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Published in The Practising Midwife Volume 24 Issue 5 May 2021
https://doi.org/10.55975/PNUQ2484

Summary

As the ninth article in our normal birth series, we highlight the key evidence around birthing pool use: a tool for optimising labour and birth physiology. Drawing upon our collective clinical and research-based experience, we provide practice tips for intrapartum care in water.
Introduction

So far in this normal birth series, the articles have combined revisiting the basics of normal physiological labour and birth processes, alongside new research findings, insights and updates. International research tells us that most women value and expect to have a normal labour and birth with midwives who are knowledgeable and competent in facilitating physiological births. While the research also found that women understood that events may change, which may require ‘going with the flow’, their expectations of midwives capable of supporting normal labour and birth is a vital point to press. We know that increasing constraints on midwifery practice risks the key components that define midwifery practice as per the Lancet and International Confederation of Midwives (ICM), negatively impacting women’s capacity to labour and give birth naturally. Therefore, it is vital that midwives continue to revisit the basic anatomy and physiological process of childbearing as core midwifery skills and that researchers continue to advance that knowledge. Accordingly, in this article we advocate that water immersion during labour and waterbirth offers a valuable tool to optimise women and birthing people’s innate capacity to labour and birth, and midwives a unique opportunity to really ‘be with woman’.

Birthing pool use is an independent factor that improves birth experiences, some maternal outcomes with no risk to the neonate, other factors influence the degree of benefit that water immersion can offer

Water immersion: a low-tech, complex intervention

Water immersion appears to be a straightforward intervention that offers women the comfort of buoyancy, space and freedom of movement. It is a low-tech intervention, and the key requirements include:

- A birthing pool big enough to enable full mobility.
- A birthing pool that is firm and stable to support women leaning/hanging against the sides.
- A water supply (clean and hot running water).
- Enough warm water filled to submerge the person’s bottom/abdomen.

However, when we unpack the evidence in favour of positive biological and psychological maternal outcomes (with no adverse effects on the neonate), we can see several things. First, the range of benefits across the birth continuum:

- Buoyancy enhances mobility, freedom of movement and positional changes that facilitate physiological labour and birth outcomes.
- Pain perception: release of endogenous endorphins/analgesic properties, enhances ability to cope with labour.
- Reduces epidural use (and therefore, subsequent risks associated with epidurals).
- Labour augmentation/reduction in the duration of labour.
- Increased number of spontaneous vaginal birth (particularly in midwifery-led settings).
- Reduces transfer likelihood from home/freestanding birth centres.
- No impact on perineal trauma/obstetric anal sphincter injury (OASI).
- Improves satisfaction.
- Enhanced feelings of safety, protection and privacy.
- Facilitates (for some) a positive state of altered consciousness during labour.
- Facilitates easier pushing (as reported by women).
- Enables positive birth experiences with positive implications for postnatal mental-emotional health and wellbeing.

Second, the level of benefit differs between care settings and models of care. For example, birthing pools are used most in
midwifery-led settings (home/alongside midwifery unit (AMU)/ freestanding midwifery unit (FMU))\textsuperscript{12} and birth pool use increases the rates of spontaneous vaginal birth at home or in a midwifery-led setting,\textsuperscript{10} but not necessarily in hospital.\textsuperscript{6} Third, the care culture as displayed by maternity professional behaviours can influence the access to and use of birthing pools.\textsuperscript{13} Therefore, with so many variables, water immersion can be viewed as a ‘complex intervention’\textsuperscript{14} defined as:’ ... in the number of interacting components; the number and difficulty of behaviours required by those delivering or receiving the intervention; the number of groups or organisational levels targeted by the intervention; the number and variability of outcomes; and the degree of flexibility or tailoring of the intervention permitted.’\textsuperscript{15} p.397

The warmth of the pool, maintaining ambient lighting and minimising distractions and stimulation will reduce the release of catecholamines and facilitate safe physiological placental birth in the pool

While we can see that birthing pool use is an independent factor that improves birth experiences, some maternal outcomes with no risk to the neonate, we also know that other factors influence the degree of benefit that water immersion can offer. Therefore, contextual information is required when assessing the maternal outcome data and applying it to clinical practice (see Figure 1). For example, the Birthplace study examined the relationship between birth setting and outcomes of 67,000 women. It found that comparable women (of low-risk status) were significantly less likely to use water immersion in an obstetric unit compared with women who birth in alternative settings.\textsuperscript{16} Only 13.3\% of first-time mothers used water immersion in an obstetric unit versus 53.7\% in a freestanding birth centre, and there was similar disparity among multiparous mothers.\textsuperscript{16} Additionally, Burns et al\textsuperscript{10} found marked differences in interventions and outcomes between midwifery-led settings in one large prospective observational water birth study (N=8,924 women).\textsuperscript{10} It found that women who used a birth pool in an AMU were more likely to be transferred to the obstetric unit and less likely to have a waterbirth when compared with similar women who laboured in water in the community (FMU/home).\textsuperscript{10} In fact, the interventions and outcomes for the women who immersed in water in the AMU setting were similar to those reported in the obstetric unit, highlighting the influence of care models and care settings, and reiterating birthing pools as a low tech but complex intervention.

**PRACTICE POINT 1**

Considering the strong evidence in favour of midwifery led place of birth and birth pool use, what initiatives are available in your area that facilitate these choices? Do share with us on Twitter @TPM_Journal
**Figure 1 Understanding context for water immersion as a complex intervention**

Women’s voices
Our recent work was a qualitative systematic review examining the views and experiences of women who had used water immersion during labour and/or birth. The seven studies we included provided rich insights into the value and biopsychosocial-spiritual benefits of water immersion. Our review, supported by numerous survey studies, highlighted the important contribution of water immersion to women’s experiences of childbirth. Physical benefits related to the buoyancy the water provided, enabling free and unrestricted movement, particularly profound for women who reported to be self-conscious about their weight. The warm water was reported to be analgesic, relieving labour pains, soothing and comforting. The properties of water, ‘cushioned the intensity’, enhancing women’s sense of control and ability to cope. Moreover, the physical separation that the pool afforded was also valued, where feelings of safety and protection were enhanced and likened to a ‘cocoon’ or ‘safe haven’. Many women reported blissful states of altered consciousness as the combined properties of the warm water and physical boundaries of the pool facilitated letting go into a liminal space of birth, for example: ‘Another world…it was like by the ocean, and then you come back to land and you are in another country…They call it ‘labourland’… It really was another world, and you think about the journey that you make from being pregnant to becoming a mother… An incredible journey.’ Rosa (Sprague, 2004).

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**Supporting labour in the pool**
Concerns around supporting labour in water can result in midwives being expected to gain specific ‘competencies’ to facilitate water immersion. In our experience, this may indicate a broader cultural fear and suspicion of water immersion and is not necessary. Of course, it is beneficial for those who have not witnessed a water labour/birth to observe someone competent and confident, and is essential for midwives to feel supported in their practice. However, as the overall physiological processes of labour and birth do not alter in a pool, other than to enhance the neuroendocrinology, we advocate that midwives equipped with the knowledge and skills of physiological land births can apply this readily to a water situation. This includes ambient lighting, soft sounds, low voices and supportive one-to-one care. Moreover, there is no reason to alter the frequency of routine intrapartum observations for women in a birth pool from those labouring on land. It is sensible, however, that birth pool water is not greater than body temperature (37°C) because labour contractions generate heat and the fetus is hotter than his/her mother. For example, we know that epidural analgesia increases maternal core temperature, which can adversely affect mother and fetus, therefore two-to-four-hourly water temperature checks are advisable.

Clinical guidance can influence when women access a birthing pool. For example, some maternity units advocate that a woman’s cervix be at least 4cm dilated before she can enter a birth pool. However, there is no evidence to support this recommendation. Furthermore, cervical dilatation in itself, is a subjective, limited measurement and does not account for effacement, cervical application to the presenting part of the fetus, its position or descent in the women’s pelvis. A women’s cervix might be one to two centimetres dilated, but fully effaced, well applied to the presenting part and the uterine contractions good while, conversely, the cervix could be ≥5cm dilated, uneffaced and a woman is not in established labour. Women should be supported to use the pool as and when they prefer and should not be contingent on cervical dilatation. It is not unusual for contractions to slow down shortly after entering a birth pool. This is a transient physiological response to the relaxation of water immersion. The pelvic biomechanics involved with getting into and exiting the pool may also facilitate optimising fetal position by creating more space. Conversely, birthing pools can take 20-30 minutes to fill, and sometimes women labour too quickly to access, therefore it is helpful to start running the pool sooner rather than later.
Key points for labour care

- Pool has enough water to submerge the woman’s abdomen and bottom.
- Pool is big enough to enable a woman to flip over and adopt different positions with ease.
- Usual observations apply, plus two-to-four-hourly water temperature checks.
- Usual advice to maintain good hydration.
- Intermittent auscultation with a waterproof sonic aid avoids disturbing the mother.
- Vaginal examinations, if required, can be carried out in the pool.
- If concerned by labour dystocia, exiting the pool temporarily may help. The exiting/entering will support pelvic biomechanics, and mobilising to empty the bladder will support both pelvic biomechanics and fetal descent. Also just walking around for a while, or resting on her side on bed/floor cushions may also assist.

Supporting waterbirth

We advocate responding to the woman’s instinctive urge to push through gentle support and encouragement, rather than coached or Valsalva pushing. Those in water for the second stage follow the same patterns of land physiological births, whereby involuntary pushing (often) begins at the height of a contraction, gradually building towards greater expulsive pushing over time. Like on land, depending on maternal position, external signs (anal pouting, rhombus of Michaelis and/or the purple line) may be observed indicating the progression of fetal descent. Some midwives prefer to use a torch and mirror to observe progress, others find it unnecessary. While waterbirths should be hands off by the midwife, some women will reach down to touch the baby’s head, which should be unhindered. Depending on the woman’s position and preferences she may wish to ‘catch’ the baby, and this should be supported where possible. Of importance, once the fetal head is born, it remains under water. Should a woman raise her bottom out of the water at this point, the rest of the birth should be facilitated out of the water and must not be resubmerged to avoid any risk of water inhalation. Additionally, traction must not be applied to the cord to avoid cord avulsion23 (see practice point below).

Retrospective research expressed concern that waterbirth may predispose women to sustaining an extensive perineal tear to involve the anal sphincter (OASI).24 However, prospectively collected data analysis found no such association.25 When a midwife assists a woman to give birth in water, typically she adopts a hands off approach – a practice that is currently not recommended for women giving birth on land. The advent of the OASI ‘bundle’ has exerted a drive to encourage midwives to
routinely adopt a hands-on approach to birth. However, the evidence supporting this intervention is less than robust and being challenged. Unfortunately, some maternity units have set the OASI bundle as a mandate, which may present a confidence and skills issue for midwives regarding water and land birth.

Cervical dilatation in itself, is a subjective, limited measurement and does not account for effacement, cervical application to the presenting part of the fetus, its position or descent in the women’s pelvis.

**PRACTICE POINT 2**

**One note of caution with waterbirth**

There have been reports of cord avulsion during waterbirth. Most of the babies were fine and did not require a blood transfusion or admission to neonatal intensive care unit (NICU). However, it is important not to exert traction on the umbilical cord as baby is brought to cuddle with mother. It is sufficient to just have baby’s head out of the water. Should a cord avulsion occur, clamp the cord immediately, assess baby’s condition, and act accordingly.

**Key points for waterbirth**

- Follow the woman’s instinctive pushing cues.
- Continue with usual observations and signs of progression.
- Adopt a hands-off approach.
- Support the woman to remain submerged during the birth, otherwise avoid re-submersion of baby’s head.
- Avoid traction on the cord as baby is lifted gently out of the water.

**Third-stage care**

Various hospital guidelines recommend leaving the pool for placental birth (whether active or physiologically managed), however, this is not necessary and may interfere with the high release of oxytocin that occurs following birth. This release of oxytocin facilitates the detachment and expulsion of the placenta. Therefore,
interfering – for example, turning lights on, talking loudly, moving the mother out of the pool – may increase bleeding and/or haemorrhage. In addition, the warmth of the pool, maintaining ambient lighting and minimising distractions and stimulation will reduce the release of catecholamines and facilitate safe physiological placental birth in the pool. Furthermore, the vast neonatal benefits from delayed cord clamping, which means enabling the woman to remain in the pool to birth her placenta followed by cord clamping, should not present a problem. It is easy to revert to active management in the event of concern. The purported risk of incurring a water embolism by birthing the placenta in water, is purely hypothetical and were it a problem, it would have manifest itself before now given the thousands of waterbirths that have happened across several countries.

**Estimating blood loss**

Visual blood loss estimates are only ever an educated guess during spontaneous or operative vaginal birth. Aids in the form of photographs of different blood volumes in a standard-size, plumbed-in birth pool with reference points to rose/red wine have been developed to guide midwives in their estimation. However, regarding waterbirth, anxiety lingers in this area even though the blood loss one sees is married to the women’s condition and factors such as the length of her labour and past history. Worry around possibly not identifying excessive blood loss in a timely manner may be making some midwives ask that women leave the pool for the third stage of labour, disrupting the crucial mother-baby skin-to-skin contact. estiMATE is an online tool developed to improve visual blood loss estimations during waterbirth, which showed promise in estimates and midwives’ confidence. A large-scale evaluation conducted during 2019 will soon be ready to submit for publication. This tool involves simulations using live models and involving a range of different blood volumes using expired blood filmed in real time will hopefully assist in resolving this worry and result in less third-stage disturbance in the absence of a problem.

Pain management is a key element of respectful and dignified maternity care, in which we advocate birthing pools should be as available as pharmacological options.

**PRACTICE POINT 3**

Most of the research regarding water immersion outcomes has involved healthy women and been undertaken in the obstetric unit setting. Further research has been upcoming or ongoing for those who may have a risk factor, for example, a previous caesarean section, or a BMI >30. Across the UK, many women deemed ‘out of guidelines’ have experienced successful waterbirths. While the physiology of birth does not change(!), our empirical knowledge of specific conditions during pregnancy and whether they affect water immersion outcomes, remain a work in progress. Another point that research has raised about women who use a birth pool is that the majority are white and high socio-economic. This raises the question: could and should we be doing more to inform all pregnant women about birth pool use, given our remit is to provide equitable care to all women?

**Key points for placental birth**

- Keep an ambient environment avoiding disturbing the mother-baby dyad.
- Support/encourage uninterrupted skin-to-skin contact and/or initiating breastfeeding.
- Observe for signs of placental detachment (cord lengthening, small acute blood loss, cramping), gently encourage woman to work with those cramps to expel the placenta.
• Observe for excessive blood loss in the pool and, if required, support the woman to exit the pool and revert to active management (if consented).

Organisational practice points

• Keep the birthing pool room free and available for those wishing to labour/birth in water wherever possible.
• Have a strict cleaning protocol in place, as per local infection control guidance.
• Organise regular multidisciplinary team (MDT) study days to raise awareness and knowledge of physiological labour and birth in water, and to troubleshoot concerns.
• Consider water immersion champions who can support inexperienced staff.
• Where possible, appropriate and with consent, encourage obstetricians and neonatologists to quietly observe a waterbirth.
• Invite women to speak about their waterbirths.
• Invite midwives to speak about the waterbirths they assist.
• Use online videos for educational purposes for those inexperienced with water labour/birth.
• Ensure all staff are competent with intermittent auscultation and usual labour care.
• Practice supporting women out of the pool, should it be required.

Conclusion

Water immersion during labour and waterbirth is a low-tech but complex intervention that optimises the normal physiological processes of labour and birth. We call for midwives and maternity professionals to familiarise themselves with labour and birth care in a birthing pool to ensure more women have access to its benefits. Pain management is a key element of respectful and dignified maternity care, in which we advocate birthing pools should be as available as pharmacological options. TPM

References


Upcoming research

At Oxford Brookes University, we are working to advance the evidence base for labouring and giving birth in water. Claire led on the recently published systematic review of women’s experiences highlighted in this introduction. This offers a rich insight to inform women and midwives in their discussion about this care option. A write-up of another systematic review is nearing completion on interventions and outcomes following water immersion for labour and waterbirth. It is a large review that includes more than 30 studies, comprising different designs undertaken by an international team led by Ethel. A scoping review of health professionals, organisational and policy barriers and facilitators for waterbirth is being led by Dr Megan Cooper, supported by Claire and Ethel. Ethel has run workshops and presented estiMATE at conferences. It is attracting significant interest in the UK and beyond from maternity personnel and it is planned to release it as a continuing professional development (CPD) tool this summer. Colleague Dr Jane Carpenter is completing a paper reporting on a secondary analysis of prospectively collected data to examine factors associated with normal birth (as defined by the Maternity Care Working Party) for women who labour in water. She is also co-supervising (with Dr Louise Hunter and Associate Professor Rachel Rowe from the National Perinatal Epidemiology Unit (NPEU)) a PhD undertaken by student Claire Litchfield investigating the outcomes and experiences of women with obesity who use water immersion in labour.

We thank our extended research group, OxMater, an international collaborative network, for contributing to our research programmes. For more information, see

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PMA Reflections on Adaptation to Continuity of Carer

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Published in The Practising Midwife Volume 24 Issue 4 April 2021

Summary

In the year following implementation of continuity of carer (CoC) caseloading teams in my trust, I noticed some initial anxiety in the midwives for whom I provide support as professional midwifery advocate (PMA). Over time, however, midwives reflected that they simply needed to adapt their behaviours, having been institutionalised by years in an on-call model and faced with more flexible boundaries on their working hours. Adapting to a new way of working takes time and honest reflection to achieve a shift in mindset and a healthy respect for those boundaries, after which midwives report a better-than-ever work/life balance.
Fear of the past

In 2016, the National Maternity Review report, Better Births, hit our desktops, and with it a sense of panic grew in the workplace. That same year, I attended the Royal College of Midwives (RCM) Continuity Celebrated conference. As a supervisor of midwives, I was keen to hear the thoughts of the nation's midwives on the recommendation within Better Births: that ‘every woman should have a midwife, who is part of a small team of four to six midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally’. The voices I heard were overwhelmingly negative. In 2016, and in the years since, the concerns of midwives have centred on work/life balance. Those working in caseload midwifery previously told the rest of us how it had been, and indeed how it would be: endless on-calls, with diminishing numbers of midwives working due to exhaustion, leading to vacancies, which in turn lead to further on-calls. Their message was clear: it cannot be done in a way that benefits midwives. Nonetheless, in the latter part of 2019, the Royal United Hospital (RUH) set about implementing continuity of carer (CoC) in several parts of the trust. To date, we have 12 teams across the trust, six of which employ a traditional caseloading model. Now a professional midwifery advocate (PMA), I offer support and guidance to midwives and maternity service workers (MSWs) within our trust and was braced for a potential stream of midwives struggling under the weight of CoC.

A caseloading future continues to worry midwives who have not yet made the switch, but it has been noted that a capping of caseload numbers has meant we have not encountered the previous problems: burnout and stress

Providing PMA support

Midwives began requesting guidance as early as April 2019, a full eight months before the first caseloading team launched. By January 2020, I was approached regularly, formally and informally, by midwives wishing to discuss their fears about the change of working pattern and how it might affect them. Those contacts continue almost daily and come exclusively from midwives not yet working in CoC. Midwives working caseloading CoC models began contacting me for discussion and support about halfway through 2020. As I predicted, they were reporting feelings of anxiety, inability to relax on 24-hour ‘Availabilities’ and a lack of work/life balance. Most are working a set clinic day, plus two or three Availabilities per week. During these Availabilities, they conduct home postnatal visits to their mothers, work on admin in their own homes (the trust provides phones and laptops) and are available for labour care for their team’s women, in the acute unit, freestanding midwifery units and at homebirths. They are protected from being called to staff busy units, at the bottom of a list of others who should be called first. They are aware they might be required to plug gaps only at the highest level of escalation. I provided restorative discussion, signposting for mental health services and guidance on methods of self-soothing, calming behaviours and techniques. We also agreed to keep in touch and see what improvement could be gained over time.

Adapting to a new way of working

It was in these follow-up sessions that I noticed a pattern. Midwives typically needed three to four months to ‘settle in’ to their new way of working. It appeared that, institutionalised by years of working an on-call model, midwives initially approach their Availabilities as if they were on calls: that they could be called without warning to attend a unit in haste, due to emergency or heavy workload, anywhere in the trust. The RUH has maternity services over a large geographical area, across initially five (now three) birthing centres, which could represent a 90-minute drive from one end of the patch to the other. On calls are therefore stressful: midwives have no way of predicting need, due to the ad hoc nature of maternity
Availabilities, midwives have realised, are different. These midwives are ‘available’ for their own team’s women, and they know who these women are. They can look at the apps in their trust-provided phones and see the small number of women who are currently due or overdue: where they intend to birth, their partners’ names and the number and type of births they have already had. Far from being required to attend immediately, midwives operate a ‘90-minute rule’: reach these local mothers in up to 90 minutes. The women know this, so they call earlier than they might if phoning the obstetric unit, waiting for the traditional ‘three in 10’. If Available, midwives often have conversations with mothers through the day and are thus aware of who is ‘niggling’, who is awaiting induction, who has had a show.

Because of midwives’ knowledge of the caseload, and the 90-minute rule, the unknown and emergent elements of on-calls are absent. Midwives can go to lunch, to an exercise class, walk the dog – safe in the knowledge that they have awareness of the caseload’s current status. Of the eight CoC midwives who contacted me in late 2020 with concerns regarding their work/life balance, six have since reported back that their anxiety has dissipated, having learned not to treat an Availability as an on call, and report a better work/life balance than in their previous roles. Of the other two, one decided to leave midwifery altogether in a bid to remove overnight working from her life, but has remained in a health profession, and the other is nearing retirement but is still battling with an inability to relax while Available.

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Conclusion

A caseloading future continues to worry midwives who have not yet made the switch, but it has been noted that a capping of caseload numbers has meant we have not encountered the previous problems: burnout and stress. It does, however, require discipline to keep to these numbers, and to put one’s phone away at 5pm if not Available: something those six midwives have gradually realised. It appears that caseloading can be fulfilling and without burnout, as long as each midwife learns a new approach to her working life and a respect for her own time and wellbeing. TPM

Reference

Concealed Pregnancy in Adolescent Women – A Reflection on Practice

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Published in The Practising Midwife Volume 24 Issue 4 April 2021

Summary

Using fictionalised case studies of two concealed pregnancies in adolescent women, both of whom wish to conceal their birth and relinquish their baby for adoption, this article discusses the literature around concealed pregnancy, adolescent brain development, legal framework for practice and woman-centred care. It is an exploration of whether I achieved the balance needed, when respecting a woman’s right to autonomy feels like a barrier to providing care that is in her best interests. The conclusion of the article is that respecting a woman’s autonomy (and therefore her right to conceal her birth) is central to the mother-midwife relationship and therefore woman-centred care, even when the woman is a teenager.
Respecting a woman’s right to autonomy

NB* The following reflection has been fictionalised, using a number of similar clinical experiences.

As I knock on the door, I smile to see a row of ‘congratulations on your new baby’ cards. As a caseload midwife, I am used to visiting women I know well – I realise now that the cards and balloons often go unnoticed. I’ve only known Saira for a couple of weeks and, as happy as I am to see the birth of her baby being celebrated, I’m uneasy about the care I’ve given her. It was a week earlier, when, after a distressed phone call, I’d let myself into her house. Guided by the familiar panicked cries of precipitous birth, I scaled the stairs two at a time, grabbed some towels and offered a calm and friendly smile as Saira’s baby made his hasty entrance into her life. Just as she followed my instructions to slide down from the toilet and pant as she birthed her baby, I followed her instructions to tidy away any signs of the birth, and keep the baby hidden from neighbours as paramedics helped Saira into an ambulance.

A few weeks earlier: Saira had presented alone to urgent care, complaining of abdominal pain and constipation. She palpated to be in her third trimester and a scan confirmed she was around 37 weeks’ pregnant. Saira decided that she wanted to continue to hide her pregnancy and give the baby up for adoption. During our first meeting, I was concerned that her only focus was to avoid her family finding out. The details of the care she received over the next couple of weeks aren’t the scope of this article; needless to say, we had been working to avoid an unplanned homebirth. Several hours following the birth, while waiting at the hospital for her baby to go to the foster carer, I was relieved when Saira finally asked me to find and tell her parents.

All through an overwhelming few weeks for Saira, her need to keep her pregnancy hidden from her family felt like an obstacle to providing good care. A few days later, a respected colleague gently questioned our role in helping Saira to conceal her pregnancy. My midwife-friend suggested that she was an overwhelmed teenager – the midwife’s job was to make her tell her parents. As the mother of teenage daughters, her argument was compelling. Likewise, a similar case the year before had arguably better outcomes with this ‘adult knows best’ approach. This article is my exploration of whether I achieved the balance needed, when respecting a woman’s right to autonomy feels like a barrier to providing care that is in her best interests.

The ‘teenager-adult’ relationship
It seems reasonable to assume that inexperienced, frightened teenagers are most likely to deny or conceal their pregnancies. It’s a storyline common to soap operas and films. I was surprised to find that research has shown this to be largely untrue in real life. This article is discussing adolescent mothers in particular, but it is important to note that women who deny or conceal their pregnancies come from all social classes, are all ages and are just as likely to be married as not.¹

Several months before I met Saira, I cared for Jade. Like Saira, 17-year-old Jade wanted to conceal her pregnancy from her family and asked for her baby to be adopted. When she was 33 weeks’ pregnant, an agency outside of health and social care informed her parents. Despite my misgivings over the ethics of this decision, with the support of her family, Jade chose to parent her baby. Over the weeks leading up to the birth, Jade, her young partner and both families had time to adjust to the pregnancy. They were supported to prepare for their transition to parenthood, and when Jade gave birth she was with her mum and her partner.

Concealing a pregnancy isn’t always a sign of underlying mental illness. In their literature review, Jenkins et al⁴ found that ‘external stresses and psychological conflicts about pregnancy’ may lead to pregnancy denial in otherwise psychologically well women. As mentioned above, concealed pregnancy is not more prevalent in teenagers, but the process of brain maturation provides an insight into Saira’s thought processes. The prefrontal cortex (PFC) is not fully developed until a woman is in her twenties. The function of the PFC includes high-level reasoning, decision making, assessment of consequences and forward planning. In contrast, the amygdala, a part of our ‘primitive’ brain, is relatively more developed – this part of the brain is concerned with our emotional reactions. This imbalance doesn’t even out until after adolescence.³ Of course, adolescents can and do make mature and rational decisions, but evidence suggests that they are more likely to act impulsively and without consideration of the consequences in conditions of high emotion or intense pressure.
While I didn’t ever consider coercing Saira into telling her parents, much less breach her confidentiality, I worried that in her 16-year-old brain, the fear of her parents’ disapproval was clouding her ability to properly consider her choices. I worried that if she concealed the birth and adoption, she wouldn’t have the support she needed to resolve any grief or deal with any strong feelings of guilt and shame. I was worried that keeping this secret would affect her relationships, her mental health and impact any future pregnancies. Mainly, I worried that in the future, Saira would feel like the adults around her had let her down.

By respecting a woman’s autonomy, we centre our care around her, so we can more effectively act in her best interests.

**The ‘midwife-mother’ relationship**

Saira was considered competent under the Gillick ruling and as midwives we have a fundamental duty to ‘listen to people and respond to their preferences and concerns’, ‘act in the best interests of people at all times’ and ‘respect people’s right to privacy and confidentiality’ as laid out in our code of conduct. Ignoring Saira’s right to privacy and confidentiality could have damaged her relationship with the professionals trying to help her. Julie Wrey, writing for the Royal College of Midwives (RCM), summed it up nicely: ‘Young people regard confidentiality as the most important thing when seeking professional advice, without confidentiality there can be no trust and without trust there can be no affinity.’ This is echoed by Larcher, who adds that early experiences build a foundation for the young person’s future relationships with professionals.
Our professional code of conduct provides the framework for creating an effective and trusting midwife-mother relationship. Woman-centred care emerges from this relationship. To be truly woman centred, it’s important to challenge the idea that a midwife can know what’s best for a woman. We only know what women tell us of their lives, so we couldn’t assume that telling Saira’s parents was in her best interests. Instead, we listened to her and led the conversation into what her life was like; her relationship with her parents; and her relationship with the father of the baby. Through a trusting mother-midwife relationship, we were able to reassure ourselves that this vulnerable teenager was safe. By accepting her fear of telling her family and acknowledging that her adolescent brain needs help to think more logically, we were able to help Saira focus on the needs of her baby. We encouraged her to explore what consequences there might be for her future, her baby and her wider family.

We took every opportunity to help her think of a way in which she could tell someone. On the day of Saira’s unplanned homebirth, another midwife who had supported Saira arranged childcare and came in on her day off. Together with the wider team we worked so that Saira was supported by midwives who had tried to understand her life and her decisions. When the events of the day spiralled out of her control, Saira was able to trust that we were all working together to help her deal with a crisis.

**Conclusion**

I’m still uneasy that Saira’s path to motherhood was so difficult. But I don’t think that there is a balance to be struck between respecting a woman’s autonomy and acting in her best interests. I can only act in a woman’s best interest if she...
trusts me to reveal what her life is like for her. By respecting a woman’s autonomy, we centre our care around her, so we can more effectively act in her best interests. The childbirth continuum is a tiny but critical window into a woman’s life. As a caseload midwife who focuses on vulnerable women, I often feel a sense of unease when I haven’t ‘fixed’ everything on discharge. But Saira doesn’t owe me a satisfactory conclusion. Had I not been smiling at her windowsill full of baby cards, the rest of the multidisciplinary team would have carried on supporting her to make informed decisions. While I wish that Saira had the support of her family earlier, when childbirth forced her to confront her pregnancy, she was able to contact midwives whom she trusted. She decided when it was time to tell her family. And a few days later, with the support of her family, she decided that she was able to raise her baby. With such an intimate but fleeting role, there are limits to how much difference a midwife can make. But by respecting her autonomy, we aimed to create an environment for Saira to empower herself to act in her own best interests and, by extension, the best interests of her baby. TPM

References

Normal Birth 8. ‘Twinkling the Rooms’: Optimising Normal Birth in a Hospital Setting

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Published in The Practising Midwife Volume 24 Issue 4 April 2021

Summary

In middle- to high-income countries, childbirth usually takes place in hospital in high-tech delivery rooms designed for the benefit of those working in them, yet women and birthing people report higher satisfaction levels and are more likely to have a normal birth at home or in a midwife-led unit (birth centre). This article explores practical ways that midwives and other birth workers can maximise the opportunity for women to experience physiological birth in a hospital setting.

Introduction
Throughout the world, women and birthing people want to give birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and clinical staff who are not only competent but kind and caring.\(^1\) Women also place importance on normal, physiological birth as an aspiration, while acknowledging the need to ‘go with the flow’ should interventions be needed.\(^1\) Throughout the whole childbirth process, women usually wish to be involved in decision-making to retain a sense of control.\(^1\) However, many high-income countries are witnessing an increasing rate of unnecessary interventions\(^2\) where women have little or no choice in where they give birth or who supports them. Most women give birth in a hospital setting yet evidence tells us that they are more likely to have a normal birth\(^3\) and feel more satisfied with their birth experience when they have their baby at home\(^4\) or in a midwifery-led unit or birth centre.\(^5\) We must continue to learn from this unfolding phenomena by exploring the factors that make out-of-hospital birth so positive and applying them to settings situated within hospital labour wards. This includes attending to the environment and those who work there, and the culture of the department.

\textit{Where are the butterflies?}
‘My youngest daughter spent some time in the alongside midwifery-led unit (birth centre) whilst in early labour and she loved it. Even though she was anticipating some complications due to an underlying medical condition, she was totally relaxed, enjoying being in the bath in tranquil surroundings. When it became obvious that she needed to be transferred to the consultant-led birth suite, she was fine with the decision but, once settled, she asked me: “Where are the butterflies?” The birth centre walls, she explained, were adorned with soothing affirmations and stencils of butterflies and flowers - the rooms were “softer” and less intimidating. This was something I’d been aware of most of my career; the stark difference between different birth environments, which means women and birthing people receive unequal opportunities to labour and give birth.’ Sheena Byrom

The contrast does not end there. Midwifery-led units (birth centres) and home-from-home environments are generally occupied by women who are deemed ‘low-risk’ and have no expected complications. But most women giving birth in a hospital high-tech setting are usually surrounded by machinery that is, by default, busier. Birth rooms are designed for the benefit of those working in them, rather than those using them, and high-tech environments may affect autonomy, freedom of movement and ability to cope with labour and thus increasing fear. Most women give birth in hospital settings through choice, or lack of alternative options - it is now the socially accepted place for childbirth. However, the evidence is stacking that the environment plays a crucial role in determining women’s experiences of birth and the physiological process of labour and birth. What a woman sees, hears or smells potentially impacts on her labour and birth - calm, relaxed environments reduce the potential for adrenaline and catecholamines excretion and encourage the production of oxytocin to support optimal childbirth processes. So, let us consider the experience of someone who chooses or who is advised to give birth in hospital – how can we optimise their potential to have the same experience and positive outcome as a woman having her baby at home or in a birth centre? There are practical ways midwives can impact on or maximise the opportunity for physiological birth in a hospital setting.
The midwife’s work

Midwifery intuition plays a part, too. Understanding how fear can affect labour and birth is important, and Scamell et al. propose practical tips for addressing fear. Knowledge of human rights law around decision-making and consent, documentation and safe care plans with the women’s choices at the epicentre are also crucial for midwifery practice, and online resources are freely available. In addition, much can also be said for strong labour ward leadership, where lead midwives actively seek to encourage midwives’ autonomy in promoting physiology.

Relational care

There is robust research evidence demonstrating the importance of continuous support in labour, which is associated with improved outcomes and positive experiences for women and their supporters. When midwives provide one-to-one support, and if they are known to the person giving birth, outcomes are improved and midwives benefit, too. Building a trusting relationship with women and birthing people and being emotionally/mentally as well as physically present and responsive, is
a precursor to a positive birth experience, regardless of the model of care or mode of birth. In his advocacy for delivering compassionate healthcare, West et al. includes the importance of ‘listening with fascination’ and being ‘present’ in the moment. This reflects the midwifery concept of ‘being with’, which relates to the midwife’s attentiveness and attunement, especially with regard to the spiritual, emotional, physical and psychological needs of the labouring person.

Holding space for the woman, letting her know you are there to support fosters positive and meaningful relationships. When a relationship has developed, even after a short time, information sharing becomes easier, so that the benefits of optimal cord clamping, skin-to-skin contact and early breastfeeding can be explained and supported, thus optimising physiology.

**Practice points**

**Maintaining presence:**

- Use the person’s preferred name and ascertain their pronouns. This will encourage a trusting bond and nurturing relationship where they feel safe and in control.
- Be in the room as much as possible, engaging, mindfully listening, looking for non-verbal cues and using eye-to-eye contact, sensitivity and warmth.
- Smiling with your eyes and sensitive touch (with consent) are interactions that may help to reduce stress and build connection.
- Don’t leave the room to do tasks that can be carried out in view. Keep hydrated while in the room, sit quietly to observe if possible.
- Place signs on doors asking for privacy and silence – add useful information such as if someone is hypnobirthing.

**Working with pain**

Although access to pharmacological pain relief is increasing, birthing people continue to report feeling traumatised by their birth experience, often through not being listened to or a sense of lack of control. We know that when there is continuity of carer (CoC) fewer pain-relieving drugs are needed, but if a woman chooses or requires an epidural, for example, midwives can continue to support her to be in control if she wishes it, to optimise physiological events. Midwives can support the mechanisms of birth with thorough knowledge of biomechanics and using aids such as ‘peanut balls’ and rebozo techniques, which create a sense of joint partnership between woman and midwife in achieving a normal birth, enhancing the relational care provided.

**Adapting the environment**
When considering a labouring woman’s hormonal responses, the environment she is in can either enhance or inhibit progress and spontaneous birth. Even the journey from home to hospital has the potential to disrupt normal physiological responses. Consider the birth room from the eyes of the birthing person and supporter: what do you see? We believe labour wards can adopt the same philosophy as birth centres – bringing the birth centre environment to them by having a seamless transition between the two and embracing tools such as aromatherapy, birth affirmations and mood lighting. In one maternity service in Lancashire, the midwives use battery-operated candles on the consultant unit (labour ward) and call it ‘twinkling the rooms’ when preparing for an admission. Adaptations can be as simple as welcoming signs on the labour ward entrance, dimmable lights and encouraging people to bring own items from home for comfort such as pillows and music of their choosing. Using sheets to cover ‘clinical looking’ equipment (drip stands, CTG monitor if not in use) is a way to create a ‘nest’. Do you have birth pools in hospital birth rooms – if no, why not?
People who choose to labour upright and mobile can have beds pushed to one side, make use of birth mats, inflatable balls and stools, birth pools and opt for telemetry CTG monitoring if available. After all, there may be pathology present in a complex setting but birth is not pathological. Arguably, labour wards require more input than birth centres to facilitate childbirth physiology because epidural anaesthesia is present and the environment often less conducive to the delicate cascade of hormones. Many hospitals are now adopting a ‘gentle caesarean’ approach to theatre-based births – low lighting, surgical drapes lowered, relaxing music, optimal cord clamping and immediate skin to skin. These types of caesarean and assisted births are becoming more popular as the service adapts to a demand for a ‘parent centred’ approach to all modes of birth. Remember the birth space isn’t just for the childbearing woman and her supporters but is also occupied by staff working in them, which can influence their wellbeing, too. Midwives have reported feeling negatively affected by the biomedical environment of hospital maternity birth if it influences their ability to support normal birth and deliver person-centred care. Alternatively, environments that display characteristics of friendliness, functionality and freedom are likely to reduce midwife stress and increase high-quality care.

Trust the team

Forging mutually respectful relationships with colleagues is essential for the delivery of safe maternity care. Sharing knowledge, providing authentic positive feedback to each other and regular communication helps to build trust and provides the foundations for compassionate care and collaboration. Foster multidisciplinary working, where obstetricians and midwives have a shared vision for optimising experience and physiological birth. Compliment your colleagues on their advocacy and ferocity to promote physiological labour; make it a badge to wear with pride.

Conclusion

All women should have the opportunity to be supported to give birth in an environment that supports physiological processes with midwives and caregivers who understand why it is important, and how to create the optimal birth space.

TPM

Practice points

Tips for practice:

1. Revisit the physiology of labour and birth and share information resources with colleagues. Start an ‘optimising childbirth’ support group in your workplace.
2. Consider the woman’s journey from car park to birthing room. How far is it? What does she see? Take photos of the journey including doors and corridors. Present these to your peers and leaders. Source photos of other birth spaces and compare them with yours, determine what messages they convey and which you prefer.
3. If the labouring person needs or wishes continuous (CTG) monitoring they will need midwifery support to adopt positions most comfortable to them and use telemetry if available. Remember upright and lateral positions can be adopted with most births.
4. Embrace creativity in the birth room. Use sheets, mats and balls to support movements and rest during appropriate stages of labour. Familiarise yourself with the mechanisms and how to ‘troubleshoot’ instead of, or alongside, interventions.
5. Lobby and fundraise for birthing pools in hospital labour wards and support their use for labour and birth.
Use battery-operated lighting to create a calm mood in rooms to support optimal hormonal responses.

Share information on and promote the positive impact of optimal cord clamping, skin-to-skin contact and early breastfeeding at all births, including assisted or operative births. Keep mother and baby together at all times, when possible.

Consider your language. ‘Risk’ is a frequently used term in hospital settings, but women do not always categorise their ‘risks’ in the same way as health professionals.

Mirror the language used by the people in our care and set precedent for the philosophy of our care. Birth plans/preferences are commonplace now and provide a useful tool in ‘getting to know’ people, giving us insight into the language they wish to use and the type of labour and birth they wish to achieve.

Remember, being physically and mentally ‘present’ in the room with the labouring woman is a key indicator for a positive birth experience.

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Challenges Faced in Maternity Care for Women with Hearing Loss
Summary

This article explores supporting women and families who are profoundly deaf. According to the World Health Organization (WHO), profound deafness is defined as having very slight/non-existent hearing ability. Profoundly deaf people are generally reliant on communicating via sign language/lip-reading, so this article will focus predominantly on British Sign Language (BSL) as the main form of communication when planning care provision for a woman who is deaf/hard of hearing (D/HH). To accommodate specific needs, additional adaptations to care will be considered, along with local and national policy.

Background

There are reportedly 11 million deaf/hard of hearing (D/HH) people in the UK, equating to 1:6 individuals. Around 900,000 people are diagnosed with severe/profound (S/P) deafness, of which approximately 45,000 are of childbearing age. A normal hearing range is between 0-20 decibels (dB) of sound, whereas only noises above 81dB are remotely audible for those with S/P hearing loss. Any loss above 40dB is considered ‘disabling’. According to Action on Hearing Loss (AHL), those with S/P deafness are often reliant on British Sign Language (BSL) as their primary channel for communication. However, discrepancies in numbers of BSL users in the UK are apparent, with the government estimating 151,000 users, as opposed to the National Institute for Health and Care Excellence (NICE), who suggests 50,000 signers. The general consensus, however, is that BSL users tend to be those brought up in deaf communities and are either deaf since birth, or shortly after. Around 1:1000 babies in the UK are diagnosed with S/P deafness; newborn hearing screening can offer early detection, which could improve speech and social development. For some, BSL is their first language and studies show that pre-lingual exposure to any form of language is beneficial to later outcomes. NICE suggest cochlear hearing implants could offer assistance with this; however controversy over their effectiveness for S/P deaf is still under debate.

Challenging notions of disability

Advocating, empowering and providing high-quality care are principle values of the Nursing and Midwifery (NMC) Code; yet research highlights distinct lack of local and national policy specific to supporting D/HH women in pregnancy. Policy instead categorises D/HH individuals as disabled. For some, however - often those born into deaf communities with ability to sign - hearing loss is not considered a disability. According to WHO, disability is defined as bodily impairment or inability to participate fully in life situations and/or physical tasks; leading to environmental and societal obstacles. Thomas and Curtis argue, however, that a person’s participation in society is hindered by environmental, organisational and attitudinal factors. This is evident within midwifery care, according to Walsh-Gallagher et al, who claim that labelling birthing people as ‘disabled’ automatically categorises them as high risk, limiting their options and directing their care pathways. This
contradicts the NMC Code, which emphasises the importance of providing woman-centred care through provision of choice and control.\textsuperscript{8} Wildschut and Duvekot\textsuperscript{14} describe ‘high risk’ as an indicator to potentially negative outcomes, including increased fetal/maternal monitoring and lower threshold for medical interventions.\textsuperscript{15} Being D/HH is not an illness and therefore it should not be assumed that natural, physiological birth is unachievable.\textsuperscript{15,16} It is firmly established that risk should be assessed on function, rather than disability.\textsuperscript{17,18} The NMC dictates that midwives must work in women’s best interests\textsuperscript{8}; this means risk-assessing based on medical need, to keep care for women who are D/HH routine/low risk. NICE guidance specifies assessing risk through lifestyle choices: body mass index, medical history and current physical/mental health conditions.\textsuperscript{18}

**Inequitable maternity care**

Equitable access to quality provision, effective communication and healthcare staff who possess understanding of disability is the right of every woman.\textsuperscript{9} The NMC and Human Rights Act stipulate that reasonable adaptations should be made to accommodate individual needs,\textsuperscript{8,19} yet despite these obligations D/HH service users report not receiving this.\textsuperscript{13} The AHL suggests maternity care experiences for disabled/D/HH women are extremely under-reported.\textsuperscript{2} As a minority group, their inclusion in studies is minimal, although a common theme emerges whereby women feel their care is marginalised because of their label.\textsuperscript{13} This could be owing to midwives lacking confidence, training and experience when encountering these women, due to infrequency of occurrences and significant differences between disabilities and individual needs.\textsuperscript{13,20} In a qualitative study by Walsh-Gallagher et al,\textsuperscript{13} 19 midwives/healthcare professionals from two hospitals voluntarily participated in group interviews aimed at identifying barriers contributing to disabled women receiving high-risk care. Midwives listened to accounts from these women, who stated that they felt they had no control over their care and were not afforded the same choices as non-disabled women, because they did not ‘fit’ mainstream criteria.\textsuperscript{13} It was suggested that midwives needed more training to prevent reverting to a ‘high-risk’ default setting. Healthcare staff conceded that women should be afforded more input in their care and, although saddened by the feedback, felt that additional training was superfluous because of the insignificant numbers of pregnant women with impairments. This goes against NMC guidance, which states that midwives have a responsibility to maintain their knowledge and competencies.\textsuperscript{8} Adapting how to communicate with women who are D/HH is essential because effective communication has been linked to greater maternal satisfaction.\textsuperscript{21} In line with NMC guidance,\textsuperscript{8} midwives should work collaboratively with women and their partners and be guided by them on preferences
for contact (text/email/text-to-speech) and method of communication. Murphy implies that this is fundamental to personalising care, as women are best placed to advise on their individual needs.

**Supporting D/HH women's needs**

Reports show that 35% of D/HH individuals struggle to understand medical advice; 32% have issues conveying health worries and 70% do not attend appointments because of a lack of interpreters. Providing a BSL interpreter is necessary to reduce barriers, maximise understanding and help women make informed choices, although for legal and ethical reasons family and friends cannot be used as translators to avoid miscommunication and potential for incorrect diagnosis/treatment. Although it is a legal requirement to provide a qualified interpreter for all non-emergency appointments, interpreters generally require advanced booking and are not available 24/7. This could be problematic when D/HH women go into spontaneous labour. In addition, supplying interpreters requires working around their availability rather than the woman’s, which, although supporting her communication needs, is not particularly woman centred. Other ways to communicate and back up information could be by using visual aids and accurately subtitled videos, in addition to signposting to local groups and websites. Information leaflets and scribing are routinely used to convey information, although should not be relied upon because only 20%-28% of written text is read. Moreover, D/HH individuals reportedly have lower literacy ability, which is believed to be because of a lack or delay in exposure to language from an early age.

**Tailoring care**

Throughout her pregnancy, the woman may encounter other healthcare professionals, therefore, with consent, a hearing loop symbol could be placed on her maternity notes, identifying her hearing loss. Other simple adaptations include greeting her personally face to face in reception rather than calling her name; talking directly to the woman/couple (not the interpreter); drawing diagrams illustrating the baby’s position; and allowing them to hold the sonicaid to feel vibrations from their baby’s heartbeat. The couple could be offered a tour of the maternity unit as familiarity with the environment and maternity team may reduce anxiety when labour commences. In conjunction, one-to-one parent education and baby-feeding classes may be beneficial so information can be tailored to meet individual needs and wishes, as can spending time
with the woman or couple to ensure she/they is/are fully informed about her/their options. Although there is no local or national guidance on this, these alterations could improve experiences for D/HH service users, making them feel more included and ‘normalising’ their pregnancy.

Other simple adaptations include greeting her personally face to face in reception rather than calling her name; talking directly to the woman/couple (not the interpreter); drawing diagrams illustrating the baby’s position; and allowing them to hold the sonicaid to feel vibrations from their baby’s heartbeat.

Conclusion

D/HH women face many difficulties when accessing maternity services and midwives need to be aware of their professional and legal obligations. Deaf people constitute a large disabled group and although it is an invisible disability, this does not mean it should be ignored. In addition, the lack of local and national policy needs to be addressed to help guide practice and possibly avoid the over-use of high-risk labelling. TPM

References


Infant Massage: The Power of Human Touch

Avril Flynn - Midwife and Childbirth Educator

Published in The Practising Midwife Volume 24 Issue 4 April 2021

One of the very many lovely things I do in my job as a midwife, and have the privilege and pleasure of, is to hold newborn babies - the joy has never waned for one minute! I do not think there is anything as soft, precious or
beautiful as newborn skin – like the perfect mixture of the softest velvet and rose petals. Encouraging parents to learn to care for that skin, that newborn, and enjoy holding, touching and getting familiar with their new little human can take some time.

The wish to touch and interact with little babies has been something held as sacred in many different cultures but infant massage as a distinct action is a fairly recent phenomenon in western society.

**Touch as the foundation**

In my practice, I have no hesitation in recommending infant massage as an excellent way to encourage maternal and infant bonding. We know that the first year, and the first few months of life in particular, lay the foundation for positive attachment, development and cognitive ability. The wish to touch and interact with little babies has been something held as sacred in many different cultures but infant massage as a distinct action is a fairly recent phenomenon in western society. There is an increasing body of evidence to support its benefits, of which the aforementioned positive attachment is just one. Among the other benefits that have also been observed in both term and pre-term infants are weight gain, improvement in colic, gastroesophageal reflux disease (GERD) and hyperbilirubinemia, and improved skin condition. Although there are obvious limitations to small sample size and possible bias in some of these studies, they nevertheless are still very encouraging.

One thing we know for sure is that infant massage carries no risk of harm.

**Benefits of infant massage**

The benefits are not just for the infant. Parents, and mothers who may have pre-existing anxiety or mental health issues in particular, demonstrate increased rates of breastfeeding self-efficacy, awareness of their baby’s cues and a decrease in stress. There is also some evidence that birthing people’s mood and sleep is improved generally by infant massage and that it provides a good source of postnatal peer support.

During the COVID-19 pandemic’s seemingly never-ending recent lockdowns, we learned to our detriment of the difficulties faced by new parents and as professionals. Midwives have been on the frontline of witnessing the loneliness and challenges of forced but necessary home confinement for families, demonstrated by the increased reports of anxiety and stress. Infant massage may be a way to combat isolation and increase connection. Although it cannot be taught in person at present, it can be instructed online or via pre-recordings. This means it is a cheap and effective way to allow parents to be familiar with and enjoy touching their babies, and for the baby to receive all the benefits of that touch in return.

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Neurodiversity and Maternity 2. Autistic Breastfeeding Part 1

Joanna Grace - Founder, The Sensory Projects

Published in The Practising Midwife Volume 24 Issue 4 April 2021

Summary

Differences between autistic people and neurotypical people can lead to misunderstandings between patients and healthcare professionals that jeopardise care provision. Understanding the possible impact of communication, sensory and pain differences can enable you to ensure clear communication and effective care for neurodivergent women in your care. In this second article of the series, Joanna draws upon her own experience of breastfeeding as a woman with autism to provide useful insights for maternity workers.

NOTE
Background

I gave birth to my first son in a cottage hospital in Germany that specialised in breastfeeding support. The expertise and equipment on hand was exceptional, so when I struggled to feed him, we got all the help in the world. However, even with all the help in the world, a combination of him not having a very strong suck and me not making quite enough milk meant that we had to move to combination feeding. Six years later I gave birth to my second son, this time in the UK, and once again breastfeeding was tricky. After the help I had first time around I knew my stuff. Alert to the possibility that I would not produce enough milk, this time around when my baby failed to gain enough weight to be discharged from the midwifery service within the usual time period, I began to combination feed. My baby was in cloth nappies, he was carried in a fabric wrap, we even had re-useable baby wipes, but I was not the rosy picture of mother earth that I might have hoped to be. It was painful. One breast was so painful that after doggedly persisting for over a week I gave up on that one entirely. I want to quantify my ‘painful’. I gave birth without pain killers. I have even had a root canal without anaesthetic! Those things were not too painful for me but feeding from that breast was.

Pain differences

Many autistic people have a different registry of pain, and express pain differently to neurotypical people. I have a high pain threshold, and I do not necessarily express pain in the way you might expect to see it. For example, I might say: ‘It hurts’, but I will not cry, you will not see strain in my face. Research carried out on autistic children found that they experienced the same amount of pain as neurotypical children but were half as likely to be given painkillers because their expression of their pain was not what the observing adults expected to see. I am the adult version of those children.
Autism and breastfeeding

There are other ways autism might affect a breastfeeding woman:

- Sensory differences. Many autistic people experience the sensory world differently to their neurotypical peers, which could impact on breastfeeding. For example, being hyper-sensitive to touch could acerbate the sensations associated with a painful latch.
- Interoceptive differences. Interoception is the sense you use to sense your internal feelings. Differences in interoception would affect a person’s ability to feel sensations within their breast. For example, hyper-sensitivity in this area could see someone struggle with the sensation of engorgement or fail to notice signs that milk ducts were clogged.
- Eye contact. As an autistic person, I am acutely aware that I do not perform eye contact as some people would wish I did. To my mind, facing someone is confrontational, but being alongside someone looking in the same direction – not looking directly at them – is companionable. This is just my viewpoint. I think it is fine to have a different opinion on this, but lack of eye contact is often spoken of as being a problem and so I feel nervous about it.

When my baby feeds, he looks directly up at me. Two little blue eyes staring up into space... looking for my eyes? Can he even see as far as my face? Am I letting him down if I do not look back at him? I do look back. I enjoy looking at his eyes. But there is this whole conversation in my head about whether I am doing the looking correctly – a societal pressure that would not be there in a neurotypical woman’s head.

I hit a wall breastfeeding

Today I hit a wall with breastfeeding and had a teary conversation with my husband about what to do. He said we had been given some leaflets in the hospital, tucked inside the red book. I was delighted to discover a slip of paper with an email address on for the breastfeeding team. I had expected to find a leaflet with a phone number, which, to me, would have been a dead end help wise. Like many autistic people, I process language differently to neurotypical people. For me, this means I can speak in a ‘typical’ manner, but I do not take in information at a typical speed. You and I could have a conversation and it would seem normal to you. I perform my replies from set phrases and patterns of
speech that I have learned. After our chat, I would have no idea what you have said. I would be pleased with myself for doing the chat well but wouldn’t have gained anything from it. Hiding one’s autistic nature is known as ‘masking’. Autistic women are recognised for masking more effectively than autistic men. Often times in my maternity care, my ability to act like all the other neurotypical women my midwife was supporting meant that the note on my file that I am autistic was overlooked. I appear like the other women, so I must be like the other women: but I am not.

**Communication barriers**

The email address was a delight to find. For the first time in my pregnancy, I had an access point for support. I cannot chat on the phone, but I can email! I emailed. And instantly got an automated response telling me that the email option had only been available through lockdown and, now practices were returning to normal, I should phone the following number. I cannot express how upsetting it was to think that for once I had support accessible to me in a way I can manage, and then to have that taken away. I did not phone. I imagine if I had, I would have been referred to support groups with other breastfeeding women. A friend of mine has a baby several months older than my baby. She has thrived in the local breastfeeding support group. She gains so much encouragement from being around the other mothers and sharing stories. It is clearly a wonderful thing. For her. For me, it would be a terrifying new social situation. I would have to spend considerable time working out what phrases I might need for the conversations I might encounter. I would worry about whether I had performed the social situation right. I would be exhausted by meeting so many new people. In other words, such a group is a wonderful support for neurotypical women. But for autistic women? Of course, I cannot speak for all autistics, nor make claims about all neurotypicals. Both autism and neurotypicism are spectrum experiences. It will be different for everyone. But for me, what I need today are clear, concise facts. I have questions about antibodies and allergies and timescales that I want specific answers for. But I am adrift in the vagueness of ‘keep going for as long as you can’ and I have no place to go to ask for help.
Conclusion

Being aware of sensory, communication and pain differences between autistic people and neurotypical people can help you to break down barriers to healthcare. Doing this will lead to better physical and mental health for your autistic patients. It will also have the happy side effect of you getting to meet us as our quirky, fun selves, not our masked performance of normality. **TPM**

Reference