Rethinking postnatal care: A Heideggerian hermeneutic phenomenological study of postnatal care in Ireland

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Rethinking postnatal care:
A Heideggerian hermeneutic phenomenological study of postnatal care in Ireland

by

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A thesis submitted in partial fulfilment for the requirements for the degree of
Doctor of Philosophy at the University of Central Lancashire

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Abstract

The postnatal period is an important and extremely vulnerable time for new mothers and their infants. Research has outlined the considerable extent of maternal physiological and psychological morbidity following childbirth. The underreporting and undiagnosed aspect of this morbidity has also been highlighted. Newborn infants are totally dependent on their needs being met and are also at risk of newborn conditions particularly if they are undiagnosed, for example neonatal jaundice. There is however, mounting evidence regarding the lack of postnatal support from health professionals, with women continuing to report their dissatisfaction with postnatal care. Research into postnatal care is pre-dominantly quantitative and clinically focused. Few empirical studies have examined the meaning women give to their postnatal care experiences.

This research aims to generate a deeper understanding of the meanings, and lived experiences of postnatal care. In addition, it aims to reveal future possibilities to enhance women's postnatal care experiences. Initially, an in-depth examination of relevant literature is undertaken followed by a presentation of the process and findings from a qualitative meta-synthesis. An in-depth exploration of Martin Heidegger's biography and explication of his philosophy is then outlined.

This research is a Heideggerian hermeneutical phenomenological study of Irish women's aspirations for, and experiences of, postnatal care. Purposive sampling is utilised in this research, which was undertaken in two phases. Phase one involved group interviews over three different time periods (between 28-38 weeks gestation, 2-8 weeks and 3-4 months postnatally), with a cohort of primigravid women and a cohort of multigravid women. The second phase involved recruiting two further cohorts of primigravid and multigravid women who participated in individual in-depth interviews over the same longitudinal period. In total nineteen women completed the study. Thirty-three interviews were held in total.

The data analysis is guided by Crist and Tanner's (2003) interpretative hermeneutic framework. The women's aspirations/expectations for their postnatal care are represented through three interpretive themes: 'Presencing', 'Breastfeeding help and

support' and 'Dispirited perception of postnatal care'. In addition, five main themes emerged from the data and capture the meanings the women gave to their lived experiences of postnatal care: 'Becoming Family', 'Seen or not seen', 'Saying what matters', 'Checked in but not always checked out' and 'The struggle of postnatal fatigue'. The original insights from this research clearly illuminate the vulnerability women face in the days following birth. A further in-depth interpretation and synthesis of the findings was undertaken. This philosophical-based discussion drew from the work of Heidegger (1962) and Arendt (1998). Engaging with these theoretical perspectives contributed to a new understanding about why some women within a similar context, have positive experiences of postnatal care while others do not. As such, the very nature that midwives and other postnatal carers are human beings has an influence on a woman's experience of her care. These carers, in their exposition of 'being' have the ability to demonstrate 'inauthentic' or 'authentic' caring practices. It is those who choose to be 'the sparkling gems' that are the postnatal carers who make a difference and stand out from the others. For the women in this study, their postnatal care experiences mattered. While some new mothers reported positive and meaningful experiences others revealed experiences which impacted unnecessarily. The relevance of these findings, recommendations and suggestions for future research are offered.

'Women who become mothers
find that it is often in the crucible of that experience,
in what in so many ways seems a sacrifice of self,
that she touches her deepest experience of the female self
and wrestles with an angel that at once wounds and blesses her'.

Naomi Ruth Lowinsky (1992, p.66)

Contents

List of Tables

List of Figures

Picture

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To you Donal, Isobel, Kate and Órla I dedicate this thesis.

1.0   Chapter One: Introduction to Thesis

This thesis presents the findings of a Heideggerian hermeneutic phenomenological study of postnatal care in Ireland. The research examines Irish women's aspirations' for, and experiences' of, postnatal care. Ontology, the study of being or existence (Stevenson, 2005) underpins this research, as it is through understanding our way of being that human experience can be meaningfully understood. This is the basis of Martin Heidegger's work as *'being just is what we understand when we have an understanding of being'* (Carmen, 2008[1], p.XIV). Within this introductory chapter the key influences underpinning the research will be identified. The framing of this research will then be presented, followed by an outline of how this thesis is organised.

1.1   Key influences underpinning research

There are four key influences which underpin the initiation of this research. The first influence relates to the increasing evidence on the substantial impact of childbirth on women's health (MacArthur et *al.*, 1991; Glazener *et al.,* 1995; Bick & MacArthur, 1995; Garcia *et al.,* 1998; Lazarus *et al.,* 1999; Amino et al., 2002; National Perinatal Epidemiology Unit, 2007; Webb *et al.,* 2008; CMACE, 2010a; Thung and Norwitz, 2010) The second influence is the mounting evidence within the international literature which indicates that women continue to be unsatisfied with their postnatal care (Mc Court *et al.,* 1998; Singh & Newburn, 2000; DH, 2004; Ockleford *et al.,* 2004; Brown *et al.,* 2005; National Perinatal Epidemiology Unit, 2007; Rudman & Waldenstrom, 2007, Bhavnani and Newburn, 2010), along with the fact that new mothers and their babies are being discharged home earlier from hospital. The third is the historical paucity of research into postnatal care, although the last five years has seen a sudden increase with the majority of research being dominated by positivistic approaches. The final influence relates to my personal pre-conceptions shaped through my midwifery clinical practice, my midwifery academic background and my personal experience of postnatal care in Ireland and Northern Ireland having had two children born in Ireland

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[1] Taylor Carman was a scholar of Martin Heidegger and is recent author of a new foreword to *'Being and Time'*.

and one born in Northern Ireland. These key influences as outlined above will be further developed in chapter two.

1.2   **Framing the research**

Based on these influences, a Heideggerian hermeneutic phenomenological study into women's postnatal care aspirations and experiences was designed.   By recruiting and interviewing primigravid and multigravid women longitudinally, this research aimed to generate a deeper understanding of the fundamental aspects of postnatal care from the perspective of the women themselves. The analysis aims to uncover the lived experiences of care following childbirth and illuminate the meaning the women gave to their experiences.

1.3   **Organisation of the thesis**

The following outline of the subsequent chapters provides an overview of this thesis:-

1.3.1   *Chapter two*

Chapter two provides a background to this research by describing the theoretical evidence and context. The key influences outlined in chapter one are expanded in detail within this chapter. Initially, the challenges and issues that new mothers experience following birth will be highlighted followed by a critical discussion on the current evidence on maternal morbidity and mortality. Evidence surrounding new mothers' dissatisfaction with their postnatal care is presented along with a critique of postnatal care research. The chapter finishes by highlighting the personal pre-conceptions which have contributed to my interest in postnatal care.

1.3.2   *Chapter three*

Chapter three focuses upon the key historical developments in Ireland which have influenced the provision of maternity care. This historical overview provides a context to the discussion presented within this chapter on the current provision of postnatal care in Ireland.

1.3.3   *Chapter four*

Chapter four presents a meta-synthesis of postnatal care. Initially a critique of the current literature relating to the various methodological approaches to a qualitative meta-synthesis inquiry is presented followed by describing in detail the process undertaken. The process includes: an overview of the identification of the studies, inclusion and exclusion criteria, the analytic strategy and presentation of the findings. The concluding summary to this chapter provides a synthesis of key issues to be considered within the research.

1.3.4   *Chapter five*

Chapter five provides a detailed description of the philosophical underpinnings and design of this Heideggerian hermeneutic phenomenological research. The chapter begins with a brief chronicle of the life events of Martin Heidegger to place his work and philosophy in context, followed by a detailed explanation of the evolution of Heidegger's philosophy. The genesis and development of Heidegger's seminal book, '*Being and Time*' is discussed at length. The work of the forerunners to Heidegger, including Frank von Brentano and Edmund Husserl is critiqued.   Heidegger's contribution to hermeneutic phenomenology is then outlined.   The final section highlights my theoretical perspective.

1.3.5   *Chapter six*

Chapter six outlines the framework and research methodology guiding the design of this research. The chapter begins by outlining the research question addressed and the setting in which the research was undertaken. Details of how the participants were recruited, the research methods employed and details of the interpretive analytical framework used to guide the data analysis are presented. The final section describes how rigour has been achieved in undertaking this research is then outlined.

1.3.6   *Chapter seven*

In this chapter, an introduction to the interpretations is presented.   Initially, an overview of all the participants engaged in this study is presented to provide a

contextual background to their narratives. The latter section of chapter seven presents an overview of the subsequent interpretative findings chapters.

1.3.7   *Chapter eight*

Chapter eight includes my interpretation of the shared meanings of the women's aspirations for/expectations of postnatal care. Three themes were generated from the data: 'Presencing', 'Breastfeeding help and support' and 'Dispirited perception of postnatal care'.

1.3.8   *Chapter nine*

Chapter nine begins with an introduction to the five main themes that evolved from the data and illuminate how the women experienced their postnatal care, these are: 'Becoming Family', 'Seen or not seen', 'Saying what matters', 'Checked in but not always checked out' and 'The struggle of postnatal fatigue'. The remainder of chapter nine presents the theme 'Becoming Family' which uncovers the women's convoluted and challenging journeys in early motherhood as they focus on becoming a family.

1.3.9   *Chapter ten*

Chapter ten presents two of the main themes, and begins by presenting the theme 'Seen or not seen'. This theme illuminates how the women's care needs were either noticed or overlooked. Directly related to this theme is the context of where the postnatal care is provided, as captured by the sub-theme 'Privacy versus exposure'. The following theme 'Saying what matters' reveals how the women experienced appropriate and inappropriate verbal and non-verbal interactions from their postnatal carers, the subsequent impact of these experiences on the women is also disclosed.

1.3.10   *Chapter eleven*

The fourth theme 'Checked in but not always checked out' relates to how some of the women experienced a 'tick box' approach to their postnatal care while others experienced a thorough approach and consequently were 'checked out'. The last

theme illuminates the women's struggle with postnatal fatigue as a new mother and reveals the extreme challenges it presents in their new world of motherhood.

1.3.11   *Chapter twelve*

Chapter 12 presents a further in depth interpretative synthesis of the meanings Irish women give to their experiences of postnatal care. Philosophically based discussion is offered as to why postnatal carers' act inauthentically or authentically in their everyday practices and thereby leaving a consequential impact on new mothers and their families.

1.3.12   *Chapter thirteen*

Chapter 13 presents a discussion centred on the broader relevance of the insights from this research and outlines recommendations for future possibilities to improve postnatal care practice and research. The limitations of this study and my final thoughts are then detailed.

2.0   Chapter Two: Background

This chapter provides a background to the research by describing the theoretical evidence and context which have guided the direction and subsequent development of the research. In doing so, the key influences outlined in chapter one will be expanded in detail. Initially, the challenges and issues that new mothers experience following birth will be highlighted followed by a critical discussion on the current evidence on maternal morbidity and mortality. Evidence surrounding new mothers' dissatisfaction with their postnatal care is presented along with a critique of postnatal care research. The chapter finishes by highlighting the personal pre-conceptions which have contributed to my interest in postnatal care.

2.1   The issues and challenges for new mothers

The birth of a baby is viewed by many people as a joyful and welcome event. For some women however, the adjustment and responsibility of taking on a new role as mother can have a stressful (Razurel *et al.,* 2011) or significant impact on their lives (Buultjens and Liamputtong, 2007). Although the majority of women have a normal labour by definition, a negative childbirth experience has been recognised by Edworthy *et al.,* (2008) in the form of post-traumatic stress. Moreover, following prolonged labour new mothers have compared their recovery similar to recovery from illness (Nystedt *et al.,* 2008).

In addition, the immediate and life changing demands of a new baby can be stressful and overwhelming for new mothers (Nelson, 2003; Gamble & Creedy, 2009). Barclay *et al., (*1997) considers that the process of becoming a new mother is complex, despite the general perception that it is a naturally occurring phenomenon. The postnatal period begins immediately following the birth of the baby and continues until the bay is three months old. For most women, it is a time of major transition that requires considerable physical, emotional and social change (Wiklund *et al.,* 2009). Currie (2009) identified there is a significant burden on mothers as they try to live up to the ideal of being a '*good mother*' (p. 667). Indeed some may actually not admit they need help, or they may refuse help because of associated guilt, obligation or awkwardness (Currie, 2009). The issues and challenges for new mothers are therefore significant. Attending to their

health and wellbeing along with that of their baby is of paramount importance because the baby and family depend on the mother's wellbeing. Dearman *et al.,* (2007) confirm that the mother is the *'the pivot upon which the family turns'* (p.153). Effective postnatal care is therefore essential as the majority of maternal deaths and disabilities occur in the postnatal period (WHO, 1998a).

2.2   <u>Maternal morbidity</u>

Recently, the WHO has confirmed the definition of the postnatal period[2] to encompass the first six weeks following delivery (WHO, 2010). Nevertheless, they acknowledge that the physiological changes which occur in pregnancy and childbirth often take much longer than six weeks to resolve. This has also been noted by other authors (WHO, 2010, Maternity Center Association, 2004, MacArthur, 2003, Rouhi *et al.,* 2011). The international literature confirms that new mothers are continuing to experience poor health as a result of giving birth and becoming a mother (MacArthur *et al.,* 1991, Glazener *et al.,* 1995, Bick & MacArthur 1995, Garcia *et al.,* 1998, Brown & Lumley 1998, Lazarus *et al.,* 1999, Albers, 2000, Amino *et al.,* 2002, Danel *et al., 2003,* Maternity Center Association, 2004, Webb *et al.,* 2008). However, research by Schytt *et al.,* (2005) found that although some postnatal women did report negative physical symptoms at two months and one year following birth, the majority rated their health positively. The minority who reported low health rated scores referred to symptoms affecting their general physical functioning and well being such as, perineal pain. Schytt *et al.,* (2005) stress the need for further research into the concept of self-rated health following childbirth. Nevertheless, Webb *et al.,* (2008) research clearly identifies that one in five women suffer from major physical postnatal ill-health which is strongly linked to maternal functional impairment. Recently published research by Yelland *et al.,* (2009) and Rouhi *et al.,* (2011) adds to this body of knowledge on maternal morbidity and confirms that 90% of women experienced one or more health problem three months postnatally.

Danel *et al.,* (2003) define maternal morbidity as *'an adverse impact on a woman's physical health during childbirth, beyond what would be expected in a normal delivery'* (p. 631). Research from a Scottish study of postpartum women reported physical symptoms

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[2] The period of time following childbirth is often described by a number of related terms that are used interchangeably, such as: 'postnatal', 'postpartum' 'perinatal' and 'puerperium'.

that occurred from delivery up to 18 months later. These include: tiredness, perineal pain, breast problems, backache, piles and constipation, tearfulness and depression, anaemia, headache, high blood pressure, urinary symptoms, stitches breaking down, other infections, nausea and vomiting (Glazener *et al*., 1995). Postpartum women have identified their new-onset health problem as *'serious'*, *'major'* or *'long lasting'* (Garcia *et al.,* 1998, Maternity Center Association 2004). Most importantly, maternal morbidity has tended to be under-recognised and unreported with the majority of women do not seek help (Glazener *et al.,* 1995, Glazener, 1997, MacArthur *et al.,* 1991, Webb *et al.,* 2008, Rouhi *et al.,* 2011)

2.2.1 *The magnitude of maternal morbidity*

International empirical evidence suggests that maternal morbidity is extensive. Results indicate the incidence of women experiencing at least one health problem following childbirth in the UK ranges from 80-87% (Garcia *et al*., 1998, Glazener *et al.,* 1995). In Australia 90% of women reported one or more health problem three months following delivery (Yelland *et al.,* 2009). Only recently has research begun to highlight the extent of the problem for postnatal women in Ireland. In 2010, the incidence of maternal morbidity was identified by researchers at the National Perinatal Epidemiology Centre in Cork. They accumulated national data through the Hospital In-Patient Enquiry (HIPE) scheme from 19 maternity hospitals between 2005 and 2008. The research included 253,765 mothers who had a singleton pregnancy and the results suggest that one in six women experienced a moderate to severe physical morbidity during or after childbirth (Lutomski *et al.,* 2010). Furthermore, an American population based study by Danel *et al.,* (2003) confirmed the magnitude of maternal morbidity is much greater than originally thought. Across the population 31% (approximately 1.2 million women) experienced some type of maternal morbidity during labour or delivery. Women who had a caesarean section were not included in these figures. Research has also linked physical postpartum health problems and postnatal depression (Brown and Lumley 2000).

Zittel-Palamara *et al*., (2008) recently reported that one in seven women who give birth will experience postnatal depression. A considerable number of new mothers are therefore unhappy following childbirth and many suffer postnatal depression in silence. Women's experience of living with postnatal depression has been researched

20

by Beck (1992), who identified 11 themes to capture the participant's experiences. These include: 'unbearable loneliness', 'suicidal thoughts', 'obsessive thinking', 'loss of self', 'lack of interest in previous activities', 'suffocating guilt', 'cognitive impairment', 'devoid of positive feelings', 'uncontrollable anxiety', 'loss of control' and 'besieged with insecurities'. In addition, Buultjens and Liamputtong's (2007) research confirms how postnatal depression is terrifying and isolating for new mothers, particularly as it is a debilitating and often a complex illness. Beck's research has also focused on women's experiences of postpartum panic disorder and posttraumatic stress disorder after a traumatic birth (Beck 1998, Beck 2004). These postpartum mood and anxiety disorders are devastating for the women and their family, while the most serious form is postpartum psychosis, occurring in approximately 1-2 childbearing women in 1,000 (Engquist *et al.*, 2009).

2.2.2 *The impact of maternal morbidity*

A significant point to consider is the impact of maternal morbidity on women and their families. Findings from research by O'Reilly *et al.*, (2009) reveal the destructive impact on women who have experienced continued pelvic problems beyond the postnatal period. Utilising descriptive phenomenology, the researchers found that pelvic injuries from childbirth had a significant impact on the women's lives causing them to have a negative self-image and a deep fear of intimacy. They also reported not being listened to by healthcare providers, how their difficulties had been trivialised leaving them feeling devalued and dismissed (O'Reilly *et al.*, 2009)

The outcome of a four year follow-up study of women who experienced postnatal depression has indicated an increased risk of future maternal illness, along with child behavioural problems (Josefsson and Sydsjo, 2007). There is also a danger that children of women who suffer from psychological morbidity following childbirth may experience long term or even permanent damage or delay in their cognitive development (Murray and Cooper, 1996). Maternal postnatal depression can have an impact on the mother-infant relationship and consequently a baby's normal development may be affected as identified in patterns of '*mechanical infant caring*' (Barr, 2008, p366). Postnatal morbidity has been identified to not only have an adverse effect on the mother and her baby, but also on her marital relationship and ability to contribute to society (Zittel-Palamara *et al.*, 2008).

2.3   Maternal mortality

Maternal mortality rates in the UK have decreased from 6.24 per 100,000 in 2003–2005 to 4.67 per 100,000 in 2006–2008 (CMACE, 2011). Nevertheless, a rise in deaths from a community-acquired Group 'A' streptococcal sepsis led to a public health alert in September 2010.   The Centre for Maternal and Child Health enquiries (CMACE)[3] issued the alert prior to the full publication of the triennial report entitled '*Saving Mothers' Lives',* as 12 direct maternal deaths occurred following genital tract sepsis (CMACE, 2010a).   Most of these women had been in contact with children who had a streptococcal throat infection, either their own children or those they had cared for. The majority of the deaths had occurred postnatally and seven of these women had died from genital tract sepsis developed following a vaginal delivery. This highlights how healthy women following a normal delivery can become critically ill and die in a very short time (CMACE, 2010a). The full report '*Saving Mothers' Lives*' (CMACE, 2011) indicates that sepsis is now the commonest cause of direct maternal deaths in the UK.

A further alert was published in December of 2010 by CMACE regarding the A/H1N1 influenza virus, which was implicated in 12 maternal deaths in the UK and one in Ireland between 1st April 2009 and 13th January 2010.   One of the recommended learning points following the CMACE investigation into the maternal deaths is that carers need to be alert to pregnant and postnatal women presenting with respiratory symptoms and/or fever even outside the seasonal flu season (CMACE, 2010b).

In the U.S. maternal mortality rates are increasing in comparison to other developed countries (Block, 2007, CMACE, 2011).   In 2007 (the last year for which figures are available), there were 12.7 deaths per 100,000, equating with 548 women. The rates increased from 7.5 deaths per 100,000 births in 1982 (Xu *et al.*, 2010)*.* The maternal mortality rate for black women is particularly high at 26.5, approximately 2.7 times the rate for white women (Xu *et al.*, 2010).   Gaskin (2008) is concerned with the underreporting of maternal deaths and the apparent masking of maternal mortality rates. Identification of maternal deaths throughout the U.S. changed in 1999 with the

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[3] Irish maternal mortality data from January 2009 will be included in the UK triennial report as CMACE Ireland has been established.

implementation of the *International Classification of Diseases, Tenth Revision* (ICD-10), aiding the identification of indirect maternal deaths. The death certificate is another method used in some of the States with a separate question enquiring about any recent history of pregnancy. This approach is not standardised throughout the country and may have led to the inaccurate monitoring of maternal deaths in the United States. Gaskin (2008) uses case studies to highlight her concern regarding the increasing maternal deaths in the U.S. She presents the sad death of Tameka McFarquhar (RIP), a 22 year old Army Specialist, who was a single mother and had no family members living nearby. Gaskin reports:

> *'...she was released from Samaritan Medical Center in Watertown, New York, a day after giving birth to her first child on December 14, 2004... On the night of December 19, McFarquhar spoke with her mother in Jamaica and told her that she had a headache. Worried about her, her mother advised her to drink some warm milk and keep herself warm. That phone call was the last time that any family member or friend heard McFarquhar's voice. No one could get her to answer her phone or her apartment door. A concerned friend notified the Watertown police, who found no probable cause to break into the apartment. Finally, on Christmas morning, McFarquhar's friend again contacted the police, who this time went to McFarquhar's apartment, only to find a horrifying scene. McFarquhar had bled to death several days earlier, and baby Danasia had died of dehydration and starvation.'* (p.3)

Ms McFarquhar's (RIP) maternal death in the postnatal period highlights for Gaskin (2008) the importance of a postnatal care home visit. Gaskin suggests that if Ms McFarquhar had been visited by a health professional following the birth, the death of her and her baby would undoubtedly have been prevented as incomplete involution of the uterus would have been easily detected by a midwife before a life-threatening haemorrhage would have occurred. Unfortunately no details, identification of important trends or recommendations are provided by the Centre for Disease Control and Prevention (CDC) in the U.S., in contrast to the triennial CMACE report in the United Kingdom (U.K.)

2.4   Women's dissatisfaction with postnatal care

Women continue to report how dissatisfied they are with routine standard postnatal care, as seen by the mounting evidence within the U.K., Australia and Sweden (Audit Commission, 1997, McCourt *et al.,* 1998, Singh and Newburn, 2000, DH, 2004, Ockleford *et al.,* 2004, Brown *et al.*, 2005, Hildingsson, 2007, Rudman and Waldenström, 2007). This issue persists in the UK despite the publication of major maternity care policies and guidelines. These include the Maternity Standard, National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004) and the NICE (2006) guidelines entitled: '*Routine postnatal care of women and their babies'*. The recent repeated survey of first-time mothers in the UK confirms that postnatal care continues to be the '*Cinderella service'* (Bhavnani and Newburn, 2010). The original study was undertaken in the UK in 1999/2000 by the National Childbirth Trust (Singh and Newburn, 2000). The repeat survey involved 1260 first-time mothers and found that they were often '*left to their own devices'* in relation to their postnatal care. This evidence highlights that there has been little improvement in postnatal care in the UK since the last survey in 1999/2000. Positive postnatal care experiences were highlighted however from those women who delivered at home or in a birth centre.

The model of postnatal care provision has changed considerably in most countries over the past 15-20 years. In Ireland, women were encouraged to stay in hospital following birth for up to ten days (Kennedy, 2002), compared to the current model where one to two nights is the average length of stay following a normal delivery. An increased pressure on postnatal beds has been one reason cited for reducing the postpartum hospital stay in Australia (McLachlan *et al.,* 2009). However, McLachlan and colleagues found that postnatal women prefer staying in hospital longer. This study suggested that postnatal women had a lack of confidence in their ability to care for their new born baby and by residing in hospital they had a perceived sense of security from the hospital staff (McLachlan *et al.,* 2009). These findings concur with Hodinott and Pill's (1999) earlier research that the postnatal discontent experienced by new mothers' was related to them feeling unprepared for motherhood and a lack of confidence in how to care for their baby. The research also indicated that because of the lack of confidence, new mothers often changed their infant feeding method from breast to formula feeding in an effort to help them cope and regain control over their lives (Hodinott and Pill, 1999).

2.4.1 <u>**Support from postnatal staff**</u>

Receiving sufficient support from postnatal staff is a main concern for new mothers. Yelland *et al.,* (2010) evaluation of postnatal care reform highlighted how consistency and continuity of care can have an improvement on women's postnatal care ratings. Persson *et al.,* (2011) also indicate that a mother's postnatal sense of security depends on her receiving adequate support from staff, as well as her family in the first postnatal week. They conclude however by stressing that the attitudes of postnatal staff should be continually discussed in maternity care units along with post basic staff education on communication and counselling. Persson *et al.,* (2011) findings of postnatal carers' disrespectful attitudes is also supported by Hildingsson (2007) who identified unfriendly and unhelpful postnatal staff. Further research by Ellberg *et al.,* (2008) reported a lack of support from staff, while Puthussery *et al.*'s, (2010) research with UK-born postnatal mothers from an ethnic minority identified the necessity for health care professionals to be 'sensitive' and 'delicate' in their interactions. Hildingsson and Sandin-Bojö *et al.,* (in press) have also found a strong link between mothers' satisfaction and receiving sufficient support from staff. In particular, satisfaction was related to their infant receiving the best possible check-up/medical care and when they received adequate support from staff in relation to their medical and emotional care needs.

Research on postnatal caregivers in Australia suggests that they have limited time available to spend with women and that they are often short staffed (Forster, *et al.,* 2006). Earlier research by Forster *et al.,* (2005) also indicates that midwives find the lack of continuity and the short length of postnatal stay in hospital challenging in their provision of care. Moreover, McKeller *et al., (*2009) highlighted an underlining culture in midwifery practice which hinders the implementation of change on the postnatal ward.

A further demand on new mothers and their partners is the increased responsibility upon them to care for their newborn infant (Hildingsson, 2007, Rudman and Waldenström, 2007). Because of short postnatal stay and the lack of postnatal care in the community, mothers are relied upon to screen their children for signs of ill health in the early postnatal period. An example is hyperbilirubinemia, a condition that can

lead to irreversible neurological damage. Research by Goulet *et al*., (2007) compared different models of postpartum care in relation to rates of newborn readmission for jaundice and also maternal satisfaction of postnatal services. In total 1,096 mothers in four health regions in Quebec, Canada participated in an epidemiological survey via telephone interview one month following delivery. The findings highlighted a considerable reduction in hospital readmissions for babies when there was an integrated community-based postnatal and hospital-linked home phototherapy service. This model of postnatal care appeared to address the needs of both mothers' and newborns' and may have attributed to the high levels of the maternal satisfaction found in the survey.

Over ten years ago MacArthur (1999) highlighted the importance of prioritising postnatal care to ensure that it reaches its full potential in order to have the greatest impact on the health of women and babies. Effective postnatal care is considered fundamental. It is possibly the most critical element in improving the immediate and longer-term maternal and infant health, when compared to any other intervention during pregnancy (Bick 2005). The World Health Organisation (WHO) (2010) also recognise the potential of delivering, via skilled providers, a *'woman-centred concept of care that promotes health as well as maintains vigilance'* (p. 1) in the postnatal period. Aspiring to do so, the WHO has recently commenced an in-depth process as outlined in their technical consultation on postpartum and postnatal care (WHO, 2010).

2.5   Research into postnatal care

Historically, there has been a paucity of research into postnatal care, although in last five years there has been an increased focus particularly in Australia, Sweden and the UK. Within Ireland, the dearth of research into postnatal care is evident. Work that has been undertaken includes studies by Cronin and McCarthy (2003), Leahy Warren (2005) and a survey by the Association for the Improvements of Maternity Services (AIMS) in 2009. Cronin and McCarthy's (2003) research employed a descriptive qualitative approach using focus groups and in depth interviews. The study aimed to identify the needs, perceptions and experiences of 13 young first-time mothers aged from 18 to 25, from an urban city district in the South of Ireland. The specific period of time when the data were collected was not identified, however the findings are reported to reflect events from birth to the first 9 months postnatally. Included in the

findings was how the young mothers felt unprepared for birth and motherhood. The women's mother was identified as the most important factor in helping them adapt to their new role and responsibilities. In addition, public health nurse support was reported, but this tended to focus on the development of the baby. The need for structured group support was also identified.

A further study by Leahy Warren (2005) examined social support provided for first-time mothers in Ireland. Using a descriptive, correlational survey, 99 first time mothers from a convenience sample of 135 completed a questionnaire at six week after birth. The findings revealed that the husband or partner was the primary source of social support closely followed by the maternal mother. Four functional components of social support were identified from the findings: informational, instrumental, emotional and appraisal. With regard to support received from health professionals, 77% of new mothers reported that the public health nurse (PHN) provided informational support compared to 52% of midwives. These results are indicative perhaps of the short hospital stay for women and the minimal contact with midwives following discharge (as discussed later in chapter three). Interestingly, 26% of respondents noted that midwives provided more instrumental support than the PHN (9%) (Leahy Warren, 2005). Overall this research highlights how appraisal and informational support can positively influence first-time mothers' confidence in infant care.

In 2010, AIMS undertook an electronic survey to examine mothers' experience of care as users of the maternity services in Ireland (AIMS Ireland, 2010). Many of the women reported that post-natal care was inconsistent and inadequate. The nature of the study however prevented women's experiences of postnatal care being examined in detail. These Irish based studies appear to tentatively explore the issues surrounding postnatal care for new mothers. It is also important to highlight that the majority of this research has predominately been undertaken from a quantitative perspective. A critique of this research approach has been detailed below.

2.6   <u>Critique of quantitative measures of satisfaction</u>

A number of studies outside of Ireland have assessed women's satisfaction with postnatal care based on quantitative surveys, notably, those undertaken by Glazener *et*

al., (1993), Garcia *et al.,* (1998), Hundley *et al.,* (2000), Yelland *et al.,* (2009) and recently Hildingsson and Sandin-Bojö (in press). Quantitative measures of satisfaction have been widely critiqued as this method does not always elicit meanings and the value of experiences. Oakley (1992) comments that when people are asked in a survey about their care they tend to report that they are satisfied. Porter and MacIntyre (1984) in their study entitled "What is, must be best", reported women's views on a range of maternity care, and concluded that women tend to report that they are satisfied with the care they received, almost irrespective of what that care is. van Teijlingen *et al.,* (2003) suggest that one of the reasons why respondents tend to answer positively to written questions about satisfaction is a reluctance to criticise their caregivers. They concluded by offering a strong caution in the usage of satisfaction surveys, as the outcomes can often be inaccurate. Furthermore, Rudman and Waldenström (2007) research surveyed 2,783 Swedish women's critical views of hospital postpartum care. The specific aim of the study was to describe the women's postnatal negative care experiences. A diverse range of negative aspects were identified from the lack of opportunity to rest and recover to difficulty in getting individualised information and breastfeeding support. However, as this approach only concentrates on negative aspects, it fails to uncover positive or future possible approaches to postnatal care.

2.7   My personal pre-conceptions

Finally, my personal pre-conceptions which have contributed to my interest in postnatal care are now considered. In the past, I have worked as a clinical midwife on the postnatal wards of a large maternity hospital in Ireland and recently as a midwife on a postnatal ward in a city hospital in Northern Ireland. In both countries I have experienced the constant busyness and sense of having to rush to ensure that women receive postnatal care. With the actual provision of postnatal care to new mothers and their babies often impacted by hospital routines.

When I work as a midwife on the postnatal ward in Northern Ireland I feel a sense of collegial support and backup from the community midwives, particularly in discharging a woman and her baby home. The community midwife will visit the new mother before 5pm the next day to provide postnatal care and subsequent days as required. Unfortunately, this is not the case in Ireland where there is no community

midwives employed. I have always encouraged the new mother however to contact the postnatal ward if she had immediate difficulties or to contact her PHN.

Working as a lecturer in midwifery at University College Dublin for the past eleven years has given me the opportunity to teach undergraduate and postgraduate midwifery students. This has presented many opportunities and some challenges. I have found teaching postnatal care challenging with the lack of research in this field. Most of the current evidence is based on guidelines that I find to be often prescriptive and at times idealistic.

My personal experience of postnatal care commenced with the birth of my first daughter, Isobel, seven years ago, in Ireland. I had a short overnight stay in the hospital following a normal delivery and on discharged home my husband and I found we had no physical support or care from our extended families, as they both lived a long distance away. My daughter had severe colic and cried for long periods of time each day for the first sixteen to eighteen weeks. I also found that I had no physical or emotional support from the PHN who visited me at home once to check my daughter. I remember ringing several health professional colleagues to see if they could assist with some resolution to the constant crying. I also tried numerous alternative and conventional therapies for example, herbal medicine, osteopathic massage and reflexology. I tried numerous medications including, infant gaviscon, colief and infacol. I was unable to breastfeed due to previous breast surgery and I purchased two different styles of infant feeding bottles to try to reduce the amount of air Isobel was swallowing while drinking her milk. The severe colic and crying nevertheless continued and when Isobel was about 12 weeks old, I commenced her on a Soya based infant formula. It was ten months after Isobel's birth, in 2004 that I commenced this research.

My second daughter, Kate, was also born in Ireland in 2007, but prematurely, at 26 weeks - gestation. She was in the Neonatal Intensive Care Unit for over eleven weeks. Although this was traumatic, my husband and I were delighted to take home a healthy child. On this occasion I had experienced postnatal care for the first two days following delivery in the hospital but I had no contact from any health professional following my discharge except for one visit eleven weeks later from the PHN when Kate came home. My last child, Orla, was born in Northern Ireland. I received

postnatal care from midwives within the hospital and on discharge home the community midwife visited every alternative day for a week.

I believe that postnatal care has an enormous potential to improve the health and wellbeing of new mothers, their infant's and families. For postnatal care to reach its potential and be effective, it needs to be prioritised by fund holders and health managers of maternity care. Further research also needs to be funded and undertaken to ensure that postnatal care is continually founded on evidenced based research. I believe that postnatal care matters to women and is remembered by them.

This summary of my personal experiences and believes outlines my pre-conceptions at the beginning of this hermeneutic journey.

2.8   **Summary**

For a new mother, having just experienced nine months of pregnancy and gone through the unforgettable experience of giving birth, there are often a number of issues, from the onset of the postnatal period, that place her and her family in a vulnerable position. These include the risk of postnatal maternal morbidity, maternal and infant mortality and the mounting evidence of lack of postnatal support from carers and overall dissatisfaction with postnatal care. The evidence therefore suggests a need to provide care which is focused on the needs of the woman and her baby, which is both effective and individualised. This care is necessary not only to help women recover from the physical and psychological processes of giving birth, but also to help them adjust to caring for the needs of their newborn baby and evolving family.

The following chapter will begin by examining in detail the key historical influences on the provision of maternity care in Ireland. The current provision of postnatal care in Ireland will then be outlined.

3.0 Chapter Three: Historical and current overview of postnatal care in Ireland

3.1 Introduction

This chapter initially focuses upon the key historical developments in Ireland which have influenced the provision of maternity care. This historical overview provides a context to the discussion presented on the current provision of postnatal care in Ireland.

3.2 Maternity care provision in Ireland - A historical overview

3.2.1 The early 1900s

The first step towards care for new mothers and their children in Ireland originated from the introduction of the Notification of Births Act, in 1907 (Barrington, 1987). It provided for the appointment of sanitary officers to ensure that the medical officer of the district was notified of each birth and made provision for the organisation of health visiting for mothers in the postpartum period. However, by 1915 appointments of sanitary officers had only been made in Dublin. Strengthening of the birth notification legislation was introduced in 1915 (before Ireland's independence) and was the beginning of a series of legislative measures designed for Britain that subsequently extended into Ireland (Barrington, 1987). This legislation empowered local authorities to appoint health visitors to care for expectant and nursing mothers at home, to provide a wide range of services including midwifery, medical and hospital treatment at confinement and food for women and children if deemed necessary. However, this Act did not make the provision of these services compulsory as demonstrated in 1917, when only £2,300 was reimbursed to 35 urban and 14 rural sanitary authorities for the maternity and infant care services they had provided around Ireland (Barrington, 1987).

The health of mothers and children received very little attention in Ireland before the first-world war. In 1915, 95,583 babies were born, with 8,753 dying before they reached

their first birthday (92/1000 live births). In addition, the same year saw 570 maternal deaths (6/1000 live births) (Barrington, 1987). Wartime concern stimulated trends in health provision for mothers and children, in particular the radical recommendations from the Carnegie Report on the Physical Welfare of Mothers and Children in 1917. The author, Dr. E. Coey Bigger recommended that permissive legislation become mandatory, that housing and sanitary conditions were improved and that maternity care provision was improved for mothers and children. This maternity care was to include more hospital beds for difficult obstetric cases, health visitors in all towns with greater than 5,000 population and maternity benefit conditional on the expectant mother attending a maternity centre. He emphasised the unacceptability of the complacent attitude in general to the high infant mortality rate[4]; stating that a baby had less chance of surviving in Ireland than his father had experienced as a soldier at the front-line in France (Carnegie United Kingdom Trust, 1917).

In Ireland, from 1913 - 1919 the legitimacy of British rule came under increased attack from militant nationalists. Following the execution of the leaders of the 1916 Easter Rising, public opinion went against the Westminster government, and Sinn Fein won a landslide victory in the 1918 election. Sinn Fein went on to form the first Dáil (Parliament) in January 1919 (Barrington, 1987). From 1919 there was continued guerrilla war against British rule, and on 11th July 1921 a truce was agreed and the Anglo-Irish treaty was signed at the end of that year. The treaty established the Irish Free State in 26 of the 32 counties of Ireland, the fall out of which lead to a civil war. The 6 counties of Northern Ireland have since been governed by the United Kingdom (UK) and thereby have a different health service provision to that of the rest of Ireland, including postnatal care[5]. The Anglo-Irish treaty also established a constitutional framework which led to the 1922 Constitution (Ruane, 1998) which was later repealed by the 1937 Constitution under the leadership of Eamon De Valera. This new Constitution was a clear break from the previous 1922 Constitution in relation to its permanency, as it is only through a referendum that changes can be brought about (Ruane, 1998). The formation of a new state therefore brought a series of legislative and constitutional change which have since influenced pregnancy and maternity

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[4] Infant mortality rate is the number of deaths among infants aged less than 1 year per 1,000 live births and is considered an important descriptor of the health status of a country's citizens (MacDorman and Mathews, 2009).

[5] Postnatal care provision in the Northern Ireland includes a national community midwifery service whereby the midwife visits the new mother and baby in her home for up to 28 days postnatal.

policies in Ireland (Kennedy, 2002). The continuing work of the courts in considering the constitutionality of legislation is in itself a vehicle of social change and one that continues to be used by lobby groups and individuals (Ruane, 1998).

3.2.2 _Maternity care provision in Ireland - 1920s to 1930s_

The 1920s and 1930s brought to Ireland a time of great hardship from civil war, poverty, unemployment, emigration, illness and death from tuberculosis. Irish women as mothers had to cope with making ends meet and struggling against the plight of poverty (Kennedy, 2002). Other legislation introduced in the late 1920s did not help their situation. This was particularly the case in terms of the '*marriage bar*' and the '*baby bar*', where women had to stay at home and not take up employment if they were married or had a baby. Furthermore, the 1929 Censorship of Publications Act prevented women from receiving information on contraception in Ireland. This restriction was dramatically changed in 1973, when a challenge through the Supreme Court in *McGee v Attorney General* held that the banning of the sale and importation of contraceptives infringed on the right of martial privacy (Ruane, 1998).

The provision of maternity care within hospitals, and indeed patient care in general hospitals, was in a serious crisis in the late 1920's due to the lack of funding. Following an intense fund raising campaign raising money through sweepstakes on horse racing, a major hospital building program was commenced. This was completed by 1942. This program provided thirteen new county hospitals, seventeen district hospitals and eight fever hospitals around Ireland (Barrington, 1987). Barrington points out that there was an increased confidence of the Irish people in hospitals which was evident by the major swing towards hospital confinements for maternity care.

Despite this major hospital building programme, infant mortality rates remained high. In 1939, the infant mortality rate was 66 per thousand births, which was higher than England and Wales. Maternal mortality rates began to improve slightly from 4.44 deaths per thousand births in 1933 to 3.39 deaths in 1939 (Barrington, 1987). This may have been due to the registration of midwives and the protection of women from untrained handywomen following the introduction of the Midwives Acts in 1931 (later superseded in 1944). The Registration of Maternity Homes Act may also have had an impact when it was introduced in 1934. This enabled the control of maternity homes in

an attempt to provide skilled treatment for all women and babies, and local authority provision of accommodation for maternity cases in all the new hospitals (Barrington, 1987).

3.2.3   *Maternity care provision in Ireland - 1940s to 1950s*

Wiley (1998) highlights that the 1940's was a time of great debate in relation to the future shape of the Irish health service system. Many countries had extended the insurance basis for their health systems through the National Health Insurance bill. England was also on the verge of introducing the National Health Service following the Beveridge Report in 1942 (Abel-Smith, 1992). In 1945, aspiring to a similar health service in Ireland, a committee of civil servants proposed that a free national health service should be introduced for the whole population of Ireland on a phased basis (Wren, 2003). Two years later, James Ryan was appointed the first Minster of Health and he pushed through the Health Act of 1947. This Act increased the state's involvement in the health service and provided services to certain members of society on a nominal or no-charge basis, with the rest of the population deemed to be able to pay for their own health care (Wiley, 1998). The Act made provision for free treatment for mothers in the ante-natal and postnatal period and for children during their school years (Wren, 2003).

The first inter-party government took office in 1948 led by John A. Costello of Fine Gael and Dr. Noel Browne was appointed Minister for Health (Barrington, 1987). The Hospital Sweepstakes began again after the 2nd World War interruption. Dr Browne became actively involved in developing a programme to treat tuberculosis, and he became renowned for his proposed reorganisation of services for mothers and children in 1950. Nevertheless, the maternity and infant care scheme met with a lot of opposition from the medical profession, Cabinet members, and the Catholic hierarchy (Wiley, 1998). Following a flurry of correspondence between Dr. Browne, the Catholic hierarchy and the Taoiseach[6], Dr. Browne decided to release the correspondence to the press in an effort to win over the people of Ireland. Subsequently, he resigned, and the press publication led to the fall of the inter-party government in 1951 as it had

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[6] The Taoiseach is the prime minister of Ireland.

highlighted that the democratically elected government was not making the policy decisions they were elected to enforce (Barrington, 1987).

3.2.4   *Key historical events in the late twentieth century*

The 1950s and 1960s saw an increasing demand on the health service and the need for the state to become responsible for financing it. This originated from a proposed white paper which also highlighted the need to regionalise hospital services (Wiley, 1998). In 1968, a controversial report commonly known as the 'Fitzgerald report' was published and outlined the recommendations for regionalisation (Consultative Council on the General Hospital Services, 1968). The subsequent downgrading of local hospitals to community centres created a lot of anguish among local communities, members of which had to travel long distances to hospital (Barrington, 1987). The Health Act of 1970 brought into effect a new framework of health boards instead of regional hospital boards linked with the voluntary hospitals (Wiley, 1998). Despite minor restructuring, this framework of administration operated largely until 2003, when following the Prospectus report[7], a new national healthcare structure was established known as the Health Services Executive (HSE) (Department of Health and Children, 2003).

The 1970 Health Act had a significant impact on the acceleration of hospital births and the subsequent decline of domiciliary births (Kennedy, 2002). The decline was also attributed to the fact that, as women had to pay for the choice of hospital or maternity home, its status became elevated. There was also the view that women saw a hospital delivery as a form of respite away from their heavy childcare and domestic demands particularly, when women were encouraged to stay for up to ten days postnatally (Kennedy, 2002). This was the origin of maternity hospitals becoming known as '*Lying-In'* hospitals. A number of the maternity hospitals in Ireland have now changed their names, reflecting the change in the length of postnatal stay. An example is the *Coombe Lying-in Hospital,* now renamed as the *Coombe Women & Infants University Hospital*.

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[7] The official title of the Prospectus report is '*The Audit of Structures and Functions in the Health System*' undertaken by Prospectus and Watson Wyatt on behalf of the Department of Health and Children in 2003.

A further influence on the increased number of women giving birth in hospitals was the downgrading of services as mentioned above, following the Fitzgerald Report (1968), and the recommendations from a discussion document '*Development of Hospital Maternity Services*' (Comhairle na nOspideal, 1976). This document recommended that every expectant mother should have ready access to care at a consultant-staffed obstetric and neonatal unit. Small maternity units around Ireland therefore closed, citing safety as the reason to do so. The policy was further endorsed in the discussion document on women's health some twenty years later (Department of Health, 1995), which commented that there are good reasons '*…why the health services should discourage home births*' (p.35). Referring to the reduction in the maternal and perinatal mortality rates the authors attribute this to the good antenatal and perinatal care provided in the hospitals. The argument that obstetric science is responsible for the decline of mortality rates is strongly contested (Tew 1990, Murphy-Lawless 1998). Murphy-Lawless (1998) argues that, from 1978-1987, Irish women experienced massive social change because of an improved nutritional diet, decreased levels of anaemia amongst pregnant women, individual women having fewer pregnancies, along with the use of oxytocic medication and blood transfusions when postpartum haemorrhage may have occurred. Yet, these major factors of social change are rarely mentioned (Murphy-Lawless, 1998). The argument that hospital births are '*safer*' than home births has been weakened recently, based on considerable evidence (Chamberlain *et al.,* 1997, Olsen and Jewell, 2004, Johnson and Daviss, 2005, Devane *et al.,* 2010). The latest statistics from 2007 highlight that 399 infants were born at home in Ireland out of a total of 71,389 live births (Central Statistics office, 2010a) These figures have doubled since 1991, when there were 184 home births (Department of Health, 1994).

3.2.5   *The Maternity and Infant Care Scheme*

The foundation of the present maternity system in Ireland is historically linked to the work of Dr. Browne. Following his resignation, a compromise was reached between the new Fianna Fail government and the Catholic hierarchy (Barrington, 1987). The 1953 Health Act legislated for the amended scheme, giving it a new title to reflect its provision; '*The Maternity and Infant Care Scheme*'. The scheme came into effect in 1954 and provided free ante-natal and postnatal care for poor women with choice of doctor and domiciliary midwife. On payment of an additional fee, the choice of hospital or maternity home was assured. Free unlimited medical care was introduced for infants

until they were six weeks old, and developmental checks for children up to six years were provided for in the health clinics. As means testing was introduced, only lower and middle income individuals could avail of this scheme. This was a measure which Dr. Browne had initially refuted. In 1991, nearly forty years after the implementation of Maternity and Infant Care Scheme, the Health (Amendment) Act was implemented, which, allowed all expectant mothers and their infants to access the services free of charge without declaring their income.

'*The Maternity and Infant Care Scheme*' was reviewed in 1980 and subsequently in 1994 (Department of Health and Children, 1994). However, it wasn't until 1997, following public pressure from a group of practising midwives, childbirth groups and academics seeking changes to the provision of maternity care, that the 1994 review report was published (Devane *et al.*, 2007). The services available for new mothers and their babies under the current scheme are prescriptively outlined on behalf of the general practitioner (G.P.). These are limited, free, pregnancy-related, general practitioner care for the baby two weeks following birth and at six weeks of age, and for the mother a postnatal examination at six weeks only (Department of Health and Children, 1994). The scheme also details specifically in the case where a '*women who cannot be persuaded to deliver in or at a maternity hospital/unit*' (p. 64), managers of the health board must arrange that a midwife attend the home birth and provide appropriate postnatal care (Department of Health and Children, 1994).

3.3   Current provision of postnatal care in Ireland

3.3.1   *The midwife and the provision of postnatal care*

Postnatal care for the majority of women in Ireland is provided for by the midwife on the postnatal ward. In the Irish maternity hospitals midwives often work in a specific ward (such as antenatal, postnatal or delivery) for a certain period of time and then may move to work in a different maternity care area. Care in the postnatal ward is provided on a 24hour basis. It is formally a medical consultant-led system, though many women are not seen by an obstetric doctor.

3.3.2   *The public health nurse and postnatal care*

Following discharge from the postnatal ward, care is transferred to the public health nurse (PHN) as there is no national community midwifery service in Ireland. The PHNs do not provide this type of postnatal service, (Hanafin, 1998) provision for their role was first introduced by ministerial policy in 1966 (Circular 27/66, Department of Health). The policy requires the PHN to make contact with a new mother and baby within 48 hours of receiving official notification (although no week-end or public holiday service exists). A further four scheduled visits are undertaken over the first year of the infant's life for developmental screening (Hanafin, 1998). This schedule of visits by the PHN has not been revised to date. Moreover, the public health nursing service is an amalgamation of three separate services: midwifery, public health and home nursing (Hanafin, 1998). The PHN has therefore a wide and extended care role in the community providing care to individuals and families across the lifespan (An Bord Altranais, 2005). Overwhelming demands are therefore placed on the public health nursing service (Hanafin *et al., 2002*). Their wide range of service provision is also further stretched as the number of registered births remains high and is expected to continue until 2016 (Health Service Executive, 2008). The recently reported annual birth rate for 2010 is 73,724 (Government of Ireland, 2011a) while the latest birth rate recorded for the first quarter of 2011 is 19,950 compared to 18,535 for 2010 (Government of Ireland, 2011b). In addition, the need for the PHN service is also influenced by the increasing age profile of the Irish population (Government of Ireland, 2011a). Despite the reliance on the public health nurse to provide postnatal care, from March 2005 entrants onto the Public Health Nurse Registration Programme in Ireland do not have to hold a midwifery registration. Instead a total number of 8 weeks (3 weeks theoretical and 5 weeks clinical instruction) on Maternal and Infant Health was introduced for PHN students who are not registered midwives (An Bord Altranais 2005). The decision to replace a comprehensive knowledge and experiential midwifery registration programme with a maternal and child health module indicates the lack of importance placed on the care of the new mother and baby in the community.

3.3.3 *The economic context of maternity and postnatal care in Ireland*

Maternity care in Ireland is provided within a mixed economy of public and private. A large number of women use the public maternity care system provided under the *Maternity and Infant Care Scheme.* Outside this scheme only those who are entitled to a medical card or a G.P. visit card can have free access to G.P. services. This accounts for 35% of the population (Department of Health and Children, 2010). Each woman is entitled to a one-off postnatal check, and two infant checks and routine infant vaccinations. Subsequent consultations for a new mother or baby cost from €45 to €70 per visit. A woman may also opt to pay for private care from a Self Employed Community Midwife[8] (SECM) who currently operates independently of the public health system. The SECM will care for the women and her baby at home throughout the pregnancy, childbirth and postpartum period.

A large number of women pay for private consultant obstetric care in Ireland. The majority of the medical and accommodation fees are covered from private health insurance while the remainder is paid by the woman. The approximate cost of private obstetric fees for antenatal, intrapartum[9] and one postnatal check-up is €4000 with private accommodation fees additional, although they are normally covered under private health care insurance. The semi private medical fees range from €1000 and include care from a consultant obstetrician or senior medical doctor during pregnancy and indirect care during labour. O'Connor highlighted in 2006 that private obstetrics in Ireland was worth at least 49 million annually between 104 obstetricians (O'Connor, 2006).

The review of the *Maternity and Infant Care Scheme* in 1994, continued to allow consultants and GPs to maintain their private-fee income. The co-existence of private

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[8]Currently there are approx 17 self employed community midwives practicing in Ireland. In September 2008 they experienced difficulty obtaining professional indemnity and a Memorandum of Understanding was then implemented between the Health Services Executive and the self employed community midwives which bind them to practice under specified terms in order to be covered by the Clinical Indemnity Scheme (CIS).

[9] For the majority, private obstetric consultant care during the first stage of labour is provided by the midwife under the indirect supervision of the consultant at the maternity hospital. During the second stage, the obstetric consultant is in attendance and provides care as necessary during the delivery.

maternity care remains a key feature in Ireland today (Kennedy, 2010) with consultants attending to their fee paying patients in public hospitals. This inequity of service provision continues to create a significant burden for the provision of public maternity care (Wren 2003). Only recently, in 2008 were practice reforms introduced in the form of a new contract for medical consultants employed in the public health system in Ireland. A key feature includes a restriction of their private practice in public hospitals to 20% of their overall clinical throughput (Department of Health and Children, 2010).

3.3.4 *Models of postnatal care in Ireland*

With the significantly reduced postnatal stay in hospital, a number of maternity hospitals have introduced early transfer home (ETH) schemes. However, accessibility of such schemes is based on the women's postal address and type of delivery. This model of care allows the woman to be discharged home twelve hours after delivery. A hospital-based midwife will then provide care up to the fifth postnatal day in her home, when the care is then transferred to the PHN.

From 1999 restricted community midwifery services have existed within small geographical pockets. These include: DOMINO[10] and home birth schemes attached to maternity hospitals and as mentioned (in section 3.3.4) there is also 17 Self Employed Community Midwives (SEM). The restricted access to community midwifery services means that for the greater majority of women located outside the catchment areas they are disadvantaged and the current services are inequitable. These services are also constrained by a restricted quota of women who can '*book-in'*, because of limited resources. In addition, two pilot midwifery–led units were established in the North East Health Region of Ireland following protest from women who saw their local maternity hospitals close. They were particularly concerned that, having to travel long distances, babies were born before their arrival to hospital. A case highlighted was the premature birth of Bronagh Livingstone in an ambulance during transfer in December 2002. Bronagh's mother had initially sought care from the recently closed Monaghan General Hospital and was then transferred to Cavan General Hospital, some 50km away. Bronagh later died shortly after arriving to Cavan General Hospital (Department of Health and Children, 2002). Unfortunately the journey towards

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[10] The term DOMINO derives from domiciliary midwife in and out and involves a women being cared for in a consultant unit by a midwife who also works in the community.

changing dominant policies and practices to favour midwifery-led maternity care in Ireland continuous to be arduous (Devane *et al.* 2007), leaving the vast majority of births, and postnatal care in Ireland provided within a centralised obstetric consultant-led system.

3.4   <u>Infant and neonatal mortality rate in Ireland</u>

The infant mortality rate in Ireland continues to decrease from 5.88 per 1,000 in 1999 (European HFA Database, 2010) to 3.2 per 1000 in 2009 (Central Statistics Office, 2010b). This rate is comparable to other European countries. A key finding, however, of the recently published 'S*tate of the nation's children, Ireland 2010*' is that the majority of deaths under the age of 18 in 2009 occurred within the first year of life (Office for the Minister of Children and Youth Affairs, 2010). The infant deaths accounted for 240 of the total 419 (Central Statistics Office, 2010). 104 of these infant deaths were classified as '*congenital malformations*' and 96 were classified as '*certain conditions in the perinatal period*'[11]. Recent figures for Ireland's neonatal mortality rate[12] highlights, that there were 169 neonatal deaths in 2009, a rate of 2.3 per 1000 (Central Statistics Office, 2010). This was in comparison to a rate of 4.0 per 1000 in 1999 (European HFA Database, 2010). Although the infant and neonatal mortality rates continue to decrease, infant and neonatal deaths still occur, particularly within the first year of life. Statistics often mask the reality of a particular event, and these statistics do not reflect the tremendous individual maternal and family suffering associated with the death of a child. Postnatal care is not only necessary to strive for the elimination of such deaths but is required for the provision of essential postnatal care. This includes promoting the emotional wellbeing of the mother and enabling her adaptation to motherhood.

3.5   <u>Summary of the current postnatal care provision in Ireland</u>

The current provision of services for postnatal mothers and their babies in Ireland is modelled on *The Maternity and Infant Care Scheme* originally implemented in 1954. Improvements have occurred, in terms of small pockets of DOMINO and midwifery-led services, but inequity still exists for the greater majority of women, and therefore

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[11] No detail regarding this classification was provided other than the report specifically stated that no stillbirths were included in this category.
[12] Neonatal mortality is defined as the death of an infant under 28 days old.

further development of maternity services nationally is required (Kennedy 2010). At present, the majority of new mothers and their babies continue to be discharged home earlier despite the absence of a national community midwifery service. Instead, there is a public health nursing service which is under increasing pressure and appears to fall short as it is only available Monday to Friday, 9am-5pm and not on public holidays. Postnatal care in the community is therefore extremely limited and is an unstructured, surveillance based postnatal service. The necessity remains to provide quality, individualised postnatal care, as strongly recommended by the National Institute for Health and Clinical Excellence (NICE 2006). Earlier discharge from hospital is also partly due to the continued increases in the demands on maternity service providers, as reflected in the 2010 birth rates and the end of the first quarter birth statistics for 2011 (CSO, 2011a,b).

An independent review of the maternity and gynaecology services in the Greater Dublin Area (GDA) recognised the considerable pressure placed on the large city maternity hospitals and stated that the hospital facilities are no longer sufficient to support the continued population growth (KPMG, 2008). Furthermore, the current rise in the GDA caesarean section rates (averaging at 23%) also adds increasing demand to service provision with the need for individualised post operative care following major abdominal surgery and the inherent risk of post delivery complications for both the mother and the baby (KPMG, 2008). Moreover, a major influence on the decision to continue to provide a shorter postnatal hospital stay is the raising health care costs (Petrou *et al*., 2004), this is particularly pertinent in the current era of economic recession in Ireland (Durkan, *et al.,* 2011). It is also supported by the recent policy document '*Programme for Government 2011'* which outlines the newly elected[13] Irish government's proposal to prioritise the delivery of more care in the community.

Subsequently, on discharge from hospital the health and wellbeing of women may be compromised from a variety of maternal morbidities (Lutomski *et al.,* 2010) and unfortunately a trend of increasing maternal mortality (CMACE a,b, 2010). Despite Ireland having consistently, the highest birth rate (17.0 per 1,000) of the 27 European countries (ERSI, 2011b) a large number of women appear to be discharged home to

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[13] On 9th March 2011 a Fine Gael led government were elected into the Irish Parliament.

limited or no postnatal care. This is confirmed by the KPMG report (2008)[14] which states that the current system of postnatal care in Ireland *'is minimal'* (p121) and does not facilitate follow-up care as recommended by CMACE for vulnerable women and their babies who have complex pregnancies, problems with mental illness, violence or substance misuse. Primarily, it is essential that postnatal care is provided, and that it is effective for both the new mother and her baby. This is imperative as women are continually reporting how unsatisfied they are in relation to their postnatal care as highlighted in section 2.4. In addition, recent evidence from the UK suggests that just having postnatal care provision within the hospital and in the community is not enough for new mothers, especially when it is highly clinically focused (Bhavnani and Newburn, 2010).

It is therefore crucial that the process of postnatal care is examined to elicit the meaning and value women give to their care experiences. To focus solely on the outcomes of postnatal care (for example, the incidence of readmission to hospital) would neglect the importance surrounding the process of care (Richens and Currie, 2004). In particular, a good outcome of postnatal care such as the initiation and continuation of breastfeeding may not necessarily mean for the individual woman a positive postnatal care experience. Thus, the aim of this research is to examine Irish women's experiences' of postnatal care using qualitative research methodology. To begin, I undertook an in depth metasynthesis of the literature to identify and synthesise quality qualitative research that explores women's experiences of postnatal care. The following chapter presents the process and results of this in-depth metasynthesis.

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[14]Consultants KPMG were commission by the HSE (Department of Health and Children) in 2007 to undertake an independent review of the maternity and gynaecological care services in the Greater Dublin Area.

4.0 Chapter Four: Meta-synthesis of postnatal care

The previous chapter presented an overview of the development and current provision of postnatal care in Ireland. In striving towards an understanding of how women experience postnatal care, a first step is to undertake an in-depth examination of the qualitative literature with the aim of uncovering the views and experiences of postnatal women.

4.1 Introduction

The current chapter provides a meta-synthesis of postnatal care including a critical discussion and presentation of the whole process undertaken. This includes: an overview of the identification of the studies, inclusion and exclusion criteria, the analytic strategy and presentation of the findings. The concluding summary to this chapter provides a synthesis of key issues to be considered within the research. Initially, I undertook a comprehensive review of the literature which failed to uncover any published meta-syntheses of studies relating to women's aspirations for, or experiences of, postnatal care. A critique of the current literature relating to the methodological approaches to a qualitative meta-synthesis inquiry is first presented.

4.2 Methodological approaches to qualitative meta-synthesis inquiry

The term meta-synthesis has been used in a variety of ways to represent different approaches to the synthesis of qualitative studies. According to Ring *et al.,* (2011) some authors use the term to describe a specific interpretive approach to qualitative synthesis while others use it more broadly. Walsh and Downe (2005) refer to meta-synthesis as the integration of the findings from a group of similar qualitative studies that aims to understand and explain phenomena (Walsh and Downe, 2005). This form of inquiry aims to amalgamate evidenced-based qualitative studies, on a specific topic into a coherent and synthesised product (Thorne *et al.,* 2004). This approach to knowledge development is based on the findings of individual qualitative studies, which are themselves an interpretation of data (Sandelowski and Barroso, 2003a). Sandelowski *et al.,* (1997) claims that qualitative meta-synthesis is not a simple endeavour but involves '*carefully peeling away the surface layers of studies to find their*

hearts and souls in a way that does the least damage to them' (p. 370). In addition, Sandelowski highlights that this process should not distort the findings from the original research, to leave '*no usable synthesis*'. The qualitative meta-synthesis is nevertheless fundamentally different from the original studies (Thorne *et al.,* 2004) as the major theoretical elements within each study are synthesised together.

One of the driving forces behind this form of qualitative inquiry is that the findings from qualitative research are increasingly being used to better understand clinical issues (Ring *et al.,* 2011). Walsh and Downe (2005) support this stance, suggesting that qualitative meta-synthesis can provide an in-depth understanding of the contextual dimensions of health care.

Noblit and Hare (1988) published the classic methodological text on which the synthesis of qualitative studies is often grounded. These authors undertook syntheses of published ethnographies by utilising the methodology of Meta-ethnography. Meta-ethnography focuses on the nature of interpretation and has influenced the development of different methodological approaches to synthesis of qualitative research. Some of these approaches have been documented in Thorne *et al.,* (2004) where individual authors including Thorne, Sandelowski and Noblit reflect on their preferred approach, particularly as no specific method is seen has more superior than another (Ring *et al.,* 2011).   The following is a summary of these authors' unique perspectives.

Thorne details the challenging journey that her and her colleagues experienced in trying to work out a methodological direction when utilising meta-study to synthesise the body of qualitative literature on chronic illness experience. Meta-study is a form of meta-synthesis, involving meta-theory, meta-method and meta-data analysis. She along with some of her colleagues conclude that meta-study was more applicable to deconstructing the existing bodies of qualitative research than as a method for combining together what is known about the experience of chronic illness. Their insights are published in Thorne *et al.,* (2002).

Sandelowski examined the precise difference between a qualitative meta-synthesis and a meta-summary. She refers to the phrase '*qualitative research integration*' and explains how this expression captures the essence of qualitative meta-synthesis. Sandelowski

states that this phrase describes an endeavour that offers a novel interpretation of syntheses, which represent the findings of the individual qualitative research reports. The novel interpretation is not found in any one-research report, while its validity rests in the inclusive nature of bringing together all the qualitative research studies on the specific experience or event. Sandelowski states that a meta-summary is a quantitative exercise that merely calculates the frequency of each thematic finding as they appear in the selected qualitative research reports. A meta-summary doesn't interpret beyond the findings given in the research reports i.e. the final product represents a sum of the parts. Sandelowski concludes that meta-summaries can be utilised as an empirical foundation on which a qualitative meta-synthesis can be build. Nevertheless a meta-summary is not the equivalent of a qualitative meta-synthesis (Thorne *et al.,* 2004).

Noblit provides an insight into the meta-ethnographic tradition. He begins by highlighting how the origins of his earlier writings were an effort to understand interpretation, and how he and his colleague Dwight Hare, as a method to work out their ideas accidentally stumbled upon 'synthesis'. This became the focus of their seminal publication entitled *'Meta-Ethnography: Synthesizing Qualitative Studies'* (Noblit and Hare, 1988). Noblit elaborates on three "moves" which he and Hare proposed in an effort to prevent an aggregative approach to the synthesis of ethnographic studies: a) moving synthesis from the level of data to the level of interpretation; b) proposing a particular theory of explanation; c) the proposal that there are multiple possible forms for meta-ethnographic synthesis including reciprocal, refutation and line of argument (Thorne *et al.,* 2004).

Thorne *et al., (*2004) clearly highlights the diverse methodological strategies utilised within qualitative meta-synthesis. The authors' collective commentary emphases the value of distinguishing the fundamental difference between qualitative meta-synthesis and meta-analysis in quantitative research, as there is often an assumption that these two methodologies are similar. Articulating this difference, Thorne *et al., (*2004) state that within the tradition of quantitative meta-analysis, scholars tend to follow the premise that their research will ultimately find a right answer or a singular truth. Quantitative researchers tend to uphold this view even if further research is needed to eventually support their claims for completeness of findings. Polit and Beck, (2004) refer to this dichotomy by highlighting that in a meta-analysis:

> *'subjective judgement and interpretation play a much less crucial role than in the case of a narrative analysis* [whereby], *readers of a meta-analysis can be confident that another analyst using the same data set would have come to exactly the same conclusions'* (p697).

In contrast, a qualitative meta-synthesis is the product of research on human experiential phenomena which is *'integrative, coherent and illuminating but rarely 'factual'* (Thorne *et al.*, 2004, p.1361). In other words, the results of a qualitative meta-synthesis can increase the richness of information and provide a deepened understanding of the topic (Seaton, 2005) without suggesting that the results are ever complete. Therefore interpretative researchers follow the premise that 'no vision of a phenomenon is ever complete' (Sandelowski, 1995, p573) because of the possibility of more than one justified interpretation (Diekelmann and Ironside, 1998).

4.3   Methodological approach

Against this background the methodological approach followed was based on the metaethnographic techniques of Noblit and Hare (1998) as adapted by Walsh and Downe (2005) these include: framing a meta-synthesis exercise, locating relevant papers, deciding what to include, appraisal of studies using quality criteria based on Walsh and Downe's (2006), analytic technique and synthesis of translation. In following these stages the rest of this chapter presents the process and results of a meta-synthesis of published qualitative research relating to women's aspirations for, or experiences of postnatal care.

4.4   Framing the meta-synthesis exercise

The purpose of this exercise is to identify and synthesise all accessible qualitative research published in English relating to women's aspirations for, and/or experiences of, postnatal care between 1990 and July 2006. The search was subsequently updated from August 2006 to April 2010. The decision to include this time period was based on the assertion that the majority of the current postnatal care recipients may not have been utilising the maternity care services prior to this period. Hence research undertaken prior to 1990 may not reflect the postnatal care aspirations and experiences

of women today.   The research question was: *'What are women's accounts of their aspirations for, and their experience of, postnatal care?'*

4.5   Locating relevant papers

The procedure involved a robust search strategy initially locating relevant qualitative research from 1990 to July 2006, which was then updated from August 2006 to April 2010. This involved searching databases including: Books@OVID/Maternity & Infant Care, CINAHL, EMBASE, Intermid.co.uk, MEDLINE, MIDIRS and PsychInfo databases (See table 1, p53). The following search terms and Boolean operators were used to search most of the databases:

> *'postpartum care OR postnatal care OR post birth OR mother AND experiences OR aspirations AND qualitative'.*

These terms were searched in titles, keywords or abstracts.

4.6   Deciding what to include

The decision to include studies from different interpretive methodologies was influenced by Sandelowski *et al.*, (1997) who proposed the inclusion of mixed qualitative methodologies within a meta-synthesis as long as methodological transparency is demonstrated. This involves the identification of elements within each study that confirm the particular methodological approach undertaken i.e. that congruent techniques were used for sampling and data collection. Seaton (2005) also supports the view of utilising multiple interpretative methodologies when undertaking a meta-synthesis. While acknowledging the challenge, Seaton also emphasises the necessity to maintain the theoretical consistency of the individual epistemologies and methodologies, to present a comprehensive interpretation of the multiple findings (Seaton 2005). The benefits of including different interpretive methodologies in a meta-synthesis stresses the uniqueness of a meta-synthesis enquiry adding that *'a qualitative meta-synthesis is less about the reduction of data than the amplification of data and interpretive innovation'* (Sandelowski and Barroso, 2003b). The inclusion and exclusion criteria for the meta-synthesis are presented in table 1 below.

Inclusion Criteria
• All qualitative studies (from January 1990 to July 2006 and August 2006 to April 2010) where the participants are women and who have experienced postnatal care • All qualitative studies which examine women's aspirations for postnatal care • All qualitative studies examining the above which are written in English and include an abstract These studies may include: • Any research paradigm using qualitative techniques for sampling, data collection, data analysis and interpretation • Participants from any race, ethnicity, nationality or class • Mixed method studies that include qualitative findings which can be separated from the quantitative findings. In addition these findings are required to be rich in qualitative narrative data specific to women's experience of, and/or aspirations for, postnatal care • Mixed method studies examining women's experience of maternity care across the childbirth continuum that include qualitative narrative data specific to women's experience of, and/or aspirations for, postnatal care

Exclusion Criteria
• Qualitative studies that focused on women being in the postnatal period rather than exploring women's experience of, and/or aspirations for, postnatal care (as in studies exploring motherhood) • Qualitative studies in which no women were direct participants (as in discourse or content analyses of media coverage on women's experience of postnatal care) • Qualitative studies in which no women participated (as in studies of maternity carers experience of postnatal care) • Qualitative studies that don't include original data • Mixed method studies where the design was too structured i.e. where data were 'forced' and little or no women's narratives included • Research identified in the search that wasn't written in English or included an abstract

Table 1: Inclusion and Exclusion Criteria for meta-synthesis

The following section provides a comprehensive description of all the search strategies utilised:

4.6.1 *Books@OVID/ Maternity & Infant Care OVID*

The Books@OVID and Maternity & Infant Care database was searched via the interface Wolters Kluwer Health/OVID and inputting the search terms highlighted above. Nine hits were initially generated in July 2006 with four articles identified for possible inclusion in the meta-synthesis. The up-dated search from 2006 to 2010 provided four

further hits with no further articles included. In total one article was included in the meta-synthesis (Search undertaken 20th April, 2010).

4.6.2 *CINAHL*

The CINAHL database was searched by inputting the search terms and Boolean operators and using the 'add row' facility to increase the search. The advanced search screen was utilised and 371 hits were initially generated in July 2006 with six possible relevant articles. Subsequently, an up-dated search of the CINAHL Plus via the interface – EBSCO host was undertaken using the same search terms and Boolean operators to locate appropriate articles from August 2006 to April 2010. 457 articles were located with 9 identified as having potential relevance and in total two articles were included in the meta-synthesis (Search undertaken 19th April, 2010).

4.6.3 *EMBASE*

The EMBASE database was searched via the Embase Biomedical Answers interface using the search terms above and Boolean operators. The advanced search screen provided 20 hits in July 2006 with five articles identified as having potential relevance. The further up-dated search in April 2010 also allowed for inclusion of alternative field limits including '*Map to preferred terminology (with spell check)*' and '*Include sub-terms/derivative (explosion search)*'. Other quick limits included: '*Humans*', '*With abstract*' and '*Only in English*'.   This search resulted in 73 hits with six of potential relevance. The total number of article included in the meta-synthesis was three (Search undertaken 19th April, 2010).

4.6.4 *Intermid.co.uk*

An advanced search of the data base Intermid.co.uk was undertaken in April 2010. The Intermid.co.uk database is the online archive of peer-reviewed articles from the British Journal of Midwifery and the African Journal of Midwifery and Women's Health. Using the advanced search mode the above terms and Boolean operators were inserted revealing 20 hits with no potential articles identified as relevant (search undertaken 21st April, 2010).

4.6.5   MEDLINE

The MEDLINE database was searched through the Pubmed interface using the search terms above, resulting in 110,644 hits. Subsequent to applying the following limits: *'With abstracts', 'Humans', 'Female', 'English', 'Adults age 19-44 years'* and limiting the search period from *'January 1990 to July 2006',* 195 hits were recorded. Two relevant articles were retrieved. The updated search from August 2006 to April 2010, using the same limits resulted in 175 hits with 4 potential articles selected. Three articles in total were included in the meta-synthesis (Search undertaken 21st April, 2010).

4.6.6   MIDIRS

MIDIRS referenced database was searched using the search term *'postnatal care/experiences'* resulting in 243 hits, five of which were retrieved for potential inclusion in the meta-synthesis. The updated search in April 2010 obtained a further 184 hits with two possible articles retrieved. Two articles were included in the meta-synthesis (Search undertaken 19th April, 2010).

4.6.7   PsychINFO

The PsychINFO database is published by the American Psychological Association and was accessed through the ProQuest interface. Following the initial search in 2006, six possible relevant articles were identified using the above terms. However, when updating the search in March 2010 using the advanced search mode and applying the limits *'Female', 'English'* and *'Qualitative'* the search revealed no results. I then inputted the term mother into the basic search mode which immediately provided a prompt *'Mothers experiences of postnatal care'* resulting in 514 hits two potential articles of relevance were identified. In total one article was included in the meta-synthesis (Search undertaken 19th April, 2010).

4.6.8 Berrypicking approach

A 'berrypicking' approach (Bates 1989) to searching the literature was also used to identify other relevant articles and sources for example, books or book chapters. Nine pieces of literature were identified on the initial search, while the updated search in April 2010 identified a further four. One article was included in the meta-synthesis. According to Bates (1989) users of this approach:

> '…begin with just one feature of a broader topic, or just one relevant reference, and move through a variety of sources. Each new piece of information they encounter gives them new ideas and directions to follow and, consequently, a new conception of the query… Furthermore, at each stage, with each different conception of the query, the user may identify useful information and references. In other words, the query is satisfied not by a single final retrieved set, but by a series of selections of individual references and bits of information at each stage of the ever-modifying search. A bita-at-a-time retrieval of this sort is here called berrypicking…' (p.410).

A similar process known as '*backchaining*' as documented by Steen *et al.,* (In press) can also be employed to identified potential relevant literature by tracing back related articles or examining quoted references. See table 2 below for the results of the database search and article retrieval.

Databases	Articles retrieved using search strategy in July 2006	Potential relevant articles identified	Articles included following inclusion/ exclusion & quality criteria (July 2006)	Articles retrieved using updated search strategy in April 2010	Potential relevant articles identified	Articles included following inclusion/ exclusion & quality criteria (April 2010)	Total number of Articles Included in the meta-synthesis
Books @OVID/ Maternal Infant Care	9	4	1	4	0	0	1
CINAHL	371	6	2	457	9	0	2
EMBASE	20	5	1	73	6	2	3
Intermid	-	-	-	20	0	0	0
MEDLINE	195	2	1	175	4	2	3
MIDIRS	243	5	2	184	2	0	2
PsychoInfo	6	2	1	514	2	0	1
'Berrypicking approach'	9	1	1	4	0	0	1
Total	853			1431			13

Table 2: Results of database search, articles retrieved and total included in the meta-synthesis

4.6.9   *Limitations of search strategy*

Limitations of this search strategy included imposing a restriction to identify relevant English language studies only. This was deemed necessary as reviewing studies in another language would have involved employing the additional expense of a language translation service or purchasing translation software package. In addition, from the outset the decision was taken when possible, that database limits would be set to include an abstract so that the initial relevance of each study could be assessed. This method may have excluded potential relevant articles. Nevertheless in searching the databases when articles without an abstract were considered to be of interest these were examined for their relevance.

A further possible limitation is the process undertaken to identify the specific articles included in the meta-synthesis from the numbers of articles initially identified as

having potential relevance from the databases (see table 2). This process involved reading each article to identify if a qualitative approach was actually undertaken, ascertaining if the data published was forced from a structured data collection approach and that the data originated from women's experiences of postnatal care. In addition, each article included was appraised for its quality as identified below (see section 4.7). The excluded articles were deemed unsuitable as they pertained predominately to research on midwives experience of postnatal care, women's experience of being a mother, were quantitative in nature or utilised structured interviews with closed questions.

4.7   **Appraisal of studies**

All studies were individually appraised to determine their quality. This proceeded according to the criteria for appraising qualitative research studies as published by Walsh and Downe (2006) and adapted by Downe *et al.,* (2007). The process of developing the appraisal criteria according to Downe and colleagues involved: the identification of existing checklists and frameworks, using a redundancy approach to eliminate non-essential criteria, mapping the findings together, concluding with a reflexive discussion. Walsh and Downe (2006) emphases that their criteria reflect the essence of qualitative research, thereby the components of integrity, transparency and transferability are visible within their appraisal checklist. As a baseline requirement the authors identify essential criteria (beside specific prompts in their article) that all qualitative studies should possess in order to be included in a meta-synthesis. The characteristics of the included studies and key findings are highlighted below in Table 3. Table 4 below also provides evidence of how each study was rated against the quality criteria followed.

Table 3: Characteristics of included studies and key findings

Number in the brackets [x] represents article code

Author(s) date country	Study design and aim	Sample selection method	Sample size	Method of data collection and analysis	Key findings and comments
Bondas-Salonen (1998) Finland [1]	Descriptive Phenomenology (Colaizzi) To explore and describe new mothers' experiences of postnatal care Part of a larger study on maternity care in Finland	Method not noted	9 new mothers Mixed parity	Longitudinal 36wks gestation, 3 weeks, 3 months & 2 ½ yrs interviews Thematic structures formed, clustered and categorised according to Colaizzi	Postpartum care, from the perspective of the new mother is sharing her new life situation. This comes from professional carers' and informal carers via learning from the midwife and listening to other new mothers stories and by being enabled to be in peace and quiet together with her child and family. Meaning of caring involves listening, enabling adjusting to mothering etc. not just the involvement of physical tasks Absence of care, purely medical care as midwives did not interact with the women, leaving the women feeling like a 'faceless machine', ignored. The women remembered two & half years later the midwives who cared for them and the names of those who didn't.
Yelland et al., (1998) Australia [2]	Qualitative – No specific design referred to Aim - To assess Filipino, Turkish & Vietnamese women's views about their care during the postnatal hospital stay	Convenience sampling implicit within the article subsequent to inclusion criteria	318 women 107 – Filipino 107 – Turkish 104 – Vietnamese Both primiparous and multiparous women	Structured interview (with one question open-ended) questions based on findings from Brown & Lumley (1997) survey , six months post birth in Mother's home Mixed method analysis including: Random sample of taped interviews were translated and transcribed, Thematic analysis using a coding schedule, Statistical calculations for assessing satisfaction	Overall postnatal women's satisfaction with care was low, one third of the women left the hospital feeling they needed more help, advice and assistance. The attitudes of carers were associated with women's satisfaction with their care, a number of women felt their carers did not take their concerns seriously.
Rice et al., (1999) Australia [3]	Ethnography To examine women's perceptions of care and their experiences during hospital stay in the first few days after birth	Personal networking and snowball sampling	26 Thai women determined by theoretical sampling Parity 1-3	Interview in their own home in Thai language by the authors, participant observation in the hospital and of cultural ceremonies & the recording of field work Thematic analysis	Some women went home earlier than the standard hospital practice of four days either because they were unhappy with the hospital practices or because they wanting to follow Thai confinement customs. Most women were satisfied with their care

Author(s) date country	Study design and aim	Sample selection method	Sample size	Method of data collection and analysis	Key findings and comments
Lock & Gibb (2003) Australia [4]	Phenomenology within a feminist framework To examine the experiences of women electing early postnatal discharge.	Convenience sample	5 Caucasian women Parity 1-3	Conversational interviews Thematic analysis guided by van Manen (1990)	The theme spatiality was discussed in detail. Spatiality related to the power of place as witnessed in the maternity hospital by the women leaving them disempowered and alienated. Whereas postnatal care at home enhances the women's journey into motherhood. Other identified themes of corporeality, temporality and relationality not included in article.
Munday (2003) Canada [5]	Phnomenology Women's experiences of the postnatal period following a planned homebirth	Not specified	10 women who had a homebirth Mixed parity of women were included	Semi-structured interviews Once between 6 weeks to 18 months postpartum Content analysis	Key themes include control, continuity and empowerment of the women experiencing care at home following a home birth. Mothers placed great emphasis on socio-emotional aspects including, relatives, friends and they did not prioritise or make reference to their postnatal physical care. These are important issues for mothers and need to be incorporated into postnatal care to enhance the postnatal experience of mothers.
Hunter (2004) England [6]	Qualitative Hermeneutical approach To identify first time couples views on the support provided by community midwives during postnatal home visits, and how improvements could be made	Convenience sample , 11 midwives distributed 26 invitations to new parents, participants were the first couple to respond	Five cohabitating primigravid couples, heterosexual parents, >18 yrs of age.	Semi-structured interviews 6 weeks postnatally in the couples own home Data analysed using a grounded, hermeneutical approach, open coding	Parents wanted more practical help, continuity of carer and extended midwife visiting. Because of feeling traumatised by events in the early postnatal period a recommendation for debriefing included
Ockleford et al., (2004) England [7]	Qualitative To find out what women experienced during the first days after giving birth and what their thoughts about these experiences were.	Indirect reference to the recruitment procedure as per Ockleford et al., (2003)	39 participants: 10 primiparous Indian women, 1 primiparous Pakistani woman, 10 multiparous white & 9 multiparous women	Semi-structured interviews 13 weeks postnatally at home and once in a participant's place of work QSR NUD*IST 4 and content analysis	Low staffing levels identified by the women as there was limited help available on the hospital postnatal ward Women were unprepared and daunted by their experience of going home with a new baby Care needs to focus on preparing mothers for the transition home

Author(s) date country	Study design and aim	Sample selection method	Sample size	Method of data collection and analysis	Key findings and comments
Baker *et al.,* (2005) England [8]	Qualitative To explore individual women's experiences of childbirth and the postpartum in the context of the changing childbirth policy	Invitation letter to a previous study originally recruited 1991-1994, recruited for this study in 1998	24 Primigravid women	Semi-structured interviews, also SADS-L tool administered (to ascertain any periods of depression) Analysis via open and axial coding; detail presented on how this approach was employed	Apparent absence of care: Women commented on the negative staff attitudes and behaviour such as being offensive, harsh, judgmental, insensitive leaving the women feeling inadequate. Their behaviour verged on bullying women, to care for their babies. Emphasis on routine approach to care with no time for interpersonal/supportive care Apparent lack of resources made women feel guilty if they asked for help, breastfeeding was not supported, help not offered with the crying baby.
Miller (2005) England [9]	Mixed methods design Women's experiences of becoming mothers set against a backdrop of policy and care delivery	Convenience sample	17 Primigravid women	In-depth interviews followed by postal questionnaire 7-8months antenatal, 6-8 weeks & 8-9 months postpartum	***Incongruent Postnatal Care*** Women didn't know what to do, to care for their babies - '*...No-one told me how to sort of bath the baby'*. In addition, for the women there was no clear basis on how the selective home visiting was decided upon – One women said'*...because I felt so dreadful I would have liked them to call every day..., but they assume...I suppose they think this is a fairly nice house, husband at home, they kept saying 'I'll not call tomorrow eh, I'll leave it for a day or two'* **Supportive/Practical Care** Some women felt supported by midwives '*She was great because she came round and she actually put me to bed and latched the baby on and made me a sandwich'*.

Author(s) date country	Study design and aim	Sample selection method	Sample size	Method of data collection and analysis	Key findings and comments
Peterson et al., 2007 Canada [10]	Transcendental phenomenological approach How do adolescent mothers perceive and describe their experiences of satisfactory and unsatisfactory inpatient postpartum nursing care.	Purposeful criterion sampling	14 adolescent mothers	Semi-structured Interviews undertaken between one week and two months post birth NVivo 2.0, following the modification of the Stevick-Colaizzi-Keen method as described by Moustakas (1994)	The mother's satisfactory care experiences were associated with staff showing they enjoyed their work through their friendliness and patience. They felt respected as the carers demonstrated their confidence in them and were satisfied when they received responsive individualised care Unsatisfactory care was described as provided in a rushed, serious, judgemental manner which did not recognise the individual needs of the mothers
Forster et al., 2008 Australia [11]	Qualitative To gain an in-depth understanding of women's views, expectations and experiences of early postnatal care.	Purposeful sampling	7 primigravid women 1 multigravid woman 42 women in postnatal women (some up to the 12 months following delivery) 2 partners	Focus groups initially explored the overall issues surrounding postnatal care Second part of each focus group examined possible alternative postnatal care packages (reported elsewhere) Thematic analysis	Women wanted to stay in hospital until confident to care for their baby at home as the hospital was seen as safe option for their baby particularly as there is no community postnatal care in Australia. Participants wanted to learn infant caring and feeding skills before discharge Participants reported how they had received both positive and negative or inadequate quality of professional care
Beake et al., 2010 England [12]	Mixed method approach To explore women's expectations and experiences of current in-patient care	Purposeful sampling	13 primigravid women and 7 multigravid women	Semi-structured Interviews utilising Thematic analysis Pre & post intervention questionnaire administered to women 10 days to 3 months postpartum [results reported elsewhere] Focus group and interview with staff [results reported elsewhere]	Themes that emerged from the semi-structured interviews with the women include the impact of the environment e.g. turning on lights at 6am, Staff attitudes on the postnatal ward, majority of the comments were positive, friendly helpful staff. All staff were busy consequently women felt guilty about ringing the bell for help, a small minority of staff were described negatively. Varied support for breastfeeding in terms of quality and depth of breastfeeding advice. Unmet information needs were highlighted relating to practical infant care and post caesarean section advice

Author(s) date country	Study design and aim	Sample selection method	Sample size	Method of data collection and analysis	Key findings and comments
Johansson et al., 2010 Sweden [13]	Qualitative To gain a deeper understanding of first-time parents' experiences of early discharge from hospital after delivery and home-based postnatal care	Not clear from the article the sample method employed	21 Parents participated (11 women and 10 men). All participants had had their first child accept one man who had a child in a previous relationship and should not have been included in the study according to the inclusion criteria	Semi-structured focus groups and interviews Qualitative content analysis	Home based postnatal care was welcomed by the parents with professional midwifery support. Women felt more secure when they could contact the midwife easy by telephone. Majority of parents felt the midwife gave them consistent advice, they were considered experienced and professional. The new role as parent was confirmed by the midwife.

Table 3: Characteristics of included studies and key findings

Table 4: Quality assessment tool utilised to assess studies for inclusion in meta-synthesis

Code	Author Year	Aims Clear?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective?	Methods appropriate for design?	Sample size and sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study ethical?	Do the data presented justify the findings	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Rating
1	Bondas-Salonen (1998)	Y	Y	Y	Y	Y	Y	Y	U	Y	N	Y	A-
2	Yelland *et al.,* (1998)	Y	Y	U	Y	Y	U	N	Y	U	Y	U	C
3	Rice *et al.,* (1999)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B+
4	Lock & Gibb (2003)	Y	Y	Y	Y	Y	Y	U	Y	U	Y	Y	C
5	Munday (2003)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	C+
6	Hunter (2004)	Y	Y	U	Y	Y	Y	N	Y	Y	Y	Y	A-
7	Ockleford *et al.,* (2004)	Y	Y	U	U	Y	Y	N	U	Y	Y	U	B-
8	Baker *et al.,* (2005)	Y	Y	Y	Y	U	Y	Y	Y	Y	Y	Y	B+
9	Miller (2005)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	U	C
10	Peterson *et al.,* (2007)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	C

Code	Author Year	Aims Clear?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective?	Methods appropriate for design?	Sample size and sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study ethical?	Do the data presented justify the findings	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Rating
11	Forster *et al.,* (2008)	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	U	A-
12	Beake *et al.,* (2010)	Y	Y	Y	U	Y	Y	N	Y	Y	Y	Y	B
13	Johansson *et al.,* (2010)	Y	Y	U	Y	Y	Y	Y	Y	Y	Y	Y	B-

Table 4: Quality assessment tool utilised to assess studies for inclusion in meta-synthesis

Quality key and rating:

(A+, A, A-): no, or few flaws. The study credibility, transferability, dependability and conformability is high

(B+, B, B-): some flaws, unlikely to affect the credibility, transferability, dependability and/or conformability of the study

(C+, C, C-): some flaws that may affect the credibility, transferability, dependability and/or conformability of the study

(D+, D, D-): significant flaws those are very likely to affect the credibility, transferability, dependability and/or conformability of the study

Walsh and Downe (2005) and Downe *et al.,* (2008)

Y = yes, N = no, U = unclear, N/A = not appropriate

4.8   <u>**Analytic technique**</u>

Analysis of the study findings followed the classic method of Noblit and Hare (1998) as adapted by Walsh and Downe (2005). This involved identifying and tabulating key metaphors, phrases, ideas, concepts and relations in each study – essentially a compare and contrast exercise to assess included studies to establish their similarities or differences.   Reciprocal translation then followed which involved me at first undertaking the initial analysis and then researcher triangulation between my research supervisors and myself. This provided a forum to confirm or disconfirm and thereby enhanced the identification of the final categories and themes.

4.9   <u>**Findings**</u>

In total, the number of hits obtained from the initial and updated search was 2,284. Of these, 48 abstracts related to women's experience of postnatal care. Following the inclusion, exclusion and quality assessment criteria, 13 papers were included in the meta-synthesis. The studies included where from five different countries: 2 Canada, 4 Australia, 5 England, 1 Sweden and 1 Finland. The quality rating of the individual, included research ranged from a C grade to A- grade (see table 4 above); with the majority of the papers omitting a reflexivity section.

Three themes emerged from the individual studies included. These were: impact of staff attitudes and behaviour; congruent postnatal care; incongruent postnatal care. These themes captured the women's experiences particularly the postnatal care practices or experiences, which are fitting or not with women's postnatal care needs. The numbers cited within the brackets e.g.[ ] in the paragraphs below represent the code allocated to each study in table 4.

Impact of staff attitudes and behaviour – The majority of the studies included in this meta-synthesis remarked on how the attitudes and behaviour of the postnatal staff impacted on the women's experiences. The friendly, warm, sensitive midwives were patient and seen to enjoy their work. Their positive attitudes enhanced the women's confidence as one woman explains: *'It was great because we were getting compliments on how good of parents we are and like that just, you know, made me tickled pink...'* [10, p.206].

Midwives who demonstrated negative qualities or attitudes were harsh, offensive, intimidating and at times bulling in their approach. One woman describes witnessing a midwife repeatedly making a woman change her child's nappy even though it was making her continually vomit. Another woman reported '*I actually heard one call one mother a cry-baby because she'd had a caesarean and she had stitches. She was puffy and bruised and sick and because she couldn't immediately jump up and tend to the baby whenever she cried they, they called her cry-baby because she would buzz for help*' [8, p.327]

Congruent postnatal care, related to the relevant, supportive and practical care that the women experienced. This theme was evident in only six of the studies [3,4,5,9,10,13]. The supportive and practical nature of the midwife made a difference to the women as reflected in this quote '*She was great because she came round and she actually put me to bed and latched the baby on and made me a sandwich*' [9, p123]. Another study highlighted how the women's satisfactory experiences were related to the postnatal carer's patience and unhurried manner, saying the ideal postnatal carer does '*not make you feel like they only have two minutes to spend with you. [They] give [you their] full attention*' [10, p205].

Incongruent postnatal care was clearly highlighted in all of the studies except two; [5] a home based postnatal care study and [13] postnatal care following a home birth study. Incongruent or incompatible postnatal care to that of what the women need was disconcerting and left the women feeling neglected [4]. One women reported her experience of ineffective postnatal care in relation to the ambiguous nature of how selective home visiting was decided upon – '*…because I felt so dreadful I would have liked them to call every day…, but they assume…I suppose they think this is a fairly nice house, husband at home, they kept saying 'I'll not call tomorrow eh, I'll leave it for a day or two*' [9, p122]. The findings in another study highlighted how the lack of staff in the hospital, particularly at night had an impact on the women. One woman expressed how distressed she felt with the slow response time; '*At night there should be more nurses – I cried because of the lack of care*' [2 p.151].

4.10   **Synthesis of translation**

The following synthesis was generated from the themes detailed above. From the included studies most of the women's experience of postnatal care was influenced by the attitude and behaviour of the postnatal carers. Some women experienced positive attitudes from staff as they listened and enabled them to commence their journey into motherhood.   This was achieved through congruent postnatal care which was supportive and practical.   The majority of the women in the studies however, experienced negative attitudes and behaviour from their postnatal carers as they were often ignored and treated harshly. This was evident in the women's encounter of incongruent postnatal care which was ineffective and absent at times. Figure 1 below illustrates this synthesis of translation.
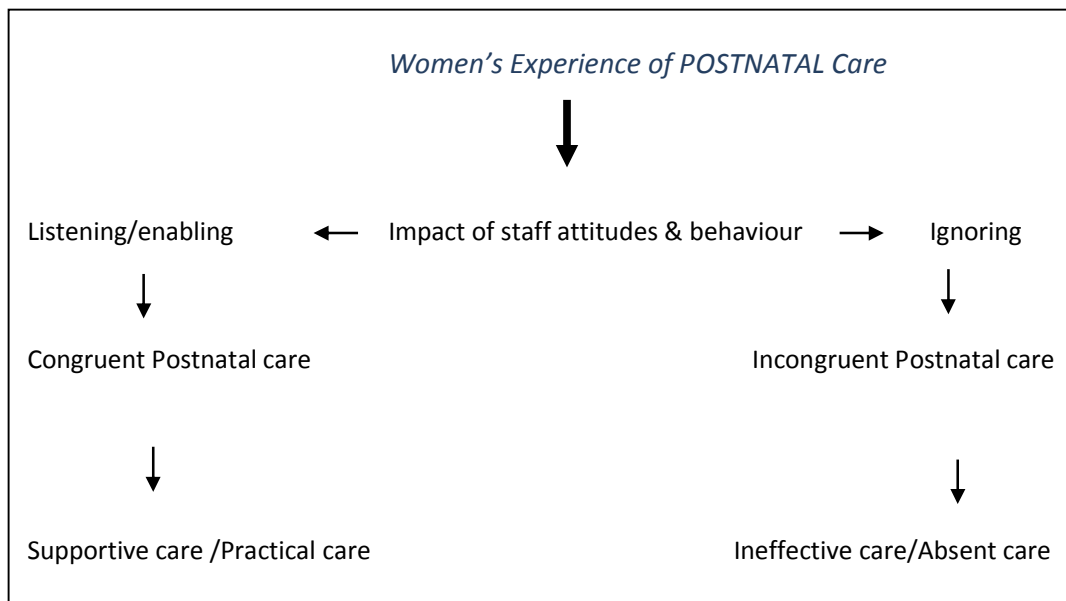
Figure 1: Synthesis of translation of women's experiences of postnatal care.

 The result of the synthesis of translation provides a preliminary and tentative understanding of women's experience of postnatal care, which has subsequently enabled the commencement of the next phase of this research, the group interviews. The following chapter provides a detailed description of the philosophical underpinnings and design of this Heideggerian hermeneutic phenomenological research.

5.0 Chapter Five: Methodology – Heideggerian Hermeneutic Phenomenology

The previous chapter presents a meta-synthesis of qualitative research which explored women's experiences of postnatal care. As highlighted in chapter four, many of the studies (which met the inclusion criteria) summarised the women's postnatal care experiences as either congruent or incongruent to their needs. To go beyond these '*already there*' understandings (Smythe, 2011, p37) and uncover what meaning Irish women give to their experiences of postnatal care I chose Heideggerian hermeneutic phenomenology as the research methodology. In order to fully understand and enact this methodology I studied in detail the philosophical underpinnings of Martin Heidegger's work. My recent publication[15] demonstrates my intense engagement with Martin Heidegger's writings, particularly his publication '*Being and Time' (1962).*

 In the beginning of my studies I explored the possibility of applying constructionism (Berger and Luckmann, 1967) as the underpinning philosophy to this Heideggerian phenomenological research. However, through my reading and knowledge development of Martin Heidegger's work, I realised that his paradigmatic stance did not originate from constructionism, which is an aspect of epistemology (knowledge theory which explains '*how we know what we know', (*Crotty, 1998 p.3)) but from an ontological perspective which focuses on the study of 'being'. This was the main focus of my research to study the reality of how Irish women experience postnatal care.

5.1 Introduction

This chapter provides a detailed description of the philosophical underpinnings and design of this Heideggerian hermeneutic phenomenological research. The chapter begins with a brief chronicle of the life events of Martin Heidegger to place his work and philosophy in context, followed by a detailed explanation of the evolution of Heidegger's philosophy. The genesis and development of Heidegger's seminal book, '*Being and Time'* is discussed at length. Initially, this section highlights Heidegger's recognition of his indebtedness to the work of Frank von Brentano and Edmund

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[15] Healy, M. (2011) Heidegger's contribution to hermeneutic phenomenological research. In Thomson, G., Dykes, F. and Downe, S. (Ed) *Qualitative Research in Midwifery and Childbirth – Phenomenological Approaches,* Routledge: London.

Husserl followed by a critique of their philosophy. Heidegger's contribution to hermeneutic phenomenology is then outlined. The final section highlights my theoretical perspective.

5.2   **Chronicle of the life events of Martin Heidegger**

Martin Heidegger was born in Messkirch, Germany on the 26th September 1889, and he died on the 26th May 1976. His father was a manufacturer of barrels and he was also a sexton for the local church. Heidegger went to school initially in Constance (1903-1906) and then in Freiburg from 1906-1909. Here, at the age of seventeen he was first introduced to Franz von Brentano's work '*On the Manifold Meaning of Being according to Aristotle*' (1862) by a pastor from Trinity Church in Constance (Krell, 1993). This book stimulated Heidegger's interest into the question of being (Moran and Mooney, 2002) and a year later he went on to critically appraise Aristotle's own work endeavouring to re-read the history of philosophy (Krell, 1993).

Following a brief period as a Jesuit novitiate, Heidegger enrolled at the University of Freiburg as a theology student and seminarian from 1909-1911. He studied mathematics and then philosophy at Freiburg and it was here that he first encountered the work of Edmund Husserl. Husserl's famous text '*Logical Investigation*s' left a profound impression on Heidegger yet instilled an inquisitive sense of incorrectness (Moran and Mooney, 2002). According to Moran and Mooney (2002) it was around this same period that Heidegger became familiar with hermeneutics through the writings of Schleiermacher while also engaging with the work of Hölderlin, Rilke, Kierkegaard and Nietzsche.

In 1915 Heidegger became a lecturer at Freiburg, was conscripted into the military service from 1915 – 1918 and later worked as an assistant to Edmund Husserl from 1919-1923. It was in 1923 that he secured the reputation as a great lecturer following the acknowledgment of his creative interpretations of Aristotle and became an assistant professor at Marburg University. In the academic year of 1925-1926 Heidegger was encouraged by the Dean of Marburg's philosophy faculty to publish his unfinished manuscript of '*Sein and Zeit', (*Being and Time). In February 1927, *'Being and Time'* was published (Krell, 1993) and he was appointed to the chair of philosophy at the University of Freiburg in February 1928 (Wrathall 2005). For ten months, from May

1933, Heidegger joined the Nazi Party. Around the same time he became Rector of Freiburg University until 1934 when he resigned (Krell 1993). After the Second World War the French military authorities involved in the Allied De-Nazification Committee and faculty from Freiburg University placed Martin Heidegger under rigorous scrutiny due to his involvement with the Nazi party. No firm conclusions were reached by the investigation as to his actual involvement. However, the committee placed a strict ban on Heidegger's freedom to lecture, publish and attend conferences. He found this very difficult and only continued to teach his philosophy in private seminars with the ban being lifted in 1951, one year before his retirement (Krell 1993, Moran and Mooney 2002).

Since then Heidegger's work has been translated into many languages and has gained considerable international recognition. In relation to the significance of Martin Heidegger's philosophy, Mark Wrathall (2005) writes:

> *it is not his misadventures with Nazism or his self-importance that is paramount in interpreting his philosophy, but his originality as a thinker and the scope and profundity of his thought itself* (p. 1-2).

5.2   **The evolution of Heidegger's Philosophy**

5.2.1   *Heidegger's interpretation of Aristotle*

As mentioned above, Heidegger re-read the history of philosophy back to Plato's student, Aristotle (384-322 B.C.). His intensive study originated from his disagreement with how knowledge had been generated by the philosophical tradition. Aristotle had provided a unique analysis of the question of what being means from an aetiological perspective, believing that there was a unity, as Hanley (2000) describes, '*between what is the case in the world, and what humans correctly perceive to be the case*' (p. 203). Signifying logic, Aristotle argued that perception is always interpreted and connected to our experience in the world. This differed from Plato's rationalist belief in disconnected knowledge, which surmised that experience is not required to reveal the truth of an idea (Stevenson 2005). In exploring his theory of perception Aristotle focused on the complex Greek term '*Ousía'*. Aristotle believed that the '*primary form of being to be investigated is ousía; and ousía is, in the most primary sense, form*' (Hanley 2000,

p.67). Thus, the mind thinks about external things: for example, an object is perceived in terms of its form with a shape, and the material that it is made up of. How the object functions is known as matter. Aristotle's views were grounded by a belief in God; this led to his argument that there was a certain order or structure in the world and that human beings also have a universal description, or understanding of unity of the ways of being. Heidegger creatively interpreted Aristotle's work (Krell 1993); he disagreed with Aristotle's restricted thinking associated with the categorisation of being, in particular the suppressive viewpoint on the individuality of human beings. As Heidegger wrote *'...even Aristotle failed to clear away the darkness of these categorical interconnections'* (1962, p. 22). The important aspect for Heidegger was not what the unity of these ways of being is, but what '*ousía'* (or form) as Aristotle's analogy for the unity of all ways of being actually means (Hanley 2000).

Apart from Heidegger's critical analyses of traditional ontology (the historical philosophical views of being) he also examined in detail Immanuel Kant's (1724-1804) work on transcendental philosophy. Kant believed that space and time and everything associated with these concepts are simply appearances from our world of experience and therefore by discovering the structure and rules of appearance we know the structure of nature itself. Blattner (2006) suggests that Heidegger's adoption of Kant's transcendental turn to ontology transformed his study into the structure and rules of our understanding of being. Subsequently, Heidegger's aim in '*Being and Time*' was to develop a general ontology of all forms of being by explaining how it is that we understand being.

Historically, Aristotle's philosophy was respected for hundreds of years until it was dismissed by the Scientific Revolution (Blattner, 2006). This change came about by leading philosophers such as Francis Bacon (1561-1626) who had given credence to science as a systematic approach to discovering knowledge. Heidegger however took issue with the philosophical schools of idealism (where ideas can exist outside the mind) and realism (where ideas about reality exist in reality outside the mind) and in '*Being and Time*' he rejected the entire debate, stating that:

> *...as long as Dasein is (that is, only as long as an understanding of being is ontically possible), "is there" being. When Dasein does not exist [the proposition of independent things] can neither be understood nor not understood. In such a case even entities within-the-world can neither be uncovered nor lie hidden'* (Heidegger 1962, p.255).

5.2.2 *Heidegger's critique of Rene Descartes dualism*

Heidegger also refers to Rene Descartes (1591-1650) work in *'Being and Time'*. Descartes was an influential philosopher of the Renaissance who through his expertise in mathematical physics provided explanations for a number of natural occurrences, such as how the heart pumps blood and how light rays enter the eye into the optical nerve. Heidegger actually praises Descartes on this aspect of his work as a founder of human epistemology. Nevertheless Heidegger questioned Descartes renowned stance on dualism:

> *Within certain limits the analysis of the extensio [the objective world] remains independent of his neglecting to provide an explicit interpretation for the being of extended entities'* (1962, p. 134).

Heidegger rejected Descartes proposition of dualism, in terms of there being a separation between the physical and the metaphysical. Descartes believed that in order to understand ourselves or to understand what the 'I' is, we need to extract it from its surroundings so that we can better comprehend the self for what it is. He stresses in the *'Meditations on First Philosophy'* that *'...the mind of man is really distinct from the body...'* (Descartes 1979, p. 22). In addition, he goes further to suggest that the body needs to be separated from the imagination, as the sense organs are so close to the imagination that they can create false perceptions (Descartes 1979).

5.3 The genesis of Heidegger's Being and Time

5.3.1 *The forerunners of phenomenology and their work*

Heidegger's indebtedness to the forerunners of phenomenology includes Frank von Brentano and Edmund Husserl. Heidegger's appreciation of Husserl is demonstrated by the dedication of *'Being and Time'* to him and in the footnote where he gives recognition to Husserl stating that *'...he has also given us the necessary tools'* (Heidegger 1962, p.490). Frank Brentano, Husserl's professor, had an obvious influence on the development of Husserl's phenomenology. Brentano's series of lectures entitled *'Descriptive psychology'* (also entitled *'phenomenology'*) laid emphasis on the accuracy of describing mental states over casual explanations. He claimed that all mental

phenomena can be divided into psychical and physical phenomena (Brentano 1995), a view that Husserl rejected (Husserl 1970). Brentano also believed that mental phenomenon can be intentional; that is, they relate to an object whether or not the object thought about really exists (Moran and Mooney 2002). Blattner (2006) further explains that intentionality is '*the mind's capacity to represent the world around it*' (p. 2). For example, one might experience being frightened and relate being afraid to some particular thing even if it doesn't exist. It was the concept of intentionality that Husserl developed within his new approach to analysing the experiences of thought and knowing through phenomenology.

In '*Logical Investigations',* Husserl identified the necessity to go back to the '*things* themselves', to the actual experiences which must have originated in intuition in an effort to understand concepts or ideas of logic (Husserl 1970). In developing his philosophy Husserl identified that Brentano may have slipped into assuming that all objects of thought are real, as Blattner (2006) clarifies:

> '*O*nce *we begin talking about 'immanent objects',... it is easy to slide into thinking about meaning as a special sort of thing...*' (p.26).

In order to avoid this Husserl introduced his technique of '*phenomenological reduction'* which somehow permits a person to have a change in attitude and suspend their beliefs and assumptions by '*bracketing*' them. Husserl uses the Greek term '*epoché'* to refer to this period of suspension into the natural attitude. He highlights that this enables pure phenomenology to be undertaken through uninterrupted reflection on experience (Husserl 1981). He states himself that this approach can be followed '*by modifying Descartes's method*' (Husserl 1981, p. 15); which inevitably provided fuel for his critics.

5.3.2 *Heidegger's novel way of seeing experience*

According to Theodore Kisiel's (1993) article entitled '*The Genesis of Heidegger's Being and Time'* it was Heidegger's move to radically transform Edmund Husserl's work which was the beginning of a more fundamental conception of phenomenology. Martin Heidegger offered a novel way of seeing experience. He critiqued Husserl's philosophy which had followed the traditional stance and in particular rejected his

notion of the 'un-living of experience' (Kisiel 1993) that is, bracketing. Instead, he embraced 'embedded in the world' experience. Kisiel agrees with Heidegger that all that is left after Husserl's objectified methodology is the *'impoverished I-relatedness reduced to a minimum of experiencing'* (p. 46).

5.4   **What is it that Heidegger offers to Hermeneutic Phenomenology?**

5.4.1   *Heidegger's project – Ontological analysis of Dasein*

Martin Heidegger commenced his work by presenting an ontological analysis of Dasein (which essentially means us, human beings) as a way of interpreting the meaning of being and also provided an analysis for the structures of existence. Heidegger notes the task of ontology is to *'explain Being itself and to make the Being of entities stand out in full relief' (Heidegger 1962, p.49).* Thereby Heidegger's methodology pertains only *'to the things themselves!'* (p.50) as experienced by us. He does not accept that his methodology will accidentally stumble on findings. Instead his aim is to uncover existing phenomena, which indicates *'the totality of what lies in the light of day or can be brought to light'* (p.51).   In defining 'logos', the second component of phenomenology, Heidegger indicates that it refers to the making manifest or making sense of what is seen.   Thomas Sheehan comments in a podcast interview from KZSU FM radio station (KZSU Stanford, 2010) with Robert Harrison entitled *Heidegger's Being and Time* that Heidegger himself had stressed to him during a meeting in 1971, that:

> *Phenomenology is not about things out there ... [it] is about the meaning of things in our world of use, of practical orientation, the significance of things. It is precisely meaning that changes things out there into phenomenon; that is things that meaningful appear to us and that we can engage with.*

> (Thomas Sheehan on Heidegger, spoken, 1971)

In this conversion, Heidegger reaffirms that what is ultimately understood through his methodology is not the meaning of things, but the entity or the being. Understanding or non-understanding can only take place through Dasein's intelligibility which is

structured via the hermeneutic[16] circle (Heidegger, 1962) (See section 5.5). Thus Palmer (1969) asserts that Heidegger's project in *Being and Time* was to deepen and radicalise phenomenology and to explicitly unite it with hermeneutics. Hence Sheehan also comments in the interview with Robert Harrison that it is Dasein who is the hermeneutist, the one who makes sense and this is a basic characteristic of human beings. According to Bleicher (1980) hermeneutics was used from an early stage to assist with understanding the language of a text, to facilitate biblical exegesis, and to guide jurisdiction. Similarly, Diekelmann *et al.,* (1989) clarifies that, '*the goal of hermeneutics is the discovery and understanding of meanings embedded in the text*' (p. 13).

At the beginning of '*Being and Time*' Heidegger emphasises that the fundamental nature of Dasein is its existence, and to each one of us our existence is our own. As Heidegger states '...*Being, is in each case mine*' (Heidegger 1962, p. 67). Heidegger does not mean that Dasein lives in isolation but that Dasein's behaviour potentially demonstrates different modes of being. Thereby '*Dasein is in each case essentially is its own possibility*' (p. 68).

In division I of '*Being and Time*', Heidegger explores the world in terms of the entities or substances within it, and the way Dasein relates to them. He notes that we have a fundamental perspective on the way we view and understand these entities through our experiences and dealings in our world. He defines them in relation to the ways of being which refers to how Dasein makes these entities or substances intelligible. These ways of being include: present-at-hand, ready-to-hand and unready-to-hand. Present-at-hand is everything that is independent of our lives (Blattner 2006), for example substances which are self-sufficient such as trees, an electrical charge or the sun. Ready-to-hand refers to how Dasein looks at objects as instrumental for its practical needs; as an unconsciously present part of reality. Heidegger states:

> '*The less we just stare at the hammer-thing, and the more we seize hold of it and use it, the more primordial does our relationship to it become, and the more unveiledly is it encountered as that which it is – as equipment*' (Heidegger 1962, p. 98).

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[16] The term hermeneutics originates from Greek mythology whereby a great messenger of the gods named Hermes not only communicated verbatim the messages he was given by the gods, but also interpreted their meaning for the people.

Blattner (2006) describes 'unready-to-hand' as the '*unavailability of some-thing for use in human practice' (p 65)*. When unready-to-hand refers to equipment there is breakdown or malfunction and we are forced to concentrate on it. Heidegger (1962) stresses that unready-to-hand does not solely pertain to something that is missing or unusable but also relates to that which concerns us greatly and requires our attention.

Heidegger also underlines the importance of incorporating the '*temporal*' aspect of being, in any attempt to give meaning to the modes and characteristics of being. Understanding entities can therefore only be undertaken in terms of their relation to time of which there are three different modes: the past, present and future (Heidegger 1962). Later in division II of '*Being and Time*' Heidegger integrates the temporal features that structure Dasein (Blattner 2006).

Dreyfus (1991) summaries Heidegger's purpose in asking the question of being and highlights that he sought to comprehend our understanding of our practices, by presenting thematically what human beings obliviously do all the time. This is because, for Heidegger, a fundamental feature of Dasein's experience is our familiarity with the world that we live in and often do not notice. According to Dreyfus (1991), this was what the philosophical tradition forgot about for over 2000 years. It is central to Heidegger's philosophy. Our familiarity or, in other words, our background is often concealed from us as we frequently take it for granted or become absorbed in our everyday life. Heidegger gives the example of the latch on the door. As we open the door to go out we often do not notice it. Heidegger identified two levels of uncovering a phenomenon: 'ontically', meaning our everyday being, and 'ontologically' referring to the phenomenological analysis of the deep structures of being, that are rarely examined or noticed, yet underlie and explain the ontic (Frede 1993). He reflects that '*Dasein is ontically 'closest' to itself and ontologically farthest; but pre-ontologically it is surely not a stranger*' (Heidegger 1962, p.37). The phrase '*pre-ontologically it is surely not a stranger*' is referring to our inability to define our own state of being as we are always currently living in our everyday mode of being, not stopping to analyse it. Consequently, as Sheehan emphasises, it is only through undertaking fundamental ontology as phenomenology that the question of being can be answered by bringing to light the things that meaningfully appear or are significant to us (KZSU Stanford, 2010). As Heidegger (1962) confirms "...*it is itself the clearing*" (p. 171), the space left

behind after the trees have been cleared away, which illuminates the phenomenon (see picture 1).

Picture No. 1 – An illustration of a clearing in a forest
Picture taken by Maria Healy

5.4.2 *Dasein as a Being-in-the-world*

As referred to above, Heidegger's philosophy places Dasein (us) as a Being-in-the-world. Using a tripartite formation he identifies three structural elements of being-in-the-world these include: thrownness (facticity), discursiveness, and understanding (projectedness). Thrownness is a basic characteristic of Dasein and refers to the certainty that we as beings find ourselves thrown into a context without having a choice; a context - which is culturally and historically significant. Heidegger asserts that the term "…"*thrownness" is meant to suggest the facticity of its being delivered over*" (p. 174). These somewhat confusing terms refer not just to how the world we live in has an impact on us, but also how we as human beings encounter our world by always being attuned to it and making sense of what matters to us. Blattner (2006) explains that in our being we are "…*tuned into the way things matter, our tuning or temper is our*

mood" (p.79). Heidegger contends that we are always 'disposed' in a mood (Heidegger 1962), and this particular 'mood' influences our interpretations of meanings of our everyday existence.

Discursiveness refers to our activities and how we articulate the world through our language by following the guidelines of interpretation (Guignon, 1993). Projectedness refers to our act of understanding, to reach ahead into the meaning of something in order to comprehend it. As humans we cannot take in things and understand them immediately, we have to identify and work things out in terms of something else. For example, a suitcase has the role as a container and transporter for clothes or similar items, but is unsuitable to carry liquids. Meaning is therefore only obtained in the projection of which something becomes intelligible as something (Heidegger 1962). Heidegger stresses that:

> *'...when something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement is one which gets laid out by the interpretation'* (p.190).

It is Heidegger's recognition of this background involvement that is unique in comparison to previous traditional philosophers.

5.5   **The Hermeneutic Circle**

The process of Heideggerian hermeneutics as a method of inquiry is circular, as it adheres to the basic principle of the hermeneutical circle which highlights the relatedness of the phenomena under investigation to its surroundings. As described by Palmer (1969) *'The part is understood from the whole and the whole from the inner harmony of its parts'* (p.77). Schleiermacher (1998) who properly credits Friedrich Ast (1778-1841) with asserting the principle *'...that everything individual can only be understood via the whole'* (p.70). Heidegger adopted the hermeneutic circle to make interpretation possible, and, in doing so, developed a three-fold structure he called 'the fore-structure of interpretation': *fore-having, fore-sight and fore-conception. Fore-having* according to Heidegger (1962) is where in every case the interpretation is based on *'something we have in advance'* (p191), the background context in *'which Dasein knows its way about'... in its public environment'* (p. 405). For example a new mother may already know from her background knowledge that a baby needs to be fed to survive. *Fore-*

sight refers to the fact that we always enter a situation or experience with a particular view or perspective. *Fore-conception* is the anticipated sense of the interpretation which becomes conceptualised. For example, when a mother senses that her baby is unwell and later her interpretation is conceptualised when the baby has developed pyrexia.

What is most important as emphasised by Heidegger is the *"working out of these fore-structures in terms of the things themselves"* (p195) so that rigorous interpretation can be possible. It "*is not to get out of the circle* [of understanding] *but to come into it in the right way"* which is essential (Heidegger p195). The interpretive process is therefore always reflexive and never ending (See Chapter 13 for my personal reflexive account). Essentially, the researcher must continually examine the whole and parts of the transcript while frequently listening to the data (if it is in audio recording format) and with reference to the participants to ensure that the interpretations are reflected in the findings (Diekelmann 2001). The interpretive process I undertook in this research is outlined in detail in chapter six.

5.6   **The linguistic nature of human experience**

Hans-Georg Gadamer, Heidegger's student, focused on how understanding is achieved. He built on Heidegger's anti-subjectivist view of us, as human beings-in-the-world, and on his belief in the linguistic nature of human experience (Moran and Mooney, 2002). Gadamer's seminal publication '*Truth and Method*' (1989) details his project of a philosophical hermeneutics developed from Schleiermacher, through Dilthey to Heidegger. Palmer (1969) explains that hermeneutics for Gadamer is in essence *'an encounter with Being through language'* (p. 42). Gadamer believed that we are involved in the historically situated and constant task of understanding the world in which we encounter and live in through language (Moran and Mooney, 2002). To uncover the lived experience, it is thus, fundamental to be attuned to and interpret the many aspects of language used to communicate the 'lived experience'.

The following section outlines my theoretical perspective as it is a critical component in the revealing of the lived experience.

5.7   **My theoretical perspective**

My philosophy and central theoretical perspective are aligned to the work of Martin Heidegger and his hermeneutic (interpretative) phenomenology (as detailed above). Heideggerian hermeneutic phenomenology seeks to enhance and extend understanding of the lived experience and practices of the individual(s); that is life, as it is lived. It is only through a detailed exploration of the first person's experience that we can understand how they live their everyday life. Heideggerian philosophy promotes the raising of questions around the taken for granted practices of everyday life. Thus, once the Heideggerian hermeneutic phenomenological researcher has described in detail the lived experience or phenomenon (such as, women's lived experience of postnatal care) she/he can reflect back on the interpretative findings and uncover the conditions of possibility for future practice (Heiddeger, 1968).

My perspective has converged from my in-depth study of Heidegger's philosophy by reading his texts, attending both the Institute for Heideggerian Hermeneutical Methodologies and the Institute for Interpretive Phenomenology in USA in 2006. My perspective has also been influenced by my previous theoretical and practical knowledge of midwifery and postnatal care, and indeed my experience of childbirth and motherhood. From this perspective, I have entered into the hermeneutic circle with the quest of uncovering the postnatal care experiences of a sample of Irish women.

According to Heidegger, understanding can be shared and often resonates with others. Another characteristic is that, '*understanding always relates to the future*' (Palmer 1969, p131) once it has a basis, understanding can be projected. Understanding therefore, not only enables the grasping and uncovering of women's postnatal care experiences, but allows for a new way of thinking about the future care of women in the postnatal period. Through my research, it was my goal to enable a new way of thinking about postnatal care. Dreyfus (1991) confirms that Heidegger's thought has enabled not only philosophers but care practitioners to recognise alternative ways of understanding and acting that have been neglected in the past. In particular, this research identifies what really matters to women during postnatal care which is the authentic nature of care provision, referred to as '*the sparkling gems*' (see chapters eight to thirteen). The

following chapter describes the method and interpretative process followed in undertaking this research.

6.0   Chapter Six: Methodology Chapter – Enacting the Hermeneutic Interpretive Phenomenological Process

The previous chapter provides detail and justification of the ontological and theoretical approach for this research.   The philosophical underpinnings of Heideggerian Hermeneutic Phenomenology are thereby outlined in detail, beginning with an in depth critique of Heidegger's predecessors.

6.1   Introduction

This current chapter outlines the framework and research methodology guiding the design of this research.   The methodological decisions are contextualised by the Heideggerian hermeneutic philosophy discussed in the previous chapter. The chapter begins by outlining the research question addressed and the setting in which the research was undertaken. Details of how the participants were recruited, the research methods employed and details of the interpretive analytical framework used to guide the data analysis are presented.   The final section describes how rigour has been achieved in undertaking this research based on Madison's (1988) principles as outlined by Plager (1994).

6.2   The research question & approach

The question guiding this research was 'how do Irish women experience postnatal care following childbirth'?   To address this question, as discussed in chapter five a Heideggerian hermeneutic phenomenological approach was selected.   Following a longitudinal, prospective approach both group interviews and in depth interviews were undertaken with primigravid and multigravid Irish women. Heidegger does not provide a methodological basis for undertaking Heideggerian hermeneutic phenomenology, nevertheless a number of authors offer how to enact this research approach (Smythe 2011, Diekelmann *et al.,* 1989, Crist and Tanner 2003). The following section describes the research setting.

6.3   <u>The research setting</u>

The research was undertaken in an urban, maternity hospital in the Republic of Ireland where all the participants had planned to give birth. Over 8,500 infants are born in the hospital per year. The hospital provides a range of maternity care options. These include private, semiprivate, public and DOMINO and homebirth care. The private and semiprivate options provide varying medical consultant care throughout pregnancy, during childbirth and in the postpartum period for an arranged fee. The public and DOMINO and homebirth maternity services are free under the Maternity and Infant Care Scheme (highlighted in chapter three). The public service is consultant-led, though another free option for women is to attend an antenatal clinic managed solely by individual midwives who refer as necessary to the obstetrician (known as the midwives clinic). The DOMINO and homebirth maternity care option is provided by a team of midwives within the hospital and at home for women who are located within a specific geographical area. Hospital based midwifery care is provided to all women irrespective of their chosen maternity care option. The type of accommodation provided in the maternity hospital is related to the chosen maternity care option. For example - private maternity care entitles the women, to a single private postnatal room if available, whereas a woman using the public maternity care service may be allocated a bed in a six bedded postnatal ward.

6.4   <u>The Participants</u>

Twenty five participants in total were initially recruited and took part in either the antenatal data collection in phase one or phase two. Following delivery six participants did not complete the research for a number of reasons (outlined in section 6.6). Therefore, nineteen women participated in all three stages of data collection. The participant's age ranged from 25 to 38 years. All the women had a partner and the majority were married, except for four women. A brief description of each of the participants is outlined in chapter seven. From the outset I decided to examine both primigravid and multigravid women's postnatal care aspirations and experiences, from the context of their hospital and community experiences. I felt it was important to make visible the postnatal care experiences from the perspective of both these groups of new mothers as they are often cared for together in the same context of the postnatal ward. On discharge, the majority have access to the same Public Health

Nursing services as highlighted in Chapter three. The intention was to collate a variety of experiences to '*spark thinking,* [about postnatal care] *not to make comparative statements about different categories*' (Smythe, 2011, p.41). In reality, for the primigravid woman, her postnatal care experience is a '*new*' event or encounter, which is offset against her aspirations. For a multigravid woman, her experience of postnatal care is also '*a new experience*' (Gadamer 1976 p.353-354) which is always informed by her previous experience(s) and aspirations. All participants gave birth in the selected hospital and all experienced postnatal care in the hospital postnatal ward. A breakdown of the maternity care options chosen by the 19 participants who completed the study is outlined in Table 5.

Maternity care options	No. of participants	Postnatal carers following discharge home
Private	3	PHN only
Semiprivate	6	4 PHN only 2 ETH & transferred PHN
Public	2	PHN only
Midwives clinic	3	PHN only
DOMINO	5	DOMINO care & transferred PHN

Table 5: Maternity care options chosen by participants

On discharge from the hospital out of the 19 participants, 12 of them had their postnatal care transferred directly to the PHN. 2 used the early transfer home (ETH) scheme were a midwife visited them in their home for up to 5 days postnatally and then care was transferred to the PHN. The remaining 5 women opted for the DOMINO service receiving postnatal care from a team of midwives in hospital and at home until their baby was 5-10 days old, care was then transferred to the PHN.

6.5   Sample population and sampling method

The majority of the women who attend the hospital are from an Irish ethnic culture while the minority are from central Europe, Africa, Asia, or Australia. Inclusion and exclusion criteria (See table 6) were developed to ensure a homogeneous sample, which is necessary to reveal what an experience means to a particular group (Patton 2002). I decided that only women with an Irish ethnic background would be included in the study, as the findings may have been culturally mis-interpreted if women from other ethnic backgrounds participated. Other exclusion criteria included women who had a planned elective or emergency caesarean section because they require post-

operative care following abdominal surgery. Their care needs are, therefore, different to women following a vaginal delivery.

The sampling method followed was purposive. Purposive sampling involves the researcher deliberately selecting participants who have experienced a particular phenomenon and are thought to be the best available people to provide the data (Parahoo, 1997). Smythe (2011) emphases the importance of collating the experience from those who are skilled at describing what happened in detail. Capturing the lived experience is a fundamental principle of Heideggerian hermeneutic phenomenology (Polt, 1999).

Inclusion criteria:
Irish pregnant women attending a maternity hospital, in Ireland
From 28 weeks gestation
Nulliparous and multiparous with a low risk pregnancy
Aged eighteen years and older (as the age of consent in Ireland is 17)
Ability to give informed consent for study participation
Adequate knowledge of English to understand the research information and converse
Exclusion criteria:
Pregnant women less than 18yrs old
Women with a high risk pregnancy (e.g. multiple pregnancy, maternal medical disorder)
Women who have either a planned elective or an emergency caesarean section
Women who experienced an adverse pregnancy outcome such as a pre-term delivery (<37 weeks), sick infant or neonatal death

Table 6: Participant inclusion and exclusion criteria

6.6 **The recruitment process**

The recruitment process was undertaken in two phases. Initially, participants were recruited between January 2007 and June 2007 to take part in a series of group interviews. Later, in January 2008[17] the second recruitment phase began to select participants for the in-depth, individual interviews. For both recruitment phases participants were recruited by an invitation leaflet distributed throughout the hospital (Appendix A and B); 33 participants in total responded. In addition a further eight participants responded to the recruitment information regarding the research, posted on two interactive, mum-to-be web sites. These interested respondents contacted me directly for further information.

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[17] Although permission was received to commence the second phase of this study in June 2007 recruitment didn't commence until January 2008 as I'd been granted leave from my studies after the premature birth of my second child.

In total, six primigravid women and six multigravid women participated in phase one of the study (See table 7). One primigravid woman was excluded from the follow–up group interviews because she had a caesarean section and two multigravid participants withdrew from the group interviews for personal reasons. In phase two, a separate cohort of seven primigravid women and six multigravid women initially participated (See table 7). Two primigravid women were excluded from the follow–up individual interviews because they had a caesarean section and unfortunately one multiparous woman delivered a baby that was stillborn (RIP).

Stages of Data Collection ↓	Phase one No. of Participants in Primigravid Group Interview	Phase one No. of Participants in Multiparous Group Interview	Phase two No. of Participants in Primigravid Individual Interviews	Phase two No. of Participants in Multiparous Individual Interviews
28 to 38 weeks antenatally	6	6	7	6
2 to 8 weeks postnatally	5	4	5	5
3 to 4 months postnatally	5	4	5	5
Total	6 Group Interviews		33 Individual Interviews	

Table 7: Number of participants involved at the different stages and phases of data collection

6.7   Data collection

I undertook data collection between March 2007 and October 2009. The group interviews were held in a large, private room situated adjacent to the maternity hospital and at the opposite end to the clinical area. The majority of the individual interviews were held in the participant's own home. On two occasions the interview was held in a meeting room within the university where I work.

6.7.1 The stages of data collection and challenges

Both research phases followed a longitudinal approach to data collection involving primigravid and multigravid women participating at three different stages. These stages were: from 28 to 38 weeks antenatally, from 2 to 8 weeks and 3 to 4 months postpartum. The 28-38 weeks gestation stage was chosen to identify women's aspirations for their postnatal care, as it is at this stage that women may begin to think about the care they wish to receive to help them recover from birth and care for their child. Two to eight weeks postpartum was chosen as a time when women's experiences of hospital postnatal care could be recalled more accurately. Finally, collecting data at three to four months postnatally allowed the women time to reflect on their overall care experience following childbirth both from within the hospital and in the community. This longitudinal approach to data collection is supported by Seidman (1991) and Benner (1994) who both advocate interviewing participants 2-3 times, as it promotes understanding through clarifying initial interpretations and allowing for crucial questions to be asked which may have been overlooked in previous interviews.

Organising the 6 group interviews in phase one was challenging, as not all participants were available to meet on the same day. In particular, I found it difficult to organise the date of the group interviews, so that all the participants were at the same stage either in their pregnancy or postpartum. In total 33 individual interviews were undertaken in phase two following the longitudinal approach mentioned above (See table 7). All women who participated in the postnatal stages of data collection experienced a vaginal delivery of a live infant.

6.7.2 The interviewing approach and methods

Highlighting the purpose of the phenomenological interview, Sorrell Dinkins (2005) states that the aim is to '*understand a phenomenon by drawing from the respondent(s) a vivid picture of the lived experience, complete with the richness of detail and context that shape the experience*'(p.113). The communicative context therefore must prevent the participants from feeling awkward or constrained by the interview process particularly by the use of foreign or abstract language (Benner 1994). In order to achieve this, two or three days before either the group interviews or individual interview I contacted each

participant and asked them to recollect either their aspirations for, or their experience of postnatal care and what it had meant to them. I also asked them to think about examples that would describe their experiences. This proved fruitful in the richness of the transcripts.

At the beginning of each group and individual interview the participants were asked a broad open hermeneutical question to elicit their postnatal care story and to seek their interpretation(s) on the meanings and significances of their experience:

> *'Can you please tell me about your postnatal care experience(s) and what does it mean to you to have had this experience?'*

Once their story was recounted, open prompt questions were used to clarify words or phrases used by the participants that had taken for granted meaning, for example: *'care' or 'support'*. In addition, to avoid causal explanations, avoid assumptions and to stay focused on their story, the participants were asked to give an example(s) of their experience(s). Another approach used to seek the meanings and significances of the women's postnatal care experience(s) was to ask them:

> *If they had a close relative who would soon be in a similar situation to themselves, having just had a baby what would they say to them about postnatal care?*

These detailed descriptions of the practices and shared meanings are according to Diekelmann and Ironside (1998)

> *...intended to reveal, enhance, or extend understandings of the human situation as it is lived.* (p.343)

6.7.2.1 *Group interviews*

I chose group interviews as the first method of data collection in stage one, to scope the research field and identify postnatal care issues concerning the women. I felt that these concerns could be further explored within a one to one interview situation in phase two. Benner (1994) emphasises the effectiveness of using the small group interview in a hermeneutic phenomenological study of health and illness, stating that group

interviews can achieve several purposes for example, creating a natural communicative context for telling stories from practice; providing a rich basis for active listening. Meanings of the participants stories can also be enriched by stories triggered to counter, contrast, or bring up similarities and simulating a work environment that creates a forum for thinking and talking about work situations.

This data collection strategy promoted an in-depth, interpretative dialogue as encouraged by Benner (1994) who emphasises that data collection, inquiry, and analysis should not be separated. The actual group interview process encouraged a dynamic that triggered the sharing of postnatal care experiences through recollection and self-reflection, when otherwise the participants may have remained silent. A sense of solidarity also prevailed and, in some cases, the group process appeared to have a therapeutic effect for some participants, particularly when there was an acknowledgement of similar experiences. For example, some participants recognised how they wanted to ask midwives questions but did not because they were busy or when they acknowledged to each other how the lack of sleep postnatally had left them with feelings of distress.

Regardless of the type of interpretative engagement, group or individual interview it was important to ensure that the phenomenological conversations was not inhibited. As described by Smythe *et al.* (2008):

> *Our interviewing style is not structured in that we follow a pre-organised plan, nor unstructured, where we go with no clear sense of why we are there...but always an interview is about something* (p. 1392).

6.7.2.2 *The individual in depth interview*

As mentioned above the majority of the interviews were held at the participants' home, which appeared to decrease the participants' sense of unfamiliarity and awkwardness. To ensure a comprehensive approach to the individual in-depth interview, I followed the 'Socratic-Hermeneutic Inter-view' as described by Sorrell Dinkins (2005) when appropriate. This alternative approach to phenomenological interviews incorporates Socrates' ideas of shared inquiry where the focus is moved away from the 'respondent' to:

'...a shared dialogue focused on reflections of both interviewer and the interviewee as they share ideas, listen, and reflect together, thus forming an inter-view'. (p.128)

This approach was applicable particularly when I was in the postnatal period myself having recently given birth to my third child. This occurred during two individual, postnatal interviews where the participant and I shared and reflected on our experiences of being in the postnatal period. Principally, each interview was unique and, what was most important, had *'...openness to what 'is' – to the play of conversation'* (Smythe *et al.* 2008, p. 1392).

6.7.3   *Recording verbal and non-verbal data*

I digitally tape-recorded each group and individual interview. I also made field notes when necessary to document the participants' annotations or gestures. For example, during the interviews as the women recalled their experiences some individuals became quite animated, grimaced, nodded noticeably, laughed or cried. I also noted moments of silence as Sorrell & Redmond (1995) highlight the importance of '*listen[ing] to the powerful silence that may speak more than words'* (p. 1122).   One woman who normally spoke quite confidently became silent and withdrawn during a group interview and when I invited her to share her experience she hesitated began to stammer, and cried. She later volunteered her experience of being in the postnatal ward; the group were captivated and silenced prompting subsequent in depth discussion.   Noting observations such as these is important within hermeneutic phenomenological research as the tape-recorder doesn't record linguistic action. Allen (1996) also comments that:

'Texts may also be produced through observation. If the observation is of linguistic action, it is not much different from interviewing' (p.179).

6.7.4   *Discontinuing data collection*

I discontinued each interview when the in-depth discussion had come to a natural end, or when the time set for the interview had been reached. Other reasons for terminating an interview was if the woman had to attend an appointment, if their spouse or

children arrived home, if they had to collect their children from school or catch a train as happened once. On the rare occasion when the interview had to be suspended, although it was often nearing completion I was able to resume the subject of discussion at the follow-up interview. The interviews normally lasted between 45 minutes to one and half hours. On completion of each interview I downloaded the audio recording from the tape-recorder onto my laptop, securing each file with a password. The audio file was then copied onto a CD and hand delivered to the typist who signed a confidentiality agreement before transcribing began. Unfortunately due to time constraints and other personal demands I was unable to transcribe the interviews myself. Once the typist completed transcribing each transcript, a hardcopy of the transcript and the audio CD was returned to me. All audio CDs and transcripts were stored securely throughout this research project and incinerated following completion.

Initially, particularly when writing the research proposal, I had found it difficult to estimate how many interviews would be required. Nevertheless, I knew when I had reached the point of data saturation when no new themes were emerging that I had conducted enough interviews. Smythe (2011) provides an analogy of a river to describe this point of 'knowing':

> '*Already the insights are emerging like a river of thought. To keep pouring in more runs the risk of overflowing the banks which somehow hold the thoughts in a coherent whole*' (p.41).

6.8 **Gaining access and other ethical considerations**

A detailed application was forwarded to the selected hospital's research ethics committee for their meeting held on the 19th of September 2005. The committee raised three issues. Firstly, they wanted the minimum age of the participants (specified as sixteen) to be changed to eighteen years and older (see section 6.8.2 and Appendix C for copies of all correspondence). Secondly, the ethics committee wanted clarification on what was meant by Irish mothers (as explained section 6.5). The third point was the committee's view that the initial schedule of interviewing the participants at two weeks postnatally did not give the mothers an opportunity to assess their care. I replied in writing on the 13th October 2005 outlining my agreement to change the age of the participants to eighteen years and older. I also clarified the term 'Irish mothers' and agreed to undertake an interview three months afterbirth, stating that I would

continue to undertake the two week postnatal interview to capture the women's experiences of their care while it was fresh in their mind. Approval was granted to undertake the group interviews on the 14th November 2005.

The original proposed dates submitted to the ethics committee for recruitment and data collection had subsequently altered due to work pressures and as I'd experienced difficulties recruiting groups of participants around the same gestation. I wrote again to the ethics committee on the 10th April 2007 asking for permission to amend the recruitment and data collection schedule along with permission to commence the second research phase, the individual interviews. I outlined my approach to hermeneutic interviewing and enclosed the participant information and consent form (See Appendix E-F). Full approval was granted on 25th June 2007.

Ethical approval was also sought and full approval obtained from the Faculty of Health Ethics Committee, at the University of Central Lancashire, Preston in December, 2005, (See Appendix D). I also informed the Research Ethics committee at University College Dublin (my employer) of the research. As the research was carried out in the South of Ireland it was not necessary to apply for ethical approval through the UK online Integrated Research Application System (IRAS).

The four moral principles to carrying out research on human subjects as reflected in the *Declaration of Helsinki* (WMA, 2000) were adhered to, as described below. These principles are Autonomy, Beneficence, Non-malfeasance and Justice.

6.8.1 *Autonomy*

The autonomy of individual participants was respected from the outset by providing them with an information sheet, phrased in simple to read English outlining the research and their role as a participant (Appendix E). All participants were given time to ask questions about the research, before written consent was obtained (Appendix F). Ongoing consent was also afforded to the participants as they were advised that their involvement with the research was entirely voluntary and that they could withdraw from the study at anytime. Confidentiality, anonymity and privacy were maintained by the use of participant identification numbers on all data files. Pseudonyms were also used throughout this thesis and in all other reports or publications.

6.8.2   *Beneficence*

The principle of beneficence refers to the necessity to protect the welfare of all participants. Under the definition of this moral principle, the purpose of the research must also have a benefit for either the participants or the wider society (Maltby *et al.*, 2010). To ensure the safety of potentially vulnerable participants, such as teenage mothers', careful consideration was given to the minimal age limit. Initially, I stated in the research proposal that the participants would be sixteen years upwards. Following a condition outlined by the local ethics committee the minimal age limit of the participants was increased to eighteen on recruitment.   This decision was related to the fact that the legal age of consent for sexual intercourse is seventeen in Ireland. Regarding the potential benefit of this research, by presenting an interpretation of women's postnatal care experiences' and highlighting taken for granted, hidden situations, it is hoped that further inquiry and a different way of thinking about postnatal care will be prompted.

6.8.3   *Non-malfeasance*

The moral issue of non-malfeasance is related to the principle of beneficence (Maltby *et al.*, 2010) and requires that individual participants will come to no harm from taking part in a research study. In the event that individual participants' became distressed emotionally from revisiting their past care experiences or had physical care needs, I asked the Director of midwifery of the hospital to appoint a senior midwife manager (who was not directly involved in the initial provision of care) to provide appropriate care and support. All participants were provided with the direct telephone number on their participant information leaflet and after each interview I also reminded them of her contact details.

6.8.4   *Justice*

To ensure a research study is ethical the issue of justice must also be ensured. The term refers to fairness and the importance of placing the needs of the participants before the objectives of the research. Within my study at no time were participants coerced or made to feel compelled to take part in the study.   Participants were given approximately three weeks to consider their role between my first contact, signing the

consent form and data collection. All participants who were eligible and who consented were included.

6.9   Data analysis

6.9.1   Transcribing and storing data

Each interview was transcribed verbatim by the same audio typist. I verified each transcript for accuracy against the audio recording. A few errors were detected particularly relating to the medical jargon verbalised by the participants, which was corrected. I read and re-read each interview in its entirety. I also transferred the audio recordings on to my I-Pod, and listened to each audio recording several times. Passwords were applied to all electronic devices used, including digital recorder, laptop and I-Pod. On completion of data analysis I deleted all audio files from the digital recorder, my laptop and I-Pod. Transcripts were also shredded thereby all data were held in accordance with the terms of the Data Protection Acts 1988 and 2003, as legislated in Ireland.

6.9.2   The process of analysis

The process of hermeneutic phenomenological analysis is iterative and non-linear (Diekelmann and Ironside, 1998), it coexists and interweaves with further data collection. Broad, sweeping themes were identified initially across the transcripts with the aid of MAXqda2, a computer software package, which I used for data management only. Once initial patterns in the data began to emerge I discontinued using MAXqda2 and commenced writing interpretive summaries and explicating the participants' central concerns. I did however find MAXqda2 an effective tool for locating key excerpts. Once I'd provisionally identified the central concerns, I discussed them at length with my supervisory team[18]. With the aid of my team I brain stormed, debated and further discussed the interpretations by always going back and forth to the transcripts and my interpretative summaries. A team approach is advocated by Crist and Tanner (2003). Although they emphasis it is not a requirement for analysis in hermeneutic interpretive phenomenology, it can nevertheless add depth and insight on this interpretive journey.

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[18] Professor Soo Downe, Professor Fiona Dykes and Dr. Gill Thomson

6.9.3 *The final interpretative meeting*

In interpreting the participants' experiences of postnatal care it was critical that the meaning of the participant's stories was told. To foster this, I organised an interpretative meeting for all the participants on 12th January 2010. All the participants across both research phases were invited; unfortunately four of them were unavailable to attend. I began by telling a number of the individual stories as I had '*crafted*' them from the raw transcripts (Smythe, 2011 p. 43). I then highlighted the patterns that emerged from the data and presented the central concerns of the participants as I'd interpreted them. Participants were encouraged to ask questions throughout the meeting, to point out unclear elements of my interpretation or identify aspects that were not included. The meeting was important as it gave me further insight and helped me unpick intricate parts of the text. Plager (1994) points out that the interpreter must remain open to new interpretations as they arise in the natural context of everyday life. Understanding for Heidegger is crucial, as Palmer explains:

> *Understanding is the basis for all interpretation; it is co-original with one's existing and is present in every act of interpretation* (1969, p.131).

Thus understanding the women's lived experiences was fundamental. Yet, not all interpretive accounts will ring true for every participant (Plager, 1994) as each experience and the related issues are different. Nevertheless the majority of the participants nodded and verbally agreed with my interpretations.

Essentially, the participants acknowledged that the language I'd used reflected the essence of what they had 'meant', in the telling of their experiences of postnatal care. This acknowledgement Smythe *et al.,* (2008) comment is:

> *'graced moments', ...when there is a shared sense of belonging to the insight that seems to go beyond what was said, yet is felt and understood as 'being true'* (p. 1396).

Smythe *et al.,* cite Crowe (2006) explaining that Heidegger originally used the term '*graced moments*' in a letter to Elisabeth Blockmann in 1919, to describe how narrated experiences can resonate immediately with how life is lived. Gadamer (1989) calls this recognition of mutual understanding a '*fusion of horizons*'. The term horizon was used by Nietzsche and Husserl and refers to our thought processes and how our span of

vision can be gradually expanded. The concept *'fusion of horizons'* for Gadamer is a process of enhanced understanding between our horizon from our encounters of the past (our historicity of understanding) overlapping with our horizon of the present. Similarly, Palmer (1969), in defining the hermeneutical experience comments that it is an encounter between a *'transmitted text and the horizon of the interpreter'* (p.207).

The following is an outline of the analytical framework that guided this hermeneutical analysis.

6.9.4 *The analytical framework*

The hermeneutical analysis I undertook for both the group interviews and the individual interviews was guided by the nonlinear approach proposed by Crist and Tanner (2003). These authors highlight a number of phases that can be followed, to assist in this interpretive process as systematically as possible, though the authors stress that the phases often overlaps. A summary of the phases are as follows:

Phase 1. – Early focus and lines of inquiry: This includes a critical evaluation of the interview and field notes within the transcripts. Subsequent interviews are conducted as informed by initial interpretations and also direct future sampling to provide deeper, richer understanding.

Phase 2. – Central concerns, exemplars and paradigm cases: The interpretive researcher or team identify central concerns, important themes, or meanings that are unfolding for specific informants. This process begins with interpretive writing of approximately 3-5 page summaries of central concerns with salient excerpts. A review of new or revised summaries may cause exemplars and paradigm cases to emerge. Exemplars are excerpts that define common themes or meaning across informants, whereas paradigm cases are vibrant stories or strong instances of particular patterns of meaning.

Phase 3. Shared meanings: As informants' central concerns become clear, the researcher/ team members observe shared meanings within and across stories.

Phase 4. Final interpretations: Subsequent interpretive notes and summaries continue to provide a line of inquiry for current narratives and future sampling. In-depth interpretations are developed and final interviews address pending lines of inquiry.

Phase 5. Dissemination of the interpretation: This phase continues to follow an iterative process between the narrative, field notes and input from the researcher/team, as interpretations are refined for publication.

6.10 <u>Ensuring rigour</u>

Within the scientific world of ensuring rigour, validity and reliability are often the chosen method to assess the quality of research. These forms of rigor are not appropriate in Heideggerian hermeneutic phenomenological research, as human lived experience cannot be measured or tested. Factors that contribute to the rigor of a hermeneutic phenomenological study include:

> *'the inevitable retrospective and historical nature of interpretive work, the involved and time-consuming need for studying participants in their everyday situatedness, and the arduous commitment involved in interpreting the text'* (Plager, 1994, p. 77).

Whilst being guided by Crist and Tanner (2003) analytical framework as highlighted above (see section 6.9.4) I took time to identify the interpretative decisions as they were made. These were noted and became part of the research log. Clearly, the hermeneutic phenomenologist must ensure that he/she does not misinterpret the participants' responses (Heidegger, 1962).

Some authors have provided a guide to promote rigour in hermeneutic inquiry. For example, Koch (1996) has published a guide for trustworthiness. Rolfe (2006), Packer and Addison (1989), and Madison (1988) offer an evaluative approach to assess the truth of an interpretative account. Packer and Addison (1989) suggest that the hermeneutic circle is a process between interpretation and evaluation. They propose that the hermeneutic circle has two components - a forward arc of projection (the researcher's interpretation) and the return arc of uncovering (an evaluation of an interpretative account). Plager (1994) presents a critique of these two evaluative approaches, suggesting that Packer and Addison's (1989) guidelines deal with issues

that can be external to the text and do not appear as comprehensive as Madison's. In addition, Plager (1994) claims that Madison's nine principles for evaluating interpretative accounts are consistent with the philosophical underpinnings of Heidegger. Heidegger himself stresses the importance of maintaining the contextual and temporal nature of an interpretative account when he wrote:

> *'Whenever a phenomenological concept is drawn from primordial sources, there is a possibility that it may degenerate if communicated in the form of an assertion. It gets understood in an empty way and is thus passed on, losing its indigenous character, and becoming a free-floating thesis'* (Heidegger 1962, P. 61).

In particular, the interpreter must stay in tune with the philosophical underpinnings of hermeneutic phenomenology (see the fore-structure of interpretation, section 5.5). If not, the interpretations revealed or uncovered may be perceived as an assertion. Madison's principles are detailed within the following section.

6.10.1 *Madison's principles*

Madison's (1988) principles for evaluating interpretations from a hermeneutic phenomenological study as outlined by Plager (1994) were adhered to within my study;

- *Coherence:* the account presents a unified picture including letting contradictions show up and making as much sense of them as the text will allow

- *Comprehensiveness:* the account must give a sense of the whole that is the context (situatedness) and temporality for the participants

- Penetration: the account 'attempts to resolve a central problematic' (p.29)

- *Thoroughness:* the account deals with all the questions posed

- *Appropriateness:* the questions must be those raised by the text itself

- *Contextuality:* the historical and contextual nature of the text must be preserved

- *Agreement:* the account must agree with what the text says (not attempt a hermeneutic of suspicion) but should reserve room for reinterpretation by showing where previous interpretations were deficient.

- *Suggestiveness:* a good understanding in the interpretive account will raise questions to stimulate further interpretive research.

- *Potential:* the ultimate evaluation of the account '*lies in the future*' in that it '*is capable of being extended*' (p. 30): that is, insights, tact, and critical discussion are revealed and possibilities uncovered that can be illuminating for future events.

My adherence of these principles of rigor is translated throughout this thesis. In regard to the principle of *coherence and comprehensiveness*, the women's stories were told from their aspirations, and their lived experiences. The stories were formed subsequent to the validation of the transcripts with the women's central concerns and main thematic areas being illuminated using excerpts, examples and when appropriate paradigm cases (see chapters 8-12). On several occasions my supervisory team and I reviewed the analysis in its entirety. Diekelmann and Ironside (1998) encourage this approach to hermeneutic analysis to expose '*unwarranted interpretations that are not supported by the texts*' (p. 2). On rare occasions when divergent, yet related themes emerged from my analysis, these contradictions were explored and their significance discussed. The interpretations were also confirmed by the participants (see section 6.9.3).

The principle of *penetration* refers to the purpose of the hermeneutic phenomenological study, and the need to address specific central concern(s). Chapter two outlines the issues and challenges for a new mother specifically, the impact of childbirth on women's health, the evidence highlighting women's dissatisfaction with postnatal care and the dearth of research, in particular qualitative research. In my analysis I present the common experiences and shared meanings of postnatal women to penetrate and illuminate the participants concerns.

In my interpretative account of the 39 interviews (6 group interviews and 33 individual interviews) I demonstrate the principle of *thoroughness* and *agreement* by ensuring that

the participant's stories were captured in detail as highlighted in chapters 8-11. Additionally, the continued iterative process of interpretation evoked further questions to emerge from my initial illumination of the women's central concerns. Taking a fresh look, as encouraged by Smythe (2010) I asked myself, '*What is this saying*'? The outcome resulted in further in-depth interpretation as presented in chapter 12 where I highlight the main thematic themes of *Inauthentic care*, *Authentic care* and *The Sparking Gems*.

All interpretations are based on the background context, as defined by Heidegger's term '*fore-having*' (see section 5.5). The researcher has therefore a key role and needs to turn a critical gaze towards themselves and how they may have impacted on the research (Finlay, 2003) (See Chapter 13 for my reflexive account). In addition, a critical discussion of the historical influences relating to the current provision of postnatal care in Ireland is presented in Chapter 3. This section preserves the participant's lived experiences within a temporal and *contextual* interpretation.

In relation to the principle of *suggestiveness,* chapter 13 proposes future interpretive research based on questions that have arisen from my interpretative findings. Finally, the *potential* of my interpretations to influence the delivery of postnatal care in the future are also suggested in chapter 13.

Hermeneutic research is circular and never ending. Interpretations are therefore tentative, following the assumption that no single correct interpretation exists. However final interpretations are often called upon or alluded to (Crist and Tanner, 2003). Nevertheless, Diekelmann and Ironside (1998) comment that the readers of the research report are the ones who often make the final interpretation. Rolfe (2006) supports this view stating that '*individual judgements of individual studies*' (p. 309), is the optimal method for assessing the quality of qualitative research.

My interpretations have emerged from the text, aided by my iterative engagement with a board range of literature and my continued thinking, writing and rethinking. Smythe's (2010) recent hermeneutic analysis of care in childbirth (which focused on the interpretive nature of safety) noted that:

Things happen, or do not happen, without necessarily input from any health professionals. Such 'things' may be so inconsequential that they are seldom mentioned, or may be taken-for-granted as 'that's just the way things are' with little consideration of how it feels to live through such events. The 'things' may not affect the physical well being of the mother or baby, or they may have the potential for serious consequences (p. 1475).

It is these seldom mentioned, taken for granted events that I reveal in my interpretation of the common practices and shared meanings of postnatal care. By rethinking postnatal care in this way I disclose the common practices that need to be eradicated or discontinued because they are either unnecessary or detrimental. At the same time I will bring to light the postnatal care practices or events that are beneficial and valued by new mothers in terms of their lived experience.

6.11 Summary

This chapter began by clarifying the research question, research approach undertaken along with presenting a discussion of the age range and type of participants included in the study. Other sections presented in this chapter include a critical discussion on: Gaining accessing and ethical considerations, the sampling population and sampling method, the recruitment process, data collection, analysis and the interpretive process undertaken in this research. The next chapter is an introduction to my interpretative findings outlined in the subsequent chapters (chapters 8-12). It also presents a brief description of each of the participants.

7.0   Chapter Seven: Introduction to the Interpretations

Within the previous chapter detail of the research process undertaken in this study is outlined.

7.1   Introduction

In this chapter, an introduction to the interpretations is presented.   Initially, this preamble presents an overview of all the participants engaged in this study, providing a contextual background to their narratives.   The following section provides an introduction to the subsequent chapters, the interpretative findings and outlines how they are presented in the latter section of this thesis.

Initially, 25 participants commenced this research across both phase one and phase two. At the outset of phase one, six primigravid women and five multigravid women undertook the first of three longitudinal, group interviews. Subsequently in phase two, seven primigravid and six multigravid women participated in the first of three longitudinal, individual interviews (see table 7). As highlighted in section 6.6 a small number of women withdrew from the study or were excluded.   All women's, (partner's and infant's) names have been replaced by pseudonyms throughout this study and only brief contextual data has been presented below in order to ensure the confidentiality of the participants. All participants are of Irish ethnicity.

7.2   Phase one, participants – primigravid group interview

Participant 1: *Grace* is a 37 year old, married woman who works as a bank manager. Grace attended a private obstetrician for her antenatal care. She initially received her postnatal care on a public ward and after approximately six hours she was transferred to a private postnatal room. On discharge home Grace's postnatal care was directly transferred to the PHN.

Participant 2: *Maura* is a 25 year old, single woman who lives with her partner. She works as a Brand Ambassador. Maura accessed the public, DOMINO maternity care option for her antenatal and intrapartum care. Following delivery Maura stayed

overnight on the postnatal ward and was cared for by a member of the DOMINO care team in conjunction with midwifery staff attached to the postnatal ward. On discharge the DOMINO midwives cared visited her at home daily for five days and subsequently her care was transferred to the PHN.

Participant 3: *Rosin* is a 32 year old, married woman who lives with her husband and mother-in-law. She is employed as a planning inspector. Rosin availed of the public, DOMINO maternity care option for her antenatal care. Following an emergency caesarean section delivery (for fetal distress in the first stage of labour) Rosin was excluded from the postnatal follow-up data collection.

Participant 4: *Paula* is a 36 year old, married woman who lives with her husband. She works as a structural engineer. Paula attended the semi-private consultant-led antenatal clinic and received her postnatal care on the public ward. On discharge home her postnatal care was transferred directly to the PHN.

Participant 5: *Bronagh* is a 32 year old, translator. She is married and lives with her husband. She attended the 'midwives clinic' for her antenatal care and following delivery received care on the public postnatal ward. On discharge home the PHN commenced responsibility for her care.

Participant 6: *Amy* is a 35 year old, artist. She is married and lives with her husband and step-son. Amy accessed the combined public antenatal maternity care service, whereby she had alternating antenatal care with her G.P. and hospital doctor in the public out-patient department. On discharge home her postnatal care was transferred directly to the PHN.

7.3 Phase one, participants – multigravid group interview

Participant 7: *Carol* is a 33 year old, woman who works as a classroom assistant. She is married and lives at home with her husband and three sons. Carol attended the semi-private consultant-led antenatal clinic and received her postnatal care on the semi-private ward. On discharge home her postnatal care was transferred directly to the PHN.

Participant 8:   *Sinead* is a 36 year old, woman who is employed as a development worker. She is married and has a two year old daughter. Sinead participated in the multigravid antenatal group interview and then withdrew from the study for personal reasons.

Participant 9:   *Rose* is a 35 year old, woman who lives with her husband and one daughter. She is a self-employed solicitor. Rose received her maternity care from the DOMINO community midwifery team and had a vaginal breech delivery of a baby boy at full term. She received continuity of care from the DOMINO team until she was 7 days postnatal, subsequently the PHN took over her care.

Participant 10:   *Claire* is a 37 year old, housewife who lives at home with her husband and two daughters. She attended a private obstetrician for her maternity care and initially commenced her postnatal care on an extra bed placed beside another woman as the hospital was busy. Within a few hours she was then transferred to a private postnatal room and on discharge home was directly referred to the PHN.

Participant 11: *Lisa* is a 33 year old, married woman who has one daughter aged three. She is employed as a part-time management consultant. Lisa attended the DOMINO community midwifery team and stayed overnight on the public postnatal ward. The following day she was discharged and received postnatal care up to Day 4 post birth when she informed the team that she no longer needed their care. The team then withdrew their services and referred Lisa to the PHN.

Participant 12:   *Deirdre* is a 26 year old, single woman. She lives at home with her partner and three year old son. Deirdre participated in the multigravid group interview but then withdrew from the study because of personal reasons.

7.4   **Phase two participants – primigravid individual in depth interview**

Participant 13: *Sarah* is a 33 year old, single woman who lives with her partner. She is employed as a teacher. Sarah attended the antenatal midwives clinic and received her postnatal care on a public postnatal ward. On day two postnatally, she was discharged home to the care of the PHN who first visited her on day six.

Participant 14: *Siobhan* is a 34 year old woman who lives with her husband. She works as a personal assistant. Siobhan attended a private obstetrician for her antenatal and intrapartum care and obtained private postnatal accommodation in the hospital. On discharge she was referred directly to the PHN.

Participant 15: *Annie* is a 36 year old, married woman who worked as a lecturer in nursing. She attended a semi-private consultant-led antenatal clinic and received her postnatal care on the semi-private ward. On discharge home her postnatal care was transferred directly to the PHN.

Participant 16: *Joan* is 27 year old, single woman who lives with her partner. She is an employed office worker. Joan attended the midwives clinic and received postnatal care on the public ward, she stayed for two nights. On transfer home the PHN undertook her care.

Participant 17: *Lauren* is a 30 year old, woman. She is married and lives at home with her husband and step-daughter. Lauren attended a private obstetrician for her antenatal care and following an emergency caesarean section for prolonged labour she was excluded from the postnatal follow-up data collection.

Participant 18: *Bridget* is a 25 year old, woman who works as a hydrogeologist. Following an elective caesarean section for breech presentation she was excluded from the postnatal follow-up data collection.

Participant 19: *Eileen* is a 32 year old, housewife who accessed the DOMINO maternity option. She was discharged from the hospital seven hours after delivery and a member of the DOMINO team provided postnatal care for her and her infant for the first 5 days at home. The PHN then undertook responsibility for her postnatal care.

7.5 Phase two participants – multigravid individual in depth interview

Participant 20: *Colette* is a 36 year old, married woman who works as a bank clerk. She has two boys aged four and five and a girl aged two. Colette attended the semi-private consultant-led clinic on this pregnancy and received her postnatal care on a semi-

private two bedded room where she convalesced for 48 hours. The public health nurse visited her once at home on her fourth day postnatal.

Participant 21: *Marie* is a 38 year old, marketing manager and is married to John. They have an eighteen month old girl. Marie attended a private obstetrician for her antenatal and intrapartum care. After a brief period of time on the public postnatal ward she was transferred to a private room where she stayed for approximately 36 hours. Marie's care was transferred to the PHN who visited Marie and her baby once on the third day after she came home.

Participant 22: *Jane* is a 36 year old, housewife and mother of two sons aged four and six. Jane also attended a private obstetrician for her antenatal and intrapartum care. After spending a night on the public postnatal ward she was transferred to a private room. The PHN commenced Marie's postnatal care at home after receiving the referral from the hospital.

Participant 23: *Catherine* is a 37 year old, woman who is married with a daughter of three years of age. She is employed as a bank manager. Catherine attended the semi-private consultant-led antenatal clinic and received her postnatal care on a five bedded postnatal ward. On discharge home Catherine's postnatal care was directly transferred to the PHN.

Participant 24: *Mary* is a 29 year old; woman who is married with a two and a half year old son. She is employed as a shop assistant. Mary attended the public consultant-led antenatal clinic and following delivery stayed overnight on the postnatal ward. As for the majority of the participants, Mary's postnatal care was directly transferred to the PHN on discharge.

Participant 25: *Rebecca* is a 38 year old woman, married with a three year old daughter. She attended the semi-private consultant-led antenatal clinic. I undertook an individual interview with her when she was 37 weeks pregnant. Unfortunately, Rebecca delivered a still born baby boy (RIP), four weeks later. I was informed by the midwife caring for her on the postnatal ward and wrote a letter of sympathy to Rebecca.

The remainder of this chapter below describes the subsequent presentation in the forthcoming chapters of the interpretive findings, synthesis and discussion.

7.6   Presentation of interpretative findings

Having outlined the philosophical underpinnings of Martin Heidegger's work and described the approach to data collection and interpretation, the next five chapters present the findings from this hermeneutic phenomenological research. After dwelling with the data, living the constant circular process of reading, thinking, writing and reflecting, the findings are presented in a way that demonstrate my evolving trajectory of thinking with the aim of *'uncovering understanding towards building an argument'* Smythe, (2011, p. 47). An overview of my hermeneutic interpretive findings including, the themes and sub-themes is presented in Figure 2, below. The headings in Figure 2 are colour coded and represent the integration of the findings illustrated in blue in Figure 3 (The aspirations for and expectations of postnatal care) and those illustrated in light green in Figure 4 (The lived experiences of postnatal care). The third heading in pink (Varied modes of solicitude experienced during postnatal care) refers to the final process of in-depth analysis undertaken. The sub-themes are critically discussed in detail in chapter 12.

| Aspirations for postnatal care | Lived experience of postnatal Care | Varied modes of solicitude experienced during postnatal care |

'Becoming' Family

The first shower
The birth of a mother
The birth of a father

Presencing

Seen or not Seen

Privacy versus exposure

Inauthentic Care

Breastfeeding help and support

Saying what matters

Idle talk

Authentic Care

Dispirited perception of postnatal care

Checked in but not always checked out

Hurried care

The Sparkling Gems

The struggle of postnatal fatigue

Figure 2: An overview of hermeneutic interpretive findings

7.7 Key codes

A number of symbols have been used in the presentation of quotes throughout the remainder of this thesis. An overview of these codes is presented in Table 8 below:-

Symbol	Meaning
Pn-	Participant number
Int-A	28-38 week antenatal gestation interview
Int-B	2-8 week postnatal interview
Int-C	3-4 month postnatal interview
ln:	Line number
[….]	Contextualised meaning added
...	Dots indicate a break in the text
(….)	Non-verbal observations recorded (laughter, tears, sighs)

Table 8: Symbols used within text narratives

7.8 Presentation of the interpretative findings

Chapter eight includes my interpretation of the shared meanings of the women's aspirations for/expectations of postnatal care. Three themes emerged: 'Presencing', 'Breastfeeding help and support' and 'Dispirited perception of postnatal care'.

Chapter nine begins with an introduction to the five main themes that evolved from the data and illuminate how the women experienced their postnatal care, these are: 'Becoming Family', 'Seen or not seen', 'Saying what matters', 'Checked in but not always checked out' and 'The struggle of postnatal fatigue'. The remainder of chapter nine presents the theme 'Becoming Family' which uncovers the women's convoluted and challenging journeys in early motherhood as they focus on becoming a family.

Chapter ten presents two of the main themes, and begins by presenting the theme 'Seen or not seen'. This theme illuminates how the women's care needs were either noticed or overlooked. Directly related to this theme is the context of where the postnatal care is provided, as captured by the sub-theme 'Privacy versus exposure'. The following theme 'Saying what matters' reveals how the women experienced appropriate and inappropriate verbal and non-verbal interactions from their postnatal carers, the subsequent impact of these experiences on the women is also disclosed.

The fourth theme 'Checked in but not always checked out' (outlined in chapter 11) relates to how some of the women experienced a 'tick box' approach to their postnatal care while others experienced a thorough approach and consequently were 'checked out'. The last theme illuminates the women's struggle with postnatal fatigue as a new mother and reveals the extreme challenges it presents in their new world of motherhood.

Chapter 12 presents a further in depth interpretative synthesis of the meanings Irish women give to their experiences of postnatal care. A philosophically based discussion is presented as to how postnatal carers' act inauthentically or authentically in their everyday practices, thereby leaving a consequential impact on new mothers and their families.

Chapter 13 presents a discussion centred on how the insights from this research may influence and create future possibilities to improve postnatal care practice and research. The limitations of this study are highlighted followed by my reflexive account.

Throughout these chapters excerpts and when appropriate paradigm cases are used to highlight and frame the findings as they are presented. Along this interpretative journey, I interweave theoretical and philosophical writings from a number of authors, predominately Martin Heidegger to aid my thinking. Smythe *et al., (2008)* comment that philosophical writings can unlock a new way of thinking about the data that goes beyond our current thoughts.

8.0   Chapter Eight – Aspirations for & Expectations of Postnatal Care

Three main themes were shared by the participants regarding the care that they hoped and expected to receive following childbirth.   These included: '*Presencing*', '*Breastfeeding help and support*' and for some women, a '*Dispirited perception of postnatal care*' (See figure 3 below)
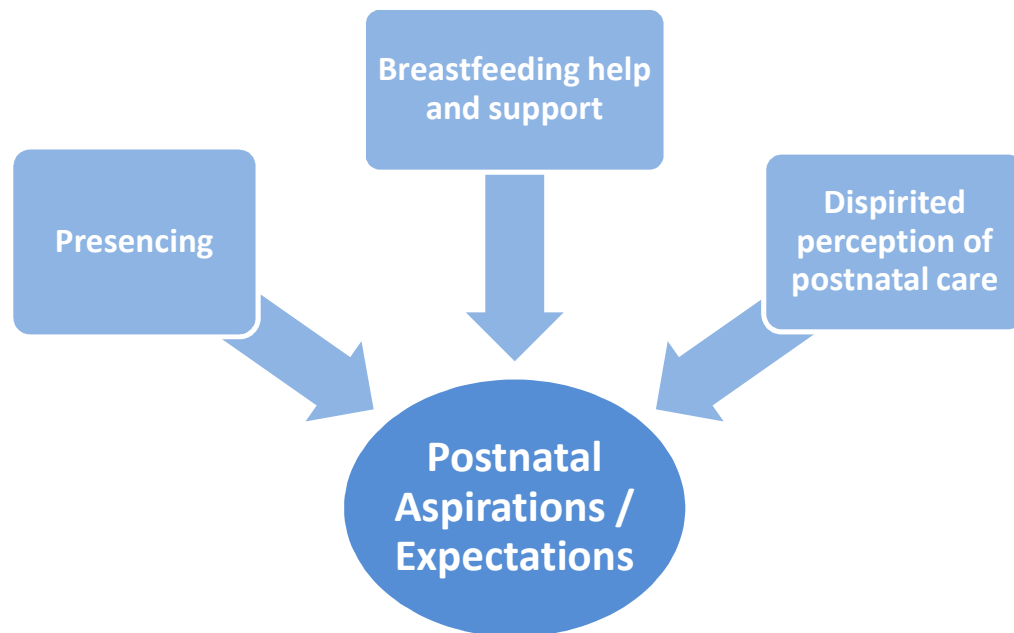
Figure 3: Women's aspirations for/expectations of postnatal care

8.1   Presencing

Many of the women talked about their desire to receive postnatal care from someone who had a presence, someone who would actively listen to their concerns, no matter how trivial. Bondas-Salonen (1998) refers to Eriksson's caring theory and notes that the caring communion, or therapeutic relationship between the carer and the patient is where there is a true presence, that can alleviate suffering and '*aims at helping the patient to be*..' (p.167). The majority of the women aspired to receiving this type of presence, above and beyond the medical care they assumed would automatically be provided. Roisin explains:

'I'm not talking about the medical care because I suppose I'm assuming that that's going to be there, what I want is over and above it, what I'm expecting is the emotional support. And that somebody will be there to say you're doing grand, keep going... I suppose someone who'll be there to listen, you know, and that there's gonna be a physical presence there, other than just Mark and I sitting there panicking, thinking are we doing things right and that there's just somebody there at the end of the phone or in the house or whatever, just to listen... Just a physical presence!'
(Roisin, int3A, 96-111)

Another woman (Amy) tells her story of how she would like to experience a presence from her postnatal carer, in contrast to a recent experience as highlighted below:

'I had an experience when I was getting my scan done, I was quite concerned that, I was taking a magnesium supplement and I didn't know if that was okay... I read in some books it was fine and others not so good. So I was asking the [health professional] who was doing the scan if she knew, if that vitamin supplement was ok and she said I don't have time to answer that, ask your GP the next time that you go. I just felt really vulnerable and I couldn't ask another question. When I visit my GP it's such a contrast, she's incredibly sensitive and just really, really listens to every tiny little voice so you don't feel anything is trivial or silly. And that's really important, you know!'
(Amy, int6A, 333-351)

Heidegger (1968) notes that '*Entities are grasped in their being as 'presence'; this means that they are understood with regard to a definite mode of time - the 'Present'* (p47). Thus according to Heidegger the task of understanding Dasein can only be accomplished in terms of temporality (time), that being their past, present and future. The use of the word '*and*' in the title of Heidegger's book '*Being and Time*' corresponds to this existential characteristic. The concept of presence in nursing has been defined as '*A mode of being available or open in a situation with the wholeness of one's unique, individual being; a gift of the self which can only be given freely, invoked or evoked*' (Paterson and Zderad, 1976, p 132).

It was important for the women in this research to experience the gift of 'presence' from their postnatal carers. Results from Berg's (2005) qualitative synthesis which focused on a midwifery model of care for women at risk, emphasised the importance

of midwives providing an 'enduring presence' for women. Berg confirms that an 'enduring presence' includes nearness and availability from both the emotional and physical perspective. Following Heidegger's notion of presence in relation to time, Berg and Dahlberg (2001) (a study included in Berg's synthesis) state, for a midwife to be available to a woman, her availability is always related to time, for example Berg and Dahlberg quote, *'I give her my time, show her that I have time for her. I stop and I sit down. …'* (p262).

Wanting to experience a presence from their postnatal carers for the women was not just about someone who would simply be present. Instead they aspired to meet carers who they could build a relationship with, someone who was knowledgeable, who had lots of practical experience, who would listen, not dictate and force their opinion. Annie reveals:

> *'I feel that it would be important that there's somebody or a couple of* [midwives] *who you could build a relationship with, who would listen to you, who were very knowledgeable and gave you lots of practical advice, lots of practical experience that they can use when they're advising you, suggest things for you to try but they're not telling you this is the way it is, and this is the way it has to be'* (Annie, int15A, 121-125)

I asked another woman (Catherine), who was pregnant with her second child to describe what she had meant by the term postnatal support as she had mentioned this term during her antenatal interview. She described postnatal support as:

> *'I mean emotional support primarily! I think with medical support they're ticking all the boxes. Emotional support is the need not to apologise for being weepy, or the need for somebody to identify that you're a little bit low and for them not to be rushed... For you not to feel that you're questions are ridiculous, because to you as a new mum or to you as the mother of a child bringing her home that's a 'big deal'! It's having somebody to engage with in a way that helps you realise it is okay, and calms you. So it's the manner and the delivery of the support that is important'* (Catherine, int23A, 455-465)

8.2   **Breastfeeding help and support**

A major concern for the women was that they wanted to receive breastfeeding help and support from their postnatal carer(s) as they wanted to do the best they could for their baby. Sarah stated:

> *'I really, really want help with skin to skin and initiating breast feeding as soon as possible after birth,that to me is a priority. I'm very flexible on any of the other things around postnatal care, but I think it's because my mum breastfed both of us and from a really early age she just kind of said to me, 'Why would people not breastfeed when you know all the nutrients is there, why would you pay somebody else to make inferior milk?' It's the only thing that I'm fixed on, that nothing gets in the way that would prevent breastfeeding from happening the easiest way possible, because I know it can be hard, so I've done quite a bit of reading around it. What I expect is that I'm gonna have somebody to listen to me before hand to know that, that's what I want to happen after the baby's born'* (Sarah, int13A, 32 – 44)

Forster and McLachlan's (2010) research provides the impetus behind why women want to receive help and support to breastfeed, and this is because they believe it will benefit their baby. Receiving professional help and support has been proven to be effective in increasing breastfeeding rates in the early postpartum period (Britton *et al.,* 2007).   Furthermore, research has shown that supportive behaviours from health professionals build the confidence of new mothers enabling them to breastfeed successfully, whereas inadequate support leads to early cessation of breastfeeding (Sheehan *et al.,* 2009).   Schilling Larsen *et al., (*2008) meta-synthesis focused on identifying what affected new mother's confidence for them to discontinue breastfeeding. Among the results the authors stress that for mothers to be supported to breastfeed, health professionals need to give them time and support in their postnatal surroundings. The new mothers need to feel they are being taken care of, so that they can care for their baby.

Unfortunately some women in this study had traumatic breastfeeding experiences in the past and these had a glaring influence on their aspirations for their forthcoming postnatal care. Below, Catherine reflects on her experience of inadequate breastfeeding support and expresses a strong desire for consistent breastfeeding help and support this time:

'While yet again the midwives and the staff are really nice, lovely people, the short fall with the postnatal care was the missing support for breast feeding, you almost had to beg for [lactation consultant] support, is that the right pronunciation? Eh and by the time a lady came down to me she was rushed, she was late, a lovely person as an individual but at that stage eh the breast feeding wasn't working out and I almost had a negative biased to it, subsequently by the time I left the hospital I hadn't breast fed. I'm nervous about it and that makes me feel nervous about going into it this time round. My husband doesn't want me to try it at all because he thinks that it was too traumatising the last time. And I'm nervous that I won't get the time from the staff to help me through it. I'm really ferociously reading my books, that's a worry for me going in to it so if I was to specify what I'm looking for I would like to see far more consistent support in breast feeding' (Catherine, int23A, 129-140)

8.3   **Dispirited perception of postnatal care**

This theme became apparent as the women told their stories from the context of their personal experiences and their knowledge of the current postnatal care service in Ireland. The women commented on how their aspirations for postnatal care would more than likely remain an aspiration and not be experienced by them. This often left them dispirited as revealed by Lauren, a first time mum-to-be:

'It would be nice if partners could stay, it would be fantastic postnatally if you could have your partner stay with you in the hospital, like in a midwifery-led unit, but that would be aspirational! I also think that to have a midwife coming into your home, would be better. Women shouldn't go home if they're breastfeeding until day three but that service really isn't available to them anymore unless they go private and pay for their extra stay in hospital! How long should a midwife call out to you? Well, a minimum of five days and aspirationally a woman on her first baby it would be fantastic if they could see somebody on a daily basis up to about ten days. It would also be fantastic if the staff that was looking after you in the hospital came to your house but that's completely aspirational!' (Lauren, int17A, 407-418)

Research from Beake *et al.,* (2010) on women's experiences and expectations of their postnatal care in an English maternity hospital supports this finding that some women expect a low level of postnatal care. Other recent research by Larkin *et al,* (In press) on

women's experiences of childbirth in Ireland also indicated how women appeared to accept the lack of maternal support as inevitable.

Sarah's comment (below) highlights how she is influenced by her maternity care experience to date and therefore has low expectations for her postnatal care, although she hopes to receive care and support to breastfeed:

> *'My expectations are pretty low I have to say I'm not starting from a point of expecting I'm gonna get an awful lot because that hasn't been my experience to date. So I've done a lot of reading myself, ...I just think I haven't really had a lot of input in my pregnancy so far from any midwife so I'm not expecting an awful lot but I'm hoping that they are gonna say 'yes she latched on, that's right, that's how it should feel, that looks right, that's how it should look'* (Sarah, int13A, 90-102)

The following chapter presents the findings from the women's lived experiences of postnatal care.

9.0   Chapter Nine – The Lived Experiences of Postnatal Care

From the hermeneutic analyses, five main themes were discovered and interpreted as the common practices and shared meanings of the women's lived experiences of postnatal care.   These were: *'Becoming Family', 'Seen or not seen', 'Saying what matters', 'Checked in but not always checked out' and 'The struggle of postnatal fatigue'*. The themes and sub-themes illuminate the women's postnatal care as it was lived from immediately following delivery until their baby was 3 months old (See Figure 4). Integrated throughout the interpretations below is a discussion of relevant literature utilised to further enhance the shared meanings generated. The rest of this chapter presents the overarching theme *'Becoming' family* and the three subthemes which underpin it, these are: *The first shower- starting afresh, the birth of a mother* and *the birth of a father.*

9.1   'Becoming' Family

The birth of a baby initiates the birth of a new family. The theme *'Becoming' family* emerged from the women's stories as they described the meanings and significances of their postnatal care experiences while on their journey to become a new family. van Gennep (1960), an anthropologist described in his seminal work *'The Rites of Passage'*, how pregnancy is a transitional period and stresses that:

> *'Returning to ordinary life* [post birth] *is rarely made at once; it, too, is accomplished in stages reminiscent of initiation steps'* (p. 43).

The overarching theme *'Becoming' family* became apparent as the women revealed their experiences of postnatal care, and explained how they attempted to navigate through different stages to become a family. The theme, *The first shower- starting afresh* will now be outlined followed by the themes the birth of a mother and the birth of a father.

Figure 4: Illustrates the interpretations of the women's experiences of postnatal care

9.2   **The first shower - Starting afresh**

The women highlighted the importance and significance of the first shower following the birth of their baby. The importance and longing to have the first shower was emphasised by most of the women. Below, Rose highlights the importance of the first shower for her to be '*clean'. S*he compares her experiences of being able to have a shower immediately following the birth of her son (her second child) to when she delivered her daughter after, having an epidural:

> *'A shower is so important, I felt so much better after him than I did after her because I was clean'* (Rose, int9A, 90-91)

Bronagh's story describes her strong desire and effort to have a shower following delivery, despite having had an epidural. She details her experience:

> *'I tried to get up and go to the bathroom and have a shower the morning after giving birth and the epidural hadn't worn off, I more or less collapsed on the floor dripping blood, I called out 'hello, I need help, I need help', the midwife and the care worker heard me and came in and were just very sympathetic. They cleaned me up and put me back in bed, helping me, in another situation it would have been a bit intimidating... but they were very professional and made you feel not in the least embarrassed about it, just great!'* (Bronagh, int5B, 156-165)

9.2.1   *The first shower provided time-out*

The shower also provided the women with time out for themselves having just experienced the intensity of childbirth. Time out allowed the woman to have a unique perspective on what had just happened, and what may come next:

> *'I really enjoyed that aspect, my partner had the baby in the room and I just went in and had a shower and I did take my time'* (Claire, int10B, 67-68)

The physical cleansing and washing in the shower was highly significant for the women as it symbolised the moving away from one phase (pregnancy and childbirth) and the entering into another (motherhood). Starting afresh for the women was

critical. The first shower post birth represented an important liminal[19] experience for the women as it created a liminal space between giving birth and becoming a new mother. The shower signified the end of one journey and the beginning of another. Siobhan explains:

> *'The shower was moving me on to the next phase, I was so excited, the end of one journey and beginning of the next journey – a new role. It made me stronger physically and emotionally'* (Siobhan, int14B, 55-57)

van Gennep (1960), (referred to above) developed a structure of ritual practices which mark significant events in people's life's. He used the concept of liminality and suggests that a rite of passage will follow three stages; *pre-liminal, liminal* and *post-liminal.* Pre-liminal is the stage which marks the break in the current status, for example, the moment of childbirth. '*The first shower*' for the women equates with van Gennep's liminal period allowing them time to reflect on their old status before coming to terms with their new status. For example, the shower allowed the woman time to reflect back to when they were pregnant before taking on their new role as a mother. The post-liminal phase is the reintegration of the postnatal woman taking on her new role and identity.

9.2.2 *The need for care and support*

The first shower was also significant to the women as it was a time, when they needed to be cared for. Some women expressed how vulnerable they had felt after delivery and how much they needed to be 'mothered'. Joan describes her experience:

> *'At the shower I felt I needed looking after as a woman, I needed someone to chat to as well in the shower; I couldn't have done it on my own.   I was vulnerable – I said to the midwife 'I'm just a vulnerable woman at this time'. She wheeled me down to the shower, she helped me wash my hair, put on my pyjamas and wheeled me back - that mattered to me'* (Joan, int 16B, 70-74)

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[19] The term liminal comes from the latin word *līmen*, meaning 'a threshold' (Oxford English Dictionary, 1989).

Another woman told of how she had experienced 'kindness' during the first shower:

'I was really very lucky with the midwives that I'd met, they were all fantastic, I had a lovely elderly lady to start with who I actually met before with my other daughter which was lovely. Her kindness was unbelievable, she did the first shower which can't be a pleasant experience for anyone, very kind, very thoughtful, doting on the baby, doting in me very much into the whole family thing' (Marie, int21B, 11-15)

Grace spoke of her surprise to experience such care:

'The midwife said you want a shower don't you? and I was like yeah and she said well just let me know when you want to go, your baby's fine there, she's fast asleep, I'll keep an eye on her and I'll bring you to the shower. She asked me if I needed any help, as she automatically helped me get my towel and wash bag. I'd felt ok and I thought 'well fair play to her' she was so thoughtful, I wasn't expecting that!' (Grace, int1B, 215-219)

The 'mothering' care that these women received during the first shower was nurturing and thoughtful. Being cared for in this sensitive way, enabled the women to begin to recover from delivery and start afresh as a new mother, assisting her on her journey to 'becoming' family. Walsh (2006) refers to this intuitive, nurturing care as *'Matrescence'*. The term was first used by Raphael (1973) in her classic text '*The Tender Gift'* and refers to the process of becoming a mother. Walsh's research involved ethnography of a free-standing birth centre in the UK, in 2004. He found the defining characteristic was matrescence where the staff nurtured the women helping them on their journey to new motherhood.

The women also spoke of their disappointment when they didn't receive matrescent care, having been left to wait for their first shower. Catherine was scathing of having to wait and expressed how having a shower for her was a basic requirement:

'The day I went into the postnatal ward I don't know it was a shift time change or whatever and by the time I could get a shower I was in the bed for about four hours. Really it's not a pleasant position and you're begging for somebody to give you a shower, and that's a basic requirement which is just too long to wait! And I had a catheter, so everything about you feels yucky and you know, it's a small thing to be

taken for a shower and to be supported to do that. I know that the girls just didn't have the time to give it to me earlier' (Catherine, int23B, 112-118)

Carol was more disparaging in her criticism during a multigravid group interview:

'I had no feelings in my legs, so they said I wasn't allowed to have my shower and I said 'that's fine'. So initially, when I arrived [to the postnatal ward] I didn't have the time to get into a nightdress, I was still in a shirt from earlier that day and it was covered in gunge, because as soon as he was born they put him straight onto my chest, which I wanted. I was covered in gunk and vomit and I wasn't allowed get changed until I came down to the ward. I said to the midwife, "can I get changed into my nightclothes?" and she said "you can't go for a wash because you've no feeling in your legs". I said again, "that's grand"! I knew I couldn't have a shower but time had passed and I should have kept on at them. I buzzed my bell at one stage because I was completely disgustingly covered in blood, the bed was actually ruined and I said "Would someone come and help me, even just to get on a pad", she said [a carer] "have you none of your own?" and I went "Oh God, I can't move my legs to get out and get the bag, I do!" I said, but "They're in that bag over there, can you get them?" so she did and she literally threw them at me! Now it wasn't a midwife, it was a carer of some sort, I don't know who she was because she had no uniform on, she was just in a white shirt, I thought I don't know who you are, but then the midwife came back.
Lisa -   *I think if women were more powerful that kind of thing wouldn't happen!*
Carol - *Like I had him at nine o'clock in the evening or ten past*
Lisa - *That's terrible.*
Carol - *It was hours, I even got to the stage were I had to say to her, 'just show me where the shower is, I'll go myself' and then you can't go by yourself, you have to wait!'*
        (Carol & Lisa, int7C & int11C, 460-479)

9.3   **The Birth of a Mother**

Raphael (1973) also referred to the term matrescence to highlight how birth, creates a new mother as well as a new baby. The sub-theme '*the birth of a mother'* came to light as it was the basis from which the women told of their postnatal care experiences. The following section will discuss the concept of the birth of a mother using the sub-themes: the unfamiliar/unknown nature of motherhood, the consequences of

unfamiliar motherhood, unreadiness-to-hand and the birth of a mother and the importance of taking care of yourself.

9.3.1 *The unfamiliar/unknown nature of motherhood*

The women in this study repeatedly emphasised how 'new' and unfamiliar they were to the role of a mother. Even the multigravid women emphasised this concern. Carol states:

> *'I have a gap of four nearly five years between Ben and Paul and I felt I'd forgotten so much in that length of time'* (Carol, int7B, 1263-1264)

As mentioned in chapter 5 (section 5.4.1), Heidegger believed that a fundamental feature of Dasein's experience is our familiarity or our background with the world that we live in. Our familiarity often leads to situations which we take for granted. Heidegger explains that we often become absorbed in our every-day activities because of familiarity (Heidegger 1962). In contrast, the new mothers' found themselves in an unfamiliar, new situation which often created maternal angst and feelings of vulnerability as they struggled to care for their new baby and 'become' family. Bronagh describes her unfamiliarity with newborn baby care:

> *'The thing that I really missed was somebody to tell you how to handle a newborn, because I had no experience of new born babies, and because it was so hectic in the ward, ...there was nobody who had the time to kind of sit down and go okay this is the baby, this is how you hold it, this is how you change its nappy'* (Bronagh, int5B, 49-52)

With other mothers describing the difficulty in interpreting their unknown newborn's cry:

> *'I suppose it's just new mother things, you're learning constantly, you're learning what, what the cry is, what the crying means and I'm still at that stage like, haven't a clue half the time'* (Annie, int15B, 166-167)

Lisa acknowledges the extreme vulnerability because of her unfamiliar situation after she gave birth:

'You realise when you've just given birth your vulnerability that you wouldn't see normally. It's the only time I've ever and maybe ever will be in such a vulnerable state' (Lisa, int11B, 317-318)

Amy also describes feeling vulnerable and afraid because of the unknown nature of her situation:

'I was feeling very vulnerable going home, I'm the youngest in the family so similarly I'd never even held a newborn baby, I didn't know, I thought she [the baby] was very congested actually in the beginning and I just kept staying awake for twenty-four hours because I was so afraid, her breathing was so strange' (Amy, int6B, 120-124)

9.3.2 *The consequences of unfamiliar motherhood*

Research on *'Maternal role development'* was first undertaken by Rubin in 1967 (1967a, 1967b) and later in 1984. According to Rubin (1984) this process is transformational, begins in pregnancy and involves the woman recognising and adopting her new role as a mother. The concept of maternal role development continues to be advanced by researches such as Martell (2001) and Squire (2003). In addition, Mercer's (2004) work has provided insight into the transitional experience of 'becoming a mother'. Clearly, some of the women who participated in this research found themselves abruptly in the unfamiliar role of new motherhood, which triggered maternal distress.

Carol tries explaining the concept of maternal distress in terms of a 'definite feeling' which is not helped with the sudden decrease in care:

'I think there is a definite feeling and it lasts and it still lasts now! It is that you're so well looked after up to having the baby and during birth and the minute you give birth it's like that's grand now, off you go, we're finished with you and, you know, get on with it' (Carol, int7C, 899-902)

Rose acknowledged how she had been in a state of maternal distress but had not realised it until her situation had changed and only then could she reflect on her previous mood:

'I didn't realize at first, I wasn't crying but I was constantly tense, it just came to me one evening when I suddenly said to my husband, oh! it's gone, I feel okay, because it was gone, he [the new baby, second child] *was asleep and she* [first child] *was asleep upstairs and I was like oh I'm me, it's gone, but I didn't even know it was there till it was gone, this constant tension! I wasn't in a fog, I wasn't in a haze, I wasn't crying but I wasn't relaxed at all, not at all. I really didn't realize how tense I was till suddenly I just wasn't one evening because things were going okay'* (Rose, int9C, 884-890)

Emmanuel *et al., (*2011) define maternal distress as a concept which describes in broader terms the emotional well-being of a new mother. The authors stress that it should not be viewed as a symptom but as a range of emotions that a women may feel post birth, for example, mild anxiety, sadness, tearfulness or postnatal depression. Utilising this perspective helps to look beyond the biomedical definition of emotional dysfunction. Maternal distress for some women however can inhibit maternal role development (Emmanuel *et al.,* 2011). Similarly, this hermeneutic analysis has revealed how becoming a mother can be distressing and cause instability on the journey to new motherhood and 'becoming' family.

9.3.3   *Unreadiness-to-hand and the birth of a mother*

Heidegger's (1962) philosophical explanation of our interaction with the world in his concept *unready-to-hand* (see section 5.4.1*)* helps us understand how a mother might experience maternal distress after the birth of her baby. *Unready-to-hand* pertains to a breakdown situation or a malfunction which we are forced to concentrate on. Blattner (2006) further explains that the concept is whatever challenges our ability for example, a new mother's ability to settle her crying baby. Heidegger claims that in an unready-to-hand situation we focus on what concerns us greatly, just as a new mother is concerned about how to care for her newborn baby. Enacting the role of a mother was challenging for Annie as she tells of her 'horrendous' experience of her first night at home:

'Our first night at home was horrendous because I really didn't know what to expect, because nobody told me what to expect and …, we didn't know what we were doing for changing and I got very frustrated and Michael got very frustrated on that first night because we didn't know how difficult it was going to be. And I suppose [the baby] *fed*

off that a little bit as well and he was probably a bit anxious as well and it was horrendous and I thought, I can't do this, I cannot do this!, this is just, I am too tired!, I am too emotional!, I cannot do this and Michael was the same' (Annie, int15B, 312-321)

Joan tells of her un-readiness to take on the role of a mother and recalls her moments of regret:

'You kind of look out the window and you're like God, but I wasn't prepared for this, it is such a life-changing experience... I was like have I made the biggest, I didn't think this through, have I made the biggest mistake of my whole life, I didn't think this through at all' (Joan, int16B, 451-454)

9.3.4 *The importance of taking care of yourself*

While grasping with the role of a new mother the majority of the women acknowledged the importance of looking after their own postnatal health and wellbeing. Gold (1997) states as a new mother, *'If you fall apart, everything falls apart...,taking care of yourself is not selfish, it's a necessity'* (p. 4). Women highlighted the importance of '*getting out of your pyjamas*', having a shower and putting on their make-up before starting the day:

'I was conscious of making sure that I got enough rest, that I had time to have a shower and brush my teeth and brush my hair and, get out of my pyjamas' (Grace, int1B, 231-232)

Colette also stressed the importance of taking care of '*yourself*' to stay healthy and reflects on the pressures on new mothers in contemporary society:

'You need to get yourself a good multi-vitamin, get your cabbage leaves, have that stuff there, instead of walking around like not knowing what to do...there is an awful lot of pressure now for women to be a certain weight, and everybody wants to be the perfect mother! It's not about that, it's about being healthy, making sure you eat, and looking after yourself, because it reflects on the children and if you don't, well' (Colette, int20B, 372-376)

Clearly, the women resonated with the pivotal nature of their new role within the family as suggested through the work of Dearman *et al.,* (2007). Annie comments:

> *'If you're not right then nothing is going to function properly in your home, and I realise that! In a family, really it's a mother who kind of brings it all together and knows how things operate and no matter how good any man is unless he's there all the time he's not gonna have a notion'* (Annie, int15C, 612-615)

Claire reflects from her personal experience of the implications of poor emotional health on her and her family:

> *'I suppose we can all sit here and talk about postnatal depression and talk about it in an abstract way but I mean the impact that it has on a couple and family is huge. When I had the severe baby blues on my first, my husband was looking at me like I'd been captured by aliens and replaced, you know, he didn't know how to deal with it because I couldn't, no-one could look sideways at me and I'd be bursting into tears. Now that only lasted a few weeks but, you know, if that turns into months or a year or longer or someone doesn't want to go and get help or whatever, I mean that would put a huge strain on a family'* (Claire, int10C, 854-861)

9.4   **The Birth of a Father**

In becoming family, the women's stories often give emphasis to how their partner[20] had also become a new father, with the birth of their baby. The following sub-themes explore this concept: significant and influential role of the father, unreadiness-to-hand and the birth of a father, unreadiness-to-hand and the impact on the relationship.

One woman stressed how her partner needed to bond with his child too, as he had just become a new father. Siobhan explained when I'd asked:

> **'Could someone else have helped you with the shower, your partner'**?

> *'I see postnatal care as three intertwined circles: the baby, the mother, and father/partner. Care for all three – I needed care, John needed care himself, and the baby.*

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[20] All the participants referred to their partners as male.

The father/partner needs strong postnatal care...John had other needs; he needed to swaddle the baby' (Siobhan, int14B, 65-68)

9.4.1   *Significant and Influential Role of the Father*

For the mothers, their partner was their significant other and often their main postnatal carer; someone who also endeavoured to hold their family together while they tried to recover. Claire and Rose recall:

'In the hospital you're expected to get on with it especially if it's your third , when I went home it was my husband who gave me a few nights rest...if you were on your own, I don't know how I'd have coped' (Claire, int10B, 110-112)

*'I'd spent the first week more or less upstairs, it was great! I got up and I moved around and I showered. David [*the partner*] was great he cared for Lisa [*first child*] the whole time, brought me up food and it was just me and him [*the newborn baby], that was great, my baby boom I called it'* (Rose, int9B, 302-305)

The influential role of the father became clear from Jane's story as she recalled how it was her husband who made her aware that her constant crying following the birth of their first child wasn't normal:

'I can remember crying from the time I went home, he was born in June, and I cried until Christmas, and he was such a good baby'

When did you eventually get help, for the crying?

It would have been January, because it was my husband he said "look I really don't think that this is, this is the way it was meant to be!" It was him who sat me down, and I went to the GP more for him, because I didn't realise, I thought this is how it is, well I have a baby, and I have a job, and this is probably just the way people are! I didn't realise that it wasn't the way things are' (Jane int22A, 320-326)

9.4.2   *Unreadiness-to-hand – The birth of a father*

A recently published metasynthesis by Steen *et al.,* (in press) on fathers' encounters with maternity care has confirmed that new fathers cannot support their partners in their transition to motherhood unless they themselves are supported, included and educationally prepared for their role. Some of the studies in this metasynthesis detail how fathers experienced excluding, dehumanising behaviour from maternity care staff. The authors conclude that fathers want to be authentically engaged and informed so that they can negotiate their own journey into fatherhood (Steen *et al.,* in press) and thereby '*become' family* by aiding their partner in her journey to motherhood.

As highlighted above in section 9.4.2. Heidegger's concept *unready-to-hand* can also help us understand how the immediate, life-changing event the birth of a baby can be for the father. Sarah details how her partner Sean wasn't prepared for his role as a new father and found it difficult to have a relationship with his daughter.

> '*Sean just didn't bond with her at all, I think only really in the last two weeks [baby now 13 weeks old] he's started to make some connection with her, he just said she's not like other babies, she doesn't smile, she doesn't look at you. She used to not make eye-contact; she was so distracted with the pain [colic]... Sean just used to say I just want my life back and that used to really hurt me because I'd think oh she'll be better, you know, and I was trying to make excuses for her saying she'll be better soon, it'll be gone in three months and then when three months came and it didn't go he was like I thought this was supposed to go, ...I mean obviously I found the crying hard, looking at her struggling but I didn't find it hard to make a relationship with her as such but Sean really did...*' (Sarah int13C, 232-241)

9.4.3   *Unreadiness-to-hand – The impact on the relationship*

The abrupt change in the everyday life activities of the mother and father following the birth of a baby can have a significant impact on their relationship. Carol explains how she and her husband hadn't been able to talk properly for a number of weeks following the birth of their baby:

> '*I think Alan was about three or four weeks before myself and my husband sat down and had a proper conversation*' (Carol int7B, 202-203)

Another women Lisa, having received postnatal care from the DOMINO team tells of how her relationship with her husband suffered after the birth of her baby. She stresses how important postnatal care was for her:

> *'I found that my relationship with my husband was terrible for those few days after the baby was born and if we didn't have the midwife coming to see the both of us, we might have 'split up', so the whole thing* [the postnatal care] *it just really important you know and I feel very strongly about that as Joe* [the new baby] *was sick and God knows what would have happened to him but it's, it's the biggest thing that has ever happened in my life and the better the postnatal care is for those first few days I think it sets you up for your family together'* (Lisa int11B, 114-120)

In summary, the theme *'Becoming' family* emerged from the text as the main goal for the women, as they revealed their experiences of postnatal care. The supporting sub-themes, *the first shower- starting afresh, the birth of a mother and the birth of a father* illustrate and uncover the meanings of their postnatal care experiences on their journey towards becoming a family. The next chapter focuses on the second theme *Seen or not seen* and the third *Saying what matters.*

10.0 Chapter Ten – 'Seen or not seen' & 'Saying what matters'

This chapter discusses the interpreted theme *'Seen or not seen'* and the sub-theme *'Privacy versus Exposure'*. The second section of this chapter will detail the third theme *'Saying what matters'* along with the sub-theme *'Idle talk'*.

10.1 Seen or not seen

This theme became apparent from the women's experiences as they described how the midwives and other postnatal carers either noticed or didn't notice their care needs. Bronagh explains what being noticed meant to her:

> *'It was about a day after my delivery and it was meal time on the ward, and I was fretting about my daughter, she needed to be fed or she was crying or something and the dinner had been set out and I wasn't eating it, and I think it was the* [the midwife manager] *noticed that and said to me 'you need to eat your dinner and you need to look after yourself and not kind of worry about your daughter the whole time, you know you need to mind yourself', and I thought that was great that she noticed and that she said it to me, and I think that helped me to think about myself as well for the next few days, if I don't look after myself I can't look after the baby, and I just thought yeah, it was great that she noticed'*

MH **Why was that significant to you?**

Bronagh:

> *'It kind of brought me back to reality and stopped me stressing out and yeah maybe it brought me back from just fussing, fussing, fussing about the baby and made me take a deep breath and realise that she's not going to starve if I leave her here for two minutes while I eat'* (Bronagh int5B, 390-409)

Maura also gives details of how she was *'seen'* and the care she subsequently received changed a negative experience into a positive one:

> *'We had to bring Michelle* [the baby] *back in as she was sick, and there was one midwife in the special care unit who just devoted so much time to us, I think she could tell how upset I was even though I knew Michelle was going to be ok, she could just really tell that I was stressed out and any chance she got she was over, explaining*

things to us, any questions we had we could go to her and she always had a smile on her face and I'd say that, even though the experience was negative because we had to come back in to the hospital with a sick child, overall it was positive because of the care we received from that particular midwife' (Maura int2B, 379-387)

In contrast, new mothers talked about feeling invisible on the postnatal ward not being '*seen'*. Claire explains how she'd felt like she had faded into the wallpaper:

'You know you get totally forgotten postnatally, it's like well we've done our job now, we've delivered the baby. I might as well have been invisible and that I'd faded into the wallpaper. The midwives weren't being in anyway mean towards me or anything, you know, they were perfectly nice and I was checked every day but there was no personal interaction this time, there was no, you know getting to know you at all' (Claire int10B, 590-594)

Claire's analogy of fading into the wallpaper as she sat on her hospital postnatal bed resonates with Charlotte Perkins Gilman's (1892) book entitled '*The Yellow Wallpaper'*; published following the birth of her daughter. The major theme of the book is the way Charlotte felt after being prescribed the '*rest cure'* which is a period of forced inactivity for the treatment of depression and fatigue. Although Gilman didn't agree with her diagnosis, her husband John enforced a period of rest as per her doctor's instructions and forbid her to continue her career as a writer and poet. She spent several days isolated in her room with nothing to do but look at the wallpaper. The isolation left her feeling that she was being watched by the wallpaper and as she scrutinised the wallpaper she could see a female trapped among the floral pattern. As time passed Gilman became insane from the enforced inactivity and began hallucinating that the woman she saw was her herself having faded into the yellow wallpaper. This sense of invisibility experienced by Claire and Catherine (below and section 10.1.1) left the women feeling overlooked and ignored:

Other mothers reported how they felt invisible, as their baby received all the care:
'I went for my 6 week check up to the doctor, he checked the baby, everything was on track but the doctor forgot to check me! I think when it's your second baby if you say your fine they kind of take it at face value, I was in and out of the doctor's in 10 minutes, 'disappointing' but if you didn't need it physically and I didn't need it

emotionally either but if you did I wonder would he have taken the time to find it out'
(Catherine int23C, 193-199)

10.1.1 *Privacy versus Exposure*

Another aspect of the theme '*Seen or not seen*' emerged from the obvious dichotomy experienced by women regarding their postnatal accommodation.   Traditionally, (as mentioned in section 3.3.3) a large number of women in Ireland choose private consultant obstetric care. An advantage of choosing this model of care is the private, comfortable postnatal accommodation available to them on payment; although a private room is not always guaranteed in some hospitals. On payment, women can also avail of comfortable, semi-private postnatal accommodation typically ranging from a two bedded room to a five bedded ward. The majority of women[21] in Ireland however, begin their postnatal care on a public ward with basic comforts and a minimum of five to six beds.

The women in this study revealed a huge dichotomy between the private and public postnatal accommodation in terms of the structural context in which they received their care.   For the women, private postnatal accommodation equated with an environment which provided personal space and '*privacy*' where they felt as being '*Seen*'. Whereas, the public postnatal ward for the women was associated with having to share space. On occasions, when the postnatal wards were very busy the women reported how the bedside locker would be removed and two hospital beds would be placed within the one bed space. Women had to share the one curtain or use portable curtains. When this happened the public ward became a place where the postnatal women experienced '*exposure*' of their physical and emotional self and their experiences appeared to be unnoticed and '*not seen*'.

Claire describes her experience of this unfair dichotomy as she is transferred from a public ward to a private postnatal room:

> *'Looking back to leave the labour ward and land yourself in a shared cubicle you know*
> *for the night, is definitely not something that should be! I did manage to get up to a*
> *private room because I was sharing a cubicle which meant I was out of that scenario*

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[21] Including women who use the limited DOMINO service.

but, if you're going to be lying awake for the night with you know three wards full of screaming babies and that's meant to be your recovery period after giving birth, I think it's a bit of a joke, to be honest! I think something needs to be done about it! I think every mother deserves the right to have a bit of rest and a bit of peace and quiet regardless of what scheme [private or public] *she's in, in the hospital you know, it shouldn't be a case of being more afraid of the post natal experience than the birth. For me, it was like the peace when I got up there! The peace and quiet was just, it was so nice, it makes you realise the difference between what most people are experiencing in the hospital'* (Claire int10B, 1011-1022)

Another woman talks about her feelings of *exposure* in the public ward:

'I found all the people and all the visitors just overwhelming, just crazy the amount of people, I'd a severe lack of privacy because at that stage I had just delivered and there were just too many people on the ward. For example even walking from the bed to the shower I felt quite uncomfortable, there were so many people around and you're in a nightdress, it's not good and then having another woman in the cubicle when I was trying to get changed it wasn't her fault' (Catherine int23B, 213-218)

Wren (2003) first commented on the continued, unfair and unequal access to the Irish healthcare system in her book '*An unhealthy state – Anatomy of a sick society*'. Little has been done in Ireland to increase capacity on busy public postnatal wards or regarding the two tier health-care system of private and public (other than the restriction of private practice in public hospitals (as mentioned in section 3.3.3) (Department of Health and Children, 2010).

Jane struggled with the unjust nature of the two-tiered postnatal accommodation she experienced:

'I felt there was a huge difference between the public ward and the private ward, and the semi private ward, a massive difference, even down to the food. And I just think it's wrong, it's so wrong' (Jane int22B, 176-178)

It is only by highlighting what matters to postnatal women that their situation may become '*Seen*'. As Heidegger (1962) confirms "*...it is itself the clearing*" (p. 171), *(*see also section 5.4.1) that brings to light the phenomenon.

10.3   Saying what matters

Many women in this study described their experiences of interacting with their postnatal carers. The women regularly commented on these experiences while they were discussing other aspects of their care. Particular interactions stood out for these women and mattered to them as they were vividly recalled.

Sarah details her first interaction with a midwife on the postnatal ward. Her story became a paradigm case highlighting what is said '*matters*':

> *'As soon as I got down to the ward I was met by this midwife who just, seemed to have gotten out of bed on the wrong side that day, she said to me 'right well we bath her' and so I said 'oh ok' I didn't really want them to take her away from me at that point and I said 'well I'd like her to, I'd like to try and feed her' and she said 'oh well we just wash her first' and I was thinking well surely that's not as important as her latching on. The midwife then said 'I'll check her temperature before I'll wash her' and then she said 'oh she's cold she has to go in the incubator!' and so I said 'oh ok then' then she said 'Maybe we'll just dress her' because I must have looked like I didn't really want her to go in the incubator so we just dress her 'where is her clothes?' she asked. So I opened the bag I had and I got out the clothes and the midwife said 'these clothes are far too big for her and all those scans you had'. She said 'you knew you were having a small baby why did you buy these for, you needed to buy tiny baby clothes'... and then she said 'oh give me what you've got!' so then she said to Sean 'and you get down the Street to Mother Care'. Within twenty minutes of arriving on the ward I had my baby taken off me to go and be dressed and Sean sent off, so I'm sitting on my own in a bed going 'where is my baby, where is my partner? I started to sort of get really emotional and I was all on my own and when Sean came back and I started to cry.*

> *They* [the midwives] *were obviously talking about me while they were having a break because I said could I have a hot pack because I was having like after pains, So she said 'oh no we don't have hot packs here that's the labour ward' so she offered me paracetamol or Ponstan and said 'oh you can have a hot shower' and then she said 'the student will come with you' and I said 'that's fine' so the student came with me and then the student said 'well I like your toes' because I had had a pedicure a couple of days before I gave birth and the reason I had a pedicure was because Sean was trying to stop me from doing things, we had just moved house and there was boxes everywhere and he wanted to stop me from unpacking boxes so he sent me off for a pedicure and a facial. So*

she said 'oh I like your' and then she laughed and she said 'oh you got time to have a pedicure but you didn't buy the right size of clothes so they'd obviously been talking about me when they were off on break.

They'd obviously been talking about me so then I just felt stupid and I felt like I'd been talked about and then I started to think but they don't know what's going on in my life and they don't know I just moved house and my mother in law just been diagnosed with cancer. So I kind of really resented this one then she [the midwife] *came back to me and said 'well right latch her on now' and I sort of was already thinking 'I don't like you I'm not listening to anything you say' ... and she latched her on and she said 'that's a proper latch' and then she said 'keep her on there for as long as you can' and then she started going a whole long diatribe about breast feeding'* (Sarah int13B, 23-69)

At the three month postnatal interview Sarah relayed the significance of her encounter:

'Well the story that I kept telling people afterwards was the story of how they sent Sean off down the Street for clothes for her and at that time how stupid I felt for not having the right stuff, that was the story that I couldn't get out of my head when people were saying 'what was it like' I was telling my visitors my immediate family who came in to see me what the midwife said to me, 'I felt so stupid' and then my sister in law brought in loads of tiny baby, baby grows for me that evening so that she [the baby] *would have something to wear that I didn't feel stupid putting her in'* (Sarah int13C, 76-82)

Sarah was left humiliated, belittled, mocked and crying. This interaction stripped Sarah of her self-confidence from the moment she entered the postnatal ward. Three months later, she vividly recalled the interaction and how she had felt '*stupid*' as she had internalised the words spoken to her. She was left dehumanised and her needs as a new mother abandoned. Thomson's (2011) research highlights the abandonment of being in childbirth in her interpretive phenomenological study into women's experience of traumatic birth. Thomson applied Heidegger's (1977) philosophical state of '*machination*' to explain how technological processes[22] and health professionals have the potential to manipulate and exploit women leading to an abandonment of being in childbirth. Polit (2003) describes Heidegger's world of '*machination*', as a world where

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[22] Heidegger did not want technology erased; instead he encouraged a balance where technology would help, not detract from nature. Polit (2003) confirms Heidegger wanted '*To use machines as they work with nature, instead of assaulting it*' (p. 174).

'beings become unbeings ... [and] the importance of everything is being destroyed' (p.142). For Sarah the importance of breastfeeding her baby immediately after she was transferred to the postnatal ward was taken away. The derogatory way she was spoken to was as if she was an 'unbeing', leaving her humiliated.

Amy tells of her immediate post birth experience:

> *'The baby had some trouble with her breathing when she was immediately born and that had been quite a stressful time, we didn't know what was going on, she wasn't being given to me, there was a lot of quietness, a lot of stuff happening in a corner and they were saying 'oh everything's fine', but there was an aura that everything was not fine! A lot of people had arrived and there was backs turned* [Health professionals at the resuscitaire] *and she was very quiet for nearly fifteen minutes, it was just all very stressful, anyway everything as you see is fine* [referring to her healthy infant], *but then while we were still in the delivery room one of the baby doctor's came back down and just casually said into the atmosphere 'oh God that baby gave us an awful fright', and I just thought, oh no so there was something really wrong and I just found myself getting all upset all over again just with the whole 'what if's'...*
>
> *Emma, the midwife, hadn't overhead so I'd said it to her and she immediately, she was so soothing, she said 'he never should have said that' and she was just very reassuring that it was an inappropriate thing to say'* (Amy int6B, 413-429)

The comment by the doctor was extremely thoughtless and insensitive. Amy was treated inhumanly, as if she was not present in the room. In contrast, the midwife was comforting and her acknowledgement of how inappropriate the doctor had been in announcing his fears, was reassuring to Amy.

10.4 Idle talk

It was highly important for the women that their postnatal carers (midwives and public health nurses) had a high level of knowledge before they would trust or indeed enter into any type of relationship. Marie (multigravid on her second child), notes the importance of *'saying what matters'* and begins by reflecting on the desired characteristics of a 'good' midwife:

'She needs to have a lot of knowledge, common sense and kindness, patience, a lot of those kinds of qualities in her personality. Knowledge is vital because it doesn't matter how nice they are, if they start coming out with rubbish to you about this or whatever, I just disengaged with them, they're talking about the most precious thing in your world [referring to her baby]' (Marie int21B, 169-173)

Marie explains further how she detected their level of knowledge in their '*Idle talk*' and either discontinued the interaction or commenced a conversation:

'You can tell almost by their [the midwife's] *facial expression when you ask them a question, if they were kind of a bit daunted by it* [or] *you can tell by them just offering advice without you asking it, like say Mary and the older knowledgeable midwives would give the advice without being asked, they would say something and you would go okay, I believe in what she's saying, I agree with that and she knows what she's talking about and you'd start a conversation. I was very aware of that this time'* (Marie int21B, 486-491)

Below, Amy illustrates the importance of effective interpersonal communication to enhance trust and foster a therapeutic relationship.

'I'm not going to accept advice from somebody I do not know because I won't trust them and because I've heard so much conflicting advice, I'm not just gonna talk to somebody who I don't have a good relationship with. I'll take advice, I'll take it or leave it but if I have someone who I know that I can build a relationship with, then I will share what I know, share what I've read and go well 'then why have I read this if you're telling me this and' then you can sort that out but if you're never going to see that person again I'm not even gonna bother telling them I've read this book or that book' (Amy int6B, 327-333)

Clearly, the women revealed how they could not tolerate '*idle talk*' as the consequences may be detrimental for the health of their baby or themselves. Heidegger (1962) defines '*idle talk*' as:

'In the language which is spoken when one expresses oneself, there lies an average intelligibility; ...the discourse communicated can be understood to a considerable extent even if the hearer does not bring himself into such a kind of Being towards what the discourse is about, as to have a primordial understanding of it' (p. 212).

Essentially, we as human beings often use language to talk about something that we don't really understand in depth, we also may not have first-hand experience of the particular issue. Talking in this way is just passing the word along and can lead to a '*closing off*' (p. 213) discouraging further questioning from the listener. Heidegger (1962) states that when:

> *Dasein maintains itself in idle talk, it is as Being-in-the-world cut off from its primary and primordially genuine relationships-of-Being towards the world, towards Dasein-with and towards its very Being-in. Such a Dasein keeps floating unattached; yet in so doing, it is always alongside the world, with others, and towards itself (p. 214).*

The women articulated on a number of occasions how their postnatal carers used *idle talk,* for example, when they gave them inconsistent information particularly about breastfeeding or verbalised slogans, in the case of Mary's experience below whose infant often cried with colic for four hours at a time:

> *'I just feel I never got to the bottom of the problem ... they'd* [PHNs) *accepted this thing that colic can't be fixed, it's something you've got to live through, and that's another slogan, that's another kind of thing that's said. So they didn't really want to go into my feeding regime... the public health nurse would just say things like, you can't overfeed a breastfed baby was what they kept telling me. So that's been my experience of having colic, you're kind of on your own. The bottom line is I don't think they care, as long as the baby is putting on weight and, you're not looking suicidal they're happy, they think they're doing their job and if your breastfeeding it's a bonus, you know, it's like they must get bonus points'* (Mary int24C, 113-124)

In summary this chapter details patterns of understanding under the themes '*Seen or not seen'* and '*Saying what matters'.* The following chapter will present the themes '*Checked in but not always checked out'* and '*The struggle of postnatal fatigue'.*

11.0 Chapter Eleven – 'Checked in but not always checked out' & 'The struggle of postnatal fatigue'

11.1 Checked in but not always checked out

This theme became apparent as the women described their experiences of the daily postnatal check and other encounters they had with their postnatal carers. A number of the women experienced a '*tick box*' procedure, were the carers would ask them closed questions and not invite in depth discussion during their interactions.

Marie compares Mary's approach to that of other midwives and suggests having two different people taking on the role, a person who ticks the boxes and 'a care person':

> '*This lady Mary she was kind of making sure everything was okay, the whole package, there were other ones* [midwives] *who came in who I knew, just came in because they had to tick boxes and say that they checked my temperature, I had a high temperature, and they'd ask 'Are you in pain?' etc., then they'd move on!*
> *Yeah, unless they kind of have, somebody who does the ticking the box bit for them and then they have someone who's actually a care person, two different roles...*'
> (Marie int21B, 132-137)

Mary also identified with this non personal, 'tick box' procedure associating it with an inexperienced person who wasn't '*into their job*':

> '*An inexperienced person would come in and do their ticking the box type thing, but then you'd ask them a question and you could tell that they really didn't know what they were talking about, or maybe they just didn't have kids themselves, maybe they just weren't into their job, maybe they felt they were underpaid, overworked, but it wasn't care*' (Mary int24B, 427-431)

Similarly, a private obstetrician also operated this 'tick box' approach to postnatal care, as Claire recalls her doctor sticking his head in the door of the postnatal room:

> '*Dr xxx was my doctor, he popped in most days when I was there. I mean literally he would stick his head in the door; he might make a comment, 'how are you'? Or, oh*

'She's still feeding'. It wasn't a check up, or 'how are you doing today?' type conversation' (Claire int10B, 278-280)

Sarah tells of her significant experience of being *'checked out'*, cared for, while she was breastfeeding:

'She sat down on the bed to talk to you and she was very hands on, she was a very tactile which doesn't bother me at all, she'd sort of touched you when she spoke to you, like on the arm or wherever and when she was showing you how to latch on she didn't just point and tell you she actually put [the baby] *in the position and she showed me different positions to lying down and different holds and things like that and she, she checked as well! I think that was one thing, she wouldn't just latch on and walk off and never come back to you - she would get you latched on and say 'that's right now but if she comes off you ring that bell and you get me back'*

She would actually even if I didn't ring she would come back and say 'are you still, are you comfortable, can you feel a different pull when you're lying down?' That's what was different about her and even the lovely one in the day hadn't done that but like sure during the day. Though they probably don't have as much time although that midwife in the night I know was incredibly busy because there were three C sections in my ward all those babies were in the nursery, so I'm sure that she was just as busy, she just made the time to come back and it's not like she came and sat with me for hours but she just came back' (Sarah int13B, 152-166)

Unlike the excerpts above Sarah experienced being 'checked out' by a midwife who enacted 'being-with'. The concept of 'being-with' for Heidegger's (1962) is a characteristic of each individual Dasein as it is an *'existential constituent of Being-in-the world'* (p.163) that of our being with others. Heidegger states that we can still be with others and be alone, as people who are significant to us do not always have to be near. As others matter to us, the concern we have as we comport ourselves towards them Heidegger refers to as '*solicitude*' or '*Fürsorge*' which is translated as "caring-for". This manner of caring-for which Dasein demonstrates in being-with others is completely opposite to the concern or '*Besorge*' that ready-to-hand or present-at-hand entities receive as objects of concern. Heidegger writes '*Thus as Being-with, Dasein 'is' essentially for-the-sake-of others*' (1962, P.160). He also confirms that '*Solicitude proves to be a state of Dasein's Being*' (1962, P.159), particularly as there are different modes of solicitude ranging from the deficient or indifferent to the positive. Sarah's experience was significant to her as she identified how the midwife on night duty was just as busy as

the midwives during the day, stating '*she just made the time to come back*'. This midwife demonstrated a positive mode of '*solicitude*' coined by Heidegger as '*leap ahead*' through her manner and considerate care, thereby enabling Sarah to successfully breastfeed her baby.

11.2 **Hurried care**

The majority of women stressed how busy and rushed the midwives were while on duty. Grace empathised with the midwives saying:

> '*I'd say they go home in the evening and they have to put their feet up and crash and have a big glass of wine or something because it did seem stressful, but they did say that we were there on a particularly busy night* (Grace int1B, 138-140)

Maura also acknowledged the hurried activity of the midwives on the postnatal ward but emphasised that '*I needed the help too*'!

> '*They're rushing around, I think I only saw one midwife where I was afterwards and she was just run off her feet and she couldn't give me the time that I needed at all, and I actually, I didn't want to ask her anything because she was so busy, she was literally running around.   I felt sorry for her in a way but I mean, I needed the help too!'* (Maura int2B, 207-210)

The impact of presenting a sense of hurrying often prevented mothers asking questions, Catherine pointed out that she didn't ask all the questions that she wanted answered because everyone was rushing:

> '*I felt everybody was rushing and therefore as somebody who was looking for advice from them I felt I was prioritising what I wanted and what I asked for support on. I probably took some things off the list because it's like 'oh I don't want to be bothering the midwives' which is wrong!'* (Catherine int23B, 104-107)

Dykes (2005) identified unrelenting temporal pressure on midwives on the postnatal wards, where most encounters between the midwife and the women were rushed and disconnected. She called for transformative action, whereby postnatal care in the UK

would be re-organised away from the hospital. Also, that priority would be given to midwives to remain on the postnatal ward and that they would not be automatically relocated to other busy areas of the hospital and most importantly that midwives would be given time to care.

11.3 **The struggle of postnatal fatigue**

A considerable percentage of women experience tiredness or fatigue in the postnatal period. The research literature cites from 46-87% of new mothers experience postnatal fatigue (Brown and Lumley, 1998, Schytt *et al.*, 2005). Fatigue is seen as a pathological state which can be detrimental to the health and well being of new mothers (Taylor and Johnson, 2010). Exhausted following labour and delivery, the women found postnatal fatigue extremely challenging as they juggled their need to get sleep with the care needs of their infant. Marie recalls feeling exhausted but unable to get some sleep, although one midwife did her best:

> *'It was pretty hectic, I just wouldn't have minded just an hour because I'd gone about three days without sleep! Literally this midwife was fantastic, she was doing her best but there were only two of them she was particularly good but she was run ragged, she really did her best for me and when she could see that I was, getting a little bit anxious, because* [the baby] *just didn't sleep a wink from the minute she popped out at delivery, so I was pretty exhausted, and I was in a semi private room, I felt very conscious of the other person sleeping, so I was walking the corridors and she* [the midwife] *even stopped and made me a cup of tea at one stage, checked if Kate was okay, she was really very kind.*
>
> *I mean at night time they should probably have maybe one or two more midwives who could look after the babies who aren't sleeping, just to walk up and down the corridor with them, so that the mother could maybe just get an hour'* (Marie int21B, 63-75)

Marie also tells her story of another midwife who didn't help that night:

> *'It was pretty obvious she wasn't as experienced as the other midwife the way she kept opening the room door, to the point where, because I was overtired, I felt myself almost getting narky by her, I felt she was winding me up more than helping me because she was kind of suggesting things and eventually I put* [the baby] *to sleep on my chest and she kept coming in to the room to check that my baby wasn't falling off and she kept*

waking me every time she did that, so I was a bit 'like'[irritated expression], *and I said into myself, I'm not going to harm my child, she's precious to me, more precious than, she is to you so please just stop opening the door and it squeaking every time you do that. Eventually I wouldn't open my eyes when she came over to me I pretended not to hear her because I thought I was going to just, I don't know what I was going to do, because I was at my 'wits end. I think I started getting more nervous actually, thinking is this baby ever going to sleep and you start building yourself into a state, 'how am I going to cope when I go home etc'* (Marie int21B, 437-446)

Claire verbalises how her experience of babies crying at night resonated with another group member:

'I went to the ward at ten o'clock, it was a six bedded ward which was full, I knew I was leaving early in the morning so it didn't bother me too much, but it was the same as you described [the other group member], *one baby would start crying and then it would go round the room, Yeah, all the babies literally, I think the two that weren't were the two that had just been born'* (Claire int10B, 89-92)

This state of maternal exhaustion, exacerbated by constant infant crying at night in the postnatal ward has been recently described by Kurth *et al.,* (2010). The impact of postnatal sleep deprivation has been highlighted by McQueen and Mander (2003). Their research highlights the profound effect on the physical, mental and social well-being of the mother and the potential negative implications for infant mother interaction, along with considerable impact on the partner and other family siblings (McQueen and Mander 2003).

One woman, Lisa described the distressing impact of not getting enough sleep had on her:

'I had all that chatter and all that noise as well and it was very, very loud and I did actually feel like killing the other babies, I did actually fantasise about it, I just couldn't stand it' (Lisa int11B, 1115-1116)

Rose immediately responded (another group interview member) on the importance of giving new mothers respite at night:

'Well that just goes to show that there should be an option for a nursery, and not for everyone, because everyone doesn't want to do it, but I mean with the babies screaming and crying, and I mean you know it could work as well for a breastfed mothers (Orla another group member' (Rose int9B, 1117-1120)

In summary, the women's experiences of postnatal fatigue in this study were considerable. They often found it difficult to cope because of deprived sleep and for some of the women they found themselves '*trembling at the edge'*[23] (BBC World Service, 2010). The mothers' accounts of their postnatal fatigue presented here are supported by previous research (Kennedy *et al.,* 2007, Hunter *et al.,* 2009, Kurth *et al.,* 2010, Taylor and Johnson, 2010).

The following chapter presents my further in depth interpretation of the women's experiences from a philosophical based discussion of how health professionals in their provision of postnatal care act authentically or inauthentically.

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[23] Seamus Heaney used this phrase to describe his current stage in life as he enters elderly adulthood.

12.0 Chapter Twelve: - Applying a philosophical perspective to postnatal care

12.1 Introduction

Having analysed, presented and discussed my interpretation of the Irish women's aspirations for, and their lived experiences of, postnatal care; I began to dwell further into the possibilities of what the findings may mean. I asked myself, 'w*hy did some of the women experience helpful and enabling postnatal care, (whether it was continual or episodic) while other women had indifferent postnatal care experiences*?' This chapter draws on Heideggerian and Arendtian concepts to interpret further the meaning of the phenomenon uncovered in this study, which is – '*Women have contrasting experiences of postnatal care*'.

This chapter begins by engaging further with Martin Heidegger's (1962) philosophical analytic of Dasein's basic state of 'Being-in' the World - '*Being-in the constitution of the 'there'*. The analytical discussion then examines the philosophical notion of '*being-oneself-the they*', with the analysis culminating on the main thematic themes of 'the inauthentic care, authentic care and 'the sparkling gems'. Hannah Arendt's philosophy in the '*Human Condition*' in particular, the integral dimension of human '*action*' is also explored. Excerpts and paradigm cases are presented to highlight the resonance of these philosophical themes.

12.2 Being-in the constitution of the 'there'

According to Heidegger Dasein's 'being-in' is always '*there*' in the world as an entity in, '*an everyday manner*' (1962, p.171). Thus, as we live our lives we do so in a shared world, in a familiar, routine manner, of which we cannot evade the context. Heidegger uses the metaphor of a clearing in the forest (as highlighted in section 5.4.1) to describe our familiarity with the world stating that it is only when the trees are cleared that we experience ourselves as situated '*here'*, along with a *yonder* (Blattner 2006). The *yonder* pertains to others and things that we encounter in the world. In essence each individual is always 'being-in' the world by way of its situation, its '*there*' (Dreyfus, 1991). As Heidegger (1962) confirms Dasein '*Being-there is Being-in*' the world (p.82).

It is '...*the 'there' of being makes the experience what it 'is'* (Smythe, 2011, p. 45). The concept of 'being-in' has two constitutive ways of being the '*there*', these are understanding and state-of-mind.

Being-there as understanding, according to Heidegger (1962) has two meanings: firstly, Being there '*for-the-sake- of-which*' relates to the role that we perform in the world, for example: a mother, a midwife. Each Dasein in our role has a '*potentiality-for-Being*' (p.183), which is our '*solicitude for Others and of its* [Dasein's] *concern with the 'world'*' (p183) (see section 11.1). This is how we disclose ourselves or relate to others in the world. The second meaning of understanding is attached to the act of interpretation as per Heidegger's hermeneutic circle discussed above (see section 5.5).

The other way of 'being-in' is our state-of-mind, our mood or our being attuned. These are our basic characteristic of our familiarity with the world. Heidegger (1962) claims that "*A mood assails us. It comes neither from 'outside' nor from 'inside' but arises out of Being-in-the world*" (p. 176). Moods have an effect on the atmosphere and can be a monitor how we are '*faring*' or as Heidegger writes '*how we are doing'* (p. 173). Our moods are also passive to us, as they are often affected by the situation we find ourselves in. Heidegger uses the term '*disposedness*' to explain what is common to all moods and how moods for us are related to being-in-the-world. Using fear as an example of a mood Heidegger describes three essential characteristics of disposedness: Firstly, disposedness discloses our thrownness, our inability to control certain circumstances in the world; disposedness also '*discloses being-in-the-world as a whole'*, as when we are frightened for example certain features of our situation are more dominant than others and finally, a facet of disposedness is our 'submission to the world': that is, when we find ourselves in a vulnerable situation, certain possibilities matter more or are more important to us than others. Moods therefore can import or disclose the way things, persons or events matter to us. The new mother's in this study often felt extremely vulnerable (also outlined in section 9.2.2 and 9.3).

In referring to the importance of postnatal care Lisa describes her acute vulnerable state:

> '*It's very important to me because I, god, I have three friends who had a baby at the same time and only one of us would have been able to go into the woods and delivery her*

baby and survive, either the baby was very sick and wouldn't have made it or we've been very sick and needed our stitches or caesarean or whatever. It's a very vulnerable sort of time and you do kind of and realise your mortality a lot, even though you know your well supported bla, bla, bla, so I, feel that the postnatal care is incredibly important, we live very easy lives now really and it's the only time I've ever, maybe ever will be in such a vulnerable state' (Lisa, int11B, 300-307)

12.3   Inauthentic - Being-one's self – the 'they'

In *Being and Time* Heidegger (1962) asked the question '*...who it is that Dasein is in its everydayness?'* (p. 149). His response clarifies that in everydayness Dasein's being or modes of being belong to Dasein (see section 5.4.1) and names the '*...subject of everydayness* [as] – *the 'they'* (p. 150) . Thus Dasein is responsible for '*who it is'* (Polt 1999, p. 60). In addition, the '*they'* or *das Man* doesn't act or stand out from others in the world but behaves as anyone else would (Polt 1999). So in everydayness the '*they'* dominates our perspective and all possibilities are often '*level down'* (Heidegger 1962, p.165) become ignored or discounted. The '*they'* appear to take the easy option as it is '*disburdened'* (p.165) by this approach and is thereby continued and retained.

Thus, our perspective or our understanding of things can be undertaken in a fallen mode. 'Falling' according to Heidegger (1962) is related to our every day 'absorption in' our activities of life where we don't become fully engaged with our particular responsibilities. The term 'absorption in' reflects our, "*Being-lost in the publicness of the "they" and in this situation we have declined our potential to be authentic and have fallen into the world"* (Heidegger 1962, p.220). Heidegger comments that being '*fallen into the world'* is a state in which we act in a programmed way with each other by conforming and not trying to obtain a unique perspective. This is disclosed by three components: idle talk (see section 10.4), curiosity and ambiguity of which every Dasein has the tendency to adhere to. Heidegger believes that when one is 'absorbed in' the '*they'* and in the 'world' then one flees from facing up to his or her capability to be authentic. Falling is a situation which most of us can drift into. It is only through uncovering the situation in which we flee that we begin to understand and interpret our being-in-the-world   (Heidegger 1962).   Accordingly, the women's undesirable postnatal care experiences (cited below and within chapters 9, 10 and 11) were instigated for the

majority, from the practises of the *'they'* (the postnatal carers). Heidegger (1962) confirms that:

> *'Dasein's understanding in the 'they' is constantly 'going wrong' in its projects, as regards the genuine possibilities of Being. Dasein is always ambiguously 'there' – that is to say, in that public disclosedness of Being-with-one-another where the loudest idle talk and the most ingenious curiosity keep 'things moving', where in an everyday manner, everything (and at bottom nothing) is happening'.* (p218-219)

Below, Paula describes, tearfully her traumatic experience of being suddenly referred by a midwife on the postnatal ward to a psychologist, for no apparent reason. The impact of this experience for Paula was significant she found herself defending her ability as a new mother; she was silenced and felt being watched. The midwives in this situation were acting in their ingenious *'they'* self. Their *'they'* perspective dominated all other possibilities:

> [Mother crying as she recalls her experience] *Well as I was saying the birth didn't go the way I would have planned, and I felt that was hard because my birth plan went out the window, it was ignored and I didn't get support from the midwife to help me* [in labour]. *I'd been doing very well and then things slowed down and I kind of got nervous, not fitting in to the plan and all that and I felt quite emotional about that afterwards, and of course you'd feel like that anyway, and then I fell in the corridor! I was walking along the corridor and I fell and I just pointed it out to* [a midwife], *and then the next thing they were sending me off to see some doctor who I didn't realise was a psychologist. 'I'd felt quite emotional in the ward because I was concerned whether we* [the mother and newborn baby] *were doing okay and the sleeplessness and all that, I'm probably not the best patient anyway, but that didn't mean that I was failing or couldn't cope or anything. I ended up defending myself, I thought I was going in to talk about why I wasn't happy with the way things had gone* [in labour] *and I had to just shut up or I'd have somebody watching me to see if I wasn't coping. I felt suddenly, instead of speaking up for myself, as I normally would do, I wasn't threatening anybody with anything!, I was just speaking out, I thought appropriately, and then I thought well now I'd better be quiet and toe the line or there'll be trouble, which I thought was very wrong! I can understand there's probably a thin line between watching out for signs of depression or things like that and they probably wouldn't*

want to feel that they'd sent somebody home that ended up not coping or whatever, but on the other hand I felt that I had to stop speaking because I was being watched'

(Paula int4B, 498-521)

Another women Jane also recalls her adverse experience of postnatal care:

'I didn't realise, because nobody had told me that he [the baby] *wasn't actually getting any milk after a certain amount of time, he was just sucking, and I was kind of left sitting there, with this child hanging off me, and I'm thinking "I'm never going to be able to move" and then I got it into my head, "he's still hungry, he's not getting anything from me" and I asked "could I give him a bottle" and I was told "no, that I was breast feeding". And I was told "no" very curtly, and she* [the midwife] *walked away, and I burst into tears.*

So when I was leaving the hospital, the same midwife said to me "now you must keep up the breast feeding!" and I felt, I felt it was nearly a threat "you must keep doing this" and then I kind of felt under pressure. So I did keep it up, and I had deliberately hadn't even bought any formula milk, so that I would keep it up. And then of course, I arrive home, and the Public Health Nurse arrived the next day, she would have been much older, nearly approaching retirement, and she told me "she'd breast fed all her children, and her daughters were breast feeding their children, and you must do this" But she kept calling to the house every few days, and I really felt she was checking up on me! And then we got to the point where, he slept through the night, but that meant I wasn't up feeding him through the night, and it made it a little bit difficult during the day, and we would get to about six o'clock in the evening, and he would just cry, and it didn't matter what I did, he would cry, and cry, and cry, and I was distraught and convinced he wasn't getting anything when I was trying to feed him. And I got to the point one evening, he was crying so much and my husband wasn't there, so I put the baby in the pram, and I walked in the rain out to the shops to get some formula milk. He cried the whole way there, and I couldn't even see that this was silly, to be crying over it, and I got to the shops, went to get the formula milk, and who did I see at the end of the aisle only the public health nurse! And I actually ran, and hid, before she could see me! And I got the formula, brought it home, and he gulped it, he absolutely gulped it, and I stood over him, I remember I stood over him nearly all night, convinced he was poisoned, because I'd given him formula milk. I was so upset. And when my husband came home, he said "this is just nonsense, you just can't let people do that" and in

fairness it probably wasn't the woman, it was my state of mind, but I felt that she was harassing me into breastfeeding' (Jane int22B, 367-396)

One way of describing these women's postnatal care experiences would be to label them as inappropriate, insensitive or even a form of negligence. Alternatively, by facilitating these midwives and public health nurses to uncover the situation in which they inauthentically acted, can enable them to understand their behaviour and address it.

Another existential concept '*Being-with*' (also referred to section 11.1), can be applied to examine why women might experience such care. There are indifferent and deficient modes of solicitude (Being-with) of which Dasein upholds for the majority of time as we pass by others in the world. For example, on a busy train we are being-with others but they do not matter to us (Heidegger 1962). Detailing the positive modes of Solicitude Heidegger (1962) defines the '*leap in*' mode of caring for the other as 'inauthentic', a 'taking care' of their possibilities for them, rendering them dependent. In comparison, to 'authentic' caring whereby there is a '*leap ahead*' (p.158), a freeing of the other for their own possibilities.

12.4 **Authentic caring**

In contrast, women who participated in this research recounted stories of experiencing pleasant, transformative postnatal care that promoted their maternal agency. Their experiences were founded on their carers '*Being-with*' them as new mothers, as their character showed genuine interest in caring. Their actions demonstrated a '*retreat from 'fallenness'* (Thomson *et al.*, 2011, p234). Thus, being authentic they responded uniquely to the individual woman's unique situation, as a new mother. On these occasions, the midwife or public health nurse was attuned or sensitive to the women's mood and thereby provided postnatal care pertinent to the mother's individual care needs (Polt, 1999). These carers thereby became authentically engaged. Identified as a paradigm case, Catherine describes in detail her experience of authentic caring:

> *'The public health nurse was nice, warm not rushed. She, herself was a mother; she ticked an awful lot of the boxes that we wanted. In the first early couple of weeks when you probably need more of the emotional type support, she supported us more than*

anyone else! We didn't need any medical support and she was the first person who we interacted with in the whole pregnancy process or postnatal process that provided emotional support.

The reason she provided the emotional support was she gave us time I never felt she was rushing in the whole time she was in my house or when we went to the [PHN's] *clinic. The second thing was she was very warm, it's as if she saw her role as being a psychiatrist as well* [mother laughed]. *It's not that you're moaning or anything but you just want somebody to understand your vulnerabilities. Or at least give you the attention, whether they are real or not, they just allow you for the first couple of weeks when you're feeling vulnerable to feel it's ok to be vulnerable rather than having to focus on* [mother banged on the table] *a list of things they want to talk to you about. The only speed bumps that came a little bit later in my postnatal care was she herself went out on maternity leave and her replacement was a different person and you could see the impact of the person versus the role.'* (Catherine, int23C, In: 416- 430)

Catherine felt supported and authentically cared for by the public health nurse in her vulnerable state of new motherhood. The public health nurse did not leap in and take over she was not in her everyday manner of being-with-another; she displayed her '*authentic Self*'. Authentic engagement or '*action*' mattered to Catherine and the other women as they could interact with their carers', ask questions and seek advice regarding their concerns. Findings from Chew-Graham *et al.,* (2009) research describe how the listening, approachable actions of some health professionals facilitated the disclosure of postnatal depression while the behaviour of others hindered the disclosure.

Another woman, Siobhan outlines her experience of authentic caring immediately after giving birth:

'They [midwives] *said 'you look starving we are going to bring you breakfast and they brought breakfast, that was care – It made me strong, they involved John* [her husband]. *The student midwife also! They cared in a way that was not in your face, they were there for you, they weren't over powering with the baby. Everything they done with Pauric* [the baby] *they involved us, it was natural. 'Those girls felt like our best friends when we were there. We felt very comfortable with them, they were*

certainly experienced. They never rushed us in that time and they didn't look like they were rushed, their focus was on us the three of us' (Siobhan, int14B, In: 28-35)

Catherine and Siobhan's experience of being 'cared-for' or *solicitude* was clearly within the positive realm of 'being-with'. Again, these postnatal carers exhibited their authentic self which mattered greatly to the women.

Heidegger (1962) clearly distinguishes between the everyday, *'they-self '*and the *'authentic Self'* (p.167). He emphasises that the *'Authentic Being-one's-Self'* does not happen by chance, or that it only occurs because the person is extraordinary. He states that the *authentic self* occurs because the self has *'taken hold of* [herself or himself] *in its own way'* (p.167) and therefore through insightfulness and determination elects to pursue the possibility to live in this authentic way. While the *'they-self'* in comparison, continues to maintain its everyday, same mode of being. Heidegger calls for those who maintain the indifferent mode of being-with, where they pass others by, to *'become acquainted with oneself'* (p161). In another words, to observe what they do or in the case of postnatal care observe how they practice. Therefore *'Dasein is in each case essentially is its own possibility'* (p. 68). This includes their choice to act authentically or inauthentically. Mary recognised the inconsistent nature of the midwives that she encountered, she comments:

> *'You're really just dependant on the personality of the midwife who you are dealing with, some were better than others so it's not always in their job spec if that makes sense'* (Mary, int24B, In: 77-79)

Another woman explains that being a midwife is not just about being 'professional' there is the personal aspect too:

> *'The three people* [midwives] *were really professional, you could tell their job meant a lot to them and they gave it their all; apart from the younger girl they probably have children themselves and so, I think it's really, it's a hard thing, because I think a midwife it's very personal, it's such a personal job that it's not really about just being professional really, it's like you'd almost have to weed them out in an interview or something, to get really good ones and I suppose it's so hard to tell*
> ***So if you were interviewing somebody, what sort of qualities would you look for?***

A lot of knowledge and common sense and kindness, patience, a lot of those kind of qualities, their personality really as well as their knowledge (Marie, int21B, In: 499-507)

12.5 **The Human Condition**

Hannah Arendt's great work also provides us with a philosophical lens in which to interpret action. Arendt's [24] book '*The Human Condition*' first published in 1958 identified three dimensions of the human active life: '*labour*', '*work*' and '*action*'. For Arendt *labour* refers to repetitive work of the labourer who produces resources for his/her own survival, for example, nourishment, or clothing; the concept of *work* is specific to what humans create and manufacture in the world, the objects or artefacts of the world; while *action* she favours as the human condition which is both existential and aesthetic and thereby an essential aspect of human activity. She defined action as both words and deeds and states that:

> '*In acting and speaking, men show who they are, reveal actively their unique personal identities and thus make their appearance in the human world...This disclosure of "who" in contradistinction to "what" somebody is – his qualities, gifts, talents, and short-comings, which he may display or hide-is implicit in everything somebody says and does. ...This revelatory quality of speech and action comes to the fore where people are 'with' others and neither for nor against them-that is, in sheer human togetherness.* (Arendt 1998, p.179-180).

Arendt utilises Heidegger's concepts of 'Being-with' and 'disclosure' (KZSU Stanford, 2007). 'Plurality' for Arendt is the fact that we are born into a world with others, that we act among and with others, while 'disclosure' of ourselves is essential as '*without the disclosure of the agent in the act, action loses its specific character*' (Arendt, 1998, p.180). For Arendt, it is only in the life of action that humans become fully authentic, in contrast to the life of thoughtlessness (Moran and Mooney, 2002). Arendt's concept of '*action*' or *praxis* is grounded in the Aristotelian understanding were the Greek *polis* created spatial freedom whereby humans could interact feely with each other (Arendt, 1998).

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[24] Hannah Arendt(1998) was a student and lover of Martin Heidegger, became a leading political theorist in the United States after fleeing from Germany in 1933 because of her faith of Judaism and National Socialism (Moran and Mooney, 2002). She studied also with Rudolf Bultmann and Karl Jaspers and lectured in University of California, Berkely and Princeton University.

Other works by Arendt include her reporting of the Eichmann trial for The New Yorker (an American magazine), where she noted that the action of Eichmann was thoughtless and described him as a "banality of evil" (Arendt, 1964). Arendt believed that Eichmann's thoughtlessness for others was because of his lack of imagination and his inability to judge for himself what actions are morally right or wrong (KZSU Stanford, 2007). Feldman's commentary on Arendt's work concludes that Arendt calls us to think what we are doing and construes that as thinking is inseparable to judging, it is judging that allows us to think from another's point of view (KZSU Stanford, 2007). It is therefore crucial that all postnatal carers critically think and reflect on the results of their action and inaction to benefit new mothers, their babies and families.

12.6   **The sparkling gems**

Some of the actions of the midwives and public health nurses were identified by the women as making a significant positive impact on them. They appeared to go beyond the 'fallen mode', think and act authentically enabling the new mother's on their journey through early motherhood. These postnatal carers stood out from the others. Sarah's excerpt below begins by her acknowledging the contrast in the caring experiences of which she encountered and points out the inconsistent advice that she received yet continues by highlighting the 'authentic' engagement of her carers referring to them as 'sparkling gems':

> *'I would say in summary you get told a lot of different information from lots of different people and that doesn't really seem very fair to a new mother, who's trying, trying to work out what you're supposed to be doing amongst the hormones and the tiredness and the crying baby and everything else that goes on in your life. So I think I would have appreciated more consistency but having said that, there were sparkling gems amongst them, you wouldn't want to flatten everything out to just being homogenous because of the experiences that were positive: the midwife who was lovely and the health care assistant who was so gentle and the public health nurse who was very pragmatic'* (Sarah, int13B, In: 552-561)

The sparkling gems identified by Sarah did not lose their way; they did not act in the falling mode of the '*they*'. These health care professionals were authentic in their postnatal care actions. Bondas-Salonen (1991) confirms that:

> *'Caring lies in the deep attitude of the midwife and her efforts to understand, to ask and to listen. It is in the midwife's professional and human behaviour. The midwife is centred on the new mother, not vice versa, and on the new mother's story, not the midwife's' (p.172).*

The sparkling gems helped 'stabilise' and support the new mother on her journey. One woman described the experience akin to a child learning to ride a bike:

> *'It's like a child learning to ride a bike, that you have the stabilizers on, just for that little while until you kind of get used to it and then you can go by yourself, so it's nice to know that you're wearing a safety helmet or that there's somebody there kind of, at the side of the road to kind of help you a little bit or to pick you up if you fall off the bike, and to dust you down and say you're grand, come on now and we'll get back on it, I'll help you again'* (Annie, int15B, 256-260)

Marie also recalls the midwife who sparkled and stood out in her caring manner (see also section 11.3)

> *'Literally this midwife was fantastic, she was doing her best but there were only two of them she was particularly good but she was run ragged, she really did her best for me and when she could see that I was, getting a little bit anxious, because* [the baby] *just didn't sleep a wink from the minute she popped out at delivery, so I was pretty exhausted, and I was in a semi private room, I felt very conscious of the other person sleeping, so I was walking the corridors and she* [the midwife] *even stopped and made me a cup of tea at one stage, checked if Kate was okay, she was really very kind'*(Marie int21B, 63-75)

Here Marie is comforted by the midwife ('the sparkling gem') whose human behaviour expresses warmth, familiarity and sharing, (the sharing of 'a cup of tea'); particularly when it mattered. Byrom and Downe's (2010) research into midwives accounts of 'good' midwifery and 'good' leadership also identified individual midwives who stood out. Midwives inspired by their midwifery colleagues commented on how 'She *sort of shines'* (p.126) in reference to those who were seen to clearly make a difference. These midwives engaged in authentic midwifery caring, through thoughtful action. Arendt (1998) also refers to '*the shining brightness'* (p.180) seen when the '*action*' of the agent is disclosed and revealed in public. Robinson (2004) also comments on how '*the midwife-*

effect is powerful' (p.515) as midwives can enhance or bash maternal agency. Interactions and encounters matter to postnatal women as these are remembered up to two & half years later. In particular, the details of those who cared for the women were recalled and the names of those who didn't (Bondas-Salonen, 1998).

12.7   Conclusion

The insights from this research clearly illuminate the communalities and differences in Irish women's lived experiences of postnatal care. In seeking to understand these converse postnatal care experiences I've presented here a philosophical based discussion as to why some of the women have had positive experiences of postnatal care while others did not. I draw on Heidegger and Arendt's philosophical work and show how the nature of being human or to use Arendt's (1998) title '*the human condition'* often leaves new mothers' in an unpredictable situation where the essence of the care they receive is dependent on the person delivering that care. Therefore a woman's experience of postnatal care will be influenced as to whether the postnatal carer discloses their inauthentic or authentic self.

From the women's narratives it became clear that the postnatal carers often enacted in the '*they*' or inauthentic self. Their practices of everydayness, repetitive postnatal caring was often thoughtless and ineffective. The women revealed how the 'action', the words and deeds of their postnatal carers represented an apparent lack of judgement as to whether their actions were morally right or wrong. On these occasions, their lack of judgement prevented them seeing, listening or ascertaining the needs and concerns of the individual postnatal women.

In complete contrast, the research findings highlighted the practices of the postnatal carers who stood out from the others, like '*sparkling gems*'. The women's stories revealed how the carers (midwives, health care assistants, public health nurses) enacted 'Being-with' them on their journey in early motherhood through their authentic behaviour. These postnatal carers were thoughtful as they responded appropriately to the women's unique situation in their '*authentic-self*'. Authentic postnatal caring is giving women full and genuine attention and really 'seeing' them, even for just a short time. This authentic engagement or '*action*' mattered to the

women as it stabilised them on their journey, they could open up and interact with their carers' and have their anxieties and concerns addressed.

This research therefore highlights the potential therapeutic benefits for new mothers, infants and their family from authentic caring. Attuned individualised postnatal care can be transformational for women and their partners as it can meet the care needs of postnatal women and their babies. It can foster healthy relationships and positive parenting and thereby facilitate the forming of a new family.

The next chapter will present a critical discussion on the relevance of the findings for women and their families and maternity care providers, along with recommendations towards a future of new possibilities for postnatal care.

13.0 Chapter Thirteen – Towards a future of new possibilities for postnatal care

13.1 Introduction

Having presented the findings and in-depth interpretations from this Heideggerian hermeneutic phenomenological study, this final chapter explores the broader relevance of the findings for women and their families, for midwives and other postnatal carers, as well as the organisation of maternity care services and policy makers. Recommendations for future postnatal care practice and research will also be outlined. A reflexive account of my journey undertaken during my doctorial studies at the University of Central Lancashire is presented in Appendix G.

13.2 Relevance of findings for postnatal women and their families

Insights from this research clearly highlight the vulnerability that women face in the days following childbirth. Consequently, what really matters to women during postnatal care is the authentic nature of postnatal care provision. When the midwives and other healthcare providers responded uniquely to the individual new mothers situation they stood out like '*sparkling gems'* from the others. The women in this study identified how these postnatal carers went beyond the *'falling mode'* of everyday postnatal practice and intuitively connected with them and addressed their care needs. For the women, the significance of receiving authentic postnatal care and '*being seen'* as an individual who had recently given birth 'mattered'. Experiencing authentic postnatal care not only seemed to promote their postnatal recovery from birth it also appeared to enable them to '*become mothers'*. The importance of receiving authentic postnatal care cannot be underestimated, particularly if it leads to the diagnoses, prevention and treatment of maternal physical and psychological morbidity (Rouhi *et al., 2011*). In addition, authentic postnatal care may have the potential to prevent the occurrence of maternal deaths. In the sad case of Ms Tameka McFarquhar (RIP) (as described in section 2.3), if she had received postnatal care from a carer who acted authentically her life and that of her baby potentially could have been saved (Gaskin 2008).

Authenic caring that enables postnatal women to *'become mothers'* is significant as highlighted by Balbernie (2001) and Zeedyk *et al.,* (2008). These authors illustrate the importance of fostering, interactive and positive parenting skills in new parents, early in the postnatal period. When a baby is born the brain is underdeveloped and is therefore sensitive to repeated experiences of terror or fear. When abuse or neglect continues, the infant normalises these experiences as they become ingrained in their state of mind (Balbernie, 2001). The impact of an infant experiencing emotional neglect early in life can therefore lead to long term attachment problems and difficulty in adapting to future stressors (Balbernie, 2001). This often presents itself as behavioural problems later in life. In some cases, treatment such as behavioural or attachment therapy may be unsuccessful (Perry, 1997).

Midwives and public health nurses are perfectly placed to make a difference towards positive mental health of the next generation by authentically caring for parents and enabling transformative learning experiences towards effective parenting. While the results of this study showed that some women had transformative experiences from authentic postnatal care unfortunately a number of women were left dissatisfied and upset by their inauthentic care experiences. The mounting evidence supports this finding (Audit Commission, 1997, McCourt *et al.,* 1998, Singh and Newburn, 2000, DH, 2004, Ockleford *et al.,* 2004, Brown *et al.,* 2005, Hildingsson, 2007, Rudman and Waldenström, 2007). Experiencing inauthentic postnatal care will be remembered by women for a number of years following the birth of their baby (Bondas-Salonen, 1998). The participants' in this study who experienced inauthentic postnatal care, expressed their extreme disappointment and emphasised how they felt deserving of quality care from the midwives and other health care providers who were scheduled to look after them. They expressed how their carers failed to identify when they looked or felt lost, isolated or worried. This can have a critical impact on new mothers and subsequently their families. The suffering is often on top of the physiological and psychological morbidity that women may experience following childbirth.

13.3   <u>Relevance of findings for postnatal health care providers</u>

These findings are highly relevant to midwives, public health nurses and other health care providers in relation to their daily practice while caring for women in the postnatal period. As highlighted in the findings, midwives and public health nurses in their everyday human behaviour of '*being-oneself-the-they*' can choose to practice authentically or inauthentically. For the women in this study, the fundamental nature of authentic care was not about the clinical role of their carer but about the personality within that role and their ability to connect with the woman. This was evident in the midwives and public health nurses who were referred to by the women as '*the sparkling gems*'. Having a midwife or health care provider who was knowledgeable was also important for the women. Some women expressed how they often disengaged with the midwife or health care provider if they demonstrated a lack of knowledge.

To remain clinically competent midwives should regularly rotate when appropriate between antenatal, intranatal and postnatal, both within the hospital and community setting. Midwives need to be 'knowledgeable' in all aspects of postnatal care. In the UK, midwives must notify their intention to practice annually and demonstrate how they maintain their competence. A similar form of midwifery supervision should be introduced within the Republic of Ireland. Enhancement of behavioural and communication skills should continue to be a fundamental part of midwifery education, and ongoing updates should be mandatory not only for midwives but also for public health nurses. Staff training is required so that health care providers develop emotional awareness and intuitive skills, so they can recognise, treat, and where possible prevent maternal physical and psychological morbidity among this vulnerable group. Modern bedside technology for documentation of postnatal care should be explored as a possibility to encourage midwives to be '*with women*' and midwives should be discouraged from unnecessary duplication of records.

The women greatly valued being given time by midwives and postnatal carers, which was unhurried. Sarah's experience outlined in section 11.1 is an example of the midwife taking time and enacting the Heideggerian concept of '*being-with*'. Sarah's experience resonates with Dykes (2005) and Curtis *et al.*, (2001) research findings of the need for midwives to 'take time' when caring for postnatal women and when they did, the women acknowledged this as an element of good care. As mentioned previously

(section 2.4.1), Forster and colleagues (2006) highlighted how postnatal caregivers in Australia found they had limited time available to spend with postnatal women due to constraints such as, staff shortages. From personal experience as a practice midwife, midwives working in a postnatal setting are often allocated a specific number of women with various individual needs. Often the complex individual needs of these women are not taken into consideration when staff midwives are allocated. The amount of time the midwife spends with postnatal women is often hindered by the necessity to adhere to daily postnatal ward routines such as meal times or to facilitate domestic cleaning. Other time consuming duties for midwives include arduous paper work and/or the use of complex software packages when discharging a woman and her baby home; often after a short hospital stay. Using onerous and time-consuming methods of record keeping is certainly a time thieve which is often undertaken at the midwives desk away from the women. In addition, the postnatal ward can often be left with minimal staff when midwives are called upon to help out in other areas such as delivery suite, leaving a '*Cinderella service*' (Bhavnani and Newburn, 2010).

Some of the women who participated in this research expressed anger at how health professionals communicated with them; some described the communication as 'disrespectful'. Persson *et al.,* (2011) and Hildingsson (2007) also concurred that women found postnatal staff to be unfriendly and unhelpful. It is imperative that midwives and all health care providers critically examine their own individual practice regularly as the impact of their demeanour and use of language can have a significant effect on postnatal women. Midwives and public health nurses in Ireland who '*do not deliver care in a manner which respect the uniqueness and dignity*' (p.6) of each woman are breaching their professional code of conduct (An Bord Altranais, 2000). To encourage authentic postnatal care in Ireland perhaps recognition should be given to the midwives and health care providers identified by women as '*the sparkling gems*'. Each year in the UK, midwives are recognised for excellence in midwifery care by the Royal College of Midwives.

13.4   __Relevance of findings for service organisations and policy makers__

Findings from this study highlight the need for a more flexible approach to rooming-out to promote the chance of new mothers being able to get sleep and enhance their recovery from the birthing experience. Women alluded to extreme symptoms of postnatal fatigue. Breastfeeding is justly promoted over formula feeding in the 'baby friendly' initiative. The routine practice of babies 'rooming in' with their mothers on a postnatal ward is strongly advocated in the UNICEF ten steps to successful breastfeeding (WHO 1998b) and the National Institute of Health and Clinical Excellence (NICE, 2006). Shakespeare and colleagues (2004) however strongly support the call to rethink postnatal care guidelines and suggest a more 'mother friendly' approach is needed on an individual basis. At local and national level postnatal care guidelines on breastfeeding need to be examined and a more 'mother friendly' approach considered when necessary to promote individual new mothers gain sleep.

Midwives and other health care providers need to focus on providing care which is person-centred and based on an individual needs. To achieve this however, it is necessary to change local and national maternity care policies. Government policy change is required to provide additional resources to ensure that effective postnatal care in Ireland is prioritised for the future health of mothers, babies and their families. This should include additional, specific postnatal care facilities within hospitals and in the community as the mothers in this study often reported overcrowding on postnatal wards.

Adequate numbers of professionally trained staff midwives are needed to meet the demand from the high, increasing birth rate in Ireland (Health Service Executive, 2008). Currently in the Republic of Ireland there is no national community postnatal service. Women are often discharged home after the birth of their baby(s) within 48 – 72 hours. Other than one planned visit by a public health nurse most women do not receive any further postnatal follow unless they attend their six week postnatal examination with their general practitioner. Health care organisations and policy makers need to review the current maternity care system. Services need to be developed for women to access if they have concerns about their postnatal health or that of their baby(s). This recommendation is something which has also recently been echoed by the WHO (2010). A recent report from the Royal College of Obstetricians and Gynaecologists '*High quality women's health care*' (RCOG, 2011) proposed a new model of maternity care

based on the critical components of safety, clinically effective, efficient and patient centred and which enhances women's experience. Perhaps this is a first step towards authentic postnatal care provision.

13.5   **Rethinking postnatal care**

Heideggerian philosophy informs our lives. Heidegger provided existential concepts which can be utilised to understand and explain phenomenon. These help to explicate and enlighten us as to what it means to be human, what a human person is, what it is like to experience an immediate, dramatic change in your life, such as becoming a new mother. Rethinking postnatal care through Heideggerian philosophy prompts the raising of questions around the taken for granted practices. The results of this research highlight how women have contrasting experiences from their postnatal care. While some women had negative experiences, others did not. I asked myself why? What made the difference from one woman to the other? Subsequently, through my in-depth readings of Heidegger's work and by following the phenomenological route I was able to engage with Heidegger's philosophical notion of '*being-oneself-the they*'. My analysis culminated on the main thematic themes of: inauthentic care, authentic care and 'the sparkling gems' as described in the previous chapter.

13.6   **Strengths and limitations of this study**

This study has contributed to the increased understanding of the lived experiences of postnatal care in Ireland. The strength of this study is in how it reveals the vulnerability faced by new mothers in the days following birth. It offers a thematic analysis, letting the voices of the women shine through. Utilising Heideggerian hermeneutic phenomenology has added a unique perspective on women's experiences of postnatal care in Ireland. However, as with all research, the study has a number of limitations which must be acknowledged. Firstly, the interpretations offered in this thesis relates to postnatal care provision within the chosen research setting between March 2007 and October 2009. Since this period of time, elements of postnatal care may have changed. A further limitation is related to the decision to only include women from an Irish ethnic background. The rationale for this decision was that women from other ethnic backgrounds for example, Chinese women may follow different postnatal care practices and customs and therefore the findings may have

been mis-interpreted. A further limitation is the collection of data from participants attending one maternity hospital, situated in one geographical area of Ireland. Consideration of the possible limitation of using group interviews is required, as participants' options and attitudes may have been influenced by other group members. The main aim of using group interviews was to initially identify the common issues relating to women's experiences of their postnatal care; however the actual group interview process on several occasions encouraged a dynamic that triggered the sharing of postnatal care experiences. Finally, a limitation may be my unintentional over emphasis of certain points which may have been influenced by my pre-conceptions.

13.7   Suggestions for future research

Further qualitative research on postnatal care needs to be undertaken nationally to explore the women's experience from the midwives perspective. Participatory action research involving midwives to identify and implement required postnatal care changes is also required, as Heidegger states it is only through uncovering the situation in which we flee that we begin to understand and interpret our being-in-the-world (Heidegger 1962).

13.8   Final thoughts

I have found undertaking my studies towards a PhD extremely fulfilling, yet challenging and all consuming as it competed constantly with my other commitments. I hope the findings of my research will inform midwives as they care for new mothers. In addition, that the policy makers are also influenced to financially support the delivery of authentic postnatal caring. Perhaps someday there will be a 'Tipping point' (Gladwell, 2000) moment were all women will experience effective and transformative postnatal care through authentic engagement from their carers'. To not engage in thinking about postnatal care and all its facets is not an option. To just 'go with the flow' is to continue in '*the they*' mode of being, leaving new mothers and their families '*trembling at the edge*'.

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List of Appendices

APPENDIX A & B

Postnatal Care Study

Are you interested in taking part in a study that aims to find out the specific care women require following childbirth, both in and out of hospital? What women need from postnatal care has been poorly understood. There is very little research that examines in-depth women's aspirations for, and experiences of postnatal care.
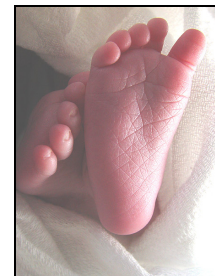
If you agree to take part, I will invite you to come to a group meeting on three occasions. The first meeting will take place when you are between 28-38 weeks pregnant. The second and third meetings will take place when your baby is between two - eight weeks old and three - four months old. I will tell you the exact date; time and place of the group meeting as soon as possible after you have made contact with me.

Your role will involve discussing with other expectant and new mothers, your aspirations for, and experiences of, postnatal care. The duration of the group meetings will be $1-1\frac{1}{2}$ hours long.

I am currently studying for a PhD in Midwifery under the supervision of Dr. Soo Downe, Professor of Midwifery Studies, at the University of Central Lancashire, Preston. The findings from this study will be presented as part of my examination and they may provide important information, which may help to develop future postnatal care services.

Please contact me if you wish to take part in this study:

Maria Healy
Lecturer in Midwifery
School of Nursing, Midwifery and Health Systems
Health Sciences Building
University College Dublin
Belfield
Dublin 4

Tel: (01) 7166477
E-mail: maria.healy@ucd.ie

Postnatal Care Study

Are you interested in taking part in a study that aims to find out the specific care women require following childbirth, both in and out of hospital? What women need from postnatal care has been poorly understood. There is very little research that examines in-depth women's aspirations for, and experiences of postnatal care.

If you agree to take part, I will invite you to come to meet me on three occasions to discussion your aspirations or experiences. The first meeting will take place when you are between 28-38 weeks pregnant. The second and third meetings will take place when your baby is between two - eight weeks old and three-four months old. I will tell you the exact date; time and place of our meeting as soon as possible after you have made contact with me.

Your role will involve discussing with me, your aspirations for, and experiences of, postnatal care. The duration of the meeting will be 1-1½ hours long.

I am currently studying for a PhD in Midwifery under the supervision of Dr. Soo Downe, Professor of Midwifery Studies, at the University of Central Lancashire, Preston. The findings from this study will be presented as part of my examination and they may provide important information, which may help to develop future postnatal care services.

Please contact me if you wish to take part in this study:

Maria Healy
Lecturer in Midwifery
School of Nursing, Midwifery and Health Systems
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Tel: (01) 7166477
E-mail: maria.healy@ucd.ie

APPENDIX C

Appendix C: Correspondence to and from ethics committee from the selected maternity hospital

8th September 2005

Dr ████████
████████████████
████████████████
████████

Re: Ethical Approval

Dear Chairperson

As part of my studies towards the degree of Doctor of Philosophy (PhD) in Midwifery from the University of Central Lancashire, I am currently planning to undertake research into 'W*omen's aspirations for*, *and experience of, their postnatal care both in and out of hospital'*. My Director of Studies and first supervisior is Professor Soo Downe. Other members of my supervisory team include Dr. Fiona Dykes and Dr. Denis Walsh. I have now reached the stage of seeking ethical approval. Please find enclosed for your attention the following documents: a completed application form, my research proposal, patient recruitment slip, participant information sheet, consent form and recruitment schedule.

With reference to my research proposal I plan to do individual in-depth interviews after the group interviews. However, at this stage I am applying for ethical approval for the group interviews only. The exact nature of the individual interviews will be clarified following the group interviews. It is when the nature of this phase is determined, based on the analysis of the MPhil phase and I will return to the ethics committee for further ethical approval. I have included an outline of the whole programme of work so that the group interviews can be set in context.

If there is any further information that you or other members of the research ethics committee require, please do not hesitate to contact me.

Thank you,

Yours sincerely,

_____
Maria Healy
Lecturer in Midwifery
Maria.Healy@ucd.ie Tel: 01 7166477

8th September 2005

Dr ██████████
██████████████████████
██████████████████
██████

Re: Ethical Approval

Dear Dr. ████

I have submitted an application for ethical approval to be brought to the ethics committee meeting on the week beginning 12th September. As outlined in my letter of application I am only at this stage applying for ethical approval for the group interviews. When I return to the ethics committee for further approval for the individual interviews, please let me know if I have to complete the full research ethics application form again? Or can I submit the interview schedule with other relevant documentation.

If there is any further information that you or other members of the research ethics committee require, please do not hesitate to contact me.

Thank you,

Yours sincerely,

_____
Maria Healy
Lecturer in Midwifery
maria.healy@ucd.ie Tel: 01 7166477

26 September 2005

Ms. Maria Healy,
Lecturer in Midwifery,
UCD School of Nursing, Midwifery and Health Systems,
University College Dublin,
Belfield,
Dublin 4.

Re: Submission to Ethics Committee: An Exploration of Womans's Needs in Ireland as They Recover From Birth & Become Mothers.

Dear Ms. Healy,

I am writing to you regarding your proposed research project submitted to the Ethics Committee. This was discussed in detail at the meeting held on the 19th of September 2005.

The Committee raised a number of issues that would need to be addressed. The most prominent is that age you specified of the participants would be from sixteen years upwards. The problem with this is that it is under the age of consent. The Committee would insist that only mothers of eighteen years and older can be included in the study.

The Committee also requested some clarification on what was meant by Irish mothers. Does this mean women just of an Irish ethnic background, or do you mean women who are simply resident in Ireland.

The third point raised was that the second interview should take place at least three months after the birth in order to give the mothers a better opportunity to asses the matters.

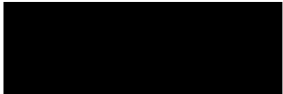I would be obliged if you could revert back to me with these changes before the next Ethics Committee meeting.

Kind regards.

Yours sincerely,

Consultant Paediatrician,
Chairperson – Ethics Committee

13th October 2005

Research Ethics Committee

██████████████████████

Re: Submission to Ethics Committee on 19th September 2005

Dear Dr. ██████████

In reply to your letter dated the 26th September 2005 outlining particular concerns raised by the ethics committee in relation to my submission; the following has been discussed with my supervisory team and will hopefully clarify these issues.

First point: We agree that mothers of eighteen years and older will only be included in the study.

Second point: The term 'Irish mothers' refers to the participants who will be of Irish ethnic background, as including women from other ethnic backgrounds may lead to the findings of the study being culturally mis-interrupted.

Third point: Further to discussions with my supervisory team, we agree with the committee that the postnatal interview should take place three months after the birth to allow the women time to reflect on the postnatal care received. Nevertheless we decided to also include a group interview two weeks after delivery to capture the women's experiences of their hospital postnatal care while it is fresh in their mind.

I have demonstrated these changes in the enclosed documents. I will return to the ethics committee for approval for the individual phenomenological interviews following the above group interviews as mentioned in my initial letter.

If there is any further information that you or other members of the research ethics committee require, please do not hesitate to contact me.

Thank you,

Yours sincerely,

_____

Maria Healy
Lecturer in Midwifery
maria.healy@ucd.ie Tel: 01 7166477

14 November 2005

Ms. Maria Healy,
Lecturer in Midwifery,
UCD School of Nursing, Midwifery & Health Systems,
University College Dublin,
Belfield,
Dublin 4.

Re: Submission to Ethics Committee: An Exploration of Women's Needs in Ireland as They Recover From Birth & Become Mothers.

Dear Ms. Healy,

Thank you for your communication dated October 13th, 2005 regarding your submission to the Ethics Committee.

Your letter states that you are happy to amend your study as per the Ethics Committee's recommendations and thus the Committee feels that you are now in a position to go ahead with your research project.

Kind regards.

Yours sincerely,

Consultant Paediatrician,
Chairperson – Ethics Committee

Chairperson

████████████████
████████████
████

Re: Amendment and further permission regarding a submission made to Research Ethics Committee on 19th September 2005

Dear Dr. ██████████

Further to your letter dated 14th November 2005 indicating that the committee had granted me permission to go ahead with my research project entitled: 'A*n Exploration of Women's Needs in Ireland as they Recover from Birth & Become Mothers'* I now request permission to amend my schedule for recruitment and data collection and seek permission to proceed to the second stage of my research.

The reason why I need to amend my schedule for recruitment and data collection is that I have experienced difficulties recruiting groups of participants who are around the same gestation and therefore the timing of the antenatal and postnatal group interviews for stage one and for the individual interviews for stage two need to be amended slightly (see enclosed original recruitment schedule and amended schedule highlighted in red for approval). Please note the actual dates of recruitment and data collection have altered due to work pressures.

In my letter to you on the 13th October 2005 I stated that I would return to the ethics committee for approval for the individual Hermeneutic Phenomenological interviews and I hereby seek that approval.   I will follow the amended recruitment and data collection scheduled highlighted above. The individual interviews will follow a non-structured format with the overall focus centring on the themes and sub-themes that have arisen from the group interviews. As per Hermeneutic interviewing the following questioning techniques will be taken into consideration during the interview:

I will steer away from emotions and feelings but instead will ask the participant questions like - *'What does it mean to you to have experienced the postnatal care that you received?', 'Can you give me an example that would show me what you mean by '…..'?*

I will aim for the participant to tell her story about her experience of postnatal care or ask the participant about the meanings or significances of her experience

I will avoid explanations and quantifications and allow the participant to tell her story of her postnatal experience.

I will avoid assumptions that may be taken for granted in commonly used phrases but instead I will ask the participant for an example where the phrase used can be put in context in order to understand what the participant means. I may ask - *'Can you tell me about a specific time when you …….?*

I will try to stay away from leading the participant

I will aim to clarify what I hear from the participants by keeping open to women's experiences of their postnatal care – I may say - *'Many of the women I've talked with have described similar experiences and how it was like '…….', as I think about the story you have shared, does '…….' Describe what this experience was like for you?*

Please also find enclosed a copy of the consent form that has also been slightly altered to obtain permission for the participant's anonymous voices to be used in a multimedia presentation at research conferences/symposia or as teaching material to help emphasise their views.

If there is any further information that you require before your next research ethics meeting later this month, please do not hesitate to contact me.

Thank you,

Yours sincerely,

_____
Maria Healy
Director of Midwifery Studies/ PhD Student
maria.healy@ucd.ie Tel: 01 7166477

25th June 2007

Ms Marie Healy
Lecture in Midwifery
School of Nursing, Midwifery and Health Systems
Health Sciences Building
University College Dublin
Belfield,
Dublin 4.

Re: An exploration of women's needs in Ireland as they Recover from Birth and Become Mothers'.

Recruitment Schedule Amended

Dear Marie,

Just a note about your research proposal and your request to amend the schedule for recruitment and data collection and seek permission to proceed to the second stage of your research.

This has been approved by the Ethics Committee.

Kind regards

Yours sincerely

Consultant Paediatrician
Chairman, Ethics Committee

APPENDIX D

29 September 2005

Maria Healey
Department Of Midwifery
University of Central Lancashire

Dear

Re: Faculty of Health Ethics Committee (FHEC) Application - (Proposal Number 129)

Following review of your proposal 'An exploration of women's needs in Ireland as they recover from birth and become mothers', the FHEC has requested that the following *conditions* be addressed prior to further consideration of the approval of the project.

In your response to FHEC, please ensure that, in addition to including updated documentation (including a new application form), you include a document in which you summarise the changes made. In this document, please ensure that you indicate:
- how you have addressed the conditions;
- whether you have adopted any of the recommendations, and, if so, how you have addressed these.

Please number your documentation 129 submitted to address these conditions (and recommendations, if appropriate) as Version (Number 2).

Conditions

1. The Committee requires sight of the consent form and would like further explanation regarding the need to read and write in English as a basis for participation.

Yours sincerely

Martin Johnston
Acting Chair
Faculty of Health Ethics Committee

Cfi: Soo Downe

5th December 2005

Maria Healy
Midwifery Department
University of Central Lancashire

Dear Maria,

Re: FHEC Proposal 129

The FHEC has approved your proposal application '**An Exploration of women's needs in Ireland as they recover from birth and become mothers'** based on the conditions having been satisfactorily met.

Yours sincerely

Martin Johnston
Acting Chair
Faculty of Health Ethics Committee

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Research Ethics

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research.ethics@ucd.ie
www.ucd.ie/research/ethics

13 June 2006.

Dr. Marie Healy
Lecturer in Midwifery
School of Nursing, Midwifery and Health Systems
Health Sciences Building
University College Dublin
Belfield
Dublin 4

Re: **Title of Project :** An exploration of women's needs in Ireland as they recover from birth and become mothers.

Dear Dr. Healy,

Thank you for notifying the Committee of the above research project As you are proposing to recruit women through the ▮▮▮▮▮▮▮▮ Hospital and have obtained ethical approval through the Research Ethics Committee there, you do not need to seek approval also from the Human Research Ethics Sub-Committee.

Yours sincerely,

_____
Dr. Michelle Butler
Chairman, Human Research Ethics Committee

SIGNATURE PAGE

Please send to: Ms Patricia Cranley, Research Grants Officer,
Health Research Board, 73 Lower Baggot Street, Dublin 2

Present Employer / Present Head of Department

Signature: _Marie Carney_   Date: _12/1/06_

Name (Printed): _DR MARIE CARNEY_

Academic Sponsor

I confirm that I have read and support this application. I have agreed the level of support with the applicant.

Signature: _____   Date: _____

Name (Printed): _____

Nursing and Midwifery Sponsor

I confirm that I have read and support this application. I have agreed the level of support with the applicant.

Signature: _____   Date: _____

Name (Printed): _____

Head of Department where research will be undertaken

I confirm that this Department will provide appropriate facilities, support and supervision to enable the fellow to carry out the research described in this application.

Signature: _____   Date: _18/01/2006_

Name (Printed): _GERARD FEALY_ [Deputy Head]

Dean of Research at Institute where research will be undertaken

NATIONAL UNIVERSITY OF IRELAND, DUBLIN
UNIVERSITY COLLEGE DUBLIN (UCD)
SUSAN M. HENGAN

Signature: _Susan M. Hedigan_   Date: _18th January, 2006_

Name (Printed): p.p. PROFESSOR DESMOND FITZGERALD
VICE PRESIDENT FOR RESEARCH

Applicant Signature: _Maria Healy_   Date: _13 / 1 / 06_

Applicant Name: _MARIA HEALY_
Researcher Id: _NA/2006/14_
Grant Title: Clinical Fellowships in Nursing and Midwifery 2006

APPENDIX E

Participant Information Sheet

Study title: An exploration of women's needs in Ireland as they recover from birth and become mothers.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. My e-mail and telephone number are listed below.

What is the purpose of the study?
This study is part of a longer project that is trying to find out what care and support women want and need following childbirth, both in and out of hospital. At the moment, not much is known about this area. This phase of the research is expected to take six months to complete.

Why have I been chosen?
You have been chosen to take part in this study along with 19 other pregnant women. This is because you are attending this hospital for maternity care on a week that was selected by chance to invite women onto the study.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving any reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will I need to do if I take part?
If you agree to take part, I will invite you to come to a group meeting (a 'group interview') three times. The first one will take place when you are between 32-36 weeks pregnant. The second one will take place when your baby is two weeks old and the third meeting will be held when your baby is three months old. I will tell you the exact date, time and place of the group meetings as soon as possible if you agree to take part. You will be asked to talk about what you want from postnatal services, and what your experiences are, with other expectant and new mothers. The group meetings will take approximately 1-1½ hours. A fuel/public transport voucher worth

ten Euros will be given to you at the third group meeting towards your travelling expenses.

I would like to use a tape recorder during the group meeting as this makes it easier for me to record information. You can ask me to turn the tape recorder off at any time.

What are the possible risks of taking part?
There are no known risks to you if you choose to take part in this study. However, if you experience any discomfort by taking part in these group meetings please inform ██████████████████ a qualified midwife, who will provide appropriate health care or advice to you.

What are the possible benefits of taking part?
There are no known benefits to you if you choose to take part. Nevertheless, you may find the opportunity to meet and talk with other new mothers beneficial. The findings of the study may help us to develop future postnatal care services.

Will my taking part in this study be kept confidential?
Your name or personal details will not be revealed to anyone outside the research team. All information and focus group reports will be filed under a number and not your name. I will erase the tapes as soon as I have typed up the information on them. No one else other than other members of the research team will be permitted to listen to them. Small parts of the discussion from the focus groups may be included in my final write up and in any article I write, but no names will be included.

Who has reviewed this study?
The National Maternity Hospital, Research Ethics Committee along with the Scientific Committee within the Department of Midwifery Studies and the Research Ethics Committee from the University of Central Lancashire, Preston, have approved this study. The Research Ethics Committee at University College Dublin has also been informed of my research as my employer. *(This information will only be included once ethical approval is obtained).*

Contact for Further Information
I am a qualified midwife, currently working as a Lecturer in the School of Nursing, Midwifery and Health Systems at University College Dublin. However, as a researcher I will not be in a position to provide health care or advice to you.

I am studying for a PhD in Midwifery under the supervision of Dr Soo Downe, Professor of Midwifery Studies, at the University of Central Lancashire, Preston, England. The findings of this study will be presented as part of my examination and may be published in journals for health professionals.
You are welcome to contact me if you want a copy of the findings.

My contact details are:

Maria Healy
Lecturer in Midwifery
School of Nursing, Midwifery and Health Systems
Health Sciences Building
University College Dublin
Belfield
Dublin 4
Tel: (01) 7166477
E-mail: maria.healy@ucd.ie

Thank you for reading this information and for considering taking part in this study.

If you are still happy to take part, having read this information, could you **please complete and sign the consent form.**

The participant will be given a copy of this information sheet and a signed consent form to keep.

APPENDIX F

Study Number:
Participant Identification Number:

CONSENT FORM

Title of Project: Rethinking postnatal care: A Heideggerian Hermeneutic study of postnatal care in Ireland

Name of Researcher:
Maria Healy
Lecturer in Midwifery
School of Nursing, Midwifery and Health Systems
Health Sciences Building
University College Dublin
Belfield, Dublin 4
Tel: (01) 7166477
e-mail: maria.healy@ucd.ie

Please read each statement below and <u>initial each corresponding box</u> indicating your consent

1. I confirm that I have read and understand the information sheet dated ▮▮▮▮▮▮ for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without maternity care or legal rights being affected.

3. I understand that the researcher will be using a tape-recorder during the interview.

4. I agree to be contacted if further clarification is required.

5. I give permission for my anonymous voice to be used in a multimedia presentation at research conferences/symposia or as teaching material to help emphasise my views.

6. I agree to take part in the above study.

As a participant providing my signature indicates that I give my permission for the information I provide in the interview to be used anonymously within research articles, books and/or teaching material, as well as for presentation at research conferences/symposia. Additionally, my signature indicates that I have received a copy of this consent form.

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Researcher   Date   Signature

APPENDIX G

Reflexive Account

This has been a long journey from when I commenced my doctorial studies in September 2004, with two granted periods of leave of absence. I have learnt a significant amount and encountered many personal life events during this period. Some of these have been very happy occasions with the births of my daughters, while others have been very challenging particularly, the illness and death of both my parents. I know they both would have been very proud of my achievements. What I have learnt is that you have to accept life events as they arise, deal with them as best you can and sacrifice some pleasures to achieve major goals.

I decided to commence my studies with Professor Soo Downe at the University of Central Lancashire following a meeting with her at a Normal Birth Research Conference in June 2004. Professor Downe's expertise and knowledge has continually inspired me throughout my journey. My other supervisors Professor Fiona Dykes, Dr. Denis Walsh (who transferred to another university) and Dr. Gillian Thomson have also been very generous with their time, encouragement and support. By choosing to study with Professor Downe meant that I had to travel a long distance by air from either Dublin or Belfast. However the expert supervision that I received was worth this. I obviously kept regular contact via e-mail and tele-conferencing.

At the beginning of my studies and again one year later, I applied for a grant from the Health Research Board (HRB) in Ireland. Twice I was shortlisted for interview and unfortunately on these two occasions I was unsuccessful. This was disappointing, time consuming and challenging however my research proposal was finely tuned by undertaking this process.

From the outset after reading Michael Crotty's (1998) work on the misuse of phenomenology by nurses, I decided that I would learn about the philosophical underpinnings of phenomenology in detail. At first, I attended a module on philosophy by Professor Dermot Moran and the following semester I attended a module on hermeneutics by Professor Timothy Mooney both from University College Dublin. I attended the ICM in Brisbane in 2005 where I met Professor Liz Smythe following her research presentation utilising Heidegger's philosophy. She mentioned to me about an Institute in Virginia, USA the following year. I was awarded a scholarship of $1000.00 from the George Mason University and £1000.00 from the Iolanthe Midwifery Trust, London to attend these Institutes. In June 2006, I attended the Institute of Heideggerian

Hermeneutical Methodologies facilitated by Professor Pamala Ironside and an Institute on Interpretive Phenomenology facilitated by a lead philosopher in hermeneutics Dr. R.E. Palmer. Furthermore I listened to podcasts by Professor H. Dreyfus at D.C. Berkley. This self-taught knowledge was highly rewarding and somewhat transformative experience for me. I was fortunate to be asked to write a chapter in the recently published text *Qualitative Research in Midwifery and Childbirth – Phenomenological Approaches* (see appendix G). This was a great opportunity to demonstrate my knowledge and understanding of philosophical texts.

Applying for ethical approval, recruiting the participants and undertaking the group and individual interviews was hard work but enjoyable. I really enjoyed meeting the women and listening to their postnatal care stories. I found the analysis challenging with the quantity of data. Also I used MaxQDA 2 as a data management tool which I found to be satisfactory but not very helpful. Following Crist and Tanner's (2003) guidelines on interpretative analysis, I was excited by the findings when they emerged.

APPENDIX H

Appendix H: <u>**Publications by Maria Healy**</u>

Healy, M. (2006) Women's Experiences of Postnatal Care: A Meta-Synthesis *2006 Normal Labour and Birth: 3rd research Conference* Grange Over Sands, English Lake District, Faculty of Health, University of Central Lancashire.

Healy, M. (2011) Heidegger's contribution to hermeneutic phenomenological research. In: Thomson, G., Dykes, F. and Downe, S. (Ed) *Qualitative Research in Midwifery and Childbirth – Phenomenological Approaches,* Routledge: London.

From Elizabeth J Kelly <ejkelly@uclan.ac.uk>   ▷

Sent Thursday, February 23, 2006 12:15 pm

To "maria.healy" <maria.healy@ucd.ie>

Cc

Bcc

Subject Normal Labour and Birth Conference Submission

Attachments   Paper presenter guidelines and details.doc   613K   Normal Labour and Birth Booking info & Form for Presenters.doc   64K

Dear Maria Healy

Normal Labour and Birth: 3rd Research Conference
7 ▯ 9 June 2006
Grange over Sands, Cumbria, UK

On behalf of the Department of Midwifery in the Faculty of Health, I am delighted to inform you that your paper entitled Women's Experiences of Postnatal Care: A Meta-synthesis has been accepted for oral presentation at our conference. We have provisionally scheduled your presentation for 2, session 3, but will let you have exact timings very soon. We have allocated 30 minute sessions for the presentations, which gives you approximately 20 minutes for presentation with 10 minutes for questions.

Enclosed are the following:
- Guidelines for paper presenters.
- A form on which you should confirm your contact details and confirm the technical requirements for your presentation.

&nbs! p; & h, which is indicated on the attached form.

On arrival at the conference, please identify yourself to the conference staff as a paper presenter. We will then be able to inform you of the room in which your presentation is to take place and arrange for any technical support you may require prior to your presentation.

The delegate pack will include a full set of abstracts. In the light of this, if you wish to make amendments, we will need a new copy as soon as possible, to arrive at least 10 working days prior to the first day of the conference.

Detailed joining instructions will be sent to you nearer to the conference date. However, if, in the meantime, you have any queries, please do not hesitate to me on my direct line number 01772 893809 or e-mail ejkelly@uclan.ac.uk

We look forward to welcoming you at the conference.

Best wishes.

Liz Kelly
Events Co-ordinator
Faculty of Health
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Preston
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Tel +44 (0) 1772 893809
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Women's experiences of postnatal care: A Meta-synthesis

Maria Healy
Part-time MPhil/PhD Student
University of Central Lancashire,

Director of Midwifery Studies & College Lecturer,
University College Dublin

Aim of MPhil/PhD

- To develop a novel representation of postnatal care based on a comprehensive process of examining the literature and from phenomenological accounts of Irish women's postnatal experiences.

  Objective 2: To undertake a meta-synthesis of published qualitative English language literature relating to women's experiences of postnatal care.

Maria Healy

A Meta-synthesis - What is it?

- It is the integration of the findings from a group of similar qualitative studies that aims to understand and explain phenomena (Walsh and Downe, 2005).

- *'…A rigorous attempt to render what exists within a body of evidence-based qualitative studies into a coherent and synthesised product'.*
  '…Capable of substantiating a more convincing argument about the major theoretical elements within the phenomenon of interest and positioned to advance the science in that particular substantive field more forcefully' (Thorne et al 2004, P. 1343).

Maria Healy

A Meta-synthesis – What it's not!

- It's not a meta-analysis!

- In the quantitative tradition a meta-analysis usually leads to the discovery of a right answer or a singular truth

- Qualitative research is a construction of human experiential phenomena that must be understood as contextual and relational

- A meta-synthesis is integrative, coherent and illuminating but rarely factual in terms of a singular truth!

- Truths that may arise from a meta-synthesis will be inherently more convincing when they are articulated in a way that acknowledges their boundedness within temporal, spatial, and epistemological locations (Thorne et al 2004).

Maria Healy

Meta-synthesis Inquiry

- Grounded by Noblit and Hare (1988)

- Not a simple endeavour… '*carefully peeling away the surface layers of studies to find their hearts and souls in a way that does the least damage to them*' (Sandelowski et al. 1997, p. 370).

- An aggregative approach to the synthesis is deemed unacceptable (Noblit and Hare 1988).

Maria Healy

The Meta-synthesis Process

Framing a meta-synthesis exercise
Locating relevant papers
Deciding what to include
Appraisal of studies
Analytic technique
Synthesis of translation

(Walsh and Downe 2005)

Maria Healy

Framing a meta-synthesis exercise

- To identify and synthesise all accessible qualitative research published in English relating to women's aspirations for, and/or experiences of, postnatal care between 1990 and July 2005.

- This search was subsequently updated in February 2006.

- The research question - '*What are women's aspirations for, and experience of, postnatal care'?*

Maria Healy

Locating relevant papers

- This procedure involved a robust search strategy.

- Keywords identified and used in all database searches included: *postpartum, postnatal, post birth, motherhood, mother, parenting, experiences, aspirations and qualitative*

- Databases searched - AMED, CINAHL, PsychInfo, MIDIRS, MEDLINE, Cohrane Database of Systematic Reviews, and Journals @ OVID

- A 'berrypicking' approach was utilised (Bates 1989)
- Written in English and include an abstract

Maria Healy

Deciding what to include

Inclusion Criteria
All qualitative studies:
- where the participants are women and who have experienced postnatal care
- which examines women's aspirations for postnatal care.

Exclusion Criteria
- Qualitative studies that focused on women being in the postnatal period rather than exploring women's experience of, and/or aspirations for, postnatal care (as in studies exploring motherhood)
- Qualitative studies in which no women participated (as in studies of maternity carers experience of postnatal care)
- Qualitative studies that didn't include original data
- Mixed method studies where the design was too structured as to force the data
- Research identified in the search that wasn't written in English or included an abstract
Maria Healy

Appraisal of studies –
Criteria for appraising qualitative research studies
Walsh and Downe (2006)

Stages	Essential Criteria
Scope and purpose	Clear statement of, and rationale for, research
	Study thoroughly contextualised by existing literature
Design	Method /design apparent, and consistent with research intent
	Data collection strategy apparent and appropriate
Sampling strategy	Sample and sampling method appropriate
Analysis	Analytic approach appropriate
Interpretation	Context described and taken account of in interpretation
	Clear audit trail given, Data used to support interpretation
Reflexivity	Research reflexivity demonstrated
Ethical dimensions	Demonstration of sensitivity to ethical concerns
Relevance & transferability	Relevance & transferability Evident

The database and research retrieval results

Database	Number of articles retrieved using search strategy	Number of articles initially perceived as relevant once duplicates removed	Number of articles which met inclusion criteria & included in the meta-synthesis
AMED	21	0	0
CINAHL	371	6	2
PSCHinfo	6	0	0
MIDIRS	243	5	3
MEDLINE	195	2	1
Cochrane	0	0	0
Your Journals at OVID	2630	4	2
'Berrypicking approach'	9	1	1
Total	3,475	18	9

Analytic technique

- Analysis of the findings followed Noblit and Hare (1988) classic method
- Analysis involved identifying and tabulating key metaphors, phrases, idea, concepts and relations in each study - a compare and contrast exercise
- Reciprocal translation - Researcher triangulation

Maria Healy

The Findings

Stages of analysis	Baker et al. 2005	Bonda-Salonen (1998)	Hunter L. (2004)
Summary or key concepts	Women's experiences of the childbirth process are influenced by maternity staff	The meaning of postnatal care for new mothers	Parents' views and experiences of postnatal care at **home**
Compare and contrast metaphors, phrases, ideas, concepts, relations and themes in original texts	**Ineffective Postnatal Care** Hospital & At home Negative Staff Attitudes & Behaviour made women feel inadequate, guilty, pressurised and annoyed because they couldn't breastfeed; Their behaviour verged on bullying women, to care and to breastfeed their babies; Emphasises on routine approach to care with no time for interpersonal/supportive care; Apparent lack of resources made women feel guilty if they asked for help, breastfeeding was not supported, help not offered with the crying baby!	**Effective Postnatal care** Postpartum care, from the perspective of the new mother is sharing her new life situation. This comes from professional carers and informal carers via *learning* from the midwife and listening to other new mothers stories and by being enabled to be in *peace and quiet together with her child and family.* Meaning of caring involves listening, enabling adjusting to mothering etc, not just involvement of physical tasks **Absence of care** Postnatal care was confirmed and appreciated when the new mother's experienced an absence of postnatal care which they had previously experienced.	**Supportive Care - Midwife** Involves the women receiving repeated reassurance particularly when experiencing difficulties with baby care, reassurance that these difficulties are normal and not their fault; they needed to be able to contact and have access to the midwife for practical advice to the '*millions*'of '*silly*' little questions about baby care; parents needed affirmation of their abilities; permission was needed that it was ok to do certain caring interventions; also needed support to get more sleep **Supportive Care –family & peers** - Practical help **Structure of the visits** – women need to be consulted about the schedule of postnatal visiting, this gives them control over the organisation of their care

The Findings

Stages of analysis	Hunter L. (2004) Cont'd	Lock, L.R. & Gibb, H. J. (2003)	Miller, T. (2005)
Summary or key concepts	Parents' views and experiences of postnatal care at **home**	Place has an influence over women's experience of postnatal care	Women's experiences of becoming mothers set against a backdrop of policy and care delivery
Compare and contrast metaphors, phrases, ideas, concepts, relations and themes in original texts	*Emotionally supportive care* was highly valued as women felt listened to and this increased their confidence; judgemental comments were not appreciated; Women felt secure with the midwives care and valued continuity *Areas highlighted for improvement* More practical help with breastfeeding; Differing advice about the care of a a colicky baby caused confusion and was unhelpful; Lack of antenatal preparation for the postnatal period **Coming through:** Moving on, 'take the rough with the smooth'; Parents should be made aware of the negative side of life with a baby and try not to worry but to talk honestly about their feelings	The **Physical environment** of the hospital verses home, where women is given a bed not a room. **A matter of control** - women had more freedom at home to self care, to accept visitors or not, '...*more control of what's happening to you, what's happening to your baby*; **A matter of confidence** – increased confidence came regarding baby care with the associated familiarity of home compared to the disempowerment in the hospital; **A matter of safety** - being in the hospital gave a sense of security but women didn't feel emotionally secure, they felt they could easily become dependant; **A matter of time** – women needed to be given time to talk, this wasn't facilitated in the hospital compared to home; **A matter of talk** – talking was crucial, women felt lonely and alienated in the hospital where communication was often constrained and stilted compared to at home; **The heart of the matter** - the home allowed for women-centred postnatal care	*Absence of Care* Women didn't know what to do, to care for their babies - '*...No-one told me how to sort of bath the baby*' *Ineffective Care* To the women there was no clear basis on how the selective visiting was decided upon – One women said '...*because I felt so dreadful I would have liked them to call every day..., but they assume...I suppose they think this is a fairly nice house, husband at home, they kept saying 'I'll not call tomorrow eh, I'll leave it for a day or two'.* *Supportive/Practical Care* Some women felt supported by midwives '*She was great because she came round and she actually put me to bed and latched the baby on and made me a sandwich*'.

Synthesis of translation

Women's Experience of POSTNATAL Care

Effective care (Supportive/Practical)/ Ineffective care /Absent care

The Lived Reality
The Context
'Moving on'
Surviving...

Maria Healy

Is Postnatal Care Important?

Does it Matter?

Thank you!

Maria Healy

3

12 Heidegger's contribution to hermeneutic phenomenological research

Maria Healy

Introduction

To be known as one of the greatest philosophers of the twentieth century is an immense achievement. Martin Heidegger has been accredited with this accolade by scholars such as Charles Guignon (1993), Richard Palmer (1969), Mark Wrathall (2005) and David Krell (1993). Mark Wrathall (2005) quotes:

> Heidegger *did* more than any other thinker of the twentieth century to develop a coherent way of thinking and talking about human existence without reducing it to a natural scientific phenomenon or treating it as a ghostly mind haunting the physical world.
>
> (pp. 5–6, emphasis added)

His philosophy has influenced other key intellectuals, including Gadamer, Derrida, Foucault, Sartre and Bourdieu (Guignon 1993). Heidegger's work demonstrates a unique way of understanding the meaning of being in the world (i.e. ontology), that is, human lived experience. This is manifest particularly within his most renowned publication *Being and Time* (*Sein und Zeit*), first published in 1927. Understanding Heidegger's philosophy is central to undertaking Heideggerian hermeneutic phenomenological research. It is therefore important that researchers who claim to be using this approach demonstrate their insight and knowledge of the philosophical underpinnings of Martin Heidegger's work for their research to be substantive and convincing. Indeed, it is argued that only through rigorous interpretive enquiry can valuable meaning be gleaned from the lived experience (Kavanagh 2002).

This chapter seeks to explore and explicate Heidegger's philosophy, beginning with a detailed explanation of its origins and a demonstration of what it is that Heidegger offers to hermeneutic phenomenology. It will examine methods that can be utilized in Heideggerian hermeneutic phenomenological research, giving examples from research which explores Irish women's experiences of postnatal care. Finally, this chapter will discuss

briefly how Heidegger's existential concepts can be used to understand and explain phenomena which have come to light during my research. To begin with, a brief chronicle of the life events of Martin Heidegger is offered to place his work and philosophy in context.

Martin Heidegger was born in Messkirch, Germany on 26 September 1889, and he died on 26 May 1976. His father was a manufacturer of barrels and he was also a sexton for the local church. Heidegger went to school initially in Constance (1903–1906) and then in Freiburg from 1906–1909. Here, at the age of 17 he was first introduced to Franz von Brentano's work *On the Manifold Meaning of Being according to Aristotle* (1862) by a pastor from Trinity Church in Constance (Krell 1993). This book stimulated Heidegger's interest into the question of being (Moran and Mooney 2002), and a year later he went on to critically appraise Aristotle's own work, endeavouring to re-read the history of philosophy (Krell 1993). Following a brief period as a Jesuit novitiate, Heidegger enrolled at the University of Freiburg as a theology student and seminarian from 1909–1911. He studied mathematics and then philosophy at Freiburg and it was here that he first encountered the work of Edmund Husserl. Husserl's famous text *Logical Investigation*s left a profound impression on Heidegger, yet instilled an inquisitive sense of incorrectness (Moran and Mooney 2002). According to Moran and Mooney (2002) it was around this same period that Heidegger became familiar with hermeneutics through the writings of Schleiermacher, while also engaging with the work of Hölderlin, Rilke, Kierkegaard and Nietzsche. In 1915 Heidegger became a lecturer at Freiburg, was conscripted into the military service from 1915–1918 and later worked as an assistant to Edmund Husserl from 1919–1923. It was in 1923 that he secured the reputation as a great lecturer (as an assistant professor) at Marburg University and afterwards he obtained the appointment to the chair of philosophy at the University of Freiburg in 1928 (Wrathall 2005). For ten months from May 1933 Heidegger joined the Nazi Party. Around the same time he became Rector of Freiburg University until 1934 when he resigned (Krell 1993). After the Second World War, the French military authorities involved in the Allied De-Nazification Committee and faculty from Freiburg University placed Martin Heidegger under rigorous scrutiny due to his involvement with the Nazi party. No firm conclusions were reached by the investigation as to his actual involvement. However, the committee placed a strict ban on Heidegger's freedom to lecture, publish and attend conferences. He found this very difficult and only continued to teach his philosophy in private seminars, with the ban being lifted in 1951, one year before his retirement (Krell 1993, Moran and Mooney 2002). Since then Heidegger's work has been translated into many languages and has gained considerable international recognition. In relation to the significance of Martin Heidegger's philosophy, Mark Wrathall (2005) writes: 'it is not his misadventures with Nazism or his self-importance that is paramount in interpreting his philosophy, but his originality as a thinker and the scope and profundity of his thought itself' (pp. 1–2).

The evolution of Heideggerian hermeneutics

As mentioned above, Heidegger re-read the history of philosophy back to Plato's student, Aristotle (384–322 BC). His intensive study originated from his disagreement with how knowledge had been generated by the philosophical tradition. Aristotle had provided a unique analysis of the question of what 'being' means from an aetiological perspective, believing that there was a unity, as Hanley (2000) describes, 'between what is the case in the world, and what humans correctly perceive to be the case' (p. 203). Signifying logic, Aristotle argued that perception is always interpreted and connected to our experience in the world. This differed from Plato's rationalist belief in disconnected knowledge, which surmized that experience is not required to reveal the truth of an idea (Stevenson 2005). In exploring his theory of perception Aristotle focused on the complex Greek term 'ousía'. Aristotle believed that the 'primary form of being to be investigated is ousía; and ousía is, in the most primary sense, form' (Hanley 2000, p. 67). Thus, the mind thinks about external things: for example, an object is perceived in terms of its form with a shape, the material that it consists of and how the object functions. Aristotle's views were grounded by a belief in God; this led to his argument that there was a certain order or structure in the world and that human beings also have a universal description, or understanding of unity of the ways of being. Heidegger creatively interpreted Aristotle's work (Krell 1993); he disagreed with Aristotle's restricted thinking associated with the categorization of being; in particular the suppressive viewpoint on the individuality of human beings. As Heidegger wrote in *Being and Time,* '…even Aristotle failed to clear away the darkness of these categorical interconnections' (1962, p. 22). The important aspect for Heidegger was not what the unity of these ways of being is, but what 'ousía' (or form) as Aristotle's analogy for the unity of all ways of being actually means (Hanley 2000).

Apart from Heidegger's critical analyses of traditional ontology (the historical philosophical views of being) he also examined in detail Immanuel Kant's (1724–1804) work on transcendental philosophy. Kant believed that space and time and everything associated with these concepts are simply appearances from our world of experience and therefore by discovering the structure and rules of appearance we know the structure of nature itself. Blattner (2006) suggests that Heidegger's adoption of Kant's transcendental turn to ontology transformed his study into the structure and rules of our understanding of being. Subsequently, Heidegger's aim in *Being and Time* was to develop a general ontology of all forms of being by explicating how it is that we understand being.

Historically, Aristotle's philosophy was respected for hundreds of years, until it was dismissed by the Scientific Revolution (Blattner 2006). This change came about by leading philosophers such as Francis Bacon (1561–1626) who had given credence to science as a systematic approach to

discovering knowledge. Heidegger however took issue with the philosophical schools of idealism (where ideas can exist outside the mind) and realism (where ideas about reality exist in reality outside the mind) and in *Being and Time* he rejected the entire debate, stating that:

> …as long as Dasein is (that is, only as long as an understanding of being is ontically possible), 'is there' being. When Dasein does not exist [the proposition of independent things] can neither be understood nor not understood. In such a case even entities within-the-world can neither be uncovered nor lie hidden.
>
> (Heidegger 1962, p. 255)

Heidegger also refers to Rene Descartes' (1591–1650) work in *Being and Time*. Descartes was an influential philosopher of the Renaissance who through his expertise in mathematical physics provided explanations for a number of natural occurrences, such as how the heart pumps blood, how light rays enter the eye into the optical nerve, and so on. Heidegger actually praises Descartes on this aspect of his work as a founder of human epistemology. Nevertheless, Heidegger comments on Descartes' renowned stance on dualism:

> Within certain limits the analysis of the extensio [the objective world] remains independent of his neglecting to provide an explicit interpretation for the being of extended entities.
>
> (1968, p. 134)

It is Descartes' belief in dualism that Heidegger rejects outright. The foundation of this is the clear separation between the physical and the metaphysical. Descartes believes that in order to understand ourselves or to understand what the 'I' is, we need to extract it from its surroundings so that we can better comprehend the self for what it is. He stresses in the *Meditations on First Philosophy* that '…the mind of man is really distinct from the body…' (Descartes 1979, p. 22). In addition, he goes further to suggest that the body needs to be separated from the imagination as the sense organs are so close to the imagination that they can create false perceptions (Descartes 1979).

The genesis of Heidegger's *Being and Time*

Heidegger's indebtedness to the forerunners of phenomenology includes Frank von Brentano and Edmund Husserl. Heidegger's appreciation is shown to Husserl by his dedication of *Being and Time* to him and in the footnote where he gives recognition to Husserl stating that '…he has also given us the necessary tools' (Heidegger 1962, p. 490). Frank Brentano, Husserl's professor had obvious influence on the development of Husserl's phenomenology. Brentano's series of lectures entitled 'Descriptive Psychology' (also

entitled 'Phenomenology') laid emphasis on the accuracy of describing mental states over casual explanations. He claimed that all mental phenomena can be divided into psychical and physical phenomena (Brentano 1995), a view that Husserl rejected (Husserl 1970). Brentano also believed that mental phenomenon can be intentional; that is, they relate to an object whether or not the object thought about really exists (Moran and Mooney 2002). Blattner (2006) further explains that intentionality is 'the mind's capacity to represent the world around it' (p. 2). For example, one might experience being frightened and relate being afraid to some particular thing even if it does not exist. It was the concept of intentionality that Husserl took hold of and developed into his new approach to analysing the experiences of thought and knowing through phenomenology.

In *Logical Investigations,* Husserl identified the necessity to go back to the 'things themselves', to the actual experiences which must have originated in intuition in an effort to understand concepts or ideas of logic (Husserl 1970) (also discussed in Chapters 1 and 4). In developing his philosophy Husserl identified that Brentano may have slipped into assuming that all objects of thought are real, as Blattner (2006) clarifies: 'Once we begin talking about "immanent objects",… it is easy to slide into thinking about meaning as a special sort of thing…' (p. 26). In order to avoid this, Husserl introduced his technique of 'phenomenological reduction' which somehow permits a person to have a change in attitude and suspend their beliefs and assumptions by 'bracketing' them. Husserl uses the Greek term 'epoché' to refer to this period of suspension into the natural attitude. He highlights that this enables pure phenomenology to be undertaken through uninterrupted reflection on experience (Husserl 1981). He states himself this approach can be followed 'by modifying Descartes's method' (Husserl 1981, p. 15); which inevitably gave fuel for Husserl's critics.

According to Theodore Kisiel's (1993) article entitled 'The Genesis of Heidegger's Being and Time' it was Heidegger's move to radically transform Edmund Husserl's work which was the beginning of a more fundamental conception of phenomenology. Martin Heidegger offered a novel way of seeing experience. He critiqued Husserl's philosophy which had followed the traditional stance and in particular rejected his notion of the 'un-living of experience' (Kisiel 1993) that is, bracketing. Instead, he embraced the embedded in the world experience. Kisiel agrees that all that is left after Husserl's objectified methodology is the 'impoverished I-relatedness reduced to a minimum of experiencing' (p. 46).

What is it that Heidegger offers to hermeneutic phenomenology?

Martin Heidegger commenced his work by presenting an ontological analysis of Dasein (which essentially means 'us, human beings') as a way of interpreting the meaning of being and also providing an analysis for the

structures of existence. Heidegger notes the task of ontology is to 'explain Being itself and to make the Being of entities stand out in full relief' (Heidegger 1962, p. 49). Thereby Heidegger's methodology pertains only 'To the things themselves!' (p. 50) as experienced by us. He does not accept that his methodology will accidentally stumble on findings. Instead his aim is to uncover existing phenomena, which indicates 'the totality of what lies in the light of day or can be brought to light' (p. 51). In defining logos, the second component of phenomenology, Heidegger indicates that it refers to the making manifest or making sense of what is seen. Thomas Sheehan comments in a podcast interview from KZSU FM radio station Stanford (KZSU, 2010) with Robert Harrison entitled 'Heidegger's Being and Time' that Heidegger himself had stressed to him during a meeting in 1971, that:

> Phenomenology is not about things out there … [it] is about the meaning of things in our world of use, of practical orientation, the significance of things. It is precisely meaning that changes things out there into phenomenon; that is things that meaningful appear to us and that we can engage with.
>
> (Robert Harrison on Heidegger, spoken, 1971)

Heidegger reaffirms that what is understood through his methodology is not the meaning but the entity or the being. Understanding or non-understanding can only take place through Dasein's intelligibility which is structured via the hermeneutic circle (Heidegger 1962). Thus Palmer (1969) asserts that Heidegger's project in *Being and Time* was to deepen and radicalize phenomenology and to explicitly unite it with hermeneutics.[1] Hence Sheehan also comments in the interview with Robert Harrison that it is Dasein who is the hermeneutist, the one who makes sense, and this is a basic characteristic of human beings.

At the beginning of *Being and Time* Heidegger emphasizes that the fundamental nature of Dasein is its existence, and to each one of us our existence is our own. As Heidegger states '…Being, is in each case mine' (Heidegger 1962, p. 67). Heidegger does not mean that Dasein lives in isolation but that Dasein's behaviour potentially demonstrates different modes of being. Thereby 'Dasein is in each case essentially is its own possibility' (p. 68). This includes choice, such as acting authentically or inauthentically.

In division I of *Being and Time* Heidegger explores the world in terms of the entities or substances within it and the way Dasein relates to them. He notes that we have a fundamental perspective on the way we view and understand these entities through our experiences and dealings in our world. He defines them in relation to the way of being which refers to how Dasein makes these entities or substances intelligible. These include: present-at-hand; ready-to-hand; and unready-to-hand. Present-at-hand is everything that is independent of our lives (Blattner 2006), for example substances which are self-sufficient such as trees, an electrical charge or

the sun. Ready-to-hand refers to how we do not look at objects as being unrelated to our practical activities but as instrumental objects, such as equipment. Heidegger states:

> The less we just stare at the hammer-thing, and the more we seize hold of it and use it, the more primordial does our relationship to it become, and the more unveiledly is it encountered as that which it is – as equipment.
>
> (Heidegger 1962, p. 98)

Unready-to-hand, Blattner (2006) describes is the 'unavailability of some-thing for use in human practice' (p. 65). When unready-to-hand refers to equipment, there is breakdown or malfunction and we are forced to con-centrate on it. Heidegger (1962) stresses that unready-to-hand does not solely pertain to something that is missing or unusable but also relates to that which concerns us greatly and requires our attention.

Heidegger also underlines the importance of incorporating the 'tem-poral' aspect of being in any attempt to give meaning to the modes and characteristics of being. Understanding entities can therefore only be undertaken in terms of their relation to time of which there are three dif-ferent modes: the past, present and future (Heidegger 1962). Later in division II of *Being and Time* Heidegger integrates the temporal features that structure Dasein (Blattner 2006).

Dreyfus (1991) summarizes Heidegger's purpose in asking the question of being and highlights that he sought to comprehend our understanding of our practices, by presenting thematically what human beings obliviously do all the time. This is because for Heidegger, a fundamental feature of Dasein's experience is our familiarity with the world that we live in and often do not notice. According to Dreyfus (1991), this was what the philosophi-cal tradition forgot about for over 2000 years. It is central to Heidegger's philosophy. Our familiarity or, in other words, our background is often con-cealed from us as we frequently take it for granted or become absorbed in our everyday life. Heidegger gives the example of the latch on the door. As we open the door to go out we often do not notice it. Heidegger identified two levels of uncovering a phenomenon: 'ontically' meaning that which is observed and 'ontologically' referring to the phenomenological analysis of the deep structures that underlie and explain the ontic (Frede 1993). He reflects that 'Dasein is ontically "closest" to itself and ontologically farthest; but pre-ontologically it is surely not a stranger' (Heidegger 1962, p. 37). The phrase '...pre-ontologically it is surely not a stranger' is referring to our inability to define our own state of being as we are always currently living in our everyday mode of being, not stopping to analyse it. Consequently, as Sheehan emphasizes, it is only through undertaking fundamental ontology as phenomenology that the question of being can be answered by bringing to light the things that meaningfully appear or are significant to us (KZSU

Stanford 2010). As Heidegger (1962) confirms '…it is itself the clearing' (p. 171), the space left behind after the trees have been cleared away, which illuminates the phenomenon.

As referred to above, Heidegger's philosophy places Dasein (us) as a Being-in-the-world. Using a tripartite formation he identifies three structural elements of being-in-the-world: these include thrownness (facticity); discursiveness; and understanding (projectedness). Thrownness is a basic characteristic of Dasein and refers to the certainty that we as beings find ourselves thrown into a context without having a choice, which is culturally and historically significant (also discussed by Thomson, Chapter 8). Heidegger asserts that the term '…"thrownness" is meant to suggest the facticity of its being delivered over' (p. 174). These somewhat confusing terms refer not just to how the world we live in has an impact on us, but also how we as human beings encounter our world by always being attuned to it and making sense of what matters to us. Blattner (2006) explains that in our being we are '…tuned into the way things matter, our tuning or temper is our mood' (p. 79). Heidegger contends that we are always 'disposed' in a mood (Heidegger 1962).

Discursiveness refers to our activities and how we articulate the world through our language by following the guidelines of interpretation (Guignon 1993). Projectedness refers to our act of understanding, to reach ahead into the meaning of something in order to comprehend it. As humans we cannot take in things and understand them immediately, we have to identify and work things out in terms of something else. For example, a suitcase has the role as a container and transporter for clothes or similar items but is unsuitable to carry liquids. Meaning is therefore only obtained in the projection of which something becomes intelligible as something (Heidegger 1962). Heidegger stresses that '…when something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement is one which gets laid out by the interpretation' (p. 190). It is Heidegger's recognition of this background involvement that is unique in comparison to previous traditional philosophers.

Our making sense of things can nevertheless be undertaken in a fallen mode. 'Falling' according to Heidegger (1962) is related to our every day 'absorption in' our activities of life where we don't become fully engaged with our particular responsibilities. The term 'absorption in' reflects our, 'Being-lost in the publicness of the "they" and in this situation we have declined our potential to be authentic and have fallen into the world' (Heidegger 1962, p. 220). Heidegger comments that being 'fallen into the world' is a state in which we act in a programmed way with each other by conforming and not trying to obtain a unique perspective. This is disclosed by three components: idle talk; curiosity; and ambiguity of which every Dasein has the tendency to adhere to. Heidegger believes that when one is 'absorbed in' the 'they' and in the 'world' then one flees from facing up to his or her capability to

be authentic. Falling is a situation which most of us can drift into. It is only through uncovering the situation in which we flee that we begin to understand and interpret our being-in-the-world (Heidegger 1962).

The method of Heideggerian hermeneutical phenomenology

The process of Heideggerian hermeneutics as a method of enquiry is circular, as it adheres to the basic principle of the hermeneutical circle which highlights the relatedness of the phenomena under investigation to its surroundings. As described by Palmer (1969) 'The part is understood from the whole and the whole from the inner harmony of its parts' (p. 77). Schleiermacher (1998) who properly credits Friedrich Ast (1778–1841) with asserting the principle '…that everything individual can only be understood via the whole' (p. 70). Heidegger adopted the hermeneutic circle to make interpretation possible, and, in doing so, developed a three-fold structure he called 'the fore-structure of interpretation': 'fore-having, fore-sight and fore-conception'. 'Fore-having', according to Heidegger (1962), is where in every case the interpretation is based on 'something we have in advance' (p. 191), the background context in 'which Dasein knows its way about… in its public environment' (p. 405). For example a new mother may already know from her background knowledge that a baby needs to be fed to survive. 'Fore-sight' refers to the fact that we always enter a situation or experience with a particular view or perspective. 'Fore-conception' is the anticipated sense of the interpretation which becomes conceptualized. For example, when a mother senses that her baby is unwell and later her interpretation is conceptualized when the baby has developed apyrexia. What is most important as emphasized by Heidegger is the 'working out of these fore-structures in terms of the things themselves' (p. 195) so that rigorous interpretation can be possible. It 'is not to get out of the circle [of understanding] but to come into it in the right way' which is essential (p. 195). The process is also reflexive in that the researcher turns a critical gaze towards themselves and how they may have impacted on the research (Finlay 2003). Furthermore, the interpretive process is never ending as it is always tentative, following the assumption that no single correct interpretation exists. Nevertheless the researcher must continually examine the whole and parts of the transcript while frequently listening to the data (if it is in audio format) and with reference to the participants to ensure that the interpretations are reflected in the findings (Diekelmann 2001).

Brief outline of my study

The central aim of my research is to bring to light women's experiences of postnatal care in Ireland. Unlike in Northern Ireland or the United Kingdom, there is no national community midwifery service in the Republic of Ireland. In the study, Heideggerian hermeneutic phenomenology is used to gain a greater understanding of how women experience care following

childbirth and give meaning to their experiences. Both primigravid and multigravid women were included, and their postnatal care aspirations and experiences were explored, from the context of inside the hospital and in the community. The research involved two phases (Table 12.1). Phase one consisted of recruiting a cohort of six primigravid women and six multi-gravid women to participate in three follow-up group interviews. Phase two included a separate cohort of primigravid and multigravid women who par-ticipated in individual in-depth interviews. Both research phases followed a longitudinal approach to data collection. The stages were from 28 to 38 weeks antenatally, and from two to eight weeks and three to four months postpartum. The collection of data and the interpretive method involved a number of processes, which are outlined below.

The hermeneutic group interview

Group interviews provide 'neutral controls on data collection' as participants challenge or question extreme viewpoints (Robinson 1999), validate infor-mation given by others, and allow the moderator to probe for deeper levels of information (Lane *et al.* 2001). Group interviews were chosen as the initial method of data collection to scope the research field and identify care issues concerning the women that may need further in-depth enquiry in phase two, while ensuring that the phenomenological conversations were not inhibited. As described by Smythe *et al.* (2008) 'Our interviewing style is not structured in that we follow a pre-organised plan, nor unstructured, where we go with no clear sense of why we are there…but always an interview is about something' (p. 1392). This data collection strategy promoted an in-depth, interpretative dialogue as encouraged by Benner (1994) who emphasizes that data collec-tion, enquiry, and analysis should not be separated.

Table 12.1 Number of participants involved at the different stages and phases of data collection

Stages of data collection	Phase one: No. of participants in primigravid group interview	Phase one: No. of participants in multiparous group interview	Phase two: No. of participants in primigravid individual interviews	Phase two: No. of participants in multiparous individual interviews
28 to 38 weeks antenatally	6	6	7	6
2 to 8 weeks postnatally	5	4	5	5
3 to 4 months postnatally	5	4	5	5
Total	6 group interviews		33 individual interviews	

Indeed the actual group interview process encouraged a dynamic that triggered the sharing of postnatal care experiences through recollection and self-reflection, when otherwise the participants may have remained silent. A sense of solidarity also prevailed, and, in some cases, the group process appeared to have a therapeutic effect for some participants, particularly when there was an acknowledgement of similar experiences.

Benner (1994) emphasizes the effectiveness of using the small group interview in a hermeneutic phenomenological study of health and illness, stating that group interviews can achieve several purposes such as:

• creating a natural communicative context for telling stories from practice
• providing a rich basis for active listening
• meanings of the participants' stories can be enriched by stories triggered to counter, contrast, or bring up similarities
• simulating a work environment that creates a forum for thinking and talking about work situations.

The hermeneutic individual interview

Highlighting the purpose of the phenomenological interview, Sorrell Dinkins (2005) states the aim is to 'understand a phenomenon by drawing from the respondent(s) a vivid picture of the "lived experience", complete with the richness of detail and context that shape the experience' (p. 113). The communicative context therefore must prevent the participants from feeling awkward or constrained by the interview process, particularly by the use of foreign or abstract language (Benner 1994). In order to achieve this, 2 to 3 days prior to both the group and the individual interviews taking place I contacted the participants to remind them of the interview and to encourage them to recollect their postnatal care experiences prior to our meeting. This proved fruitful in the richness of the transcripts. The majority of the interviews were held at the participants' home. At the beginning of each interview the participants were asked a broad open hermeneutical question to elicit their postnatal care story and to seek their interpretation(s) on the meanings and significances of their experience: 'Can you please tell me about your postnatal care experience(s) and what does it mean to you to have had this experience?' Once their story was recounted, open prompt questions were used to clarify words or phrases used by the participants that had taken for granted meaning, for example: 'care' or 'support'. In addition, to avoid causal relationships and explanations the participants were asked to give an example(s) of their experience(s). Another approach used to seek the meanings and significances of the women's postnatal care experience(s) was to ask them: 'If they had a close relative who would soon be in a similar situation to themselves, having just had a baby what would they say to them about postnatal care?' These detailed descriptions of the

practices and shared meanings are according to Diekelmann and Ironside (1998) '…intended to reveal, enhance, or extend understandings of the human situation as it is lived' (p. 343).

To further ensure that a comprehensive approach to the hermeneutic interviewing was undertaken the 'Socratic-Hermeneutic Inter-view' as described by Sorrell Dinkins (2005) was followed when appropriate. This alternative approach to phenomenological interviews incorporates Socrates' ideas of shared inquiry were the focus is moved away from the 'respondent' to '…a shared dialogue focused on reflections of both interviewer and the interviewee as they share ideas, listen, and reflect together, thus forming an inter-view' (p. 128). This approach was applicable particularly when I, the interviewer, was in the postnatal period myself having recently given birth. Principally, each interview was unique and, what was most important, had '…openness to what "is" – to the play of conversation' (Smythe *et al.* 2008, p. 1392).

Data analysis

Prior to data analysis, each interview was transcribed verbatim by the same audio typist and checked for accuracy against the audio by myself. Each interview was read in its entirety. As the process of hermeneutic phenomenological analysis is iterative and non-linear, broad, sweeping themes were initially identified across interviews with the aid of MAXQDA2, a computer software package for data management. The specific analytical approach used for both the group interviews and the individual interviews followed the methods proposed by Crist and Tanner (2003). They highlight a number of phases that can be followed to assist in approaching this interpretive process as systematically as possible, although the authors stress that the phases may overlap. These include:

Phase 1: Early focus and lines of enquiry

This includes a critical evaluation of the researcher's interview and field notes within the transcripts. Lines of enquiry from initial interpretations guide subsequent interviews and direct future sampling to provide deeper, richer understanding.

Phase 2: Central concerns, exemplars and paradigm cases

The interpretive researcher or team identify central concerns, important themes, or meanings, that are unfolding for specific informants. This process begins with interpretive writing of approximately three to five page summaries of central concerns with salient excerpts. A review of new or revised summaries may cause exemplars and paradigm cases to emerge. Exemplars are excerpts that define common themes or meaning across

informants, whereas paradigm cases are vibrant stories or strong instances of particular patterns of meaning.

Phase 3: Shared meanings

As informants' central concerns become clear, the researcher/team members observe shared meanings within and across stories.

Phase 4: Final interpretations

Subsequent interpretive notes and summaries continue to provide a line of enquiry for current narratives and future sampling. In-depth interpretations are developed and final interviews address pending lines of enquiry.

Phase 5: Dissemination of the interpretation

This phase continues to follow an iterative process between the narrative, field notes and input from the researcher/team, as interpretations are refined for publication.

During each of these phases time was taken to identify the interpretive decisions and recommendations. These became part of the research log as an audit trail. It is important that the hermeneutic phenomenologist ensures that he/she does not misinterpret participants' responses. Plager's (1994) principles for evaluating findings from a hermeneutic phenomenological study were adhered to in my study; these include the following.

- Coherence: the account presents a unified picture, including letting contradictions show up and making as much sense of them as the text will allow.
- Comprehensiveness: the account must give a sense of the whole that is the context (situatedness) and temporality for the participants.
- Penetration: the account 'attempts to resolve a central problematic' (p. 29).
- Thoroughness: the account deals with all the questions posed.
- Appropriateness: the questions must be those raised by the text itself.
- Contextuality: the historical and contextual nature of the text must be preserved.
- Agreement: the account must agree with what the text says (not attempt a hermeneutic of suspicion) but should reserve room for reinterpretation by showing where previous interpretations were deficient.
- Suggestiveness: a good understanding in the interpretive account will raise questions to stimulate further interpretive research.

The researcher has a key role as highlighted above, in that he or she writes themselves into the process through reflection on their experience of data

collection and analysis. By keeping a study diary as emphasized by (Gadamer 1976), I was able to leave a decision trail on the theoretical, methodological and analytical choices I made throughout the study.

Using Heidegger's existential concepts

Within division I of *Being and Time* Heidegger articulates a phenomenology of everyday life. Later on in division II he presents existential themes that represent an exploration into how we as human beings can change in light of our experience with the extreme challenges of life (Blattner 2006). His philosophy can thereby provide conceptual insights that can be used to understand and explain phenomenon which have come to light during hermeneutic phenomenological research. Three themes from my research into women's experiences of postnatal care in Ireland are presented here to illustrate how Heideggerian concepts can help to illuminate interpretations. These include: 'moods'; 'unready-to-hand'; and 'being-with'. All names used are pseudonyms.

Moods

For Heidegger, moods, or attunement, are a basic characteristic of our familiarity with the world. Heidegger (1962) claims that 'A mood assails us. It comes neither from "outside" nor from "inside" but arises out of Being-in-the world' (p. 176). Moods have an effect on the atmosphere and can be a monitor how we are 'faring', or as Heidegger writes, 'how we are doing' (p. 173). Our moods are also passive to us, as they are often affected by the situation we find ourselves in. Heidegger uses the term 'disposedness' to explain what is common to all moods and how moods for us are related to being-in-the-world. Using fear as an example of a mood Heidegger describes three essential characteristics of disposedness: First, disposedness discloses our thrownness, our inability to control certain circumstances in the world; disposedness also 'discloses being-in-the-world as a whole', as when we are frightened for example certain features of our situation are more dominant than others and finally, a facet of disposedness is our 'submission to the world': that is, when we find ourselves in a vulnerable situation, certain possibilities matter more or are more important to us than others. Moods therefore can import or disclose the way things, persons or events matter to us. This Heideggerian concept became apparent in my interpretations as per the comments from research participants Marie and Claire – it is the little touches that matter to them:

> …particularly for second time mothers, when you don't necessarily need to be shown how to do stuff you just need a little bit of isn't this a wonderful time of your life kind of experience, and here's a cup of tea.
>
> (Marie)

> Oh it's very important to have your name, for me it was really important that my name was being used…in the [postnatal] ward it nearly, it kind of makes me laugh about the Mum thing, you know, you're just Mum up there, you know, there's no name when you're up on the ward, it's like 'Mum do this'.
>
> (Claire)

Unready-to-hand

As mentioned above, Heidegger's concept of unready-to-hand pertains to a breakdown situation or a malfunction which we are forced to concentrate on. It also relates to that which concerns us greatly and requires our attention. For some of the women in my research, becoming a new mother was very challenging, particularly when they felt unprepared. These findings mirror Heidegger's unready-to-hand concept. Below Annie describes the 'horrendous' experience of her first night at home with her new baby:

> … our first night home was horrendous because I really didn't know what to expect, because nobody told me what to expect and …, we didn't know what we were doing for changing and I got very frustrated and Michael got very frustrated on that first night because we didn't know how difficult it was going to be. And I suppose [the baby] fed off that a little bit as well and he was probably a bit anxious as well and it was horrendous and I thought, I can't do this, I cannot do this!, this is just, I am too tired!, I am too emotional!, I cannot do this and Michael was the same.
>
> (Annie)

Sarah explains her concern about her husband's inability to bond with their baby who suffers from colic:

> Sean just didn't bond with her at all, I think only really in the last two weeks he's started to make some connection with her, he just said she's not like other babies, she doesn't smile, she doesn't look at you. She used to not make eye-contact; she was so distracted with the pain [colic]… Sean just used to say I just want my life back and that used to really hurt me because I'd think oh she'll be better, …and I was trying to make excuses for her saying she'll be better soon, it'll be gone in three months and then when three months came and it didn't go …I mean obviously I found the crying hard, looking at her struggling but I didn't find it hard to make a relationship with her as such, but Sean really did…
>
> (Sarah)

Heidegger emphasizes that 'Anything which is un-ready-to-hand in this way is disturbing to us' (Heidegger 1962, p. 103).

Being-with

The concept of 'being-with' for Heidegger (1962) is a characteristic of each individual Dasein as it is an 'existential constituent of Being-in-the world' (p. 163) that of our being with others. We can still be with others and be alone, as people who are significant to us do not always have to be near. As others matter to us, the concern we have as we comport ourselves towards them Heidegger refers to as 'solicitude' or 'Fürsorge', which is translated as 'caring-for'. This manner of caring-for which Dasein demonstrates in being-with others is completely opposite to the concern or 'Besorge' that ready-to-hand or present-at-hand entities receive as objects of concern. Heidegger writes 'Thus as Being-with, Dasein "is" essentially for-the-sake-of others' (1962, p. 160). He also confirms that 'solicitude proves to be a state of Dasein's Being' (1962, p. 159), particularly as there are different modes of solicitude, ranging from the deficient or indifferent to the positive. According to Heidegger, positive modes of caring for other can be 'inauthentic', defined as a 'leaping in' for the other, a 'taking care' of their possibilities for them rendering them dependent (also refer to Chapter 3). This is opposed to 'authentic' caring, whereby there is a freeing of the other for their own possibilities.

Some of the women in the study experienced authentic care, as described by Jane:

> Well they [the midwife] would make a point of asking me had I had some sleep, had I eaten, how was he [the baby], how was I feeling, you know, all that type of thing and then there was, you know, the physical check up as well, they did all of that and as I say, in that kind of a nice chatty way, it wasn't an interrogation of anything … you felt like it was more of a friend and a chat and so I think you were more likely to be open with them.
>
> (Jane)

This authentic caring for the new mother helps build maternal agency and exhibits the core element of being a midwife and as per the International Confederation of Midwives definition of a midwife (ICM 2005). Theresa explains below how she responded when a midwife demonstrated an indifferent aspect of solicitude and highlights the subsequent outcome:

> When I knew a midwife wasn't interested I just didn't bother engaging with them, you know, I didn't really ask them anything.
>
> (Theresa)

In summary, by utilizing the Heideggerian existential concepts during the interpretation phase I was able to illuminate how the women's postnatal care was experienced and internalized.

Conclusion

Heidegger's contribution to the genesis and development of hermeneutic phenomenology is momentous. He has provided a philosophy, created the basis for a methodology, outlined the hermeneutical method, and provided existential concepts which can be utilized to understand and explain phenomenon. By fully comprehending the underpinnings of Heidegger's work the hermeneutic phenomenological researcher can uncover insightful meanings and significances of phenomena for those who experience it.

Note

1 The term hermeneutics originates from Greek mythology whereby a great messenger of the gods named Hermes not only communicated verbatim the messages he was given by the gods, but also interpreted their meaning for the people. According to Bleicher (1980), hermeneutics was used from an early stage to assist with understanding the language of a text, to facilitate biblical exegesis, and to guide jurisdiction.

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