services from them. The loneliest women, and those least well integrated into helpful networks, are often the geographically mobile middle-class women who do not have their first babies until their late twenties (MacIntyre and Cunningham-Burley, 1993: 66).

Another, more recent study of a small group of working class mothers in an inner-city setting found that kinship – especially female kinship – was an integral part of their everyday lives (Mitchell and Green, 2002).

Cliff and Deery (1997) have suggested that peer support *is* lacking in the experience of younger, single women who do not attend antenatal classes. On the other hand, they claim that the women who *do* attend find the information available in antenatal classes less valuable than that obtained from relatives, friends or books, which may be slightly contradictory.

Podkolinski (1998) looked at the various types of support received by a sample of women in the early postnatal period and found that most support came from partners and women's own mothers. Those who had attended antenatal classes did find that such peer support was valuable to them. Nevertheless, Podkolinski concluded that most women do not receive regular or prolonged support from other female relatives, friends or neighbours. This, she found, was often due to the new mothers' reluctance to ask for help, linked with a growing cultural trend for coping 'alone' in the nuclear family environment. This is in marked contrast to traditional community support mechanisms practiced in non-western societies (Vincent Priya, 1992). New mothers' lack of willingness to ask for help may also be connected with the dominant view of new

motherhood as a time of joy and happiness. That view is challenged by Nicolson (1998), who argues that the postnatal period is characterised by loss (of freedom, former identity, and so on) as much as by gain. Thus, new mothers find their status, identity and wellbeing influenced by a range of factors for which they may have received little or no preparation. Caring for a new baby and negotiating a different (parental) relationship with a partner emerge as the most important changes in this respect. The apparent lack of coverage of these issues in antenatal classes raises questions about how expectant and new parents learn to cope with these changes.

2.5.3. Infant care skills

Social and cultural changes in Britain have affected not only the way in which babies are cared for, but also the ways in which new parents *learn* infant care skills. The traditional observation of infant care practices in close-knit communities has diminished to such an extent that many new parents have had nothing to do with babies until the arrival of their own (Oakley, 1993). Breastfeeding, for example, has been the dominant form of feeding in traditional communities, and young girls "learn the techniques unconsciously at an early age" (Vincent Priya, 1992: 116). Collective childcare as practiced in such communities also generates the kind of knowledge that the majority of western parents must acquire in other ways. This has led to a diversity of knowledge sources in a variety of sectors, and these are outlined below.

2.5.3.1. The statutory sector

Medical intervention in the field of infant care and development began early in the twentieth century, in Britain. The British Paediatric Society was established in 1928,

reflecting national concerns with infant health and mortality. In the same vein, the health visiting service was set up during the same decade, giving the former middle class philanthropists a statutory role in promoting good hygiene and nutrition for mothers and their infants (Davies, 1988). Thus, issues of infant care entered the public health domain, giving rise to the role of the 'expert' in mothering issues, especially for poorer, working class women, but later for all (Oakley, 1984). The medicalisation of early infant care skills now extends to all social classes through the widespread take-up of maternity services, including midwife and health visitor care as standard. Indeed, a failure to utilise such services may be seen as deviant and the woman's lay opinion or intuition held to be inferior to that of the so-called 'experts' (Miles, 1991).

Mainstream education has a rather patchy record in the way that it has embraced parenting skills; it has also been distinctly gendered. For example, schoolgirls were routinely taught housekeeping skills, including elements of infant care, during the early decades of the twentieth century, but the 'mothercraft' elements had disappeared by the 1970s, when the traditional gender differences in the school curriculum became outlawed (Bruley, 1999). More recently, though, infant care skills have begun to be reintegrated into mainstream education for both sexes, but only to a limited extent. For example, the National Curriculum now includes Personal and Social Health Education for secondary school pupils, which encompasses issues such as of sex education and drugs awareness (HMSO, 2002). Within this subject, however, there is greater attention to pregnancy prevention than to parenting skills, despite the fact that most young people will go on to become parents at some stage (Ferri and Smith, 1996).

Policy measures related to reducing teenage pregnancy in Britain, which currently has the highest rate in Europe (TPU, 2003) have been outlined in section 2.2.1. Additionally, it can be seen that initiatives designed to help raise teenagers' awareness of the realities of parenthood have been patchy and diverse. They often include the use of dolls that are programmed to cry and need feeding regularly, in order to focus teenagers' awareness on the rigours and responsibilities that parenthood brings. In some areas, teenage mothers have also been invited back to the classroom to enlighten their peers about the downside of becoming a mother before completing full-time education (e.g. Waterhouse, 1999). Such measures may be seen as preventive (of pregnancy), rather than enabling (of learning parenting skills), however. Despite such initiatives, a report on parenting in the 1990s suggested that

A more explicit and universal commitment is required, which can only be achieved by giving preparation for family life a central place in mainstream education through the national curriculum (Ferri and Smith, 1996: 50).

Controversy still surrounds these issues, particularly in terms of what sort of 'family life' is being prepared for. The conservative notion of marriage as the building block of family life continues to influence policy initiatives in this area, despite the fact that 'traditional' nuclear families are now in the minority in Britain and that over a third of all live births occur outside marriage (Social Trends, 1999). It may be that the government focus on teenage pregnancy prevention, teamed with the promotion of 'traditional' moral values misses the point in terms of preparation for the reality of parenthood in a diverse society. As a result, many adults become expectant parents with little or no knowledge of parenting skills. Mary Nolan claims that

The majority of clients with whom childbirth educators work are expecting their first baby. Many will never have held a newborn baby, never have seen a woman

breastfeeding, and never have been involved in the care of a very young child (Nolan, 1998b: 8)

Nolan goes on to suggest that these expectant parents' anticipation of learning even the basic infant care skills on the hospital postnatal ward may be misplaced in the light of shortened postnatal stays and diminishing midwife resources (Dowswell et al, 1997). Indeed, she advocates the teaching of such skills in all antenatal classes as a fundamental part of their remit to prepare for the transition to parenthood. It has already been noted that NHS classes in particular may be lacking in this respect, despite often being termed 'parentcraft classes' (Kelly, 1998). Chalmers and McIntyre (1994) argued that the need for both pre- and postnatal parentcraft courses is ever greater with the demise of the extended family, but criticised the paucity of such provision across all sectors. They further argued that any evaluation of antenatal classes "should assess their impact on adjustment to parenthood rather than on the birth process itself" (Chalmers and McIntyre, 1994: 120).

Even if parenting skills were adequately addressed in antenatal classes, the question remains how they could be imparted to those who do *not* attend. This perhaps reinforces the argument for infant care skills and other parenting issues to be addressed more comprehensively in mainstream education.

2.5.3.2. Multi agency provision

In response to many of the shortcomings identified above, a plethora of parenting programmes have sprung up in Britain since the mid- 1990s (Whyte, 1996). Smith and Pugh (1996) estimated that around 28 000 parents were participating in a variety of statutory and voluntary sector programmes at that time, with reasons ranging from a

desire to be 'good enough' parents (Winnicott, 1964) to having tangible problems with raising their children. Many parenting programmes employed public sector workers such as health visitors, social workers and psychologists, based on Department of Health identification of a need for such services nationwide (Department of Health, 1994). Others were placed more firmly in the voluntary or private sectors, where parents would expect to pay for the sessions attended (Whyte, 1996). Some overlap was evident, however, in the extent to which statutory sector workers might refer families to courses run by voluntary or private sector organizations.

In Plymouth, the community-based programme, 'Parentwise' was one of those targeted specifically at disadvantaged inner city parents, many of whom were struggling to cope with parenting issues. Funded principally by the statutory sector, this multi-agency programme started in 1992, embracing a multi-agency approach to parenting issues stemming principally from economic deprivation (Chapman and Jones, 1994). At one point in its early development, Parentwise ran experimental courses on antenatal education, which were unsuccessful due to the very small numbers of clients attending. Peter Jones, a community psychologist who evaluated the project, believed that this was largely due to adults' failure to engage with the importance of parenting issues prior to *becoming* parents (Jones, 1998). This is an argument refuted by Nolan (1998b) in claiming that first-time expectant parents are keen enough to learn about childbirth - an experience which none of them have had yet either.

Questions have been raised about the extent to which parent education programmes may be remedial, rather than preventive, as well as the tendency for a 'middle-class bias' to permeate their methods and models of parenting (Whyte, 1996). Indeed, the fact that

significant social class differences exist between self-referrals and referrals from health professionals do suggest parallels with similar issues raised in relation to antenatal classes (Nolan, 1995). Nevertheless, this is the approach that has been taken since the launch of Sure Start in 1999. Local programmes include family support, advice on nurturing, health services and early learning (Sure Start web site, 2002).

Plymouth is one of the areas in which a Sure Start programme has operated since the initial rollout. In addition, Sure Start Plus funding was allocated in April 2001 for work with teenage parents in the city. These initiatives exemplify the multi-agency approach through their encouragement of partnership working between families, health professionals, schools and social services. Thus, they engage with lay, statutory and voluntary sectors.

2.5.3.3. The lay sector

This sector consists of non-professional sources of knowledge, and may include families, friends, the popular press and the Internet. The influence and accessibility of the former may have diminished for many expectant parents (e.g. Oakley, 1993; Chalmers and McIntyre, 1994), but the informal and usually unreported nature of such contact makes this difficult to claim with any certainty. Indeed, this area seems to be under-researched. Although general lay knowledge and health beliefs have received some attention (e.g. Calnan, 1987), very little has been done to investigate the quality and extent of familial advice on infant care skills received by expectant and new parents. A perceived diminution in this area might be apparent, however, in the growth of pregnancy and parenting books and magazines, as well as - more recently - a host of web sites devoted to these issues.

An Internet search for 'Pregnancy and Parenting Magazines' (UK only) undertaken in February 2002 yielded almost four hundred hits. Listed on the various web pages were advertisements and subscription details for countless monthly magazines, including the most popular titles, *Mother and Baby*, *Pregnancy and Birth*, *Baby Care and Pregnancy*, *Practical Parenting* and *Prima Baby*. While the first of these titles was launched forty years ago, the last - *Prima Baby* - first came onto the UK market in 1999, with debut sales of well over fifty thousand (Hodgson, 2000). The contents of such magazines range from health and fashion advice for parents and infants to practical advice on infant care, maternity pay and benefits and 'returning to work' issues, for example. Their authors include journalists, health professionals or other more experienced parents. Hence, an overlap between what counts as 'lay knowledge' and what counts as 'medical knowledge' is immediately identifiable in such media (e.g. Kirkman, 2001). This also applies to television and radio programmes - accessed in a lay context but often presented by qualified health professionals. The Internet as a source of information about health issues has also blurred the boundaries between lay and 'expert' knowledge, to the extent that previously specialised and often obscure information may now be accessed by anyone with a will to do so (Hardey, 1999).

Web sites devoted to issues of pregnancy and parenting have proliferated in recent few years. These are no longer set up just by well-known organisations such as the NCT, but by individuals or small groups who perceive a need for such information. One of these is the 'UK Parents' site, founded in 1998 by a mother of two children for the dissemination of information and advice about parenting. The site claims to have had 137, 185 visitors in an eighteenth month period. A similar site - 'Mumsnet' - claims also

to have been set up by parents, for parents. Indeed the two founders were mothers of young children who had originally met each other at antenatal classes. They decided, based on that experience, that other mothers were the best sources of information and advice. The web site therefore represents a broadening of that opportunity to include many more parents (Mumsnet web site, February, 2002).

The growth in both the availability and the accessibility of these cultural resources suggests a strong demand for information about parenting and infant care skills. Indeed, the diversity of knowledge sources now available in this sector may contribute to what O'Keefe et al (1998) termed a 'personal media repertoire'. The choices inherent in such diversity may also involve uncertainty and conflict, however. It is not only the methods of accessing infant care advice that have changed over time, but also the content. The following section outlines a number of these changes.

2.5.3.4. Changing patterns in infant care advice

Infant care practices, along with antenatal and childbirth arrangements, have changed significantly over time. Medicine, public health and psychology have all played a part. Overwhelmingly, the growth of 'expert' advice on infant care has been linked to the rise of these disciplines.

From the late nineteenth century, infants' emotional and psychological development was studied by psychologists (such as the American G. Stanley Hall) in order to regulate them to fit in with the demands of industry (Ehrenreich and English, 1979). This 'behaviourist' approach, focusing on regularity and discipline, became the prescribed norm in Britain and America for several decades, following the advice of self-appointed

'experts' such as Frederic Truby King. Truby King was an Edinburgh-trained physician who, in the early 1900s (in New Zealand) devised a strict regime of infant care based around regular four-hourly feeds of formula milk. Breastfeeding was deemed by King to be suitable for dairy calves, but not for human babies (Time Magazine, February 2002). King also advocated "strictly monitored naps and vigorous airings in the perambulator, all undertaken on the dot, regardless of how much the child wailed" (Clanchy, 2000). Crying babies were not to be picked up; mothers would be chastised for 'giving in' to their babies' demands. Affection was discouraged. Indeed, mothers' (and babies') natural instincts were suppressed in favour of the 'scientific' methods of the experts (Kitzinger, 1978). It may be that the origins of mothers' doubts and uncertainties about how to care for infants were established around this time. Although Truby King's rigid infant care doctrine has since been discredited, it is still alleged that his advice on formula feeding contributed to the steep decline in breastfeeding in the postwar period (Clanchy, 2000).

In the early 1950s, the most fashionable childcare 'guru' was Dr Benjamin Spock. An American physician by training, Spock's approach was far less draconian than King's. His *Common Sense Book of Baby and Child Care* (1946) sold millions of copies - its popularity endorsed by parents' desire to *enjoy* their babies. Spock rejected the 'old school' of thought, replacing it with advice to encourage infants to explore their environment in a context of parental warmth, affection and encouragement (Humphries et al, 1988). Breastfeeding was promoted once again as an integral part of this context.

Interest in infant development was fuelled at this time by the work of child psychologist Jean Piaget (1896 - 1980) who stressed the importance of stimulation of infants at

certain pivotal stages of their development. Infants were now regarded more as thinking, intelligent and sensitive beings than had been the case at the beginning of the century. Play was seen as an important element of learning and newer, more open approaches to toilet training and table manners paved the way for more greater involvement in infant care by fathers as well as mothers (Humphries et al, 1988).

Research into the effects on infant development of mother-infant bonding and maternal infant attachment (Klaus and Kennell, 1983) has continued to endorse the 'instinctive' approach to infant care. This is reflected in the latest wave of baby care books by popular British authors such as Dr Miriam Stoppard. As a physician and an experienced mother, Stoppard's approach perhaps exemplifies the overlap identified above between lay and medical knowledge bases. Her advice combines both maternal and medical 'advice' that draws on research into various issues such as bedtime routines and sleeping arrangements. The latter, for example, has been contentious to the extent that co-sleeping - once seen as one way of 'spoiling' a baby, as well as perhaps contributing to Sudden Infant Death Syndrome (SIDS), may now be promoted as beneficial to both parents and infants (e.g. McKenna et al, 1994). Another - related - change has been seen in advice about babies' sleeping positions. While babies were traditionally put to sleep on their sides or their fronts (in case of vomiting), the current advice (to diminish the risk of SIDS) is to place them on their backs (Foundation for the Study of Infant Deaths, 2002).

Having outlined the main changes in infant care practices in over the past century, the review now picks up on the issue of paternal involvement in infant care, to explore the division of infant care tasks between new parents.

2.5.3.5. Gender and the division of infant care

Post-war social and economic changes generated a redefinition of gender roles in the home as well as in the workplace. As indicated above, progressive approaches to child rearing included a more active role for fathers, beyond that of disciplinarian and breadwinner. Men became more involved from the moment of birth; in the hospital labour ward - previously a female-dominated area, fathers were present in only nineteen per cent of cases in the 1960s. By the 1990s, this figure had risen to around ninety per cent (Draper, 1997). While this change was allegedly encouraged by women themselves (Woollett et al, 1982) and supported by birth writers such as Sheila Kitzinger, others remain sceptical about the role of fathers at birth. Michel Odent, for example, maintains that the father's presence distracts the labouring woman and interferes with the initial bonding process between herself and her baby (Odent, 1997). Those in favour suggest that the father may have a valuable role in advocating for and supporting his partner, as well as forming early emotional bonds with the baby (e.g. Chalmers and Meyer, 1996; Copstick et al, 1986; Rodholm, 1981).

Antenatal classes appear to have accommodated - and to some extent, encouraged - this trend. While they are not prescriptive on this issue, NCT classes in particular cater mainly to couples, thereby encouraging active paternal involvement even before the baby arrives (NCT, 2001). Changes in British paternity leave entitlement also reflect a cultural change in respect of fathers' role in the early postnatal period, at least. The Government's Green Paper, *Work and Parents: Competitiveness and Choice* (HMSO, 2000), suggests an introduction of two weeks' paid paternity leave for all working

fathers from 2003. At present, around 85% of working fathers take about seven to eight days off work (DTI, 2000).

Once home, the distribution of infant care tasks between new parents appears to be affected not only by fathers' working patterns, but also by infant feeding method. For women who elect to breastfeed, there is a clear physiological limit to fathers' involvement, which may prove to be frustrating for fathers (Henderson and Brouse, 1991) as well as perhaps initiating jealousy on their part (Raphael-Leff, 1991). It has been found that many women make the choice to bottle-feed based on an expectation of higher levels of paternal involvement in that activity (Earle, 2000). However, paternal participation rates in infant care are somewhat lower than might be expected, especially in view of the popular notion of the 'new man'. Rustia and Abbott (1993) suggested that the 'culture of fatherhood' has changed more rapidly than the 'conduct of fatherhood' - a view echoed by Ann Oakley (1993). Oakley claims that, "So far as the role of men is concerned, the evidence about fathers' participation in childrearing has always been at odds with the twentieth-century notion of the liberated male" (Oakley, 1993: 99).

There seems to be a discrepancy between the extent of domestic involvement *claimed* by fathers and their partners' *perceptions* of such involvement. For example, Chalmers and Meyer (1996) found that most of the new fathers (94.7%) in their study reported taking an active role in caring for their babies; their partners' views were not reported, however. By contrast, Paula Nicolson (1990) found that, after the first month with a new baby, 82.6% of women were satisfied with the father's contribution but that after three months, this figure had slumped to 18.1%. After six months, none of the mothers was satisfied with their partner's domestic behaviour. In Moss et al's (1986) study of the

transition to parenthood, women who received higher levels of domestic help from their partners also reported greater marital satisfaction, and vice versa. A large proportion of the women "felt that their partner did not understand the reality of full-time childcare" (Moss et al, 1986: 66).

A number of studies have indicated ongoing perceptions among fathers that childcare is still 'women's work' (e.g. Walzer, 1996; Trevelyan, 1996; Sanchez and Thomson, 1997). Nicolson (1990) found new mothers reporting that their partners regularly came home from work only to read the newspaper or watch television, rather than take over responsibility for the care of the baby. The implication here, as Walzer (1996) suggests, is that childcare does not really count as 'work'. Indeed, Ann Oakley has claimed that while men are keener than they used to be to get involved with their infants, they have

chosen the more pleasurable aspects of childcare - playing with the baby rather than changing its nappy, or playing with the baby so that the mother can get the dinner ready (Oakley, 1993: 13).

The extent of new fathers' involvement with their infants may be influenced by social class, with middle-class fathers participating more than their working-class counterparts (Rustia and Abbott, 1993). The infant's gender may also play a part; fathers have been found to spend more time with boys than with girls (Oakley, 1993; Lewis, Newson and Newson, 1982). Additionally, first-time fathers spend more time on infant care and related domestic tasks than do multiple-time fathers, perhaps linked to spending more time with the older children (Rustia and Abbott, 1993).

A recent study of couples expecting their first baby showed that both partners anticipated a greater workload after the birth, but that women anticipated significantly more work than men (Gjerdingen, 2000). The evidence outlined above suggests that this

may be quite realistic. Nevertheless, calls have been made to introduce expectant parents to the notion that life after a first baby might be tougher than they anticipate. Patricia Hewitt of the Institute for Public Policy Research, suggested that antenatal classes, for example, do not adequately involve fathers or prepare them for the reality of infant care. This, she claimed, adds to the cultural notion that parenting is the province of mothers:

In the very early weeks and months of parenthood it is so easy for the mother to become competent and so easy for the man to become incompetent - the one who says "what do I do now?" to the expert mother (Hewitt, cited in Trevelyan, 1996: 213).

Susan Walzer (1996) argues that:

The tendency for mothers to take responsibility for this kind of work is an underrecognized stress on marriages as well as a primary way in which mothering and fathering are reproduced as gendered experiences (Walzer, 1996: 220).

In fact, it has long been acknowledged that the arrival of a first baby may impact negatively on the parental relationship, for these and other reasons. The concluding section of this review therefore explores that issue and questions the extent to which new parents may be prepared for such disruption.

2.5.4. Parental relationships

There is a raft of literature suggesting that the quality of couples' relationships may deteriorate following the arrival of a first baby (e.g. Cox et al, 1999; Glogertippelt et al, 1995; Levy-Shiff, 1994; Dalgas-Pelish, 1993). Not only is this associated with an imbalance in the division of infant care tasks, but also the lack of sleep - resulting in extreme fatigue - that new parents tend to experience. Decreased levels of affection, sexual activity and general happiness are all common in the first postnatal year (Glogertippelt et al, 1995; Elliott and Watson, 1985). Exacerbating factors may be

particularly wakeful babies and a perceived lack of partner support on both sides (Belsky, Lang and Huston, 1986). Pregnancy and the early postnatal period have also been highlighted as times of increased risk of domestic violence (Jasinski, 2001; Hedin, 2000). As a result, many maternity units have incorporated policies for addressing these issues (Marchant et al, 2001).

For women, the transition to parenthood involves more loss of former identity than for men (Nicolson, 1998). Loss of the autonomy, self-esteem and financial reward conferred by paid employment may be particularly difficult for new mothers (Dennerstein, 1995), although the parental relationship effects may be mitigated by paternal flexibility in the domestic arena (Levy-Shiff, 1994). For men, additional stressors may include the financial requirement to work longer hours at precisely the time when maternal and infant support is needed at home (Cappuccini and Cochrane, 2000; Raphael-Leff, 1991). Feelings of exclusion from infant care arising from breastfeeding and perceived 'over-involvement' by the mother may also impact negatively on the parental relationship (Henderson and Brouse, 1991). In a study of new fathers carried out by these authors, frustration, anxiety and fatigue were the terms most often used to describe the early postnatal period. One participant claimed that "The first three weeks were a nightmare. The worst three weeks of our marriage" (Henderson and Brouse, 1991: 297). The authors concluded that most of the fathers were unprepared for the level and intensity of disruption, despite having attended prenatal classes. Indeed, in a study conducted by Nichols (1995), no differences in this aspect of the transition to parenthood were found between attenders and non-attenders of antenatal classes. Given the lack of coverage of postnatal issues generally in such classes, this is probably

unsurprising. However, this is an area that merits such inclusion, as all the evidence about parents' postnatal expectations indicates a desire for realism (e.g. Chalmers and Meyer, 1996; Combes and Schonveld, 1992).

As the section on maternal wellbeing has already demonstrated, there is a popular misconception that new parenthood is a time of great joy, perhaps leading to cultural pressures to 'pretend' that all is well, in spite of any difficulties. For example, in Dalgas-Pelish's (1994) study, parents claimed to have experienced *increased* satisfaction in the quality of their relationship when asked outright. However, their responses to individual questions on this aspect of the transition clearly demonstrated the opposite. The relevance of this issue to other social aspects of the transition to motherhood should not be understated, especially as it appears to be so closely linked with maternal wellbeing. Indeed, all of these psychosocial facets of the transition to parenthood seem to be inadequately addressed in the statutory and voluntary antenatal education sectors. Chalmers and McIntyre's (1994) assertion that the demise of the traditional family requires more to be done in these areas through formal means is apparently still relevant. Yet, the paucity of provision in these crucial aspects of the transition to parenthood also still applies. It may indeed be the case that any meaningful evaluation of antenatal classes "should assess their impact on adjustment to parenthood rather than on the birth process itself" (Chalmers and McIntyre, 1994: 120).

2.6. Conclusion

This chapter has examined the main changes in the ideology and practice of UK maternity service provision. Within that sphere, clinical antenatal care has been considered as a key element of such a service, whereas antenatal education has not.

Indeed, it remains unclear whether antenatal education forms part of the clinical or the *educational* facets of maternity care. As it stands, there continues to be a number of ongoing problems with antenatal education, both conceptually and practically.

First, its physiological emphasis may divert attention away from other - equally important - aspects of the transition to motherhood. The literature indicates that, while many new parents experience emotional and relationship difficulties in the early postnatal period, little preparation is offered in this respect by either the statutory or the voluntary sectors.

Second, while misgivings are regularly expressed by service providers about levels of non-attendance, particularly among those perceived as most in need of the service, little has been done to tackle that issue. The most recent policy initiatives (identified in section 2.2.1.) continue to suggest an unwillingness to recognize or address either of these concerns. This may be strongly related to a lack of consumer-orientated research into the strengths and weaknesses of antenatal education.

Finally, amid these uncertainties about antenatal education generally, the role of the lay sector has been overlooked. While it tends to be assumed that 'antenatal education' is the formalized and rather prescriptive service offered by the NHS, it may be more helpful to broaden the definition to include all of the information and support sources utilized by new mothers. Moreover, such sources need to be considered *across* the transition to motherhood, not just up to the point of the birth itself. This may help to facilitate inquiry into the usefulness of antenatal education in an *applied* sense, instead of the somewhat abstract and speculative ways in which it has so far been done. With this in mind, the following chapter specifically addresses the research questions arising from

this literature review. It also sets out in detail the methods employed in trying to answer those questions.

Chapter 3 Methodology

3.1. Introduction

This chapter explains the processes involved in the research project as a whole, from planning and formulation of research questions to data collection, analysis and subsequent writing up. A two-phase, multi-method approach was used for the data collection, as outlined in Table 3.1. overleaf. The forthcoming discussion of those methods - including the difficulties encountered in recruiting participants to the study – will be critical and reflexive, emphasizing the perceived weaknesses as well as the strengths.

3.1.1. Overview

Initially, it will be useful to review the aims and objectives of the study. This review follows immediately below. Thereafter, in section 3.2.1, the chapter proceeds with an account of how the research process got off the ground, in terms of making contact with relevant individuals and selecting a suitable approach. Section 3.2 continues with an explanation of the case study approach; its limitations and benefits. Method triangulation is then briefly discussed in section 3.3.1.

Section 3.3.2 introduces the concept of reflexivity and its role in the research process. This is followed by a discussion of ethics and the recruitment of participants to the study in section 3.4. The problems encountered in accessing and recruiting are subsequently explored in some depth, as these turned out to be key features in the research process. In fact, these difficulties turned out to have implications for the *theoretical* emphasis of the research project, as well as for its methodology.

Table 3.1. Data Collection Sources

Data Source	Research Instrument	Data type (Qualitative / Quantitative)
<u>Case Study Participants</u> (9) 5 Antenatal class attenders 4 Non-attenders	Semi-structured Interviews and Participant Diaries *	Qualitative
<u>Questionnaire Respondents</u> (39) 32 Antenatal class attenders 7 Non-attenders	16-page Questionnaire 10-page Questionnaire	Qualitative and Quantitative
<u>Local Health Professionals</u> (5) 2 General Practitioners 1 Community Midwife 1 Community Psychologist 1 Health Visitor	Semi-structured Interviews	Qualitative

*Appendix 10 gives case-by-case data sources.

The chapter proceeds in section 3.5 with an account of the case study interviews and their subsequent analysis, then goes on to describe – in section 3.6 – the questionnaire survey design, distribution and data analysis. Interviews with local health professionals are described in section 3.7, while a concluding section (3.8) draws out the main

features of the research process, summarising the methodology and highlighting its overall benefits and shortcomings.

3.2. Aims and objectives

According to the main issues and questions that emerged in Chapter Two, the principal aims of the study were as follows:

- To investigate the range, accessibility and content of statutory and voluntary antenatal education services in the Plymouth area.
- To investigate factors affecting non-attendance for such services, including non-attenders' perceptions of such services.
- To examine the role of lay systems of knowledge and support in the transition to parenthood.
- To investigate the differential impact of different patterns of knowledge and support on the experiences of new parents, with particular attention to the three key areas of maternal well being, parenting skills and parental relationships.

3.2.1. Getting started

Examining the *impact* of antenatal education on the transition to parenthood was central to the aims and objectives of the study. As such, it was necessary to focus not only on antenatal classes themselves, but on their role in the process of becoming a parent. In the early stages, I had hoped to observe some classes run by the NHS and the NCT in order to establish clearer ideas about their style and content. First, therefore, I contacted various local NCT representatives, all of whom were interested and helpful. However, it transpired that no suitable classes were being run at the time. There was either insufficient demand, or else the classes were too small to accommodate an observer in addition to the teacher, trainee, postnatal supporter, etc. I was assured of being

contacted when a suitable set of classes arose but despite telephoning at courteous intervals over the following two months, this began to look less and less likely. The local Active Birth teacher also seemed interested in the research, but regretted that demand for classes in Plymouth was particularly low and that nothing was planned for the foreseeable future.

Turning to the NHS, it was agreed in principle – following a meeting with the Community Midwifery Manager in December 1996 – that some classes could be observed as soon as ethical clearance had been obtained from South and West Devon Health Authority. By the time such permission had been granted (in June 1997), however, it was beginning to seem that such observation might in any case prove to be unnecessary. First, it appeared - from the accounts of some of the community midwives - that classes varied somewhat depending on the midwife who was running them, as well as on the characteristics of the local area and the particular client group. Second, early interviews with expectant mothers who were attending such classes suggested that a fairly accurate picture of their style and content would soon emerge in any case. The fact that women's own perceptions of antenatal classes and their usefulness was of greatest importance led to the eventual decision not to undertake such observation. With hindsight, this modification to the research methods was felt to be appropriate. The required data was gathered effectively through discussion with the main research participants, whose descriptions and evaluation of antenatal classes proved to be both insightful and informative.

3.3. The case study method

Given the requirement to explore the role of antenatal education in the transition to parenthood, a case study approach seemed particularly appropriate. It was my intention to recruit to the study a number of first-time expectant mothers in the final trimester of pregnancy, in order to study their experiences until three to six months after the birth of their babies. In this way, antenatal education in its various forms could be evaluated in relation to its impact on the *experience* of parenthood. Additionally, prenatal expectations could be compared to the reality of new motherhood, especially in the three key areas of maternal well being, infant care skills and parental relationships. In effect, a longitudinal study was required, and this indeed constitutes one aspect of the case study approach. As Bromley has described:

A case study usually deals with a relatively short, self-contained episode or segment of a person's life. The episode is usually important in that it is formative, critical or culminant – the sort of episode one would regard as a life-event worth mentioning in a life history. (Bromley, 1986:1-2)

The birth of a first child meets all of these criteria, although the transition to parenthood is arguably more of a process than an 'episode'. Nevertheless, there must be a cut-off point. For the purpose of this study, three to six months postpartum seemed an appropriate time by which to assess the impacts of antenatal education in the three key areas outlined above.

It is generally accepted that the use of case studies involves small numbers of cases because of the detailed and often complex nature of the inquiry (Bowling, 1997; Bryman, 1989). This was certainly true of this research project, which attracted fewer

participants than was originally envisaged. More detailed discussion of this takes place later in the chapter, in sections devoted to access and recruitment.

Small numbers of cases do raise questions about the validity and reliability of the data collected. This is an inherent criticism of case study research, which tends to lend itself more to depth than to breadth. Stake, for example, claims that, ‘The real business of case study research is particularization, not generalization’ (Stake, 1995:8). Within this study, while some generalizations *are* made, they are made with due recognition of the limitations of the sample size. The methodological approach adopted is, on balance, that which came closest to enabling the research questions to be answered. Every method has some limitations. The important thing is to recognize and acknowledge them. A balance needs to be struck between satisfying the requirements of scientific research and obtaining data both relevant and appropriate to the aims and objectives of the study. Here, that balance is what I have sought to achieve, aided by method triangulation as explained below.

3.3.1. Method triangulation

The case study approach enables a combination of qualitative or quantitative methods, the choice of which is determined by the nature of the inquiry. Indeed, a combination of methods is often seen as desirable in helping to promote what Denzin (1978) has termed ‘method triangulation’. Validity and reliability may be enhanced through such an approach:

By combining several lines of sight, researchers obtain a better, more substantive picture of reality; a richer, more complete array of symbols and theoretical concepts; and a means of verifying many of these elements (Berg, 1989:4).

In an attempt to achieve this, a two-stage approach included a variety of research instruments. The first stage focused on the case study participants, using semi-structured interviews as the principal research tool, augmented by participant diaries. In the second stage, a fairly lengthy questionnaire – designed to take account of the earlier case study findings – was distributed to a larger sample of new mothers in the area. Throughout the study, a selection of local health care professionals was interviewed in order to obtain a service provider's perspective. More detail about each of these methods is given below. First, though, I account for the role of my own values and assumptions in the research process.

3.3.2. Reflexivity and its implications for the research process

The role of the researcher in the research process often invokes controversy. While natural scientists tend to reject the notion that researcher values are linked to the research process itself, social scientists have increasingly accepted that the two may be inseparable. The focus of disagreement is whether objectivity can be maintained if researcher values impinge on the choice and execution of a particular piece of research. Even among social researchers, some disagreement is evident; epistemologically as well as methodologically, a broad divide has existed between those who favour either qualitative or quantitative research, as the latter has often been defended as being more objective, and hence more 'scientific'. However, as Ann Bowling has argued:

Although many scientists strive for value freedom, it is naïve to assume that that is achieved in any field of research. Critics of the idea that research should be governed by value-free neutrality argue that research, and social science in particular, is intrinsically value-laden. Values are inherent in natural and social science from the inception of an idea to its development as a viable research project, to the choice of research method and the synthesis of the whole research process and results, as well as from the decision of a funding body to sponsor it to the decision of journal editors to publish it (Bowling, 1997:103).

What Bowling's argument encapsulates is the notion of *reflexivity*. As a concept, this is hard to define simply and neatly. Essentially, it concerns the relationship between the researcher and the researched, and recognizes that knowledge is a social *process*, rather than merely a product (E.g. Woolgar, 1988; Sheppard, 2001). Reflexivity therefore represents both a discourse and a research strategy, in which subjectivity - rather than objectivity - is recognized and valued. A vast literature now exists around the various strands of reflexivity as "a signal topic in contemporary discussion of qualitative research" (Macbeth, 2001: 35) and it would be diversionary to engage with here it in great detail. Basically, it should suffice to acknowledge explicitly the *interactional* nature of the research process, in which "personal, social and local factors influence the research process and its results" (Breuer et al, 2002: 2).

Around half a century ago – pre-dating more recent attention to reflexivity as outlined above - Max Weber (1964, 1979) had argued that, in order to understand the behaviour of individuals and groups in society (the 'interpretive' approach) a social researcher must be able to empathise to some extent with the subjects being studied. This aspect of

social investigation has been developed particularly (though not exclusively) in feminist research, in which qualitative approaches are favoured in order to gain more meaningful insights into women's experiences. Perhaps unsurprisingly, therefore, the importance of reflexivity is especially strongly espoused by feminist researchers. Stanley and Wise (1993), for example, claim that:

Whether we like it or not, researchers remain human beings with all the usual assembly of feelings, failings and moods. And all of these things influence how we feel and understand what is going on. Our consciousness is always the medium through which the research occurs; there is no method or technique of doing research other than through the medium of the researcher (Stanley and Wise, 1993: 157).

This has particular importance when, as here, primary research of a potentially sensitive nature is undertaken. The relationship between the researcher and the 'researched' cannot be ignored; neither can the choice to undertake the research in the first place, nor the way in which participants' experiences are interpreted and analysed. There are both positive and negative aspects to this, however. On the one hand, 'researcher effect' needs to be minimised or, as Robert Stake has suggested. 'For all their intrusion into habitats and personal affairs, qualitative researchers are non-interventionists. They try to see what would have happened had they not been there' (Stake, 1995: 44). On the other hand, the quality of the data may be enhanced when an appropriate level of empathy exists between the participants and the researcher. In terms of this research project, the fact that I was a mother myself engendered greater interest in this field than might otherwise have been the case. Furthermore, it was fairly straightforward to establish a rapport with the participants because they knew that I had experienced (my own version of) the transition to motherhood that they were currently undergoing. The fact that I was simply a researcher rather than a midwife or health visitor, for example, also seemed to be beneficial. Some of the case study participants admitted that they had felt able to

speak quite freely during interviews because they understood that I had no other ‘agenda’.

Having engaged with the notion of reflexivity and its implications for my own role in the research process, the chapter now proceeds with a discussion of access and recruitment. Necessarily, this includes a review of ethical considerations in relation to the gathering of the primary data.

3.4. Ethics, access and recruitment

Ethical approval for the research project had been sought first from the Human Science Faculty’s sub-ethics committee and, second, from South and West Devon Health Authority. Approval was granted by both (Appendix 1), prior to the commencement of data collection. However, the process of gaining permission from the local health authority generated some interesting paradoxes. It was slightly disconcerting to note that the application form was geared primarily to *clinical* research and that the women whom I had already imagined as research participants would be known, according to this administrative procedure as ‘patients’. As part of the procedure, I was required to agree to inform these women’s GPs of their participation in the research, despite the fact that this in itself would involve a breach of their confidentiality. Additionally, I was required to produce a ‘patient consent form’ which I duly did, under the title, ‘Participant Consent Sheet’ (Appendix 2). It began to seem clear in reality (as well as in the literature), that discourses surrounding pregnant women differed markedly between clinicians and social scientists. This added to my perception, already suggested by discussions with local midwives, that a strong sense of ownership exists on the part of the medical profession in its dealings with pregnant women.

Having decided to interview a number of expectant first-time mothers, the first major challenge came in the form of how best to access such a population. Early contact with local community midwives suggested that prospective participants could be introduced to me at antenatal classes. However, non-attenders would be more difficult to access because midwives could not breach their code of confidentiality by divulging that any particular woman was pregnant. In order to circumvent this problem, an open letter was designed for distribution to interested and eligible participants. This open letter (Appendix 3) included a brief explanation of the research and its procedures, plus a contact number for women to call if they were interested in taking part. At the foot of the letter was a small section to sign agreement to having one's name forwarded to me. A sample of this letter, together with a covering letter (Appendix 4) was sent to ten primary care practices across the city. Subsequent telephone contact with the midwives attached to those surgeries resulted in a dozen or so recruitment letters being sent to each. It was thus anticipated that, over a period of around six months, sufficient numbers of expectant mothers would be forthcoming.

3.4.1. Problems of access and recruitment

In terms of the number of case study participants, I had hoped to recruit around ten to fifteen antenatal class attenders and a similar number of non-attenders. The timeframe for this stage of the data collection was to be approximately one year. In fact, recruitment proved to be so difficult that only five attenders and four non-attenders participated, and the whole process of data collection took closer to eighteen months.

Despite my expectation that local community midwives would play a key role in helping to recruit participants to the study, most of the eventual participants were not, in fact, accessed in this way. The first participant was acquainted with a close friend and, having expressed an interest in the research, agreed to take part. The second participant was recruited via her GP. Indeed, these were the only case study participants for the first two months, and both were attending antenatal classes. Greater publicity would clearly be necessary. Following discussion with the Maternity Services Manager at the main hospital, a number of recruitment letters were also made available in the waiting area of the antenatal clinic. It was felt that this would assist in generating more participants. It should be noted also that, since most pregnant women attend for *clinical* antenatal care, one could reasonably expect to access a representative mix of participants, both in terms of their social characteristics and in terms of attendance or non-attendance at antenatal classes.

It began to seem that the recruitment process would be slower than expected. In November 1997, I contacted the offices of a weekly local newspaper, the Plymouth *Extra*, which is delivered free to over one hundred thousand homes in the area. Following a telephone discussion about the research, an article was subsequently printed which informed readers about the research and appealed to any suitable prospective participants to come forward if interested. This appeal yielded only one participant, the third to be recruited to the study. She was also in the process of attending antenatal classes so, with only three case study participants and not a single ‘non-attender’, things were looking rather bleak.

By this time, a series of courteous telephone enquiries was being made to the local community midwives to try to establish why recruitment was proving to be so difficult. Most of the midwives to whom I spoke assured me that they were doing their best, and some had even passed on further copies of my recruitment invitation letter to colleagues. There seemed to be little choice but to be patient. However, discussions with supervisors suggested that perhaps some sort of incentive should be offered to prospective participants. One idea was that all participants could be entered into a draw to win an item of baby equipment – for example a pushchair. It was suggested that I should write to a large company to ask for sponsorship in this respect, which I subsequently did. Unfortunately, the request was turned down. Various alternatives were considered and finally it was decided that gift vouchers would be given to participants to thank them in a tangible way for taking part in the research. These were either sent with a congratulatory note following the birth of the baby or taken along to the first postnatal interview. It is difficult to assess the extent to which this small measure actually assisted with recruitment. Overall, it was felt to have had a minimal impact. Most participants expressed pleasant surprise at receiving such a gift but its greatest value probably lay in helping to maintain good relations rather than in boosting recruitment.

By February 1998, one further participant – Sally – had been recruited to the study as a result of the letters displayed in the hospital antenatal clinic. In fact, she was the only participant who responded in that way. Again, this was disappointing in view of the daily throughput of expectant mothers. It was not until April that the first non-attender (Mandy) was accessed. She was also the first to be recruited via her community

midwife. In May 1998, two more non-attenders (Gina and Laura) were recruited to the study – both of them via the same GP. He was also instrumental in recruiting the final antenatal class attender – Diane – who entered the study in July 1998.

By this time, a year had elapsed since the first case study participant had been accessed. Only one more participant was recruited after this; Joy, another non-attender, via her community midwife – in early September 1998. Despite the fact that many valuable interviews took place with all nine of the participants over this time, there was considerable frustration concerning the difficulties of recruitment.

3.4.2. Reflections on the problems of recruiting case study participants

Follow-up/reminder letters (Appendix 5) had been sent to all of the participating surgeries in May 1998. Numerous telephone calls had been made both before and after this. Indeed, a lot of time was spent trying to make contact with community midwives who, throughout a typical week, may be accessible at their surgeries for only a small proportion of the time that they actually work. In terms of enthusiasm, one can only speculate about how seriously some of the individual practitioners took my requests for help. Some appeared to be quite pessimistic from the outset, while others were clearly very interested and therefore perhaps keener to assist. It should be noted that I fully appreciated that these people were already very busy and that, as such, I did not wish to add significantly to their workload.

A particular example of the role of one inner-city surgery may help to illustrate some of the dilemmas of recruitment in this case. At one stage – in March 1998 – a meeting took place between myself, a GP and one of the community midwives in a surgery located in

a particularly deprived part of Plymouth. The GP himself had expressed interest in the research following an earlier discussion about a separate issue with my Director of Studies. As a result, the meeting was set up and I explained the aims, objectives and procedures. This particular GP made clear that he felt quite strongly about many of the social aspects of the study. For example, the link between poor social characteristics and low rates of breastfeeding was seen as a particular problem in the practice. Indeed, both he and the midwife were adamant that the majority of expectant mothers attending their surgery were unlikely to attend antenatal classes. Therefore, not only did this appear to be a potentially fertile recruitment ground, but also the GP and lead midwife were both interested and motivated. They seemed fairly sure that they could help. In fact, several weeks elapsed without hearing anything from the midwife or her colleagues. A follow-up letter was sent to her at the end of May, and a telephone call was made one month later. Finally, in June 1998 – three months after the initial meeting – a potential participant was identified. Arrangements were made to call upon her at home at a prearranged time. Unfortunately, however, when I arrived, the woman claimed that it was not convenient after all. A follow-up letter elicited no response. It was clear that this expectant mother did not wish to participate in the study and, in fact, no participants at all were forthcoming from that particular surgery.

There were many times throughout this period when I felt that, had I been a practising midwife or similar, then recruitment may have been more straightforward. For example, much of the literature appeared to have been generated by researchers who were also practising clinicians. Therefore, the advantage of women's openness during interviews was offset by the problems inherent in trying to access them in the first place. An

example of the frustration that I occasionally felt was illustrated by the refusal of the local antenatal (hospital) clinic to allow me to talk informally to mothers in the waiting room there. This I had accepted without question. However, it transpired in an interview with one of the case study participants that she herself had been approached by a clinical researcher whilst waiting in that same place during late pregnancy. She had been asked to participate in a study which involved having a clinical instrument inserted into her vagina for the purposes of obtaining some measurement which she did not fully understand. She had agreed and co-operated with this. What I found particularly interesting, after hearing this account, was that ‘insiders’ – i.e. those working in the hospital environment – could apparently have free access to prospective study participants, whereas a social researcher and an ‘outsider’ like myself, could not. Despite my best efforts, there was clearly a range of factors which either unfairly or unfortunately made the recruitment process very difficult. Thus, while the number of case study participants turned out to be quite small, the process of trying to make that number larger was very educational.

Having documented the difficulties associated with the recruitment of case study participants, the chapter now proceeds with a detailed description of the data collection methods.

3.5. The case study interviews

Interviews took place in women’s own homes on three occasions throughout the relevant transition period. First interviews were conducted during the third trimester of pregnancy. Second interviews were scheduled to take place at around six weeks postnatally although, in some cases, complications with the health of either the mother

or the baby led to a later second interview. This had a knock-on effect for some of the third interviews, which were planned for three to four months after the birth but occasionally went up to six months. It was felt that respect for the demands facing these new mothers overrode the importance of sticking rigidly to the planned dates for the interviews. Overall, however, the broad postnatal time frame of six months was adhered to.

First interviews were preceded by preliminary contact with the participants, either by telephone or by letter. Such preliminary contact enabled brief introductions and a chance to arrange a mutually convenient time for the interview. Before any of the first interviews took place, the participants were given a verbal explanation of the purposes and procedures of the research project. They were assured of anonymity, and given a participant consent sheet to sign and retain a copy of. The latter also contained a written account of the research procedures and purposes. All of the participants were satisfied with these explanations, and all were happy to sign agreement. Following the completion of these preliminaries, the participants were asked whether they had any objection to the tape-recording of the interviews. No one objected, so each of the first and subsequent interviews was audio tape-recorded in full.

Before starting the interview 'proper', the participants were asked to complete a very brief questionnaire (Appendix 6), which served two purposes. First, it was designed to elicit confirmation that the participation criteria (first baby, singleton pregnancy) were being met. Second, my supervisor and a colleague had suggested that research participants like to feel that they are 'giving' something to the researcher. On these bases, therefore, such a questionnaire was completed in all cases.

The interviews were conducted according to an interview guide which included certain core topics and questions. There was some variation according to whether or not the interviewees were attending antenatal classes. The guides used for the first, second and third interviews are detailed in Appendices 7, 8 and 9. In keeping with this semi-structured method of interviewing, the interviewees were free to pursue in greater or lesser depth any particular topic. Most of the questions were open-ended, as befitted the research topic and the main themes. As Melia (1997) has suggested,

Informal interview data are yielded by a series of questions and general lines of enquiry embedded in a seemingly natural conversation with the interviewee. The data can be seen, then, as an account of the interviewee's opinions and views, arrived at as a result of the interaction with the interviewer (Melia, 1997: 34).

Overall, there tended to be a conversational tone in these interviews and, in all cases, even at the first interview stage, a good rapport was established between myself and the interviewee. The average length of the first interview was forty-five minutes, although this ranged from twenty-five minutes to just over one hour. The second interviews were of a similar length, whereas third interviews were shorter, overall, averaging around thirty minutes. The main reason for this was that the fewest changes occurred for the new mothers between the second and the third interviews.

At the end of each of the first interviews, the participant was given a blank notebook and asked to keep a diary. This diary could include any feelings or experiences which they felt like recording in the latter stages of pregnancy and the early days of motherhood. The expectant mothers were assured that they could keep the diaries as mementos, but were asked whether they would mind me photocopying them to use as additional data. Most women seemed enthusiastic about this, although in the end only three of them kept diaries. The data contained in these diaries was, however, very

insightful and proved particularly useful for ‘filling in the gaps’, for example for participants whose circumstances led to only two rather than three interviews taking place. Appendix 10 contains a table of data collection sources for each participant, while Appendix 11 gives biographical descriptions of each of the case study participants.

A stamped, addressed envelope containing a postcard on which to complete details of the date of birth, sex and name of the baby was also given to each woman at the end of the first interview. Each participant was asked to return this to me so that a follow-up interview could be arranged at the appropriate time. The idea was derived from Ann Oakley’s (1992) study, in which this method was used successfully to enable similar follow-up. In fact, seven of the nine participants remembered to return the card, while one forgot to do so and was subsequently telephoned instead. Another had experienced considerable trauma over the health of her baby, but was contacted again by letter. Overall, the method worked quite well, and enabled me to send cards of congratulation to the new mothers as well.

The first interviews were generally straightforward to the extent that only the participating expectant mother and I were present. Women’s partners, if they were living with one, were never present. This was in contrast to the second and third interviews when the new baby was also there. A number of consequences followed from this. First, there was usually some delay in starting the interviews, during which time the baby was being admired and ‘small talk’ took place. Second, having commenced interviewing (and tape-recording), there tended to be ‘natural’ interruptions while the baby cried, or was fed or ‘changed’, or similar. Also, on more than one

occasion, a third adult was present for some or all of the time. In some cases, this was a partner, while in others a sister, mother or mother-in-law was also in the room. This was only ever problematic on two occasions, when a question of a potentially sensitive nature arose, and I was unsure of whether to proceed with it. In both cases, the new mothers themselves perceived the possible difficulties, and steered the discussion accordingly.

At the end of the final interviews, the participants were asked how they had felt about taking part in the research. The responses were mainly favourable and, in some cases, extremely positive. Finally, sincere thanks were given in respect of their participation, together with further reassurance about their anonymity throughout the remainder of the research project.

3.5.1. Analysis of case study data

The audio tapes of the interviews were transcribed in full as soon as possible after the interviews took place. Although this was very time consuming, it was both necessary and beneficial. Not only could hard copies of the data be produced for later analysis, but also the process of transcription enabled a greater familiarity with the data. At such an early stage, this proved to be valuable in terms of the recognition of certain recurring themes and issues. The latter were noted down separately and used as a basis for the later categorisation of key concepts. Some of the early findings led to a slight modification or inclusion of further questions for later interviews. The dominant themes formed the basis for an ongoing process of theoretical sampling (e.g. Glaser and Strauss, 1967), which also had implications for the content of the later questionnaire

survey. Despite the intellectual rigour demanded by this approach, it is not without its critics. Robert Dingwall, for example, has commented that:

The dominant kind of qualitative study appears to be one in which the investigator carries out a bunch of semi-structured interviews which are then taped and transcribed.....In effect, the researcher is simply looking for some good quotes to illustrate a previously determined position on some personal or political issue (Dingwall, 1997:52).

In this study, the ‘good quotes’ reflect, quite literally, the participants’ own feelings and experiences, without which there would be no raw interview data. As to the ‘previously determined position’ to which Dingwall refers, it needs to be stated that very little, if any, research is carried out in a theoretical vacuum. Instead, it proceeds on a paradigmatic basis (e.g. Kuhn, 1970) and – as section 3.3.2. suggested - with due acknowledgement of the reflexive process that is required to make sense of *any* process of social investigation.

It should be noted that the data analysis began *during* the interviews, to the extent that question order was often determined by previous responses. Mason (1996) asserts that most qualitative researchers select from literal, interpretive and reflexive approaches to the data. In this case, all three have been utilised, often in that order. First, women’s own perceptions and experiences have been recorded ‘verbatim’ and hence, literally. To ignore this would effectively discredit those experiences. Second, the selection of those data and their social contextualisation is necessarily interpretive. Finally, previously explained, the role of the researcher in relation to the researched cannot be ignored. Thus, the process of data analysis was effectively a constant feature of the research, from the time at which the first interviews took place to the writing-up of the project as a whole.

Cross-sectional analysis was necessary in order to make the data manageable and accessible throughout this period. This was facilitated through an ongoing process of categorisation. The process began quite simply with the identification of particular themes and issues from the original interview transcripts. These were then transcribed further, and grouped together with others of a similar nature. In the end, hard copies were produced of all the responses from the participants relating to, for example, antenatal class content or infant feeding experiences. Further categories and sub-categories were produced as part of an ongoing process of 'constant comparative analysis' (Strauss and Corbin, 1990). This involved frequent comparisons with earlier interview transcripts and with secondary data sources. It quickly became clear that one of the potential pitfalls of this approach might be to deviate from the original research focus, because of the tendency to follow up all sorts of tangential issues. As Mason (1996) has suggested, it is crucial to be aware of the ontological consistency between the research questions, the categories and the analysis. While pure forms of the constant comparative method insist on theory generation, this may be inappropriate if the original research questions remain unanswered. Therefore, while a modified version of this method was used, the final analytical approach was perhaps closer to what Yin (1984) describes as 'relying on theoretical propositions'. Basically, this involves using the original research questions to guide the analysis.

In the end, the main categories derived from the case study data consisted of those which were predetermined by the interview topics and those which were generated 'unlooked for' by the participants themselves. An example of the former would be 'experience of breastfeeding', while an example of the latter would be 'the postnatal

hospital experience'. The categories, when finally constructed, helped to inform the organisation of the results chapters in both chronological and thematic order.

The participants' diary entries were photocopied and then analysed in a similar way to the interview transcripts. Integration of data from these sources tended to occur somewhat later, however, because the diaries were not completed until the final interview stage. Although only three participants provided diary entries, these were very detailed and candid. They were especially illuminating on the issue of hospitalisation during childbirth, and the experiences of the participants at that particular time. On balance, the decision to use this method of data collection was felt to have been appropriate, but it would have been helpful if all or most of the participants had been able to keep a diary.

Having outlined the methods used in the analysis of the case study data, the chapter will now focus on the questionnaire survey; its design, distribution and data analysis.

3.6. The questionnaire survey

The purpose of the questionnaire survey was to elicit data from a larger sample of first time mothers. The key difference (to the case studies) lay not only in the data collection method, but also in the retrospective nature of the questions. For example, while expectant mothers could be asked about their *expectations*, new mothers targeted by the questionnaire could only be asked about *a posteriori* feelings and experiences.

3.6.1. Questionnaire design

The questionnaire was to cover all of the topics included in the case study interviews, plus a small number of issues generated by the case study analysis. Therefore, quite a

lengthy questionnaire was required. In terms of the format, there seemed to be little point in trying to reduce the length because earlier research has suggested that, beyond eight to ten pages, questionnaire length may not adversely affect response rates (e.g. Nachmias and Nachmias, 1991). In its final form (Appendix 12), the questionnaire contained twenty six pages. However, this was divided into two parts; the first – numbering sixteen pages – applied only to women who had attended antenatal classes, while the second – numbering ten pages – was for those who had not. A cover sheet emphasised the requirement to complete only the relevant part of the questionnaire.

Despite the fact that closed-ended questions usually enable more straightforward data analysis, it was decided to include a mix of closed and open-ended questions. Many of the topics were simply not suited to a closed-ended categorisation. For example, new mothers were asked to indicate how they had felt since the birth of their baby. This required a precise and meaningful response. Similarly, respondents were asked to explain the effect of the new baby on their relationship with their partner, if they were living with one. The diversity of possible responses would have rendered inappropriate a narrow range of response options.

Apart from the broad division of the questionnaire into two parts, as explained above, it was also necessary to decide upon a suitable running order for the questions. A thematic approach was adopted for this, in which the main sections became:

- Antenatal classes
- Information and support
- Caring for a new baby

These sections broadly reflected the research aims and objectives. In the case of the second part of the questionnaire – for non-attenders of antenatal classes - the ordering of these sections was changed, however. It was decided that, to begin by asking why these new mothers did *not* attend antenatal classes might seem rather negative and slightly off-putting. Therefore, those respondents were asked first about caring for babies, followed by their views on antenatal classes and, finally, information and support. In terms of the question order *within* the sections, this was identical for both parts, except that there were clear differences in both order and content for the sections relating to antenatal classes. Finally, biographical details were requested at the end of the questionnaire, in both cases. Given the fullness of the questionnaire overall, it was decided not to ‘clutter’ it with a coding format but instead to develop a coding frame once the questionnaires had been returned. More detailed explanation of coding and analysis is given below, following details of the method by which the questionnaires were distributed. The questionnaire went through several drafts en route to its pre-testing stage. It was then pre-tested with the help of case study participants (both attenders and non-attenders), whose feedback led to further amendments prior to its distribution. The problem with using existing participants at this stage was that bias may have occurred because of their involvement and interest in the research. Therefore, this was not ideal, but given the difficulties already encountered in recruitment, this seemed the only feasible route to take at the time.

3.6.2. Questionnaire distribution and response

It was felt that health visitors would be the most suitable people to approach in connection with the questionnaire distribution. They tend to be the most frequent

professional contacts for mothers with young babies, and practice both in baby clinics and women's own homes. The behaviour of the case study participants had suggested that first time mothers make extensive use of this service. Therefore, questionnaire distribution by health visitors in baby clinics was decided to be the most effective and straightforward method. Following consultation with the Community Nursing Service and subsequent telephone discussions with a number of local health visitors, ten practices were selected for this purpose. Seven of these already taken part in the case study recruitment; the other three were included as a result of 'snowballing', where a particular health visitor suggested the likely co-operation of another in a different practice. As before, the ten practices were scattered over the Plymouth area.

It had been agreed with the health visitors and their managers that professional assistance would not be given to women in completing the questionnaires. All that was required of the health visitors was the identification of first time mothers with babies under the age of six months who were prepared to take a questionnaire for self-completion. Each participating health visitor was sent fifteen copies of the questionnaire for distribution in their clinic. All of the questionnaires had cover sheets with clear instructions and stamped, addressed envelopes to facilitate their direct return to me. In total, therefore, one hundred and fifty questionnaires were made available for distribution in this way.

The eventual response rate was twenty-six per cent; a total of thirty-nine questionnaires. Two further questionnaires had to be rejected because one was returned blank and the other was from a second time mother. Of the thirty-nine useable questionnaires, thirty-two were from mothers who had attended antenatal classes, while only seven were from

mothers who had not. Difficulty in accessing non-attenders was therefore reflected in this method as well as in the case study phase. Given the prevailing social characteristics of non-attenders (e.g. Cliff and Deery, 1997), it may not be surprising that so few responded, however. It is often asserted that respondents to postal questionnaires differ from non-respondents in terms of their social class and literacy levels (e.g. Nachmias and Nachmias, 1991). In this particular case, it may be suggested that women who chose not to attend antenatal classes may also have chosen not to complete a rather lengthy questionnaire. Interviews with non-attenders did suggest that, overall, they could not be 'bothered' to attend classes, although the application of this possible explanation to questionnaire non-response is quite speculative.

It had been hoped that the saliency of the topic to the target population would help to enhance the level of response (e.g. Cartwright, 1978, cited in Bowling, 1997) but, again, there is no way of knowing how influential this was. Follow-up measures to increase the response rate could not be taken in this case because of the way in which the questionnaires were distributed. Once they had been forwarded to health visitors for distribution, the process was essentially anonymous.

3.6.3. Analysis of questionnaire data

Upon their return, the questionnaires were numbered for reference and checked for their levels of completion. As the vast majority had been completed fully, the extent of item non-response was very small. A coding frame was constructed first for the closed-ended responses. Variable labels were assigned to correspond with each of the closed-ended questions, and value labels were created accordingly. Inadequate or missing responses

were coded '9', while inapplicable items were coded '8' (Bowling, 1997). All data were entered into the Statistical Package for the Social Sciences (SPSS).

The responses to open-ended questions were transcribed in full on a question-by-question basis and categorised according to the main thrust of the response. Value labels were then assigned for each category. This aspect of the questionnaire analysis required considerable care and attention, particularly when responses to individual questions were varied and diverse. The objective was to minimise the number of categories without losing the meaning and detail contained in the responses. Once completed, these data were also entered into SPSS.

Initial analysis involved the production of descriptive statistics such as frequency tables and case summaries. Further univariate and bivariate analysis (mainly cross-tabulation) was carried out on a thematic basis to correspond with the main research questions and themes. Given the small sample size, extensive statistical analysis involving multivariate tests was not appropriate. Indeed, the number of variables was far greater than the number of respondents. Therefore, while a manual method could have been used, SPSS enabled a more efficient means of producing the type of statistics required to help answer the research questions.

3.7. Interviews with local health professionals

It was stated earlier that, in order to obtain a wider view of the relevant issues, a selection of service providers had been interviewed. This group consisted of a community midwife, a health visitor, two GPs and a community psychologist involved in facilitating a local parenting skills programme. Each of these professionals was based

in the Plymouth area and had considerable experience in dealing with new or expectant first-time mothers.

The first health professional with whom discussion took place (at his surgery) was an inner-city GP serving a relatively deprived patient population. He helped to advise on the design of the recruitment letter for case study participants, and subsequently contacted me with details of three women who were willing to take part in the study. One of the issues highlighted by this GP was the difficulty which family doctors have in distinguishing between attenders and non-attenders of antenatal classes, as this tends to be the province of midwives. On the issue of social characteristics of expectant and new mothers attending the practice, this GP displayed a non-judgmental attitude; although he was fully aware that many were teenagers who elected to bottle-feed rather than breastfeed and who also chose not to attend antenatal classes. It was clear that he perceived his role as one in which patients' decisions should be respected and supported, without trying to change them. Occasional references made by the relevant case study participants bore this out. By contrast, the local midwife had been perceived by the new mothers as overly persuasive and interfering. This applied particularly to infant feeding decisions and non-attendance at antenatal classes.

The other GP with whom a discussion took place was also responsible for a deprived inner-city patient population. However, he expressed far greater concern about the social characteristics of many young families in the area, describing the majority as 'deprived and ambitionless'. He felt that the social aspirations of young men centred mainly on obtaining heroin, while the young women 'just get pregnant'. According to this view, pregnancy in very young women is a 'social problem', although not all health

professionals agree. This GP was particularly interested in the 'lay knowledge' aspect of the research, although it was clear that, in practice, he took rather a dim view of it. For example, he asserted that, among his maternity patients, there existed a dominant view that 'breastfeeding causes breast cancer'. This he attributed to expectant mothers' friends and relatives.

By contrast, a longer and more detailed discussion with a community midwife practising in another (not particularly affluent) area of Plymouth yielded very different views. She acknowledged that very young, single mothers are often seen as having or being 'social problems', but did not subscribe to this view herself. Indeed, based on her many years of experience and personal observation, she felt that such women 'tend to make very good mothers'. She cited the role of lay knowledge and support as one of the key reasons for this, adding that, in many families, pregnancy at the age of sixteen or seventeen is a cause for celebration rather than criticism. This midwife was also helpful in terms of explaining how antenatal classes in her particular area were facilitated. In terms of the content of such classes (many of which she herself was responsible for), she reiterated that considerable variation occurs between individual areas and, indeed, between different cohorts of expectant mothers. She did emphasise, however, that certain core topics are always included. Her description of those topics closely resembled those given by new mothers participating in the study. As well as providing a fairly extensive account of the nature of her involvement with first time mothers, both pre- and postnatally, this midwife was instrumental in helping to recruit case study participants.

Discussion about postnatal issues for first time mothers took place with a health visitor practising in central Plymouth. Most of the women in her care were living on low incomes in private rented accommodation. She described her client group as a 'mobile population'; the majority of new mothers were unmarried. Most of these women did not attend antenatal classes. In fact, the nearest NHS class location was almost two miles distant, which effectively made them 'inaccessible', according to this practitioner. That aside, she felt that most of her clients preferred not to attend in any case because 'they don't like the middle-class feel of it'. Rather unusually for a health visitor, however, this practitioner endeavoured to establish contact with women *before* the birth of their babies. By doing this, she felt better able to help support them after the birth. As many of the new mothers lacked family support, especially from their own mothers, this health visitor claimed to try to compensate for this to some extent by visiting such women more frequently and for longer than is often the case. She saw the support and encouragement of these new mothers as central to her professional role. Indeed, her description of this was reminiscent of the earliest foundations of health visiting, in which a social, rather than a medical view of health appeared dominant.

Finally, a local community psychologist (and member of the National Parenting Forum) was interviewed on the basis of his previous involvement with a local parenting skills programme. One aspect of this focused on prenatal preparation among a socially disadvantaged population in Plymouth. Despite being well publicised by local health professionals, these sessions were apparently poorly attended, which led to the cessation of that aspect of the programme. Parallels were drawn between this and the wider issue of non-attendance for formal antenatal education among certain social groups. This led

to further discussion about the desirability of universal, compulsory parenting-training as currently practiced in Finland (Vehvilainen-Julkunen, 1995). However, the imposition of white, middle-class values is seen as problematic. Overall, it was suggested that the reintroduction of family and relationship skills as part of the 'Personal, Social and Moral Education' strand of the National Curriculum may be preferable.

Further professional views derived from these interviews are integrated where appropriate into the forthcoming results chapters, as well as in the final policy implications chapter.

3.8. Conclusion

This chapter has detailed the processes involved in gathering and analysing appropriate data to meet the aims and objectives of the study and to answer the research questions. It must be acknowledged that, because of the small number of participants involved, this can be seen to have been partial rather than complete. Indeed, a number of issues have been raised by the difficulties inherent in researching 'hard to reach' populations. These are both methodological and ideological. For example, while non-attendance at antenatal classes tends to be seen as problematic, there is little evidence either in this or any other study to suggest that this is a problem for the expectant mothers themselves. It seems rather to be a problem for those providing the services. Nevertheless, while the service providers are in a stronger position (in terms of access to such populations) to investigate factors affecting non-attendance, they appear to be unmotivated to do so.

This paradox has been magnified by my own experience, in which a strong motivation to undertake precisely such research has met with considerable challenges, including occasional resistance from service providers.

Methodologically, there are, of course, problems associated with small sample sizes. The most obvious of these is that generalization is not possible. This problem is mitigated, however, when the research – as here – is exploratory. Indeed, it was stated at the outset that generalization was not a goal of this particular piece of research. Nevertheless, it had been hoped that greater numbers of participants would be forthcoming in both the case study and the questionnaire stages. As the earlier sections have shown, all reasonable efforts were made to achieve this. Minor modifications were undertaken and considerable flexibility was necessary, particularly in relation to the time frame for the data collection. Even with the benefit of hindsight, it is difficult to suggest what other – more productive – measures could have been employed to increase the sample size.

In terms of the quality and appropriateness of the data produced, the methods employed were largely successful. For example, the in-depth interviews with case study participants yielded rich and detailed accounts, which helped not only to answer many of the research questions but also to identify issues requiring inclusion in the questionnaire survey. The longitudinal approach enabled useful comparison of prospective and retrospective views and experiences. Participant diaries turned out to be the least useful research instrument. For the three participants who did keep diaries, some useful and interesting data was produced, however. On balance, the

comprehensiveness of the interview data almost certainly offsets any potential loss through the non-completion of diaries.

The questionnaire survey, small sample size notwithstanding, was also successful to the extent that the data helped to answer the research questions and in many ways backed up responses yielded by case study participants. There were some issues on which responses appeared to contradict the trends identified among case study participants, but these tended to be issues of a sensitive nature, which perhaps highlights the way in which responses may vary according to whether a question is posed face-to-face or anonymously. The clarity of the questionnaire design was evidenced by the completeness of the returned versions, with item non-response being minimal. On balance, the questionnaire format and content worked well to elicit retrospective data concerning the transition to motherhood.

Overall, it is felt that an appropriate combination of methods was employed in this study. The quality of the data produced exceeded expectations, despite the problems of accessing participants. Indeed, the recruitment difficulties provided a challenge far greater than was originally envisaged. This challenge can now be seen to have been a particularly valuable part of the research training process, however.

Chapter 4: The role of antenatal education in the transition to parenthood

4.1. Introduction

Chapters Four to Seven present the data generated via the case study interviews and diaries, together with the results of the questionnaire survey. They are mostly presented in that order, section by section, to reflect the way in which the research was undertaken; i.e. the case-study interviews generated qualitative data against which the questionnaire data could be compared, contrasted or expanded upon. The overall structure of the results chapters reflects the thematic issues identified in the literature review; i.e. the main stages in the transition to motherhood.

Chapter Four is concerned with the local setting, style and content of antenatal classes, including attenders' perceptions and experiences of them. Integral to this is the extent to which expectations and experiences of antenatal education may converge or diverge in the view of those women who chose to attend them. Additionally, preliminary discussion of the impacts of antenatal class attendance reflects the issue of social support, suggested in Chapter Two as a key probable attraction of antenatal classes. Questions of non-attenders and their reasons for non-attendance are presented thereafter. Having looked at the evidence for both of these groups, the related themes of information and support are continued with a consideration of sources *other* than those generated by antenatal class attendance. Thus, the role of lay and informal sources is examined. Participants' anticipated support sources postnatally are also suggested here. Indeed, at this point, the relevance of a broader than usual definition of what *constitutes* antenatal education begins to emerge.

The theme of expectation among the case-study participants is further developed in Chapter Five with the data concerning the upcoming birth, feeding intentions and general expectations of being a new mother. Any anticipated effects of a new baby on the parental relationship are also considered. The results of these investigations complete the prenatal stage of the transition to motherhood as anticipated and experienced by those in the study.

In Chapter Six, the results focus on the early postnatal period beginning with perceptions of childbirth and the hospital experience. Continuing the earlier approach, in terms of women's expectations, attention then turns to infant feeding experiences. Thereafter, issues of general infant care, parental relationships and social support are presented and discussed. In each case, the new mothers' expectations - together with the extent to which antenatal education in its various forms may have *influenced* those expectations - are compared and contrasted with the lived experience of each of these elements of new motherhood. It will be seen that social support is implicitly linked with all such elements; in the following section, that issue is considered more explicitly, with mothers identifying and evaluating their support sources in relation to their earlier expectations. Finally, the data concerning new mothers' own perceptions of their postnatal wellbeing are presented. Thus, the chapter concludes by focusing on the maternal condition as influenced by each of the elements outlined above.

4.2. Antenatal education: local provision

4.2.1. NHS antenatal classes

NHS antenatal classes are run at a number of community venues in the Plymouth area. Many of these are attached to primary care practices or local clinics. Others

take place in church halls or community centres. All such NHS antenatal classes are organised and run by community midwives in conjunction with health visitors and physiotherapists. Most courses consist of around six sessions of about two hours each. The classes usually take place during the day, although sometimes an evening session is arranged within a course, to better enable working partners to attend for at least one session, usually focusing on labour and birth.

Community midwives are accountable to the community midwifery manager at the local (Derriford Hospital) maternity unit. In terms of antenatal class curricula, community midwives have some freedom (within broadly agreed parameters) to determine what the structure and content will be, based on their knowledge of the local population and individual and group requirements. At a meeting with local community midwives attended in connection with this study, it emerged that the midwives acknowledge amongst themselves a number of key differences in socio-economic profiles between communities. For example, amid a discussion about rates of attendance at classes, one midwife was heard saying to another, ‘Yes, but your mums are very different from mine’. The midwife who was speaking served a relatively socially deprived community in which attendance would be expected to be lower than in the more affluent area served by her colleague. Additionally, when asked to elaborate on rates of attendance, there was a consensus that this is very difficult to quantify, since records are apparently not kept. The midwives estimate that only around one in ten expectant mothers attend antenatal classes, and most of these are first time mothers-to-be.

By comparison with attendance rates for clinical antenatal care, which is estimated to be around ninety-nine per cent, these figures are of course low. The midwives themselves thought that this could be partially explained in terms of working

mothers being unable to take time off work for antenatal classes. Although they are legally entitled to do so, in practice, it is argued, employers may frown upon this by comparison with more 'serious' antenatal clinical checks.

Despite the high levels of non-attendance implied by local community midwives, it is difficult to ascertain how many first-time expectant mothers do not attend antenatal classes. The fact that the local community midwifery service does not keep records on non-attendance also means that non-attenders are difficult to access. The methodological difficulties have already been discussed in depth in Chapter Three.

4.2.2. Voluntary sector provision

Classes run by the National Childbirth Trust are qualitatively different from those run by the NHS. Classes are run by specially trained NCT childbirth educators, and the timing and location of classes depends upon local demand. In the Plymouth area, there may be brief periods in which no classes are running, or there may be two or three courses of classes in various stages of completion at any one time. A local co-ordinator (to whom I spoke at the outset of this study) explained that classes are run according to when the attenders' babies are due. Classes are held either in the home of the childbirth educator or in the home of one of the expectant parents if that is considered convenient by all concerned.

The NCT also runs short courses usually held within the local maternity unit at Derriford Hospital, Plymouth. Generally, however, the classes do occur within a home setting and usually take place in the evenings, as most clients tend to be couples rather than just expectant mothers. There is also a charge for attending the course, which varies regionally. In the Plymouth area, at the time that this research was started, one course of around eight NCT sessions cost about £42. Such a charge

may be considered to be a deterrent to many expectant parents, particularly in the light of more general expense associated with the birth of a first child. This also compares unfavourably with NHS classes, which are provided free at the point of use to all expectant parents.

4.3. Attendance at antenatal classes.

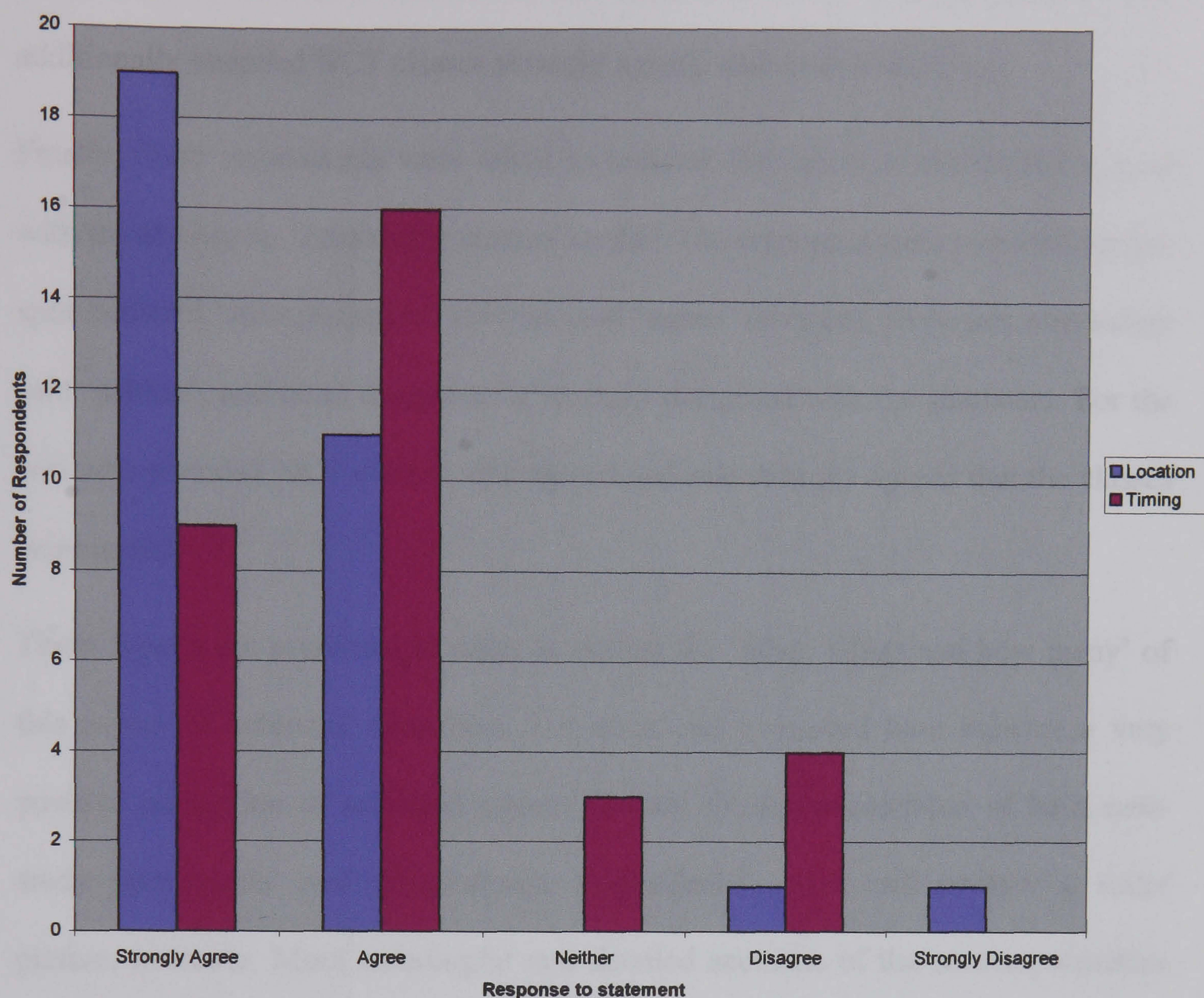
Five of the nine case-study participants and thirty-two of the thirty-nine questionnaire respondents attended NHS antenatal classes. Two case-study participants and two questionnaire respondents also attended NCT classes in addition to NHS classes although no-one in the study attended only NCT classes.

Of the thirty-two attenders in the questionnaire survey, the majority (twenty-six) attended between four and six NHS sessions. Only three attended one to three sessions or seven or more sessions. Both of those who attended NCT classes went seven or more times.

Twenty (62.5%) of the attenders were accompanied to NHS classes by a partner, relative or friend, while twelve (37.5%) were not. In this category, most (fourteen) were accompanied by a partner, while two were accompanied by a relative, two by a friend, and one by a 'birthing partner'. Most respondents were not accompanied to all the sessions that they attended, however. Eleven were accompanied between one and three times; eight were accompanied four to six times, and only one of the NHS attender was accompanied for seven or more sessions. By contrast, the two NCT attenders were accompanied in both cases by their partners, with one of these attending seven or more times and the other, between four and six times.

It is worth noting here that NCT classes tend to be held outside office hours, often in the evenings, which may help to facilitate the attendance of working partners. The

Figure 4.3. Respondents' views on convenience of both time of day and location of classes



implications of this for expectant parents as opposed to expectant *mothers* will be discussed in more detail later in the chapter. While it is not known whether this was actually the case for the NCT attenders in this section of the study, both of them agreed that the time of day at which the classes were held was convenient for them. The NHS attenders were also broadly supportive of the time of day at which classes were held, although a small number disagreed. Responses from NHS class attenders to the statements, '*The time of day at which the classes were held was convenient for me*' and '*The location of the classes was convenient for me*' are set out in figure 4.3.

These figures do not appear to support the claim (Kelly, 1998) that expectant mothers find the timing of classes difficult but, of course, these are the women who

actually attended, rather than those who were unable to do so. Hence, a strong element of self-selection has influenced these views. The two respondents who additionally attended NCT classes strongly agreed with both statements.

Finally, these respondents were asked to indicate the extent to which they agreed with the statement, '*I found the classes useful*'. The responses were overwhelmingly split between 'strongly agree' (fifteen) and 'agree' (sixteen). Only one respondent said 'neither', and none disagreed or strongly disagreed with the statement. For the two who attended NCT classes, one agreed and one strongly agreed that the classes were useful.

These figures are presented in order to outline the 'what, where and how many' of this aspect of antenatal education. The responses presented here indicate a very positive perception of antenatal classes overall. Further exploration of both case-study participants' and questionnaire respondents' views will provide a fuller picture, however. More meaningful and detailed accounts of the content, structure and style of the classes are considered below.

4.4. The informational content of antenatal classes

4.4.1. Case-study participants' perceptions of the content of antenatal classes

At the time of first interviews with case-study participants, questions about the antenatal classes (if any) which they were attending, or had attended, were exploratory. Hence, the questions as posed were, "What are/were your antenatal classes like?" and "What has been covered in your antenatal classes?" This approach enabled a variety of emphases which included not only the participants' various perceptions of the way in which the classes were conducted, but also their responses to how useful they felt that the informational coverage was for them.

The first case-study participant, Tracey, had attended only the first NHS class of a planned six-week course at the time of the first interview. Her account of the first class is interesting because it illustrates a number of questions and issues of importance to her (and, apparently, others in the class) at this stage in the transition to motherhood:

We were just introducing ourselves. She [the midwife] gave us a pen and paper and said 'Write down what you want to cover in these classes and any questions you might have'. The last hour was with the physiotherapist.

When asked about the kinds of questions and issues raised by herself and others in the group, Tracey explained:

Before I went, I thought of loads of things that I wanted to ask, and I got there and my mind went blank. And she split us up into three groups and there was about six in each group. She gave us pen and paper and said, 'Write down what you want out of these classes'. I asked, 'What if we want to breastfeed, but we can't, and the baby don't take off it? Do we have to buy a car seat to come home from the hospital, or can you put it on your lap?' 'Oh, you have to buy a car seat', she said. 'When do they decide if they have to do a caesarean?' And she wasn't really answering them; she just said, 'Oh, breastfeeding – we'll talk about that in week three', and 'Pain relief – we'll talk about that in week four'. Then, she was just not really answering them there and then. Oh, and *breathing* – that was the big one; we were all saying. And she said she'll cover that as well. And then a video for those that want to watch it. (Tracey: interview one)

In addition to highlighting the issues which Tracey (and others) felt to be important, this account goes some way towards indicating what the main issues for coverage might be, as well as the *way* in which such issues may be covered. For example, the midwife who was facilitating the classes in this case asked for the women's own questions and issues, but then seemed to incorporate them into an apparently pre-planned agenda. Indeed, a community midwife who assisted with the recruitment of participants to the study was asked about this during a discussion of class content. She claimed that, in the community-based antenatal classes that she runs locally, attenders are routinely asked to contribute their own questions and issues for coverage. She also stated, however, that she had never yet (over a period of many

years) had any issue raised which would not have been covered in any case as part of the standard agenda.

This issue is contentious. Some recent research, for example, questions the extent to which those who attend antenatal classes are able to influence the content of those classes (e.g. Nolan, 1998; Underdown, 1998). Indeed, Mary Nolan asserts that all women who attend antenatal classes bring with them not only existing knowledge derived from various informal or lay sources, but also a desire to learn more about the issues likely to affect them. It is now increasingly recognized that childbirth educators may carry out their duties more effectively when acknowledging women's varied knowledge bases whilst facilitating further learning in a shared environment which takes account of a diverse range of learning needs (Nolan, 1998). This issue is one that must be borne in mind as further accounts of antenatal class attendance are explored.

Tracey's account of her first antenatal class, while useful for the reasons mentioned above, is also rather limited on the basis that she *had* attended only the one class at the time of the first interview. Diane, by contrast, had attended all of her NHS classes (at a different location) by the time we first met up to discuss the prenatal issues. Diane did not go into great detail about the content of her classes. This may have been because such detail was no longer particularly salient for her. It can be seen from the account given below, however, that her informational needs were not met in the way that she had expected:

Yeah, they were very good! Very informative. We had a physio. there, and a midwife. And I think I got more out of talking to the physio. and the other girls than I did talking to the midwife. I think the midwife was more – *telling* us what to do – than informing us. And we were all just discussing things amongst ourselves, and what we'd like to do and, um, I think it's probably because she only had an hour to get so much in. It was just an overload of information instead of discussing what we'd *like* to do, or whatever. (Diane, interview one)

Although Diane felt that there was enough information, she was clearly critical of the way in which the information was imparted, notably in a one-way direction from the midwife to the expectant parents in the classes. Additionally, there is a strong indication that the interests and concerns of the latter were not incorporated for discussion in the way that Diane, at least, had hoped that they would be. This experience illustrates one of the recent criticisms of antenatal classes which suggests that they are ‘too much like school’ (Cliff & Deery, 1997).

Participatory learning approaches, as suggested above in relation to Nolan’s (1998) arguments for more involvement on the part of attenders themselves, have been propounded as a necessary measure to improve services since the mid- 1990s (e.g. Rees, 1996). Despite this, Angela Underdown found in her study of ten different antenatal classes led by ten different health professionals in Hertfordshire, that group facilitation skills were generally inadequate and that a directive teaching style tended to be favoured instead. Her observations led her to conclude that better training and support was needed to ensure that health professionals were properly equipped to undertake the style of facilitation necessary to meet expectant parents’ learning needs. Such needs included emotional and psychological issues as well as physiological ones that still tend to be given precedence in classes. (Underdown, 1998).

The experience of the next case-study participant combines a number of the issues considered above. Barbara attended NHS classes at the same community venue as Diane, but several months earlier. The two women were unknown to each other:

I’ve been to NHS classes at [name of venue], and I’m going to NCT now. It was all very – planned out – and very straightforward. We spent an hour with the midwife – looking at various aspects of labour – and then an hour with the physiotherapist, doing relaxation and breathing exercises. It is mainly geared to labour. We had one

session on breastfeeding as well. But there wasn't anything on parenting skills. That might be covered at the NCT classes, though. (Barbara, interview one)

When Barbara was asked to expand on this, she replied,

There wasn't anything about parenting skills at all. I thought that was disappointing, because that's so important, you know? Also, some girls knew they were having a caesarean, so you wonder how relevant the classes are to them. It says on the leaflet, as well, that baby care will be covered. But it wasn't. But at the NCT classes, they're going to do it, I think. That's where the classes differ. (Barbara, interview one)

Following this discussion, Barbara actually showed me the leaflet provided by her community midwife. It clearly stated that infant care skills would be covered in locally-run NHS antenatal classes, a fact which added to Barbara's bewilderment at the absence of any such coverage. In terms of the organization and content of the classes overall, Barbara's perception closely matched that of Diane.

One other participant – Rhona – attended NHS classes at the same venue but, again, she attended the sessions independently of both Diane and Barbara. Her account of those classes was bound up with and compared to the NCT classes which she had also been attending with her partner:

They [the NHS classes] were good, actually. It was a six week course and there was one afternoon when partners were invited. They certainly taught us enough and showed us enough. And in a way, they were probably a bit more realistic than the NCT classes because they were run by the midwife from the hospital. So we went through all the various types of pain relief and whatever. Whereas the other [NCT] classes, we went into all the pros and cons – how it would affect the baby, how it would affect *you* – and we went into everything in more depth. At the NHS classes, they were saying, 'Well, this is what's available – have whatever you need'. But at the NCT classes, they were definitely trying to deter us from pain relief. They were trying to make you more aware of the options and to stand up for your rights. In fact, we really liked the NCT. I mean, the NHS classes were very good; they told you what to expect, what to take with you and all that sort of thing. But it was more – matter of fact – we didn't *discuss* it. It was just, like, listening to their side of it. (Rhona, interview one)

This account contains further evidence that while apparently 'enough' information was given, that information was imparted not only in a directive style but also was seemingly quite prescriptive. Rhona's perception was clearly that the mode of learning utilized in the NHS classes was focused far less on question and discussion

than on a ‘here is what will happen’ approach by the midwife. This perception was heightened by comparison with the NCT classes, in which a discursive and critical approach was actively encouraged. This comparison led Rhona to conclude that the learning needs of both herself and her partner were met more satisfactorily by the NCT than the NHS classes. Nevertheless, on the issue of infant care skills, both the NHS and the NCT failed to deliver:

Nothing. Nothing on – if your baby’s crying for five hours, what do you do. Nothing on how to bath it or how to change a nappy, or how *often* you need to bath it. None of that. We – all of us – at the NHS and the NCT classes, we all felt sure they would show us how to bath a baby or how to change a nappy, but – none of it. (Rhona, interview one)

Like Barbara, Rhona and others in her group had expected that infant care would form at least part of the agenda. They were all disappointed. In view of the points of discussion above, the NHS classes in particular appeared not to embrace topics which fell outside the health professionals’ planned curriculum. Sally’s account (below) of her attendance at two different sets of NHS classes provides further evidence of this:

I went to two different NHS classes. One was at the hospital maternity unit, the other was at my local clinic, run by the community midwife. The first session was general introductions, and a discussion of the advantages and disadvantages of pregnancy. Then we covered different kinds of pain relief, and breathing exercises, and the stages of labour. There was also a labour video. The midwife talked about breast-feeding and there was a video about that as well. The classes were good, but it would have been good to have earlier classes, about once a month. But it was nice to be with other people who are in the same boat as you...you don’t feel so isolated. (Sally, interview one)

Sally’s description of her antenatal classes focuses primarily on the ‘labour and birth’ issues that seem to form the backbone of such classes. Her main criticism here seems to be the timing of the classes, although this may have been linked to a deeper sense of personal concern (even worry) about managing the transition to parenthood which was unrepresentative of most of the participants. On the issues of infant care

and parenting skills, Sally had not volunteered anything about such coverage in her classes, so I asked her about this:

Um, no. We didn't really touch on that, apart from breast-feeding. I must admit, I would have liked a session on that; I mean, admittedly, they say that they'll show you in the hospital, but for my own peace of mind, I'd like *something*. So I think it would have been nice to have had a session on that. (Sally, interview one)

Tracey, who at the time of the first interview had attended only one class, was later (postnatally) to verify that her antenatal classes, too, had lacked attention to infant care issues:

No, there wasn't much on baby care. It was mostly about labour and birth, and feeding. (Tracey, interview two)

The qualitative evidence presented here suggests that such topics as infant care were strongly perceived as needed by the women who attended antenatal classes.

As a consequence of these findings, I raised this issue with a local community midwife who had agreed to be interviewed in connection with this study. She explained that classes do tend to vary in emphasis, depending on the particular area in which they are located, and on who is running them, as well as the preferences of the women attending at a given time:

But I have to say, yes, I think a lot of the infant care is left until afterwards, rather than in the antenatal classes. A lot of women's focus is *labour*. And it's inevitably that, as that seems to be uppermost in people's minds. (Community Midwife)

There are two points of particular note, here. The first is that despite alluding to the fact that women's preferences are incorporated into antenatal class curricula, there is no evidence thus far to indicate that this actually happens. The second point is that the participants in this study who expressed regret at the lack of coverage of infant care issues were apparently fully aware that they *would* need such skills, irrespective of how heavily the prospect of the birth itself was weighing on their minds. Nevertheless, the point made above about the alleged pre-eminence of labour and

birth was echoed by a local NCT teacher. She claimed that, although she felt that the coverage of infant care issues to be important, it tended to be difficult, in practice, to encourage expectant mothers to see beyond the birth itself.

A similar view was propounded by a local community psychologist who was also interviewed as part of this study. His views were sought primarily because of his experiences of co-ordinating a local parenting programme. On the issue of prenatal infant care skills, he agreed with both the NCT teacher and the community midwife about labour and birth being uppermost in pregnant women's minds. Further, he suggested that most new parents cannot identify their needs in advance of the baby's birth, i.e. until the baby is 'a reality'. Interestingly, he suggested that it is 'easy for you and I' (experienced parents) to stress the importance of infant care skills, but that one cannot expect those who do not yet have a child to share the same view. While not wishing to labour the point, this view, while apparently quite logical, was not shared by those respondents who were quite *open* to the acquisition of infant care skills prenatally.

The relevant literature on this issue confirms that this is a problematic area for both health professionals and expectant parents attending classes. For example, Combes and Schonveld's (1992) research found that those responsible for running antenatal classes feel that "pregnant women do not always know their own needs, and that part of the health professional's role is to contribute what they knew from past experience women would find useful" (Combes and Schonveld, 1992:37). This does not necessarily sit comfortably alongside what women say they want, however. Mary Nolan has conducted critical research on this issue and claims that:

Hearsay evidence would suggest that many childbirth educators believe that it is not possible to interest parents expecting their first babies in matters beyond labour and the birth of their child. However, if asked to set their own agenda for antenatal

classes, parents themselves will, in the author's experience, frequently ask for a balance of birth and postnatal topics (Nolan, 1997: 24-25).

This was apparently made difficult for the expectant mothers who were interviewed, however. Some of them seemed to half-question the absence of infant care issues at the time they attended, and Rhona in particular claimed to have discussed this deficiency with others in her class. Others, however, gave the impression that they had not noticed the omission of such important topics until they were reminded about them afterwards – for example, during the interviews for this research. This further suggests that expectant parents' learning needs were not incorporated effectively into the class curricula.

Infant feeding seemed to be the major aspect of postnatal care covered at the antenatal classes attended by the case-study participants. Not all were impressed by the way in which this topic was presented, however:

They really pushed breastfeeding at the classes. It was just, like, "You will breastfeed. And if you can't breastfeed, well yes, there's the bottle, but if you give up, it's like, horrendous". And we all came out and we all went, 'Cor - talk about BULLDOZED!' (Diane, interview one)

We had a midwife at the classes who was obviously very into breastfeeding. They didn't come in and say, "You must breastfeed", but you could tell, she was a real exponent of it, you know? There were a couple of videos on breastfeeding; some Scandinavian thing, and quite funny really. The prodding around with the boobs and everything. There were boobs 'in your face', everywhere! And one woman in the video attached to a breast pump - one on each boob - and she looked like a cow! And I must admit, that put me off! And I mean, after watching, I thought....well, I haven't changed my *mind*, but it was *offputting*. It was a bit over the top. (Sally, interview one)

Evidently, these two women perceived that the style in which breastfeeding was promoted in their antenatal classes was somewhat 'over the top', to use Sally's phrase. It is worth noting at this point that both of these participants were intending to breastfeed anyway, and the way in which this issue was covered was therefore perceived as particularly inappropriate. Infant feeding will be explored in greater depth later in this chapter.

The case-study participants who described the content and style of their antenatal classes made little or no mention of social and emotional issues such as postnatal depression or parental relationships postnatally. These are, however, important issues in the transition to parenthood (Combes and Schonveld, 1992; Nolan, 1997). Whilst they are apparently marginalised in antenatal classes, they may be difficult areas for expectant parents to identify as being important, particularly prior to the birth. It is for this reason that in the later questionnaire survey, the retrospective opinions of new mothers were sought in relation to these issues.

To summarize so far, the case study participants' perceptions of the content of antenatal classes were as follows:

- Labour, birth and infant feeding were the main topics covered in NHS classes.
- These topics were presented in a directive and somewhat prescriptive, rather than a discursive style.
- General infant care and parenting skills were covered either inadequately, or not at all.
- NCT classes were more critical and discursive, but still lacked adequate coverage of infant care issues other than feeding.
- Social and emotional issues were not given due attention in antenatal classes.

The qualitative evidence presented is useful to the extent that it begins to paint a picture of what local NHS classes in particular, are like. It also contains illustrative data on how some of the women attending those classes felt about the issues covered, and the way in which the information was presented. In order to generate a more representative set of responses, the above data was used to construct a more detailed framework of questions about antenatal classes. These were included in the questionnaire, the relevant responses from which are outlined in the following section.

4.4.2. Questionnaire respondents' expectations of the content of antenatal education

One of the few published studies of antenatal class attendance among first-time expectant mothers (Hiller and Slade, 1989) categorised women's reasons for attending as follows:

- a) to gain information and increase knowledge
- b) to increase confidence and decrease worries
- c) to meet other women
- d) to learn about relaxation and antenatal exercises
- e) miscellaneous reasons (e.g. for interest)

Source: Hiller and Slade (1989:11)

In this study, the questionnaire asked new mothers why they chose to attend the classes that they did. Thirty-one of the thirty-two attenders responded to this open-ended question. All of them had attended NHS classes, and two of those had, additionally, attended classes run by the NCT. The responses were varied and often contained more than one reason; however, they were categorised (together with the number of responses) as follows:

- a) invited by health professional (14)
- b) to gain information (11)
- c) to meet other expectant parents (2)
- d) other (4)

Responses in the first category suggested that many expectant mothers went to the NHS classes because they thought it was the 'right thing' to do. 'My midwife arranged them for me' (17, NHS) typifies the responses in this category, suggesting an element of passivity without specific expectations in terms of class content. By contrast, the second category contained rather more explicit reasons from women,

focusing on gaining or increasing information and knowledge. Within this category, a split occurred; some women specified labour and birth information while others focused on postnatal issues, particularly infant care skills. Indeed, one of the NCT class attenders gave that very reason, while the other emphasised meeting other expectant mothers - thus coming into the third category. Within that, gaining information was also mentioned, but the principal reason remained, one might argue, social. This apparent difference in style and expectation was highlighted by one of the respondents whose reason was categorised as 'Other':

I attended one NCT/Active Birth (?) class and didn't like their approach. I'm not the type of person who likes sitting around on beanbags cross-legged and massaging complete strangers. I preferred the NHS class immediately. The people and the midwife were a lot more realistic and genuine. (37, NHS)

Of course, this does not explain the woman's reason for having chosen the NCT (or possibly Active Birth) class that she so disliked. It may be useful, however, in illustrating why perhaps so many respondents in this study did not cite their reasons for attending classes in terms of anticipated content. Despite the fact that, at the time of responding, they had all *acquired* knowledge of the latter, they could not have known what to expect prior to attending. Nevertheless, the evidence suggests all sorts of reasons why the women chose the classes that they did, with straightforward open-mindedness perhaps leading the way. The number of women opting to 'go along' with what their midwife or GP suggested indicates a degree of passivity among NHS class attenders in particular. While most in that category did not give any reasons based on anticipated class content, others were more explicit. Being 'given' information by midwives running the classes appeared to dominate here and, according to the evidence outlined in Chapter Two (e.g. Kelly, 1998), it might be expected that these women would prove to be satisfied in that respect. However, the respondents whose emphasis here was upon *postnatal* issues might, for the same

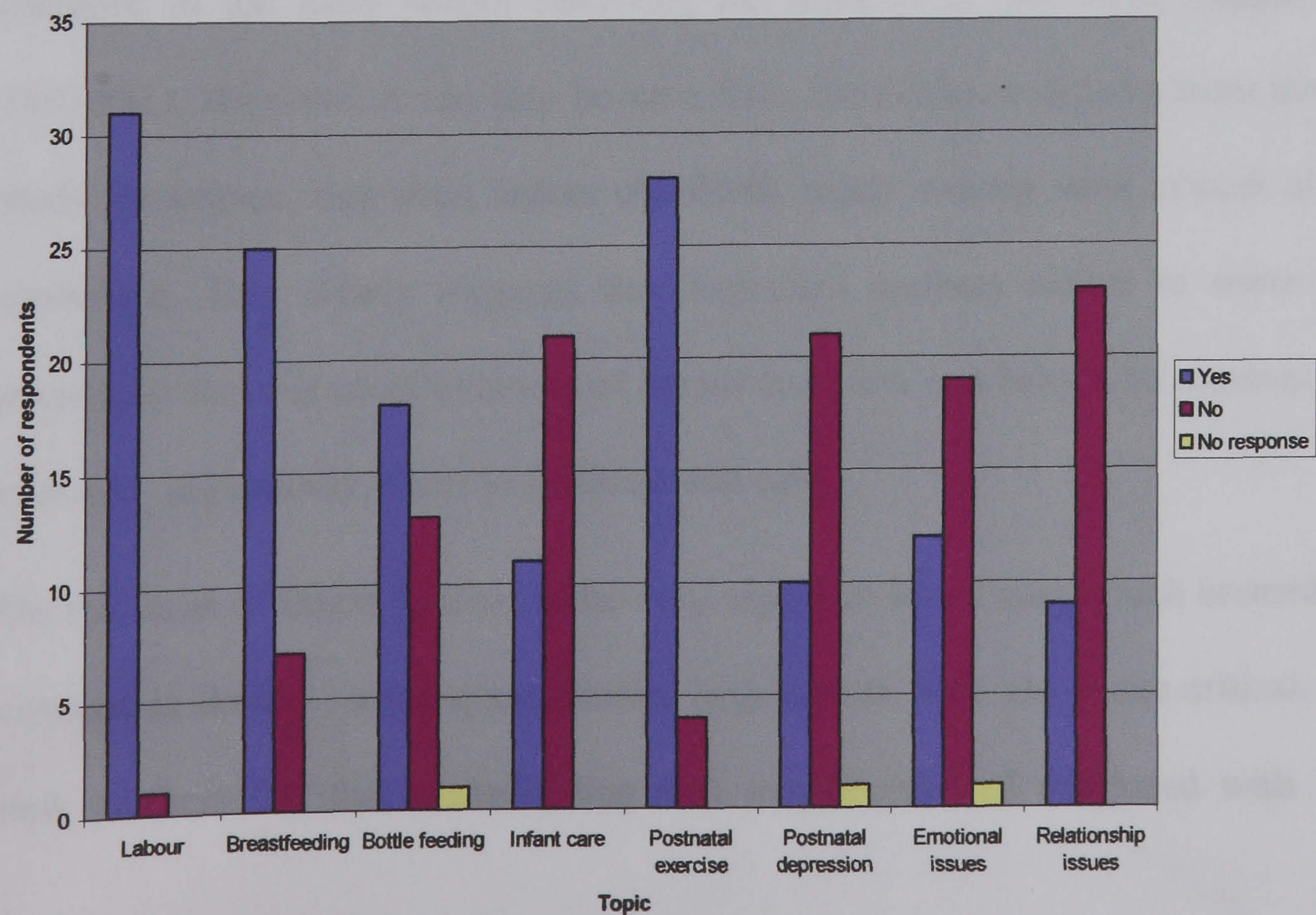
reason, prove to be disappointed. With these issues in mind, the following section presents the questionnaire respondents' accounts of the topics covered in the antenatal classes that they chose to attend.

4.4.3. Questionnaire Respondents' perceptions of the content of antenatal classes

Respondents were asked how *adequately* they felt that a number of topics had been covered in their classes (see Figure 4.4.)

The figure shows that the topics most clearly perceived as being covered adequately were labour, postnatal exercise and breastfeeding. These are the topics suggested by the literature and the case-study data as being the cornerstones of antenatal classes. Conversely, the topics seen to be *least* adequately covered were infant care, emotional issues and postnatal depression, as well as relationship issues. A large minority also found that bottle-feeding was not covered adequately. Again, these

Figure 4.4. Respondents' views of the adequacy of coverage of each topic in NHS antenatal classes



findings are generally consistent with those of the relevant case-study participants.

Respondents were also asked to indicate how they thought their antenatal classes could have been improved. Several made strong reference to postnatal issues, which they thought were put second to birth preparation:

More information about life after having a baby – feeding and what hard work it is. (1, NHS)

Less about labour and more about infant care. (6, NHS)

More discussions regarding life with a new baby – e.g. relationships/emotions. (18, NHS)

More about life after the birth; knowledge and skills on how to look after a new baby. Simple issues such as how often to change a nappy. How many clothes he should wear. (22, NHS & NCT)

These citations clearly indicate that ‘life with a new baby’ was perceived as an important area for coverage. Nevertheless, it was deemed to have been largely lacking in both the NHS and the NCT classes attended. It is important to re-emphasize that these women, at the time of completing the questionnaire, were all in the situation of living ‘life with a new baby’ and, because of this, the issue was at the top of their agenda. As one study of the transition to motherhood shows, ‘realising’ – ‘this baby is mine and I have to care for it’ emerges as a dominant category in the early weeks following the birth of a first child (Rogan et al, 1997:881). However, it can also be seen from the evidence derived from the case-study interviews, that even before childbirth, many women were critical of these omissions. This clearly suggests that expectant mothers realise to some extent *prenatally* that the usual outcome of labour and birth is a baby who requires active care and, importantly, skills to facilitate that care.

On the issue of infant feeding – the only aspect of infant care which seemed to be covered in depth – some questionnaire respondents were also quite critical. Many new mothers felt that breastfeeding was overemphasized compared with bottle-

feeding. Furthermore, the breastfeeding coverage was deemed, retrospectively, to have been unrealistic:

[They could have] talked about bottle-feeding more, so you don't feel so guilty if you don't breastfeed. (19, NHS)

Would have liked more on looking after a child after birth, and more on bottle-feeding, as classes were very pro-breastfeeding. (17, NHS)

The relationship between expectations and reality of breastfeeding will be considered more closely later. For now, it is enough to note that while feeding apparently did represent a significant learning area in antenatal classes, not all of the attenders were satisfied with the way in which the topic was handled.

Although only four respondents focused primarily on labour and birth in response to this question, opinions were mixed:

By telling us about the labour and the birth, they need to tell us the reality of it all. When you are going through it, it is different (totally) than what they tell you. (4, NHS)

This account suggests that the labour and birth preparation were perceived as unrealistic. The following also indicates some criticism in terms of breadth and depth:

The relaxation techniques were useful but could be in more depth. Different types of delivery discussed, e.g. more complicated situations. (34, NHS)

Another respondent, however, felt that the topic of labour was introduced too early and in too *much* detail:

Our first session was on labour. As most of us were first-time mums, this was a topic that frightened us all. The session was graphic and painful! Some did not attend the following week! The structuring of the presentations over the weeks is important, and I feel that 'easing' us into the labour would have been more beneficial and would have improved the class atmosphere. (10, NHS)

This is a particularly interesting observation because it suggests, even with the benefit of *the experience* of birth, that labour was 'flagged up' early on as being the most important topic for coverage in the classes. This is significant because women

may take cues from health professionals about the prioritisation of certain issues over others. While labour and birth coverage are indeed issues of great concern to women in the third trimester of pregnancy (e.g. Raphael-Leff, 1991), it is questionable whether the way in which they are prioritised in antenatal classes influences the way in which expectant mothers view the transition to parenthood overall.

On the other hand, those who are responsible for scheduling the content of classes argue that topics need to be presented in order of chronological importance. For example, some expectant mothers may be very close to their due date of delivery when classes begin. Therefore, they should at least receive coverage of that topic. Indeed, midwives tend to argue that information about all other topics is accessible either on the hospital postnatal ward, or at home via women's own community midwives or health visitors. This is contestable in the light of ever-shorter postnatal hospital stays, however (Audit Commission, 1997; Dowswell et al, 1997).

Finally, on this topic, one of the respondents offered quite a balanced view of the handling of labour and birth in her antenatal classes:

The information on labour was very good and I suppose no-one can actually prepare you for the experience, but I did feel better informed. (37, NHS)

Two respondents felt that, on reflection, nothing in their antenatal classes needed to have been improved:

I thought they were beneficial; they didn't need improving. (38, NHS)

I feel the classes provided every bit of information I needed so there is nothing I can think of that could improve these classes. (2, NHS)

In summary, the questionnaire respondents' perceptions of the content of antenatal classes were as follows:

- Labour and birth were the main topics covered in classes, but some mothers felt that the coverage was unrealistic.
- Coverage of infant feeding, whilst generally perceived to be adequate, was strongly biased in favour of breastfeeding. Mothers who subsequently bottle-fed were especially critical of this.
- Infant care skills were covered either not at all, or in far less depth than most of the respondents wanted.
- Other postnatal topics, including emotional and relationship issues, were largely perceived to have been marginalized or omitted.
- Despite a variety of perceived inadequacies, most respondents felt that they had gained information as a result of attending antenatal classes.

The responses derived from the questionnaire respondents and the case-study participants are therefore fairly consistent in terms of perceptions of informational support. In turn, they reflect many existing criticisms documented in the literature. Overemphasis on labour and birth is probably the most obvious of these. Although this may not in itself be problematic (except on grounds of seeming ‘unrealistic’ (Niven, 1992), its effect on marginalizing the coverage of important postnatal topics such as emotional and relationship issues may be costly.

It has previously been found that ‘women in retrospect often wished that classes had covered this topic’ (Combes and Schonveld, 1992:37). However, it would be difficult to ‘wish’ this in any way *other* than in retrospect, given that classes must have been attended in order for an evaluation to be possible. Therefore, although the questionnaire respondents cited such issues within the context of the postnatal period, it must be re-emphasized that the transition to parenthood accounts for considerably more than just labour and birth. As Mary Smale has suggested:

Pregnancy, labour, birth, breastfeeding and the postnatal period are sometimes seen as separate in research and in the organization of the maternity services, but

women's lives may feel more continuous, despite the drama of birth. (Smale, 1998:192)

4.5. Additional benefits of attending antenatal classes

Of course, expectant mothers do not usually choose to attend antenatal classes just to gain information from health professionals. As suggested above, a significant number cited meeting other people in a similar situation as a major reason for attending. The limitations of local support networks – particularly for middle-class women – is a key contributory factor. Mary Nolan makes this explicit in her assertion that, from an historical perspective, “antenatal education can be seen as an artificial construct, attempting to replace the factual information and the emotional insights traditionally transmitted through the women's network” (Nolan, 1997: 1199).

In her earlier (1995) study investigating the socio-economic profiles of antenatal class attenders, Nolan had already demonstrated that a middle-class bias exists. A number of studies was examined by Combes and Schonveld (1992). Their analysis led them to sympathise with practitioners' claims that those who attend antenatal classes are those who are probably *least* in need of doing so. Indeed, such claims were also made by Plymouth community midwives during a meeting held at the outset of this particular study. Such criticisms are, however, based on a narrow view of antenatal education as *information orientated*. While gaining information is clearly important, there is reason to believe that the expectant mothers in this study had broader needs and expectations. These included a strong desire for *emotional*, as well as informational support. Whilst not actually conceptualized in this way by the participants themselves, it is nevertheless apparent that many attenders of antenatal classes enjoyed the benefits of meeting other expectant parents.

4.5.1. Case-study participants' perceptions of the emotional support role of antenatal classes

The pre-natal interviews with case-study participants included discussions about the content of the antenatal classes that they attended, as outlined above. Within this, the participants had been asked whether and to what extent informal discussion with *other* expectant parents at the classes had been facilitated. Additionally, they were asked whether they had stayed in touch or made friends with any others from their classes.

Sally, in her description of the NHS classes that she attended, had already suggested that:

It was nice to be with other people who are in the same boat as you...you don't feel so isolated. (Sally, interview one)

Likewise, Diane emphasised discussion with other mothers-to-be as an important component of her experience of the classes overall:

Yes – we had a twenty minute coffee break when we could chat together. A few of us have got together and we've been going to aquanatal classes once a week. We all said we'd miss the classes because it was nice to get together and compare notes, really. I think we will stay in touch, because we're all either going back part-time or not going back to work at all. It's important for our children to have friends of their own age, and we're all in the same area. (Diane, interview one)

Clearly, Diane not only maximized the opportunities for informal discussion within the classes, but also valued the experience of further activities beyond the antenatal class setting itself. Notably, she anticipated a personal requirement for social support beyond the birth of her baby. It is interesting as well that she refers to 'our children' and their future social needs. This again demonstrates that, even before the birth of a first child, it is possible for expectant parents to *anticipate* postnatal issues.

Tracey, who had attended only one of her NHS classes at the time of first interview, had not had sufficient opportunity to 'network' at that time. She did, however,

confirm that the schedule enabled informal discussion between those attending the classes:

Yes – we had ten minutes of chatting at the beginning. Then we had a coffee break, when we could all talk to each other. (Tracey, interview one)

Sally, who had attended two sets of NHS classes, also felt that informal discussion was encouraged:

Well, we used to have a coffee break, and they encouraged us to talk to each other. There is one girl I've kept in touch with. She's had her baby now. Her husband was away as well, so we've kept in touch. (Sally, interview one)

Barbara also felt that, in both the NHS and the NCT classes that she attended, there was sufficient opportunity for informal discussion, with a break half-way through in each case. However, she added:

But we haven't really kept in touch. The NHS and NCT classes were different in that respect. The NCT class – in the second week, we were given a class list with all our addresses and telephone numbers on. Whereas, at the NHS class, it was left up to you to maintain contact afterwards and to write down people's phone numbers. I got the phone numbers of about three girls. We've been in touch once. That's about it. (Barbara, interview one)

This account of the different approaches of the NHS and the NCT is interesting but fairly unsurprising. For example, it has already been noted that the NCT embraces a more discursive approach to antenatal education, whereas the NHS tends to be quite directive and 'information orientated'. Also, of course, NCT classes are usually smaller and take place in comparatively cosy settings, often within the homes of either the teachers or one of the expectant parents. Such settings, combined with the clientele they attract (Nolan, 1995) are perhaps more conducive to the promotion of supportive relationships between expectant parents who attend.

The following account indicates that, while this was not particularly the case, there was a key difference between NHS and NCT classes in terms of promoting

relationships between expectant *mothers* and relationships between expectant *parents*:

From the NHS classes, four of us decided to go swimming. And one of the girls, who lives on the next street, did the NCT classes as well. And they're into sailing, and my husband's into sailing, so we've actually been to each other's houses for dinner and we've been out – so – it's amazing! From the NHS classes, there's about six of us that will definitely keep in touch. We all live in the area, so we can all go to the park, and that sort of thing. I think we'll keep together more from the NHS classes, but the NCT people – we'll probably do more as *couples*, because the fellas have all met. (Rhona, interview one)

The differences in the relationships between those from the NHS classes and those from the NCT can perhaps be explained on the basis of geographical location as well as on the basis of social class. For example, community-based NHS classes invariably include expectant parents who live in a particular locality. By contrast, NCT clients tend to be more scattered, but make the effort to come together in a particular setting in order to learn by the NCT's methods.

Additionally, because classes are often held in the evenings rather than during the day, male partners are more likely to attend. It can be seen from Rhona's account that her intention was to utilize her opportunities for local contact in ways which would benefit both herself and her baby during the daytimes, by going to the park, etc. By contrast, the contacts established through NCT classes were couples with whom she and her partner planned to socialize together *as a couple* and later, as a young family. Shared interests (sailing, dinners) helped to facilitate this.

Thus, the NCT may usefully help to promote relationships between families, rather than just mothers. At the same time, however, those families tend to be middle-class families. The relationship between this and local *family* support will be explored in more detail later.

These accounts of case-study participants' experiences of informal emotional support, derived from antenatal classes, are limited because of the small numbers involved. Nevertheless, they provide useful insights into the ways in which expectant parents can, if they choose, establish and maintain supportive links with others in a similar situation. In this sense, antenatal classes may be seen as useful forums - albeit 'artificial', in Nolan's (1997) view - for expectant parents who might otherwise have little or no access to traditional lay support.

In summary, case study participants' perceptions of the emotional support role of antenatal classes were as follows:

- Case-study participants who attended antenatal classes felt that suitable time was allocated for informal discussion between expectant parents.
- The NCT classes *actively* promoted contact and support outside the class setting, whereas the NHS classes apparently did not.
- The NCT, because of its ethos and the timing of classes, appeared to encourage *couples* to establish and maintain contact.
- The NHS classes, by virtue of local community settings and daytime schedules, were more likely to enable *mothers*, rather than couples, to establish supportive contacts.
- Most of the case-study participants perceived the opportunity for meeting other expectant parents as a valuable aspect of attending antenatal classes.

4.5.2. Questionnaire respondents' perceptions of the emotional support role of antenatal classes

In order to gain some more representative data on this issue, the questionnaire respondents were asked, 'How useful do you think it is, to meet with other parents-to-be at antenatal classes?' The responses from those who attended classes (NHS

only or both NHS and NCT) indicated that twenty-nine out of the thirty-two felt it was ‘very’ or ‘fairly’ useful. Only three respondents felt that it was ‘not very’ useful. Respondents were also asked whether they had enough opportunities to talk informally with other expectant parents at the classes. The vast majority of 28 (87.5%) said ‘Yes’, while only 4 (12.5%) said ‘No’. These findings support the accounts of the case-study participants, suggesting that opportunities to meet and talk informally with other expectant parents at antenatal classes may be a particular strength.

However, the questionnaire also invited new mothers to state whether they had kept in touch or made friends with other expectant parents from their antenatal classes. Only fifteen (46.9%) reportedly did so, whereas seventeen (53.1%) did not. When compared with the responses to the question about the perceived usefulness of meeting other expectant parents at classes, this figure is lower than might be expected. None of those who described such opportunities as ‘not very useful’ kept in touch with others from their classes, but a significant number who might have hoped to do so postnatally did not. While the evidence as it stands does not enable an informed explanation for this, it might just be that the usefulness of such contact was more specific to late pregnancy, rather than to the more diverse sets of circumstances that might be encountered following childbirth. Indeed, when asked what they *liked most* about their antenatal classes, more responses fell into the category ‘meeting other mums’, than any other. The following examples illustrate the ways in which some of those respondents articulated this preference:

Meeting new friends in the same situation. (12, NHS)

Meeting other people in the same situation and having a chance to discuss any queries. (34, NHS)

The chance to get out and be with other mums who know exactly how I felt and what I was going through. (36, NHS)

Evidently, these women valued the emotional support opportunities offered by the antenatal class setting. They were quite explicit about valuing this aspect of the classes most. Others, moreover, implied a strong appreciation of the perceived warmth of that setting whilst offering a more *implicit* account of the emotional support opportunities of being with other expectant parents:

There was a really friendly atmosphere and I was made to feel really welcome. (19, NHS)

Friendly, down-to-earth people whose company each week was the most important factor. (37, NHS)

In our small group with no partners present we were not afraid to raise any issues that concerned us. (1, NHS)

The final comment, above, is in direct contrast to that of a mother who attended both NHS and NCT classes. Although she liked the physiotherapy sessions best in her NHS classes, the best aspect of the NCT classes for her were:

Attending with husband – sharing the experience together. Meeting couples as a couple. Issues at classes led to discussion at home. (22, NCT)

This experience seems to mirror that of Rhona, the case-study participant who found the NHS classes good for meeting other new mothers locally, but who also found that the NCT classes facilitated supportive relationships between new parents as *couples*. Although there is too little evidence in this study to make any generalizations about the mothers who attended NCT classes with their partners, those couples do seem to fit quite neatly into the categories identified by Nolan (1995). That is, they are self-selected; older, married and middle-class. They do seem to have sought out similar couples whose needs for social (emotional) support were also perhaps greater than for *informational* support.

The mothers who attended NHS classes seem also to have focused principally on the social/emotional benefits of attending antenatal classes. Although, as the above data indicates, many of them also valued the informational content, it is known that such information can be derived from alternative sources. Printed media, family and friends are just some of those, and their relative value to the expectant and new mothers in this study will be considered later. The important point is that face-to-face contact, with its opportunities for discussion and mutual support, is not so easily accessed by alternative means. This seems to be especially true for middle-class women whose lifestyles may lead them to lack local community support. While the latter may represent the main mechanism for emotional (as well as instrumental and informational) support in non-western societies (e.g. Vincent-Priya, 1995; Kitzinger, 1978), they have tended to diminish within industrialized - and medicalized - cultures, including the UK. Artificial constructs such as antenatal classes may indeed serve a dual purpose, therefore. Not only do they provide a forum in which childbirth practices can be learnt; they also involve the construction of a social community, which may act as substitute for more traditional community support settings.

This raises the questions, ‘What alternative resources are utilized by those who choose *not* to attend antenatal classes?’ ‘By what means do they access such informational and emotional support?’ These questions will be addressed later in this chapter, following exploration of the accounts of those non-attenders.

In summary:

- Those who attend antenatal classes may be actively seeking out emotional, as well as informational support opportunities.

- Meeting other expectant mothers was what the questionnaire respondents felt to be the single most enjoyable aspect of antenatal classes.
- Despite claiming to value the company of other expectant parents, the majority did not maintain contact once the classes had finished.
- Antenatal classes appear to act as artificial substitutes in the light of diminishing traditional community support mechanisms.

4.6. Non-attendance at antenatal classes

Less research has been undertaken on the subject of non-attendance at antenatal classes than on the form and ideology of the classes themselves and the clients that they attract. This may be due to the fact that non-attenders are far more difficult to access for research purposes. That was certainly the case in this particular study, as detailed in Chapter 3.

A review of the literature appertaining to non-attenders suggests that research has focused principally on who does *not* attend antenatal classes (e.g. Nolan, 1995; Combes and Schonveld, 1992, McIntosh, 1988) and, less often, the reasons *why* they chose not to attend (e.g. Cliff and Deery, 1997).

Identifying the type of expectant parents who do not attend is relatively straightforward. Most studies show that they tend to be younger, unmarried, poorer and less well educated than those who attend antenatal classes. While this is a basic dichotomy, there are some variations and overlaps.

For example, Cliff and Deery's study found that older, married, working-class women were also quite likely to attend classes, which indicates that social class is by no means the key variable. Indeed, they suggest that material factors may be more pertinent than social class *per se* (Cliff and Deery, 1997). There is, however, a broad consensus in this field that a clear distinction exists between 'attenders' and 'non-

attenders' of antenatal classes. This has been regarded as a problem requiring remedy for at least the past two decades, although there are differences in opinion as to what the problem is, and how it might be remedied. For example, in her discussion of this issue, Mary Nolan asserts that the

...socially advantaged women take a slice of the antenatal education cake out of all proportion to their numbers and obstetric risk and those at greater risk of adverse perinatal outcome receive the least education (Nolan, 1995:144).

While Nolan's criticism focuses principally on perinatal risk factors associated with social deprivation (such as low birth weight), it could be argued that clinical antenatal check-ups (which 99% of expectant mothers in the UK do attend) represent the best safety-net in that respect.

There is, however, the broader antenatal educational base to consider. That is, that in the UK at least, antenatal classes have developed over the course of the twentieth century to offer education and guidance to women approaching childbirth and new motherhood. Those who attend such classes are, however, also most likely to be fairly knowledgeable already, through their access to a broad range of literature, for example. In this sense, those responsible for running antenatal classes often find themselves 'preaching to the converted'. This was certainly the view of Plymouth community midwives, many of whom articulated such a view during a meeting at the local maternity unit in December 1997.

It appears to be a matter of concern (as highlighted in the literature and by local health care professionals) that younger, poorer, unmarried mothers-to-be tend not to present at antenatal classes. Such concerns are often couched in terms of practices such as breastfeeding, which is least likely to be undertaken by mothers with these social characteristics, for example (e.g. White et al, 1992). Genuine concern may only be justified, however, if non-attendance is *clearly linked with* particular

difficulties in the transition to motherhood. Existing studies of the efficacy of antenatal education in the UK make no such links, however. Indeed, as indicated in Chapter Two, most such studies fall short of applying antenatal education to new motherhood at all. Because of this, participants in this study – attenders and non-attenders – were followed through to at least three months postnatal in order to help highlight any such links.

The remainder of this section will focus on the issues of non-attendance, as explained by the relevant participants in this study. As before, the questionnaire responses will be considered after the case-study data.

4.6.1. Case-study explanations for choosing not to attend antenatal classes.

Four of the nine case-study participants had chosen not to attend antenatal classes. They were Laura, Mandy, Gina and Joy. During the first (prenatal) interviews, they were each asked whether they had been invited to attend classes; whether and what they knew about antenatal classes, and whether they knew anyone who had ever attended antenatal classes. The purpose of such questions was to try and throw some light on the reasons that they gave for not attending classes themselves.

Gina's explanation was as follows:

My midwife mentioned it. But I haven't thought about going to any of them. I think I had a leaflet or something, about it. But I can't remember where they are held. I don't think it's necessary, really. I know some of the pelvic exercises – my sister had a proper exercise sheet – so I just thought, instead of going to the classes, I'll do them in my own time.

Asked what she thought antenatal classes are like, Gina replied:

Well, it's all, like, *breathing* and that, as well. But I don't want to go. I'll just wait 'til the time comes.

Did she know anyone who had been to such classes?

Um....no. I don't know no-one that's been. I've heard about it – what sort of things they do – but I don't actually know nobody that has gone to them.

It appeared that Gina may have constructed her opinions partly on the basis of information given by her community midwife:

Um....I just got told, like, even your partners can go with you and, like, see the sort of things that go on, and do all the proper breathing and that. Yeah – um.....I wouldn't mind, if it was a bit closer, but it's just – getting there all the time. 'Cos I reckon in a way it would be good to do, if it would help you through it. But I haven't really thought of definitely going. (Gina, interview one)

Gina's responses were rather vague, but should probably be categorised as 'not being bothered' – a category constructed by Perkins (1978) in her study of non-attendance of antenatal classes. In any case, it was clear that Gina felt that antenatal classes were not for her. Interestingly, she alluded to the 'formal' on two occasions within her explanation, referring to a 'proper exercise sheet' and 'proper breathing'. However, the main reason for choosing not to attend seemed to be 'getting there'. Gina had no private transport and was experiencing fatigue in these late stages of her pregnancy. These factors, combined with the most fragile social connections to the experience of formal antenatal education, perhaps account for her decision not to attend.

Mandy's reasons for not attending antenatal classes were articulated in greater detail:

The reason I'm not going is that I think I'd feel stupid – with everybody being there. At first I thought it was breathing exercises and that, that they did, but now they don't do that so much. They concentrate more on what happens during labour and when you go to the hospital. But I didn't know that at the time. So I thought that I'd feel stupid. My partner wouldn't have been able to make it, because he's working long hours, so that's why I'm not going. With the breathing exercises, not having a partner with me – not being able to take anyone else. I didn't want to be on my own. (Mandy, interview one)

Mandy had, however, been invited by her community midwife to attend the classes:

Yes, and she kept asking me if I was going to go, and I said 'Yeah', and then I missed the first day. Then, I went to the antenatal clinic and she said, 'You missed it

last week. Are you coming up?', and I said, 'If I can make it'. But – that was it, really. Just a bit off-putting. So I just didn't bother going up. I felt a bit guilty, because when I went on the labour ward tour at the hospital, it turned out that everyone else had been to antenatal classes, and I was the only one that hadn't been. And I didn't know that you got taught pain relief, when you went to your antenatal classes. I wasn't sure *what* pain relief I could have, or anything *else*, right up until I eventually *asked* the midwife, but it felt as if she was pressuring me into going, and I didn't particularly fancy it. I told her that, and she said it was my decision, really. And the midwife who did the labour ward tour asked who had been to antenatal classes, and they all put their hands up and I was stood there with my partner, not putting my hand up. And she says, 'Oh, you don't know anything about pain relief and you haven't seen a video on labour, so you don't really know what you're doing'. And I said, 'Well, no, I don't know a lot really. Most of what I know, I've been reading about'. And she said, 'Well, it's up to you whether you go or not'. So I'm just gonna go up there and cross my fingers, I think!'.

When asked to elaborate on what she knew about antenatal classes, and whether she knew anyone who had been to them, Mandy replied:

Most of it was from what I've read. But a lot of people that I know, who've had babies recently, hadn't gone, and some had gone. And the ones that had gone said that they didn't really learn a lot, so.....I didn't bother going. (Mandy, interview one)

There appears to be a slight contradiction between Mandy's justification based on the experiences of friends, and the feelings of ignorance she had already described during the labour ward tour. Therefore, whilst apparently regretting the missed opportunity to learn about pain relief in antenatal classes, Mandy was adopting a 'wait and see' approach to childbirth, rather like Gina in the previous account. Of course, her initial reason for choosing not to attend was the inability of her partner to accompany her. It is interesting that so many non-attenders state this, when in fact it would appear that most of the expectant mothers who attend NHS classes during daytime sessions do so 'alone'. It has already been noted, however, that such mothers-to-be tend to be *aware* that they will meet others in the same situation. By contrast, neither of these two non-attenders made any links between antenatal classes and social support, or the opportunity to meet other expectant mothers.

Mandy's explanation of 'feeling stupid' was echoed by Laura. She, unlike the previous two non-attenders, was not living with the baby's father. She was evidently very conscious of this, in addition to being only seventeen years old. Her community midwife had apparently encouraged her to go to antenatal classes, however:

Yeah, my midwife gave me the letter. Every time I go down [for clinical checks], she says, 'Are you going yet?' and I say, 'No. I really don't want to.' You know? She's alright but I don't think she likes the idea of me not going. But she's alright. I wouldn't feel comfortable. Certain things I just don't feel comfortable with. That's one of them. I've seen a lot of it – on telly, like – when they go through it. And I thought, I couldn't sit there and do that in front of loads of people. I just couldn't. I'd be too embarrassed. It's to do with my age, as well, 'cos most of them are gonna be, like – older – and married, and all that. And I'm not. And I feel a bit embarrassed about that. My friend went, and my cousin. But they only went once and they didn't like it. (Laura, interview one).

Therefore, Laura clearly thought that antenatal classes were 'not for her'. Again, there is evidence that younger, single women perceive that antenatal classes are for older, married women, or at least for those who have a partner, preferably one who is accompanying them. Laura's reasons typify those given by non-attenders in Cliff and Deery's (1997) study. Indeed, all three non-attenders whose accounts have been considered thus far would fit into the categories established by Combes and Schonveld (1992) and Nolan (1995). Although two out of the three had partners, none of the women were financially secure, and all were housed in local authority accommodation except for Laura, who lived with her own mother.

The final case-study non-attender was Joy. Her explanation for choosing not to attend was couched in terms of *independence* from what she perceived as a prescriptive approach within antenatal classes:

What I know of antenatal classes is, it's to prepare you for the labour. Breathing exercises and stuff? Am I right? I don't really know much about them. And, um, well – I just thought that I don't think someone else can – um, it can *help* people, but I don't think it can help *me*, because I'm going with my own body, and seeing what it does when I actually go into labour. And my husband's doing some massage, and that's about it. We're just doing it between us, really. Whereas, when you go to antenatal classes, I think they tell you, 'This is how you *breathe* when you're in

labour; this is how you....', and I don't want to be told that. I just want to do it naturally; see what my body wants to do. So that's really why I decided not to go.
(Joy, interview one)

Joy added that one of her friends had been to antenatal classes and had tried to persuade her to go. Additionally, she had been told about the classes by her community midwife. She claimed not to know where local classes were held, however, having declined the midwife's invitation to attend them. On the issue of antenatal class content, it appeared that Joy's opinion was based loosely around snippets of information gleaned from TV and 'other people':

Um....just watching things on TV andfriends, you know.....people who have recently had children. Um.....I haven't really talked to many people about it, but...
(Joy, interview one)

In response to Joy's question about whether her views on antenatal class content were correct, it seemed appropriate to add that infant feeding would be covered as well. This was necessary in light of the fact that she intended to breastfeed, yet claimed to know very little about it. She had hitherto been unaware that breastfeeding would form part of the antenatal class curriculum.

Overall, it must be stated that Joy's explanation is rather different from those of the other non-attenders. She clearly wished to 'do her own thing', and while this does bear similarities to the explanations of both Gina and Mandy, in terms of 'waiting and seeing', there was no suggestion of feeling stupid or embarrassed. Additionally, Joy was living with the father of her baby, who already had three children from a previous relationship. Therefore, while Joy was a first-time mother, her partner was an experienced parent. On the basis of this interview data, it is impossible to tell whether this affected her decision or not, however.

It can be seen from the interview data above that, while explanations vary between individual participants, there is one common reason linking the four. All, in their

own way, claimed that antenatal classes were ‘not for them’. They appeared to see themselves as different from ‘others’ who *did* choose to attend such classes. This difference was mainly due to perceptions of attenders as older, married women, doing things ‘properly’, in a prescribed way. By contrast, these non-attenders were linked by three main characteristics; age, social class and housing tenure. All four of the non-attenders were aged twenty-five years or under. The average age for the birth of a first child in the UK at present is twenty-seven years (ONS Birth Statistics, 2000).

Second, none of these non-attenders was living in owner-occupied accommodation. Finally, these women’s relationship to the labour market appeared to be quite tenuous; none of them had been engaged in salaried full-time employment immediately prior to their pregnancies. Therefore, despite the very small number of participants considered here, it can be seen that the social profiles of these non-attenders closely resembled those identified by Cliff and Deery (1997). In that study, social class and material factors were identified as the principal defining social characteristics of non-attenders of NHS antenatal classes.

Having examined the explanations of the case-study non-attenders, the relevant questionnaire participants’ accounts will now be explored.

4.6.2. Questionnaire respondents’ explanations for choosing not to attend antenatal classes

Of the thirty -seven new mothers who completed and returned the questionnaires, seven had not attended antenatal classes, although one respondent had attended a single session and subsequently chosen not to return. She categorised herself as a non-attender, by completing that section of the questionnaire.

Cross-tabulation of data showed a significant association between educational level and non-attendance of antenatal classes; those educated to 'A' level or above were more likely to attend than those educated to GCSE level or below ($p=0.039$).

Within the sample, maternal age was not found to be associated with attendance or non-attendance, however. Age categories were constructed for women aged twenty-seven or over, and twenty-six or under (as the average age for a first birth in the UK is twenty-seven), and equal numbers in both categories attended antenatal classes. Four of the seven non-attenders fell into the higher age category ($p=0.732$).

Attendance or non-attendance was similarly unaffected by whether or not the mother was living with the baby's father. Twenty-nine of the thirty-two attenders were living with a partner, while three were not. Only one of the seven non-attenders was not living with the baby's father ($p=0.698$). As with the 'age' characteristic indicated above, this is somewhat surprising in the light of previous studies suggesting rather different background characteristics for non-attenders (e.g. Nolan, 1995). This is a very small sample, however, and its limitations must therefore be acknowledged.

Of the seven non-attenders, six women claimed to have known of the existence of antenatal classes, while only one claimed not to have knowledge of them. All six who did know had been told about classes by their community midwives, and had also been invited to attend. The following reasons were given by the seven non-attenders, in response to the question, 'Why did you decide not to go to classes?'

The first two responses were given by mothers whose circumstances made attendance at classes unfeasible:

I was told at 28 weeks I would have to have a caesarean. (28)

Baby was born early. (32)

The next three suggested that they felt no need to attend classes:

I had a rough time with my pregnancy so it was one of the last things on my mind! I also thought that it would all come naturally when he was born. (27)

I went to 1 NHS class and was surprised that I was already well informed about what was covered – most of it was common sense. Also class sizes were large and I got very claustrophobic and dizzy and had to leave the class early. (29)

Time and hassle, and I think they would only tell you what you already know. (31)

The final two responses indicate that other commitments prevented attendance:

My job made it impossible. (30)

I was always so busy doing something on the day they were on. (39)

Therefore, the explanations are centered around practical reasons for non-attendance. Unlike the case-study non-attenders, the reasons cited above seem not to be particularly ideological in terms of consciously rejecting classes. However, a closer look at the questionnaire respondents' beliefs about antenatal class content may suggest otherwise.

When asked, 'What do you think antenatal classes are like?' and 'What has led to this opinion?' the following responses emerged:

Breathing exercises, keeping healthy and fit during pregnancy. Videos on labour. Teaching about nappies, feeding weaning, bathing, etc.

From what other people have told me and what I read in leaflets and magazines. (27)

A midwife would explain breathing/relaxation before labour. TV. (28)

Basic grounding in different areas of childbirth and parenting. Family and friends. (30)

The three responses above appear to be generally quite accurate, despite being a little over-optimistic about infant care coverage. The sources of information are clearly varied as well, covering a range of lay origins. The next two responses differ, however, in that they suggest a clear disenchantment with the idea of such formal antenatal education:

My visions of antenatal classes are lots of women sat on mats in a big room learning to relax themselves.

All the pregnancy books that I read before birth. (39)

A lot of talking, and how to bring up your child. Health & safety of your baby; feeding, colic, teething, etc. etc.

I have been told by my friends and family what they are like. I think if your not sure about being a mother you should go because some people haven't got a clue about motherhood. (31)

The first of the above responses encompasses a rather stereotypical view of antenatal classes, and this respondent obviously did not feel that classes were for her. The second response also carries a 'not for me' message, although much of the emphasis is once again on infant care, which we know does not usually form a major part of antenatal class content.

The following account was given by the non-attender who had, in fact, attended one NHS class before deciding that they were not for her:

To me it was like being back at school. The class was just like taking an exam. I felt like I was being treated as if I was thick and the other people at the class were competing to get involved because there wasn't much opportunity to give feedback. The class I attended and opinions given to me by friends who also have children. (29)

Although this opinion is based on attendance at one session only, the respondent's views are, at least, couched in terms of her own, rather than others' impressions. Interestingly, this mother has related her experience very clearly to a negative perception of 'school', which is precisely how many of Cliff and Deery's (1997) respondents explained their perceptions of antenatal classes. Indeed, many of the apparently quite negative views encountered thus far can be identified in the following extracts from that paper:

Whilst attenders valued the classes because they involved coming into contact with 'people like me', these women took the opposite view that the classes were not for 'people like them'.

The younger, single, working-class women, by contrast [with those who typically attend], clearly perceived the classes to be an extension of school and the midwives as agents of the middle class establishment in whose eyes they were not 'proper mothers' (Cliff and Deery, 1997: 143)

Finally, there was one new mother whose baby arrived too early for her to have attended antenatal classes. Her account clearly reflects her desire to have attended, given the opportunity:

I think they are really helpful. I wish I had chance to go – might of made things a lot easier. I would probably have been prepared with what to expect. (32)

This response says a lot more about regretting the loss of the classes than it does about perceived content, and source. However, this respondent clearly implies that she believes antenatal classes assist in preparing for labour and birth. In answer to the question, ‘Now that you have your baby, do you ever wish that you had attended antenatal classes, this respondent said ‘Yes’. She shared this view with respondent number 30, whose job had made it impossible for her to attend. Only one respondent answered ‘Don’t know’ and this was the new mother who had had an elective caesarean. The three respondents whose views on antenatal classes were most negative – numbers 29, 31 and 39 – were consistent overall in claiming to have no regrets about their decision *not* to attend classes. This view was echoed by respondent number 27.

The main views and explanations of the non-attenders are summarised below. These findings give rise to further questions concerning alternative sources of knowledge and support. These questions, as applied to both non-attenders and attenders of antenatal classes, will form the basis of the following section. To summarise, however:

- Non-attendance among the questionnaire respondents was significantly associated with lower educational attainment, but not with age. Neither were single mothers-to-be less likely to attend antenatal classes.
- The majority of non-attenders knew that antenatal classes were available locally, and had been invited to attend by their community midwives.

- Non-attenders' perceptions of antenatal class curricula closely resembled attenders' perceptions, overall.
- Non-attenders' knowledge about antenatal classes was derived from a broad range of formal and lay sources.
- Most non-attenders in the study indicated that they felt antenatal classes were 'not for them'.

4.7. Informal and lay sources of information and support

Apart from antenatal classes, there are many other ways in which expectant mothers gain information and practical or emotional support. Information derived from GPs and midwives, for example during prenatal checks, may be termed 'informal', while other sources such as relatives and friends, or books and magazines, may be categorized as 'lay'. It has been decided to amalgamate the presentation of results for these two categories, as very little data was collected in relation to informal (professional) sources, especially among the case-study participants. By contrast, all of the participants in the study had – to a greater or lesser extent – access to lay knowledge and support, mainly from relatives and friends.

For non-attenders of antenatal classes in particular, such lay support appeared to be crucial in helping to facilitate the transition to motherhood. Indeed, the results will suggest that expectant and new mothers with 'non-attender' social characteristics were more likely to make use of their comparatively greater access to lay support, often in the form of their families of origin. By comparison, many of those who attended antenatal classes used the emotional support opportunities within them to form local alliances with others in similar circumstances. This may have helped to compensate for their generally weaker family ties locally.

While there is some variation on this within both the attenders and the non-attenders in the study, a sufficiently clear difference exists to uphold the earlier assertion that antenatal classes may indeed be an ‘artificial community construct’ (Nolan, 1997).

The results will be presented as before, using case-study interview data followed by relevant data derived from the questionnaire survey.

4.7.1. Case-study participants’ use of informal and lay sources of information and support

During the prenatal interviews, the case-study participants were asked to describe sources of knowledge and support other than that obtained from antenatal classes. For non-attenders, such informal and lay sources were also, of course, the main sources. Initially, the expectant mothers tended to focus on informational support, mainly appertaining to pregnancy and birth, as the extracts below will illustrate. Beyond this, however, the participants were also asked to anticipate their main sources of support *after* the birth. Here, the emphasis changed to practical and emotional support, as might be expected, given the anticipation of a new baby to care for. As suggested earlier, social support may be broadly defined as ‘the resources provided by other persons’ (Cohen and Syme, 1985: 4-5). The mothers-to-be in this study were fully aware that such support would be necessary after their babies were born, and all had apparently given some thought to this prior to the interviews.

Below, then, are the responses given by the non-attenders, in response to the question, ‘What kinds of knowledge sources are you using?’

I’ve been reading the Pregnancy book that the midwife gives you when you first find out you’re pregnant. It goes through all the stages of pregnancy and labour. I’ve been reading all the leaflets; I’ve just been reading all the basic ones that the doctor

and midwife give you. But most of my knowledge comes from my Pregnancy book. I've been reading 'Baby and You' magazine as well, and 'Mother and Child'. (Mandy, interview one).

I've been reading books and leaflets and magazines – the Pregnancy magazine? I've been reading that one 'cos my friend – she gets them – and then she gives them to me. So, yeah, I'm usually reading something about it! You've got to be prepared, haven't you? (Laura, interview one)

I've got some books – from a car boot sale, actually, and there's a really good one – from Vogue. It's, like, years old, but it's really good. It tells you absolutely everything. (Joy, interview one)

I've got a few books I've read – pregnancy books that I've borrowed – and, I've heard all different stories from people as well. (Gina, interview one)

Clearly, the emphasis here is upon *pregnancy and birth* as described mainly in magazines and books. Were these women acquiring knowledge on a 'need to know' basis, after all? The non-attenders were also apparently dutifully reading leaflets distributed by GPs and midwives – an informal source as opposed to the other 'lay' sources. The following responses from participants who attended antenatal classes show very little difference in the range and choice of printed sources, however.

The midwife gave me a book called 'Emma's Diary', following a woman's pregnancy right through. It's got questions and answers in it. I get some magazines as well – 'Mother and Baby' magazine, or 'Our Baby' – whichever one looks best, each month really. And the leaflets from the midwife. (Tracey, interview one)

I've bought magazines like 'Pregnancy' and 'Babycare', and 'Pregnancy and Birth', and the various pregnancy books. You're given one by the Health Authority as well, before and after you have the baby. You're also given a booklet by your GP. So I've done loads of reading up on it, but it's a question of being able to put it into practice. (Barbara, interview one).

I've bought a couple of magazines – 'Motherhood and Birth'; 'Pregnancy and Birth' – stuff like that. They're quite interesting but I wouldn't buy one every month. I've read a lot of books as well. (Sally, interview one)

I'm buying magazines – 'Baby', 'Parents' – that lot. I think they're quite a benefit, actually. There are some good stories. They have features on various issues. (Diane, interview one)

Rhona had already experienced two miscarriages prior to this pregnancy and had therefore been reluctant to 'tempt fate' by reading a lot. She did admit to reading more now that she had reached the third trimester, however:

I've bought a couple of magazines, but actually I had a pile of them from the first time, and they tend to repeat the same things over again anyway – I guess they have

to, don't they? Because people buy them all the time, at different stages. But friends have given me magazines and leaflets, and whatnot. I've got a couple of books on active childbirth; water births, the Alexander Technique, and stuff - that I've been reading. (Rhona, interview one)

When asked about childcare books, Rhona replied, 'I haven't read anything!' This may have been typical, as the accounts above - from attenders as well as non-attenders - suggest. Reading about issues only as far as the birth itself appears to have been fairly standard for these expectant mothers. Only Barbara and Diane's descriptions suggest a consideration of infant care issues at this point.

As so little information about infant care had apparently been obtained from antenatal classes, both attenders and non-attenders were asked how they expected to learn about this very important issue. It had already been established that only four of the nine case study participants had any previous experience of dealing with babies.

Therefore, a genuine need for information was clearly evident. As Oakley (1992) has suggested, most new parents in the modern UK have not even held a baby until the arrival of their own. During the interviews, many of the expectant mothers seemed quite apprehensive about their lack of experience, particularly in view of the fact that they would soon need to care for their own babies. There was considerable hesitancy on the question of how they would learn such skills. Most appeared to be hoping, rather than expecting, that health care professionals would provide some guidance on the hospital ward, postnatally. Some were intending to rely on their own mothers or other relatives, however. The following examples of responses indicate a diverse mix of professional, lay and informal sources of support on this issue:

I'm hoping they'll show us in the hospital. And they say you don't have to bath it every day, so you can 'top and tail' it. And, um, people have given us hints, like

doing the eyes separately I case there's an infection. But, changing nappies, I mean, that's all they need, to start with, you know? Keep them clean, feed them, and they need plenty of sleep. So, I mean, [nervous laughter] I guess I haven't got up to that chapter in the book, actually! You know, when you get home and....um....what they need, and....(Rhona, interview one)

I think the midwife comes 'round after the birth, so she could always, you know, show me (Tracey, interview one)

My mum's been going through everything with me, like how to bath it, and everything like that. Because I didn't want to go to classes, 'cos I was a bit embarrassed? But my mum's been going through everything with me (Laura, interview one)

It is interesting that Laura, as a non-attender, was under the impression that infant care skills are an integral part of antenatal classes, whereas Tracey and Rhona, who had attended classes themselves, knew that they were not. Overall, it appeared that the expectant mothers were broadly aware of the deficit in their knowledge of infant care skills, but unsure of how to compensate for it. Thus, while most were entering the transition to motherhood with a reasonable knowledge of labour and birth, they were largely embarking upon the responsibilities of *mothering* on a wing and a prayer.

So, what were their expected sources of support after the birth of their babies? All of the case study participants were asked to consider this question during the first interviews. A broad distinction was observable, between attenders and non-attenders, with the former tending to emphasise the role of friends and the latter, relatives. Generally, though, it was *lay* support that was anticipated by all:

Friends, probably. I've got two friends with three year-olds, and another whose baby is a few months old. My parents are in Plymouth, but my mum doesn't really know much about babies; my dad looked after me while my mum was working. But I would go to friends with babies, more than my parents (Sally, interview one).

Probably our friends, who have got a couple of little girls. We've got a lot in common and we're the same sort of age. Yeah, I think I've got quite a good support group. Not as great as I would have in Bristol, where my parents and my brothers and sisters live but, again, if I was ill, my sisters would be on the train straight away, which is nice to know (Diane, interview one).

Definitely my mum. She only lives a couple of doors away, so I can just go and say, 'Help!' My mother-in-law's in Liverpool, so she can't exactly come to the rescue, so I think I'll be running to mum (Tracey, interview one).

My family are all in Australia, and his are up in Nottingham. So, it's really friends – and each other. I expect my neighbour, two doors down, to be brilliant, and also the couple in the next street, that we met at the NCT classes. They're due three days after us, so that'll definitely be a good reciprocal arrangement, as far as support is concerned (Rhona, interview one).

Probably my neighbours. There's a single parent living next door, with a daughter. She's sort of a friend. There's also a middle-aged couple at the end, who've been supportive during my pregnancy. They know that my husband's away a lot of the time. But my family are all in Sheffield, and my husband's are all in Lincolnshire. They're on the phone, but they're too far away to help, really (Barbara, interview one).

As indicated, four out of five of these attenders were expecting to rely upon friends and neighbours for support postnatally. Only Tracey had close family living nearby. The fact that the other women described the absence from their locality of their own relatives suggests that, had those same relatives been *available*, then perhaps they would have been their first choice for support. To some extent, these descriptions reinforce the point that antenatal classes may serve to compensate for the comparative absence of close family support among those who elect to attend them. The non-attenders, by contrast, seemed to have much more in the way of family support upon which to draw not only prenatally, but also postnatally. These are their descriptions of their anticipated sources of support after the birth of their babies:

I think my mum will help, 'cos she already helps with my sister's baby. And my sister will probably be quite good as well. So I would ring my mum first, but if I thought the baby was ill, I would contact the doctor or health visitor (Gina, interview one).

Not my own mum, but I think my grandmother will be supportive, and my 'in-laws', especially my partner's mum. We haven't really got friends who would be helpful, but there are neighbours in the block [of flats] that've got kids. There are some other young mums (Mandy, interview one).

Well, my mum, obviously. But not really friends. I don't really have lots to do with people my age, 'cos they're just after one thing off everybody and they don't really care about anyone. But, like, my mum's friends and my next door neighbours are like friends, you know? (Laura, interview one).

Probably my mum and my sister. My cousin's moving here as well. So, yeah, I've got a lot of help if I need it (Joy, interview one).

Clearly, these women's circumstances were qualitatively different from most of the antenatal class attenders. All had their own mothers (as well as other relatives) living

close by, and all except Mandy were anticipating a great deal of support from them. By contrast, friends were mainly absent from the equation. Laura, in particular, suggested that friends of her own age would not be appropriate as supporters. This may be due to the fact that, at seventeen, there would perhaps be limited availability of friends for whom babies had any lifestyle relevance. Mandy and Joy had already intimated that their own mothers might be 'interfering', and so both were rather cautious in that respect.

There were no expectant mothers among the case study participants who felt, prenatally, that they would not be able to mobilise support *postnatally*. This may be important in terms of their transition to motherhood, as it has been claimed that, irrespective of either quantity or quality, the ability to mobilise social support may be inversely related to depression (Cutrona, 1986). Social support is generally thought to act as a stress buffer and, in the early days of life with a new baby, may have a beneficial effect on mothers' psychological well being (e.g. Oakley, 1990; Tarkka and Paunonen, 1996; Lee, 1997). Therefore, it will be necessary to revisit this issue later, to find out whether the participants' expectations of support were matched in reality.

Finally, the participants who were living with the baby's father were asked whether and to what extent they expected their partners to be supportive following the birth of their child. Nearly all of the participants were optimistic about the extent to which their partners would get involved. There were no clear differences between attenders and non-attenders, in this respect. Nor were there any particular differences between those whose pregnancies were planned and those that were not. Indeed, Laura was perhaps the only mother whose pregnancy was so 'unplanned' that the baby's father had already written himself out of the equation. Interestingly, the responses were

couched mainly in terms of what partners might do for the baby, rather than for the women themselves:

He'll do everything. I won't have to ask him; he'll just do it. He's already said to me that, although he works long hours, he wants to do the night feeds and that, so.....he's as good as gold (Mandy, interview one).

Very supportive. He'll be here more or less for the first three or four months, and it'll be a lot easier for me. Even if he's not there to feed because I'm feeding it, he'll still give me a hand with the housework, or cook. And I know he won't mind doing it. He does it now. So, yeah, he'll definitely get his hands dirty (Diane, interview one).

I think he'll do a lot, to do with the baby. I think he'll be very helpful. He'll probably be more into helping with the baby and taking over with the baby, perhaps, than doing the housework (Rhona, interview one).

Well, he's taking two weeks off work, which he says he wants to take to really get used to – well – learning off me, really! So we can feed it and change it and bath it, and really get used to the idea (Tracey, interview one).

Only one of the responses appeared significantly less optimistic than the others:

I reckon he'll be alright in the beginning, but I reckon he'll get a bit fed up. I've got a feeling he'll just... 'cos with your own [baby], it's gonna be here all the time, isn't it? (Gina, interview one).

It could be argued that Gina's expectations of partner support may be quite realistic, given the extent to which male partners' enthusiasm tends to wane after the first couple of months with a new baby (Nicolson, 1990). As with the general social support sources considered above, the outcomes of partner support postnatally will be revisited later, to ascertain whether or not the mothers' generally high expectations were justified.

Before going on to consider the range of informal and lay support sources utilised by the questionnaire respondents, it should be re-emphasised that the expectant mothers above did not refer to psychosocial issues when anticipating postnatal support. In other words, they appeared not to have considered emotional support for themselves in what could reasonably be expected to be a rather traumatic life-change. Instead, they had focused on infant care and housework tasks, just as when considering

infant care, they had anticipated practical, rather than emotional issues. This may be unsurprising given the lack of attention to emotional issues in antenatal classes. For the non-attenders, with close family ties locally, this is rather more surprising, however. One might have expected them to show more of an awareness of such issues. As it happened, virtually no acknowledgement was made, and it will remain to be seen whether or not this was a realistic stance to adopt.

In summary:

- In late pregnancy, participants sought mainly *informational* support, especially related to pregnancy, labour and birth. This was mainly derived from lay sources, particularly printed media, supplemented by informal sources such as leaflets distributed by health professionals.
- Few, if any, differences were distinguishable between attenders and non-attenders of antenatal classes, in terms of the above.
- Information about infant care was marginal by comparison with labour and birth. What little there was had been obtained from lay sources, although informal support was anticipated postnatally by some of the antenatal class attenders.
- Anticipated postnatal supporters were mainly friends, for antenatal class attenders and relatives (especially the woman's own mother) for non-attenders.
- All of the participants expected to be able to mobilise appropriate lay support postnatally.
- In terms of partner support after the birth, the majority of participants (both attenders and non-attenders) were optimistic about how involved their partners would be.
- Anticipated partner support was nevertheless focused primarily upon practical, rather than emotional issues.

4.7.2. Questionnaire respondents' use of informal and lay sources of information and support

In view of the fact that questionnaires were distributed to new rather than expectant, mothers, it was clearly not possible to ask about *anticipated* postnatal support. Instead, these respondents were asked to indicate the importance for them of various lay, professional and informal support sources. From ten categories ranging from friends and relatives to health professionals and mass media sources, the most important sources of support overall were felt to be midwives, closely followed by health visitors. GPs and partners shared third place, with 56% of new mothers rating their support as 'very important'. By contrast, the least important sources of support were felt to be 'other relatives' and TV programmes. Only 20% and 13% respectively thought that these were 'very important'. Some qualification of these responses is necessary, however. The timing of the questions, coming during the period of new motherhood, rather than in late pregnancy, almost certainly had an effect. For example, the 'books' and 'magazines' categories are underrated by comparison with the views of the case-study participants, as evidenced in the previous section. While only 20% rated magazines as 'very important' postnatally, the same question might well have elicited a very different response if posed before to the birth. Similarly, the popularity of health visitor support among the questionnaire respondents is consistent with their status as new, rather than expectant mothers. For the case-study participants, such support was largely irrelevant. To this extent, such comparisons between the two sample groups are severely limited. Nevertheless, these differences are useful in highlighting the changing nature of support as the transition to motherhood itself progresses.

Despite the limitations outlined above, the data reveals some significant comparisons between both groups of respondents. For example, it has already been suggested that non-attenders of antenatal classes attach more importance to the support of their own mothers, by contrast with the attenders, for whom friends are more significant. This again supports Nolan's (1997) claim that formal antenatal education acts as a substitute for the traditional female community support network.

The issue of social support will be revisited later, as part of the process of exploring the social impacts of the transition to motherhood for those in this study. At this juncture, however, it is necessary to consider the women's *expectations* of birth and motherhood, in the light of the information and support thus far received by them.

This is the subject of Chapter Five.

Chapter Five: Expectations of motherhood

5.1. Introduction

This chapter explores the expectations of the case study participants as they neared the end of their pregnancies and approached the impending birth and new motherhood. The chapter will be structured in the following way. First, the women's expectations of the birth will be explored against the backdrop of the preparation received by them, from the range of sources outlined above. Second, their expectations of infant feeding will be investigated, followed by their expectations of motherhood generally. Finally, the chapter will look at participants' views about the anticipated effects of a new baby on their relationships with their partners.

5.2. Expectations of the birth

Originally, my intention had been to focus only upon the *social* aspects of the transition to motherhood. Birth itself, which I felt was over-researched by comparison with the key themes investigated here, was not intended to play a large part in this study. This is not to suggest that the birth itself is unimportant. On the contrary, for any expectant mother this is a critical process which represents the defining moment of the transition overall. However, despite never intending to ignore the birth entirely, I found increasingly that it would have been arrogant and insensitive not to ask participants how they felt about the upcoming birth. Similarly, when interviewing mothers with their new babies, it would have seemed improper to ignore the process by which their babies had arrived. New mothers are famously enthusiastic about 'debriefing' in any case, so that is how this particular aspect of the

transition to motherhood found its way into the study. As it happens, the resultant data were quite illuminating.

The following citations outline the expectations of the birth as felt at the time by some of the non-attenders of antenatal classes. The main focus was upon pain relief, especially their willingness to accept it if offered:

I've seen most of the things they've got up there, from when my sister had her baby. So I didn't bother going on a tour of the labour ward. But I've decided I'll probably go for the epidural anyway (Gina, interview one).

I'm having the epidural – they've got that on my notes and everything. I've got a birth plan, but my midwife has said that things don't always go the way you think they will. But I don't mind how much pain relief and stuff I have, because if it's got to be done, it's got to be done (Laura, interview one).

Joy was unique among the non-attenders, in anticipating less, rather than more intervention during the birth. Her view is consistent with her reasons for choosing not to attend antenatal classes, preferring to do things 'her own way':

In the book the midwife gave me, it tells you all about the drugs and stuff, in labour? I've decided that I wouldn't have anything except the gas and air. I don't want an epidural because I've heard that you can get back problems. That's what some of my friends have said (Joy, interview one).

By contrast, those who had attended antenatal classes were keen to adopt a more 'natural' approach to labour and birth. Like Joy, Diane was firmly against the idea of having an epidural:

I want to try and go for a natural birth. I'm going to try and stick it out in the bath for as long as I can, and then whack the TENS machine on, and have a go with that. I don't want an epidural. I don't like the idea of a needle being stuck in my back. My sister had a lot of back trouble after an epidural. So I've got it in my birth plan, and I've told my husband, 'No matter how much I'm screeching, do NOT let me have an epidural' (Diane, interview one).

Rhona, on the other hand, whilst also in favour of a 'natural' approach, was less against epidurals than the painkilling drug Pethidine, which she had researched as part of her course of NCT classes:

Well, we would *like* a natural childbirth. I mean, I really don't want Pethidine. Perhaps if I did have something, perhaps an epidural (Rhona, interview one).

These views are fairly representative of the non-attenders and attenders, respectively. In terms of their social characteristics, their expectations of birth, and particularly their views on the desirability or otherwise of analgesia, are consistent with the findings of Nelson (1983). Here, she argued that working class women are less concerned than middle class women with the process of birth itself, and more concerned with the end product – the baby. On the face of it, it would appear that non-attenders are generally less 'anti-intervention' than attenders, although lay sources of information, such as family and friends, also seem to be quite influential in this respect.

Kate Figes, writing in *The Guardian* has recently argued that the NCT in particular is guilty of fostering unrealistic expectations of childbirth: "The purpose of childbirth is to have a baby rather than to experience labour, but the NCT ignores that – preparation for parenthood in its classes is almost non-existent." (Figes, 2000)

The NCT does, however, encourage women to question childbirth procedures, including the place of birth, as Rhona discovered:

The midwife and doctor didn't really give us an option. And you just accept that. But at the NCT classes, it was pointed out that, as the first labour is the longest, it's the ideal time to have it at home. So we thought about it, and I mentioned it to my midwife, and she just sort of said, 'Oh, *next* time, dear, if everything goes well.' (Rhona, interview one).

Given that all nine of the case study participants were planning to have their babies in hospital, it began to appear questionable whether, in fact, any choices had been offered about the place of birth. One of the central tenets of *Changing Childbirth* (Department of Health, 1993) had been a renewed emphasis on maternal choice. When this issue was raised with the participants, however, very little awareness of this was evident:

If it's your first baby, you have it in hospital. That's what the midwife said. She said, 'If it's your first one, you must have it in the hospital.' (Diane, interview one).

When asked if she would have wanted a home birth, however, Diane replied:

Well, I would rather be in hospital for my first, because I don't know what it's going to be like, and I'd feel safer there (Diane, interview one).

Despite this decision, Diane was clearly led to believe that she did not have a choice.

This was also the case for Joy and Mandy, who claimed:

I wasn't given a choice about hospital or home. No-one actually said anything to me. It's all – *assumed* – that I was going to go to hospital. I don't really mind, but maybe if I had another child, I might have it at home, 'cos, I mean, I do *like* the idea (Joy, interview one).

No. It was never mentioned. I would have liked to have been offered it, but I thought maybe it was because it was my first baby (Mandy, interview one).

The remainder of the participants had no strong views. Most just went along with the expectation of a hospital birth. Notably, however, not one of the participants was offered a choice in this. A national survey undertaken by the NCT (1997) found that sixty per cent of women were not offered a choice about the place of birth, despite home birth coming out as the preferred option by seven per cent of women. The fact that the hospitalization rate for childbirth remains at ninety-eight per cent clearly implies that these women's choices are not being met. Indeed, the NCT's report claims that there is still strong resistance to home births from health professionals. The case study accounts, outlined above, appear to suggest that some community midwives may be less than enthusiastic about home births, especially for first-time mothers. Therefore, all of the women were booked for a local hospital birth.

By the end of their pregnancies, the case study participants were understandably very keen just to have their babies. Some of their diary extracts reveal the extent to which they felt 'fed up', and were longing to get the process of birth out of the way. As these extracts show, there were many conflicting feelings of excitement and apprehension:

I feel a lot happier with my friend (a very experienced midwife) here. I'm not worried about the labour at all. And we're ready now – all organised, I think. I can't sleep at night – am looking forward to at least *some* sleep when the baby comes.

And, 2 days later:

I feel so excited, I've had all the signs that I'm in labour. (Rhona, diary entry)

Tracey also wrote of feelings of excitement at the impending birth:

We're counting down the days now – wishing time away, both getting excited. I'm looking forward to getting the birth over with. I've been feeling heavy and tired lately and had bad heartburn for a week now. Just 18 days to go to my due date. I wonder what date it'll actually arrive! (Tracey, diary entry)

Tracey's 'due date' came and went, however, with no signs of labour. By this time, she was evidently quite fed up. Almost three weeks after the entry above, she wrote:

Felt fed up today. Went for a walk and saw a few people, neighbours etc. and we had the same conversation with everyone we saw: "You still here?" or, "Haven't you had it yet?" If the hospital let me go two weeks over, it could be another 12 days yet. I HOPE NOT! Family and friends keep phoning to see how I am. I know they mean well, but I have nothing to tell them. (Tracey, diary entry)

Four days later:

Resorted my hospital bag – baby 6 days late now.

And the next day:

Still nothing happening.

Finally, two days later, Tracey was admitted to the maternity unit suffering from high blood pressure. After two days under observation, amid confusing messages from her health carers, Tracey was clearly becoming even more fed up:

STILL IN HOSPITAL. Blood pressure higher again. Doctor keeping an eye on it today. If still high, will induce me at 6pm today. Later, lady doctor came round – told me Induce put off 'til tomorrow. I got very upset. I'm fed up with one minute being told something, next minute something else. (Tracey, diary entry)

This account of the late stages of Tracey's pregnancy shows how frustrated she felt, waiting for the onset of labour. Laura, who also kept a diary, experienced similar feelings when her due date came and went, with no signs of her labour beginning:

2 days over – I'm fed up. I want it all to be over and done with now. (Laura, diary entry)

Several days later, there were still no signs of the onset of labour, although a possible induction had been discussed during a clinical checkup:

I am 9 days over now and getting more and more fed up – I am so frustrated. I've been walking everywhere today, but nothing is happening.

And two days later:

I am 11 days overdue. Well, I guess they will have to start me off after all. I'm scared, excited and happy that it shall all be over soon (Laura, diary entry).

Feeling 'fed up' and excited were evidently the most common feelings experienced by these first time mothers-to-be. After nine months of pregnancy, they all felt ready, albeit with different expectations of the birth itself, to embark on the process of new motherhood. But what were their expectations of new motherhood, in terms of the impacts on themselves and their partners? How would they adapt to the demands of twenty-four hour care for themselves and their new babies? In order to begin the process of comparing expectations with experience, the discussion will now turn to planned methods of infant feeding.

Summary

- A broad distinction was discernible between attenders and non-attenders, in terms of the desirability of clinical interventions during childbirth.
- Non-attenders showed a greater desire for analgesia during childbirth, whereas the attenders had higher expectations of a 'natural' birth.

- Towards the end of pregnancy, most of the case study participants were ‘fed up’ with being pregnant. This feeling became more pronounced as due dates were exceeded.
- Earlier apprehensions about the birth itself tended to give way to ‘excitement’ as due dates were approached or exceeded.

5.3. Expectations of infant feeding – planned method prior to the birth

In recent decades, numerous social changes, including the rising number of women in paid employment, increased geographical mobility etc, have resulted in diminishing traditional support networks for many new parents. Smaller nuclear families now tend to be relatively isolated, and opportunities for learning basic life skills such as parenting have diminished accordingly. One consequence of this trend is that the majority of new parents have no firsthand experience of infant care before their own children arrive. Another is that women have far less exposure to the practice of breastfeeding in their own communities.

This cultural trend may have impacted on the breastfeeding rate nationally which was 45% during the 1980s (Martin and White, 1988), although this had increased to 68% by 1995 and to 71% by 2000. However, these figures represent the prevalence of *initial* breastfeeding (i.e. at birth) whereas, after six weeks, the figure is around 43% in England and Wales (Hamlyn et al, 2002). Within this, there is considerable variation between social classes, with middle class women being more likely both to initiate and to continue breastfeeding beyond six weeks. In fact, the report’s authors suggest that the improvement in breastfeeding levels nationally since the 1980s may be due to the older average age at which women are now giving birth for the first time. Nevertheless, the promotion of breastfeeding generally continues to be a core health promotion issue, which accounts in part for the very positive way in which

this topic was covered in the antenatal classes attended by those in this study. It is in this cultural context that the participants' choice of feeding method will be considered.

As breastfeeding was the first choice for most new mothers in the study, this method of feeding will be considered first. Among the case-study participants, not all of those who intended to breastfeed offered clear reasons for that choice; they just felt that it was 'for them'.

Ideally, I'd like to breastfeed. (Sally)

Yeah, I want to breastfeed, although I don't know much about it. (Joy)

I definitely want to breastfeed. (Rhona)

Others were clearer about their reasons, articulating them in more detail:

Well, it's for the baby, really. They say that the colostrum is beneficial, but also, the mums from another [antenatal] class came back and we noticed that all the the breastfed babies were really quiet, and all the babies that were crying were the bottle fed babies. So I think breastfeeding makes the baby more content. Even before the classes, I had more or less made my mind up about breast-feeding. But if I can't breast-feed I'm not going to bash myself over the head about it. (Diane)

I do want to try to breastfeed. I think it's better for the baby; more nutritious. So I will if I can. (Barbara)

I've been planning all along to breastfeed. I think it's more natural. (Tracey)

Those who intended to bottle feed went into more detail generally about the reasons for their choice. This may have been due to a perceived need to *justify* their decision:

I've heard a lot of people have problems with breastfeeding. Um....some of my friends have got mastitis from breastfeeding and others have been so red-raw that they basically had to go on to bottle feeding. Um....my other excuse for bottle feeding was - because my partner wanted to be involved as much as possible - bottle feeding, he could be involved. But then, there's expressing milk, isn't there? So..... I just felt that bottle feeding was the best thing for us to do. (Mandy)

This explanation reveals both 'push' and 'pull' factors. It is interesting that Mandy has conceptualised her rationale for bottle feeding as an 'excuse'. Indeed, most participants seemed to be aware that breastfeeding is generally considered to be the

healthier option. Cultural familiarity with bottle feeding tended to outweigh such considerations, however:

I'm gonna bottle feed. I think breastfeeding's more nutritious for them, or something. I've *never* thought of breastfeeding, though. I've always wanted to bottle feed. That's what I've, like, *known*. And I'd prefer that, anyway. I'd find it easier. People that breastfeed, they've gotta just - it's just *there* isn't it? I couldn't *imagine* myself doing that! So I've just thought of bottle feeding from the start. I've seen other people in my family doing it, and so that's my choice. I've got some milk tokens, so my mum told me to get a few tins in, just in case. She said it's always handy to have some tins in. (Gina)

Gina's explanation for her choice of feeding method suggests both a strong cultural influence and some degree of embarrassment about breastfeeding. This combination of reasons also accounts for the following participant's choice:

I don't want to breastfeed 'cos I've got eczema - really bad, everywhere. I wouldn't feel comfortable, obviously. And the bottle feeding - my mum's been showing me, and I've seen her doing it with my little sister, so But the midwife goes on and on about breastfeeding - 'It's good for the baby, it's good for the baby', you know? (Laura)

Each of the three participants above were young (twenty-one years or under) non-attenders of antenatal classes. Among the case-study participants overall, the tendency was for older attenders of antenatal classes to choose breastfeeding and for younger non-attenders to choose bottle feeding. What is highly questionable, however, is the extent to which antenatal classes influence women's choice of feeding method. A local community midwife who was interviewed in connection with this study claimed:

I think most people know, long before they are ever having a baby, what their gut feeling about it is. Not necessarily that they've thought about 'Will I breastfeed?', but they will either have a view that that is the best thing to do, *or* they'll have a complete disgust - which some people *have*. (Community Midwife)

This view is supported Earle (2000), whose prospective qualitative study found that the majority of mothers make feeding decisions either before conception or early in pregnancy. Gregg (1989) claims that early in childhood, girls form opinions of breastfeeding as either 'rude', or 'best for babies'. It is not possible to claim with

any certainty that this applies to the women in the case studies, as they were not asked to indicate the duration of their beliefs and preferences. Nevertheless, most participants did express quite firm views either for or against breast/bottle-feeding, and the women's own references to cultural influences does indicate a pre-existing preference in most cases. White et al (1992) found that a woman whose mother or friends had breastfed was more likely to breastfeed also. In retrospect, it would have been useful to ask the mothers which method of feeding their own mothers chose.

Questionnaire respondents (who had all had their babies already) were asked how their babies were fed up to the age of three months, and whether that was the *planned* method. If not, they were asked to explain why they changed. The choice to bottle-feed was the smallest category. Three of the nine case-study participants chose this method, while only three of the thirty-nine questionnaire respondents did so. Five of the questionnaire respondents chose 'both' (i.e. to breast and bottle-feed), but none of the case-study participants chose both methods. The largest chosen category was breastfeeding. Thirty-one of the questionnaire respondents had chosen this method, together with six of the case-study participants. This amounted to thirty-seven mothers altogether, 77% of the new mothers in the study.

Summary

- A clear distinction between attenders and non-attenders of antenatal classes was evident, in terms of planned infant feeding method.
- Among the case study participants, the majority of non-attenders planned to bottle-feed, whereas all of the attenders planned to breastfeed their babies.
- Cultural factors, rather than attendance/non-attendance at antenatal classes, appeared to be most influential in this respect.
- Expectant mothers who planned to breastfeed perceived this method as 'natural and nutritious'.

- Expectant mothers who planned to bottle-feed chose the method for convenience, despite showing an awareness of the nutritional superiority of breast milk.

5.4. Expectations of being a new mother

Having established how the expectant mothers felt about the upcoming birth, and their plans for infant feeding, they were then asked to describe what they thought being a new mother would be like. Two of the women who had attended antenatal classes and who were accustomed to full-time employment prior to the birth, were optimistic while stressing firm intentions to maintain organization and *control* in the postnatal period:

I think it'll be alright, as long as we have the house tidy every night before bed, and whatnot. And if I shower before my partner goes to work, and at least get *dressed*, even if I go back to bed – at least I'll be up – and not in my nightie at one o'clock in the afternoon, as people say happens! And, this is all how we'd *like* it to be, but whether or not it will be like that... (Rhona, interview one).

I think I'm quite realistic about it. It's just about organisation, isn't it? If you're organised and efficient, I don't see the problem (Diane, interview one).

Apparently, both of these women assumed that good planning and organisation would be the key to managing their new lifestyle successfully. Crying babies and lack of sleep were not mentioned, although the following two accounts suggest a greater awareness of these issues in the early postnatal period:

Broken nights. Not much sleep. I think it will be very tiring to start with (Tracey, interview one).

I think it'll be alright, really. I know what I've got coming to me, with my sister (Gina, interview one).

These two accounts suggest quite realistic expectations, based in part upon observation of the experiences of others. Despite acknowledging such issues, neither of these expectant mothers appeared to be particularly fazed at the prospect. Others,

however, were evidently quite worried about the prospect of motherhood, especially the demands of caring for a new baby:

I'm scared. I am very scared. To be honest, it's just things like – this baby, it's so small – I think, 'How am I going to change it? How am I going to bath it?' You know? I never got scared until I was about six, seven months' pregnant and I suppose it was real then, you know? It was really going to happen (Laura, interview one).

It fills me with quite a lot of panic, actually. I mean, I am a worrier and a panicker anyway, so that's not surprising, but I sort of think, 'Will I know when it's hungry or whether it's crying 'cos it's ill, or some other reason? Will I know what to do? Will I know how to bath it properly?' And sometimes, I get quite frightened about it. I mean, I do want the baby, but it panics me to such an extent that I think, 'Oh God, what am I doing?' I mean, I'm looking forward to it, but with apprehension! It does worry me. I'm looking *forward* to it, but I just can't imagine what it's going to be *like* (Sally, interview one).

There are perhaps rather different explanations for these two sets of concerns. Sally, for example, explains her own anxieties in terms of her personality; she describes herself as a natural worrier. Additionally, however, there is evidence that a lack of previous experience of infant care exacerbates her sense of apprehension. The fact that she claims not to be able to imagine 'what it is going to be like', is in stark contrast to the description of Gina, for example. Therefore, it seems that lack of previous access to, and observation of new babies and their primary carers engenders greater uncertainty in expectant first time mothers. Barbara's feelings about new motherhood, as outlined below, also suggest that lack of previous experience adds to the sense of trepidation:

Um...I feel very happy. But I haven't looked after a tiny baby before – that scares me, in a sense (Barbara, interview one).

Laura's uncertainties about new motherhood are ostensibly couched in terms of fears about caring for the baby. However, her circumstances – being very young; living in her parental home and without the baby's father, clearly add to her sense of vulnerability. Uncertainty about her housing situation and longer term employment prospects clearly influenced her feelings of being 'scared about everything'. Indeed,

looking at the case study participants' characteristics overall, it would appear that housing tenure, marital status and access to full-time employment for one or both partners determines the general sense of security overall in the transition to parenthood. Mandy, for example, seemed to share some of Laura's sense of vulnerability, and hence uncertainty, based on similar social and material factors. She and her partner were living in council-owned accommodation, on a low income, and without private transport. Mandy felt that her family would be 'interfering', which added to her general sense of apprehension at the prospect of motherhood. When asked what she thought being a new mother would be like, she described her feelings thus:

A big upheaval. Because, even though I've known I've been pregnant for eight months, in a couple of weeks, I'm going to become a mother! And it's just hit me, that. Whether we're going to get everything right. People criticising; saying whether I'm doing the right thing. Interfering – something like that. It's just very – different. Learning how to do the feeds; changing nappies; making sure you've sterilised everything properly. And if it's crying, and doesn't want feeding and changing, what could be up with it? Looking out for illnesses and everything – it just brings you to reality. It's starting to get a bit worrying now. And with everybody, well – there's been a lot of interfering on my side of the family, and I am really worried at the moment. But it's just waiting and seeing, really (Mandy, interview one).

Mandy's expectations share similarities to others in the study, especially concerning infant care tasks. However, she also highlights the sense of 'realising' that there will soon be a real baby to care for. The category 'realising' was an important one in the research undertaken by Rogan et al, (1997). In this, the ways in which women adapted to new motherhood, and the strategies they adopted, were studied in conjunction with their previous experience of infant care. The research found that many new mothers took some time to reach the point where they consciously realised, 'this is my baby and I have to care for it'. Among the case study participants, there is some evidence that the state of 'realising' has a precursory stage, prenatally. This can be recognised also in Joy's account, below, of her

expectations of new motherhood. Here, she too alludes to feelings of apprehension, even worry, at the prospect:

Like I said to you on the phone, I've been worried, this past week or so, because it's becoming so close now. You know, I'm just thinking...you know...I mean, my husband says he'll take a week off work, and I'm thinking. 'Oh, great! Thanks!', but you know, I've got a lot of people around me, so...(Joy, interview one)

It appears from this statement that Joy had anticipated a longer period of initial support from her partner, whose long hours of work she had already expressed irritation about. However, she also accepted that other relatives would be available to help if necessary. Her feelings are perhaps supportive of Levitt et al's (1986) assertion that a shortfall of partner support can have a deleterious effect, even if substituted by support from other quarters.

Summary

- Most expectant mothers felt apprehensive at the prospect of new motherhood.
- Those without previous infant care experience were most concerned about managing basic infant care tasks.
- The younger non-attenders felt most vulnerable about potential interference from relatives. Such vulnerability seemed to be linked to financial insecurity.
- Older, married attenders who had worked full-time prior to the birth were most optimistic about establishing and maintaining control of their postnatal situation.
- Those with experiential knowledge of infant care appeared to have the most realistic expectations of new motherhood.

5.5. Expectations of the effect of new parenthood on couples' relationships

Apart from concerns about labour, birth and the prospect of caring for a new infant, the expectant mothers in the study were also on the brink of a tremendous change in their household dynamics. The transition from couple to family is profound and

irreversible; it represents probably the greatest change that most couples will ever experience. The impact upon couples of the transition to parenthood has, in the past, been described as a time of ‘crisis’ (e.g. Dyer, 1963; Le Masters, 1957), whereas more recently, the less dramatic term, ‘disruptive’, tends to be applied to this period (Marks and Lovestone, 1995). As well as gaining a new infant, which may confer considerable happiness, this period is often characterized by loss and constraint, financially and socially. Most studies have found that in the first year following the birth of a child, marital relationships take a downturn (e.g. Glogertippelt, 1995; Dalgas-Pelish, 1993). Fatigue and stress arising from infant care demands also takes its toll on sexual relations (Elliott and Watson, 1985). Fathers may feel excluded when mothers are closely involved in caring for their babies, especially if breastfeeding contributes to a feeling of marginalization (Raphael-Leff, 1991).

Nichols’ (1995) study found no difference between attenders and non-attenders of antenatal classes in terms of these impacts. Some research has suggested, however, that the quality and stability of the prenatal relationship may imply less disruption and greater satisfaction postnatally (Gladieux, 1978). Tomlinson et al (1990) suggest that married partners have more positive family dynamics in the transition to parenthood, which may be explained by ‘continuing societal approval of the traditional family form’ (Tomlinson et al, 1990:687).

With these issues in mind, the case study participants were asked to describe how they felt the arrival of a baby would impact upon their relationships with their partners. Some of the most positive responses were, indeed, elicited from those who were married and whose pregnancies were planned:

I think we’ll be okay. We’re both very down-to-earth. Quite good, strong moral values. So I think we’ll be okay. And we’re not – as far as our relationship goes – I

think we're not into fighting or anything anyway. We've never really had a fight (Rhona, interview one).

I think it's what we've both always wanted – to have a baby. And, um, on the physical side, we probably haven't done much in the past few months anyway, because he's been worried about me and the baby. He has been a lot more attentive and caring during the pregnancy (Barbara, interview one).

Tracey also anticipated few or no problems as, again, the baby was very much wanted. Indeed, her husband had been hoping for a child for the past four years, and was now 'really excited'.

Mandy, whose pregnancy had not been planned but, along with her partner, was very pleased at the prospect, described the expected effects on their relationship as follows:

To be honest, I think it'll make it stronger. Because he actually adores children. He wanted to become a father anyway. Um...it *was* an accident – I mean, it's taken me a long time to adjust – but I do actually think it will make us stronger, rather than fall apart. I do think it'll make us stronger, so...I'm *hoping*! (Mandy, interview one).

Mandy's expectations are clearly optimistic, although laced with hope, rather than certainty. Gina, on the other hand, was far more hesitant about the prospects for closeness as a result of the baby's arrival:

I dunno, I don't know whether it'll bring us closer, like, 'cos we'll be a proper family then. We're quite close now, but he's , um...I reckon when the baby's here, he'll feel more closer to us both , then. Yeah, I do. Yeah, 'cos he can't wait. And I reckon he'll be quite good, so I'm looking forward to it, in a way (Gina, interview one)

Gina had to think long and hard before offering this response. It was clearly an issue which troubled her even more than her description suggests. 'Uncertainty' would probably be the best term to describe the anticipated effects of the baby on their relationship.

Diane had clearly given this issue considerable thought, and was apparently quite realistic about the extent to which a new baby would impact on her relationship with her partner:

I think it'll change things quite a bit. I think in a good way, but I don't think he fully realises how – um – how much *time* it's gonna take up. I don't think a lot of blokes do. I don't think he really realises it. But he'll adjust. He's quite good at adjusting. It'll take him a bit of time, I think. And we talked long and hard about it, 'cos we had a couple of years to discuss it, so it's not out of the blue (Diane, interview one).

Diane acknowledges here that she understands that a baby *will* generate changes in the parental relationship. Very few of the expectant mothers did acknowledge this. Additionally, Diane implies that she anticipates how much time the care of a baby will take, and this is the main focus of Joy's description, below:

Um, I think it's gonna bring us even closer, because at the moment he doesn't see it as a baby, he just sees it as a bump. And he said, 'When the baby's out, I'll get excited because it's a baby.' But he's a typical working man, 'Oh, I can go to work and someone else can look after it.' Because he just works so much. And he's just got a promotion, so he works even *longer* hours, even in the evenings. And then, every other weekend, he sees his kids, and every other weekend he's *working*. So, you know, he's got to change, when the baby's actually born. He's just gonna have to spend more time at home (Joy, interview one).

This expectation already suggests potential difficulties in the postnatal relationship. Joy's concerns about her partner's long working hours are reflected in the literature, where the irony has been noted that, just as fathers need to spend more time at home, the requirement to earn more money forces them to work longer hours (e.g. Raphael-Leff, 1991; O'Brien, 1982).

Overall, the mothers-to-be in this study were clearly quite divergent in their views of how a baby would impact on their relationships with their partners. Certainly, there is some evidence to suggest that the current state of the relationship may influence expectations of how things will pan out, postnatally. A return to these issues in later chapters will illuminate the extent to which the case-study participants were accurate or otherwise in terms of their expectations.

Summary

- Most of the participants felt that the arrival of the baby would strengthen their relationship with their partner, and bring them closer together.

- Those with unplanned pregnancies seemed more hesitant about the extent to which the baby would bring them closer to their partner.
- Practical impacts received less attention than emotional impacts. However, time taken to care for a child was an issue of concern for two of the mothers-to-be.
- Overall, the expectant mothers were mostly positive about the likely impacts of the transition to parenthood on their relationships with their partners.

This chapter has outlined the case-study participants' expectations of motherhood in terms of childbirth, infant feeding intentions and 'becoming a mother'. It has also incorporated women's expectations of relationship impacts resulting from the transition to parenthood.

Expectations of the birth were structured along the lines of an inverse relationship between social class and desired levels of medical intervention in childbirth, as suggested by Nelson (1983). Feeding intentions appeared to be strongly influenced by cultural factors, such as whether breast- or bottle-feeding seemed the 'normal' thing to do. In particular, the younger and less well-educated non-attenders of antenatal classes showed a propensity for bottle- rather than breastfeeding.

Expectations of motherhood generally appeared to be fairly realistic, although this was influenced by previous infant care experience. Those who had been involved in caring for babies before were more likely to acknowledge issues such as crying and lack of sleep. By contrast, some of the antenatal class attenders who had worked full-time prior to the birth were (perhaps unrealistically) expecting to be able to exert similar levels of organisation and control in the postnatal situation. Almost all of the women expressed some degree of apprehension at the prospect of new motherhood, however.

Finally, the participants highlighted practical as well as emotional issues in relation to anticipated relationship changes. Such practical issues focused on infant care and housework tasks, while emotional facets of such change related to expectations of feeling 'closer' to partners after the birth. Becoming a family, instead of a couple, was an integral part of this.

Having outlined the participants' expectations in these areas, the following chapter considers the *reality*, as the focus moves on to their experiences in early postnatal period. Here, the questionnaire respondents' views are also integrated as appropriate.

Chapter 6: The Early Postnatal Period

6.1. Introduction

The participants' expectations of many key aspects of new motherhood have now been explored, against the backdrop of various types of formal, lay and informal preparation. In this chapter, their experiences will be compared with those prenatal expectations. First, their perceptions of birth and the hospital experience will be examined, and the usefulness of various types of preparation for this, assessed. Following this, the new mothers' infant feeding and general infant care experiences will be considered, and questions raised once more about the extent to which they felt adequately prepared for these responsibilities. Finally, the issue of parental relationships will be revisited, to question the nature and extent of changes generated by the arrival of a new baby. As before, prenatal expectations will be compared with the reality of the postnatal situation.

The case study participants were interviewed about six weeks after the birth of their child. Questions were posed on the issues outlined above, and the first issue to be discussed was invariably the birth itself.

6.2. Childbirth and the hospital experience

The majority of the case study participants did not have the childbirth experience that they had anticipated. Having said that, it is extremely difficult to imagine, in advance, what the situation will be like. Overall, the most interesting point to emerge was that those who had planned to resist analgesia such as an epidural ended up having one, and vice versa. Indeed, the younger women experienced more straightforward deliveries, overall. In some cases, the experience was better than anticipated:

It was fourteen hours. Near the end, I begged for the epidural, but they said I was six centimetres dilated and as soon as they fetched the anaesthetist, I felt like pushing. So then the midwife could see the head, and in the end, I didn't have the epidural, so I was glad, in the end. I did have some gas and air, but I didn't have any stitches or anything so I was chuffed, really. I don't think it was that bad, really. I was expecting worse (Gina, interview two).

Laura also found that the birth to be relatively problem-free:

It was over and done with quite fast, in the end. I was two weeks overdue, so they put in a drip, and four hours later I needed to push. And it was two pushes – eight minutes – and she was born. I did have the epidural in the end 'cos it was a bit painful, but the birth was no problem, really (Laura, interview two).

On the day of the birth, Laura made the following entry in her diary:

At 11pm, the pains were too bad; asked them for an epidural. I've had loads of examinations, the baby's getting stressed, so 10 more minutes and start pushing. 3.30am, started pushing and my baby was born at 3.38am, I didn't hardly feel anything. I have a bouncing little girl who weighed 6lb 7oz. She likes her milk and she is feeding well. It feels strange being a mum, picking her up, changing her, etc. is all very scary (Laura, diary entry).

These two new mothers, neither of whom had attended antenatal classes, experienced fairly straightforward births, therefore. Indeed, the experiences that they had quite closely resembled their expectations. Both had healthy daughters, and were delighted. The following descriptions suggest something of an 'intermediate' experience; not particularly easy, nor especially traumatic:

Yeah, I had a normal delivery, and an epidural. I also had an episiotomy. And I lost quite a lot of blood (Sally, interview two).

Thirty-six hours of non-stop agonising pain. I started the Monday afternoon and went right the way through until a quarter past twelve, the Wednesday morning, in labour. In the end, my back was giving me problems and I had to have an epidural, and that stopped the contractions, so I had to have hormone injections (Mandy, interview two).

Mandy had decided not to attend antenatal classes, and was adopting a 'wait and see' approach. Her description of the birth does indicate that the experience was somewhat worse than she had expected, however. By contrast, Rhona, who had attended both

NHS and NCT classes, found that her birth experience was not very different from what she had imagined:

I tried for a waterbirth, but it didn't work. We knew what was coming, really. And when I said to my partner, 'I'm desperate for painkillers', and the gas and air was making me feel sick, he knew straightaway, 'Epidural, please'. (Rhona, interview two).

Rhona's baby was normal and healthy, and the following excerpt from her diary shows the plethora of emotions she experienced at the time:

Baby was born at 1.33am. Thank goodness it's all over! He is lovely; we both cried (with relief, I think). I stayed awake watching him for the rest of the night. At 7am, asked a midwife if I could pick him up – she laughed and said, 'He's all yours, you can do what you like!' It felt very strange at first – how do you do the most basic things? Told them I wanted to come home the same day – no problem, just had to wait for my Rhesus neg. test result. They helped me feed him and when [my partner] came, we 'top and tailed' him. [My partner] came at 10am with some flowers, and we both wept with joy, looking at our son (Rhona, diary entry).

Among those whose birth experience fell short of expectations was Joy, who had been hoping to 'do things naturally', but who, in the end, had more intervention than originally planned:

I was in labour for twenty-six hours. Then I had a ventouse. I had gas and air, and an epidural - which I didn't want – but, towards the end, I was just so tired (Joy, interview two).

Despite this, Joy was not particularly disenchanted. She was clearly delighted to have a healthy daughter, and was quite phlegmatic about the birth experience overall. Barbara, by contrast, was more surprised at how things turned out for her, and intimated that she had not felt prepared for it, despite having attended both NHS and NCT classes:

The baby had a foetal heart monitor, and in the end I had an epidural as well. It wasn't far off what I had expected, but I was surprised at how small he was. He wasn't premature, as such, just 'small for dates'. He was 5lbs 2oz, so he had to go into an incubator at first. He also had low blood sugar levels. So he ended up in Special Care, which was a bit of a shock. I wasn't prepared for any of that, at all (Barbara, interview two).

This account suggests a lack of preparation not for the birth, as such, but for the way in which the baby required special attention. It does seem that antenatal classes do not really prepare expectant mothers for such eventualities. Indeed, as will be seen later, a number of new mothers in the study were quite critical, postnatally, of the expectations of childbirth generated in their antenatal classes. Parke and Beitel (1988) have suggested that “Deviations from a normal birth sequence can be a significant source of stress for families due, in part, to the violations of their prior expectations” (Parke and Beitel, 1988: 231). This was certainly the case for Tracey, for whom labour, birth and pregnancy outcome came as a shock for which she had been unprepared. The following series of excerpts from her diary describe her experiences:

FINALLY BABY BORN. Induced 10.30am. Back and tummy pains by 12 o'clock. Contractions started. Baby's heartbeat went from 160 down to 60. Doctors very concerned. Fresh blood loss – called midwife. They took me down to labour suite as concerned at blood loss. 2.30 I was 1.5 cm dilated – they broke my water. Had epidural three times – painful – the epidurals didn't work. Still having back and tummy pains. Baby had emptied bowel inside me. 6.30pm, doctor decided to do emergency caesarean section. I was very nervous, but glad to think it's all going to be over very soon. I had a different injection in back – spinal block, I think. I kept awake through operation. [My partner] put on green theatre outfit and came in with me. I couldn't see the operation. For a few minutes, they didn't tell us the sex – had to ask. Doctors put suction tube in her mouth. Doctors told us that she was okay. She's beautiful – lots of black hair. (Tracey, diary entry).

Clearly, this was a disempowering experience for Tracey and her partner, and did not resemble the childbirth experience they had anticipated. Nevertheless, they were relieved at the outcome. The following day, Tracey was settling into her new role as 'mother', on the postnatal ward:

I had a few hours sleep last night – she was a bit unsettled. Lot of mucky sick – the midwives took her a few times as I couldn't get out of bed – still attached to tubes and bags and drips, and my legs numb and heavy. Later, had a shower and was detached from the tubes. I think it was the best shower I've ever had. We kept looking at the baby, and we've decided on a name.

She didn't sleep too well. The midwife put her in bed with me, so I could be close to her – felt lovely. She slept, but I couldn't. I was afraid that she might roll off bed, but midwife said don't worry, she can't roll anywhere yet (Tracey, diary entry).

The next day, however, things began to go wrong again:

Terrible day – we noticed [the baby] shaking. Doctor came to check her, and took her down to Intensive Care for checks – I was so upset and worried sick. Doctor told us, could be either infection, meningitis or brain damage. We cried and cried all night. [Partner] stayed in my room in the hospital all night. We went down to Intensive Care at 2.00am to see her – no news 'til the morning. I tried to express my milk, but I didn't collect any. She's in an incubator and on a drip; everybody's upset. We love her so much already. She's having a brain scan and test tomorrow. [My partner's] been pushing me around in a wheelchair; I find it difficult to walk too far at the moment (Tracey, diary entry).

And the following day:

Moved from the ward to Intensive Care to be nearer to her. I tried expressing milk again – no good. Dr. took us into interview room and mum came in. Terrible news – told us that her brain has been damaged. Can't say how she'll be, yet, or she might be okay. Cried so much again. Giving her different drugs to control the fits. It's been the most upsetting and stressful time of my life (Tracey, diary entry).

Evidently, the birth and the subsequent questions about the baby's health were extremely harrowing for Tracey and her partner. The fact that none of these outcomes resembled Tracey's expectations perhaps exacerbated the situation. Even breastfeeding, which she had planned prenatally, was adversely affected by the circumstances. To this extent, there was, without doubt, a 'violation of prior expectations'. In terms of preparation, however, there are clear limits. Antenatal classes do tend to promote an assumption that babies will be born normal and healthy, and indeed this is usually the case. It is questionable whether more attention should be given to potentially distressing scenarios, such as that experienced by Tracey. On the other hand, far less attention is given to coverage of caesarean sections than normal vaginal deliveries, for example. This is remiss in the light of a 22% caesarean section rate in England at present (NHS Maternity Statistics, 2001 - 2002). At Plymouth's Derriford Hospital, where all of the

participants' births occurred, the rate is comparatively low at 14% (South West Good Birth Guide, 2001), but this still means that a considerable number of women undergo the procedure. As Kelly (1998) has stated, “While it is not possible for midwives to prepare prospective parents for every eventuality, childbirth educators can be overzealous in promoting utopian outcomes to the whole birthing experience” (Kelly, 1998:23).

Tracey's experience, although exceptional, resulted in her remaining in hospital for longer than expected (three weeks) after the birth. She missed the antenatal class reunion, but claimed that she would have felt unable to face it in any case, because of the experience she had had. She also claimed that, when she later bumped into other new parents from her class in the town centre, she felt envious because she perceived that they had had 'easy times' by comparison. Partly as a result of this, she did not keep in touch with any of them.

Another participant who felt disenchanted by her childbirth and hospital experience was Diane. Her delivery was not as complicated as Tracey's but she was clearly disappointed with the quality of treatment that she received:

It was horrendous, actually, and not something I'm keen to repeat. I know I was adamant about not having an epidural, because of my back, but I had an epidural in the end. The TENS machine was good, but it was all going very slowly. So I had the epidural, which was fine, and they brought in the registrar and finally had a Ventouse extraction. But it turned out that, unbeknown to me, they had had me scheduled for a caesarean the next day! And I thought, 'Well – nobody told ME!' (Diane, interview two).

Apart from hearing that a caesarean had been discussed without her knowledge, Diane was fairly phlegmatic about the way the birth had turned out. Her experience on the

postnatal ward was, however, extremely disappointing. First, she was taken to the Transitional Care ward:

All I wanted to do was to go somewhere nice and quiet for a bit of rest. And it was, like, 'Well, it's an open ward.' And it was so noisy! I closed the curtains around the bed, and the midwife didn't like it. She got really stroppy, and she said, 'This ward has an open curtain policy.' Well, the ward was really busy; there were lots of visitors. My husband was with me; I'd given birth – what – four hours before? Just getting over the epidural – felt like shit – I *looked* like shit, and the size of my boobs! I wasn't going to flop them out and let everybody watch me breastfeed! I was so upset. I'd come from Norfolk ward and I thought I'd be going back to Norfolk ward. But when I asked the midwife which ward I was going back to, she said, 'Argyle.' She was really stroppy. She said, 'Come on then! Haven't you packed your stuff? Get a move on!'

I had to carry my own bag. There was me, shuffling along the corridor, and she knew I'd had Ventouse, and she knew I'd had stitches and an epidural. So she just said, 'Come on then!', and she walked on ahead really quickly. And there was a woman delivering flowers for me, at the door of the Transitional Care ward; and she said 'Are you okay? Let *me* carry your bag for you.' And it just made me feel so upset, that the woman delivering the flowers had got more understanding than the midwife. And then I finally got onto the ward, and I just sat down and cried. I was listening to this midwife hand over to the next midwife, and she just talked about me. She said, 'Oh yes, she's a complainer.' And I just couldn't believe it. The more I think about it, the more I think of making a complaint (Diane, interview two).

Diane was so angry and disappointed with her experience, that she felt she would be unable to face having another hospital delivery in the future:

I've already said to my husband, that I would find out everything about a home birth for next time. It was an awful start, and I firmly put the blame with the midwives. It spoilt it for me. I couldn't bond with [the baby] for a couple of weeks. I just didn't want to know (Diane, interview two).

Sally's experience of the postnatal ward was less traumatic. However, like Diane, she felt a need for privacy, which initially was unavailable. Additionally, she sought reassurance, particularly concerning breastfeeding, which the postnatal ward staff seemingly did not have much time to provide:

The midwives in the hospital don't really have much time to spend with you, although there was one who was really good. She was there a lot. And I got really upset and I was saying, 'he's crying', and conscious of other people on the ward, and stuff like that. And, um, she arranged for me to go in my own room....she thought that might relax me. And it did. I still had problems breastfeeding, but I felt better in myself. You

know, I wanted to go home, but [the baby] was a bit jaundiced, and I had to stay and see a physio. about his feet*. But I really wanted to go home (Sally, interview two).

(*Sally's baby had been born with slightly deformed feet, which later required operations to straighten them.)

None of the other participants expressed strong feelings about the hospital experience. For most, it appeared that the birth was somewhat more difficult than expected, and in Tracey's case, considerably more complicated. Those who had attended antenatal classes had apparently not been led to expect so much intervention. By contrast, most of the non-attenders required less intervention, and experienced a birth that neither disappointed nor surprised them. Having said this, most of the non-attenders were younger and physiologically fitter for a straightforward delivery.

The antenatal class attenders in the case study sample did not make particular links back to the formal preparation for birth that they had received in those classes. The questionnaire respondents were, however, asked explicitly to state whether their antenatal classes had provided them with realistic expectations about the birth. Of the thirty-two women who attended NHS classes, twenty-three (59%) felt that their expectations were realistic, while six (15%) did not. Three (8%) answered 'Don't know'. For the two women who had also attended NCT classes, one felt that her expectations were realistic, while the other did not. These views were consistent across both NHS and NCT classes.

Summary

- Most of the case study participants experienced more intervention during childbirth than they had anticipated.
- The most straightforward births were experienced by the younger women who had not attended antenatal classes.

- Those who experienced complications in labour felt that their antenatal classes had not adequately prepared them.
- The majority of questionnaire respondents felt that their antenatal classes had provided them with realistic expectations of the birth.
- Postnatal ward midwives were often less supportive of new mothers than had been anticipated.

6.3. Experiences of infant feeding

In the previous chapter, expectant mothers' infant feeding plans were discussed alongside their reasons for choosing a particular method. It was noted that the vast majority – especially of questionnaire respondents – intended to breastfeed. Among the case study participants, the non-attenders of antenatal classes were more likely to choose bottle-feeding, however.

Here, the new mothers' experiences of infant feeding will be explored by comparison with their prenatal expectations, including the sources of those expectations. Breastfeeding – by far the most popular choice, but also, for many, the most problematic – will be considered first.

Among the case study participants, Diane had been particularly eager to breastfeed. Her decision had been made prior to attending antenatal classes, and she had been advised by her midwife that patience and perseverance would be required to establish successful breastfeeding. Nevertheless, the reality of breastfeeding did not match her expectations:

I don't know...he wasn't latching on. I tried everything - got sore nipples and then mastitis - so in the end, I had to express. I also gave him some bottles, and he did go back on to the breast but I wasn't getting on well with it. He was just chewing me! After two and a half weeks I just felt that bottle-feeding would be better, and he seems more content with that. And my milk seemed quite watery. I didn't think he was

getting enough. The breastfeeding was harder than I thought. But my midwife did do a lot for me, so I had the support. But I didn't honestly take to it (Diane, interview two).

Some aspects of this experience were echoed by Barbara, another of the case-study participants:

I was breastfeeding, but because he was small - on special care - he was getting fed by a tube, and I was sort of breastfeeding as well. And then he came up on the ward with me and...he was very small, very hungry and he - the baby - wanted to feed between midnight and three a.m., so of course he wasn't putting on any weight, and I had all this literature on breastfeeding and, it says there's no such thing as them not getting enough breast milk, but there is! And that's what happened with me. So he's being bottle-fed now (Barbara, interview two).

Barbara's baby had been 'small for dates' and was on a transitional care ward for the first couple of days. This did not, in itself, prevent Barbara from breastfeeding. However, her concern about the baby's weight seems to have fuelled her decision to switch to bottle feeding, based in part on the belief that the baby 'wasn't getting enough' breast milk. This was also one of Diane's reasons for stopping. Health professionals are aware of this common perception among new mothers, and Mary Smale, writing about reasons for cessation of breastfeeding, claims that:

The two main reasons women give for discontinuing breastfeeding are the perception that they have insufficient milk, and sore nipples (White et al, 1992). Discussion about the psychological context of the perception of milk insufficiency could fill a whole chapter. In one study no objective weight gain difference was found between babies of mothers who stopped breastfeeding and those who did not (Wylie & Verber, 1994). It is probable, once technical difficulties such as incorrect positioning have been eliminated, is to some extent one of perception – the woman's or another's – or it may represent the offering of an acceptable explanation rather than articulating a complex set of other reasons for discontinuing (Smale, 1998: 189).

Dykes and Williams (1999) found that first-time mothers tended to experience breastfeeding either as empowering - when successful - or as confidence sapping when not. Indeed, they found that the women in their study conceptualised breastfeeding as a 'journey' in which most felt that they had 'fallen by the wayside'. Like Smale, they

suggest that women's perception of the inadequacy of their breastmilk is often a reason for stopping. The authors claim that midwives and health visitors in particular have a central role to play in supporting new mothers via consistent information and postnatal encouragement. These issues are highlighted below.

Barbara, for example, had found breastfeeding more demanding than she had anticipated through her reference to the baby wanting to feed in the middle of the night. On this issue Diane was more explicit when she admitted that breastfeeding was harder than she had expected it to be. She was not alone in this, however. The following two accounts are from new mothers who also found breastfeeding difficult, and certainly harder than they had expected, but who persevered and subsequently breastfed successfully:

At the classes, they made it [breastfeeding] sound very idealistic, but my major gripe was, neither of them said how *difficult* it is. And that really, I mean...., I know they can't put people off, but I really feel that, if they said it's difficult, then I would have been more *prepared* and I wouldn't have felt so *distraught* about it in the hospital. I know now that breastfeeding is difficult for a lot of people, but I didn't know that at the *time*. If I had, I would've just carried on and....I know it's worked out *now*, but for a few days I felt.... we even got the bottle stuff and everything in case things didn't work out. It's okay now; I just found it really difficult (Sally, interview two).

The breastfeeding is what got me *down*. I had blocked ducts and mastitis, and that was horrible. And I got, sort of - *lumps* - so when he latched on, it was painful. I was in agony. And we ended up going out and buying steriliser, bottles - everything. And I hired an expressing machine, because I just couldn't have him *on* there, it was so painful. But I persevered (Rhona, interview two).

In both cases, these mothers had reached the point where they had seriously considered switching to bottle-feeding because of the difficulties they had experienced with the breastfeeding. Of particular importance in both cases also was the role of social support. Sally had found that many of the midwives on the postnatal ward did not have enough time to provide adequate support, but she explained that:

One midwife - a student - was lovely. She'd had problems with feeding herself, and she was really helpful. I was at the end of my tether; I thought he wasn't getting anything, and we were both getting stressed. And when we came home, I was still having problems with the breastfeeding, but my own midwife was brilliant. I was a total wreck, but she was fab. She said, "Oh, we'll get this sorted, don't you worry." And in Mothercare, there was a notice on the wall, about a breastfeeding counselling line, so I phoned them, and it all helps, to talk to people that have been through it (Sally, interview two).

I rang the NCT breastfeeding counsellor and she told me various things to try. And she came one day and sat with me, and chatted, and it was just a bit of *support*. (Rhona, interview two)

The nature and extent of the links between social support and successful breastfeeding are difficult to assess. Some studies have shown that postnatal support from health professionals is beneficial in helping breastfeeding mothers to continue (e.g. Houston, 1984), while others have found social support not to be a significant factor (Cooper et al, 1993). Among the case study participants, there is a similar level of discrepancy. For example, Diane acknowledged considerable support from her midwife, but still did not continue breastfeeding. The opposite was true for Rhona and Sally, for whom social support was perceived as helping to facilitate their continued efforts, despite the difficulties. However, it was not only the support of health professionals and voluntary organisations that were pivotal in these cases, but also the support of partners. Rhona spoke appreciatively of her partner's support for her efforts to establish breastfeeding when she explained:

He sat up with me in the night being really supportive and encouraging. He really encouraged me to keep going, which now I'm really grateful for. And he did *know* when I reached crisis point, and he went out and bought bottles and whatnot. So he was *great* with that part of it. (Rhona, interview two).

This high level of support was evident in Rhona's partner's account of the breastfeeding issue, as written in her diary by him:

Our game plan regarding feeding has been tested on three occasions now, and I think Rhona has done exceptionally well in persevering.

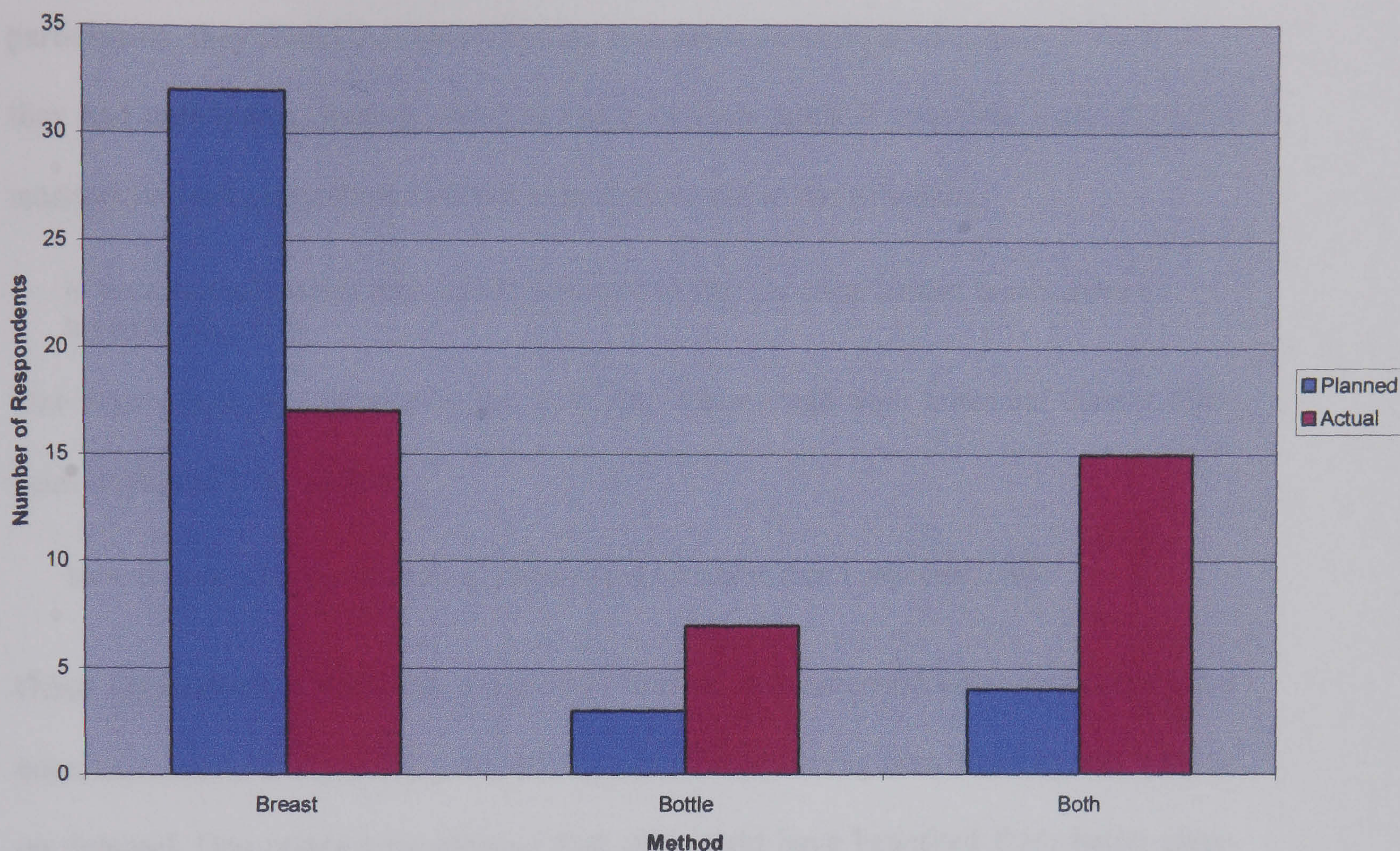
Perhaps what distinguishes Rhona's experience is the broad range of support sources which she was able to utilise. Added to this was her determination to continue breastfeeding, despite the difficulties she encountered. Nevertheless, irrespective of whether those who chose to breastfeed continued or not, the experience was harder than they had anticipated. Sally, in particular, expressed disappointment that the difficulties were not outlined more realistically in her antenatal classes. Had they been, she felt, the experience would have seemed less traumatic. Mary Smale has echoed this concern, claiming that, 'caregivers should offer information not only about how breastfeeding works, but also about what might go wrong and how to deal with problems' (Smale, 1998: 195). In addition to more realistic antenatal preparation, there is apparently also a need for greater support on the postnatal ward. As mentioned in the previous section, many new mothers were disappointed at the lack of time which postnatal ward staff were able to find to support them. This early postnatal period on the hospital ward has nevertheless been found to be most crucial for supporting breastfeeding mothers (Buckell and Thompson, 1995).

For the questionnaire respondents, a similar set of problems arose. These will be considered following a look at the data comparing intended and actual infant feeding outcomes. As indicated in the previous chapter, the majority of respondents (thirty-one of the thirty-nine) had intended to breastfeed prior to the birth. Figure 6.1 shows a high attrition rate. The number who actually fed their babies in this way, up to the age of three months was only seventeen, which amounted to 35.4%. This represents a reduction of more than half.

Background characteristics such as maternal age, educational level and marital status were cross-tabulated with data on feeding methods. Age was found not to be significantly associated with breast or bottle-feeding ($p=0.383$); neither was educational attainment ($p=0.517$). Whether respondents were living with or without the baby's father did not seem to affect feeding method outcomes either ($p=0.211$).

Figure 6.1 shows the figures for planned and actual feeding methods. The largest difference between planned and actual methods occurred among those mothers who had planned to breastfeed but who actually used a combination of breast and bottle milk. In most such cases, the mothers had breastfed exclusively for a short time but then, for a variety of reasons, made the transition to bottle-feeding. Those reasons will be explored in more detail below. Figure 6.1 also shows a 100% increase in actual over planned bottle-feeding, from six to twelve. Again, this shift can be accounted for as a switch from planned breastfeeding to actual bottle-feeding. Given these data, there is a clear indication that many more mothers had planned to breastfeed than actually did so. The reasons for the choices made by these mothers, as well as their reasons for change, can now be explored with reference to the data obtained from case-study interviews and from open-ended questionnaire responses.

Figure 6.3. Questionnaire respondents' planned and actual feeding methods



In-depth discussion about breastfeeding was clearly not possible with this sample. However, many cited problems with breastfeeding in response to the questions: 'What have you found most difficult about caring for your new baby?' and 'Could you describe anything about caring for your new baby that you were quite unprepared for?'. The following responses typify the difficulties that many of the new mothers described:

Breastfeeding - he had problems latching on - can get quite frustrating for both of us. (12)

Feeding and being confident that she has had enough. (17)

Coping with the demands of feeding. (35)

The fact that breastfeeding isn't as straightforward as it looks and it takes a lot of patience and perseverance. (12)

I thought that breastfeeding was going to be the easiest thing but it turned out to be quite stressful. (19)

All of these mothers had attended antenatal classes and yet, like some of the case-study participants, they found that breastfeeding was more demanding and more difficult than they had anticipated. Indeed, some of these mothers made it clear that their antenatal teachers had not given them realistic expectations about breastfeeding:

In the antenatal classes they should have told us that not every mother is successful in breastfeeding. (19)

One respondent, in response to the question, 'How could your antenatal classes have been improved?', suggested:

How to cope with breastfeeding, which was a lot worse than I expected. (16)

Other respondents echoed this suggestion, feeling that antenatal educators could have been more realistic about the potential rigours of establishing breastfeeding and feeding on demand. One respondent claimed that she would have benefited from being given the contact number of a breastfeeding helpline. A significant minority of mothers stated that they simply did not feel well enough to breastfeed after the birth and so decided to bottle feed instead. In a small number of cases, problems with the baby's health perinatally made breastfeeding unfeasible:

Baby was premature and fed by nasal gastric tube so breastmilk dried up. (28)

My baby was born 8 weeks early so I expressed milk for 4 weeks, but because he was so small he wouldn't take to the breast so went on to bottle. (32)

Two of the case-study participants also found the reality of infant feeding to be quite different from their expectations. Again, this difference arose primarily from problems with the babies' health. Tracey, for example, had intended to breastfeed, but was unable to do so because her baby was placed in an incubator in intensive care. Tracey herself

was traumatised not only by an emergency caesarean section, but also by the news given to her by doctors that her baby was possibly brain-damaged.

Mandy, who had intended to bottle feed, was shocked by the diagnosis of the rare condition phenylketonuria (PKU) in her baby. This condition, which involves a protein allergy, requires the careful management of infant feeding. As a result, Mandy was required to give precisely-measured, special bottle feeds based on frequent blood test results. This was all done under the guidance and supervision of a trained dietician. Apart from this particularly unusual experience, however, the mothers who chose to bottle feed related no problems with their chosen method. The only issue of concern to them was, as mentioned above, their perception that not enough attention had been given to this subject during antenatal classes.

It is noteworthy that only one mother in the sample - a questionnaire respondent - made the decision to breastfeed after the birth despite having decided prenatally to bottle feed. Like so many of the new mothers, however, she ended up switching to bottle feeding before three months had elapsed. Of the sizeable number who did switch fairly early from breast to bottle feeding, or who used a combination of methods, many found that their initial frustration or disappointment was tempered by the fact that their partners were able thereafter to share in the task of infant feeding. Indeed, this realisation had in any case influenced the decision of some bottle feeding mothers. This finding is consistent with those of Earle (2000), who found that a desire for paternal involvement was a significant factor affecting women's choice to bottle- feed.

Summary

- The majority of new mothers in the study had planned to breastfeed, but only around half were successful in doing so.
- Most new breastfeeding mothers felt that this method was more difficult than they had anticipated.
- Some of the antenatal class attenders felt that breastfeeding coverage should have been more realistic, in outlining the potential difficulties.
- Popular cultural images of breastfeeding may contribute to unrealistic expectations.
- In terms of sustaining breastfeeding, the role of social support is unclear.
- Professional support in the hospital postnatal ward may be most beneficial.
- Antenatal class attenders who chose to bottle-feed felt that this method was frowned-upon by health professionals.
- Mothers who had planned to bottle-feed generally did so, however, with few or no problems.

6.4. Experiences of general infant care in the early postnatal period

In the previous chapter, the case study participants' expectations of new motherhood were described in relation to a number of influencing factors. Maternal age, personality, housing tenure, employment status and previous infant care experience all appeared to influence the ways in which participants regarded the transition to motherhood. Despite considerable variations, most women were apprehensive, overall. The prospect of carrying out basic infant care tasks appeared daunting, especially for those with no previous infant care experience. The majority (five of the case study participants and twenty-three of the questionnaire respondents) fell into this category.

New mothers in the study were asked about their experiences of infant care in two different ways. The questionnaire respondents were asked to describe anything about caring for their new babies about which they felt quite unprepared, and also what they found most difficult about caring for a new baby. The case-study participants were asked during second interviews how competent they felt about caring for their babies. Responses among these participants ranged from positive and confident on the one hand to hesitant and unsure on the other. Those who seemed quite confident, and who perceived themselves to be fairly competent tended to be those who had already had some experience of infant care before their own babies had arrived. These were also mainly the non-attenders of antenatal classes:

When she was born, it all just came naturally. I couldn't believe it. I wasn't afraid to hold her or anything. I've just picked it up naturally. I never thought I would, but I have. Sometimes I'll say, 'Mum, can you help me with this?', or 'Can you show me how to do this?', but other than that, I'm just using my initiative and doing it myself (Laura, interview two).

This may be an example of experience proving to be better than expectation, as Laura was one of the expectant mothers who had described herself as 'scared' at the prospect of infant care. This issue of expectation versus experience will be explored in greater detail later in this chapter. This participant was also perhaps advantaged in that she lived in her parental home, and so received the constant support and guidance of her own mother. Other non-attenders of antenatal classes who were living with their partners, nevertheless shared similar perceptions of their competence in the area of infant care:

Fine. I knew that they cry a lot, and.....um.....but it comes naturally in the end, or at least, I found that. I mean, I didn't like bathing her at first, but I actually take her in the bath with me, now (Mandy, interview two).

Yeah, I'm okay with all that. Yeah, fine (Gina, interview two).

The only attender of antenatal classes from the case-study group who seemed to be truly confident about infant care was also benefiting significantly from informal guidance:

I feel okay about it. My sister had her baby six weeks before us, so I've watched her and learnt a lot from her (Tracey, interview two)

These accounts would suggest that the close proximity of new mothers' own families, as well as previous exposure to the reality of infant care is beneficial in terms of caring for one's own infant. Overall, those in this category, mostly non-attenders, appeared to be quite confident about infant care tasks, and this may be attributable to the availability of lay support. A local health visitor with whom these issues were discussed during the research, was convinced of the importance of women's own mothers, within the transition to motherhood. Of twenty-seven new mothers with 'problems' in her own caseload, twenty-one were without maternal support, which she felt was a major contributory factor. As a part of her own health visiting service, she claimed to visit such new mothers more frequently, and for longer, in order to offer reassurance which she felt would otherwise come from their own mothers.

Other case-study participants were somewhat ambivalent on this issue, admitting to difficulties in some areas but success in others:

I'm feeling more and more competent, but I wasn't managing the early mornings very well. I'm *not* an early morning person, but at four or five o'clock in the morning, he was screaming for his feed, and I would be sound asleep and it was just awful. That would get on top of me. But I am feeling more confident, and I have to be, with my husband being away working (Diane, interview two).

Well, the breastfeeding is alright now. But other things....I don't know, like, how do you know if the baby's got diarrhoea? Because breastfed babies have such runny nappies anyway, so how do you know? And things like winding the baby; I never know long to go on for. Things like that. I still feel I'm maybe not so good as other mothers but.....I think it'll come (Sally, interview two).

The second of these accounts is particularly interesting because it suggests that this new mother thinks there is a 'correct' way of doing things and that while 'other mothers' know what it is, she does not. By contrast, the following account demonstrates that some new mothers realise quite quickly that there is not necessarily a 'right' or 'wrong' way of managing infant care tasks:

When we came home and changed the first nappy, it as, like, 'Oh! How do we do this?' But we did everything together; every nappy, every bath. So, things like that, you muddle through and you still wonder, I mean some people put talcum powder on their babies.. is that the right thing to do or isn't it? But that's where the other girls from the antenatal classes come in, because we sit around and talk about who uses which nappies, and so on. And I guess that's better than having someone standing up and telling you how it *should* be (Rhona, interview two).

'Muddling through' appeared to be the way in which most of the new mothers managed these early days with a new baby:

I think it's about trial and error. Nobody can really teach you how to be a parent (Barbara, interview two).

Rogan et al (1997) found that this early postnatal period is characterised by feeling 'unready' for motherhood, to a greater or lesser extent. Those without previous infant care experience were found to be more 'unready' than others. Realising the constant demands of new motherhood led to strategies of 'working it out', similar to the 'muddling through' described by some of the mothers in this study.

The process of 'working it out' was very quickly applied to basic infant care tasks, such as bathing and nappy-changing. While many new mothers in the study had expressed apprehension and uncertainty about these tasks, they rapidly gained confidence. However, the fact that so many, especially antenatal class attenders felt so daunted suggests that more 'parentcraft' should be introduced in those classes. Indeed, Nolan (1998) has argued that they should emphasise the central role of the baby in relation to

every topic discussed. She suggests that midwives who run antenatal classes should make greater use of dolls to enable expectant mothers to acquire 'hands on' skills. Indeed, it is clear from some of the participants' accounts of their classes, that such an approach would be welcomed. All in all, however, basic infant care challenges were quickly worked out.

By contrast, the task of infant feeding - especially breastfeeding - turned out to be far more problematic than many had expected, as the early part of this chapter indicates. Indeed, it may be claimed that overall, the infant care difficulties which most mothers experienced were not really the ones that they had anticipated.

6.5. Particular infant care difficulties experienced by new mothers

In the questionnaire, participants were asked to describe what they had found most difficult about caring for their new babies. Responses to this question fell into three main categories; 'feeding', 'tiredness/lack of sleep' and 'crying'. Feeding difficulties have already been considered in depth, above. Tiredness and lack of sleep was, not surprisingly, closely connected with feeding and crying. Some of those who did report this as an early difficulty were still quite positive about the resolution of this problem with the passing of time, however:

At first it was the sleepless nights but now she is into a routine. (5)

The lack of sleep to start with, but it does get better. (9)

The baby's crying was clearly problematic for many new mothers, who also claimed that they often did not know why the baby was crying or what to do about it:

Getting used to what he is crying for. (32)

His crying for long periods without being able to console him. (16)

Worrying if being unable to calm her when crying a lot. (18)

‘Crying’ was mentioned by only one of the questionnaire respondents who were asked to describe anything about caring for a new baby for which they had been quite unprepared. Many respondents again cited ‘feeding problems’ and ‘lack of sleep’, however. A follow-on question asked the new mothers to suggest what might have been useful in preparing them for whatever they had described. For ‘lack of sleep / sleepless nights’ the responses tended to be ‘nothing’, although those who cited feeding problems often suggested, as explained above, that antenatal classes could have been more realistic in preparing them.

The largest category of response to this question was, however, ‘How time-consuming it all is’. The following examples illustrate the various ways in which new mothers described their experiences, together with their thoughts on what, if anything, might have been useful in preparing them:

How long everything takes to do and the amount of things needed to take with you when you go out. (Nothing really) (33)

How time consuming. (Nothing) (34)

They take over your life. (Nothing) (7)

How much time taken of the day. (Discussed at classes) (18)

Where the time disappears! (Nothing) (15)

How time-consuming it would be, especially as he is awake a lot. (I don’t think anything can, as when you are pregnant, you only look to the labour, which is bad enough. If people would have told me how tired I would feel after, I think I would have been much more apprehensive about the birth than I was.) (36)

These comments indicate the extent to which full-time infant care can bring a significant lifestyle change. The majority of these mothers were of the opinion that nothing could really have prepared them. The final account also returns to the point about the birth taking precedence - for this woman at least - over the postnatal period.

There is, however, a marked difference between ‘tasks’ and ‘lifestyle’, and it may therefore be the case that even those mothers who felt that they could have been better prepared for infant care *tasks* could have had only a limited preparation for the impact on lifestyle of a new baby.

The widespread perception of infant care as extremely time-consuming was shared by many of the case-study participants. It appeared that most were surprised and frustrated at how little they were able to accomplish aside from infant care tasks. Two mothers in particular had held the view that new babies just feed or sleep for most of the time. Consequently, they were surprised by the reality of the various demands placed upon them:

I thought most babies, they just have a bottle and then they’re asleep! But not her! Some days, she’ll have half an hour [of sleep] all day! She isn’t very good in her pram, either. Take her out and she just cries. I thought *that* was unusual as well, ‘cos some of ‘em, they’re *gone*, aren’t they? When they get out (Gina, interview two).

I don’t know - it’s stupid really. But, like, I wasn’t - I thought it was, like, um..... bottle feed; back to bed, sleep. And it just doesn’t go like that! You can change her and feed her and then she’ll just stay awake, or sleep for an hour maybe (Laura, interview two).

Such realisation added to the frustration felt by these and other new mothers who were unable to find enough time to do other things that they felt were pressing upon them, like housework:

I don’t care how much housework I’ve got to do. That gives me a *break*. I just want to do something other than - sat here, listening to him cry, or feeding him (Diane, interview two).

At first, I was so tired, because at that stage the baby wanted cuddling all the time, and I just couldn’t *do* those things like putting the washing on (Rhona, interview two).

Several questionnaire respondents cited similar dilemmas when asked to describe the difficulties of caring for a new baby:

The time spent caring for the baby and trying to continue a busy routine. (29)

Still got to do the everyday things; cleaning, cooking etc. (32)

Not being able to do simple household chores. (18)

Unable to carry out other tasks around the house. (22)

Such experiences begin to reveal the huge impact of a new baby on women's lifestyles.

Clearly, many of the new mothers in this study were trying to adjust not only to the tasks involved in caring for a baby directly, but also to the management of a variety of other demands placed upon them daily. It was the realisation that that were required to 'do everything' that appeared to come as such a surprise to so many. The time-consuming nature of infant care also impacted significantly on the ability of new mothers to engage in self-care. A number of questionnaire respondents cited this as one of the most difficult things about having a new baby:

Straight after the birth, initially doing any small task proved difficult; even finding time to have a bath or wash hair. Now baby is in a good routine (sleeps all night 6pm-6am) everything is fine. (21)

Having time for my own things. (15)

The baby comes first and I have little time for myself. (24)

Can't put yourself first anymore. (14)

The questionnaire did not really provide sufficient scope to yield data on how the mothers resolved such problems, although some responses indicated that the passage of time played a significant part. For example, the account of respondent 21, above, shows the contrast between 'initially' and 'now'. It also refers to 'a good routine', which for most new mothers and babies takes a few weeks to establish. One coping strategy did emerge clearly from interviews with the case-study participants, however. This will be considered in the next section.

6.6. Managing the difficulties

Some of the case-study participants who had initially experienced the (apparently widespread) dilemmas of time-management and ‘fitting everything in’, seemed to make a conscious effort to change their approach. In many cases, this involved leaving a crying baby for sufficient time to enable the accomplishment of other tasks:

Well, sometimes I just leave her crying, ‘cos I think - well - I’ve *got* to do some things. Like doing her bottles and things. They’ve got to be done if there’s no bottles in the fridge. And you’ve got to go and make some more. (Gina)

If he starts crying, it’s quite easy to let him cry, because you’ve got to get on with things and you’ve got to save your sanity sometimes. (Diane)

Another participant - Sally - did not go upstairs to pick up her crying baby for several minutes at the beginning of the second interview. She indicated that she was waiting to find out whether the baby was ‘really crying’ or not. It was only when it became obvious to her that he was crying for a feed that she went up to collect him from his cot. Indeed, many of the case-study participants adopted a similar approach. Some mothers explained that they felt the baby was crying ‘just for the sake of it’, and that by responding immediately each time, that they would ‘make a rod for their own back’:

I’m just gonna have to let him cry, because he’s just gonna have to *know* that. He’s just, like, crying for crying’s sake, ‘cos he just wants to be picked up. A couple of times a day I’ll just let him scream, because I think it’s - he’s beginning to realise he can’t be picked up all the time. My mum says, “Oh, go on and pick him up”, but I think, at this early stage, they’ll just *expect* it. (Diane)

Sometimes, when I’m at my mum’s and my sister’s, my sister will try and pick her up all the time if she’s crying. Like, quite a few people do that - go to pick her up, and I’ll say “No, *leave* her, ‘cos that’s making it worse for *me*”. I’m trying to get her better. (Gina)

In both of these cases, the mothers were very firm in their views, and felt that others were making things harder for them by adopting the response that they, themselves, were consciously rejecting. Thus, they were saying ‘no’ to other relatives as well as to

their babies. Both of these women were apparently unwilling to be drawn into an ‘artificial’ situation. They were clearly aware that, in the absence of the mother or sister, no-one but themselves would be on hand to respond to the crying baby. They did not want their ‘training’ to be undone. Gina’s explanation even implies that a crying baby has a sort of ‘illness’ that can be ‘cured’ by not responding to it. Diane also indicated quite clearly that she wished her baby to *know* that he would be unable to gain her immediate attention by crying. Sally’s account, below, also focuses on being the main carer, although she does not report receiving conflicting advice:

Now that my partner’s away, if the baby cries, I’ve just got to get on with things on my own. He’s just going to *have* to wait. If he cries, I don’t *like* the fact that he’s crying, but....when you’re on your own you’ve got to do things for yourself. Okay, sometimes when he has a whingey cry, I *do* pick him up, but if I’m busy doing something, I won’t. Whereas, at first, I would. (Sally)

By contrast with the accounts considered above, the following mother chose a different approach:

I try to figure out why she’s crying. I don’t believe in leaving babies to cry, though. If she needs a cuddle, I’ll pick her up and cuddle her. Sometimes [my partner] will make me sit here; he’ll say, “Give her five more minutes”, and I say, ‘Well, when she cries, I feel I *want* to pick her up’. (Joy)

This is actually the reverse of the preceding accounts, as in this case the advice is to leave the baby to cry, against the mother’s wishes. All of the mothers appeared to go along with their own instincts and beliefs, despite conflicting advice from those around them in many cases.

6.7. Sleeping arrangements

Case-study participants were asked during the second interview, to explain the sleeping arrangements for their babies. Of particular interest was the subject of co-sleeping

which has traditionally been criticised for reasons similar to those of picking up crying babies. The issue of safety has also been questioned, although some recent research has indicated that co-sleeping may actually be beneficial in this regard (e.g. McKenna et al, 1994). As far as the study participants were concerned, such research findings were outside their knowledge sphere, confined as they are to the academic literature. Therefore, it was broadly assumed that the new mothers in the study would consider sleeping arrangements in terms of cultural perceptions of safety, convenience and ‘training’, the latter category relating to the perception of ‘making a rod for one’s own back’.

All of the case-study participants initially adopted the practice of having the baby sleeping in the parental bedroom. Although none of the new parents placed their babies to sleep in separate rooms from the outset, three did so after six to eight weeks. The general feeling appeared to be that having the baby in the parental bedroom in the early weeks was both safer and more convenient, particularly for night-time feeds. Only two of the case-study participants described taking the baby into bed with them but, in both cases, this occurred as the night wore on, usually following a night-time feed when the baby failed to settle afterwards. None of the participants took the baby straight into bed with them at bedtime:

He doesn’t sleep through the night. So I usually take a bottle to bed with me, so it’s ready. Then I just give him his bottle, and usually I take him into bed with me for the rest of the night. I don’t think I’m making a rod for my own back, though, because he will go to sleep initially in his cot, or downstairs in his travel cot, which is fine.
(Diane)

Evidently, Diane had adopted what she considered to be a convenient way of managing her baby at night. Additionally, she had considered whether perhaps she might be

‘making a rod for her own back’, and decided that she was not. The question of safety did not arise. The account given by the following participant, however, encompasses all of the issues around sleeping arrangements indicated in the opening paragraph above. In addition, this next account offers an interesting insight into the range of knowledge sources utilised by a new mother:

Sometimes, at night, when I’m really tired, more often than not after his late feed - at about one o’clock or whatever - if he won’t settle, I’ll bring him into bed with me. I do know someone who’s done that, and even though the child is nearly three now, he still goes into bed with them. And I have been told, by my next-door neighbours, “Be careful, because if you keep bringing him in.....”. But then, another friend of mine had the baby in bed with them, and the baby’s now quite happy in a cot. And another friend whose baby whose baby was born just after mine - her husband’s a paediatrician - and they are *always* having their little girl in with them. And I trust them, because he’s a paediatrician, so it can’t be all that wrong, can it? We’ve got the cot in with us anyway. I have read somewhere that it’s safer to have the baby in the same room as you. And we won’t put him in his own room until he’s about six months old. (Sally)

It is clear from this account that Sally had weighed up her options, based on observation, knowledge and advice from various sources. It would be easy to suggest that, on the issue of co-sleeping, for example, Sally had favoured the example of the paediatrician above less ‘medicalised’ opinions. While this may be true to some extent, it would be fairer to suggest that this approach in any case coincided with what Sally herself felt was the best way for her to manage the situation. The perceived appropriateness of this approach had also been reinforced by the experiences of another set of friends.

It is not known whether those participants whose babies slept in the parental bedroom but not in the parental bed had consciously decided *against* co-sleeping, for whatever reason. The responses given were above were prompted by a question about sleeping arrangements generally, and therefore the respondents were free to describe as much or as little as they deemed important on this issue. Overall, it can be concluded only that

new parents appeared to adopt sleeping arrangements for their babies which fitted into a personal model of safety and convenience.

Summary

- Basic infant care tasks were generally less problematic than anticipated, especially for those with previous experience (mainly non-attenders).
- ‘Muddling through’ was the term used by some new mothers to describe the way in which they managed the early postnatal period.
- Lifestyle impacts were profound. Most new mothers were struck by how ‘time-consuming’ the demands of new motherhood proved to be.
- Younger mothers were especially surprised at the relentless nature of the demands. In this sense, expectation and reality differed considerably.
- ‘Crying’ and ‘lack of sleep’ were particular problem areas. Most new mothers felt that nothing could really have prepared them for this, however.
- ‘Leaving the baby to cry’ was a frequently adopted strategy, despite much lay advice to the contrary.
- For reasons of convenience, all case study participants slept in the same room as their babies for the first few weeks.
- General infant care experiences in the early postnatal period did not seem to be affected by attendance or non-attendance at antenatal classes.

6.8. New parenthood and couples’ relationships

6.8.1. Case study participants

The previous section included case study participants’ expectations of the impact that a new baby might have on the parents’ relationship. Most women had positive expectations, and felt that becoming a family would strengthen the relationship with

their partner. In the light of these expectations, the participants were asked during the second interview to describe the sort of changes they had experienced. Some of the case study participants reported positive changes, similar to those that they had expected:

The bonding between [my partner] and I has been incredible. Even changing that first nappy. We did everything *together*. And that, I think, was really good (Rhona, interview two).

We're closer than ever. I think having to go to the hospital with her brought us closer, in a way. The sex has gone out of the window, though! My partner says it's a good contraceptive. But other than that, we are closer than what we ever were (Mandy, interview two).

Others felt that the impact of the baby on their relationship had been more problematic:

I think her birth brought back for him the things that went wrong with his first family. And he took a lot of it out on me. He wanted my attention, but I had to give *her* most of my attention. And I did ask him to leave at one point. I couldn't look after him as well as her! I think he realised then that this is his last chance to make a success of family life. But it *has* brought us closer. I feel more, like, *cosy* now (Joy, interview two).

Joy's experience perhaps reflects the apprehension that she had experienced prenatally.

It also seems to typify Henderson and Brouse's (1991) assertion that a father's feeling of exclusion during the mother's early involvement with the baby can exacerbate parental tensions.

In a similar vein, Diane found that some anticipated difficulty in her partner adjusting to the new situation resulted in some friction in the couple's relationship:

There has been a lot of friction between us. Things like, when the baby's crying. He thinks there must always be a reason for it, and I say there doesn't. But he sees it all as my responsibility, really, as if I'm the expert. But at the same time, I don't think he's accepted the situation, really, because when he's home, that's when I want my break (Diane, interview two).

Clearly, divergent opinions on how to handle the baby accounted for some of this tension. Additionally, however, Diane has implied that her partner is not doing his 'share'. This issue of partner involvement with the baby, and other support for the new

mother will be considered in more detail below. For now, it is interesting to note that Diane's partner saw her as the 'expert' in baby care. Inherent in this, perhaps, was the expectation that she would also do most of the caring.

Sally also found that the baby's arrival impacted somewhat negatively on her relationship with her partner. By contrast with Diane, however, she *wanted* to be seen as the 'expert' in terms of infant care, and this was equally problematic:

Well, to be frank, we've never argued so much as we do now. I mean, before, we'd have the odd spat – I mean, if you're with someone twenty-four hours a day, you're bound to. But we seem to be arguing more now than we ever did. We have different views over the baby. And some of it's because we're both so tired. I was very protective of the baby as well. I kept saying, 'Don't do this; do it like this.' So I suppose I am very bossy about the baby (Sally, interview two).

In view of the fact that Sally had been very apprehensive prenatally about the prospect of caring for a new baby, this description indicates a significant growth in confidence. Interestingly, it seems that greater equality between the parents engenders greater harmony at this stage of the transition to parenthood. Rhona's account (above) of bonding with her partner through an equitable sharing of these new experiences is in sharp contrast to the descriptions of both Sally and Diane.

Barbara's brief description of the most notable changes for herself and her partner include three of the main issues already encountered: tiredness, diminished sexual activity and disagreements over the baby:

It hasn't really been any different. If we do argue now, it does tend to be about the baby rather than anything to do with ourselves. And we haven't actually had sex yet! We're both too knackered, to be quite honest (Barbara, interview two).

It is interesting that Barbara starts by claiming that nothing has really changed, but then goes on to cite quite significant changes. Also, her perception that arguing about the baby is not really the same as arguing about anything to do with 'ourselves' suggests

that the reality of the new family dynamic had not been fully accepted. Overall, Barbara's response characterises some of the ambiguities described by Dalgas-Pelish (1993). In that study, it was found that while new parents tend to report increased satisfaction in their relationships, more detailed responses clearly suggest the opposite.

Finally, Gina's description, which suggests a negative impact initially, encapsulates much of the early disruption brought about by the arrival of a new baby:

Um, well, the first couple of weeks, we weren't getting on too well because it's all a turmoil, isn't it? You don't know what you're doing, and nothing's *done*, like – there's things to be done – and she's been crying...but it's getting better now (Gina, interview two).

It would appear, from the case study participants' various descriptions, that there is no real difference in the experiences of attenders and non-attenders of antenatal classes, in this respect. This supports Nichols' (1995) findings, and is unsurprising in view of the fact that such issues were not discussed in antenatal classes. Overall, the disruption brought about by the arrival of a new baby seems to be fairly commonplace, with most couples reporting at least a temporary negative impact on their relationship.

To summarize the experiences of case study participants:

- For most of the participants, there was a negative impact on the couple relationship following the arrival of a new baby.
- While some women had anticipated some tension between themselves and their partners, for others the impacts were unexpected.
- Tiredness, diminished sexual relations and arguments about the care of the baby were frequently cited by those who reported negative impacts.
- Greater equality in responsibility for the baby seemed to be the only significant factor affecting couples' satisfaction with their relationship at this time.

- There was no evidence of a difference between attenders and non-attenders of antenatal classes.

6.8.2. Questionnaire respondents

The fact that the questionnaires were distributed only to new rather than expectant mothers meant that *anticipated* effects on couples' relationships could not be investigated. However, on the question of actual effects since the birth of the baby, the respondents wrote very full and frank answers. This, combined with the content of those responses, suggested that this was, for the new mothers concerned, a very significant issue.

The responses were made to the open-ended question, 'Could you explain the effects that a new baby has had on your relationship with your partner?' When transcribed, the responses were grouped into the following broad categories:

- 1) None
- 2) Closer
- 3) Apart
- 4) Strain
- 5) Other

Only two respondents omitted to answer this question; for three other women, the question did not apply because they were not living with the baby's father.

The largest category, with thirteen respondents, was 'closer', followed by 'apart', with nine. Five women mentioned a 'strain' on their relationship, while four women claimed that there had been no impacts at all to describe. Three responses were categorised as 'other'.

A sample of the responses will be given according to the numbered list above. First, therefore, are two examples from those who claimed not to have noticed a difference:

There is no different effects; we are still the same as before, a very loving couple. (5)

None whatsoever. We are a very close couple. We have been together for 7 years and the pregnancy was planned. (4)

The second of these women implies that the prenatal state of the relationship might make for less agitation postnatally. This claim was made by Gladieux (1978), and there is already some evidence among the case study participants to support it.

The majority of responses to this question included some mention of the baby bringing the couple 'closer', although quite often this was also combined with less positive comments. For example:

It has brought us closer together emotionally, although we have had to talk through some teething problems. E.g. some things I say make my husband feel useless and he sometimes forgets he has a family and makes outside commitments. Our sex life has obviously slowed down but we expect to get back to normal very soon, and my husband is very understanding and supportive about this. (16)

Again, there are echoes here of many key issues mentioned by the case study participants. Overall, however, this new mother has decided that, on balance, the baby has brought the couple closer together. Similarly, the following description is somewhat ambiguous. Closeness is mentioned first, but the new mother then goes on to describe her perceptions as somewhat contradictory:

It has made us closer but we are both tired but because I am on maternity leave it is assumed that I sit around all day doing nothing, which is rather irritating. (33)

This apparent failure on the part of new fathers to appreciate the extent of the demands of infant care is another issue to be explored in more detail later. Indeed, it appears to characterise the fathers who do less to involve themselves in infant care than their partners would like. The following response contains further evidence of this:

It has brought us closer together but I get a bit annoyed sometimes because he could do more for me, such as getting up during the night to change the baby, or allow me to get an hour's nap during the day, as sometimes I get very tired and end up snapping at people. (38)

Once again, considering the extent to which this mother apparently feels undersupported by her partner, it is perhaps surprising that she described the experience as bringing the couple 'closer'.

By contrast, the following two descriptions are entirely positive:

Our relationship has become stronger in a different way. We discuss everything to do with our child and bend over backwards to support each other as much as possible. Our relationship was strong before the birth of our child but it has grown stronger since the birth. (2)

Closeness – something very special we share. Everything has to take a 'back seat' – baby has priority over each other's needs for his well being. (15)

What these two descriptions have in common is a theme of sharing and discussion. As noted in relation to the case study participants, this egalitarian approach seems to be most successful in mitigating the potentially *disruptive* effects of a new baby on the couple's relationship. By contrast, those whose responses were categorised as 'apart' rather than 'closer', tended to stress that they had less time for each other. The following responses describe this phenomenon in various ways:

Don't have much time for each other. Can snap at each other due to stress sometimes. (18)

Less quality time with each other. Less physical contact (excluding sex). Impatient about sex (from partner's point of view). Less communication. A lot more stress (responsibility). General arguing about the above. (11)

Limited sex. Difficult to get 5 mins. together alone. (7)

No time alone. Sex life dwindled. (28)

Communication, sexual relations and 'time together' for new parents were all marked by decline in Moss et al's (1986) study, and the responses above tend to include all of these aspects. Indeed, the transition to parenthood appears to place considerable strain

on the parental relationship. The following responses, all of which were categorised under the heading of 'strain', demonstrate this point still further:

Slightly strained as we are both tired a lot of the time. My husband works a 7-day shift pattern and so has very little time. (8)

'Time' and 'tiredness' feature prominently again in this description of the impact of the baby on the couple's relationship. This particular account perhaps typifies Belsky et al's (1986) assertion that the changes are greatest for the mother, who immerses herself in caring for the baby, while the father continues to work rather longer hours away from home. The following account also implies this, as the respondent has emphasised that infant care is 'full-time work':

It has put a lot of strain on our relationship because I would really like some help because I need a 5 minute break sometimes. Looking after a baby is full-time work; even when you try and eat your tea, you can't. A partner should take turns getting up in the night as well, and he doesn't. (31)

This response, in common with some of those above, shows that when the mother perceives an unequal sharing of infant care responsibilities, disharmony results. Additionally, however, it shows that the mother feels that her partner does not appreciate the extent of the work involved in caring full-time for an infant. In Moss et al's (1986) study, fifty-one per cent of mothers shared this view.

In the following two descriptions, there is a clear suggestion that early stresses can be mitigated by the passing of time and, in particular, addressing any problems through communication:

We don't spend as much time together as we did. It has been rather stressful as we are both new parents, but we seem to be getting there. At first we were just thinking about the baby all the time, but now we are learning to think about each other more as well. (19)

Roughly at first; it was a hard strain, but now all sorted out. (26)

In the 'other' category, one of the responses focused particularly on the woman's changed role, and the implications for the couple's relationship:

Our relationship has changed quite a lot. I get taken for granted a lot more now, especially as I have given up work so money is tight, but we also communicate a lot better now as we have joint responsibility for our child and have to make more decisions together. (29)

Another respondent emphasised lifestyle changes in a rather more positive way:

It has helped us to move on in our relationship but it is hard not to take each other for granted. We now value quality time with each other as opposed to spending loads of money on meals out and holidays. (36)

While the reported impacts are quite varied overall, there is clear evidence that the arrival of a child has a profound effect on couple's relationships. In some cases, this is positive. In others, the effect is - temporarily at least - quite negative. Of the thirty-four women who responded to this question, thirty of them reported a perceived change. This should, therefore, be considered as an important issue affecting the majority of new parents. Only twenty-three of the thirty-two women who had attended antenatal classes reported that this issue was covered adequately (if at all) in their classes. This ties in with midwives' own accounts of the extent to which the issue receives coverage (Kelly, 1998).

Cross-tabulation of respondents' accounts of relationship effects with whether or not they felt the issue was covered adequately in antenatal classes showed no significant association, however ($p=0.68$). Equal numbers of women attending antenatal classes (eleven in each category) reported either principally positive or principally negative relationship effects. Given the incidence of parental disharmony suggested by these findings overall, it may be asserted that greater coverage of such lifestyle adjustments may need to be addressed more fully in antenatal classes.

Summary

- The vast majority of the questionnaire respondents described changes in their relationship with their partner, following the birth of their first child.
- Those who reported positive impacts described an increased feeling of ‘closeness’, often linked to feeling like a ‘proper family’.
- Many of those who reported negative impacts described their new situation as ‘strained’. Many also felt that the demands of caring for a new baby had driven them apart from their partners.
- As with the case study participants, those whose partners were less involved in infant care reported more negative impacts.
- The accounts of the questionnaire respondents on this issue support and, in many ways clarify similar findings based on the case study interviews.
- The results support suggestions in the published literature which claim that couples’ relationships are disrupted in the transition to parenthood.
- New parents might be better prepared for these lifestyle impacts if discussion took place during antenatal classes.

6.9. Social Support in the early postnatal period

In this section, new mothers’ experiences of social support from partners, relatives, friends and professionals will be considered. Earlier, their expectations of support were outlined, together with some discussion of the role that social support can play in helping to facilitate the transition to motherhood. Initially, the extent of partner involvement in infant care will be discussed here in relation to both case study participants and questionnaire respondents. Thereafter, more general partner support will be considered before moving on to consider a wider range of support sources. Throughout this section, the participants’ experiences will be compared with their

earlier expectations. Finally, some assessment will be made of the usefulness of the various support sources. Further evaluation will, however, depend on consideration of the mothers' general well being. That will be the focus of the following chapter.

6.9.1. Paternal involvement in infant care

Data concerning partners' involvement in infant care were obtained in two main ways. The case-study participants were asked about this in both postnatal interviews. Questionnaire respondents were asked to indicate how supportive their partner was in four specific areas: emotional issues; babycare, housework and financial issues. In this particular section, only the responses to the item concerning infant/babycare will be considered. This quantitative data will be presented first, followed by the qualitative data generated by the case-study method.

The questionnaire respondents were asked: 'How helpful / supportive is your partner concerning babycare?' The responses show that the vast majority (97%) of partners were perceived by new mothers to be either 'fairly' or 'very' helpful. Elaboration was offered by only two of the respondents; for example, the only respondent who had described her partner as 'not very helpful' with babycare added the following:

A partner should take turns getting up in the night as well, and he don't. (31)

The other additional comment came from a respondent who described her partner as 'fairly helpful' with babycare:

Sometimes I wish I didn't have to ask and he would take the initiative. (37)

Although the question as posed did not ask how *satisfied* the new mothers were with the level of their partners' involvement, the weighting of positive responses may be taken to indicate that the majority were reasonably satisfied in this respect. Far more detail on this issue was generated via the case-study interviews, however. There are two reasons for this. The first is that the conversational nature of the inquiry rendered possible more explicit and meaningful responses. The second is that the case-study participants had already been asked, prenatally, how supportive they expected their partners to be after the birth of the baby. Therefore, comparisons can be made between the mothers' anticipated level of paternal involvement in infant care and their experiences of such involvement.

The following responses are taken from interviews with the case-study participants, in which mothers focused their responses on the issue of paternal involvement in infant care. Prenatally, the participants had been asked how supportive they expected their partners to be and, as the previous chapter shows, the majority had positive expectations. Mandy had been one of the expectant mothers who anticipated extensive involvement from her partner. Was he, then, as involved as she had expected?

No. He's less involved because I'm the one that's got to take all the blood and everything else. He doesn't make up bottles because they're so complicated to do. I know the maths. and everything, so I've got to do it. Plus, he's always at work, so when he comes home from work, she's in bed asleep (Mandy - 2nd interview).

(NB: Mandy's baby had a protein allergy, the management of which required daily blood tests and special feeds.)

By the time of the third interview, the situation had apparently deteriorated. Not only was her partner doing less, mainly because of work commitments, but also Mandy was clearly more disenchanted:

At the moment it's sort of, like, all down to me. Because my partner's now doing shift work, so he never gets to see her that often. Because he's working nights and then doing early mornings, I look after her during the night. He tries his best, but he's not doing an awful lot like he was at the very beginning. He's more of an outsider, because he's not doing very much. I think he's just, like - when he comes home from work he thinks I'll still do everything, and he doesn't have much to do with her, which is hard on me (Mandy - 3rd interview).

Mandy's experience reflects the tendency for male partners to work longer hours outside the home at precisely the time when the new mother is usually most in need of his support (Raphael-Leff, 1991; O'Brien, 1982). While this issue was not emphasised specifically by other participants, it certainly appeared that many partners were unappreciative of just how demanding it was to care for a baby all day. For example, Rhona's experience, below, illustrates how many mothers long to distance themselves now and again from contact with the baby, in order to do other things:

He's great with the baby. I couldn't *wait* for him to come home after work, but initially it was just because I was so knackered. I just wanted him to take the baby away from me. And [my partner] would go and put the kettle on, and I'd say, "No, no, *you* have the baby. Let me do everything else." Because at that stage, the baby wanted a lot of cuddling and I just couldn't *do* those things, like putting the washing on. So it was hard to start with, but I wanted [my partner] to have the baby, and then let me do the rest (Rhona -2nd interview).

Gina also found that, when her partner returned home from work, she wanted to do other things, even if they were just basic household tasks, in order to have a break from the baby:

He's good with her, really. But now he works, at night times, I get up for her most of the time now. And when he comes in from work, I'll say, "'Ere you are [with the baby]", and he thought I was *joking* at first! And he'd say, "Let me sit down for a little while." But you just can't wait to hand her *over*. I know it sounds horrible, but it's justtoo *much*. You want a *little* break (Gina -2nd interview).

Interestingly, by the time of the third interview, Gina was far more positive, although the fact that her partner's mother was present may have affected her response:

Yeah, he's brilliant with her. He'll do things if I ask him to, but usually I have to ask (Gina, interview three).

Like Gina and Rhona, Diane was disappointed to discover that her partner felt that the baby was almost entirely her responsibility:

[My partner], I think, sees it that I look after the *baby*, and [my partner] does all the housework and the cooking and ironing, and he's been *great*, don't get me wrong, but not actually doing much with *him*. It's as if it's *my* job, and it's really stressing me out (Diane – interview two).

To a certain extent, he's still like that. The NCT sent a questionnaire, and that was interesting - how his views differed from mine. He still sees things through rose-tinted spectacles, I think. But overall, he's still been doing mostly housework, whereas I want him to do more of the care of the baby (Diane – interview three).

These experiences further illustrate the claim that new mothers feel that their partners often do not 'understand the reality of full-time childcare' (Moss et al, 1986: 66). Because so few fathers undertake this role full-time, even in countries where paid parental leave may be taken by either parent (Sanchez and Thomson, 1997), their appreciation of the scale of involvement continues to elude them. Despite this, at least one of the new mothers found that her partner was more involved than she had expected:

I've been lucky, really. I mean, I know most partners go back to work after a couple of weeks, and I've been spoilt, really, because he's been around. He changes [the baby's] nappy; in fact, you know, he does a lot more than I do, sometimes. I mean, he'll give me a break when I'm tired and - if I can't get him *settled*, and he *does* - but I've been told mainly that's because the baby can sense the stress and *tell*and often the dads are calmer. But he's good like that - to calm him down. (Sally - 2nd interview)

Clearly, this situation was enhanced by the fact that Sally's partner was not working during the early postnatal period. Later, however, their experience began more closely to mirror some of the others:

Because he's working now, it's difficult. But often he'll come home and feed him. But I mean, I do most of it. Sometimes - I don't know - sometimes I feel as if it's my baby and...sometimes I feel as if he's not *spontaneous* in giving help. So there is that. But I mean, sometimes I just feel I'm more aware of things that need doing, and doing them

properly. And I say to him, “I know that you’ve been at work all day, but I’ve had him *all day*.” And I feel I’m doing most of it, but that’s because he’s at work. If you think about it logically....but I feel I can’t do *everything*. You know? (Sally – interview three).

Joy found that her partner’s actual involvement quite closely matched her expectations:

I do wish he would do more, but that’s not really him. He is quite good with her, although he won’t get up in the evening or the night to feed her (Joy – interview two).

A number of themes and issues emerge from the accounts given above. Perhaps the most obvious is that most of the partners turned out to be less involved in infant care than the mother had expected. Only Sally found that her partner was more involved than she had expected, but even in this case, she found over time that she was increasingly required to tell him what needed to be done. All of these new mothers expressed at least some disappointment with the way in which their partners acted in this respect. The disappointment was less noticeable with Gina and Joy, both of whom had anticipated their partners’ behaviour quite accurately. To put this another way, there was a fairly close match between expectation and experience. The net result was that they appeared less critical of their partners’ level of involvement.

Most of the participants complained that their partners lacked initiative. This is consistent with many of the new mothers’ observations that their male partners see infant care as principally the mother’s responsibility. The boundaries of such responsibilities apparently lie beyond the immediate provision of infant care, however. Walzer (1996) argues that the division of labour of infant care is characterised not only by the actual tasks involved, but also by the planning, organisation and emotional labour associated with those tasks. An integral part of this maternal effort includes the

work involved in trying to get the father to ‘help’ with infant care. Thus, the new mother finds herself with ‘another invisible, mental job’ (Walzer, 1996:226).

Rhona’s experiences also appeared to match her expectations in terms of the extent of her partner’s involvement. However, the anticipated emphasis on infant care, rather than upon other domestic tasks, turned out to be inaccurate. Therefore, she found it necessary to ask her partner to relieve her of babycare tasks at the end of the day, rather than having him focus on things that she preferred to do herself. Indeed, this tendency for partners apparently to ignore the fact that the mothers had been involved in caring for a baby all day was widespread and problematic. Gina, Mandy and Sally - as well as Rhona - found this to be the case. These mothers were clearly irritated by the fact that their partners not only failed *spontaneously* to offer them a break from infant care at the end of the day, but also that their partners intimated that infant care was not ‘work’.

One explanation for such paternal beliefs might be the persistent ideological dominance of paid over unpaid labour; hence, perhaps, a cultural economic reason. Changes over time were hard to discern, possibly because the relatively short time frame of the case studies provided little scope for this. Nevertheless, some evidence of a diminution in paternal involvement was presented in the accounts of both Joy and Mandy. Overall, the participants whose expectations were most closely matched by experience were generally less *dissatisfied* than those who had high expectations which subsequently led to disappointment. This relationship between expectations and experience continues to be a key indicator of how well new mothers adjust to the demands of early parenthood.

Summary

- Most new mothers found that their partners were less supportive in the early postnatal period than they had anticipated before the birth.
- The mothers who seemed least satisfied were those whose partners' support fell short of expectations.
- Partners seemed more willing generally to undertake household chores than infant care responsibilities.
- Some new mothers found that their partners believed that infant care was principally the mother's responsibility.
- Many new mothers complained that their partners seemed not to appreciate that infant care was 'work'.

6.9.2. General partner support

The questionnaire respondents were asked directly about general partner support, and this was then broken up into separate areas of housework, infant care, emotional support and financial support. In response to the question, 'Is your partner as supportive as you would wish?', twenty-two replied 'Yes', eleven replied 'Sometimes' and only two replied 'No'. There were three mothers to whom the question did not apply and one who omitted to give a response. On the basis of this evidence, it may be claimed that most new mothers felt that their partners were generally supportive. In order to find out whether the mothers' expectations had been failed, met or exceeded, they were then asked whether their partner was as supportive as they had *expected* him to be. Fifteen claimed that their partner was more supportive than they had expected. Fourteen claimed that their partner was as supportive as they had expected, and five claimed that their partner was less supportive than they had expected. Only one said 'Don't know'.

Again, these are mainly positive responses implying that, for many new mothers, their experiences of partner support *exceeded* their expectations.

Figure 6.9.2. shows the extent to which respondents felt their partners were supportive in four different areas.

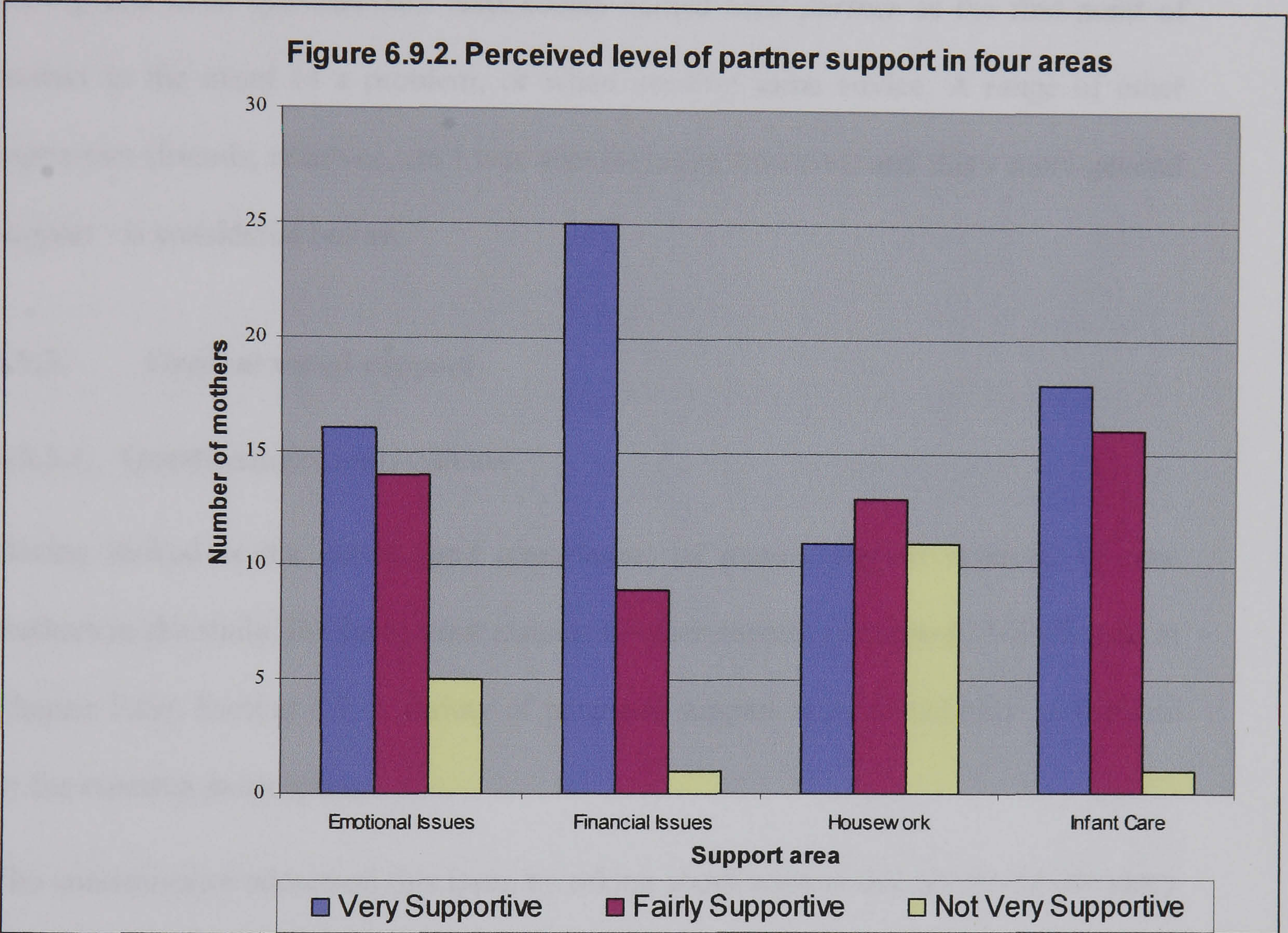


Figure 6.9.2. indicates that partners were more supportive than not in all four areas in question. Nevertheless, there is still a strong suggestion of a gendered division of labour, especially when financial support is compared with housework support. Here, the number described as ‘very supportive’ more than halves. Yet, this is unsurprising in light of an abundance of literature on this issue (e.g. Walzer, 1996; Oakley, 1993; Nicolson, 1990). Interestingly, the figures presented here for support with infant care

and housework are broadly reversed among the case study participants. The latter, mainly, had claimed that their partners chose household tasks over infant care tasks.

The main conclusion to be drawn from this evidence is that partners were generally found to be supportive, often more so than expected. This is further reinforced by the finding that most questionnaire respondents named their *partner* as the first point of contact in the event of a problem, or when needing some advice. A range of other supporters (friends, relatives, etc.) was also included, however, and this - more general support - is considered below.

6.9.3. General social support

6.9.3.1. Questionnaire respondents

Having looked at the extent (and importance) of partner support received by new mothers in the study, the focus now extends to other sources of support. As indicated in Chapter Four, Section 4.7, a variety of postnatal support sources had been anticipated by the research participants.

The questionnaire addressed this issue by asking about sources and perceived adequacy of social support. Respondents were first asked to indicate who they turned to first, in the event of a problem or when requiring some advice. Of the thirty-seven women who responded, ten (26%) cited their partner. Six (15%) claimed to turn to their own mother first, and a further six (15%), chose 'other relatives'. Five (13%) claimed that their health visitor would be the first point of contact, and another five (13%) stated that they would ask a friend. Only one new mother claimed that she would contact her midwife first but, of course, midwives make routine home visits for only around ten days, so this

particular support source was irrelevant to most respondents in the postnatal period. Four responses (10%) were categorised as 'Other', and these included 'birthing partner' and 'the book my midwife gave me'. The respondents themselves occasionally differentiated between serious and less serious reasons for seeking advice; for example, one respondent wrote, 'My sister unless urgent, in which case, GP'. Overall, though, the responses suggest that, amid a variety of support sources, most new mothers turned principally to those *closest* to them. In effect, this means lay or informal support from family and friends.

In order to get some idea of the *accessibility* of informal social support, the respondents were also asked whether they had relatives or friends to whom they could turn for support, living nearby or within easy travelling distance. Thirty-three (85%) of these new mothers claimed that they had access to supportive relatives and thirty (77%) to supportive friends. Only six (15%) did not have access to supportive relatives and nine (23%) claimed not to have access to supportive friends. Overwhelmingly, therefore, these new mothers were able to access informal support. When asked whether they felt that they had enough help and support, thirty-six (92%) said 'Yes', while only two (5%) said 'No'. Only one respondent wrote 'Don't know'.

Cross-tabulation of data related to perceived adequacy of social support with attendance or non-attendance for antenatal classes yielded no significant association ($p=0.701$). Indeed, the majority (twenty-nine) of the thirty-two attenders claimed to have sufficient social support, as did all seven of the non-attenders.

Maternal age was not found to be significantly associated with perceived adequacy of social support, either ($p=0.181$). However, the only two respondents who claimed *not* to

have enough support were in the lower age category. Similarly, being with or without a partner was not significantly associated with perceptions of social support ($p=0.158$). Only one woman living without, and one living *with* the baby's father reported inadequate social support generally.

Investigating the type and extent of social support received by new mothers is relevant because of its implications for general well being. There is a general consensus that social support benefits health, and a few studies which show a beneficial impact for new mothers (e.g. Tarkka and Paunonen, 1996; Langer et al, 1993). However, a number of methodological dilemmas surround this relationship, not least of which is the problem of operationalizing a concept such as 'well being'. Ann Oakley (1992) drew particular attention to this during her study of the impact of social support interventions during pregnancy. There, she found evidence of positive benefits for new mothers.

In this particular study, such a link is difficult to demonstrate. Among the questionnaire respondents, most felt that they had adequate support. However, some of those women also reported overwhelmingly negative feelings since the birth of their child. Conversely, the two respondents who had felt *undersupported* had mixed feelings that were neither entirely positive nor entirely negative. More detailed examination of postnatal feelings and maternal perceptions of wellbeing will be considered in Chapter Seven.

6.9.3.2. General social support: case study participants

The case study participants had been asked, prior to the birth, who they expected to be supportive in the early postnatal period. Most participants had fairly clear ideas and

expectations. Anticipated informal support sources varied, but a broad distinction was identified between antenatal class attenders who emphasised friends, and non-attenders, whose main supporters were expected to be relatives. In this section, it will be seen that, while in many cases reality matched expectations, there were some participants for whom expectations of support were *not* fully realised. By contrast, one or two of the new mothers were pleasantly surprised when, for example, a mother or mother-in-law turned out to be more supportive than anticipated.

Mandy, for example, had claimed late in her pregnancy, that she was not expecting her own mother to be supportive after the birth. Indeed, she feared ‘interference’ from her family, but not support. She had, however, expected some support from her mother-in-law. Despite this, around six weeks after the birth of her child, she described her support sources as follows:

My mum has helped in a lot of ways. And my partner’s mum’s very good. She knows what she’s doing, and I trust her (Mandy, interview two).

And at three months after the birth:

My sister’s been really good. She’s been around here most days, lately, helping out with the baby and keeping me company (Mandy, interview three).

Therefore, Mandy’s family support was wider-ranging than anticipated. There are a couple of interesting points to make about this. First, Mandy’s baby had been born with a rare (protein allergy) disorder, which made infant care more than usually complicated. Second, Mandy had developed postnatal depression shortly after the birth. This second issue will be considered in more detail in Chapter 7, Section 3. In this context, however, it may be that the existence of such problems helped to engender greater family support than Mandy had originally envisaged.

Another non-attender whose expectations of such support had been negative – again, linked to perceived interference – was Joy. In the early postnatal period, however, she was evidently pleased to describe her main informal supports as follows:

My mum and my sister. They really are good. They're very good with her. She even slept at my sister's house the other night (Joy, interview two).

For some other participants, the opposite was true. Tracey, for example, one of the antenatal class attenders anticipating maternal support, found that the reality fell short of her previous expectations:

I haven't called on my mum as much as I had expected to. She has babysat a few times, but we have too many differences in approach, really (Tracey, interview two).

This demonstrates that Tracey's mother, while supportive to a certain extent, was not actually providing the *type* of support that Tracey felt she needed. Inappropriate support, or support which undermines the confidence of a new mother may have a deleterious effect overall, in spite of the quantity of support available (Collins et al, 1993).

Differences in approach were not an issue for Laura who, as a teenager without a partner, had been apprehensive about 'everything' prior to the birth of her baby. She had anticipated that her mother, with whom she was living, would be her main supporter, and she was not disappointed in terms of quality *or* quantity of that support. Indeed, Laura's mother was observed as being highly supportive during both of the postnatal interviews, and this was consistent with Laura's own reports of her mother's involvement in all three areas - i.e. instrumental, informational and emotional.

Gina, another young non-attender of antenatal classes, had also anticipated extensive support from her own mother. While that support was initially forthcoming, Gina felt that it began to dwindle quite quickly:

My mum was very supportive in the beginning. But now the baby's getting a bit older, she doesn't come down so often. Sometimes I could do with her here, though (Gina, interview two).

Like the questionnaire respondent in the previous section, Gina had neither a car, nor a telephone or washing machine. It is therefore unsurprising that she felt the need for longer-lasting support from her mother. In describing her early experience of infant care, she had focused on the difficulties of 'getting everything done'. In order to do the family's washing, for example, a whole morning had to be spent at the launderette.

The importance of maternal support for new mothers was highlighted by a local health visitor whose views on this issue had been sought during the study. She expressed the firm belief that the support of their own mother is 'crucial' to new mothers. Within her work, she claimed to visit more frequently - and for longer - those new mothers who lacked maternal support, in order to offer the type of reassurance which might normally come from their own mother. Indeed, her concerns to address this issue in practice are reflected in a number of studies which seek to find out whether postnatal intervention by health professionals can help to prevent or alleviate the social causes of postnatal depression (Oakley, 1992; Clement, 1995; Mauthner, 1997; Morrell et al, 2000). This is perhaps another example of the substitution of formal for informal or lay support mechanisms, rather like Nolan's (1997) view of the modern-day role of antenatal classes. On that issue, however, the health visitor interviewed was clearly of the view that antenatal classes do not in any case address the issues most commonly affecting

socially disadvantaged new parents: poor housing; lack of stability in relationships and isolation, for example. This to some extent confirms what is already known about the lack of attention to social and emotional issues within antenatal classes. Nevertheless, there is little evidence here to suggest that attendance or non-attendance particularly affected women's experiences in this way.

The remainder of the participants received broadly the level and type of informal support that they had expected. The one who anticipated most support from friends was Rhona. She had been new to the area and had no relatives living nearby. Her support sources were directly linked to her attendance at NHS and NCT classes:

Friends. Without them, things would be really stressful. Just talking about things with friends really helps. And without the classes, we wouldn't *know* most of those people (Rhona, interview two).

Here, then, is a clear example of the type of beneficial social support which antenatal classes can help to facilitate for those who want or need it. Those without access to relatives were particularly resourceful in cultivating relationships with others in similar circumstances. In most cases, the women's own mothers were accessible for support, whether or not this had been anticipated prenatally. Additionally, other relatives seemed important as supporters, particularly to those new mothers who had not attended antenatal classes. Overall, there were no case study participants who lacked informal support in the early postnatal period. Despite prenatal suggestions that antenatal class attenders would rely more upon friends than family for support (and vice versa), the postnatal experience indicated that this held true only when no relatives were accessible.

Summary

- The vast majority of new mothers in the study had access to informal social support.
- After their partners, the most popular supporters were women's own mothers, other relatives and friends.
- A large majority felt that they had enough help and support in the early postnatal period.
- A very small minority claimed to have inadequate social support.
- Perceptions of adequacy of social support among questionnaire respondents were not significantly associated with attendance or non-attendance at antenatal classes, nor were they associated with age or marital status.

Having looked at the participants' early postnatal experiences in terms of infant care, parental relationships and social support, Chapter Seven goes on to examine the ways in which these experiences impacted on new mothers' perceptions of their own wellbeing. As before, the relationship between prenatal expectations and postnatal experiences is used to help frame these accounts and their subsequent analysis.

Chapter 7: Maternal Well Being

7.1. Maternal wellbeing

The aim of this chapter is to explore new mothers' perceptions of the transition to parenthood, focusing in particular upon their *feelings* about their situation. The section begins with a statement of theoretical approach, which aims to clarify the distinction between medical and social definitions of wellbeing. Thereafter, a chronological approach will be taken, which aims to chart new mothers' expectations and experiences from late pregnancy to the early postnatal period. Factors affecting wellbeing, such as social support, maternal circumstances and the baby's behaviour will all be explored for their relevance in this respect.

7.2. Defining the terms

Within this section, maternal wellbeing refers to what might be described as 'psychosocial' wellbeing. This term has been selected as most appropriate because it marries together not only an emphasis on the mother herself, but also her social circumstances. Psychological wellbeing, by contrast, implies very little - if any - focus on the latter. Indeed, by focusing exclusively upon the individual, this term ignores the fact that pregnancy, birth and motherhood represent parts of a social process, involving social relationships (Clement, 1998; Nicolson, 1998; Oakley, 1993).

This is an important epistemological distinction that serves to continue the perspective already adopted in this study. For example, it has been claimed that the biomedical 'pathologisation' of birth and motherhood has been disadvantageous to women. This phenomenon is not, however, limited to physiological aspects of motherhood. It also

helps to inform medical explanations for disorders such as postnatal depression. Such explanations are limited because of their tendency to classify women as 'well' or 'ill', whilst apparently marginalising or ignoring the middle ground. In reality, it may be 'normal' for new mothers to experience a range of emotions in response to a life-changing event such as childbirth, some positive, some negative. Indeed, social explanations enable women themselves to describe their feelings holistically, without the rigid mechanisms which characterise medical labelling, diagnosis and treatment.

Previous studies such as that of Nicolson (1998) indicate that women themselves do not conceptualise their own perceptions of wellbeing in a medical sense, but rather, in a social sense. Despite this, they are frequently constrained (as are social researchers) by the dominant medical discourse which 'regulates women's own accounting of their experience' (Nicolson, 1998:86). Perhaps an example of this might be some of the measures that exist to help operationalise the rather vague concept of 'wellbeing'. A number of these are reviewed by Bowling (1991). In essence, however, subjectivity must be considered to be a strength in this area. Questions such as 'How do you feel?' are necessarily open-ended and individualised. Therefore, the following consideration of new mothers' wellbeing avoids artificial measurement and relies predominantly on women's own accounts of their feelings.

7.3. Case study participants' perceptions of wellbeing

As earlier chapters have already demonstrated, maternal mood begins to be affected some time before the baby is born. During pregnancy, women's expectations of the birth and the upcoming responsibilities of caring for a baby begin to dominate their

thoughts and plans. In the third trimester, expectant mothers become increasingly apprehensive and, in some cases, worried. Raphael-Leff (1991) even suggests that it is common for first-time expectant mothers to feel distraught – sometimes anticipating death - as the time of the birth approaches.

The case-study participants in this study varied in terms of their concerns about the birth and new parenting responsibilities. Prenatally, their feelings were best captured in their responses to questions about how they felt at the prospect of impending motherhood. These responses were outlined in Chapter 5, Section 5.4, and summarised as follows:

- Most expectant mothers felt apprehensive at the prospect of new motherhood.
- Those without previous infant care experience were most concerned about managing basic infant care tasks.
- The younger non-attenders felt most vulnerable about potential interference from relatives. Such vulnerability seemed to be linked to financial insecurity.
- Older, married attenders who had worked full-time prior to the birth were most optimistic about establishing and maintaining control of their postnatal situation.
- Those with experiential knowledge of infant care appeared to have the most realistic expectations of new motherhood.

In essence, there seem to be a number of factors that may appear singly or in combination to generate greater or lesser apprehension in expectant first-time mothers. To take just two examples of women who described themselves as ‘worried’, Laura was very young, tenuously housed and without a partner, while Sally was older, married and materially secure but with a personality which she described as ‘a natural worrier’. Both were quite pessimistic – but for different reasons – about the transition to motherhood.

In studies which aim to find predictors of postnatal depression, the most common has been depression during pregnancy (e.g. Appleby et al, 1994). However, it may be the case that prenatal depression itself may be caused by social or economic disadvantage (Seguin, 1995). In Ann Oakley's (1993) study,

... the occurrence of depression was associated most strongly with four 'vulnerability factors': lack of a job outside the home, housing problems, a segregated role relationship with the baby's father and little previous experience with babies. In the presence of four factors, the depression rate was 100 per cent, falling to twenty per cent for those with one factor. It may well be that a relatively simple index of housing conditions, such as tenure, is more predictive of maternal depression than any number of enquiries into mothers' psychological constitutions (Oakley, 1993: 86-87).

Ann Oakley's assessment is generally consistent with her broader view of birth and motherhood as social rather than medical phenomena. Indeed, the only 'medical' predictor of depression that she could see was a particularly unsatisfactory birth experience. Given these observations, it might be expected that the most socially and economically disadvantaged women in this study would experience the poorest outcomes in terms of maternal wellbeing in the transition to motherhood. This may be borne in mind throughout the following accounts.

During the second (postnatal) interviews, the participants were asked how they had been feeling, in themselves, since the arrival of their baby. They were also asked whether their feelings were 'surprising' to them, and whether they felt that such feelings were 'normal'. If appropriate, they were also asked whether such issues had been covered in antenatal classes.

Rhona had been one of the expectant mothers for whom organisation and control had seemed particularly important. Aside from this, she had appeared to have fairly open

expectations of motherhood generally. Her account of her feelings in the early postnatal period is as follows:

Well, certainly the classes say you'll be blue on about the third day, and I actually cried that day. I was alright for a bit after that, but when [the baby] was about three weeks old, I went – really – like a *heap*. I had some really *low* days. I'd just feel so *down*. And we were going up to see my husband's family, and I'd just got a cold and – the Friday night – I just thought, 'I can't go; I don't want to go, I don't want to speak to people.' And the baby had a really bad rash and I was just so – *low* – and everything was hurting, and I cried and cried and cried. And on the Saturday morning, I got up and cried and cried and cried. And I *knew* my husband really wanted to go – and then you get this guilt, from feeling so depressed, and it's not fair on your partner, and I thought 'I need to stop crying and pull myself together.' But it's a vicious circle, really, those first few weeks. But then things did start to improve. But I was very teary, the first few weeks. Not *every* day, but every few days. But I think, when I was feeling glum, it was probably just quite normal. Um – *overtiredness*, more than anything. (Rhona, interview two).

When Rhona was asked whether she was surprised at these feelings, she replied, 'Yeah! I expected just to feel thrilled to have my baby.' Apparently, nothing much had been made of this issue in either the NHS or the NCT classes which she had attended, although the immediate 'postnatal blues' had been briefly discussed. When asked, therefore, whether she thought that more attention should have been paid to maternal wellbeing in classes, Rhona's response was:

Yeah, yeah. And for the first couple of months, you know, if you do cry a lot, that's quite *normal*. You see, the other really good thing about meeting up with the girls afterwards – a lot of them went through that. So we could say, 'Oh, I cried my eyes out', and, 'Oh, so did I!' And that was great. But yeah, I guess it is glossed over a bit, really (Rhona, interview two).

Clearly, Rhona was able to normalise this experience through her contact with friends made at antenatal classes. Nevertheless, she was surprised at the negative feelings she experienced, and neither the NHS nor the NCT classes had prepared her. Interestingly, she adopted a 'pull yourself together' approach, especially when she felt that she was

distressing her partner. This was also a feature of Diane's experiences, as evidenced below:

I was getting really stressed out about things. And my husband said, 'Are you sure it's not postnatal depression?' Because I was getting really, really stressed out and crying all the time. It was just – not *like* me at all! I'm not a crybaby. I always – shove it away, and that's it. And, uh, so *that* surprised me. How emotional I was (Diane, interview two).

In response to whether she felt it was normal to feel that way, Diane replied:

To a certain point. And then it got to a couple of weeks, and I thought, 'Now this is getting...', I was getting *worried* about it. I was just getting really stressed out and upset. *All the time*. I was yelling at my husband all the time. And I thought, 'I'm not gonna *do* this; I've got to calm down. I don't know whether it was my hormones getting back into place or what. But that freaked me out a bit; that I really didn't feel in control (Diane, interview two).

The similarity to Rhona's experience is evident in Diane's determination not to feel, or behave, in the way that she did. She was clearly trying to tell herself to 'stop it', and was particularly alarmed that she did not feel 'in control'. Diane, like Rhona, was one of those mothers who had felt determined to be in control postnatally. The fact that she felt out of control was quite disempowering for her. When asked whether she had considered talking to anyone about her postnatal mood, she said:

For about ten seconds. I thought to myself, 'Right, if it gets – if this continues for a couple of weeks – then I probably will go and have a chat with my doctor', but I sort of calmed down. And I was, like, always snapping at my husband and he'd say, 'Well, what's wrong?', and I'd say, 'I don't know what's wrong.', and he'd say, 'Well, you *must* know what's wrong', and I'd say, 'Well, I *don't*. I don't know why I feel like this.' (Diane, interview two).

Diane was also asked whether anything, including her attendance at antenatal classes, had prepared her for such an experience:

Well, my sister and my midwife had both said that you get emotional after the baby. People *say* it, but the penny doesn't drop until you're actually experiencing it. And some people don't have it, and some people do. And I think I was, sort of, like – for *me* – I'm normally in control of my emotions most of the time, and I think it's quite *weakening* (Diane, interview two).

The final section of Diane's analysis is very revealing; she clearly equates 'control' with strength and 'lack of control' with weakness. The fact that she experienced the latter was quite distressing for her, and more than a little surprising. Both her personality (positive and confident) and her prenatal employment situation had accustomed her to organising and controlling events around her. The sheer unpredictability of new motherhood came as quite a shock against such a background. In Rogan et al's (1997) study of the transition to motherhood, 'being disorganised' and 'loss of control' were two significant categories to emerge in the process of becoming a mother. Some of the consequences for women were a temporary loss of confidence and loss of self-esteem. When added to other consequences such as 'feeling drained' and 'feeling isolated' (Rogan et al, 1997), it is hardly surprising that the net result is a feeling of depressed mood. Although such a response is widespread, it may prove to be more than usually distressing for women with personal characteristics like Diane's.

By contrast, there were other participants in the study whose prenatal self-doubt became almost a self-fulfilling prophecy in the early postnatal period. Sally, for example, had described herself as 'a natural worrier' even before the birth of her baby. This personal characteristic remained firmly in place after the arrival of her child, and is evident in this description of her mood in the weeks following the birth:

Well, I don't feel I've got postnatal depression but I think, the first few days, I was up and down. I was completely stressed about the breastfeeding and his feet. I had a long labour, an epidural and I lost a lot of blood, and I felt totally *shattered*. And I thought I was a hopeless mother. I'm still worried about everything. My husband is the one that has to calm me down. I still think, 'Oh, God, I can't be on my own'. I do worry. Sometimes, when people are admiring [the baby], I think they must be thinking, 'How has *she* managed to produce such a lovely baby, because *she's* nothing special'. Because my husband, I mean, he's quite handsome (Sally, interview two).

Sally's account reveals a number of insecurities and, in particular, a lack of confidence in herself. Much of this appears to be based on comparison with others. For example, she regarded herself as unattractive compared with her husband. In an earlier account of her experiences of infant care, she had felt that she was 'not as good as other mothers', and so on. What marks out Sally's experience from that of, say, Diane – above – is that Sally was not surprised at her own reaction to her situation. Indeed, she seems to have *expected* to feel the way that she did. By the time of the third interview – at around four months after the birth – she was describing her mood as follows:

I still worry about things, but I know that's what I'm *like*. I *am* a worrier. But, I mean, I'm better than I *was* (Sally, interview three).

Thus, it could be argued that Sally's phlegmatic acceptance of her own reaction to new motherhood was based on self-knowledge and, in particular, a close match between expectations and experience. Others, however, were quite surprised at feeling better than they had expected, after the rigours of the first few days:

I thought I'd be worse, in terms of depression, like, with the *crying* all the time, but I was only like that a few times. I was like it a bit up at the hospital. And then I came home and – nothing was getting done and – she was crying and, it just gets you so *easily*. But I think I'm alright really. Sometimes I get my up and down days but I think I'm alright (Gina, interview two).

This suggests that Gina, like most new mothers, experienced mild postnatal blues, but nothing more serious. By contrast, Mandy found that her immediate postnatal mood worsened to become postnatal depression. She did not recognise the symptoms herself, but those close to her did:

I've got postnatal depression. My mum noticed it and so did my mother-in-law. They said they thought I should see my doctor, so I did. I've got to take Prozac and I'm going back every fortnight to make sure they're working. I do seem to be doing better than what I was when I first went, but I still don't feel quite – myself – at the moment. And I'm not eating. I haven't been eating for ages, and the doctor keeps telling me off for that. But I can't face it, really (Mandy, interview two).

Three months after the birth, at the time of the third interview for this study, Mandy was still depressed and still taking Prozac as prescribed by her doctor. She was feeling a little better overall, but still having what she described as ‘good and bad days’. She appeared to accept the diagnosis of postnatal depression quite readily, despite not having recognised it in herself initially. There are, according to a local health visitor, a number of women who seem to be postnatally depressed but do not admit it. She claimed to be especially persistent in asking new mothers how they felt if this situation seemed evident. This health visitor found that, in her area, postnatal depression was three times more common than ‘normal’ (around 10% nationally, according to most studies). In her experience, women would ‘keep quiet’ for as long as possible, attributing their feelings to tiredness and lack of sleep. At around six months, when no improvement was noticeable, many women started to admit to feeling genuinely depressed.

In this study, some difficulty arose during interviews when participants who claimed to be feeling ‘fine’ actually appeared to seem quite low, if not actually depressed. One such participant was Tracey. Only one postnatal interview took place because of a number of problems with her baby’s health. During this interview, however, Tracey’s responses were often monosyllabic, and she seemed very dull compared with how she had been during the prenatal interview. Additionally, she seemed not to be interacting at all with her baby, which appeared quite strange and uncomfortable in the circumstances. She did admit to feeling a little isolated at home with the baby, and was considering returning to work part-time in the near future. Overall, however, she claimed to be ‘happy’, despite not appearing to be so.

Another participant who claimed to feel happy but who appeared quite ‘wobbly’ was Barbara. The breastfeeding had not worked out well for her, and the neighbours whom she had expected to be supportive were actually not. In addition, Barbara’s husband was working away from home, returning only at weekends. Getting out and about with the baby was awkward too, because Barbara’s flat was on the second-floor, which made manoeuvring a pushchair quite difficult. One would have expected that such a combination of factors might have led Barbara to feel quite isolated. However, she claimed not to have any negative feelings, during the second interview, and it appeared that she was ‘putting on a brave face’. This later became evident when she claimed, in a telephone conversation, that she was moving house in order to be with her partner. Apparently she had been missing him very much, and had found that his appearance at weekends only was quite disruptive to her own routine with the baby.

In contrast to this, another participant – Laura – seemed cheerful and confident in both of the postnatal interviews. Prior to the birth, she had felt particularly vulnerable because of her youth and lack of a partner. However, a fairly straightforward birth and extensive support from her own mother had enabled a smoother transition to motherhood than Laura had expected. Despite all this, she claimed to feel ‘a little depressed’:

Sometimes I cry and cry. But then I pick up; do some bottles or whatever – put some clothes away or something. I’d rather just get up and ...pick myself up, you know? But I wouldn’t go to any doctors ‘cos I’d be afraid they’d put me on some drugs, or something. ‘Cos that seems to be the answer for everything these days, doesn’t it? So If I feel I’m getting down, I have a little cry and then I go and do something. Keep busy (Laura, interview two).

Laura did not confide in her mother (with whom she was living) about these feelings. She did seem to manage herself very well, though. Her occasional low mood was

temporary, and by the time of the third interview - three months after the birth - she was feeling fine, especially as the baby was bigger, which made her feel more confident.

According to the experiences of this very small sample, it seems that temporary feelings of emotional distress are quite normal following the birth of a child. Nicolson (1990) distinguishes between depression and anxiety lasting just a couple of weeks after the birth and actual 'clinical' depression. She asserts that 'some degree of depression following childbirth should be included within the parameters of normal experience' (Nicolson, 1990:693). This echoes Lee's (1997) claim that 'happiness' and 'depression' are just the two ends of a continuum of normal adjustments to motherhood. In terms of women's own *definitions* of these feelings, one woman's sense of 'depression' might be another's sense of simply 'feeling a bit down'. While several of the case study participants felt at least a little 'down', only one of them had been diagnosed as suffering from postnatal depression. She was also the only woman who had consulted a doctor. Others – including Laura – implied that they felt that prescription drugs would be an unsuitable response to negative feelings after the birth. According to research undertaken by Whitton et al, (1996), this is a common response. In that study, the vast majority of new mothers who were experiencing postnatal depression had not contacted their doctor and did not feel that pharmacological treatments would be appropriate.

Perceptions of severity of negative mood may also depend on women's prenatal expectations of how they should or *might* feel after the birth. Clearly, this covers a vast spectrum, as the evidence above has indicated. However, there is some suggestion that realistic expectations auger better for new mothers than simply an expectation that everything will be fine. Those who anticipated being in complete control of themselves

and their new maternal situation appeared to fare worst, in this respect. Given that those women to whom this applied had attended antenatal classes, it could be argued that insufficient preparation had been offered. Nevertheless, amid the plethora of factors that may affect maternal well being, personality seems to play a key role. Therefore, there may be genuine limits to the extent of prenatal preparation that is feasible within the lay, informal *or* formal sectors.

Summary

- Almost all of the case study participants felt at least a little ‘down’ following the birth of their babies.
- Most new mothers felt worse than they had expected, in the early postnatal period.
- Antenatal classes appeared not to have prepared women for their postnatal feelings.
- Factors affecting low mood were many and various, but personality seemed to be particularly influential.
- Social class appeared to be less important than the literature had indicated.
- Medical treatments for postnatal depression or ‘low mood’ were seen as irrelevant or inappropriate by most of the case study participants.
- According to the views and experiences of this group, some feelings of depression are normal following the birth of a baby.

7.4. Questionnaire respondents’ perceptions of well being

The questionnaire respondents were asked to describe how they had been feeling since having their babies. As with the case study participants, a wide range of emotions appeared evident in their responses. Indeed, categorizing the data was made difficult by the variety of emotions reported within individual responses. Initially, nominal

categories were constructed in order facilitate cross-tabulation with other factors. Hence, self-reported wellbeing was described either as 'positive' or 'negative'. There were nineteen responses in each of these categories, with one omission. When cross-tabulated with attendance or non-attendance at antenatal classes, no association was found ($p = 0.096$). Indeed, six out of the seven non-attenders reported feeling mainly positive in the early postnatal period, while eighteen attenders felt negative, compared with thirteen who were mainly positive.

Previous infant care experience also appeared not to be significantly associated with self-reported maternal wellbeing. On this issue, equal numbers of those with previous infant care experience felt either positive or negative. There was also no association between reported wellbeing and perceptions of adequate social support.

More detailed consideration of how women felt in the early postnatal period may be derived from broadening the categories to take account of 'mixed feelings' and changes over time. The following categories were constructed on that basis:

Mainly positive	(6)
Mixed	(15)
Initially negative; now positive	(13)
Mainly negative	(4)

In the following accounts, the baby's age is included because case study results indicated the importance of changes over time for new mothers.

In the first category (mainly positive), typical responses were as follows:

I have been feeling very well and have no problems with coping with a new baby.
(Respondent 25; 7 week old baby)

Very happy; content, fulfilled. (Respondent 21; 5 month old baby)

In the second category (mixed), which was also the largest, the following responses were included:

Excited/proud. Very happy/very tired! Sometimes a bit low/tearful/worried. Mixture of lots of emotions! (Respondent 12; 4 week old baby)

Most of the time I feel very lucky and humble to have a baby and am beginning to enjoy her company. However, there are times when I wish things were back to the way they were before I had the baby – just my husband and I. (Respondent 10; 6 month old baby)

Lots of mixed emotions – happiness, worry, protective pride, confined. (Respondent 15; 4 week old baby)

Within these two categories, the baby's age did not seem to make much difference, although it might be expected that negative feelings such as anxiety would be more prevalent in the early weeks. Nevertheless, the relentless physical demands, such as feeding and nappy-changing do not diminish significantly over a six month period. It may be partly this realisation of the ongoing nature of the demands of motherhood that accounted for two of the responses above. For example, one mother's use of the word 'confined', and another's reference to 'the way things were' before having the baby suggest a clear recognition of the loss of earlier freedoms. This ties in closely with the explanations of both Nicolson (1990) and Rogan et al (1997), in which it is claimed that the transition to motherhood is characterised by losses as well as gains.

In the category 'Initially negative; now positive', the following responses were typical:

In the first month I was overwhelmed by the responsibility. The next two months, I struggled to cope and was tired and a bit depressed, but since then we've got into a routine and now I'm enjoying every minute of it! (Respondent 29; 5 month old baby)

First week – on high. Following weeks – tired and sometimes short-tempered. Fifth week – can see light at end of tunnel; feel I am adjusting and getting more sleep. (Respondent 20; 5 week old baby)

When he was born I had PND. I got over that and ever since then I have been quite happy. (Respondent 27; 6 month old baby)

With thirteen of the thirty-eight responses, this was a large category. Many new mothers mentioned tiredness, frustration and early difficulties with breastfeeding. For most, the early stresses seemed to abate as they gradually adjusted to the demands of motherhood. For others, however, negative feelings were still dominant at the time of completing the questionnaire:

Very tired; sometimes very low. (Respondent 8; 6 month old baby).

I have mood swings, e.g. sometimes I get very upset about the simplest of things. Feeling I have to put an act on to relatives and even husband because he won't truly sit down and listen to me about my feelings and even wishes to forget them. (Respondent 11; 7 week old baby)

Take each day as it comes. I have felt as though I'm not coping well (husband thinks I am). (Respondent 7; 4 month old baby)

In the final two of the three examples above, things seemed to be made worse by the fact that these women's partners were not taking their feelings seriously. 'Putting on an act' for loved ones is also perhaps a reflection of the common belief that new motherhood is a time of celebration and happiness. This, according to Nicolson (1990), is a popular assumption in both lay and professional circles. Although happiness may be the dominant emotion at a superficial level, the reality for most new mothers is far less happy, at least in the very early weeks. In order to assist new mothers in the process of adjustment, a more honest and realistic approach within all sectors would probably be more helpful. Like many aspects of the transition to motherhood already explored here, it appears that the promotion of *realistic* expectations may represent the best type of preparation.

Summary

- Equal numbers of respondents felt 'positive' or 'negative' in the early postnatal period. Neither state was found to be significantly associated with previous infant care experience, social support level or type of antenatal education received, however.
- Most of the questionnaire respondents experienced mixed emotions during the early postnatal period
- Many new mothers felt quite negative initially, but then found themselves adjusting and feeling more positive
- A smaller proportion of the questionnaire respondents reported only positive feelings
- In the smallest category, some new mothers still felt overwhelmingly negative after four or five months with their babies
- There is some evidence to suggest that cultural pressure to appear 'happy' may exacerbate new mothers' already negative feelings
- As with the case study participants, the experiences of the questionnaire respondents suggest that it is quite normal to feel at least a little depressed at some stage in the early postnatal period.

7.5. Conclusion

This and the preceding three chapters have described the transition to motherhood as experienced by a small sample of women in the Plymouth area. In so doing, the key themes of infant care, parental relationships and maternal well being, identified in Chapter Two, have been explored using a chronological approach. This approach took the final trimester of pregnancy as a starting point for the gathering of data related to this transition. It ended with the new mothers' experiences three to six months into the

postnatal period. 'Expectations', prior to the birth, were compared and contrasted with the 'experience' of new motherhood.

Throughout this process, the participants' various types of antenatal education - whether formal, informal or lay - were used as a means of shedding light on their expectations and experiences. The respective value of these various forms of antenatal preparation has also been questioned. For example, the usefulness of antenatal classes (both formal and informal) was considered in the light of recent concerns over their effectiveness, relevance and typical client base. Issues of non-attendance were also explored, giving opportunities for non-attenders to highlight alternative sources of antenatal education. Attention to these yielded a broader concern with social support issues for all expectant and new mothers. Here, it was seen that satisfactory mobilisation of social support may be more important for maternal well being than antenatal education in its formal guise. Nevertheless, the latter is apparently useful as a vehicle for generating such support among those who would otherwise *lack* lay support. Indeed, the emotional support opportunities afforded by antenatal classes appeared more valuable than the information-based ethos upon which the classes were founded.

The issues of greatest importance to women in the transition to motherhood were most often those not well covered by formal or even informal antenatal education. It seems that cultural, social and economic changes have undermined the ability of middle-class women in particular to adjust to the reality of being mothers. Diverse information sources exist to enable them to gain information about many aspects of the transition to motherhood, especially childbirth. However, the accounts of the new mothers in this study suggest a mismatch between the expectations generated by those sources, and the

actual experience of being a new mother. If anything, the lay education and support encountered by many of the women in this study was most realistic and hence useful to them. This emerged as especially important for maternal well being, the centrality of which is obvious in light of the other themes considered here.

The next and final chapter revisits the principal themes and topics to have emerged both here and in the preceding chapters. In so doing, it sets out to discuss the issues and their policy implications in greater depth.

Chapter 8 Discussion and policy recommendations

8.1. Introduction

This study sought to investigate the ways in which antenatal education - in its various forms - impacts upon the transition to motherhood. According to the issues identified in Chapter Two and restated above, the aims and objectives of the study were as follows:

- To investigate the range, accessibility and content of statutory and voluntary antenatal education services in the Plymouth area.
- To investigate factors affecting non-attendance for such services, including non-attenders' perceptions of them.
- To examine the role of lay systems of knowledge and support in the transition to parenthood.
- To investigate the differential impact of different patterns of knowledge and support on the experiences of new parents, with particular attention to the three key areas of maternal wellbeing, parenting skills and parental relationships.

The research methods and instruments used were:

- Semi-structured interviews with case study participants (attenders and non-attenders of antenatal classes) spanning late pregnancy to six months after the birth. Participant diaries.
- Questionnaires administered to first time mothers who had given birth within the past six months. Again, both attenders and non-attenders of classes were targeted.
- Interviews with relevant local health professionals.

The literature review (Chapter Two) suggested that statutory - formal - antenatal education focuses mainly on labour and birth while largely ignoring postnatal issues. Consequently, many new parents feel unprepared for the rigours of caring for a new

baby. Additionally, the postnatal period presents challenges of personal adjustment for new mothers in terms of their changing role and responsibilities. Parental relationships may be strained and, in the absence of family support, shortened postnatal hospital stays may add to the problems of adapting to new parenthood. Successful breastfeeding, for example, may depend on extensive professional support in the early postnatal period. Crucially, all of these factors affect maternal wellbeing. The latter may be shaped by the extent to which new mothers feel prepared and supported in adjusting to their new roles and responsibilities. Popular assumptions that new motherhood automatically confers happiness remain dominant. Such assumptions may, in turn, inform women's *expectations* of new motherhood.

Given the longitudinal approach adopted in this study, the dominant comparative theme of 'expectations v experience' will be used to frame the forthcoming summary discussion. Within this, the emergent issues of 'unreadiness' for motherhood and the closely associated tension between learnt and natural elements of the transition will also be discussed. The structure of the chapter broadly reflects the chronology of becoming a mother, beginning with antenatal education / preparation and moving on to childbirth and postnatal issues. Comparisons between formal and lay approaches and between attenders / non-attenders of antenatal classes will be integrated as appropriate. Finally, the chapter considers the strengths and weaknesses of the study as a whole before ending with a summary of policy recommendations generated by the research findings.

8.2. Formal antenatal education: expectations and experiences

8.2.1. Labour and birth

“The relaxation techniques were useful but could be more in-depth, with different types of delivery discussed, e.g. more complicated situations.” (Questionnaire respondent #34).

The participants had been able to able, in retrospect, to highlight any differences between what they had expected from classes and what they had actually experienced. Indeed, the reported experiences ended up illuminating the original expectations. The vast majority of those attending classes (whether NHS or NCT) expected coverage of relaxation techniques and pain control in labour, together with the various stages of labour itself. Overall, these expectations were matched, although later criticisms emerged over the way in which ‘normal’ vaginal delivery was covered by comparison with caesarean or forceps deliveries. The new mothers felt that all eventualities should have been dealt with, in order to provide more realistic expectations of the birth itself. These comments resonate with those of Kelly (1998) who claims that realistic rather than ‘utopian’ childbirth expectations need to be promoted. In light of the twenty-two per cent caesarean section rate in England and Wales (Department of Health, 2003), this claim is justified. None of the participants had voiced expectations of a complicated delivery, yet several went on to have one. Childbirth educators may be in a difficult position where this topic is concerned, however, as they wish to reassure - rather than to frighten - the women who attend antenatal classes. Furthermore, the issue of repetition may be problematic, as the literature accessed by many of the women in the study echoed the coverage of labour and birth within the classes. It was unclear whether such

repetition was perceived by these women as reassuring, possibly representing an element of familiarity in an unfamiliar situation. Finally, and related to the previous point, is the immutable fact that those who have not yet experienced childbirth may never fully understand or feel prepared for it.

8.2.2. Infant care skills

“We didn’t really touch on that, apart from breastfeeding.” (Sally, Interview One)

Most of the participants had expected information and advice on infant feeding and general infant care. Some women had thought that postnatal social / emotional issues might also be discussed. As the results detailed in Chapter Four suggested, many of those who attended antenatal classes were disappointed to find that coverage of postnatal topics was minimal. The lack of infant care advice was especially criticised. The women attending the classes were fully aware that they would soon have a new baby to care for, and no knowledge of how to do so. Apprehensions were exacerbated by the absence of any previous experience of babies, together with – in many cases – the absence of family support following the birth. One such participant was especially disappointed as the literature provided by the local NHS Trust - describing its antenatal class topics – had detailed ‘infant care skills’ for inclusion in the programme, yet the classes had failed to deliver it. Instead of complaining, she waited to see whether the topic would be dealt with in her NCT classes instead. In the end, neither type of antenatal class dealt with the topic, leaving this expectant mother and others *like* her with absolutely no preparation. Health care professionals may claim (as one interviewed in this study

had done) that it is hard to encourage expectant mothers to see beyond the birth, but the extent of expectation among the participants contradicts that view. Indeed, their expectations matched those encountered by Nolan (1998). Her recommendation that basic infant care skills (and practice – possibly with dolls) should form an integral part of antenatal classes was echoed quite loudly by the attenders in the study. This deficiency contributed greatly to widespread feelings of ‘unreadiness’ for motherhood - a concept that recurred at all stages of the transition.

The only infant care topic to be covered in any depth was infant feeding. Breastfeeding was emphasised although, retrospectively, those who chose to breastfeed were critical of the lack of realism imparted by those who facilitated their antenatal classes. In essence, most women were unprepared for how difficult breastfeeding turned out to be. By contrast, those who expected to bottle-feed were critical of its lack of coverage. As with coverage of childbirth, a more realistic and less *idealised* set of expectations in this respect might usefully be encouraged among women attending antenatal classes.

8.2.3. Other postnatal issues

“There should have been more discussions regarding life with a new baby – e.g. relationships / emotions.” (Questionnaire respondent #18)

The lack of attention to personal / emotional issues following the birth emerged as a major criticism. According to the questionnaire respondents, this was the *least adequately* covered of all the topics in antenatal classes. While physiological postnatal care (e.g. postnatal exercise) was covered, the equally important topics of parental relationship changes, maternal wellbeing and postnatal depression were

discussed either inadequately or not at all. Prenatal expectations were hard to identify because women were asked about these issues retrospectively, and may not have been aware of their importance until after the birth. However, childbirth educators should realise and explain their relevance to expectant parents, in order to raise awareness of possible negative outcomes in these areas. It may be the case that community midwives feel unprepared to tackle psychosocial issues, preferring to concentrate instead on labour and birth. Indeed, this reflects the biomedical emphasis within maternity services more generally. The apparent rigidity of the NHS antenatal class format might be better suited to the midwives running the classes than to the women attending. The level of responsiveness to ‘consumer demand’ seemed minimal, according to participants’ own reports. By addressing just *this* element of the classes, a number of beneficial changes – encompassing many of the topics felt to be marginalised – might result.

8.2.4. Teaching and learning style

“It was just an overload of information instead of discussing what we’d like to do, or whatever.” (Diane, Interview One)

It was harder to assess the expected *style* (as opposed to content) of the classes from the perspective of those who attended, although the criticisms that later emerged concerning the overly directive approach (of NHS classes in particular) did suggest a marked departure from earlier expectations. The expectant mothers wanted more in the way of discussion, but the midwives running the classes tended to impart information based on ‘what to expect’ in the maternity unit. This resonates with Nolan and Hicks’ (1997) assertions regarding the prescriptive approach utilized by

NHS community midwives. Indeed, the directive style *was* perceived by many as being too prescriptive, especially by comparison with NCT classes, in which discussion of the issues was actively encouraged. These findings supported Underdown's (1998) evaluation of the teaching style that prevails in NHS antenatal classes. Given that most participants in the study (whether attending antenatal classes or not) claimed to have read extensively around the topic of labour and birth, it seemed remiss to repeat the information in classes without going further by *discussing* it. As it turned out, many attenders were forced to adopt compensatory strategies by utilizing coffee-break time to discuss issues between themselves.

8.2.5. Social benefits

"It was nice to be with other people who are in the same boat as you... you don't feel so isolated." (Sally, Interview One)

The social benefits of attending classes – i.e. meeting other expectant parents - were widely anticipated and, in many cases, actively sought. In fact, the attenders placed a high value on the opportunities afforded to meet and talk with others in a similar situation. There was no real distinction here between the NHS and the NCT classes, except that the latter provided more for *couples* than just for mothers. This valuable social benefit may represent one of the real strengths of formal antenatal education. As Nolan (1997a) suggested, the antenatal class setting appears to fill a gap in terms of substituting for the traditional women's network. It is also apparent that those for whom traditional networks may be harder to access are also those most likely to attend antenatal classes. Looked at in this light, it may be over-simplistic to suggest that '...socially advantaged women take a slice of the antenatal education cake out of

all proportion to their numbers and obstetric risk...' (Nolan, 1995: 144). It could be claimed instead that formal antenatal education offers these women precisely what they lack - opportunities to meet others in similar circumstances and to initiate relevant support networks. Importantly, a number of women were clearly aware of the desirability to have relationships with other new mothers once their babies had arrived. Their expectations of postnatal social needs were therefore quite explicitly acknowledged, casting further doubt on some professionals' claims that women are unable to see past the birth itself.

8.2.6. The expectations of non-attenders

"My visions of antenatal classes are lots of women sat on mats in a big room learning to relax themselves." (Questionnaire respondent #39)

The non-attenders' perceptions of the style and content of antenatal classes were purely prospective and could not, of course, be compared with experience in most cases. The one exception concerned a questionnaire respondent who classified herself as a non-attender, but who had, in fact, been to one antenatal class. The experience was just as 'bad' as she had expected – just like being back at school and with inadequate opportunity for discussion, apparently. It is interesting that this is a common, yet uncannily accurate perception of non-attenders. Many in this study thought that antenatal classes would be quite directive, reflecting Cliff and Deery's (1997) research which indeed found that they are 'too much like school'. This did not sit well with younger, unmarried mothers-to-be in particular. Some expressed fears of a judgmental attitude, not only from the health care staff running the classes

but also from other women attending them. On content, most were able to suggest that labour and birth would receive the greatest attention, while some also felt infant care issues would be covered. The really interesting distinction related to an ‘us and them’ perception – which the quote at the top of this section strongly implies. Several case study non-attenders, for example, referred not only to a ‘proper’ way of learning (i.e. the formalised approach to antenatal education), but also to ‘proper’ expectant mothers, who happened to be older and married. Hence, the younger and often unmarried non-attenders were acknowledging either subtly or overtly – an awareness of cultural *stereotypes* (of motherhood) into which they felt they did not fit.

8.3. The role of lay antenatal education

“I’ve got a few books I’ve read – pregnancy books that I’ve borrowed – and I’ve heard all different stories from people as well.” (Gina, Interview One)

Lay antenatal preparation consisted mainly of books and magazines or information and advice from relatives or friends – and was utilized by both attenders and non-attenders of antenatal classes. The principal distinction between the two groups was that these represented the *only* sources of preparation for the non-attenders. Conversely, the antenatal class attenders accessed both lay *and* formal sources. There is, however, a great deal of overlap between the two. For example, the chances to develop lay networks from earlier meeting at antenatal classes represented a lay ‘spin off’ from a previously formal setting. Additionally, many of the books and magazines commonly accessed by expectant mothers contain articles

written or approved by doctors or midwives. These could therefore be described more suitably as ‘informal’ despite appearing in the lay sector. Similarly, information or advice given by friends and relatives may in turn reflect more formal influences. Examples of this might be the former or current medical advice concerning frequency of infant feeding or, perhaps, recommended sleeping positions for new babies. In light of this, considerable caution is required in distinguishing explicitly between lay and formal information sources.

Despite the overlaps, a couple of distinctions were evident between attenders and non-attenders in the study. First, human information sources - relatives, friends and acquaintances - were accessed differently by the two groups. The main distinction concerned families. While most of the non-attenders drew heavily on information and advice from their own mothers and sisters in particular, this was less common among those attending antenatal classes. Geographical mobility, perhaps linked to higher socio-economic status, appeared relevant here, as many of these women lived a long way from their families of origin. By contrast, the non-attenders seemed to have more local (and accessible) family ties. Friends - including recent friends or acquaintances accessed *through* antenatal classes - played a larger part in the lay antenatal preparation of antenatal class attenders overall. Second, expectations of the birth might be implied by the type or content of the literature accessed. For example, books about water birth were mentioned by some of the attenders but none of the non-attenders. This suggests greater expectations of choice and proactivity in childbirth by those attending antenatal and – in particular – NCT classes.

For all of the participants, a diversity of information sources was accessed prenatally. The fact that all of these women drew on lay sources of information, irrespective of whether or not they attended antenatal classes reinforces the need to broaden the definition of what constitutes 'antenatal education'. It may be unrealistic to ignore or devalue the role of lay knowledge by comparison with the 'formal' knowledge accessed through antenatal classes. Indeed, as discussed above, the extent of the overlap may be great enough to make comparisons unhelpful. And yet, that view remains implicit among those who view non-attendance for antenatal classes as a 'problem'. None of the evidence from this study suggests that non-attenders fared any worse than attenders in terms of birth preparation and outcome but, as the following section suggests, *expectations* of the birth might have been differentially affected by the type of preparation received.

8.4. 'Coming, ready or not!' Expectations and experiences of birth and the postnatal period.

8.4.1. Labour and birth

"I'm having the epidural. They've got that on my notes and everything. I've got a birth plan, but my midwife has said that things don't always go the way you think they will." (Laura, Interview One)

When speaking of the upcoming labour, most participants focused on the form and extent of pain relief that they wanted or expected during the birth. Whether or not they had attended antenatal classes, all seemed familiar with the various types of analgesia on offer in the hospital setting. Many had made decisions about what they were or were *not* prepared to accept in this respect, prior to the birth itself. Indeed,

the choices made were implicitly linked with the extent of control that individual participants may have expected to have during labour. For example, two of the women claimed to want a more 'natural' birth experience: one of them was explicitly against epidural anaesthesia; the other, against Pethidine. Interestingly, the epidural emerged as a benchmark for the extent of intervention expected or desired, with a further distinction between attenders and non-attenders of antenatal classes. Most of the non-attenders preferred the prospect of an epidural – and had already planned to have one, while most of the attenders were adamantly against it. This reflects Nelson's (1983) assertion that better-educated middle-class women wish to engage with the childbirth experience more fully, with less medical intervention. These decisions clearly imply an expectation of *choice*, although it has already been established that this had not been extended to the place of birth. None of the case study participants had been offered the choice of a home birth, despite an expressed interest by three of them. These women had been deterred by their midwives, apparently on grounds of safety. As NHS policy does not expressly prohibit home births for first-time mothers, it seems in reality that *persuasion* by health professionals, such as that experienced here, serves to encourage expectant mothers into the hospital setting. These findings resonate with a nationwide NCT survey in which it was found that sixty per cent of women were not offered a choice about where to give birth, while those who wished for a home delivery tended to be persuaded otherwise (NCT, 1997). Therefore any notion of choice in this matter may be illusory. The practice also quite clearly upholds the biomedical view of childbirth as 'normal' only in retrospect.

The most negative reports were associated with the greatest disparities as, for example, in the case of Diane. She found not only that her choices of pain relief were invalidated by her situation, but also that the postnatal ward staff were patronising and demeaning. Her summary view of the experience was one of great disappointment and in no way reflective of her prenatal expectations. Other participants' criticisms of the hospital setting focused on the shortage of staff support on the postnatal ward and the failure of staff to consult or inform them about decisions concerning either their own or their babies' care. Interestingly, the younger women who had not attended antenatal classes were seemingly less dissatisfied overall with the birth or the hospital experience. Most of them had also had quite straightforward deliveries without the need (or time) for the epidurals they had already planned. The key exception in terms of the hospital experience was Mandy, whose baby developed health problems early on, and who found the hospital staff quite offensive and inconsiderate of her feelings. Her own childbirth experience had been worse than expected, but was probably eclipsed by subsequent problems with her baby's health. Tracey, the only participant to have had an emergency caesarean section, also experienced grave problems with her baby's health. The anxieties that stemmed from that situation may also have diminished the disappointment with the birth that, in the absence of subsequent problems, might have been perceived more acutely.

In summary, most of the participants' experiences of childbirth differed from their earlier expectations. For some, the reality was better than expected; for others, worse. Key differences between expectations and experience were closely aligned

with the issues discussed above. There was, in effect, an expectation of choice (of pain relief, in particular) that often was not met, and an expectation of safety and reassurance more generally within the hospital setting that also proved disappointing for some. Nevertheless, most had acknowledged that they did not really know *what* to expect. The most important implication of a worse-than-expected birth and hospital experience seemed to be the subsequent effect on maternal wellbeing, as discussed further in section 8.4.7.

8.4.2. General infant care

“I haven’t looked after a tiny baby before. That scares me, in a sense”. (Barbara, Interview One)

Infant care was an area that most of the case-study participants had viewed with trepidation. Doubts about basic infant care ability (e.g. holding, bathing or dressing the baby) seemed to be influenced more by previous inexperience than by attendance or non-attendance at antenatal classes. Consequently, those with previous infant care experienced (perhaps with younger relatives or friends' babies) appeared less apprehensive - though somewhat more realistic - about the prospect of caring for their own babies.

The questionnaire respondents' evaluation of antenatal class content had indicated a perceived lack of coverage of infant care skills, and most felt that classes did not provide them with 'realistic preparation for life with a new baby'. As discussed earlier, all five of the case-study participants who attended antenatal classes claimed that infant care skills were omitted. Disappointment was expressed by most of these women, although some of them had hoped that midwives on the hospital postnatal

ward would show them the basics of infant care initially. We know, however, that the average postnatal hospital stay has been reduced to two days (Audit Commission, 1997), a very short time in which to gain confidence in this respect. Additionally, as suggested above, new mothers had found that postnatal ward staff were often too busy to offer much help.

The suggestion (made by two of the health professionals interviewed for this study) that expectant mothers are 'unable to see beyond the birth itself' was not borne out by the participants in this study. Instead, they clearly and precisely indicated a need for advice on infant care that was subsequently not delivered despite its having been promised in some of the literature on antenatal classes provided by the local health authority. This represents a poor response to consumer demand that is also at odds with the spirit of preventive health care. Moreover, antenatal class providers need to be aware that their client base is largely made up of women for whom lay advice and information may be especially difficult to access. The cultural reality is that growing numbers of first-time expectant mothers have absolutely no previous experience of infant care.

Rogan et al's (1997) study of the transition to motherhood utilised the concept 'unready' to describe how first-time mothers felt about caring for a new baby. Those without any previous infant care experience were found to be more 'unready' than those with. That same study conceptualised the ways in which new mothers coped as 'working it out'. A parallel can be drawn here, as many of the new mothers in this study described the process as 'muddling through'. They tended to learn by trial and error, with most of the basic infant care tasks about which they had felt most

apprehensive turning out to be rather less daunting than expected. This was not the case with infant feeding, though. Breastfeeding in particular emerged as surprisingly problematic experience for many of the new mothers, as discussed below.

8.4.3. Infant feeding

“At the classes, they made it [breastfeeding] sound very idealistic, but my major gripe was, neither of them said how difficult it is.” (Sally, Interview Two)

As with the issue of pain relief in labour, most of the expectant mothers in the study had fairly firm ideas prior to the birth about how they would feed their babies. Among the case-study participants, a distinction emerged between attenders and non-attenders of antenatal classes, with most of the former electing to breastfeed and most of the latter, to bottle-feed. Overall, those who had elected to bottle-feed had no problems with the method. The opposite was true for the breast-feeding mothers.

They stressed the nutritional benefits and the 'naturalness' of breastfeeding, apparently with little regard for the 'learnt' aspects of this method. Interestingly, none of the women who planned to breastfeed expressed *doubts* about the anticipated success or failure of their chosen method. The unspoken consensus appeared to be that breastfeeding would come naturally *because* it was natural. Not a single expectant mother suggested that they might need to learn or be supported in this endeavour. Unlike the issue of labour and birth, on which they acknowledged 'unreadiness' the women were surprised by the difficulties of breastfeeding because they did not *realise* that they were unprepared. This may have some cultural links with (unrealistic) perceptions of breastfeeding - as 'natural' and straightforward -

gleaned from magazines and advertisements, for example, as well as from occasional observations of already-established breastfeeding on the part of others. The difficult experiences that many participants had with breastfeeding represented a gross mismatch with their earlier expectations, leading to complaints that the antenatal classes (where applicable) had failed to provide realistic coverage of this. Frustration and disappointment were the logical consequences. Therefore, childbirth educators have a role to play in stressing the potential difficulties in establishing breastfeeding, while more could also be done on postnatal wards to assist and support those who choose this feeding method. Further elements of realism might be introduced through mentoring strategies, perhaps by encouraging new mothers to revisit the antenatal class setting in order to discuss their own experiences of breastfeeding.

8.4.4. Becoming a mother: Lifestyle impacts

“The baby comes first and I have little time for myself.” (Questionnaire respondent #24)

Participants' expectations of new motherhood were largely influenced by previous domestic or work experiences. For example, those previously in full-time employment focused on *organizational* aspects of life with a new baby, drawing parallels between paid work and new motherhood. As these women generally had little or no previous experience of babies, they based their expectations of new motherhood on paid work, i.e. something to which they *could* relate. Associated with this was a clear desire to remain in ‘control’ of the postnatal situation, by using organizational strategies that might be applied in the workplace. Despite their earlier

optimism, such expectations turned out to be unrealistic. The unrelenting and unpredictable demands that they faced – especially if breastfeeding – were completely unfamiliar and emotionally draining. In essence, the experience was much harder than expected. Indeed, the reality of life with a new baby provoked comment from many of the case-study and questionnaire participants on how little time there was to get everything done during the day. This applied to both attenders and non-attenders. Women were surprised and disappointed by how little time - and energy - was left for themselves. They found themselves ‘muddling through’ as best they could in the early weeks following the birth, and gradually reached a ‘working it out’ stage (Rogan et al, 1997) within about three months. By contrast, those participants (principally non-attenders) with limited employment experience but greater experience of babies and general infant care suggested more realistic expectations of new motherhood. Crying babies and lack of sleep, for example, were commonly anticipated by women in this category, and these expectations were clearly related to earlier (usually family) experiences. In this respect, lay antenatal preparation may be more useful and realistic than its formalized counterpart which, of course pays little attention to these issues anyway. Antenatal classes should, however, go further in acquainting expectant mothers with the more significant lifestyle changes that accompany the arrival of a first child.

8.4.5. From ‘couple’ to ‘family’: the new parental relationship

“We don’t spend as much time together as we did. It has been rather stressful as we are both new parents, but we seem to be getting there.”
(Questionnaire respondent #19)

Expectations of changes in the 'couple' relationship among case study participants were fairly optimistic overall and, in retrospect, overoptimistic. Most of those who were living with the baby's father felt that their relationship would be *strengthened* by the arrival of a baby. Such beliefs appeared to be linked to wider notions of the 'natural' progression from couple to family. As such, 'bringing us closer together' was how most of the expectant mothers had anticipated this change. The literature on this topic would have suggested more negative outcomes for most couples, however. Anxiety, fatigue and perceptions of inadequate partner support are common stressors contributing to decreased (rather than increased) satisfaction with the parental relationship postnatally (e.g. Cox et al, 1999). Identity and lifestyle changes for the woman – as suggested above – also contribute to a temporary deterioration in the couple relationship (Nicolson, 1998). As it turned out, many of the women did experience these phenomena. Not surprisingly, the reality was at odds with earlier expectations because of a lack of appreciation of the extent of the changes to come. Within the formal sector, antenatal classes are again responsible for misconceptions in this respect, as they fail to raise awareness of the realities of such issues. Indeed, this was the *least* well covered topic, according to those who attended, reflecting the low ranking of this topic in classes nationally (Kelly, 1998). Yet, as with breastfeeding, it is incumbent upon those 'in the know' to help enlighten and hence *prepare* first-time expectant mothers for possible future difficulties.

There is considerable untapped potential in the antenatal class setting for raising awareness by using a 'bottom-up' approach, with far greater input from experienced mothers. Again, a discursive approach to this and other psychosocial issues might

usefully be encouraged. Although it would be facile to suggest that better coverage in antenatal classes could directly *prevent* postnatal relationship difficulties, awareness-raising might at least help to normalize the issue for those concerned. A key problem for NHS antenatal education as it stands, however, is in its orientation towards expectant *mothers*, rather than expectant *parents*. On this, NHS classes might usefully embrace the NCT approach, by facilitating greater involvement on the part of couples.

8.4.6. Social support

“I haven’t called on my mum as much as I had expected to. She has babysat a few times, but we have too many differences in approach, really.” (Tracey, Interview Two)

Adequate lay support in the postnatal period had been anticipated by most of the case study participants, although a distinction had emerged between attenders and non-attenders of antenatal classes. The former stressed the support of friends (including new ones made at classes), while the latter emphasised a greater role for relatives. In particular, the non-attenders expected their own mothers or mothers-in-law to be key supporters in the transition to motherhood. Thus, while some differences emerged, all of the participants expected to be able to *mobilise* lay support which, according to Cutrona (1986), would be expected to act as a stress buffer for the new mothers. Indeed, social support is supposed to promote maternal wellbeing despite difficulties in establishing - as Oakley (1992) has asserted - precisely *how* this happens. Furthermore, quantification is problematic, while perceived *quality* of support seems

to be especially important (Cutrona, 2000). In particular, emotional support from a woman's partner is seen as pivotal (Sheppard, 1997; Priel and Besser, 2000).

For most of the women, the *actual* support they received in the early postnatal period closely resembled their earlier expectations. In a couple of cases, though, this varied either in origin or in the *type* of support received. One of the non-attenders, for example, had overestimated the quantity and duration of support from her own mother. Another participant chose to accept less maternal support than was offered because of differences in approach to infant care. This exemplified Collins et al's (1993) assertion that inappropriate support may actually be deleterious, rather than beneficial to maternal well being, especially if it is perceived as undermining the *confidence* of the new mother. The antenatal class attenders were successful, overall, in mobilising the support of friends, including those they had met through antenatal classes. One of these women was emphatic about the importance of these relationships in helping to reduce the stresses of new motherhood. Additionally, she highlighted the value of antenatal classes in affording the opportunities to make such beneficial and mutually supportive links. Her own relatives were inaccessible, making the support role of friends even more significant. This in turn is consistent with Nolan's (1997a) interpretation of antenatal classes as modern substitutes for traditional support networks.

The questionnaire respondents also reported plentiful lay support. The vast majority drew on support both from relatives and from friends. No distinction was apparent between attenders and non-attenders of antenatal classes in terms of the extent of support nor, indeed, did it seem to be related to maternal age or marital status. This

applied also to partner support, as the same group of respondents was largely *satisfied* with the level and quality of partner support they received. Financial, emotional and infant care support were generally perceived to be adequate, although support with housework was not. Overall, most of these women found their partners to be 'as supportive' as they had as they would have wished. Indeed, from a range of possible lay support sources (including friends and relatives), partners were named as the first choice for most of the new mothers.

The case-study participants were more critical, however. The in-depth accounts enabled by both pre- and postnatal interviews suggested *less* satisfaction with partner support overall than had been anticipated prior to the birth. Thus, the postnatal reality fell short of expectations in most cases. Specifically, the unequal sharing of infant care tasks and housework prompted feelings of dissatisfaction – even bitterness. Partners' perceived lack of initiative and spontaneity in these areas was especially criticized. Several women complained that their partners assumed that baby care was principally (or even exclusively) the mother's responsibility – based on partners' apparent beliefs that the mother was the 'expert'. Yet more work - i.e. the *delegation* of tasks - then fell to the women concerned, representing 'another invisible, mental job' (Walzer, 1996: 226).

This issue has important implications for those involved, as it has been found that greater paternal flexibility in the domestic arena is significant in helping to mitigate parental relationship problems (Levy-Shiff, 1994). Further, as indicated below, they can impact negatively on maternal wellbeing. Strategies for addressing these issues may come not only from the individuals concerned, but also from the wider

community. Childbirth educators, for example, have an important role to play in encouraging expectant parents to anticipate and discuss their postnatal strategies. More fundamentally, much of the responsibility for inequalities in *expectations* of domestic responsibilities must lie within mainstream education (e.g. Ferri and Smith, 1996). It is in such a comprehensive setting that young peoples' attitudes to gender roles - within both public and private spheres of life - may effectively be addressed.

8.4.7. Maternal wellbeing

“Well, I don’t feel I’ve got postnatal depression but...” (Sally, Interview Two)

Maternal wellbeing came to represent an important culmination of all the preceding and, of course, *new* experiences encountered by the women in the study. Experiences that matched or approximated to earlier expectations resulted in more positive feelings of wellbeing, whereas the reverse was true when the reality failed to match expectations.

Expectations were, in fact, quite high – perhaps unrealistically so – for most of the participants. Many of the expectant mothers were looking forward to the baby's arrival with, as already discussed, little knowledge of or preparation for the diversity of demands to come. Women's experience of the birth (especially when compared with their prior expectations) seemed to have a significant impact on wellbeing. Oakley (1993) found that an unsatisfactory birth experience was the only reliable 'medical' factor affecting depression. In this study, a disappointing birth experience combined with infant health problems appeared to be the most influential factor. Indeed, each of the women with such outcomes experienced postnatal depression as

defined *either* by a physician *or* by self report. The women for whom breastfeeding was initially very difficult also described themselves as feeling 'down', but this tended to pass once the problems were resolved. Partner involvement and support seemed to have a pivotal role, either as a stress buffer or, less often, as a stressor in itself. Similarly, more general lay support was seen as beneficial, but did not, apparently, provide compensation in the event of more serious disappointments with, for example, the birth experience.

Actually, relationship between social support and maternal wellbeing among the participants in this study appears to be far from straightforward and is difficult to evaluate. A number of questionnaire respondents who had reported feeling 'down' or depressed were not, apparently, lacking in social support. Conversely, the small minority who claimed to have *inadequate* social support in the postnatal period also reported mixed, rather than negative feelings. It appears that a range of factors influence maternal wellbeing. Some of these, such as the personality of the mother and her material circumstances suggest themselves as being relevant (e.g. Seguin, 1995) but fall outside the parameters of this study.

In keeping with the spirit of this piece of research, in which the participants accounts were central, 'maternal wellbeing' was broadly defined as the way that women *themselves* felt about becoming mothers. This conceptualization encompassed the social, emotional and psychological - as well as the physiological - dimensions of the transition to motherhood. This holistic approach represents a departure from the somewhat reductive medical model in which wellbeing has mainly been seen as the absence of (postnatal) depression, reflecting the biomedical model of health and

illness more generally (Bowling, 1991). Indeed, earlier research suggested that women themselves do not conceptualize their own wellbeing in such a way (Nicolson, 1998). The first-time mothers here used a range of terms to describe how they had felt since the birth. The broad spectrum of language that they used suggested various emotional responses, many of which had apparently changed quite frequently in the course of the early postnatal period. It seemed exceptional, rather than usual, for women to describe their postnatal mood/s as either 'well' or 'depressed', suggesting an unwillingness to engage with a biomedical discourse. Additionally, the respondents' accounts of their own state of wellbeing did seem to be closely related to lifestyle changes brought about by the arrival of a baby. Hence, 'lack of sleep', fatigue and loss of autonomy appeared to influence maternal wellbeing, along with the factors discussed above. All of these changes and their impacts on maternal mood are consistent with Rogan et al's (1997) model of the transition to motherhood, where 'muddling through' and gradually 'working it out' emerge as highly significant concepts. Furthermore, this reality (for most of the women) represented a close approximation of Nicolson's (1998) social model of postnatal wellbeing/depression, in which 'happiness' may be expected but is rarely attained in the early postnatal period.

The traditional, biomedical emphasis in maternity services begins with clinical antenatal care which has invariably focused on the physiological wellbeing of both mother and unborn child. The fact that around ninety-six per cent of pregnant women attend regularly for clinical checks (Audit Commission, 1997) implies widespread consumer support for the service, despite little evidence of its clinical effectiveness

(Sanders et al, 1999). The service does, however, provide opportunities for informal information and support from midwives and GPs, as well as representing a gateway to local antenatal classes. Issues of maternal wellbeing may therefore be addressed *prenatally* in a broader sense than the term 'clinical' may at first suggest. Some research into the factors influencing postnatal wellbeing and depression among new mothers has suggested late pregnancy as a useful point of intervention. In particular, 'listening visits' from midwives may be beneficial throughout the transition to motherhood (Clement, 1995; Elliott et al, 2000). One attempt at evaluating such a strategy (in a community setting) concluded that it may not be cost-effective (Morrell et al, 2000). However, re-allocating scarce resources from clinical checks of dubious value to professional social support of *probable* value may still represent a better option for the future.

8.5. Strengths and weaknesses of the study

The aim of this section is to weigh up the relative merits and shortcomings of the study as a whole. This will take the form of methodological and epistemological aspects of the research process.

8.5.1. Methodological evaluation

The aim of the study was to explore the role of antenatal education in the transition to motherhood. To this end, it was important to investigate women's own expectations and experiences in some detail, so the case-study method was adopted. On balance, this was a useful research method because it afforded opportunities to interview first-time expectant mothers in depth, and to get to know them and their

circumstances through observation as well as through semi-structured interviews over a period of some months. This longitudinal approach enabled prior expectations of motherhood to be compared with the *experience* of motherhood, thus representing a key strength.

Interviewing women in their own homes was a privilege but also a considerable responsibility. Indeed, a careful balancing act was required to be effective as an interviewer yet friendly and responsive to questions that some of the participants had about infant care in light of the fact that I was a mother myself. The latter was, however, useful because there was a shared identity which helped in establishing a rapport with participants. It would have been churlish and inappropriate to *avoid* conversations about sore breasts or crying babies, for example, despite the fact that my principal role was to interview the women as was clearly stated in the invitation to participate. Indeed, one young mother's comment that my interest in her situation was friendlier and altogether preferable to that of her health visitor was quite thought provoking. She had claimed to enjoy our meetings and found my demeanour neither threatening nor judgmental. This view, also echoed by some of the other participants, suggests that the responses noted during the interviews were fairly full and honest. On balance, the research tool was most suitable for gathering the type of data required. 'Rich and meaningful' is perhaps an overused phrase in qualitative research, but still describes quite aptly the quality of data yielded in this case. A survey style – especially postal -questionnaire *on its own* would have been entirely *inadequate* because the social element of the research would have been lost.

The larger-scale questionnaire survey that *was* undertaken following the initial qualitative phase also had its merits. For example, it facilitated access to a larger sample of respondents. As discussed in Chapter Three, section 3.5.1.2, the number of useable returned questionnaires was still quite small at thirty-nine in total. As with the case study participants, recruitment was more difficult than anticipated, especially for non-attenders of antenatal classes. This ‘hard to reach’ group represents a challenge not only for health professionals charged with their care but also for researchers like myself attempting to explore their views about relevant services.

On the subject of the questionnaire survey, there were some topics - such as breast-feeding difficulties or extensive fatigue induced by general infant care demands – on which the questionnaire results very closely reflected those of the case study interviews. There were others, however, on which considerable divergence existed. One of these related to perceived levels of partner support; here, the questionnaire respondents appeared far more satisfied overall than the case study participants. One possible reason for this might include the broader time-frame afforded by the questionnaire, in which new mothers of babies up to the age of six months were surveyed, compared with around three to four months for the case study participants. It did seem from the questionnaire responses that perceptions on a range of issues could change quite markedly over this postnatal period. Another methodological reason might have been the closer rapport and hence greater *openness* afforded by interviewing the case study participants personally. While there is no way of

knowing for sure, it is important to *question* whether the choice of research instrument may have been in some way responsible for any such differences.

An especially valuable aspect of utilizing different methods of data collection was that a fuller picture could be obtained in relation to core questions about antenatal class provision, for example, within both the statutory and the voluntary sectors. Together with data elicited through interviews with local health professionals, this represents a clear example of method triangulation (Denzin, 1978). So, for example, it can be seen from a combination of the data obtained that NHS antenatal classes are perceived by their clients to be biased in favour of labour and birth preparation. The marginalization of infant care and emotional issues is perceived by those women as problematic, especially in retrospect when the reality of new motherhood renders their omission from classes particularly noticeable.

The diary method had its limitations but also many advantages. While two participants were successful in keeping quite detailed diaries, only one other had managed to do so, and that ended soon after the birth of the baby. On reflection, it was probably unrealistic to expect that any mother with a new baby would be able to find time to write about her experiences. Hence, more entries were made in the prenatal than the postnatal phases of the transition to motherhood. The diary data that *were* provided did, however, prove to be very useful in augmenting mothers' verbal accounts. Such data 'filled in the gaps' in a sense, capturing - in one particular case - the fear and frustration of being stuck in a hospital with a sick newborn and very little (or conflicting) information from staff. The intensity of feeling that was captured - often in a very 'immediate' way - by some of the diary entries enhanced

the sense of privilege that I felt in relation to the research project as a whole. After all, the participants were often willing to share very intimate feelings and experiences. By treating those confidences seriously and respectfully, I hope to have represented them as faithfully as possible throughout this thesis.

On that reflexive note, it should be emphasized that some selectivity was necessary in terms of what to include and what *not* to include within the results chapters. Clearly, it was unfeasible to cover every single item of information gained from the primary research phase. On balance, however, I feel that a fair and representative sample of the data obtained have been included and that the principal research questions have been satisfactorily addressed as a result.

In summary, despite the small sample sizes for both the qualitative and the quantitative phases, the in-depth approach taken via combined research methods make the data as valid and reliable as possible.

8.5.2. Epistemological evaluation

This piece of research afforded the opportunity to gain insights into and experiences of antenatal education from the perspective of first-time mothers themselves. This is a departure from previous research focusing on teaching style (Underdown, 1998) or content (Kelly, 1998), for example. An original aspect of this study is its *application* of the perceived usefulness of antenatal education to the *experience* of new motherhood. This is important because it is hard to assess the effectiveness of a service without looking at its usefulness in practice. Interestingly, there were significant differences in women's perceptions of antenatal classes between the

antenatal and postnatal stages of the transition to motherhood. In other words, while many of the attenders found them satisfactory *while* they were attending, the reality of new motherhood led to more critical assessment in retrospect. This reinforces the importance of exploring impacts over time and circumstance, rather than just taking a ‘snapshot’ of antenatal class content on its own. In particular, first-time expectant mothers cannot be expected to know whether what they are learning is relevant or not, until their babies are born and they are faced with the reality of parenting. Many case study participants acknowledged this at the time – adopting a ‘let’s wait and see’ approach. In the end, the failure of many classes to cover topics like infant care or parental relationship issues did turn out to be problematic.

Another positive element of this research is its broadening of the working definition of ‘antenatal education’ to include lay, as well as statutory and voluntary provision. This effectively acknowledges that non-attenders of antenatal classes *do* have access to antenatal education, while recognizing that there are *differences* between the patterns of antenatal education received between themselves and their class-attending counterparts. Given that most women in any case use a combination - or ‘index’ - of knowledge sources, including the media, family and friends, health professionals and so on, it is difficult to isolate the value of one source from another. While this may represent a weakness in terms of being able to separate out the value of antenatal classes *per se*, it is important to acknowledge the issue. It can also be argued that every individual utilises a unique and distinctive set of knowledge. This calls into question the appropriateness of distinguishing between attenders and non-attenders of antenatal classes at all, except as a practical or policy-related categorisation.

In terms of the biomedical discourse and its continuing influence upon maternity services, the discussion above serves to highlight the problems inherent in categorising women as deviant or disadvantaged simply because they choose not to attend antenatal classes. As the study has shown, lay antenatal preparation may be more relevant, practical and realistic than the alternative that is offered in statutory and voluntary sector settings.

8.6. Policy recommendations

In light of the research results and discussion, the following recommendations emerge:

- Comprehensive re-structuring of antenatal education in the statutory sector, focusing less on unqualified ‘tradition’ and more on consumer needs. This should include:
 - a) A change in title from ‘classes’ to ‘groups’ (or similar) in order to minimize resemblances to ‘school’.
 - b) A bottom-up approach, with far greater emphasis on client-led discussion.
 - c) A supportive, rather than directive role for health professionals.
 - d) Realistic and more diverse preparation for labour and birth.
 - e) A broader agenda that covers all important postnatal issues *realistically*.
 - f) Encouragement of expectant couples – not just mothers – where applicable.
 - g) Rigorous evaluation to ensure that clients’ needs are met.
- Greater appreciation by health professionals of the value of *lay* antenatal education. This should include:
 - a) A more tolerant approach towards younger, unmarried mothers choosing not to avail themselves of formal antenatal education.

- b) Greater respect for expectant mothers' choices concerning, for example, bottle-feeding.
 - c) Recognition and facilitation of expectant mothers' needs for peer support in the transition to motherhood.
- A genuine commitment to *choice* for new mothers concerning the place of birth.
 - Increased guidance and support for new mothers on postnatal wards, particularly with regard to breastfeeding.
 - Comprehensive and realistic incorporation of parenting issues into mainstream secondary level education.

Appendix 1

Local Research Ethics Committee's confirmation of research approval

From the office of the Chairman of the
PLYMOUTH LOCAL RESEARCH ETHICS COMMITTEE
(Committee Secretary - Linda Farr - Tel: 01803 861876/Fax: 01803 866411)
(Short Code from Derriford Hospital - #6410)

**South
& West Devon
Health
AUTHORITY**

Please quote Plymouth Trial No on all correspondence

AJRB/LMF

19th June 1997

THE LESCAZE OFFICES
SHINNER'S BRIDGE
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Ms S Burley
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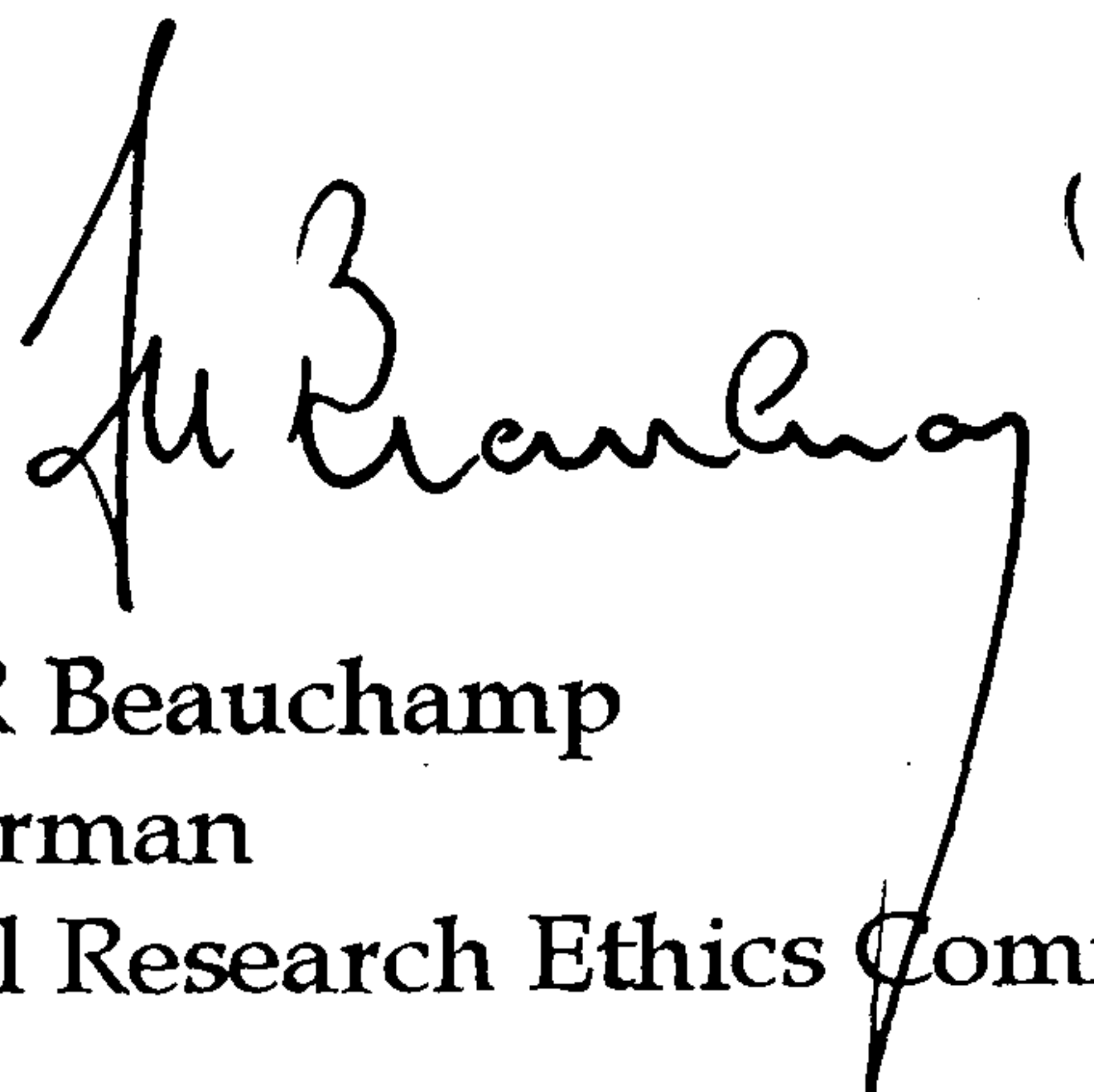
Dear Ms Burley,

*Changing Childbirth: the role of Antenatal Education - Plymouth Study
No 893*

Thank you for your letter of the 17th June 1997 enclosing copy letters to Mr Morsman and Dr Morris together with the signature of your Head of Department. This all appears to be satisfactory and I am now able to give Chairman's approval for the study to go ahead.

The Committee requests that you forward a report on progress and outcome in due course.

Yours sincerely



A J R Beauchamp
Chairman
Local Research Ethics Committee

Appendix 2

Participant Consent Sheet

Participant Consent Sheet:

Changing Childbirth: the role of antenatal education
Suzanne Burley, Dept. of Social Policy & Social Work, University of Plymouth - PhD research project

This research project aims to investigate how first-time parents experience social aspects of the transition to parenthood, from the later stages of pregnancy to the first few months with a new baby. In particular, the research will focus on mothers' well-being, parental relationships and parenting skills. The research generally questions how, and from which sources, new parents find out about these and other aspects of the transition to parenthood.

In order to explore these issues, the project will involve each expectant/new mother (or couple) : -

1. Completing a brief questionnaire at the outset of the research.
2. Engaging in three interviews with the researcher (once in pregnancy and twice postnatally). These interviews will be tape recorded only with the prior consent and agreement of you, the participant.
3. Keeping a simple diary of interesting/important observations about your pregnancy and the early stages of parenthood. While the researcher may (with your consent) use some of the recordings as part of her research, you may of course keep this diary as a personal souvenir.
4. Observing antenatal classes where appropriate; again, with the prior consent of all present, including yourself, other attenders and teaching staff.

IMPORTANT
All information provided, whether verbally (including tape recordings) or in writing will be kept anonymous and confidential throughout. You may at any time and without penalty choose to withdraw from participation in this research project.

If you agree to participate according to these research methods, please indicate by signing below.

I agree to participate in this research according to the information presented above, and understand that I may change my mind and withdraw at any time.

Signature.....

Name(please print).....

Date.....

Appendix 3

Open letter to prospective research participants

Are you expecting your first baby?

Would you be prepared to share your views about becoming a mother? As a researcher at the University of Plymouth, I am interested in your views about pregnancy and becoming a parent. For example:

- *Where do you find out about antenatal care and education?*
- *Who do you turn to for support, advice or reassurance?*
- *What will new parenthood mean for you?*

If you are interested in discussing any of the *social* aspects of becoming a parent, for this local study, I would be delighted to hear from you. We would need to meet up 3 times, once before and twice after your baby is born, to discuss your views and experiences.

All information given will be treated as confidential, and your name will not be used in connection with anything you may choose to tell me about. Also, if you change your mind at any time about taking part in this study, your wishes will be respected immediately.

Please complete the section below if you want to take part in the study, or if you just want to find out more about it.

Thank you.

Suzanne Burley

.....
I agree that my name and telephone number may be passed on to Suzanne Burley in connection with the study outlined above. However, I understand that *this in no way obliges me to take part* in the study if I happen to change my mind.

..... **Signature**

..... **Name (Please print)**

..... **Telephone number**

Appendix 4

Letter to Plymouth primary care practices requesting recruitment assistance



**Faculty of Human Sciences
Department of Social Policy &
Social Work**

University of Plymouth
Drake Circus
Plymouth
Devon PL4 8AA
United Kingdom

Telephone: 01752 233235
Fax: 01752 233209

Our ref: SB/gmw
Your ref:

Date: 10 March 1998

Ann Jeffries, CSW, MPA
Head of Department

Dear Dr.

I am writing to ask for your assistance with a local research project concerning the transition to parenthood. This forms part of my Ph.D. study at the University of Plymouth. The project itself has the approval of the South and West Devon Health Authority Ethics Committee, a copy of which is enclosed. Also enclosed is an outline of the aims and methods of the project overall.

In order to obtain the necessary data, I need to gain access to first-time expectant mothers, especially (but not exclusively) those who choose not to attend parentcraft classes. Therefore, would you and/or the midwife attached to your practice be prepared to assist by distributing to patients, where appropriate, letters of introduction to this study? I enclose a sample of this letter for your consideration. As you can see, this would require the communication of personal details, with permission, in order that I could then make contact with potential participants.

Perhaps, if you feel able to assist in this way, you might discuss this matter with your midwife, whom I will then contact by telephone within the next week or so.

I would be very grateful for your co-operation in this study, if possible. Please contact me if you require any further information or clarification. Thank you.

Yours sincerely

Suzanne Burley



**THE QUEEN'S
ANNIVERSARY PRIZES**
FOR HIGHER AND FURTHER EDUCATION

Appendix 5

Follow-up letter to Plymouth primary care practices



Faculty of Human Sciences
**Department of Social
Policy & Social Work**

University of Plymouth
Drake Circus
Plymouth
Devon PL4 8AA
United Kingdom

Tel 01752 233235
Fax 01752 233209

Ann Jeffries CSW MPA
Head of Department

Our ref: SB/NS/001
Date: 28 May 1998

Dear

**Re: Changing Childbirth; The Role of Antenatal Education
Department of Social Policy and Social Work - PhD Project**

Thank you for supporting this research study by assisting in the recruitment of participants.

So far, seven primiparous women from the Plymouth area have volunteered to take part in the study, but more are needed! In particular, women who are not attending antenatal/parentcraft classes are especially welcome.

It has emerged that some potential participants do not have a telephone number. If this is the case, could you please note an address so that I can contact them, with their consent.

I do appreciate that you are already extremely busy, but would be very grateful for your continued support in this regard.

Thank you.

Yours sincerely

SUZANNE BURLEY
PhD Postgraduate Researcher

Appendix 6

Brief questionnaire administered to case study participants

This survey is part of a study examining the role of antenatal education in the transition to parenthood. All information given will be treated in the strictest confidence.

Questionnaire for expectant mothers

(Please tick all boxes which apply)

Will this be your first baby? YES ☐ NO ☐

Is this a multiple pregnancy (e.g. twins)? YES ☐ NO ☐

On which date is your baby due?

Are you attending (or planning to attend) parentcraft classes?
YES ☐ NO ☐ DON'T KNOW ☐

If YES, which classes?
NHS ☐ NCT ☐ ACTIVE BIRTH ☐

Where do you intend to have your baby?
HOME ☐ HOSPITAL ☐ DON'T KNOW ☐

Do you plan to: BREAST FEED ☐ BOTTLE FEED ☐
BOTH ☐ DON'T KNOW ☐

Are you married to or
living with the baby's father? YES ☐ NO ☐

What is your normal occupation?

What is your partner's occupation?

How old are you? Years

Thank you very much for taking the time to complete this questionnaire. All responses will remain anonymous and confidential.

If you would be prepared to be interviewed more fully about your views and experiences of becoming a mother, please let me know.

Suzanne Burley: University of Plymouth.

Appendix 7

Interview guide / topics covered during the first case study interviews

Pregnancy

Whether planned or unplanned.

Any previous history of pregnancy.

How the participant feels / has felt during pregnancy.

Expectations of / plans for labour and childbirth.

Antenatal classes

Whether attended. *If so*, which ones, where, when, etc.

Content, style and format of antenatal classes.

Perceptions of classes' usefulness.

Whether further opportunities developed for meeting other parents-to-be.

If not attended:

Whether classes were known about – e.g. did community midwife inform / invite?

Participant's general perceptions of antenatal classes, and how such views were derived.

Participant's reasons for choosing not to attend antenatal classes.

Other sources of information about pregnancy, birth and new motherhood

Whether, for example, books and magazines had been accessed.

The role of other lay and informal sources, e.g. friends and family.

Partner

Whether living with baby's father.

How partner feels about impending parenthood.

Anticipated level of partner support in early postnatal period.

Any anticipated impact/s on relationship of the arrival of a new baby.

Infant care

Whether any previous hands-on experience and, if so, in what capacity.

Anticipated sources of information / learning about infant care.

Infant feeding plans for the early postnatal period.

Reasons given for either breast or bottle feeding choice.

Expectations of motherhood

Expectations of looking after baby.

Expectations of impact on self, including lifestyle.

Expected sources of postnatal social support

Anticipated level of involvement by friends, relatives, or others.

Any plans for returning to work / education / training.

Appendix 8

Interview guide / topics covered during second case study interviews

Birth and the hospital experience

Perceptions of labour and birth. Whether better or worse than expected.
Perceptions of hospital care, including postnatal stay.

Infant care

Feeding method and experiences of feeding.
Sleeping arrangements and sleeping patterns.
Coping with crying.
Other basic infant care tasks.
Extent of partner involvement in infant care.

Perceptions of early motherhood

Participant's perceived level of confidence / competence in caring for the baby.
How similar / different to prenatal expectations.
Lifestyle impacts.

Parental relationship issues

Whether and how the couple relationship has changed since the baby's arrival.

Social support

Main support sources, together with type and extent of support.
Perceived usefulness of such support.
Whether similar or different from those anticipated pre-natally.
Extent and type of partner support.
Whether partner support equalled or exceeded prenatal expectations.
Any support identified as needed but not forthcoming.

Maternal wellbeing

How mother has felt, in herself, since the baby's arrival.
Whether feelings identified were surprising or unsurprising.
Identification of factors affecting maternal wellbeing.
Measures employed to promote wellbeing / overcome negative feelings.

Retrospective on antenatal preparation

If antenatal classes were attended:

How useful they now seemed, in light of the *experience* of birth and new motherhood.
How, in retrospect, classes might have been improved.
Whether an antenatal class re-union had been attended and, if so, what happened.

If antenatal classes were not attended:

Whether, at any time since the birth, participant wished they had attended classes.

Appendix 9

Interview guide / topics covered during third case study interviews

Infant care

Any notable changes in infant behaviour or infant care tasks since previous interview.
Infant feeding and sleeping issues.
Strategies for dealing with infant care difficulties.
Perceptions of competence / confidence in caring for infant since last interview.
Extent of health visitor involvement, e.g. baby clinic visits.
Type and extent of paternal involvement in infant care.

Parental relationship issues

Any impacts / changes in impacts on the couple relationship since previous interview.
Coping strategies for dealing with any such changes.
Domestic task-sharing.

Social support

Any changes in source, type or extent of support since previous interview.
Extent of and satisfaction with partner support.
Use of mother and baby groups / involvement with other new parents.
Any perceived shortcoming in type or extent of social support.

Maternal wellbeing

How mother feels now, including any changes in sense of wellbeing since last interview.
Factors affecting any such changes – whether positive or negative.
Strategies for coping with personal difficulties.
Perception of ‘the best thing’ about being a new mother.
Perception of ‘the worst thing’ about being a new mother.
Perceived usefulness of participant’s own pattern of preparation for motherhood.
Suggestions for elements and sources of preparation that would have been useful.
Advice that this mother might give to *another* first-time expectant mother.

Plans for the future

Any plans for more children.
Any plans for returning to work / training.

Feedback on research participation

How the participant felt about having taken part in the study.

Appendix 10

Table of data collection sources for case study participants

Antenatal class attendance status	Name of participant	First interview?	Second interview?	Third interview?	Diary kept?
<i>Attender</i>	Barbara	Yes	Yes	Yes, by telephone. (Had moved away)	No
<i>Attender</i>	Diane	Yes	Yes	Yes	No
<i>Attender</i>	Rhona	Yes	Yes	No. (Went to Australia for 3 months)	Yes
<i>Attender</i>	Sally	Yes	Yes	Yes	No
<i>Attender</i>	Tracey	Yes	Yes	No. (Baby too ill.)	Yes
<i>Non-attender</i>	Gina	Yes	Yes	Yes	No
<i>Non-attender</i>	Joy	Yes	Yes	Yes	No
<i>Non-attender</i>	Laura	Yes	Yes	Yes	Yes
<i>Non-attender</i>	Mandy	Yes	Yes	Yes	No

Appendix 11

Brief description of case study participants

Attendees of antenatal classes:

Barbara is 32 years old, and married. She and her partner live in a small, owner-occupied first-floor flat close to the city centre. She is a recent graduate who works part-time to provide administrative support from home to her partner, who is a self-employed businessman. He, however, works away during the week and is usually at home just for weekends. Barbara attends antenatal classes run by the NHS and the NCT. The pregnancy was planned.

Diane is 28 years old, and married. She lives with her partner in spacious owner-occupied accommodation close to the centre of Plymouth. Both Diane and her partner work full-time; she as an administrator and he in the armed services. Diane plans to return to work on a part-time basis after the birth of their child. The pregnancy was planned and Diane is attending NHS classes in a community-based setting.

Rhona is 30 years old, and married. She and her partner live together in owner-occupied accommodation close to the city centre. Rhona had been employed full-time as a white-collar worker, but elected to become a full-time mother and had already resigned prior to the third trimester of pregnancy. Her husband's income was deemed sufficient to support the new family. Despite this material security, the couple are new to the area and lack a well-developed social support network. Rhona elected to attend a course of community-based NHS antenatal classes, as well as an intensive course of NCT classes held at the local maternity unit. The baby was planned and very much wanted, especially as Rhona had already experienced two miscarriages.

Sally is 35 years old, and married. She and her partner live together in owner-occupied accommodation within a pleasant suburban area of Plymouth. The pregnancy was not planned; however, the baby was very much *wanted* by both parent-to-be. The timing was awkward because Sally's partner was seeking work, while she had only recently graduated from university. Her post-baby plans were to return for postgraduate study at a later date. Sally chose to attend two courses of NHS antenatal classes; one at her local health centre and the other at the hospital maternity unit.

Tracey is 27 years old, and married. She and her partner live in owner-occupied accommodation very close to the city centre. Tracey's husband works full-time, as did Tracey until the late stages of pregnancy. She intended to return to work on a part-time basis some time after the birth. The pregnancy was planned, and Tracey was attending NHS classes in a local community setting.

Appendix 11 (Continued.)

Non-attenders of antenatal classes:

Gina is 19 years of age. She lives with her partner in local authority accommodation, within a relatively deprived area of Plymouth. Neither Gina nor her partner were in paid employment by the latter stages of her pregnancy and were, therefore, reliant upon welfare benefits. Around the time of the birth, however, Gina's partner did find a paid job. The baby was not planned but was, nevertheless, wanted. She did not attend any antenatal classes because she claimed they were too awkward for her to get to.

Joy is 24 years old and very recently married. She lives with her husband in local authority accommodation, some distance from the city centre. Joy was attending college prior to the pregnancy, and is undecided about future working plans following the birth. Her partner works full-time. He also has three children from a previous relationship, although this will be Joy's first baby. The pregnancy was not planned, but Joy is looking forward to becoming a mother. She has chosen not to attend any antenatal classes, claiming to prefer to 'do things' in her own way.

Laura is 17 years old. She lives in her parental home with her mother and younger sister. The baby's father was also a teenager and, in Laura's own words, 'didn't want to know.' The pregnancy was unplanned. Laura had only just left full-time education, and done some part-time work in a fast-food outlet. Following the birth, she intends to continue such part-time work and, later on, to undertake secretarial training. Laura chose not to attend antenatal classes because of feelings of embarrassment about her own circumstances and the prospect of discussing childbirth among strangers.

Mandy is 21 years old and living with the baby's father. They reside in local authority accommodation within a particularly deprived area of the city. Neither Mandy nor her partner had been employed for some time prior to the pregnancy, although her partner did find work at around the time of the birth. The pregnancy was unplanned, but both parents-to-be are pleased at the prospect of having a baby. Mandy feels isolated on the estate, having no private transport, few friends locally and anticipating 'interference' from her own family. She chose not to attend any antenatal classes.

Appendix 12

The Questionnaire

Questionnaire for first-time mothers

What is the questionnaire for?

This questionnaire survey forms part of a study being carried out at the University of Plymouth. The study focuses on the ways in which expectant parents *find out* about parenthood, and the ways in which the transition to parenthood is *experienced*.

Is it confidential?

Yes, definitely. Nor will you be asked at any stage to give your name. Therefore, all information will be treated as anonymous and confidential.

Who should complete the questionnaire?

Any new mother who has had her first baby within the last 6 months.

Why bother to complete the questionnaire?

Because your views are valuable and interesting. All the information that you are able to provide will be very greatly appreciated.

How long will it take?

Only about 15 minutes. *You do not need to complete both parts* - just complete Part 1(White) if you went to antenatal classes, and Part 2 (Yellow) if you did not.

What should I do with the completed questionnaire?

Just check that all of the relevant questions have been answered, then put the questionnaire in the pre-paid envelope and post it back as soon as possible.

Questionnaire for first-time mothers

(Please tick all answers which apply, or write the answer in your own words where appropriate)

1. Did you attend any antenatal classes? (These are sometimes called ‘parentcraft’ or ‘relaxation’ classes)

Yes ☐ *(Please continue below at Question 2)*

No ☐ *(Please go to Part 2- the yellow pages)*

2. Which classes did you attend? *(Tick all which apply)*

- National Health Service☐
- National Childbirth Trust☐
- Active Birth☐

(From this point, please place your answers only in the sections for the classes which apply to you, and ignore the others)

3. Why did you choose these classes?

NHS:
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NCT:
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Active Birth:

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4. Please indicate the extent to which you agree with the following statements:

“The time of day at which the classes were held was convenient for me”

NHS:

Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NCT:

Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Active Birth:

Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

“The location of the classes was convenient for me”

NHS:

Strongly agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NCT:

Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Active Birth:

Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How many times did you attend the classes?

<u>NHS</u>	<u>NCT</u>	<u>Active Birth</u>
1-3 <input type="checkbox"/>	1-3 <input type="checkbox"/>	1-3 <input type="checkbox"/>
4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>
7 or more <input type="checkbox"/>	7 or more <input type="checkbox"/>	7 or more <input type="checkbox"/>

6. Did anyone accompany you to the classes?

Yes ☐

No ☐ (Please go to Q.8)

7. If ‘Yes’, who accompanied you?

.....

7a. And how many sessions did they attend with you?

<u>NHS</u>	<u>NCT</u>	<u>Active Birth</u>
1-3 <input type="checkbox"/>	1-3 <input type="checkbox"/>	1-3 <input type="checkbox"/>
4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>
7 or more <input type="checkbox"/>	7 or more <input type="checkbox"/>	7 or more <input type="checkbox"/>

8. Please indicate the extent to which you agree with the following statement:

“I found the classes useful”

<u>NHS:</u>					
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NCT:

Strongly Agree

Agree

Neither

Disagree

Strongly Disagree

☐

☐

☐

☐

☐

Active Birth:

Strongly Agree

Agree

Neither

Disagree

Strongly Disagree

☐

☐

☐

☐

☐

9. Please indicate which topics you think were covered adequately in the classes:

	<u>NHS</u>		<u>NCT</u>		<u>Active Birth</u>	
	YES	NO	YES	NO	YES	NO
Labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottle feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postnatal exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postnatal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Do you think that, as the parents-to-be, you were given enough opportunity to raise your own issues for discussion in the classes?

NHS

Yes ☐ No ☐ Don't know ☐

NCT

Yes ☐ No ☐ Don't know ☐

Active Birth

Yes ☐ No ☐ Don't know ☐

11. Did you have enough opportunities to talk informally with other expectant parents at the classes?

NHS:

Yes ☐ No ☐ Don't Know ☐

NCT:

Yes ☐ No ☐ Don't Know ☐

Active Birth:

Yes ☐ No ☐ Don't Know ☐

12. How useful do you think it is, to meet with other parents-to-be at antenatal classes?

Very ☐

Fairly ☐

Not very ☐

13. Have you kept in touch (or made friends) with other new parents from your antenatal classes?

NHS

NCT

Active Birth

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

14. Did your antenatal classes provide you with realistic expectations about the birth?

NHS: Yes ☐ No ☐ Don't know ☐

NCT: Yes ☐ No ☐ Don't know ☐

Active Birth: Yes ☐ No ☐ Don't know ☐

15. Did your antenatal classes provide you with realistic expectations about life with a new baby?

NHS: Yes ☐ No ☐ Don't know ☐

NCT: Yes ☐ No ☐ Don't know ☐

Active Birth: Yes ☐ No ☐ Don't know ☐

16. What did you like most about the classes?

NHS:

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NCT:

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Active Birth:

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17. What did you like least about the classes?

NHS:

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NCT:

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Active Birth:

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18. Thinking back, how could your antenatal classes have been improved?

NHS:

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NCT:

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Active Birth:

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Section 2

This section asks about other sources of information and support in becoming a parent:

19. New parents gain information and knowledge from various different sources. Please indicate the importance for you of the following knowledge sources about becoming a parent:

Mother	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Other relative/s	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Friends	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Partner	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Midwife	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
GP	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Health Visitor	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Books	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Magazines	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
TV Programmes	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>

20. Do any relatives to whom you can turn for support live nearby, or within easy travelling distance?

Yes ☐ No ☐

21. Do you have friends to whom you can turn for support living nearby, or within easy travelling distance?

Yes ☐ No ☐

22. If you have a problem, or need some advice, who do you normally turn to first?

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23. Do you feel that, in general, you have enough help and support?

Yes ☐ No ☐ Don't Know ☐

24. Please describe how you have been feeling since having your baby:

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*If you are living with a partner, please answer the following questions.
(If you are not, please skip to Question 30)*

25. Is your partner as supportive as you would wish?

Yes ☐

No ☐

Sometimes ☐

26. Has your partner turned out to be as supportive as you had expected?

More supportive	As supportive	Less supportive	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. How helpful/supportive is your partner in the following areas?

Emotional issues	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>
Babycare	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>
Housework	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>
Financial issues	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>

28. Could you explain the effects that a new baby has had on your relationship with your partner?

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29. What is your partner’s normal occupation?

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Section 3

This section asks about the tasks involved in caring for a new baby:

30. Did you have any experience of looking after babies before the birth of your own?

Yes ☐ No ☐

If ‘Yes’, what kind of experience?

.....

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31. By what method was your baby fed until the age of 3 months?
(Or up until now, if your baby is under 3 months old)

Breast ☐

Bottle ☐

Both ☐

31a. Is this the method you had planned before your baby was born?

Yes ☐

No ☐

If ‘No’, why did you change?

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32. What have you found most difficult about caring for your new baby?

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33. Could you describe anything about caring for your new baby that you were quite unprepared for?

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33a. What would have been useful in preparing you for this?

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34. What do you think is the best thing about having a new baby?

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35. What do you think is the worst thing about having a new baby?

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36. How old is your baby?

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37. Please indicate which of the following you have access to in your household:

Telephone ☐

Car ☐

Washing Machine ☐

38. Are you planning to return to paid employment before your baby is 1 year old?

Yes ☐ No ☐ Don't know ☐

38a. Can you explain your reason for this decision?

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39. Please add anything else which you feel is important:

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Finally, please could you answer the following questions about yourself:

40. Your age

41. Your normal occupation

42. The point at which you finished your education:

Before taking any exams ☐

O' Level /GCSE ☐

A' level ☐

HND ☐

Degree ☐

Higher degree ☐

Other (Please state) ☐

.....

THIS IS THE END OF THE QUESTIONNAIRE.
THANK YOU FOR TAKING THE TIME TO
COMPLETE IT.

Part 2

**Please complete this part of the questionnaire if you chose
NOT to attend antenatal classes**

Section 1

(This section asks about the tasks involved in caring for your baby)

1. Did you have any experience of looking after babies before the birth of your own?

Yes ☐ **No** ☐

If ‘Yes’, what kind of experience?

.....
.....
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.....
.....

**2. By what method was your baby fed until the age of 3 months?
(Or up until now, if your baby is under 3 months old)**

Breast ☐
Bottle ☐
Both ☐

2a. Is this the method you had planned before your baby was born?

Yes ☐

No ☐

If ‘No’, why did you change?

.....

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3. What have you found most difficult about caring for your new baby?

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4. Could you describe anything about caring for your new baby that you were quite unprepared for?

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5. What would have been useful in preparing you for this?.....

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6. What do you think is the best thing about having a new baby?

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7. What do you think is the hardest thing about having a new baby?

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8. How old is your baby?

.....

9. Please indicate which of the following you have access to in your household:

Telephone	<input type="checkbox"/>
Car	<input type="checkbox"/>
Washing Machine	<input type="checkbox"/>

10. Are you planning to return to paid employment before your baby is 1 year old?

Yes ☐ No ☐ Don't know ☐

10a. Can you explain your reason for this decision?

.....
.....
.....
.....

Section 2

This section asks about your view of antenatal classes:

11. Were you aware, during your pregnancy, of which antenatal (or ‘parentcraft’) classes were available?

Yes ☐
No ☐ (PLEASE GO TO Q. 14)

12. How did you find out about the classes?

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13. Were you invited to attend antenatal classes?

Yes ☐ No ☐

14. Why did you decide not to go to classes?

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15. Could you explain what you think antenatal classes are like?

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16. What has led to this opinion?

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17. Now that you have your baby, do you ever wish that you had attended antenatal classes?

Yes ☐

No ☐

Don't
Know ☐

Section 3

This section asks about the various sources of information and support in becoming a parent

18. New parents gain information and knowledge from various different sources. Please indicate the importance for you of the following knowledge sources about becoming a parent:

Mother	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Other relative/s	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Friends	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Partner	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Midwife	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
GP	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Health Visitor	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Books	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
Magazines	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>
TV Programmes	Not very important <input type="text"/>	Fairly important <input type="text"/>	Very important <input type="text"/>

19. Do any relatives to whom you can turn for support live nearby, or within easy travelling distance?

Yes ☐

No ☐

20. Do the friends to whom you can turn for support live nearby, or within easy travelling distance?

Yes ☐ No ☐

21. If you have a problem, or need some advice, who do you normally turn to first?

.....

.....

.....

.....

.....

22. Do you feel that, in general, you have enough help and support?

Yes ☐

No ☐

Don't know ☐

23. Please describe how you have been feeling since having your baby:

.....

.....

.....

.....

.....

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*If you are living with a partner, please answer the following questions.
(If you are not, please skip to Question 29)*

24. Is your partner as supportive as you would wish?

Yes ☐ No ☐ Sometimes ☐

25. Has your partner turned out to be as supportive as you had expected?

More supportive	As supportive	Less supportive	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. How helpful/supportive is your partner in the following areas?

Emotional issues	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>
Babycare	Not very helpful <input type="text"/>	Fairly helpful <input type="text"/>	Very helpful <input type="text"/>

Housework	Not very helpful	Fairly helpful	Very helpful
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial issues	Not very helpful	Fairly helpful	Very helpful
	<input type="text"/>	<input type="text"/>	<input type="text"/>

27. Could you explain the effects that a new baby has had on your relationship with your partner?

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28. What is your partner's normal occupation?

.....

29. Please add anything else that you feel is important:

.....

.....

.....

.....

.....

.....

.....

Finally, please could you answer the following questions about yourself:

30. Your age

31. Your normal occupation

32. The point at which you finished your education:

- Before taking any exams ☐
- GCSE ☐
- A level ☐
- HND ☐
- Degree ☐
- Higher degree ☐
- Other (please state) ☐

.....

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU
FOR TAKING THE TIME TO COMPLETE IT.

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