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Midwifery and Mental Health: Narratives of New Zealand Midwives

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ABSTRACT

New Zealand has a midwife-led maternity system, and over 75% of women engage an independent midwife for maternity care. It is estimated that one in four mothers will experience symptoms of psychological disorder in the ante-and post-natal period. This research questions the meaning of a pathological maternal body and symptoms of anxiety through the experience of midwives. Developed through consultation with midwives and feminist standpoint epistemology, this research aimed to understand how midwives are narratively positioned in their practice and how midwifery ideology could inform psychological practice in maternal mental health. As a feminist project, the research accounted for what was salient to the midwives and how working with clients with mental health issues impacted on them personally and professionally. To bring voice to the narratives produced through twelve interviews, a feminist standpoint epistemology was engaged to locate midwives in their own ideological framework, and the political and institutional power relations in which they are embedded. Researcher reflexivity, the context of tensions between midwifery and biomedical discourse, and the contradictory meaning of the maternal body were brought to the analysis. A structured approach to narrative analysis brought meaning to how midwives' identities and experiences intersect at ideological, personal, interpersonal and professional levels. The structural analysis allowed for an understanding of the complexities faced by New Zealand's midwives in their practice. It enabled an understanding of the technologies of gendered power relationships that produce the maternal body through the medical gaze, and the effects for midwives as they oscillate between biomedical and midwifery ideological narratives of maternity and maternal mental health. It also provides an understanding of the effects of narratives of risk where biomedical narratives produce the maternal body as deficit physiology and psychology, particularly reducing women's distress to a symptom of disorder and excludes the sociocultural context of women's experience.

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CHAPTER ONE - Introduction

We know that birth takes a woman from one place in her life to another. The birth of a child certainly does change her viewpoint of herself and I believe her viewpoint of the world. (Sareef, nd)

My Position as Researcher and Mother

I am a mother of two beautiful girls; not only were they born, but a new aspect of me as ‘mother’ was born with them. The birth of my children was significant in transforming my view of myself, and my body. My children came into the world with the assistance of two particularly incredible midwives, who encouraged me at every step, and helped me to see the beauty and deep source of strength in a woman’s body’s ability to be pregnant and give birth naturally, but I did not always see things this way.

In late adolescence my body, in particular my reproductive system, had been pathologised and diagnosed as faulty. I internalised the notion that I was ‘defective’ and may never have children naturally. I had become constituted through a medicalised conception of my body, and I accepted this as part of my identity through a biomedical definition of ‘condition’. I was resigned to the knowledge that if I ever got pregnant, I would need close observation from the medical fraternity.

When I unexpectedly fell pregnant, I was full of fear that something would go medically wrong; after all I had a ‘defective body’ and a family history of medical intervention in pregnancy and birth. This was ‘normal’, and there was no reason why I should expect a different experience. I would have undergone any test or procedure to ensure the safety of my pregnancy and child, and I always anticipated accepting every kind of intervention or pain relief possible when in labour. I held a view of my reproductive body as a site of risk that needed to be medically managed. I had been already categorised by virtue of my biology – something over which I had no control. This understanding of my risky reproductive body produced, for me, conflicting emotions as I negotiated my maternal body through physiological changes. I was both amazed at my body’s ability to give life and concerned about my health and that of my baby. I experienced excitement, joy, and heightened anticipation; but also uncertainty, stress, ambivalence and anxiety. I was also aware of feelings of grief that were related to a sense of loss of my identity. As a student of psychology, I was informed by research focus on post-natal depression, but found very little research about antenatal mental health issues – as I attempted to make sense of my conflicting emotions.

My relationship with my midwives enabled me to shift my assumptions that pregnancy was a universal physiological event where all mothers experience this transformation in the same way. Being able to talk with my midwives about my birth choices empowered me to consider choices that had not been visible to me before. It became possible to understand the contradictions I was experiencing as ‘normal’ and ‘natural’. My midwives were able to coach me through pharmaceutical- and technology-free births, and encouraged me to take ownership of the process and to trust in my own ‘defective’ body. Their respect for me, belief in the process and their trust in my ability, along with their appreciation of who I am in my social context meant that I was able to understand the process of maternity through the midwifery principle of ‘woman as embodied’ rather than through a bio-medical gaze. Through this experience, I understand midwifery as a practice that has the potential to produce counter-narratives to the dominance of the biomedical narrative that inscribes women’s experiences of maternity, and therefore I became interested in midwives’ understanding of maternal mental health.

To contextualise the relationship between a defective reproductive body and the gendered experience of maternity meant attending to the literature that questioned the historical, social and cultural meanings of gender produced through dominant narratives of sexual difference. Reproduction has become a site of regulation through the biomedical disciplining of women’s maternal bodies.

Feminist Critiques of Biomedical Dominance

The principle of ‘woman as embodied’ implies understanding the experience of maternity as gendered. Given that pregnancy is something that women experience in and through their bodies, the meaning of biological difference and pregnancy as social experience goes beyond physiology, and in this instance, feminism can be concerned with how the body is constructed and transformed through gendered social practices (Lorber & Moore, 2011; Parry, 2008).

In its most potent sense, feminism is a form of cultural critique and proponent of social change through a pursuit of resistance to patriarchal power relations (Morawsky, 1997). Feminist engagements with psychology have troubled the gendered effects of a bio-medical gaze that objectifies women through a patriarchal normalising scientific discourse, and have challenged the dominant psychological narrative of sexual differences that are not “natural, essential, or biological” (West & Zimmerman, 1991, p.14), and produce women’s sexual difference as deficit (Lorber & Moore, 2001; Marecek, Kimmel, Crawford, & Hare-Mustin, 2003; Nicolson, 1992; Rutherford & Granek, 2010)

Feminist critics of a biomedically-defined psychology have maintained that women's experiences cannot be defined or understood within traditional categories of biological differences developed through dominant norms and narratives that position women through their sameness or difference from men (Harding, 1991; Jack, 1991; Sawicki, 1999). Throughout history, women's bodies have been met with suspicion, and according to Price and Shildrick (1999), have represented a "site of unruly passions and appetites that might disrupt the pursuit of truth and knowledge" (p. 2). The meaning of the difference produces knowledge that understands physiology and gender as embedded in social and cultural relationships (Hare-Mustin & Maracek, 1988).

The body produced through the biological gaze depends on binary opposites, characterised through the Cartesian dualism that separates the mind and the body. This elaborates a theory of personhood that privileges the function of the mind and the human ability to 'reason', and relegates the body to a mechanical function (Price & Shildrick, 1999). Feminist accounts of the relationship between women's bodies and women's psychologies have critiqued the ways women's bodies have been represented as pathological, linking the meaning of women to body (Nicolson, 1992; Ussher, 1991). Morgan (2005) argues that the split between body and mind also positions women as the opposite of reason and rationality. In other words, binary opposites are hierarchically organised through gendered relationships of domination and subordination where one term defines what the other is not. Women become closely connected to irrationality, the body, and emotion, while men are assumed to possess control, reason and rationality. This gendered hierarchy characterises the reductionist, biomedical approach to the body, which reduces the body to a number of 'systems' that can be scientifically categorised. This system of bodily categorisation is presented as objective 'truth' (Davis & Walker, 2010). Knowledge produced in our Western culture is dominated by assumptions of the feminine body, and particularly the maternal body, as weak and deficient.

Feminist critiques of the knowledge claims of scientific research challenge the deficit model of female psychology, particularly through the repeated examination of women's distress as symptoms of disorder (Ussher, 1991, 2010, 2013), and negate the socially and culturally embedded aspects of women's experience.

It can be advanced that feminism, as a form of cultural critique, is deeply concerned with the body – something to be reclaimed from a patriarchal standard of rationality and reason, and claimed as part of a foundation for doing gender (Price & Shildrick, 1999). For example, Ussher (1997, p. 1) argues that feminist psychology seeks to challenge the material and socially constructed binary towards an "interaction and interrelationship" between the lived and felt gendered body, especially where a psychological narrative of reproduction has become

understood as a crisis in women's lives; a process that places them at risk of psychological disorder.

The biomedical gaze has transformed the maternal body into a technologically observable body, rendering it unpredictable, disruptive and leaky, dispossessing women of their body (Kitzinger, 1992). Where the psychological gaze disorders women through emotional and physical vulnerability associated with childbirth, women are positioned as victims of an uncontrollable biological body (Einstein & Shildrick, 2009; Ussher, 2010) and subject to psychological surveillance.

The focus on women's reproductive bodies as a site of control has been referred to as the "colonisation of the womb", and the oppression of women and modern obstetrics (Ehrenreich, 1993, p. 492). It is the gendered social power relations that authorise biomedical knowledge of female pathology within a "fetocentric environment" (Baker, Precilla, Henshaw & Joanne, 2005, p. 319) that act to define, discipline and disempower women and their bodies. It is how women are positioned as compliant consumers of scientific hegemony, with responsibility for good outcomes (Marshall & Woollett, 2000), which have become the focus of feminist critique. As argued by Braun and Wilkinson (2001), women's bodies continue to be a site of contestation.

The Construction of the Maternal Body

The early feminist work of Bartky (1988) and Bordo (1993, 1997) have enabled more insight into how gendered power relations produce particular women's bodies, and have argued for the need to analyse cultural representations of women's bodies. Braun and Wilkinson (2001) have argued that the meaning of the body is both a cultural effect and a biological entity.

Drawing on the Foucaultian accounts of normalisation enacted through disciplinary power and biopower, Bartky (1988) theorises the production of women's bodies as docile, in constant need of coercive attention to the functioning of the body through a relentless process of surveillance. She argues that gendered disciplinary practices aim to produce an idealised (feminine) woman against the background of bodily deficiency. Disciplinary power attends to the institutional practices for managing bodies and rendering them docile through techniques of normalisation. Biopower regulates the power inscribed in the control of the population through technologies of categorisation and measurement to produce norms and is directly concerned with processes of birth, death, health, reproduction and illnesses of a population, that Foucault (1976) argues is a pervasive and persistent method of social control. These forms of power are inseparable, and knowledge and power control the movement, location and capacity of people, and the behaviour of bodies. The histories of women's bodies are intimately connected to the system of reproductive technologies that both constitute and discipline them (Sawicki, 1999).

The systems of power render women's bodies as docile, productive and useful, through technologies of normalised disciplinary practices, and through biomedically constituted gendered power relations. Resistance to the norm is read as pathology and conformity read as evidence of good health and conduct (Barkty, 1990). The production of maternal bodies through a biomedical gaze requires coerced attention to bodily function that is constantly under surveillance. This taken for granted and legitimated social power relation has the result of upholding certain narratives whilst silencing others (Harding, 1987). The notion of technologies of gender in relation to maternity suggest that the internalisation of an outsider patriarchal gaze, the process where a "woman lives her body as seen by another, by an anonymous patriarchal Other" (Barkty, 1990, p. 72) needs to be problematised.

Approaching this work from a feminist perspective is a means of alternative knowledge production; the construction of a counter-narrative that challenges legitimated hegemonic knowledge is a site through which the meaning of women's bodies is negotiated and renegotiated. In this research, I take up a position of respectful feminist critique, with an insider perspective on the complexities of being located within normalised disciplinary practices, where conformity to the medical model is evidence of a responsible, docile body.

Feminist Standpoint Epistemology

Feminist standpoint epistemology is important to issues of reproduction because it enables women to make problematic in our research those issues that are problematic in our lives (Woliver, 2002). Feminist standpoint research is woman-centred, and involves strategies of construction and de-construction, presentation and re-presentation of women's experiences, and makes observable the stories and voices that can be lost under a patriarchal empiricist frameworks (Campbell & Wasco, 2000; Morawsky, 1997). In this research, feminist standpoint can be understood as the diverse historical and cultural gendered power relations that produced women's lived experiences (Harding, 1986). What is critical to a feminist standpoint epistemology is the place of women's experience; women's stories are at the centre of the research that question the gendered power relationship through which the maternal body is produced, and in this research, how that is implicated in women to women relationships through the practice of midwifery.

Feminist standpoint epistemology as a social epistemology is interested in understanding the contextual and relational experiences, commonalities and contradictions of women's marginalisation and oppression within patriarchal society (Bold, 2012; Kralik & van Loon, 2008). From this perspective, all knowledge is said to be situated and consequently, women's experiences can be understood as being located within a continuing process of making

meaning - embedded in social power relations (Harding, 1995). Lived experience both informs and forms an epistemological position. If this experience is shared by a number of people, even among diversity, they will also share a standpoint, allowing for women within these groups to begin to resist any marginalisation and oppression, and begin to re-frame and bring their experiences to light (Hirschmarm, 2008). Harding (1991) argues that this type of theoretical approach to research gives access to the ways in which women resist patriarchal ideologies and institutions. She stated that by “trying to reconstruct the story from the perspective of the lives of those who resist oppression . . . we can come to understand hidden aspects of social relations between the genders and institutions that support these relations” (pp. 126-127). It is, therefore, an epistemology that is specifically located and partial.

Feminist standpoint epistemology has, at its foundation, a recognition that women’s lives and experiences, told through their voices, as the *source* of knowledge. Feminist theory has been developed for women by women, and midwifery literally means ‘with woman’. Both feminist research and midwifery are concerned with a ‘for women, by women’ approach to their practice, and provide the ability to address both the setting in which women are cared for, and access to the experiences of the women themselves (McCool & McCool, 1989). Jordan (1997) argues that ‘authoritative knowledge’, through which the mechanisms for how one body of knowledge gains a position of authority over another, includes historical narratives to suppress competing forms of knowledge through the devaluing of other paradigms - such as midwifery.

From this standpoint, it was clear to me that I needed to incorporate not just the voices of the midwives as participants in this research, but to locate them in their own sphere, and expand that to the social and historical locality of their position. This raised questions around the influence of social and institutional power relations that produced midwifery, and by extension the women with which they work. Consequently, it was necessary to question the influences of knowledge and power in midwifery practice. Feminist standpoint therefore, cannot be regarded as value-free or as inherently ‘natural’, but rather that reality is constituted by socio-political influences and that the materially experienced moments are described under a framework that privileges a particular point of view (Bartky, 1988). Because the lived experiences of midwives are unlikely to be an exact fit for the societal and political descriptions of them, the *aim* of this research was to explore the ambiguities, silences, conflicts, contradictions, and power relations implicit within their context (Cheek & Rudge, 1994), and their impact on how midwives negotiate the terrain of maternal mental health.

This research aims to include the social, embodied, natural experience of a group of women in their political sphere. In addition to this, because midwifery itself crosses boundaries between a medical world and that of everyday women, it is necessary to look into how this

functions within society's structure and power relations. The aim of this study then, is to hear the voice of midwives, positioned in a tension between gendered understandings of the pathological maternal body and maternal mental health.

The following chapters trace the history of midwifery in New Zealand's context and the influence that the medical gaze on maternity has had on midwifery's practice, along with psychology's attention to maternal mental health. The methodology and method produced for this study through these enquiries will be outlined, and concluded with an analysis and discussion of narratives in this work.

CHAPTER TWO - The Gestation and Birth of Midwifery in New Zealand

The transition from almost all births taking place at home to almost all births taking place in the hospital took just over two generations. In those two generations, birth changed from being an event in the life of a family to being a medical procedure. New mothers became patients, and the care of newborns became a thriving medical specialty. (Rothman, 1991, p. 29)

Our current understandings of midwifery and the maternal body are embedded within the historical and cultural narratives through which contemporary midwifery emerged. The narratives generated within these climates have influenced societal movements, which both enabled and constrained the practice of midwifery in New Zealand.

Midwifery as a practice has been ever-present, but its visibility has ebbed and flowed in society over time, along with continual change to the profession's perceived respectability and autonomy. It is difficult to pinpoint when the profession of midwifery began, but it has been well documented that communities across cultures have and do practice midwifery. There is evidence of a structured midwifery practice within Greek and Roman times, and many cultures have records and histories that include discussion of women who attended births (World Health Organization, 2011). The term 'midwife' – meaning 'with woman' has been located as originating in medieval times (Donely, 1986; Rothman, 1991).

The practice of midwifery, historically, was more than biomedical; maternal bodily processes were understood to transcend the physical. Ehrenreich and English (2010) have argued that knowledge of the maternal body exceeded the physical, and therefore practices of midwifery were not the object of regulation or jurisdiction. Midwives were usually married women who had their own families, or widows who needed a 'respectable' way of earning a living. They were tasked with being 'with women' through pregnancy and beyond; their role was to support women in their communities, and in their multiple contexts, through the processes of maternity, and not to govern the bodies of women through regulatory power (Stojanovic, 2010). Midwifery and maternity have had a long relationship that was normalised through cultural practices. There is evidence as far back as the 1600s that there were attempts to control woman-centred practices, and midwives were not immune from accusations of being charlatans or witches, particularly where women's knowledge was being contested by an increasing attention to science and medicine: "[T]hey were called 'wise women' by the people, witches or charlatans by the authorities" (Ehrenreich & English, 2010, p. 2).

Subsequently, the increasing relationship between scientific knowledge and the control of the people contributed to suspicion towards women and women's bodies. The practice of midwifery, which was centred on maternal processes, resulted in many midwives being burned as witches, and a foundation was laid for medical narratives to be promoted as containing superior knowledge about the body, and pregnancy and birth (Ehrenreich & English, 2010).

The turn to the medicalisation of the maternal body appeared as a result of the narratives generated in Victorian Britain in the late 1800s. These narratives had a focus on population growth, and morbidity and mortality rates that were a culmination of science and population health and control (biopower). Even at this time, midwifery was a practice for the working class/poor and doctors increasingly cared for upper classes despite criticisms from the scientific medical community who suggested that midwives were responsible for dangerous practice that was not grounded in scientific training (Donely, 1986; Ehrenreich & English, 2010).

The British medical fraternity condemned midwifery as a 'female' practice that had no scientific, or 'medical' basis, and was therefore shunned by physicians. Even the judgements levelled at midwifery were based on women's biology – women were unable to attend universities, and therefore unable to practice 'medicine' as they were viewed as lacking the mental capacity to do so safely. In addition, as women were viewed as lacking rationality, there was a view that they would be unable to engage in the 'reasonableness' of medicine (Ehrenreich & English, 2010).

Midwifery in New Zealand and the Medicalisation of Birth

Even though power struggles were occurring over the medicalisation of women's bodies and midwifery as a practice in Britain, many of the new settlers in New Zealand were working class people, and there was initially a shortage of doctors. Accordingly, midwifery was necessary and midwives took responsibility for care of women in childbearing. In the early days of the newly established New Zealand colony, midwives were women who worked in the community, and had a relatively autonomous working environment where they had a sense of responsibility, and relationship with women in the population (Donely, 1986; Pairman, 2005; Stojanovic, 2010).

Childbirth for European settlers in New Zealand was largely family centred. The majority of births took place in the homes of the women, or at unlicensed maternity homes, known as 'lying-in homes', which were run by local midwives. These locations became considered by the state as a dangerous and inappropriate setting for birth, and up until this point other services or locations had been unavailable to women who could not afford to access hospitals or pay for skilled attendants. Nevertheless, despite outcomes and statistics that indicated otherwise, 'unskilled' midwifery practice was implicated in high levels of maternal

and infant mortality, as it had been in Britain, and concerns were raised about the risk to the population if untrained midwives attended births. In addition, the birth rate among the middle class settler population was declining while the birth rate among the Māori population continued to rise at steady levels – a concern for the newly fledged British Empire colony - which held the view that New Zealand had to increase its population in order for the colony to succeed. Prior to colonisation, the Māori population had culturally inscribed birthing practices that were well-established, the knowledge of which was passed down through generations, but this was displaced by the settlers' knowledge of maternity processes (Gilkison, Giddings, & Smythe, 2013). There was a view that childbearing women needed to bear healthy children for the continued development and preservation of the European population (Mein Smith, 2002; Pairman, 2005; Stojanovic, 2010). Moore (2013) explored how the British government managed infant mortality rates in the early twentieth century – around the same time that midwifery was being regulated in New Zealand. As in New Zealand, morbidity and mortality rates among childbearing women were of concern to the government at that time. It was noted that the quality of the population would be affected should this be allowed to continue. Infection was seen as the leading cause of medical complication in childbearing, and 'unskilled' midwifery was implicated in the incidence of infection and, by extension, maternal and infant mortality, and birth in hospitals was promoted as the solution (Donely, 1986).

A Royal Commission inquiry in 1904 reported that the declining birth rate among settler women was due to the “selfishness of women (in limiting their families), the distribution of early contraception [such as condoms], and the decadence of society” (Donely, 1986, p. 32). This judgement was particularly focused on those mothers who were seen as the most 'qualified' – white, middle class women who were deemed the most able to advance the success of the colony's population (Mein Smith, 2002). This report had the effect of rendering the maternal body as a resource for the empire, a moral narrative, which in turn allowed for the control of the population, through the control of the process of reproduction. This culminated in the development of the 1904 Midwives Act.

While a brief document, the 1904 Midwives Act sought to address two pressing societal issues – maternal and infant mortality and a declining birth rate. This Act provided for registration, education, and regulation of the profession, and increased control over mortality, and morbidity and by extension, women's reproductive bodies. Until this point, the practice of midwifery was brought to New Zealand with women settlers who had apprenticed with more experienced midwives in their communities. Calls to formalise midwifery by the state was proposed to counter the mortality rate, and responsibility was firmly placed on the dangerous and risky practices of women's knowledge in favour of the scientific medical model that was

emerging. The experience of a 'natural process of maternity' became governed by the state through state maternity hospitals. This was driven by the New Zealand Health Department coming under increased pressure from their British counterpart to bring New Zealand's health practices into line with that of the rest of the British Empire (Donely, 1986; Mein Smith, 2002).

It was reasoned that formalising midwifery training would allow the 'dangerous and risky' lay midwifery to be phased out, and competent, well-trained practitioners could take its place. Under the Midwives Act 1904, state maternity hospitals were opened, and student midwives were trained within them (Pairman, 2005). The 1904 Midwives Act allowed for midwives to attend births, but within the confines of the state controlled system. They were endorsed to attend 'normal' births somewhat autonomously, but only in a situation where a medical practitioner had not accepted the primary responsibility for care of a woman, and usually in attendance at one of the state maternity hospitals. Now, the environment was one of hierarchical practice; the practice of midwifery was under the supervision of the medical profession and, as such, midwives were required to be registered under such a system. Those who had previously completed overseas training under medical direction were able to apply to be registered, but midwives who had not completed at least three years of demonstrable practical experience were required to go through the training programs offered within the state-run maternity hospitals (Pairman, 2005).

The increasing influence of the government on the quality and quantity of the population in Britain through reproduction and disease control began to be managed as a resource in order to ensure economic success. Throughout this time, New Zealand was dependent on the narratives transferred from the 'mother country' to the newly fledged colony in New Zealand. The notion that the population in the United Kingdom had to be managed in terms of its value to the state can be converted into the New Zealand context – the aim was to regulate population growth and ensure the success of economic systems and the success of a colony (Moore, 2013).

The Midwifery Act 1904 was promoted as intending to improve the support and outcomes for women birthing in unsuitable environments, and to increase the availability of skilled birth attendants for working class women (Donely, 1986; Pairman, 2005), yet it had the effect of starting to de-emphasise and phase out traditional midwifery.

Between 1904 and 1920, the move to the medicalisation of birth in New Zealand echoed that of other western countries (Grigg & Tracy, 2013), and has become a global, political and social movement to regulate the profession of midwifery and the control of women's bodies. The birthing process was no longer based in women's private spaces, with women birth attendants that espoused the 'natural' process. Instead, birth progressively became a publicly mediated process. The state, through the medical model, was taking control of the legitimacy of

maternity - which made women's bodies more predictable (Donely, 1986). Through these narratives, the maternal body had become a publicly mediated space. Alongside the changes in the practice of midwifery were morally inscribed expectations that women were to produce healthy children for the greater good - that of the British Empire. Truby King and his Plunket organisation were 'educating' mothers in the skill of 'mothercraft' in order to produce mothers that were fit and capable of caring for the nation's children in the long term (Mein Smith, 2002; The Poverty Bay Herald, 1912). These moral narratives led to 'good women' seeking medical intervention through childbearing, and lost their history of engagement with midwifery. The First World War further strengthened these narratives, where a loss of many of the population's men in battle produced a desire to protect and proliferate the existing population. A campaign in the 1920s led by Dr Truby King promoted the idea that "perfect motherhood *is* perfect patriotism" (Mein Smith, 2002, p. 306) continuing the moral narratives of what constituted good mothering, and held women responsible for bearing children in particular ways, for the greater good.

Birth Spaces

Between 1904 and 1920, seven state maternity hospitals were opened – subsequently named St Helen's hospitals – that formed the basis of the state run maternity services. The brief for the St Helen's hospitals was to deliver maternity services for married women of working class, staffed by midwives, under the supervision of the more-knowledgeable doctors. Despite the availability of this new maternity system, most women continued to give birth in their homes until the after the First World War (Pairman, 2005). However, there was a continued concern about infant and maternal welfare and mortality rates, influenced by losses suffered during the First World War. The power of these 'safety' narratives were strengthened in a campaign run by the New Zealand Government in 1924 to promote 'safer' birth. The moral and medical narratives of what constituted a 'good mother' were reinforced through the provision of specific services and spaces designated for medicalised birth. This had the result of further fragmenting midwifery practice and continued to reinforce a patriarchal view of the maternal body. Due to this, in the early twentieth century, society's view of a 'normal' birth changed from being seen as a cultural and physiological process to a largely medicalised process – and what emerged was a split between technical and natural practices.

By 1924, the medicalisation of childbirth had become the dominant practice and the Nurses and Midwives Act that changed the practice of midwifery in significant ways, was introduced (Donely, 1986; Pairman, 2005). Prior to the establishment of the St Helens hospitals, and subsequent medical presence, midwives had worked through women's knowing of the naturalisation of maternity; they attended women during labour and birth in their homes and also

in a range of private midwife-run 'lying-in' homes. The introduction of the Nurses and Midwives Act 1924 resulted in compulsory registration, and midwifery practice became governed by a newly minted Nurses and Midwives Registration Board, creating a professional link between nurses and midwives. This meant that the lines drawn between the professional training programmes offered were becoming blurred given nursing and midwifery was now governed under the same professional body, which controlled the training and requirements of midwifery through the medical model (Pairman, 2005). Despite the linkages in training between midwifery and nursing, in 1925 there were still distinctions between the two professions, and the scopes of practice differed somewhat. A special interest group had been created within the registration board at this time, to represent midwifery's interests.

At this stage, midwives were able to be birth attendants without a doctor being present provided there were no complications evident, though this was done under medically sanctioned methods, whereas nurses worked alongside doctors who were the primary health providers. By the 1930s, over seventy per cent of births were taking place in hospitals (Donely, 1986; Pairman, 2005). The medicalisation of birth happened quickly, and was partly in response to continued pressure to produce healthy children that ensured the continued success of the British Empire. Now, the normal physiological process of birth was sterilised. The equipment used during births was surgically sterilised, and women were subjected to many different medical practices that were promoted as reducing the risk of infection, even though women still commonly experienced puerperal fever. All women and medical personnel present for the birth were required to wear surgical masks and gowns, family and support people were not permitted in birthing suites, as they were seen as complicating the process, and getting in the doctors' way. Birthing women were required to undergo repeated invasive medical examinations and procedures both during and after birth. Mothers and babies were separated while in hospital and babies were kept in nurseries, only brought to their mothers for feeding on strict four-hourly schedules (Pairman, 2005). Such technology was a far cry from a community based, women-centred midwifery process that had previously been enjoyed by women and their chosen birth attendants.

Through the perceived legitimacy of medicine and policies, the movement of birth to hospitals was unrelenting. The success of the medicalisation of childbirth was measured through better outcomes in morbidity and mortality, and became increasingly legitimated and reproduced through legislation. Doctor-attended, medically sanctioned birth was promoted by the Health Department in the 1930s as being the safest and simplest model of care. With the improvements in anaesthesia and analgesia and developments in medical technology, the accessibility of a pain free birth with was available only through doctor-attended birth in

hospitals. It is reasonable that 'pain-free birth' was appealing for women, and it gave doctor-led care an advantage over midwife-led care (Rothman, 1991).

However, increased use of pain relief multiplied the risk for complications for the mother and baby. The use of analgesia increased risk of respiratory and cardiac difficulties, which in turn increased the number of interventions that were required in birth, such as forceps deliveries. Pregnancy and birth were now viewed as inherently perilous, and hospital birth had become the routine, 'normal' way of giving birth. The focus of maternity care was now on the physical – the biomedically-defined birth itself. This stripped away the significance of the maternal experience, and there was disregard for maternal psychological factors. The increased risk that had been identified in this setting reinforced the notion that labour and birth at the hospital, with a doctor present, was the safest location for childbearing women. In addition, legislative and social changes had produced the maternal body as a site of risk, in particular, risk of mortality (Pairman, 2005; Stojanovic, 2010). The message of risk, and its reduction through the surveillance and 'safety' of the hospital environment, served as an element of patriarchal control over women's bodies. The moral trajectory of the medicalisation and control of women's bodies was for the greater good, where the governance and reduction of risk had the aim of a 'healthy' pregnancy and the production of a viable newborn (Clews, 2013).

While the medicalisation of birth coincided with an overall reduction of maternal and infant mortality, which further reinforced medicine's dominance over childbirth, it also had the result of regulating and 'procedurising' birth. It could be argued that this was interrupting the process of normal physiology, and stripped the midwifery practice of 'being with women' of its social and cultural context, rendering women's maternal bodies the subject of intervention, limited to the birth event (Clews, 2013; Donely, 1986). This emergence of pregnancy and birth as inherently 'risky' resulted in a societal shift in the way these processes were monitored and conducted, with the sterilisation of birth and the surgically conducted procedures that surrounded it. Birth became a medical event that required close medical monitoring and observation, and midwifery care as conducted in the community was aligned with risk, as it was outside the confines of a safe and paternalistic hospital environment. This increased medical gaze resulted in constant surveillance for abnormality and risk (Clews, 2013; Klima, 2001). The impetus behind the medical profession achieving dominance over childbirth, and gaining a permanent presence within the maternity hospitals, was the focus on access to pain relief and safety from assumed disease, along with the proximity of assistance should complications arise. The system established through St Helen's hospitals set the standards for midwifery practice and birth that continued for the next thirty years and beyond (Pairman, 2005).

Scope of Midwifery Practice

Some smaller institutional midwifery training programs remained through the Auckland-based St Helen's hospitals, but these were progressively phased out. By 1956 any training in maternity care was absorbed into a three-year nursing curriculum and this meant that midwifery itself eventually became integrated with the nursing profession. This signalled the demise of the majority of direct entry midwifery training programs, and the underlying philosophy of being 'with women' that had existed up until this point slowly faded from visibility. Midwifery became defined as a sub-specialty in nursing, and to become a maternity nurse, nurses had to complete extra training in midwifery principles on top of their three-year nursing program. This included learning a sterilised approach to conducting birth and maternity care as a best practice philosophy (Pairman, 2005).

In addition, competition was emerging for the availability of practical training for midwives and obstetric medical students. St Helens hospitals had been the exclusive training ground for midwives, and access to maternity services for medical students' training was being demanded. As well as competition with medical student training, there has been a continued presence of competition between midwives and nurses. The medical profession declared that nurses were the ideal assistants for birth, and they preferred to have maternity nurses present than midwives - privileging the biomedical model where doctors knew the best course of action, and nurses were the 'obedient' helpers of doctors (Ehrenreich & English, 2010; Pairman, 2005). As a result, by the late 1950s, any remaining midwifery training was terminated, to make way for the training of maternity nurses. Despite these changes, doctors even argued against specialised maternity nursing training being present in hospitals as, in their view, it impacted on the availability of training opportunities for medical students (Pairman, 2005).

In 1971 the Nurses Act was passed, removing the word midwifery from any legislation. Under this Act, it was requisite that doctors were present at all births, resulting in midwifery's philosophy of being 'with women' being relegated to the past. By the time this legislation was passed, midwifery and nursing were effectively indistinguishable from one another, and the notion of midwifery and nursing as being distinct professions had all but disappeared (Guilliland & Pairman, 1995). The word 'midwife' had been expunged from legislation that governed midwifery practice, and the ability for midwives to practice autonomously had been disconnected – a separate professional identity no longer existed. The success of the medicalisation of birth saw the demise of women centred midwifery practices as women and midwives became increasingly disconnected from each other. The New Zealand Nursing Association (NZNA) now governed midwifery registration and education, and a special interest section was set up for midwives. Midwifery had been subsumed into nursing, and many

midwives and their practice philosophies, had become entrenched in the medical model. Moral and medical narratives that constituted ‘good mothering’ advocated medically managed pregnancy and birth, entrenched in the medical model. Without the availability of midwives, and alongside the legitimacy of medicine, the majority of women now birthed in hospitals (Pairman, 2006).

The Struggle for Autonomy

Through the dispensation afforded by legislation, the biomedical model had reconstructed the maternal body as a site of risk, and birth as a medical event, which had reconstructed midwives’ skillset – midwifery was now a specialist postgraduate nursing qualification. Midwives had become obstetric nurses who worked with delegated ability under the direction of doctors. Even in rural communities and small local hospitals where some midwives were still practicing, it was still only within the confines of the medical community and *always* under the supervision of doctors (Donely, 1986; Guilliland & Pairman, 1995; Pairman, 2006).

The education of nursing itself had changed during the 1970s and 1980s, moving from apprentice-style hospital based training programs to institutionally based education through polytechnics. The curriculum was shifted to be more liberal, medically focused and comprehensive, and the aim of nursing education was to produce ‘better’, well-rounded nurses who would be able to work across a variety of settings. Midwifery education was embedded within nursing’s curriculum, and was also delivered in tertiary institutions, as a post-basic programme. The midwifery representatives in the midwives special interest section of the NZNA lobbied for specific post-basic programs to be delivered in the St Helen’s maternity hospitals over twelve months, but this was unsuccessful, and 1979 saw the final closure of the St Helen’s training programs (Donely, 1986; Pairman, 2006). The replacement programs that were established required that midwifery students complete the academic requirements of nursing and midwifery simultaneously, and the curriculum itself was also criticised, with the Midwives Section stating that there were severe limitations to the theory and practice components. Additionally, the Midwives Section was vocal in their opposition of the increased workload required for midwifery students to complete such qualifications (Pairman, 2006). In the late 1970s and early 1980s the philosophical conflicts produced by the merging of midwifery and nursing became a catalyst for midwives to become politically engaged; to make a stand against the existing system, and strive to reclaim a separate professional identity (Pairman, 2006).

In addition to the political clash within nursing and midwifery, women’s groups were complaining about their treatment in maternity services. These objections had been building as far back as the late 1930s, but under social expectations and moral norms little room had been

made for women to voice their objections. Women's displeasure at the sterility of birth environments, invasion of privacy through invasive routine procedures, separation of women from their babies, and the lack of support for women were some of the main issues presented. However, despite their objections, the medicalisation of maternity and childbirth remained policy until continued protests by women resulted in these rigid procedures starting to be relaxed amid renewed calls for women-centred maternity care in the late 1980s (Mein Smith, 2002). Society's views on childbirth were changing. Women were demanding a more humane and family friendly approach to childbirth, and they wanted more involvement in their own maternity care and experiences. Women's resistance to the medical model resulted in key changes to clinical environments, such as labour wards, which became less surgical and more woman-centred. However, increasing technological advances, such as the development of epidurals and narcotic-based painkillers becoming routine in medically managed maternity care, medical intervention in births was increasing; episiotomies were being pushed as best practice, and the availability of caesarean section options was climbing. The biomedical construction of birth held its power over the maternal body through its practice; hospital based birth was still maintained as the safest and least 'risky' option. This seemed to be at odds with the espoused reduction of the sterility and medicalised approach to birth (Donely, 1986; Pairman, 2006), and the view of the maternal body and birth as 'risky' persisted.

The Move to Autonomy

Along with consumer led advocacy groups reclaiming birth as a 'natural' event, midwives were also railing against the notion that midwives must first become nurses and then build on their basic nursing training by completing further qualifications in midwifery. The NZNA were clear in their governing policy documents that midwifery existed as a subset of nursing, but the Midwifery Section was campaigning to use the World Health Organisation (WHO) definition of a midwife which stated that: "A midwife is a person who is able to give the necessary supervision, care and advice to women during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility and to care for the newly born infant" (Donely, 1986, p. 15). The significant use of the word 'person' was what the Midwives Section of the NZNA focused on - the WHO saw midwives as other to or more than simply nurses (Donely, 1986). Women were taking birth back into private spaces, and an ability to give birth 'naturally' was being taken up as a powerful position, removing itself from the medicalised, sterilised way of birth (Price & Shildrick, 1999). Midwifery as a profession was key to this movement, the existence and presence of midwives was allowing women the choice to take control of their own bodies (Grigg & Tracy, 2013) and affirming the power of the maternal body.

In 1985, the midwifery and consumer lobbying resulted in the acceptance of the WHO definition of the midwife, but due to the legislation in existence – the 1971 Nurses Act – midwives were still unable to work autonomously, and remained accountable to doctors. The New Zealand College of Midwives argued that midwives working in hospital maternity wards did not have the chance to practice as midwives, as their role was still that of an obstetric nurse and midwives were present as assistants to the doctors rather than performing the duties of traditional midwifery (Donely, 1986; Grigg & Tracy, 2013).

Some midwives were attempting to practice ‘traditional’ midwifery in an attempt to return to a natural process of woman centred birth that took the gendered material experience of the maternal body into account, and attended births in women’s homes. However, where this occurred they were always under the supervision of doctors, and midwives were unable to book and care for women independently. These midwives had no access rights in hospitals, and so were unable to be with women through labour and birth in medically defined spaces. Many found working relationships with sympathetic doctors who were willing to attend homebirths so community based midwives were at least able to work alongside doctors and somewhat maintain their role as ‘guardians of normal birth’ (Donely, 1986; Guilliland & Pairman, 1995).

At this stage in the mid-1980s, a consumer-led group called “Save the Midwife” emerged, which sought to raise the public profile of the midwife, and illustrate the issues that the state controlled maternity service was facing. In this climate, smaller maternity hospitals were closing, and women had fewer options available to them for their maternity care. They argued that it was important to maintain midwifery as a specialist service in childbirth, as it preserved the options for care during pregnancy and birth (Guilliland & Pairman, 1995). This mirrored other Western movements, where women were attempting to challenge the dominant scientific-medical narrative. Modern obstetrics had been implicated in the continued oppression of women, and consumer groups were challenging such oppressive practices through reclaiming of the maternal body and the process of reproduction, in an attempt to recover control of birthing practices and experiences (Paterson, 2010). Concurrently, the Midwives section of the NZNA was generally in conflict with their governing body regarding the issue of midwifery practice and education. In 1988, The Midwives Section eventually made the decision to officially separate themselves from nursing by closing the nationwide Midwives Section offices, and reopen as the New Zealand College of Midwives. This separation was due to an inability to internally resolve conflicts such as whether midwives should actually be considered nurses, and whether midwifery should have even been governed by nursing (Pairman, 2006).

Political engagement by both women and midwifery culminated in a major change to the New Zealand system of maternal health care. Helen Clark, in her role as the Minister of Health

pushed through an amendment to the Nurses Act 1977 - the Nurses Amendment Bill 1990. This saw midwifery's position transformed significantly. Through the 1990 legislation, midwifery was once again legislated as a profession, and midwifery was enabled a position of relative autonomy with direct entry educational opportunity (Pairman, 2006). Helen Clark (who would later become Prime minister), had referred to her role in this transformation many times over her political career, even discussing it in her valedictorian speech when she left Parliament, and it remains something she counts as a significant win for midwives and New Zealand women: "I'm proud of the Nurses Amendment Act 1990 which I took through Parliament as Minister of Health. It gave midwives the right to autonomous practice and set up direct entry midwifery education . . ." (Clark, 2013). Consumer and political support was invaluable for the regained autonomy for midwifery. Advocates for the political move to midwifery-led care framed their argument within patriarchal politics, and connected the 'colonisation of the womb' (Ehrenreich, 1993) with gender inequality – particularly with respect to women's health care. The Nurses Amendment Act 1990 removed legislative barriers, and allowed for midwives to provide maternity care independently, without a doctor's supervision. This represented a shift away from the medical gaze in maternity care towards woman-centred midwifery practice (Pairman, 2006).

As well as the Nurses Amendment Act 1990 establishing midwifery's autonomy through law in 1990, there were also changes to the New Zealand Bill of Rights Act 1990. Two sections within this Act are particularly relevant to maternity care. Section 10 states that 'every person has the right not to be subjected to medical or scientific experimentation without that person's consent', and section 11; 'everyone has the right to refuse to undergo any medical treatment' (New Zealand Bill of Rights Act, 1990). This meant that regardless of a woman's apparent choice of obstetric care, she no longer had to be subjected to 'routine' procedures without agreement, and informed consent became a large part of any health practitioner's mode of service delivery. For midwifery, this meant a mode of arrival to woman-centred care; care that took a woman's material and psychological experience into account and allowed for 'natural' birth to have material meaning that was not dictated to by the biomedical system (Grigg & Tracy, 2013).

From 1996, midwives were required to attend all births, and doctors who delivered babies had to pay a midwife out of the lump-sum maternity payment they received from the government. Offering maternity care was no longer financially viable for many general practitioners, and they gradually stopped providing it, but they continued to care for children and mothers after birth. This was a significant win for midwifery, and midwives were finally able to autonomously provide maternity care, as they had done traditionally and historically (Mein Smith, 2012; Pairman, 2006). This system was the first of its kind for midwives around the

world, and in New Zealand, the first of its kind for a woman-dominated profession. Through this legislative shift, childbirth was being recognised as a natural life event rather than a medical complication. Midwives had attained a more equal and autonomous status in the provision of maternity services, and this was considered a triumph for the woman-centred profession of midwifery and for women themselves (Guilliland, 1999). However, a medicalised philosophy of the maternal body persists, and is replicated through medical technologies and practices that reinforce the dominance of medicine over maternity and midwifery. The dominance of technology impacts the care of pregnant women even today by influencing aspects such as the monitoring of pregnancy through practices of ultrasound and laboratory testing, the often medical settings of birth, and the constant surveillance of the maternal body as a site of risk to the foetus (Parry, 2008).

Despite midwifery successfully gaining autonomy of practice, resulting in shifts in societal attitudes towards women's healthcare, and the New Zealand maternity system espousing midwifery-led care as best practice, there has not been a widespread reversal of medicalised birth. However, the legitimacy of the medical model of pregnancy and birth remains where obstetricians are positioned as 'experts' when a pregnancy is technologically identified as more 'risky' or 'complicated', despite risk and complication not being defined effectively in many cases (Clews, 2013; Guilliland, 1999). The medical narrative of childbirth continues to maintain that pregnancy and birth is inherently dangerous, and when coupled with the idea that the female body is also risky and unpredictable, it becomes necessary to marginalise the discourse of midwifery that seeks to normalise and preserve pregnancy as a natural and non-pathological process (Thachuk, 2007). However a need for women to be offered choice with relation to their maternity care has been identified, and affirms the notion that midwifery should be at the forefront of this choice (Crossley, 2007).

Given the social and political history of midwifery, the process of the normalisation of the medicalisation of childbirth and pregnancy has been constant and insidious. Although the advent of technology has been instrumental in the identification and management of disease, it has been applied to pregnancy and birth in the same way, which results in many women being unable to achieve a safe and satisfying birth experience (Klima, 2001). The legislation that allowed midwifery's independent practice has in many ways served to reinforce the bio-medical model of pregnancy and birth as pathology, with midwifery being subjected to complicity in the continuation of an 'expert centred', hierarchical experience. Changes in legislation, rather than resulting in the liberation of women's healthcare, has in fact served to reproduce a medicalised model of birth. The obstetrician has been replaced by another 'expert' – the midwife – who makes decisions based on their clinical knowledge, often in consultation with other maternal

health ‘experts’ (Paterson, 2010). The continuity of maternal medicalisation can be framed within feminist theories through a consideration of the societal influences on knowledge and power which afford privilege to the medical model of birth, and the resultant dominance of obstetrics over midwifery as a site of knowledge about women’s bodies and birth (Clews, 2013).

The Contemporary Form of Midwifery

The legislation that governs healthcare in New Zealand requires that midwives uphold Māori as the Tangata Whenua (people of the land) and actively honour the principles of the Treaty of Waitangi; partnership, protection and participation. All healthcare in New Zealand is provided on the basis and understanding that these principles are upheld in all aspects of practice (Ministry of Health, 2000). In addition to recognition of the status of Māori people, midwifery’s current legislative guidelines state that midwives adhere to their legal responsibilities under the Health Practitioner Competency Act (2003), and associated bodies such as the Health and Disability Commissioner Act (1994), and along with Acts that govern the use and distribution of personal information such as the Privacy Act (1993) and the Health Information Privacy Code (1994). Yet there is a tension between these Acts and midwifery’s statements and literature (i.e. Pairman, 1998; New Zealand College of Midwives, 2013) which defines the relationship as a partnership, and professional friendship and states that midwives must do what is necessary to ensure their clients have the best outcomes possible.

Midwives practicing in New Zealand aim to work in partnership with their pregnant clients, and has describe this relationship as reciprocal, where it is understood as a professional friendship (Pairman, 1998). In New Zealand, we have a unique system for maternity care. For women who are citizens and permanent residents, maternity care is publicly funded. Over seventy-five per cent of pregnant women in New Zealand select an available midwife as their Lead Maternity Carer (LMC). The midwife relationship usually begins within the first 6 – 12 weeks of pregnancy, through the birth of the baby and continues into the postnatal period, 5 - 6 weeks post-birth (Grigg & Tracy, 2013; Ministry of Health, 2012a). As a result, the relationship is one that develops and continues over a considerable period. The continuity of care and support provided by such a relationship has been proven beneficial to a pregnant woman’s adjustment to pregnancy and motherhood, and to favourable outcomes in midwifery service delivery (Raynor & England, 2011). A LMC is able to attend their clients during birth at a place that is chosen by the women – whether this is in a hospital unit, a birthing centre or at the women’s homes. No other primary health professional has access to providing continuity of care in multiple settings. The fact that midwives are the only professionals who are allowed to go into other health settings, and provide this continuity of care is significant. If a woman needs to

gain access to other services, the midwife will work alongside these services, and maintain the relationship she has with her client (Grigg & Tracy, 2013). The complex relationship between midwifery and medical institutions, as well as a partnership between midwife and client that cares for and works with women on their terms (World Health Organization, 2011) provides the context for this research.

Looking at the relationship between midwives and their clients, Pairman's (1998) analysis suggested that this could be viewed and organised around values of both partnership and friendship. This enables space to consider a professional friendship that includes shared experience, mutual respect and genuine care for each other. This understanding of the relationship is now utilised by the New Zealand College of Midwives, and merges aspects of both the expectation of the delivery of professional services with that of a more intimate friendship between women. It is significant that it is a relationship between women; a space where women feel empowered, open, safe, and relaxed. The relationship between client and midwife is one of intimacy, and as the private space of a woman's body is the focus of the services provided, it is imperative that trust and respect are at its foundation. The relationship becomes collaborative, and exists for a fixed purpose and time (New Zealand College of Midwives, 2013).

Research has shown that professional psychosocial support is different from informal support in that it does not require the same sense of obligation for reciprocity that is often found among women who have strong social relationships (Luyben & Fleming, 2005; Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). While the research supports the position of midwifery in New Zealand, it is important to understand the experiences of those who do not fit a low category of 'risk'. Risk is often understood through certain conditions such as socioeconomic status, ethnicity, or mental disorder, and raises questions of how this might be significant for women who do not become classified under a low category of risk, and how their needs may differ within different socioeconomic groups, cultures and individual experience.

If professional support has proven beneficial for low-risk women, then this type of support from a midwife would be equally as useful, if not more so, for women who require more intervention or support, such as those with mental health problems, or specific cultural needs (Nicolson, 1992; Seng, Sparbel, Low, & Killion, 2002). For the majority of women in New Zealand, the healthcare provider that they have the most contact with during their pregnancy will be their midwife. New Zealand's one to one care model is recognised internationally as best practice, and recognises the work of the midwife as a unified approach that is based around the integration of specialised medical care with a partnership relationship between client and midwife (New Zealand College of Midwives, 2011). It is the midwife, in conjunction with the

client, who will manage and plan their client's physical and psychosocial care during pregnancy (Ministry of Health, 2012a).

Few studies have examined the partnership between midwives and their clients from midwives' point of view. Early research in the UK (McCrae & Crute, 1991) sought to ascertain the qualities of the relationship through interviews with midwives and their clients. They reported that the relationship between women and their midwife is a resource that is difficult to quantify, and a 'special' type of relationship is developed that is not commonly seen with other health providers. Midwives in their study acknowledged that they had a desire to feel needed, and that when clients acknowledged their input and help that they felt closer to their clients. These midwives also described feeling conflicted between their professional role and their personal involvement in their clients' lives; illustrating a tension between midwives' professional identities that are ascribed through the institutions they work in, and the preservation of their personal identities. This study contradicts research that stated that professional support required little to no obligation for reciprocity (Seefat-van Teeffelen et al., 2011). Midwives described divergence between system and hospital policies and their professional philosophy and personal perspective on what constituted good practice in working with clients (McCrae & Crute, 1991; Elliott, Ross-Davie, Sarkar, & Green, 2007).

Midwives have stated that they are aware of a difference between woman-centred and biomedically defined care, articulated as a difference between "a pregnant woman, and a woman who is pregnant" (Pairman, 1998, p. 7). The distinction is, no doubt, based on the philosophy that pregnancy textures a woman's experience but is not the extent of her experience. Their relationship is established with the expressed purpose of safeguarding care during pregnancy and childbirth leading to a healthy mother and a healthy baby through a positive birth experience (Pairman, 1998). In other words, midwives are professionally responsible for providing healthy outcomes for their clients under our medical system, but they also recognise the diverse psychosocial contexts in which women experience maternity. The ongoing tension between institutional and client relationships has been understood by participants in a study conducted by Seibold, Licqurish, Rolls and Hopkins (2010) as "providing a bridge between her [the woman] and a very big system" (p. 529).

The consideration of tensions created between the biomedical and women-centred narratives raises questions surrounding the impact that this tension may have on the practice of midwifery, and how midwives are positioned within the contrasts and contradictions created by such tensions.

CHAPTER THREE - Maternity and Mental Health

To be of service to a mother with mental illness, a provider must know that the client is a mother, must identify her strengths and weaknesses as a mother, must ascertain what her natural supports do and do not do both psychologically and practically, must learn what her hopes and expectations are for herself as a mother and for her children, and must determine what services she needs as a mother. How to start? Listen to the mothers.

(Nicholson, Sweeney, & Geller, 1998)

Mental Health and the Maternal Body

As outlined earlier, women have been constructed as ‘deviant’ in a historically patriarchal society, and a view of women as ‘uncontrollable’ or the out of control body was systematically produced. This chapter addresses psychology’s narrative of women’s maternity through dominant narratives that produce a gendered disorder of the body and mind.

Historically, psychological narratives were strengthened and appropriated by medical science, which progressively defined women in biological terms, positioning women as incapable of transcending their bodily desires. Through these dominant narratives, women were further positioned as being weak, inherently passive, reliant on men’s support, and predestined to become ‘mothers and wives to men’. Sexuality was a defining quality of the female nature. Certain moral codes have inscribed standards of chastity, deportment, and gender divisions and segregation (Appignanesi, 2008). Of course, the foil for dependent ‘weak’ women was morally decent, strong, and disciplined men who offered women protection. Historically, women who did not meet acceptable moral standards were more likely to be detained in asylums, run by medically trained psychiatrists, as patients, and be labelled as ‘mad’ (Hogan, 2006; Ussher, 2010). Many women were diagnosed with psychological disturbances, such as hysteria, and again the body was implicated in the development of such disorder, with the womb being incriminated specifically – it was indicated that it was due to the wanderings of the womb that women experienced hysteria (Kukla, 2005). Medical publications make it clear that doctors have assumed women to be uniquely susceptible to mental instability due to their biology, and protecting women involved regulating their sexuality and menstrual cycles. In Victorian times, mothers were directed to attempt postponement of menstruation in their daughters, and doctors pursued the regulation of women’s minds through the regulation of their bodies (Appignanesi, 2008; Ussher, 2010). Women have been historically and contemporarily inscribed with a

predisposition to madness through their physicality, especially their faulty hormones (Ussher, 2010).

The contemporary understanding of women's physical and mental health is derived from this specific knowledge base – that of biomedical definition that has developed through societally located and influenced narratives through Western history. Disorder is located in the physiological body, requiring treatment in a medically defined space that will allow the medical practitioner to return the ailing body back to a 'normal' healthy status (Morgan, 1999). For women, there are also socially inscribed narratives of mothering that are derived from the production of biomedical knowledge, especially where 'biological instincts' are implicated in good mothering, and the maternal experience is designated as an inherently 'happy' one (Kukla, 2005). If mothering is not experienced as joyful, or a woman does not meet certain standards of conformity to surveillance methods (submission to diagnostic tests in pregnancy, well-child checks for the baby, vaccinations and so forth) then a woman cannot meet the standards of a 'good' mother (Sixsmith & Boneham, 2004). Due to the biomedical understandings of the physiology of pregnancy, childbirth and early mothering, it is often assumed that all women experience the transition to motherhood in a consistent, predictable way, yet the normalisation of the process of maternity is a Western concept, and De Souza (2004) argues that it excludes the multiplicity of experience among not only individuals, but also in cultural diversity. Any deviation from this accepted 'norm' has the result of alienating those that do not fit a particular socially inscribed norm – such as mothers experiencing the effects of mental illness (Houvouras, 2006). There is a certain amount of ambiguity however. Reviews undertaken on the subject of childbearing and the body have revealed an ideology where pregnancy and birth are viewed as a period in which women have a lack of control over their bodies – the pregnant body is constructed as being uncontrollable, unsafe, and unrestrained (Carter, 2010; Price & Shildrick, 1999). Paradoxically, mothers are also subjected to social narratives that impute certain responsibilities such as effective self-care during pregnancy, leading to an assumed individual accountability for foetal outcomes (Carter, 2010), which can be difficult for some mothers when experiencing mental health problems – serving as another site where marginalisation and alienation are given opportunity to take place.

The increasing political and social turn to biomedical technologies that police women's bodies has come under scrutiny through critiques of power (Bartky, 1988). This biomedical narrative requires certain gender-marked practices reinforced by governmentality and biopower (Morales, 2006). In the New Zealand medical system, it can be contended that the modern medical elite largely consists of male authority and, as Harding (1991) discussed, in medical research and practice, 'typically female' afflictions (such as a medicalised view of pregnancy)

are less likely to receive attention in research and in funding, although reproductive technologies are utilised that produce “the female body as a kind of factory that derives its fundamental value from the quantity and quality of its products – that is babies” (Harding, 1991, p. 45).

Consequently, a woman’s psychological identity can be conceptualised as embodied; an embodiment that encompasses social constructions of womanhood, mothering and the bodily experience of sickness and health (Sixsmith & Boneham, 2004).

In line with dominant medical narratives of illness and pregnancy, research that attended to risk in the maternal body has favoured biomedically described phenomena. Through this, mental health itself becomes biomedically defined as well, with particular diagnostic systems that are in line with the dominant biomedical understandings of disorder, and the widely used psychiatric diagnostic systems such as the ICD-10 (World Health Organisation, 1992) and DSM-IV-TR (American Psychiatric Association, 2008). The understanding and practice of women’s psychological health are interwoven with mainstream biomedicine, which excludes the meaning of gender in the experience or treatment of mental health problems, and usually positions mental disorder as being located in the medically defined body (Einstein & Shildrick, 2009). Nonetheless, pregnancy and mental health problems do not exist purely in the biological space, and can be considered as social phenomenon in the way that these are understood and defined. Medical standards are based on white, middle-class masculine bodies, and there is an assumed universality; this does not take into account the variances between and within genders, and excludes pregnancy as a gendered experience (Lorber & Moore, 2011).

Under a Western biomedical framework, along with what can be considered normal adjustments, and hormonal, physical, and emotional change, there is an increased possibility of a range of other psychological issues being experienced by pregnant women. Commonly identified difficulties reported in research include low self-esteem and body image problems (Jomeen, 2004). In addition, some women also experience significant psychopathology such as depression, bipolar disorder or personality disorders, and/or substance abuse/dependence (Frayne, Nguyen, & Allen, 2009). In western society, these disorders have been found to be most prevalent in women during the childbearing years (McCauley, Elsom, Muir-Cochrane, & Lyneham, 2011), and women have been said to outnumber men in lifetime prevalence of psychological disorders (Ussher, 2010). Within these dominant understandings, women are positioned as having higher rates of mental health problems than men, and are at greater ‘risk’ for major depression, postpartum depression, anxiety and panic disorders, and post-traumatic stress disorder. They will experience more adverse physical and psychosocial side effects from treatments and medications that are regularly prescribed and employed at a higher rate for

women than men (Einstein & Shildrick, 2009; Fisher, de Mello, & Izutsu, 2009; Kulkarni, 2007).

Nevertheless, psychosocial influences, such as socioeconomic status, access to healthcare and intimate partner abuse can further impact a woman's understandings of pregnancy, and her mental health throughout (Jomeen, 2004). Additionally, childbirth itself has been linked to yet further psychological and physical transformations and adjustments that may influence the development, relapse or recurrence of biomedically defined pre-existing mental health problems, including psychotic symptoms, and psychiatric disorders. Some studies state that the number of women with pre-existing mental illness who are having babies is rising, and pregnancy itself has been presented as a risk factor for relapse of mood disorder in women (McCauley et al., 2011; McCauley-Elsom et al., 2009). Similarly, women with a family history or previous diagnosis of psychiatric disorders such as depression, bipolar, puerperal psychosis, are understood to be at an increased risk for relapse, either during pregnancy or postnatally (Jomeen, 2004; O'Hara, 2009). These dominant narratives of the medically and psychologically disordered body are prevalent in research on maternal mental health. Such research has revealed that a woman's psychological and emotional symptoms in pregnancy can vary according to a range of psychosocial and physiological factors. For instance, women who are in stable heterosexual relationships tend to experience more social approval and support in Western society, resulting in a healthier physical experience of pregnancy itself, and meet the culturally produced criteria for good mothering (Frayne et al., 2009; Jomeen, 2004; Ussher, 2010).

Women's Mental Health

Data from empirical studies estimate that between ten and thirty per cent of women will experience clinically significant mental health problems during pregnancy and the postpartum period (Frayne et al., 2009). Yet, it has been proposed that this number is problematic, and will depend on women seeking help, or even recognising that what they are experiencing is a significant problem (Cox, Murray, & Chapman, 1993; Raynor & England, 2011). Antenatal and postnatal depression are framed in a biological manner; in narratives about women's health, hormones are implicated in psychological disorders which locates them within a woman's body - and less attention is paid to the psychosocial factors present in women's lives as risk or protective factors in and of themselves (Howarth, Swain, & Treharne, 2010; Kearns, Neuwelt, Hitchman, & Lennan, 1997).

Historically there has been limited consideration of maternal mental health as a risk factor in maternal mortality and morbidity (Fisher et al., 2009). It has been suggested that mental health problems that arise during pregnancy and the postpartum period can induce higher levels of distress, and have more significant social consequences than if those problems arose at other

times in a woman's life (Elliott et al., 2007; NICE, 2007). The Perinatal and Maternal Mortality Review Committee (2013) found that one of the leading causes of maternal death is suicide, indicating that mental disorder is a contributing factor in the death of New Zealand women. It has been reported that when this occurs after childbirth, it is normally associated with severe depression or postpartum psychosis (Fisher et al., 2009). Yet, further contradictions exist in literature, where pregnancy is sometimes considered a protective factor for suicide, even though suicide is a leading cause of maternal mortality (Fisher et al., 2009; PMMRC, 2013). While the concept has been promoted that women can be at higher risk of depression after the delivery of a child, some studies have indicated that there was no higher incidence during the postpartum period than there was for other women, where others stated that the risk of development of depression after birth is up to three times higher (e.g. Boath, Bradley, & Henshaw, 2005; Cox et al., 1993; Eberhard-Gran, Tambs, Opjordsmoen, Skrandal, & Eskild, 2003). The focus on bodily symptoms may not provide the information needed to assess women's mental health effectively using traditional, biomedically defined, standardised assessment techniques.

Multiple studies report that mental health problems present far-reaching consequences for the long-term psychological wellbeing of women and their babies (McCauley et al., 2011; O'Hara, 2009; Rothera & Oates, 2011). Nonetheless, studies conducted were usually researching women who were more likely to reach symptom thresholds to be eligible for treatment under specialist services. There is a scarcity of research into the availability of services for women deemed as having low to moderate symptomatology, who would be excluded from treatment and professional support under current biomedical understandings and classification systems of mental disorder.

The Psychological Focus on Women

Throughout Western history, women have usually been identified as being 'crazier' than men (Ussher, 2010). Women's emotional responses are much more likely to be viewed as 'pathological' and reframed as psychiatric or biomedically-bound symptoms (Eriksen & Kress, 2008). As outlined earlier, women who were classed as 'difficult' in the 16th century were rebuked as witches, in the 19th century they were 'hysterical' and in the 20th and 21st century as pathological under legitimated Western diagnostic systems such as the DSM and ICD. What is common to these attitudes to women's mental disorder in history and in current times is that many disorders with which women are diagnosed are directly linked to the essence of 'being woman' (Ussher, 2013).

Feminists have long criticised the validity of dominant diagnostic systems, and outlined that women's psychological behaviour has been abnormalised within particular social and gender-role contexts. Gender-bias exists within diagnostic categories that do not take the impact

of socialisation and individual experience into account, resulting in a pathologising of behaviours that may actually be normal reactions to an individual's particular circumstance (Eriksen & Kress, 2008). This may be due to the language used in the diagnostic criteria that are commonly employed. Some criteria for particular disorders appear to favour one gender over the other (e.g. borderline personality, dependent personality and post-traumatic stress disorders). While gender neutrality may be near impossible to achieve in practice it is something that should be remembered when making a diagnosis, as women and men may express symptoms differently, and these expressions could in fact reflect gender roles in society (Hartung & Widiger, 1998).

Women may be more likely to be diagnosed as 'mentally disordered'; they do not meet the same social standards for psychological 'health' as men. Women are seen as more likely to be submissive, less competitive and aggressive, and be more emotionally expressive than men. These characteristics have been expressly linked to inscribed biological difference – hormones, reproductive processes such as menstruation and pregnancy, and an assumed essential difference between men and women (Kukla, 2005; Stewart & McDermott, 2004). Due to pre-defined assumptions of gender difference, practitioners may be more likely to base a diagnosis on the gender of a client, evident in the disparate numbers of women receiving diagnoses of typically 'female' psychological afflictions such as borderline and histrionic personality disorders, and depression and anxiety disorders. It has been suggested that even apparently objective diagnostic criteria employed by systems such as the DSM could be viewed as exaggerations of typically 'feminine' characteristics – such as emotionality, low self-esteem, dependence, and social withdrawal (Eriksen & Kress, 2008). Women's emotional reactions to their circumstances are often considered an indication of psychopathology, whereas men experiencing the same 'symptoms' may be said to be experiencing an understandable response to particular circumstances and this is not deemed abnormal, nor are men's symptoms pathologised in the same way. In fact, men and women expressing the same symptomatology can often be given completely different diagnoses by practitioners (Stewart & McDermott, 2004; Ussher, 2013). These could be evidence of more weight being placed on certain types of information garnered from a woman client, and possible neglect in attention to other factors in the case – creating practitioner bias.

For women, the consequences of diagnosis under Western categorisation systems may be that labels and/or stigmas are produced that can prove to be problematic for women (Gough, 1992). These labels can result in social stigmatisation and prejudice which, rather than attaining the goal of guiding treatment, can actually create further problems in functioning for the affected client (Szabo & Coryell, 2004). Women may identify with the label given to them and

internalise negative connotations, which would have further detrimental effects on their self-esteem and functioning, leading to further diagnostic abnormalisation. Barriers to efficient, reliable and valid diagnosis include the social and cultural definitions of what is included within a normal range of behaviour. This could lead to conflict between what maybe impacting an individual's functioning in reality, and reduced consideration of the social and cultural systems within which women live (Leckliter & Matarazzo, 1994). Thus, it must be clarified that the symptomatic behaviour displayed by the client is dysfunctional and causing impairment at the individual level, and is not something that simply deviates from societal norms (Canino & Alegria, 2008).

Maternal Mental Health in New Zealand

In 2011, the New Zealand Ministry of Health published the Healthy Beginnings guidelines that outlined background and best practice guidelines for perinatal maternal and infant mental health. At the beginning of the document, it stated:

Recent research has demonstrated the importance of effective intervention for mothers and infants (in the context of whānau) with emotional or regulatory problems, relationship problems, mental health disorders and/or AOD problems. Evidence has shown that the developing mother-infant relationship is often an essential part of clinical intervention. This means clinicians in these services must be multi-skilled and able to assess and treat the mental disorders of both the mother and the infant as well as the relationship between the mother and her infant. (Ministry of Health, 2011, p. 1)

Based on the above statement, The Ministry of Health argues that the development of effective intervention is something that requires attention, not only for the wellbeing of the mother, but also that of the child. The assumption is that the risk of a woman developing mental health issues is amplified around the time of childbirth. There is particular concern with the mother-child relationship based on assumptions of good mothering, and risk. According to the Ministry of Health, publically funded early intervention strategies and services can reduce these risks, which also results in fewer services accessed later on for either or both the mother and child (Ministry of Health, 2011). Seefat-van Teeffelen et al. (2011) also noted that time and service availability can reduce the quantity and quality of support in some settings. In addition, those women who may have a greater need for support, such as women experiencing mental illness, can often delay seeking support or treatment due to the fear of encountering stigma and judgement from health professionals (McCauley et al. 2011). One of the difficulties with the dominant narrative of gender-neutral unified services that aim to meet individual needs, under a

predetermined model of care, is the ability to distinguish the relationship between normalising experience and pathologising experience under the hegemonic medical view of disorder. Concerns have been raised with regard to the lack of available services in the provision of treatment for such clients and, in addition, the high costs associated with establishing routine screening of women during pregnancy and postnatally. It is worth noting that this raises certain ethical issues relating to the accuracy and treatment aspects of assessment – if women are identified as at risk, is there going to be an effective intervention based on assessment alone (Leverton, 2005)? These issues remain unresolved; however, work has begun that is aimed at developing new approaches and treatments and adaptation established depression treatments for postpartum depression in particular (Darrah, 2011).

The maternal mental health service in New Zealand is particularly concerned with the high rate of mental disorder in the postnatal period – including depression, psychosis, and bipolar affective disorder. It has been estimated 15 per cent of pregnancies will result in maternal psychiatric disorders appearing during the perinatal period. Māori/Pacific Island women are over-represented in statistics on Mental Health (Ministry of Health, 2002a), and this perspective can be different from that in a mainly Pakeha population.

The symptoms experienced in the postnatal period are similar to symptoms experienced at other times during the lifespan, however psychotic disorders may be more acute and severe, develop faster, and biomedical narratives present the belief that birth can trigger a bipolar episode in some women. In such cases, women will need urgent access to specialist services (Ministry of Health, 2011). The Ministry of Health has compiled recommendations for maternal mental health services that should include: “health promotion, screening and assessment, interventions including case management, transition planning and referrals, access to respite care and specialist inpatient care for mothers and babies, consultation and liaison services within the health system and with other agencies” (Ministry of Health, 2011, p. 21).

However, while these recommendations are intended to extrapolate how mental health services may be accessed by women, it serves to reinforce the notion of maternal pathology, and does not mention a consideration of psychosocial contributors, and further reinforces the biomedical approach to the management of maternal mental health (Appignanesi, 2008). It must also be remembered that a woman’s wellbeing during and post-pregnancy is influenced by her feelings of happiness as well as feelings of insecurity. Social, emotional, and physical changes during pregnancy, birth, and new parenthood are all implicated in the development of these responses (Frayne et al., 2009; Raynor & England, 2011). This is particularly pertinent when, according to definitions under Western medical narratives, many symptoms such as low energy,

disturbed sleep, changes in appetite and mood are often assumed to be linked to the physicality of womanhood itself (McCauley et al., 2011; Ussher, 2010).

For women during pregnancy and the postnatal period, the services provided in New Zealand include antenatal care, screening for drug and alcohol use and maternal mental health issues, and that these have a direct access pathway should they meet particular thresholds. The professionals that are mandated to provide these services are LMCs, GPs, Well Child/Tamariki Ora, public health nurses, obstetricians, Family Planning, and Iwi health services (Ministry of Health, 2011). Accordingly, midwives and other practitioners need to be aware of the possibility that a woman will employ responses that fall in line with social-desirability, and attempt to give the 'right' answer so she is not seen as 'crazy'. For instance, postpartum clients may be concerned that if they are diagnosed with a mental illness they will be seen as a bad mother, and their baby will be taken from them (Frayne et al., 2009).

Further, it is not clear what the referral pathways are, simply stating that access for women is through referral from primary health providers *such as* GPs and midwives (Ministry of Health, 2011). There is a threshold for access to Maternal Mental Health services in New Zealand that is also unclear; District Health Board Maternal Mental Health services state that access is available for women who are pregnant or planning pregnancy and have moderate to severe symptomatology, but are not more specific about what this means in practice. Some even list exclusions for women who have had a prior diagnosis of anxiety disorder, personality disorder; physical/sensory disorder; intellectual disability; or drug and alcohol dependence/abuse. There are also few guidelines on what services are available for women who fall outside these thresholds, other than advice to contact a general practitioner in the first instance (Mothers Matter, 2013). In addition, information is not offered on what services may be available in the community for primary health providers to refer to, particularly for women whose symptoms are in a low to moderate range.

Women who develop moderate to severe psychological problems are able to access available mental health services and there are discernible pathways for intervention. However, a gap exists in services for women considered low to moderate in severity, and outside service thresholds. Some women in these categories may be treated through primary care settings such as through their GP, but other primary service providers, such as midwives and health visitors, carry the majority of these cases without continued input and support from mental health services (Warriner, Byrne, & Graham, 2011). This raises questions as to why access to services is reserved only for women with moderate to severe symptomatology.

Assessment and Referral

As maternal health care is provided through normative biomedical health care narrative, there are necessarily exclusions for certain clients, and others experience marginalisation. No single district health board catchment area provides a full range of services to all women, and some areas are more equipped than others to provide access to mental health services. Services throughout New Zealand have been developed in an ad hoc way, which means there are some gaps in services, and difference from district to district (Ministry of Health, 2011). It stands to reason that as mental health issues can affect women's functioning in various domains, and will likely impact on the midwife/client partnership. The unique partnership between a pregnant woman and a midwife forms the foundation for a woman's experience of maternity care, and the quality of this relationship is crucial to the extent to which this is a positive experience (Raynor & England, 2011). In fact, it has been shown that women who were cared for by independent midwives had better outcomes than those who were looked after by midwives in 'shared care' (Guilliland & Pairman, 1995).

In an ideal situation, collaboration with the client, professionals involved in her care, and maternal mental health services to ensure effective physical and mental health management and treatment would be carried out. Many women, however, may fail to seek help for mental health issues or symptoms may not be identified as significant, and instead be explained as adjustment to pregnancy or new motherhood. Some of the somatic symptoms experienced in pregnancy can mimic those seen in depression or anxiety (Frayne et al., 2009; Matlin, 2012), which can reduce the number of women who are accurately identified as being either at risk or have developed mental health problems. A number of issues exist relating to the identification, management, and referral for maternal mental health issues. These include the assessment techniques themselves being developed under biomedical narratives, with the specific purpose of defining 'normal' and 'abnormal' levels of symptoms, along with the variability in available services provides barriers to effective identification and management for some practitioners, and restricts professionals' ability to refer to appropriate services (Rothera & Oates, 2011).

Research on the assessment practices of maternity care providers during the early postnatal period found that while participants felt that assessment was important, there were no standardised screening processes across and among services. Participants stated that they felt midwives had a part to play in assessment and support for postnatal women, but due to time constraints had reduced opportunities to fulfil this in practice. It was found that even though there was awareness that psychosocial assessment should be taking place, there was a reliance on any issues being picked up antenatally by professionals involved in their care. There was an expectation that anything picked up would be included in clinical notes, and reviewed by the

professionals who were involved antenatally (Yelland, McLachlan, Forster, Rayner, & Lumley, 2007). This is significant, given that practitioners - such as midwives - in New Zealand are not trained in psychological assessment, nor are they given standardised assessment techniques or questions that have to be asked. Health providers like midwives do not always receive extensive training in mental health, and often have limited ability to refer to maternal mental health services directly. Some may also have restricted access to sufficient professional support to manage and deal with clients with mental health needs at a level that is going to be effective for the client and the practitioner (Ross-Davie, Green, Sarkar, & Elliot, 2006).

Nevertheless, it has become policy for all health providers in New Zealand to ascertain whether a woman is smoking cigarettes (Ministry of Health, 2007), and to ask about family violence (Ministry of Health, 2002b), and the Ministry of Health has stated that “care providers are in an ideal position to assist victims of family violence before the abuse reaches crisis point” (p. 8).

Midwifery and Maternal Mental Health

Currently, midwives do not extensively, or formally, carry out screening for trauma or mental health issues. Midwives do not often feel confident in their level of knowledge surrounding definitions of psychopathology (McCauley et al., 2011). Additionally, some clients may be unable or unwilling to disclose either pre-existing conditions or current mental health issues as they may not have been formally diagnosed, symptomatology may be exacerbated or caused by pregnancy itself, or the level of symptoms may not be clinically significant, but still have an impact on psychological functioning (Raynor & England, 2011). Screening for postnatal depression is becoming increasingly common, however there has been some controversy surrounding the potential to over pathologise women who may be classified as at risk of developing postnatal depression – particularly when the practitioners involved in screening may not have sufficient training to conduct it safely. It has been suggested that practitioners may be over identifying affective symptoms in women as postnatal depression (Cox et al., 1993).

While there are best practice guidelines in existence for the identification and treatment of depression, and general information is available (e.g. Ministry of Health, 2012c), standardised questioning surrounding a woman’s psychological state has not become system-wide policy, and the mode of screening appears to be at the discretion of the professional working with the woman. In addition, referral practices are also not as clear for mental health issues as they are for other conditions. There are guidelines available for referral to secondary and tertiary services published by the Ministry of Health (2012c) in order to assist primary caregivers, such as midwives, in making decisions about referral to other services. Specialist maternal mental health services are based within the various District Health Boards throughout New Zealand (Mothers

Matter, 2013), and an inpatient unit exists in the South Island that caters to mothers suffering from severe maternal mental health issues, along with the additional development of an Auckland-based specialist maternal mental health in-patient unit (Johnson, 2013). Yet on the whole, maternal mental health services appear to have been overlooked to an extent in an official referral guideline process, which can result in confusion for professionals working with pregnant and postpartum women as to where and how maternal mental health services are accessed.

Rothera and Oates (2011) conducted surveys involving a range of professionals working with postnatal women who had been identified as having postnatal psychiatric conditions. They found that midwives were more likely than other primary health providers to seek advice and support and refer to specialist services, even when a woman's symptomatology was, in biomedical classifications, regarded as being low to moderate in severity. Other key findings in their study were that there was a range of areas where improvements could be made to services. These included increasing the skills and knowledge of those who were not specialist mental health practitioners, expanding specialist service availability, and providing clear demarcation for professional boundaries and responsibilities in the screening and identification of postnatal psychiatric disorder. This is echoed in other studies that have been conducted, and some emphasis has been placed on the education of midwives in these areas (McCauley et al., 2011). Given that many women who may experience mental health issues meet the criteria of 'abnormal' or come to be known through a biomedical definition of disorder, this needs to be understood through the position of midwifery in 'protecting the normal' in pregnancy and childbirth. Psychosocial monitoring and intervention have become accepted and expected parts of midwives' role. Midwives are not trained to provide psychosocial support in an in-depth capacity, and McCauley et al. (2011) reported that midwives do not feel prepared to work with mental health in a meaningful way, and also suggested they did not have enough knowledge in mental health assessment.

Due to the relatively common occurrence of mental health problems said to be experienced in pregnancy, and the fact that three quarters of women in New Zealand have a midwife as their LMC, it is plausible that midwives have to manage and work with a large proportion of women in their client base who have either pre-existing or new mental health problems. Given the lack of studies, particularly in New Zealand, on how midwives identify and manage these clients, the extent to which mental health problems have the potential to complicate outcomes and professional relationships is not known. This is significant, given that midwives do not have extensive formal training in mental health, and that the main focus of their work is supposed to be on the management of the pregnancy and associated factors

(Ministry of Health, 2012b) – instead, midwives are taking on multiple roles alongside their job as a skilled pregnancy and birth practitioner.

Rothera and Oates (2011) advanced the view that it was crucial for health professionals to have a complete understanding of mental health risk factors, and an awareness of the symptomatology of disorders that they are likely to see. While midwives' focus is predominantly on the 'normal' care of women and their families through pregnancy and birth, their position allows them to influence the health and well-being of women and their children, and some studies have suggested that they should be able to recognise and be involved in the support and treatment of such women. As primary health providers, it has been suggested that it is necessary for midwives to hold skills and knowledge of mental health assessment, and the impacts and implications of mental illness in pregnancy and the postpartum period (McCauley et al., 2011).

Midwifery is itself a specialist area, yet people appear to expect more from midwives than other specialists. It is possible this has been overlooked in research given the unique maternity healthcare system that is utilised in New Zealand. To date, a medical perspective appears to have been privileged in the research on midwifery care, in the legislation that has governed it, and in the social climate over time. Mothers are not a homogenous group, and can range in age from teenage to middle age – a woman can become pregnant at many points in her lifespan from menarche to menopause (Klima, 2001). Because of the standardised biomedical approach to mental health care and treatment for women, there may be issues that arise from working across diverse groups; midwifery has to therefore navigate the boundaries between the biomedical model and its more women-focused approach to maternal health care.

However, to date, little research in a New Zealand context has been carried out investigating midwifery service delivery for clients who experience mental health problems, or attention to how midwives deliver these services, or what impact it has on them as practitioners. The midwives' stories appear to be marginalised in favour of investigation of pregnant women's perspectives and medical phenomena.

CHAPTER FOUR - Methodology

Narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy, drama, comedy, mime, painting, stain-glass windows, cinema, comics, news items, conversation. Moreover, under this almost infinite diversity of forms, narrative is present in every age, in every place, in every society; it begins with the very history of mankind and there nowhere is or has been a people without narrative. (Barthes, 2004, p. 65)

Methodolatr

In order to be free to discover what worked best for this research project, it was appropriate to look at the various theories that assist in positioning midwifery and women, that help in discussion of power relations, extrapolate dominant social narratives and discourses, and provide the best fit for finding the answers desired about maternal mental health and midwifery. Questions are raised about how to address the relationship between midwifery and maternal mental health, where the complexities of biomedical and socially produced norms enable and constrain practice. Drawing on feminist critiques of the biomedical model and the gendered construction of the maternal body, it seemed necessary to firstly position the research through feminist standpoint epistemology. Rather than beginning with a set method, it was necessary to problematise biological determinism and normative discourse in the practice of midwifery where medicine and culture interact (Chapters two and three) and how they texture narratives of maternal mental health. Here, the history of midwifery is understood as the narrative production of knowledge and practices through which gendered social relations are reproduced.

To understand the practices of maternal mental health, it seemed appropriate to engage in narrative inquiry to bring into view the shifting moments of social action that are enabled and constrained according to the subject positions available through cultural narratives (Davies & Harre, 1990). Therefore, bringing together feminist standpoint epistemology and narrative inquiry it is possible to engage in research that legitimate marginalised knowledge attending to how social/cultural processes resource lived experience. Narrative inquiry requires attention to midwives narratives of maternal mental health.

As shown in the previous chapters, women and their bodies have been positioned through social narratives, legislation and hegemonic biomedical science, and those who do not fit desired social norms are constructed as defective and in need of fixing (Parker, 2005). Narrative gives the participants the opportunity to describe what is salient for them in their

practice (Bold, 2012). This is also linked to feminist standpoint theories, where all knowledge ought to be produced through consideration of the social and political placement of the women being researched, and narrative is appropriate in order to discover what is relevant for the midwives to maintain their voices and viewpoints and stories. The intention of this research is to focus on participants' perspectives while exploring their experiences and to record and report them, and make their voices and stories visible (Kralik & van Loon, 2008).

Chamberlain (2000) discussed the concept of 'methodolatory' and outlined the idea of researchers privileging method over substance and, as a result, becoming constrained by methods and their attached theories, rather than looking at what is best for the research itself. According to Chamberlain, researchers can become stuck in the prescribed use of certain methods, resulting in an inability to fully access the story that needs to be told through the research. Due to the very nature of this research, some qualitative methodological boundaries could be crossed, and qualitative research objectives should be privileged, rather than undertaking this research from a position of methodological prescription (Chamberlain, 2000).

For this project, a narrative methodology from a feminist standpoint can bring an understanding of the social power relations in the complex relationship between the biomedical and the 'natural' view of women and maternity that position the maternal body and the practice of midwifery, and bring a renewed view of the people in the spaces in between this apparent dichotomy. Not only was mental health in women, and midwifery as a profession, being researched, but also a wide range of other factors that were both historically and currently locating this research. These included; New Zealand's maternity system, the biomedical model, political contexts, a socially constructed understanding of pregnancy and birth, the social construction of women and their bodies and, in addition, this was likely to be undertaken through stories that were verbally recounted in qualitative interviews.

As a result of the complexity of epistemological and methodological issues that formed my research interest, it was essential to engage epistemologies and theories that would help in understanding what was being investigated. The objective was to discover what was salient for the midwives in their practice, and how working with women with mental health issues impacted on them personally and professionally. It would have been inappropriate to adopt an empirical research design for this project as the concepts and constructs that would need to be included and tested in such a study are not yet known. Designing a questionnaire, or accumulating statistical data to find objective "truths" would not achieve the goal of discovering what matters to the midwives as professionals and as women nor elicit the stories that are obscured through post-positivist research methodology. Consequently, utilising narrative inquiry in this study afforded the ability to collect and collate the midwives' personal expressions of

their experiences, how they are positioned in the practices of midwifery, and their lived experiences of working with pregnant women who have mental health issues.

Narrative Theory

The social world itself can be said to be ‘storied’. Social stories are commonplace, and provide ways in which people can construct personal identities and personal narratives, and explore how these have either aligned with or conflicted with the self, culture, and society (Murray, 1997; Riessman, 1993). When people tell stories, ‘narrative form’ is given to experience. Characters are created and positioned in time and space, and it can be said order that makes sense of events through the teller’s perspective is imposed. Thus, it can be argued that narratives are an attempt by individuals to normalise or explain an event. Therefore, narrative provides access into a set of social and cultural meanings, through which an experience is made meaningful in particular ways (Riessman, 2008). Within Western society, various narratives contest for dominance and authority, and through social power relations, particular narratives become privileged over others, serving to exclude or marginalise others (Gergen & Gergen, 1986). This is embedded and visible in the framework of this thesis – in particular, through privileging feminist critiques of the biomedical model and understandings of the maternal body as pathologised, which is in turn produced through historical, social and cultural power relations that inscribe women’s bodies with meaning.

Reissman (1993, 2008) argues that narratives function to structure experiences, but this structure has particular meanings dependent on the particular position within narrative theory. Holding an understanding of narrative structure is essential to sense-making, as some narratives are valued over others, which is evident in readings of historically and socially positioned narratives about women and their bodies that have the result of positioning women in particular ways; as ‘deficient’ or ‘other’ to accepted norms (Bartky, 1990). Narratives generated through feminist standpoint epistemology can be understood as a form of cultural critique and proponent of social change through a pursuit of resistance to patriarchal power relations. It questions the gendered social power relations that produce knowledge that inscribe meaning on women’s experiences, and location in social relationships. Location in social relationships as a basis for narrative inquiry in psychology has been linked to meanings that people bring to their lived experiences and how, through telling particular stories, ‘we’ constitute our social identities (Stephens & Breheny, 2013).

Narrative inquiry examines the ways in which stories are created and used by people to make sense of the world. In this way, narratives can be viewed as social products that are produced by people in story form within the context of specific social, historical and cultural

locations, and as interpretive devices through which experiences are represented to the world, the individual, and others (Bold, 2012).

Narrative Analysis

There is no ‘one’ way to undertake narrative research; narrative analysis can be understood as a ‘family’ of qualitative approaches, with a common goal of presenting narratives in meaningful ways that produce alternative ways of knowing (Riessman, 2008). Narratives can be considered knowledge of lived experience in their own right, and the intentions of narrative analysis are to represent commonalities within stories, and reconfigure these into a unified and coherent whole, where the movement within the story unfolds, and culminates at an endpoint (Polkinghorne, 1995). Narrative is used in particular ways, and is a tool with which to communicate a story. However, narrative is not in itself neutral or objective, and there are decisions made by the people involved in a telling about the type of language that is used, along with how it is interpreted by the receiver of the story. In narrative research, the story that is obtained is done so from within the confines of the interview construction, and the imposed order of the talk within it (Riessman, 1993).

Representation of Experience

While narrative analysis can obtain stories about experience from participants, it does not allow researchers direct access to the lived experiences of participants (Riessman, 1993). An academic theoretical framework, my own history, knowledge, and socio-political positioning and experiences of maternity, along with that of the participants informed this research project, and the questions contained within it. Accordingly, this influenced the co-construction of interviews, the transcription process, and the analysis (Murray, 2000). The data gathered within interviews are representations of an experience, which are being retold for a purpose. As such, the meaning within the participants’ stories is fluid and changes throughout the process. The information is not fixed, and does not remain static over time. All data collected in such a way is open to interpretation, and re-interpretation, and has the constructed nature of narrative research (Riessman, 1993). Representation happens as the experience is occurring, and it is selective on the part of the individual. Of note, is what an individual attends to in that moment - the sensory stimulation, evoked emotions, and historical interactions and experiences that give meaning to this event. Consequently, the subjective meaning drawn from this experience is selective, and the consequence is a partial representation of an event, where an individual discusses the experience with someone else, while drawing on his or her own positioning and context to represent it. In this case, interviewing is a process of narrative production; the interview is a place where experiences are told about, and it includes asking and answering questions, listening

and talking, and stories become co-constructed between the interviewer and research participant (Riessman, 1993). Consistent with feminist standpoint epistemology - and the notion of story production offered under narrative inquiry - a conversational, unstructured interview strategy was adopted with broad research questions and prompts introduced throughout the interview process as and when appropriate. These interviews were active, and involved input, insight, and sharing of information on the part of both researcher and participant. In this manner, knowledge was generated through active dialogue – with both parties in the conversation listening and talking (Thompson, 1992).

In analysis the extrapolation of meaning and representation is additionally selective and partial, as the interview is necessarily transformed from a spoken story to a text-based, transcription. After the gap created between the actual storying of experience and the reconstituted, retold version of it, the re-telling of the story adds to a gap in representation, through the decisions made in the transcription process about the level of detail to include from the spoken conversation, for example. This results in a transcript unavoidably being an incomplete and partial representation of a re-told event. The analysis of the multiple narratives, produced during the research process with multiple participants, involves the identification of common storylines, or themes, from which the narratives are organised into a combined narrative, by the researcher. At this stage, there are many decisions made about the representation of fragments of the (retold) narrative, and about form and style, order, organisation, and presentation. Eventually the objective is to generate a “metastory” that demonstrates and expresses the storylines located from the conglomerate of participants’ stories. This level of representation is informed by the context of the research, along with influences from the researcher’s values, cultural, theoretical, and methodological standpoint and positional context. This aspect of representation is inescapable, given that the participants’ stories are not already put together in such a way that would meet the requirements of academic research, and it must be made to fit the appropriate composition for such an endeavour (Riessman, 1993). Consequently, the research process itself informs the interpretation of the data, and adds to the analysis itself and the production of the metanarrative, culminating in a complete academic work (Maynes, Pierce, & Laslett, 2008).

As the intended audience encounters the completed written work, readers interact with and interpret the narrative through their own sociocultural positions. All written material has the potential for multiple voices and multiple constructions or interpretations. The material encountered by the reader is limited by the writer’s location where representation is necessarily incomplete, and partial (Riessman, 1993).

Reflexivity

Feminist psychological theorists (e.g. Campbell & Wasco, 2000; Harding, 1986; Kralik & van Loon, 2008; Morawsky, 1997) have advanced the notion that human behaviour cannot be investigated without taking into account the specific context within which the individual is located, and have made the point that any inquiry is, in fact, subjective. All knowledge and scientific discovery is grounded in gendered social, historical, cultural and political value systems (Harding, 1991; Henwood & Pidgeon, 1995). Feminist psychology has proposed that in research there should be more active involvement rather than objective detachment, and that researcher reflexivity is key to ensuring that research is sound. In this vein, any discovery through research is not independent of its researchers and methodologies, and instead is part of an overarching cultural practice (Morawsky, 1997). This takes into account the personal values, biases, and so forth, that have influence on the production of data and analysis of results (Kralik & van Loon, 2008).

Feminist standpoint theory assumes that as the knower and the known cannot be disconnected, and the position of the researcher is crucial to the research process - the researcher is occupied with elucidating the foundations for knowledge (Harding, 1995). This means that in order for the research to be ethically and methodically viable, reflexivity on the part of the researcher must be a central component of the research process (Henwood & Pidgeon, 1995). It is important that the researcher is aware of and acknowledges their own values, experiences, and reactions while undertaking the research, and being aware of how this contributes to the shaping of the outcomes, along with how this has had an effect on the researcher and participants personally, before, during and after the process (Willig, 2008). It is also imperative to have an understanding of how the researcher has defined and expanded or limited the research question itself, and whether the research methods chosen have constructed and co-constructed the findings with the participants. Additionally, there must be mindfulness of the implications this has for knowledge gained through the research process, and any effect that this may have had on the participants and the researchers involved in the study (Gergen, 1985).

As a result, reflexivity forms part of a method that unites the views of participants through the assumptions, obligations and values of the researcher with the wider cultural assumptions that yield frameworks for understanding. The role of the researcher becomes a central point from which knowledge is explicated (Henwood & Pidgeon, 1995). In this research my own position has been explicit through my own experience, the context of tensions between midwifery and biomedical discourse, and the methodological framework, each informing the method and analysis.

Method

This project was evaluated by peer review and judged to be low risk under the Massey University Human Ethics Committee guidelines. Even though it was considered low risk; consultation and support for the research from those consulted was part of the ethical evaluation process necessary for low risk ethics, including academic and LMC support.

In order to ensure ethical conduct, this research was peer-reviewed and judged to be low risk under the Massey University Human Ethics Committee guidelines. Participants were given an information sheet that outlined the nature and purpose of the study (Appendix A), informed consent was sought from the midwives as research participants, including permission to interview, record, and utilise their stories in a narrative analysis. This consent was obtained in the following way; an information sheet was given to the participants prior to the interviews being conducted (Appendix B), and participants were informed of their right to withdraw from the study. The participants were also offered access to the transcripts of the interviews in order to be sure that they felt their voices had been accurately represented, and a transcript release form (Appendix C) was signed that gave permission for the re-presentation to be used in analysis. This review of the transcript allowed the researcher to de-brief with participants after the interview, and ascertain if there was anything they wanted to amend, or add to their story (Sullivan & Riley, 2012). Furthermore, the participants' confidentiality was closely guarded in documentation, through removal of identifying features, and pseudonyms were employed in the writing process.

Sample

The participants in this study were 12 midwives who had experience in practicing independently as Lead Maternity Carers (LMC). The midwives recruited as participants in this research who had experience working as a Lead Maternity Carer, and provided primary health services for women during pregnancy and the postnatal period.

Within the sample, along with eight midwives that identified as coming from a Pākehā/European background, two midwives identified as Māori/Pacific Island ethnicity and two worked primarily with a many clients that identify as Māori and Pacific Islanders that convey a breadth of experience that could be included in the data. Māori and Pacific Island women are over-represented in statistics on Mental Health (Ministry of Health, 2002a; Taha Advisory Group, 2013), and this perspective can be different from that in a predominantly Western sample.

The participants were recruited through direct contact with independent midwives and the collectives they worked within. A convenience based sampling process was employed.

Recruitment began by talking to midwives I had previous contact with who were able to give me contact details for colleagues. I also obtained details for local midwifery collectives from health directories, and through information given to me through a local GP practice. Furthermore, from one interview to another, I was referred by participants to other midwives and organisations, and midwives who had heard about my research through their networks contacted me. The decisions around the sample size were to make the research project practical, as there is a high level of detail and analysis employed in narrative research and large numbers would not be time effective (Reissman, 1993). Moreover, it is now well established that data saturation occurs at around 8 – 12 participants in research that has as its criteria the number of participants who best represent the knowledge sought through the research question. Data saturation means that sufficient data is gained to account for replication and comprehension of the phenomenon being studied (Morse, Barrett, Mayan, Olson & Speirs, 2002). A data set is considered complete when nothing new is being added (Bowen, 2008).

The midwives who were participants in this study had a range of experience, from 18 months post-graduation through to careers spanning more than two decades and across continents. They worked in a range of areas throughout New Zealand from the South Island through to north of Auckland. As a result the range of experience was hugely varied, and the descriptions of their work within DHBs had variances within them as well. There are differences within a range of domains; social position – both of the midwife and clients that they work with, the midwife's professional experience level, area, DHB, size of service, culture, workload, and even those that are similar in various demographic categories have a wide variety of experiences within them. The aim for this study is not to generalise the results to a wider population – this in itself would be contradictory to the tenets of the theoretical and epistemological standpoints of qualitative and feminist research (Sullivan & Riley, 2012). In this work I do not seek to represent midwifery as a whole, but to understand the experiences of midwives. While generalisation in an empirical sense is not the goal of narrative research, it is expected that the stories generated through this research have the potential to go beyond the individual level, and speak to a wider social construction or position (Maynes et al., 2008). Consequently, a variety of experiences are highlighted that *could* be experienced by any, and all, midwives in New Zealand.

Data Collection

As the result of a review of available literature, consultations with midwives, other postgraduate psychology students, and lecturers in psychology and midwifery, the following research question was developed:

How do midwives identify and manage clients with mental health problems, and what impact does this have on their practice?

Prompts and questions were developed from the research objectives prior to the interviews being commenced, in order to direct discussion around the research question. All prompts or questions were open ended, and allowed the participants to speak freely about their experience. The rationale behind this was to focus the conversation, but at the same time minimise restriction of the narrative production as much as possible, to allow the midwives to take responsibility for the stories they wanted to tell, and to present their views in a way that was logical and meaningful for them (Riessman, 1993). Each interview took around an hour on average, and ranged from 45 minutes to 90 minutes, and in total generated 264 pages of data. These interviews were carried out at a time and place that convenient for the participants and included participants' homes and workplaces.

Interviews were conducted by the researcher, either in person or over video calls through Skype. All were digitally audio-recorded, and subsequently transcribed personally by the researcher in order to maintain the integrity of the co-construction. This enabled full immersion of the researcher in the content of the narratives. Field notes, and reflexive commentary on the part of the researcher were recorded and intended to be included during the analysis process (Riessman, 1993). The transcripts included the entire conversation between the interviewer and participant in order to maintain the integrity of the conversational style of the interviews, and to produce comprehensive transcripts as narratives for analysis (Sullivan & Riley, 2012). The transcripts were returned to participants for review, in order that they may ensure that the transcripts were an accurate representation of the interview, and to provide participants with the opportunity to amend or add to the content. One participant amended some of the transcript for clarity.

From the research question, a number of lower level questions were identified for use as prompts in interviews that would be presented to participants in the endeavour to answer this question effectively. As the interviews were unstructured, and given the conversational style of the interviews, these prompts were not intended to be a complete and exhaustive list of topics to be raised during interviews, as there was an awareness that other questions or topics could present during the process. The prompts used included:

- Please tell me about your experiences with pregnant clients who have experienced mental health problems.
- How do you identify and manage these clients?
- Can you give me examples of how this impacts on your practice?

- Can you tell me how you view your role as a practicing independent midwife (LMC)?
- How do you find resources for you to draw on to deal with clients with mental health issues (both practically and personally)?

All records of the narrative collection process; including transcripts, researcher field notes, reflexive diary entries were stored securely and access to these was only granted to those people directly involved in the research project (the researcher, and academic supervisor) (Hugh-Jones & Gibson, 2012).

Data Analysis

As the experiences represented in this work are retold in the interview process, through a conversation between participant and researcher, they are produced within the limits of that relationship (Crossley, 2003; Riessman, 1993). According to Stephens and Breheny (2013) narrative structure is, in itself, a source from which we can infer and investigate aspects of the nature and structure of a social world.

Riessman (1993) offers an argument about interpretation where language is neither neutral, nor transparent, but instead is active and constructive, and social experience and subjective meaning are embedded within it, the process of ‘telling a story’ allows an individual the ability to create an ordered account of events or experiences, through which the disorder of life is reorganised, and attributions for personal ‘meaning’ in a social realm can be accessed through narratives of experience (Stephens & Breheny, 2013). Similarly, feminist standpoint permits us to access stories of women’s lives and experiences through their voices as the *source* of knowledge (McCool & McCool, 1989).

The approach to narrative analysis by Murray (2000) and Stephen and Breheny (2013) enabled consideration of the historical, social and cultural narratives that have produced dominant understandings of maternal mental health, and how they interact with midwives’ narratives of their relationships with their clients. In the current study, a structural approach to narrative analysis provided a framework to understand and comprehend the experiences of maternal mental healthcare through the meaning given to it by midwives through their personal, cultural, and historical location. Murray (2000) suggested four distinct levels of analysis that can be applied to the structure of narrative data in psychological research: personal, interpersonal, positional, and ideological. Utilising these levels of analysis allows for exploration of experience, how social structure is significant, and where participants place themselves within it.

Personal Level

At the personal level of analysis in narrative research is it possible to untangle where individuals position themselves in a social world, and how they organise their responses to their environment (Stephens & Breheny, 2013). This is the point at which narratives are expressed as experiences and allows expression of their sense-making order to a story. It has also been described as having a personal function for healing and self-care (Murray, 2000). For the midwives involved in this study, this could be significant, as within the literature to date, and by their own telling, their stories have not been the centre of previous research.

Interpersonal Level

The interpersonal level of analysis is concerned with how interpersonal processes influence the narratives that are produced. In this stage of analysis the narrative is a co-construction between the researcher and participant. For example, it is necessary to consider how an interview and its context give weight to the construction of a story, or influence the way it is produced. Additionally, midwifery is in an interpersonal space that is 'in between' the technological, biological, natural and gendered constructions of the maternal body and its processes. The interviewer and participant interactions are usually purposefully constructed and artificial, and in this context stories are constructed with a specific objective in mind. They differ from that of a 'natural' conversation, and as a result, it cannot be known how a participant may put their story together differently in another context. The questions that are asked, the rapport built between the researcher and midwives involved, and the flow of conversation all have influence as to how a narrative may unfold. Analysis as representation is also linked to earlier discussion of the shifting nature of narrative, and the way in which feminist standpoint research privileges the voices of the participants (Harding, 1991; Murray, 2000; Riessman, 1993).

Positional Level

The broader social framework, and the moral and social functions of narratives within it, can be understood at the positional level. While the narrative is still necessarily a co-construction, it is important to separate out the narrator, the characters and the audience, and look at how these are influenced by power relations and subject positions (Stephens & Breheny, 2013). The positions of the researcher and participants are taken into account at this stage, and reflexivity on the part of the researcher is crucial here. Given that in this case, there is a researcher present, controlling and arranging an agenda for interview, it is possible that there is an imbalance in how narratives may otherwise be constructed (Murray, 1997). In order to fully comprehend and understand the narrative, it is imperative that the positional context is recognised and made explicit so an understanding of how midwives position themselves in

relation to the social power relations they are embedded in, and the context (gendered power relations) that frame the position of the researcher can be advanced.

This can have an effect on how a story is constructed, and how an individual may represent the self – for example, an individual presenting a picture of themselves that conforms to social desirability is something that may be often recognised at this stage of analysis (Murray, 2000) in this research, this may be linked to how midwives manage their professional identity within their complex relationship within dualistic biomedical and natural narratives.

Ideological Level

Social representation and ideologies function to enable and constrain midwifery's practice. Given that the world we live in is facilitated by spoken, written and acted stories, it is important to not overlook the influence that stories presented in literature and the media have on the construction of narratives (Murray, 2000). For the midwives in this study, this will be particularly pertinent; media representation of midwives' failure to provide appropriately medically based care, for example, may have influenced public perception of the profession. This is likely to mediate the stories they construct, in order to contribute to the social representation of what they do, and how they do it, within the context of a problematic relationship between biomedical and women-centred practice. Through this level of analysis it is possible to examine how sociocultural and political assumptions condition the public's thoughts and practices, and extends to the midwives in how their stories are embedded in this broader social framework (Stephens & Breheny, 2013).

Guided by the research question of how midwives, within their professional relationships, manage maternal mental health – as outlined in earlier chapters - the focus was initially on identifying similar storylines within the responses given by the participants. As I listened to midwives' stories in interviews, I began to gain insight into what I was being told, and began to keep a journal of what took my interest, which is partially formed by my own experience, and earlier reviews of research literature. Guided by the interviews, I began to read more widely in literature, and to incorporate feminist analyses of the construction of the maternal body, and how it is constructed within patriarchal power relations. Consequently, the earlier chapters in this thesis were revised to attend to the interests or focus of questions and stories that emerged from the midwives' talk. This enabled me to privilege the emerging and shifting objectives of the research, over a constrained and prescribed mode of conducting narrative analysis, and to move beyond descriptive depiction of stories to a more interpretive and in-depth view of the narrative production (Chamberlain, 2000). In doing so, this allowed the context of the thesis to become informed by the midwives as co-constructors of narrative production, and an awareness of Riessman's (1993) arguments about the shifts in representation

allowed me to be attentive to the ways in which narrative construction was occurring. It is also important to make clear that participants have translated their experiences into narratives to express their view, and my role as researcher is to transform that further into academic text, which has an effect on how these stories are re-presented.

Each transcript was reviewed a number of times, and revisited when and where necessary throughout the process, for example if clarification or extrapolation was needed. Common storylines were identified within the transcripts, and these storylines were then examined to find common themes, relationships, and connections among them in order to identify different levels of interpretation and meaning. Stephens and Breheny (2013) argue that narrative structure cannot provide meaning in and of itself. By using a more systematic approach to the stories our participants tell us, we can begin to notice how experience is constructed at the intersection of personal, interpersonal, and cultural narratives. The structural approach to narrative (Murray, 1997, 2000) enabled the question to become how midwives positioning within biomedical and women-centred approaches to maternity care create meaning and how that affects their understanding of maternal mental health

Integrating the Levels of Analysis

As illustrated above, narratives evolve, and produce multiple functions - from a personal attempt to convey a lived experience through to forming part of a social commentary (Stephens & Breheny, 2013). In this sense, they can be analysed at these multiple levels, as social performance, co-constructed events in themselves, and as critical social interpretation. These personal stories can be compared with the broader social framework within which they exist, and at other stages in between, and in addition can co-exist in the same space and time (Murray, 2000).

At times this is organised around storylines to bring coherence to the analysis, which allows the events in this narrative to be highlighted and brought to the fore (Riessman, 2008). Accordingly, integrating these stories with a structural analysis means that significant differentiations of the same event for the midwives in the sample are recognised and analysed in a more comprehensive way. This enables recognition of the structural influences illustrated in the stories told by participants, whilst highlighting the diversity inherent in the stories that were told. Together with the structural approach to analysis that utilises the levels of analysis as described by Murray (2000), this allows the focus to be taken off the semantic organisation and order of the narrative and placed on the meanings within a structural framework.

The following analysis is organised by taking up the structural analysis suggested by Murray (2000), and presenting it through the participants' narratives, with exploration of how the storylines tie in with the four levels of analysis.

CHAPTER FIVE - Analysis

The whole point of woman-centered birth is the knowledge that a woman is the birth power source. She may need, and deserve, help, but in essence, she always had, currently has, and will have the power. (McCue, as cited in Sanchez, 2011)

The Location of Midwifery

Midwifery as a practice is constituted through dominant historical, social and cultural conditions that produce a tension between maternity as a biomedical risk and as natural and normal. Midwives' lived experiences, and their subject positions are enabled and constrained within and through these narratives. Understanding the positioning of midwifery is necessary to how midwives' identities and experiences are textured through their personal, interpersonal and cultural narratives that bring meaning to maternal mental health. This chapter analyses the participants' stories to make sense of how midwives are positioned within and between the binary of biomedical and women-centred narratives, and how their identities and experiences affect their practice with clients with mental health issues. The units of analysis were the stories elicited during the interview process, which were transcribed in detail, and re-presented in text form (Riessman, 2008). How do the tensions created in the differences between the two ideological narratives impact on midwives' personal, interpersonal and professional identities and influence the facilitation of midwives' care for women with mental health needs?

To make sense of the relationship between midwifery and maternal mental health, all the midwives ordered their stories beginning with their personal position in a women-centred narrative that assumes maternity is natural, normal and holistic. Through this position, they also located themselves at positional and ideological levels, through their professional identity that was often at odds with dominant biomedical and technological narratives of maternal risk. The midwives who participated in this study constituted midwifery as a practice, and discussed their own multiplicity of positioning (personal/interpersonal/positional/ideological) before they began telling the stories of their work with clients who have mental health problems. Thus, in order to discuss midwives' experiences of maternal mental health, it is necessary to begin with midwifery itself.

Participants' stories worked to position themselves, and their profession, within an ideological framework that is often contradictory. Considered obstetric practitioners in a medical context is at odds with midwifery's women-centred practice philosophy (Davis & Walker, 2012; Donely, 1986; Seagal, 2010). At a professional level, the midwives consider this difference as

producing a contradictory maternal body that is either risky or normal. The midwives positioned themselves as resistant to risky maternal bodies in their relationship with women. The difference is in their relationship with women.

Emily: Doctors and midwives have a different way of doing the birth, doctors are there to see things as a pathology, midwives see things as normal until it proves otherwise and then it's handed over. Just at the very core, it's a different view of the woman.

The medicalisation of women's pregnant bodies has become a socially mediated 'truth'. This 'truth' is constituted through social norms embedded in dominant narratives of risk that work together to ensure conformity to the 'authoritative knowledge' that legitimates medical intervention. In this instance, the knowledge and language used within the scientific paradigm of medical obstetrics holds more authority over other knowledge systems such as the knowledge contained within the profession of midwifery (Clews, 2013; Hunter, 2006). Midwives are working intimately with women to normalise the experience of pregnancy, birth and mothering with a view of the maternal woman as a natural cultural narrative. This view resonates with Pairman's (1998) research, in which distinctions were made in the language used to describe pregnant women; distinctions that make evident the contest over the meaning of the maternal body. The midwives positioned themselves in the difference between pathology and normality. Their ideological and positional difference is embedded in their holistic understanding of the maternal woman, and privileges the woman rather than the object of the medical gaze.

Emily: there is a difference between looking at a pregnant woman and seeing a woman who is pregnant . . .

Within this context, the midwives talked about their professional qualifications and training, and their specialisation in obstetrics as an important dimension of their practice. Specialisation in obstetrics however, for the midwives, was not the dominant narrative for their practice, but discussion of this specialisation enabled them to position themselves in an interpersonal space; the in-between space of risky and natural maternal bodies. Midwives work between the medical understanding of the maternal body and the natural and gendered maternal body of their ideological position.. In this way, they perform the correct processes and procedures required in order to remain connected to, and remain within, the socio-political framework provided by New Zealand's health system, including legal and ethical standards, and enable midwifery to be practiced in a women-centred manner. The midwives, at a positional

level (health professional), placed themselves as different from the medical profession through their on-going relationship with women through the maternal process.

Charlotte: As LMCs we are the sometimes the only health professional a woman will ever see through her pregnancy birth and postnatal. . . some GPs may not even be aware that she was pregnant let alone having had her child.

Marion: I think it's such an unusual role. What other role as a healthcare provider do the clients have this much access to?

In this study, the midwives' stories are embedded in a broader ideological and social framework that understands maternity as a natural process. The medical fraternity's view of pregnancy as pathology and midwifery's desire to maintain pregnancy and birth as a normal physiological event, within the gendered context of women, creates tensions for midwives. Midwives in this study positioned themselves as a conduit between women and the medical system. Inside this in-between space midwives advocated for a women-centred point of view providing an interpersonal space for engaging with women through the process in her social context rather than through her risk. While at a positional level midwives presented themselves as advocates for women, they do so within the structural confines of an institutionalised biomedical system of maternity care. In this way, the midwives respond to the hegemonic view of pregnancy care, where obstetrics holds the authority over the meaning of the maternal body, and midwives are responsible for the gap in meaning between the two (Stapleton, Kirkham, & Thomas, 2002). Midwives themselves understand clear professional boundaries between scopes of practice, and are obligated to assess medical risk and refer appropriately. This places midwives as responsible for the connection between biomedical and natural maternal processes, within an ideological power structure that privileges the notion of risk.

Sarah: You are the person who is looking after all normal pregnancy stuff, and if you have anything that's abnormal you have to refer to an obstetrician or psychiatrist or whoever. So if anything crops up that you aren't medically qualified to look after, you refer.

Midwifery does not fall into a 'lay' category – midwives are highly skilled and highly trained professionals in their own right. However, nor are they of the 'medical' fraternity. Midwives sit, uncomfortably at times, squarely on the boundary that separates the two worlds, and at times become the conduit for translation of communications. This is consistent with other

studies, where midwives described themselves as a channel between women and a medical system (Seibold et al., 2010), where they positioned themselves as advocates for women.

As the midwives positioned themselves through their social and political assumptions, and the practice of midwifery as the interpersonal, they were able to form a professional identity that produced a relationship that attends to the maternal process as natural. Through this relationship, they support women to understand, through their own bodies, the meaning of medical interventions, including choices between them (e.g. continuing with labour or consenting to a medically advised caesarean section). In this way, it was important to midwives' professional identity to ensure women were well informed of the implications of technological interventions.

As members of the health profession, the midwives felt that while tension exists, their in-between position can be a powerful one that they understand can empower and inform women as to the meaning of choice, and act as advocates in the medical system.

Emily: [My role is] to filter that information, to make sure that they understand that information and make sure that they are having an opportunity to make sure that they are making informed choices rather than just having medical things done to them.

Marion: We have to be quite intuitive and quite able to look at the whole situation, the body language. I think we're in a very strong position to be able to just support and help women, not help as in be helpers and rescuers, but advocates.

Midwives' personal location illustrates a contest between meaning, creating tension between two ideological narratives (biomedicine and midwifery), and a positional level of analysis allows those ideological and positional constructs to be examined. Meaning is ascribed differently, depending on which narrative is taken up. The issue here becomes whether this contest over meaning and knowledge can be supported under Western health care rationalisation and the resultant maternity services developed and offered within it. The dominant biomedical understandings that frame pregnancy and childbirth as discrete events through technologies of intervention and recovery ignore women's social, psychological, and emotional experiences of the maternal process – the very focus of midwifery's ideological framework, and midwives professional identity.

Emily: That should be the philosophy of all midwives. We are the guardians of normal birth. We are primary caregivers; that's where our scope of practice is. We learn and know the physiology of it, we know it's not just airy fairy witchcraft, we know women's

bodies were made to have babies and give birth, and they can do that given the chance to, and given the support.”

The midwifery-led system in New Zealand was expected to result in reduced rates of medical intervention, but due to the dominance of narratives that position women and their bodies as risk, and the increased surveillance and supervision of the maternal body, medical interventions in childbirth are increasing – over 95% of births occur in a hospital (Ministry of Health, 2012b). Caesarean section procedures have become more commonplace over time. For instance, in the 1980s, caesarean sections comprised 9% of births and by 2013 one in four women in New Zealand births were performed by caesarean section of which 50% of these were elective (Campbell, 2013). While the change to midwifery-led maternity services has worked in some ways to challenge the biomedical interventions into the processes of pregnancy and birth, the dominant knowledge within the biomedical model could be concurrently working to substantiate the dominant discourses, even though this may not be intentional (Davis & Walker, 2012). This creates a tension between the repressive and productive functions of power held within midwifery’s structure. While midwives believe that they are in a position to uphold maternal bodies as natural, and advocate for the normality of maternity for their clients, their position within the hegemonic system both advances and silences their message.

Emily: The role of the med students is not to learn about normal birth, it’s to learn about assisted birth, and medicalised birth, and caesarean. It’s not about normal birth, and this has an impact regardless of what they say, it has an impact.

In this way, maternity is institutionalised through the dominance of a medical narrative that leads to a focus on assisted or medicalised intervention. Given the position of midwifery within our health system in New Zealand, this is a tension that informs midwifery practice. The relationship between mother and foetus is minimised, especially where the medical/technological gaze attends to the product (baby) rather than the woman’s efforts and input (Glen, 2012; Rothman, 1989; Seagal, 2010). In this way, maternity is institutionalised through the dominance of medical discourse that leads to a focus on assisted or medicalised intervention. Very often, the information given to women regarding their care is knowledge that is produced through a technological gaze (Clews, 2013).

While midwives do not position themselves within the dominant narrative of the medical fraternity, they are aware that there are ideological aspects of the biomedical model that they must take up in their practice. At a personal and positional level, it is through the taking up of these aspects of the biomedical model that they are enabled to resist the pathologisation of

women, and to practice in a women-centred way. This allows their personal positioning to be enacted, within and through the multiplicity of interpersonal and ideological positions. Participants in this study understood their professional position to act as translator for the women in order to bring the concept of ‘informed consent’ to everyday life. There are limits of choice that are produced through a hegemonic narrative - where women consent, but may not fully understand the implications of consent within the gaze of the medical institution. Midwives’ positional and ideological location produces a site of resistance to the limits of medical discourse.

Julie: And I say that to women . . . I will say, “this is what’s going to happen, this is what they’re going to say, but nobody can make you do anything, and it’s not consent if they make you afraid to say no.

Despite cultural narratives that assume pregnancy and motherhood as natural, a “rite of passage into womanhood” (Lorber & Moore, 2011, p. 45), biomedical narratives and their reproduction in social and cultural discourse exert control of this ‘natural’ process in ways that are not always explicitly observable (Rothman, 1989). While women’s bodies are under such scrutiny, there is no place for the ‘natural’ process that is understood under midwifery’s ideological and personal assumptions to genuinely take place.

Under patriarchal biomedical understandings, women themselves are considered a risk to their own bodies and babies and therefore must be watched carefully to ensure that they do not do harm to their bodies, and especially their foetus. Midwives themselves have become inadvertently complicit in perpetuating this ‘control’. During pregnancy and the initial postnatal period, participants in this study talked about how midwifery is tasked with assessing whether babies are “thriving” and how they have become professionally responsible for ensuring that the mother is not putting her new child at risk. These responsibilities are on the boundary of midwives’ professional scope of practice, and are also illustrative of a tension in how midwives see themselves.

Charlotte: . . . [T]here might be LMCs out there who have absolutely no knowledge or interest in being that person, yet they’re placed in that position that is outside of their scope and that could be detrimental to that woman predominantly, but to the midwife as well. It can be quite traumatising – you get blamed for stuff, it is a bit of a can of worms.

Within their accounts, the midwives’ professional identity was necessarily compliant to notions of risk, through their assessments of the biomedical process, and within the regulation of

their practice. Midwives' practice is carried out with an understanding of the implications of how women adhere to the biomedical model as evidence of the desire to be a good mother. A 'good' mother is more likely to submit to the tests, checks and procedures recommended to them by medical professionals in their position of authority over knowledge. The midwives talked about how women will agree to be "poked and prodded", and even consent to invasive surgery being performed on their bodies for the sake their babies – and to adhere to 'good mothering'. Through this account, the midwives made sense of the number of women who do not question biomedical surveillance, and they were personally aware of the pressures faced by their women clients.

Emily: More often than not, if anyone says to a woman, "you're putting your baby at risk" - they will cave. The minute you say that, you can do what you want with them. You could cut their stomachs open without anaesthetic or an epidural. If it's going to be good for the baby, they will agree to anything.

Midwives are constrained by biomedical standards of practice prescribed by New Zealand's governing bodies and understand their position as primary carers to be one of vulnerability – the vulnerability is produced through managing risk. As primary caregivers, midwives carry the burden of responsibility for maternal and foetal outcomes. A study carried out by Seibold et al. (2010) found that midwives often feel under suspicion, and constantly threatened by blame, resulting in a disempowerment of the midwifery profession as practitioners become overly cautious to avoid legal liability. Participants in this study echoed this feeling, stating that they had to ensure that they met specific record keeping legal obligations, in order to ensure that they were 'covered' if something did go 'wrong' in their care of women. The participants also discussed how this position was often unavoidable, given their 'in-between' role, and the vulnerability it creates for them.

Amanda: Midwives are in that vulnerable position of being there when a baby dies (...) of course it's going to be a midwife! Who else is going to be there? That's our job!

Laura: . . . [Y]ou'd be surprised at what midwives put up with from women because there is nothing else – and they know that there is nothing else

The interconnectedness of midwives' personal and professional identities, and the multiplicity of midwives' positioning inform client interactions. Along with this, the representation of midwifery within medical and social narratives reveals structural and hierarchical pressure on midwives and women within a biomedical framework. Not only do

midwives experience conflicts, contradictions, and complexities in their work with women and the other professionals (Skinner, 2011), their in-between position requires them to take up or resist an increasing number of socially re-produced expectations of care.

Laura: Once upon a time, we were supposed to be midwives. But unfortunately over the last 20 years, that has changed considerably, as we are expected to take on more roles...we were supposed to change them so that they came out with a better life or whatever it was. I have struggled with that concept for all this time because actually 9 months in somebody's life is a blink of an eye, and we were never trained to be counsellors, psychiatrists, psychologists, marriage guidance counsellors, social workers, CYFS employees, GPs etcetera. So, over this period of time, midwifery has broadened its scope without actually giving us the tools to go with that.

Biomedical Constructions

Pregnancy and the maternal body is so regulated, managed and proceduralised, that routine interaction with doctors, nurses, midwives and other professionals is now seen as 'normal'. Any deviation from that norm is seen as being dangerous, risky, or framed in the negative as the 'alternative' to the 'right' way to be pregnant and give birth (Mardorossian, 2003). To a degree, midwives themselves seem to be caught up in the dichotomy of the medical narrative of the positive effect that technology has had on low risk birth, and will sometimes justify the interventions that they see, which are in contrast to their philosophical assumptions.

Amanda: And look what happened hundreds of years ago, a lot of people died and a lot of people were never the same again after childbirth.

Whilst hospitals now promote 'natural' birth with minimal intervention as the 'best' option, they also will use these exact arguments against natural birth in other locations, such as a homebirth, stating that they are risky outside of a hospital environment (Mardorossian, 2003; Seagal, 2010). Under a biomedical gaze, the technologies of maternity are justified as the safest, and most appropriate view of pregnancy and birth, and therefore, obstetrics as a practice within hospitals retains control of maternal bodies through the argument of safety in its scientific stability (Davis & Walker, 2012). This context has shaped the cultural knowledge that gives meaning to the maternal body, or 'maternal environment' – as it is known in an obstetric context (Rothman, 1989) – and the processes of pregnancy, labour, and birth. Technology has allowed us to go through the mother's body to look directly at the developing foetus, which has become a patient in its own right (Glen, 2012). We can now attach monitors, conduct tests on bodily

fluids in a laboratory, and a plethora of new technologies are being developed and implemented every day. Technological advances survey the maternal body and assess risk in ways that could be argued to be detrimental to women's agency and autonomy, limit their choices surrounding their own bodies, and that of their babies. Some participants used the example of elective surgery, as the routine use of technology in medicalised care for pregnant women, to politically question how far intervention into the maternal body has come.

Julie: There's a lot of our health dollars going on elective caesarean sections. If we told a lot of women that they had to pay 10 grand to have a caesarean section, they probably wouldn't have one. There's no other elective surgery you can have that's funded. I think if it's medically indicated, then absolutely fine, but not just because they don't want to. I think our health dollar is so skinny, that I could think of much better things to spend our health dollars on for women in pregnancy.

Nevertheless, women use these technologies of surveillance as tools in self-governance. These technologies are utilised in ways that reinforce adherence to desirable social norms, such as identification with 'good mothering' narratives that are re-produced at personal and ideological levels. Surveillance is productive in that it allows for safety within 'normal' for members of society. In this instance, women are engaging in endorsed self-care practices, which places the responsibility for care with the women themselves, permitting standards to be met for 'good mothering' narratives (Holmes & Gastaldo, 2002). Under the model for partnership, midwifery espouses a shared responsibility between a woman and her midwife for health care during pregnancy and the postnatal period. At the personal level, midwives are embracing this as an important part of their daily practice. However, midwifery's practice guidelines state that a woman should be referred for genetic testing, additional monitoring and be intensely scrutinised should a previous or current pregnancy not meet the standards of 'normal' as prescribed by the biomedical model. This prescription for midwifery practice reflects ideological influences that stem from biomedical narratives.

Paradoxically, while midwifery practice in New Zealand is independent, midwifery still plays an important role in extending the medical surveillance of the maternal body (Davis & Walker, 2012). Independent midwifery has assisted in disrupting the medical gaze to a certain extent, and shifted midwifery's traditional position in the biomedical hierarchy, however midwives are required to submit clinical reports, complete referrals to other medical professionals, and disclose clinical notes that were meticulously collated during a woman's care on discharge from midwifery services. This is done under a biomedical understanding of pregnancy and birth – client information must all be noted, collated, and monitored in order to

maintain the ‘normalcy’ of childbirth and prove that midwifery has ‘done the right thing’ in situations that may have been assessed as risky. The midwives in this study, stated that they feel that they have to prove that they are doing the ‘right thing’; despite an apparent autonomy contained in law and research. Some participants stated that they feel the medical fraternity does not really trust them to undertake care in pregnancy and birth autonomously. It seems that their autonomous professional identity is constantly under scrutiny, managed through the processes of monitoring compliance to a clinical authority that positions them as obstetric assistants, and undermines their philosophical positioning.

Laura: [T]hey still have that boy's syndrome crap. (...) You get the idea that all midwives are pathetic until you've proven you know what you're doing"

It appears the midwives themselves are aware that the ideological position of biomedical discourse, reproduced in cultural narratives, affects their practice at an interpersonal level. The same powerful narrative of risk is reproduced in their clients' talk – and again the midwives are positioned in-between – working the boundaries of technologically produced maternal bodies and natural gendered maternal bodies - normalising women's own narrative assumptions of risk.

Julie: . . . in pregnancy, [people tell me] "I'm too big", "I'm too small", people say, "I'm huge", people say, "I'm too small." And I say, "Well that's why I'm here. Because I'm here to tell you that you're just right. That's what I do". How do they know "you're too big?" . . . Too big for what? Too big for who? Too small for what? Nobody says, "you're great!". There's all this measuring up, and being the right size, the right formula.

Midwifery's practice, where women's subjective knowledge is as valued as much as medical knowledge, generates tensions for midwives supporting women navigating the medicalised system within which they are embedded.

None of this is to say that the medical advances and increased knowledge of biological processes and anatomy in the last century or longer have not benefited individual women. The development and refinement of the caesarean section has certainly saved lives, and our knowledge of how to reduce morbidity and mortality through scientific study has reduced incidents of maternal and infant mortality. However, it must be remembered that the scientific knowledge that we now hold is based on and produced through certain social, political and patriarchal ideals (Rothman, 1989), and these have shifted the meaning of the maternal body to risk. The process surrounding pregnancy and birth is directed not because of what we know

about birth, but rather, what we know about pregnancy and birth has shaped the way it is conducted (Davis & Walker, 2012).

Professional Friendship

LMC midwives work with women in their homes, and wider communities. This community-based position is something that is significant to the midwives in this study, as it allows for midwifery practice within the biomedical framework, but is enacted through the notion of midwifery being a set of social and political assumptions that position women at the centre. Midwives are positioned as primary health providers, and midwifery as a profession is sanctioned to be undertaken in women's sociocultural contexts. At a personal level, this allows midwives to explain their experience, and link their experience with an ideological and positional understanding through the maintenance and understanding of the multiple positions through which their practice is produced. However, at interpersonal and ideological levels, this also creates complexities within their work, as midwifery is a practice that encompasses the gendered context of women's lives and also necessarily crosses specific professional and biomedical boundaries.

Julie: You are a grass roots community worker. And you are a default counsellor, you are a default social worker, you are in people's homes and you do see things and hear things and observe things, and see things in relationships or with other children that might make you alarmed as well. How a mother is treating another child with a new baby there, you might be the only person that sees it. So that's just part and parcel with how it is.

Structural analysis enables an understanding of the complexities of midwives' practice that are an interconnected web of personal, interpersonal, positional and ideological levels of social structure in the production of narratives (Stephens & Breheny, 2013). In the account above, Julie has described how her practice is often complex, and at the personal level, she is reflective of a women-centred approach to midwifery practice – her positioning makes explicit the sense she has to make from a woman's context. Yet, personal and positional levels are informed by an ideological standpoint that allows midwives' practice to be carried out with an awareness of their daily interactions with clients and other professionals, at an interpersonal level. Midwives' in-between standpoint within such complexity leads to partnership with their clients as a position that they take up in order to fulfil expectations that are acknowledged by the public, their profession, and the authority of the health system.

A core tenet of midwifery is that of partnership, and the midwives in this study were concerned with presenting this throughout their talk. Midwives, clients, and the public uphold the notion of this relationship being a ‘partnership’ that has certain characteristics that are unique to their particular dynamic. The participants in this study have assimilated their complex positioning as a part of their personal and professional identity, one that is also reproduced within social norms and expectations at an ideological level. Telling themselves through their social and political philosophy and their professional identity enables them to develop relationships with their clients in particular ways, with particular values.

The participants saw the relationship between client and midwife as the foundation of what they do on a daily basis. They see midwifery’s role as being one of support, one of friendship – and of enduring reciprocity.

Audrey: I think that you and the woman both give each other that stuff, otherwise neither of you would remain in it, the woman would go on and have another baby or whatever with someone else.

Gulliland and Pairman (1995) described the midwife-client relationship as one of professional friendship, and the New Zealand Council of Midwives (2013) describe it as a partnership (2013). It is clear that there is an understanding of this relationship being an enduring one that encompasses continuity of care, and shared responsibility. It is evident that the midwives in this study live this philosophy. Midwives get to know their clients, both physically and psychologically, in the context of a relationship. They spend time with their clients in their own environments, they have relationships with the members of diverse family systems, and they practice within the community. These midwives are personally, emotionally and professionally invested in their clients negotiating the terrain of maternity, and have a holistic view of the woman in her sociocultural context. Clients are described as “my women”, “gifts” and “partners”.

Melanie: Exactly that, partnership. It’s amazing that I know a woman for 8 sometimes 9 or 7 months. I meet her so often, I know her family, I know where she lives, and I know what she brings with her. I know the partner or the support person who comes, and that is just, you feel so much better than just walking into a room and saying hello, this is my name and this is how I am today. You can see how a woman is changing during labour. Sometimes you can tell on the phone which stage of labour she’s in; by the way she’s talking. That’s just amazing.

Charlotte: She was a gift. Even though it was a really challenging relationship to be in, she provided me with something in my career that I would have never been exposed to if she hadn't given that to me.

A structural analysis facilitates an understanding of how the identification with and assimilation of complex positioning enables midwifery's practice. At the personal level, midwives are describing the foundation for their practice, they are telling about how they practice a woman-focused approach. The word midwifery means "with woman", and the midwives in this study live that philosophy at a personal level. All the midwives spoke from the standpoint that their practice is on an equal footing with the women they work with. Their clients are their partners, collaborators, and accomplices. The midwives talked about trust and reciprocity, and a willingness to 'go the extra mile', and in this way, their personal meanings cannot be separated from their professional practice. Understanding the midwife-client relationship as one of mutual understanding and trust, participants describe the relationship as one from which they derive much personal and professional satisfaction. At the same time, they are also aware of the responsibility of their professional identity as midwives to be 'gatekeepers' for public wellbeing – that of the women and infants under their care.

In many cases, women will engage the same midwife for subsequent pregnancies – further attesting to the bond evident in the midwives stories, and evident at a personal level through their taking up of particular narratives in order to practice. Not only did the midwives talk about their relationships with their clients, but often through their clients the relationship also became professional friend to sisters, cousins, friends, and acquaintances, an effect of practicing with families in communities. The participants in this study were aware of how this relationship is multifaceted in itself, and works to explain their personal and positional view as a community based worker.

Julie: You know the family and you might have looked after the sisters, and you know the grandparents. It's a lovely relationship. And they're people who you could be friends with. You really do like each other, but your friendship is based around the pregnancy.

Participants reflected that a midwife's best advertising is through word of mouth, and therefore their relationships in the community are enduring. One of the vital aspects of their community based practice, and their on-going relationships within families, was the midwives' personal investment in their relationships with their clients. They were willing to go the extra mile, and to do what it took for their clients to have the best experience and outcome possible.

Midwifery is also positioned within a structural framework; one that encompasses the personal level in the identity of midwives' day-to-day practice. The biomedical and women-centred narratives are produced interpersonally in this context, and at the positional level reflective of the legislative, ethical and practice framework provided by the system within which midwifery is located. In addition, the ideological level provides explication of the sociocultural understandings and structure of midwifery that sustains the positional, interpersonal and personal levels of analysis – the expectations and norms within society inform the legislation that is created, and the guidelines and codes of ethics for midwives. Midwives in this study are embedded in all of these influences and identified with them to the extent that they form part of their professional and personal identities. At an ideological level of analysis legislative Acts that produce midwifery as a legitimate practice are some of the most significant influences on midwives day-to-day practice. At a personal level, midwives necessarily integrate dominant understandings into their professional identities. Ideologically, it is evident that the social and political assumptions that legitimate midwifery are directly influencing the ways in which participants made sense of their experiences. The tensions within their multiple locations are continuous as they make attempts to reconcile their professional identity with a holistic view of women and maternity.

The Normal Side of Abnormal

In their discussion of their relationships with their clients, the midwives contextualised their practice with those who may experience mental health problems, through an intersection of their narrative identities to bring a meaningful understanding to issues of maternal mental health. Midwives are uniquely placed in their work with a population that is typically 'managed' through risk both of the maternal body and its psychology through biopower exerted on a regular basis. In order to produce an understanding of pregnant women and their psychological wellbeing, the midwives offer us an understanding of maternity care within our communities. Midwives talk about their work with clients and maternal mental health, was centred on the intersections of identity, service, clients, biomedicine, power relations and society.

The word 'normal' represents a powerful construct in our society. There is no necessity to define 'normal' as it is taken-for-granted and gains its meaning through what it is not (Morgan, 2005). For those who do not enjoy the safety of normality, their abnormality becomes a risk to be managed and returned to normal as quickly as possible. As argued in Chapter 1, this same binary operates through gender. The process of maternity produced through the scientific gaze positions pregnant women as deficient if she does not have a normal response to cultural narratives of 'good mothering'. In this section, women's maternal body and her psychology are so intertwined with dominant narratives that produce her as deficit that midwives, through their

professional identities, use their relationship with the client to normalise rather than pathologise their clients' emotional/psychological response to their changing bodies and lives.

Marie: Society as a whole doesn't always accept that somebody who has had a baby could feel like that, especially when everything has gone well. So again, they have those sorts of feelings, and often women would say to me that they'd put it under something, and that they were too busy and would try and deal with it later.

The midwives in this study took up an ideological position that assumes that, like natural birth, the feelings of their clients can also be understood as a normal response to the changing conditions of their lives. Often however, their clients were positioned through dominant narratives that exclude 'negative' feelings (in the story above, the client hid/put aside her feelings as she 'managed' being a 'good mother'). In this way, midwives are also responding to the effects of dominant social and cultural narratives that inform their clients. In Marie's account, midwives also attend to the social pressures women face, and the lack of recognition of maternal mental health issues. From an ideological position, midwives normalise feelings of depression that are attributed to the maternal process, but are aware that some women exceed normal expectations, and are ignored.

Existing mental illness is something that the midwives take seriously. All participants had taken clients with a range of mental illnesses and/or substance disorder at some stage in their career, with varying degrees of success. The dominant ideology surrounding both maternity and mental health in Western society has taken "normal" and "abnormal" to demarcate the boundaries of risk. The promotion of childbearing as a 'natural' concept in the governance of maternity care also serves to reinforce the significance of accepted norms for the "good" mother, and the "good citizen". Midwifery has maintained a space in which "normal" could be redefined for the physicality of childbirth for women, and yet there was a tendency, that the midwives in this study recognised, to understand mental health issues as abnormal. The midwives, at an interpersonal level, saw themselves as being responsible for ensuring that their clients did not abnormalise the normal.

Charlotte: The big thing is making sure that they are not abnormalising what are actually normal (...) events.

The midwives drew on their professional knowledge of postnatal depression as a way to contest the meaning of the maternal body as abnormal, by enabling their clients to understand what they are experiencing within their bodies. In Camille's account, we can see how

psychological knowledge of postnatal depression, is taken up to reassure her clients of the 'ordinariness' of some form of maternal depression and illustrates how midwives' professional knowledge and practice and their interpersonal relationship works within the ideological assumption of natural, and mediates the risk of developing the disorder.

Camille: In general, I explain that there are 4 postnatal depressive disorders that exist. The first one is not actually a disorder, and that's the postnatal blues. It happens to 8 out of 10, it's a routine thing and so expect it, and you'll be fine ... But with the other 3 disorders, I will sum it up to them: 1. Postnatal depression – pretty common; some say 1 in 4, I'd say one in 3, at least some level of it. 2. Postnatal psychosis, which is very rare, fortunately its kind in the way that the woman herself often has no idea what is going on ... So the other thing that I'll mention is 3. Post-traumatic stress disorder. And I'll mention the fact that for some women their labour and birth can lead to that as a trauma afterwards. And I work very hard to make sure that they don't get that. It's about communication during the labour, and debriefing about the birth afterwards. But I sum it up as those 4.

In this way, midwives position themselves in a therapeutic relationship within the boundaries of normal and abnormal, and work in partnership with their clients to manage risk. The midwives in this study described awareness that the New Zealand system, even while it is hailed as the best in the world, is failing some of our women. Through their complex positioning, their ideological assumptions enable them to normalise a (risky) trauma response to the maternal body for their clients. Charlotte told a story about a client who had a history of trauma that made her particularly anxious about her birth, yet was not eligible for mental health services or any other secondary care. She described how she had coached her through a natural delivery and her client had come out the other side of it empowered. Charlotte told the story of how they worked together to ensure that they had everything in place for it to be a safe and relaxed process, and how it produced an outcome that was more than simply the birth of a baby.

Charlotte: She was very grateful and felt healed, and it was a really mutual thing, we were very much partners. There wasn't the midwife and then her; there wasn't an imbalance at all.

In the midwives accounts, their talk of 'being with women' recognised the partnership between women and their midwives, and it is through this relationship that midwives understand experiences of stress, anxiety and depressive symptoms as being normal. As a result, many of

the participants felt that the knowledge midwives accumulate through their relationships can inform our understandings of the incidence of maternal mental health problems that is not as visible to other health professionals. Participants in this study expressed how they are often the only health providers that see women in their most intimate moments, and see their coping and mothering styles, and that these usually private aspects of women's lives are not always made visible outside the home. The midwives therefore understood themselves as being necessary to managing early signs of mental health issues within their professional identity.

Camille: Often, nobody else knows that it's going on. Women can be very good at covering it up. So what I say to them is that the most important thing that they do, is not to do nothing. I'll often say it's best to nip it in the bud early.

When discussing standards of mothering as being something that women are under pressure to do well, especially when there are mental health issues evident, participants in this study were adamant that individual situations needed to be taken into consideration, and that there isn't always a 'one size fits all' approach that can be utilised. This further advances midwifery's women-centred narrative as a means to account for differing contextual needs among their clients, which is juxtaposed with a biomedically-defined pathological narrative, which assumes sameness. They are also aware that sociocultural expectations that emerge from biomedical narratives of risk and have become normalised are often difficult to change for a range of reasons. Their ideological assumptions create a space through which the midwives are able to recognise the normal, and also recognise that there could be complex social issues that impact on their clients' process.

Julie: ... some women, you know they're not going to be a problem to birth. They're just going to have their baby - they'll come in, and go into labour, and baby will fall out, and they'll make gallons of milk and they'll breastfeed. But socially, they are complex, and your role with them is much more on a social sense than anything else. It might be around domestic violence, someone who lives in a violent relationship, has grown up in a family of violence, who wants to make a change, says all the right things, but just can't quite get there. You put all the right connections there, you get all the right things going, and they really want to make the change, but it's just so ingrained. I see that as part of our job.

The participants also recognised that their professional position between biomedical and natural narratives enabled a space to 'give permission' to clients who struggle with aspects of

the dominant narratives of good mothering. Midwives in this study often employed a commonly understood mothering narrative that positions women in particular ways in our society. For example, under the current system in New Zealand, women are encouraged to breastfeed in order to be ‘good mothers’, and the participants in this study often discussed it as a site of anxiety for mothers-to-be and new mothers if they did not meet societal expectations. Almost all of the participants discussed societal pressure to be a ‘good mother’ as a cause of undue distress and a contributor to maternal mental health issues. Due to this, using breastfeeding as an example of the good mother narrative that is pervasive in our society, Julie said:

Julie: There’s all this pressure on you to breastfeed. People say: “To be a good mother you should be breastfeeding”. Well, actually, to be a good mother you need to be happy! ... We all know that breast is best for your baby. But what’s best for you? Breast needs to be best for you as well as your baby. There’s no point sitting there crying and being miserable and hating and resenting that breastfeed, when actually you can formula feed your baby. I’ve seen some women, and you know they’re unhappy, and they’re crying and the baby isn’t gaining weight. They’re anxious, they’re hating it, but they feel duty bound as a “good mother” to breastfeed. And when you give them “permission” to not breastfeed, and they stop - they make a transition.

The midwives in this study understood the tension between normative assumptions of ‘breast is best’ to have material effects on their clients’ experiences, and psychological wellbeing. In the interviews, I drew on my own experiences and generated conversations about the operation of a ‘good mother’ double standard in the public sphere. This double standard was clearly articulated by Julie, who stated:

Julie: [P]eople don’t want you to breastfeed in public, but definitely don’t bottle feed”.

Through the co-construction of the narrative interviews, this was a direction that exemplified the interpersonal, personal and positional levels operating simultaneously. The participants in the current study understood the ‘spaces’ as gendered, and it was their understanding of the sociocultural gendering of maternity and mothering that reflected their personal identity to make sense of their own identity as women.

Charlotte: I think it’s so much hard wired into us to be nurturers; it’s how we’ve evolved. We are nurturers and it goes beyond our own children and family - and I think

if you can relate to a woman and her plight then you will do what it takes, and I think it's because we are women.

Mental Health – Falling Through the Cracks

Overwhelmingly, the participants all felt that being able to identify issues that might impact on their client's psychological wellbeing at an early stage was crucial for client outcomes. All the midwives discussed how early identification did not happen as frequently as it should for a variety of reasons; ranging from a lack of knowledge on the part of the midwife, or a lack of availability of suitable services to which to refer clients. Another issue that was raised by participants was that they felt personally under-resourced. The majority of the participants stated that they felt they did not have enough knowledge or education to be able to engage with mental health definitions and diagnoses. What was significant to this storyline was that the midwives themselves drew on their intuition based on their experiences, and knowledge of the woman herself, to counter their claims of a lack of clinical knowledge surrounding mental health.

Laura: I'll work on what they're giving me. And I'll work on the markers that I'm looking at; well that I think I'm looking at. And hope like hell that I'm right, and we'll just muddle along, because unless she's going to go to somebody like you or someone else who has got a degree in naming things, I can't do that.

Midwives in this study expressed that they were aware of a gap in services for women who experienced mild to moderate difficulties, and this reflects findings by Warriner et al. (2011) that pregnant women with mental health issues relied primarily on midwifery services and reported a lack of consistent support from mental health services – this sentiment was echoed consistently throughout all the interviews in this research. The participants stated that often they and their clients would feel shut out from decision making processes once a referral to secondary mental health services had been made, and outlined how this affected the women-centred continuity of care model, and outcomes for their clients.

Amanda: We are not going to pretend that we know it, but I think if we worked together we could actually offer a huge amount to the women. Because someone stepping in who they've never met before isn't going to get the same result as someone they know.

Skinner (2011) examined midwives' concern with 'keeping the normal' for women, and the challenges they face in doing so alongside identification and management of risk. There was a focus on how this informed the ways in which referral guidelines were utilised; Skinner found

that midwives have the complex task of managing risk, and simultaneously promoting the normal, while aiming for an anxiety-free birth. The midwives in this study echoed these findings, which is illustrative of tensions between personal and ideological positions. While maternal mental health services are recognised as a primary healthcare provider, the midwives in this study experienced the discontinuity of the midwife-client partnership meaning that the reality of referral to that service is often difficult to achieve. Participants tended to refer to a general practitioner to mediate a referral pathway to maintain their professional integrity for managing risk, and meet the legal obligations of a midwife under section 88 of the Public Health and Disability Act (2000), and while they do refer to GPs, the midwives are aware it may not always be the best option.

Camille: There's just not really an in between, apart from see your GP... So our women are not getting the support they need, even at the GP level, they don't have much of a clue on it either.

Laura: I muddle through it because I don't know what she's got. I have no idea what you'd call it. All I know is that she has got this marker, this marker and this marker. And they're the ones that I'm going to work on, and say "right well I think you need to do this, or maybe see your GP, or maybe try this . . . I am happy to use alternatives as well, but at the end of the day, I'm not trained to put a name on these things.

As midwives see themselves as experts in the normal, they do not want to be experts in abnormal mental health. They can recognise when something is not right, but at the same time, they know their own limitations, and they need guidelines. Midwives articulated a need clear referral processes, and services available to refer clients to. From personal and professional positions, the midwives in this study privilege maintaining a partnership with their women clients where mental health issues arise, even if that is alongside maternal mental health services. What was significant to the midwives in this study were their experiences of understanding themselves as default counsellors, social workers, supports, and mental health workers as they negotiated the difficult terrain of normal and early identification, or prior knowledge of mental health issues, especially when the normal processes of stress and sleep deprivation are likely to exacerbate symptoms.

Sarah: If you haven't picked them up early, you're going to have problems . . . Because for an awful lot of people with mental illness ... well it's an enormous stress having a baby, and then sleep deprivation on top of that... it can really upset things.

Midwives' willingness to 'do what it takes' is connected to their personal and professional positions, even within the complexities of maternal mental health issues. There was a strong sense of a standpoint among the midwives that doing what it takes is based on their interpersonal relationship that assumes continuity of care, especially where their client does not meet the criteria for other services. In this way, mental health care is assimilated into midwives practice.

Charlotte: Some people, you do worry about. Some people, even when you discharge them, they're the kind of people you remember for their complexity.

Emily: We travel with the woman, we travel alongside the woman. And, in doing that (...) as you watch a friend I suppose - you identify and recognise signs of depression or mental health issues. You do that with your women.

An integrated approach to analysis is warranted here, as the midwives' narrative positions are not easily separated. The ideological level consisting of sociocultural norms, expectations and legislation is informing the positional level where these influences are being performed and exercised within the context the midwives are working. These in turn, influence how midwives identify and undertake their practice at a personal level, the development of identity talk and personal philosophy – especially when midwives are faced with mental health issues. At times, this resulted in making decisions about privileging their personal position in relation to their clients' needs.

Marion: I stayed on call for her because I just thought that she was not going to be able to deal with another midwife who didn't really know her. So I did stay on call for her because I didn't want to add to her anxiety.

As the midwives discussed complex cases in which they had personally invested substantial time and effort into holistic midwifery care, they were also quick to talk about the success stories. The participants appeared to derive much personal satisfaction and sense of achievement from working with these types of clients, despite discussion about the increased workload. Analysis at a personal level (Murray, 2000), was understood as success being shared between midwife and client and reiterates the reciprocity of the interpersonal where they reflected on their personal success as fulfilment and was meaningful as a personal success for a client.

Sarah: [I had a client] with anxiety problems, obsessive-compulsive disorder, panic attacks . . . but the funny thing was that I really, really got on with her well, and I have enormous respect for that mum, she was just amazing. I was expecting everything to fall apart, and she was just amazing. I actually feel quite tearful remembering her.

All of the participants in this study had experience working with women from a diverse range of social and cultural backgrounds. Midwifery's ability to undertake care in a woman-centred way means that midwives are less likely to categorise women based on broad diagnostic categories that are utilised within a biomedical model that tends to be gender-neutral and Euro-centric. The four participants that had worked extensively with women from Pacific Island and Māori populations stated that their experiences with maternal mental health were different from that seen within a generalised western population.

These four midwives told stories of how family structures and social supports differed culturally, and that in their experience, maternal mental health was not as visible among their clients who were embedded in wider family units that were seemingly more oriented toward a maternity as natural philosophy.

Amanda: I think that's where the Islanders have it totally over [Westerners], because there is often good family support. It's not even just family support. It's like the extended family, it's not even (...) it's just there. It's just there to be a part of it all.

Midwives in this study theorised that ideologies within Māori and Pacific Island cultures and midwifery's women-centred position surrounding maternity were closely aligned. Participants postulated that this alignment may be due to the way that Pasifika and Māori women's extended families are involved with a pregnancy and birth; that it is more centred on the mother and baby as part of a larger family and community unit than their European counterparts, and less involved in the biomedical assumptions of risk. The midwives felt that the support given within such an environment contributed to a perceived lower incidence of maternal mental health problems.

Marie: Maybe the symptoms are different, or something? And the other thing is that the family picks up so much that it's not seen as easily or . . . Yeah, and perhaps it's not acknowledged. Because we don't see it. We don't see it as such, but we don't really look for it either.

The Māori and Pacific Island view of women during pregnancy and the postnatal period is one of inclusion and acceptance. Kenney (2011) outlined the similarities between midwifery's

practice ideologies and Māori view of maternity processes, and stated that there may be philosophical similarities between modern western midwifery practice and the Māori worldview. Māori view birth as being “located within and the responsibility of whānau [family]” (p. 127), and historically it was normal for whānau and extended whānau that assisted women in birth and the care of children in their own sociocultural location and context (Kenney, 2011). This positioning and ideology differs from a western biomedical ideology where care is provided in a one-size-fits all manner, with the notion that all women do pregnancy and birth in the same way because of biological sameness (De Souza, 2004). This aligns closely with midwives’ view of themselves as community based, grass-roots workers that allows them to support and work in partnership with their clients, within the community, in a women-centred fashion.

Pauline: When we look at the cultural traditional way, if one Samoan is pregnant, everyone is . . . the extended family, the cousin the aunty, everybody. So they all contribute and that’s where I find that hardly any women have any depression, because it’s how they cope with it.

In Pauline’s account, understanding pregnancy through traditional cultural assumptions produces the pregnant body as a social body. Two of the participants were careful to distinguish that their view of maternal mental health within their practice with Māori and Pacific Island women was not so much about a cultural difference, but more of a distinction in the view of maternal process, where mothers are supported, and held as part of a social/community body rather than viewed through and individualised risky body.

Pauline: They’re collected together. Being together for them is not being isolated. Not like other families, they’re isolated - but island women they are never isolated.

Despite acknowledgement that maternal mental health issues are not explicitly assessed through culturally specific criteria under the governance of maternity care, participants in this study continually returned to the practice ideals of midwifery and partnership, and discussed their own personal ideals for women-centred midwifery care, where they are guardians of the normal, and the similarities between midwifery and the women and families that they have worked with from different cultural positions.

Marie: It’s a community thing. And you’ve got to put it into perspective that it’s all quite normal in the community.

Cavernous Gaps

The midwives in this study highlighted that gaps in service exist for clients that may experience mental health problems. They discussed difficulties they had with referral to appropriate services where the criteria for service is not met, despite midwives' working knowledge suggesting need. While maternal mental health services do exist, the midwives stated that these services are difficult to access due to their being overstretched, or geographically inaccessible for some of their clients. There can be a long waiting time for referrals, and as outlined in Chapter 3, the criteria for mental health services is measured through biomedical assumptions of moderate to severe levels of symptomatology. These midwives stated that the majority of women they see that could benefit from support from a maternal mental health service do not meet the criteria and there is a 'cavernous gap' in service for these women. Again the juxtaposition between abnormal and normal maternity was explicated in their accounts, where increasing technologies into the maternal body for safe outcomes do not recognise a more pressing risk on the boundaries of normal and abnormal depressive symptomatology.

Emily: I think they're putting a lot of money into obstetric interventions and things to make very small differences when we know that the biggest killer of our women in maternity is suicide. And I don't see any extra funding going there, it's not proportional, funding that goes into maternity to save lives is not going to the thing that is killing most of our women!

Amongst societal expectations of what constitutes the potential for "good mothering", the stigma of a pregnant woman's position breeches sociocultural norms, also produce gaps in service. Teen mothers, economically disadvantaged mothers, single mothers, and mothers with disabilities such as mental health problems are often criticized for taking the 'risk of maternity'. It is as if they are morally deficit and unable to parent effectively (Lorber & Moore, 2011). In addition to the challenges of the passage to motherhood imposed by sociocultural norms, those who are deemed 'less worthy' are marginalised or excluded from making autonomous decisions. The participants in this study understood the marginalisation of some of their clients by external agencies as a relationship of power over their moral deficit. Their professional knowledge of these situations meant they were left to try and manage the 'normal', and try to enable the mothers to make informed choices, through a continuity of relationship that privileges maternity as natural.

Camille: I've noticed is that there's maternal mental health that sit at a certain level, and then if you don't get to that level, there's nothing there... The system drives you

nuts, and you end up getting no-where. There's not a simple way to get a woman seen. We don't have that for mental health. It's a big problem... That's a quite cavernous gap there, where a woman has to get highly unscrewed to be helped.

Most of the participants told stories about investing their own time and resources in their clients' care as this was sometimes the only way some women could access particular products and services. Participants described how they have driven clients to doctor's appointments, attended specialist services as a support person, or have even paid for clients' prescriptions and counselling sessions out of their own pockets. The 'cavernous gap' was navigated at a personal level.

Audrey: Some [clients] are quite happy to pay, but there are others that are not, and you know they would benefit [from counselling]- then the midwives will often go and pay for it. I pay sometimes, if I find the woman is not happy to pay for it or she can't. I know a particular midwife who does it quite a lot and she will pay for [counselling] as well.

The participants in this study also traversed the gap in services through ensuring their positional and ideological positions were enacted; they were keen to ensure that women had a smooth path to motherhood, regardless of any biomedical assessment of risk.

Marion: For those sorts of clients, usually I will go out of my way to make sure that I am there for their birth, and postnatal visits too - because I know so much about them, and I know all their funny little ways - I don't want to upset the applecart and add to their stresses.

The midwives in this study valued both scientific and midwifery knowledge as legitimate in their professional practice, despite the tensions between them. What was realised through their talk was the impact dominant understandings of maternity had on their practice of promoting and supporting women's autonomous choices alongside midwifery's philosophy that a 'normal' birth can be an ordinary life event (Clews, 2013). Echoing the findings by Hyde and Roche-Reid (2004), the participants in this study talked about 'the normal' and described how they are 'guardians of the normal' – echoing the underlying assumptions of midwifery, and, under an analytic eye, the personal level is made meaningful through their practice philosophy. Participants also discussed how women's sociocultural location puts pressure on women to perform in specific ways under dominant mothering mandates. The midwives understood their personal response to financial pressures, stress, and mental illness among other diverse issues as contextual differences within a normal process.

Julie: I am keeping the normal. I see my role as keeping the normal. Looking after the pregnancy and keeping things as normal as I can and then taking on board the care and advice or the treatment or whatever that is prescribed. I keep the normal in the face of what can potentially be abnormal or more complex.

At positional and ideological levels, midwives and women are constrained by the positions they are allocated within the tensions of health provider/patient relationships, which have often been represented through unequal power relationships. At a personal level, the midwives gave examples of how their understanding of professional partnership did not reproduce the same power imbalances produced within the medical fraternity.

Laura: I say to people, "look, I'm really, really open minded. I'm not going to judge, I'm not here to judge. I'm here to help you have a great pregnancy and a normal birth ideally and have a baby and an experience that you come out at the end of and you feel great about."

Midwifery's definition of itself as a guardian of birth normality becomes vital as a site of resistance to the dominant biomedical narratives of pregnancy and birth, and it is visible through the positional and ideological levels of analysis outlined by Murray (2000). At an interpersonal and positional level, midwives want to 'keep the normal' and they want to ensure that the women they work with are able to have as 'normal' an experience as they are within their power to provide. This is especially true for the women that experience mental health problems at some point in their journey to motherhood.

The midwives' narratives shifted and evolved throughout the interview process. There appeared to be a fluid transition between discussion of personal practice ethos and discussion of social influence and political engagement. Through this fluidity, the participants' narratives held multiple meanings. At a personal level, the participants were conveying a narrative about their lived experiences that allowed exploration and explanation of their personal viewpoints and practice philosophies. Through identification of the personal level, it became simpler to extrapolate how the interpersonal level has influence on the way in which the narratives were created. Participants were able to highlight the tensions created for their practice concerning their positional and socio-political views. The ideological level of analysis forms part of a social commentary, in which power relations and structures, and their influence on the practice of midwifery, can be identified. (Stephens & Breheny, 2013). The storylines generated within the

narrative that was generated can be evaluated at these multiple levels, as co-constructed events in themselves, social performance, and as critical social interpretation. The stories are examined within the broader social framework they occur in, and how the social framework has influence at a personal level of experience, and at all interpersonal stages in between. The structural framework can allow for recognition of how all these levels co-exist in the same space and time (Murray, 2000).

CHAPTER SIX - Discussion

The ways in which rhetoric or figuration disrupt logic themselves point at the possibility of random contingency, beside language, around language. Such dissemination cannot be under our control. Yet in translation, where meaning hops into the spacy emptiness between two named historical languages, we get perilously close to it. (Spivak, 2004, p. 370)

I began this research project wondering about maternal mental health that arose from a question about how the meaning of a pathological maternal body and symptoms of anxiety were normalised through the relationship with my midwife. I became interested in how midwives told of their experiences working with maternal mental health through their practice of partnership. As a student of psychological practice, I was interested in how midwives are narratively positioned in their practice, and how midwifery ideology could inform psychological practice in maternal mental health. The initial objective of this research was to uncover what was salient for the midwives and how working with women with mental health issues impacted on them, personally and professionally. As I began discussing the research with midwives to inform the research question, and began a literature review, it became evident that there was a gap in the research literature that drew on the experiences of midwives themselves. What I presented as a context for discussion was a particular interest in how midwives experience, identify and manage mental health issues, and how their expertise informs their case planning, treatment and practice. As the interviews took place, I became acutely aware of the need to include the social, embodied, natural experience of a group of women in their political sphere.

To bring voice to the narrative produced through the interviews, I engaged a feminist standpoint epistemology to locate midwives in their own sphere, and expanded that to question the historical and sociocultural locality of their position, and the political and institutional power relations in which they are embedded. The aim of this study became to hear the voice of midwives positioned in a tension between gendered understandings of the pathological maternal body and maternal mental health and the natural maternal process of midwifery.

Undertaking this research from a standpoint epistemology through a structured approach to narrative analysis has allowed for a representation of midwives' experiences to be at the centre. The structured approach to narrative analysis enables a questioning of the technologies of gendered power relationships that produce the maternal body through the medical gaze and the effects for midwives as they oscillate between biomedical and midwifery ideological narratives

of maternity and maternal mental health. As shown in the analysis, stories do order events but they also structure how the midwives make meaning of these events within the conditions that inform their practice. It is through the structure of their narratives that we are able to comprehend the relationship between midwives and their clients. The analysis brings meaning to how midwives' identities and experiences intersect at ideological, personal, interpersonal and professional levels. The structural analysis allowed for an understanding of the complexities that are faced by New Zealand's midwives in their practice. It enabled the extrapolation of how the midwives positioned themselves through their social and political location. What was evident through the analysis was that the midwives were constantly negotiating their legitimacy within the biomedical system and at the same time retaining their legitimacy within midwifery that makes possible a gendered understanding of the normal maternal body as authentic through women centred practice.

What emerged through the analysis was the positioning of midwives at the interpersonal level, where they were responsible for the translation of the technologies of masculinist biomedical interventions into risky maternal bodies into a feminist standpoint that values the natural processes of maternity, including symptoms of anxiety and depression. As health care professionals that occupy a position in between two ideological frameworks, the midwives are able to meet both the requirements of risk and pathology and resist through their professional position to bring informed consent into everyday life. Within this tension, midwives balance their scopes of practice and their responsibility for assessing medical and psychological risk. Being located in-between also renders midwives vulnerable to the conflicts, contradictions and complexities of the socio-political categorisation of risk and symptoms.

Through their legitimate position in midwifery, and practice of partnership with their clients, the midwives have accumulated knowledge of maternal mental health issues that may not be visible to other health professionals. Their relationships with their clients enables them to recognise a diverse range of complex social issues that impact on their clients psychological wellbeing. The midwives therefore understood themselves as being in a position to manage early signs of mental health issues within their professional identity. Midwives' intimate knowledge of their clients enables them to recognise that a client may have needs that are beyond their knowledge of diagnosis. However, gaps in resources both for supporting women in the community and for engaging maternal mental health were evident. From their in-between place, the midwives identified a gap in services for women with mild to moderate mental health needs that are exacerbated by the context of their daily lives. Midwives faced a challenge in referring clients to mental health services; in their experience, mental health frameworks exclude the presumption of women-centred continuity of care and midwives experienced the discontinuity as

having detrimental outcomes for their clients. From their practice of partnership, midwives negotiate the boundaries between normal and early identification of mental health issues and gendered maternal processes that can exacerbate symptoms. What midwives open up is a space in which mental health care is assimilated into midwives practice, privileging their personal position in relation to their clients' needs.

What was significant about the gaps was in the meaning of gender in the difference between abnormal and normal where the increasing surveillance of the maternal body to ensure safe outcomes produces a risk on the boundaries of normal and abnormal depressive symptomology. The effects are twofold: For example, increased technology over the maternal body marks the moral boundary of good mothering and, the prioritized funding on advancing obstetric technology excludes a bigger risk, that of maternal suicide. The midwives recognised the diversity of the gendered sociocultural meanings of maternity and how some of their clients were marginalised through their moral deficit (e.g. poverty, teenage pregnancy, single mothers, mental illness), rather than as a response to diverse contextual differences within a normal process.

Despite feminist criticisms levelled at hegemonic biomedical constructions of the female body, the biomedical knowledge that inscribes the maternal body and maternal mental health with meaning remains dominant. And, despite New Zealand's contemporary midwife-led maternal healthcare policy, it is the legitimacy of the medical gaze and maternal risk that dominates. It is little wonder that midwives commonly recognise stress, anxiety and depressive symptoms where their clients understand their bodies as faulty. Through their socio-political position in midwifery, midwives attempt to normalise a range of symptoms they understand as emerging from narratives of risk. Seldom do women relish the mythical "glow" often seen in various social narratives to be present during pregnancy. In its place, the maternal woman often faces the arduous task of instituting a sense of comfort in her new maternal body, which is at risk. The implications of the risk of women's bodies letting them down in birth and breastfeeding for example, can contribute significantly to the development of symptomology.

Women frequently report being significantly worried by the innumerable changes that occur within and to their body throughout the entire maternal process. Midwives draw on their knowledge and experience to understand how these symptoms are commonly experienced beyond what is assumed.

The narrative produced through this thesis offers a challenge to psychological research and practice. Midwives' partnership model of practice gives us an insight into the social power relationships that bring meaning to the maternal process. The production of the maternal body and reference to maternal instinct are made meaningful through sociocultural narratives. Butler

(1990) argues that in place of an objective female body we should attend to “those specific power relations by which the trope of the maternal body is produced” (p. 92). The understanding that midwifery brings to maternal mental health calls for an understanding of the morality and politics of psychology’s gendering stories (Coombes & Morgan, 2004). The problematic relationship between the maternal body and psychology requires an understanding of the tension between biomedical and women-centred differences in the meaning of maternity and motherhood, and their material effects. The midwives open a space for psychology to negotiate maternal mental health by understanding the maternal body through the material conditions of women’s lives rather than through pathology.

The limitations of this research are bound within the epistemological assumptions that guide the ethical and methodological conduct of this research. I brought my own experience, the context of tensions between midwifery and biomedical discourse, and the contradictory meaning of the maternal body to the analysis. The analysis then is consistent with the tenets of feminist standpoint epistemology, and the structured approach to narrative analysis was not to represent midwifery, but to listen for the potential beyond the individual level and speak to a wider narrative construction of maternal mental health. The analysis therefore suggests a set of experiences that *could* be experienced by any, and all, midwives in New Zealand. These conditions are also limits.

Future research could focus on the experiences of psychologists working in maternal mental health and take account of the ways they position themselves through their stories. This has the potential to open spaces for psychology and community to inform each other where their practices can enable a meaningful maternal process.

REFERENCES

- American Psychiatric Association. (2008). *Diagnostic and Statistical Manual of Mental Disorders - Text Revision* (Fourth ed.). American Psychiatric Association.
- Appignanesi, L. (2008). *Mad, bad, and sad: A history of women and the mind doctors from 1800 to present*. London: Hachette Digital.
- Baker, S. R., Precilla, Y. L., Henshaw, C. A., & Joanne, T. E. (2005). 'I felt as though I'd been in jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism and Psychology*, 15 (3), 315-342.
- Barthes, R. (2004). Introduction to the structural analysis of narratives. In M. Bal (Ed.), *Narrative theory: Major issues in narrative theory* (p. 65). New York: Routledge.
- Bartky, S. (1988). Foucault, femininity, and the modernization of patriarchal power. In L. Quinby, & I. Diamond (Eds.), *Feminism and Foucault: Paths of Resistance* (pp. 61-86). Boston: Northeastern University Press.
- Bartky, S. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. New York: Routledge.
- Boath, E., Bradley, E., & Henshaw, C. (2005). The prevention of postnatal depression: A narrative systematic review. *Journal of Psychosomatic Obstetrics and Gynecology*, 26 (3), 185-192.
- Bold, C. (2012). *Using narrative in research*. London, UK: SAGE Publications Ltd.
- Bordo, S. (1993). *Unbearable weight: Feminism, Western culture, and the body*. Berkeley: University of California Press.
- Bordo, S. (1997). *Twilight zones: The hidden life of cultural images from Plato to O.J.* Berkeley: University of California Press.
- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research*, 8 (1), 137-152.
- Braun, V., & Wilkinson, S. (2001). Socio-cultural representations of the vagina. *Journal of Reproductive and Infant Psychology*, 19 (1), 17-32.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Campbell, K. (2013, June 6). *Kiwi mums opt for surgical births*. Retrieved September 12, 2013 from The New Zealand Herald:
http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=10888696

- Campbell, R., & Wasco, S. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology*, 28 (6), 773-791.
- Canino, G., & Alegria, M. (2008). Psychiatric diagnosis - is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, 49 (3), 237-250.
- Carter, S. K. (2010). Beyond control: Body and self in women's childbearing narratives. *Sociology of Health and Illness*, 32 (7), 993-1009.
- Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of Health Psychology*, 5 (3), 285-296.
- Cheek, J., & Rudge, T. (1994). The panopticon re-visited?: An exploration of the social and political dimensions of contemporary health care and nursing practice. *International Journal of Nursing Studies*, 31 (6), 583-591.
- Clark, H. (2013, March). Personal Communication.
- Clews, C. (2013). Normal birth and its meaning: A discussion paper. *Evidence Based Midwifery*, 11 (1), 16-20.
- Cox, J. L., Murray, D., & Chapman, G. A. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry*, 163, 27-31.
- Crossley, M. L. (2007). Childbirth, complications and the illusion of 'choice': A case study. *Feminism & Psychology*, 17 (4), 543-563.
- Darrah, A. J. (2011). *The distressing case of modern mothering: Expectations, losses, and postnatal distress*. Christchurch, New Zealand: Unpublished Doctoral Dissertation, Massey University.
- Davis, D. L., & Walker, K. (2010). Re-discovering the maternal body in midwifery through an exploration of theories of embodiment. *Midwifery*, 26, 457-462.
- Davis, D. L., & Walker, K. (2012). Towards an 'optics of power': Technologies of surveillance and discipline and case-loading midwifery practice in New Zealand. *Gender, Place and Culture*, 20 (5), 1-16.
- De Souza, R. (2004). Motherhood, migration and methodology: Giving voice to the "other". *The Qualitative Report*, 9 (3), 463-482.
- Donely, J. (1986). *Save the midwife*. Auckland: New Women's Press.
- Eberhard-Gran, M., Tambs, K., Opjordsmoen, S., Skrandal, A., & Eskild, A. (2003). A comparison of anxiety and depressive symptomology in postpartum and nonpostpartum mothers. *Social Psychiatry and Psychiatric Epidemiology*, 38, 551-556.

- Ehrenreich, B., & English, D. (2010). *Witches, midwives and nurses: A history of women healers*. New York: The Feminist Press.
- Ehrenreich, N. (1993). The colonization of the womb. *Duke Law Journal*, 43, 492-587.
- Einstein, G., & Shildrick, M. (2009). The postconventional body: Retheorising women's health. *Social Science and Medicine*, 69, 293-300.
- Elliott, S., Ross-Davie, M., Sarkar, A., & Green, L. (2007). Detection and initial assessment of mental disorder: The Midwife's role. *British Journal of Midwifery*, 15 (12), 759-765.
- Eriksen, K., & Kress, V. E. (2008). Gender and diagnosis: Struggles and suggestions for counsellors. *Journal of Counseling & Development*, 86, 152-161.
- Fisher, J., de Mello, M. C., & Izutsu, T. (2009). Pregnancy, childbirth and the postpartum period. In World Health Organisation, *Mental health aspects of women's reproductive health: A global review of the literature* (pp. 8-43). Geneva, Switzerland: World Health Organisation.
- Foucault, M. (1976). *The birth of the clinic*. London: Routledge.
- Frayne, J., Nguyen, T., & Allen, S. (2009). Motherhood and mental illness: Part 1 - towards a general understanding. *Australian Family Physician*, 38 (8), 594-598.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.
- Gergen, K. J., & Gergen, M. M. (1986). Narrative form and the construction of psychological science. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 22-44). Westport, CT: Praeger Publishers.
- Gilkison, A., Giddings, L. S., & Smythe, L. (2013). The shaping of midwifery education in Aotearoa, New Zealand. *New Zealand College of Midwives*, 47, 18-23.
- Glen, J. F. (2012). 'Smile for the camera': A critical exploration of the meanings of routine ultrasound for pregnant couples. Wellington, New Zealand.
- Gough, H. (1992). Some reflections on the meaning of psychodiagnosis. *Journal of Personality Assessment*, 59 (2), 410-423.
- Grigg, C. P., & Tracy, S. K. (2013). New Zealand's unique maternity system. *Women and Birth*, 26, e59-e64.
- Guilliland, K. (1999). Midwifery in New Zealand. *Future Birth: The Place to be Born Conference*. NSW: Birth International.
- Guilliland, K., & Pairman, S. (1995). *The midwifery partnership: A model for practice*. Wellington, New Zealand: Victoria University of Wellington.

References

- Harding, S. (1986). *The science question in feminism*. Ithaca, NY: Cornell University Press.
- Harding, S. (1991). *Whose science? Whose knowledge?* Ithaca, NY: Cornell University Press.
- Harding, S. (1995). "Strong objectivity": A Response to the New Objectivity Question. *Synthese*, 104 (3), 331-349.
- Hare-Mustin, R., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist*, 43 (6), 455-464.
- Hartung, C. M., & Widiger, T. A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin*, 123 (3), 260-278.
- Henwood, K., & Pidgeon, N. (1995). Remaking the link: Qualitative research and feminist standpoint theory. *Feminism & Psychology*, 5 (1), 7-30.
- Hirschmarm, N. J. (2008). Feminist standpoint as postmodern strategy. *Women & Politics*, 18 (3), 73-92.
- Hogan, S. (2006). The tyranny of the maternal body: Maternity and madness. *Women's History Magazine*, 54, 21-30.
- Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing*, 38 (6), 557-565.
- Houvouras, S. (2006). Negotiated boundaries: Conceptual locations of pregnancy and childbirth. *The Qualitative Report*, 11 (4), 665-686.
- Howarth, A., Swain, N., & Treharne, G. (2010). A review of psychosocial predictors of outcome in labour and childbirth. *New Zealand College of Midwives Journal* (42), 17-20.
- Hugh-Jones, S., & Gibson, S. (2012). Collecting your data. In C. Sullivan, S. Gibson, & S. Riley (Eds.), *Doing your qualitative research project* (pp. 101-126). London, UK: SAGE Publications Limited.
- Hunter, L. P. (2006). Women give birth and pizzas are delivered: Language and Western childbirth paradigms. *Journal of Midwifery and Women's Health*, 51 (2).
- Hyde, A., & Roche-Reid, B. (2004). Midwifery practice and the crisis of modernity: Implications for the role of the midwife. *Social Science and Medicine*, 58, 2613-2623.
- Jack, D. (1991). Preparing to listen. In *Silencing the self. Women and depression* (pp. 1-28). Cambridge, MA: Harvard University Press.

- Johnson, M. (2013, May 27). *Help for vulnerable new mothers*. Retrieved May 28, 2013 from New Zealand Herald:
http://www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=10886382
- Jomeen, J. (2004). The importance of assessing psychological status during pregnancy, childbirth and the postnatal period as a multidimensional construct: a literature review. *Clinical Effectiveness in Nursing*, 8, 143-155.
- Jordan, B. (1997). Authoritative knowledge and its construction. In *Childbirth and authoritative knowledge: Cross cultural perspectives*. California: University of California Press.
- Kearns, R. A., Neuwelt, P. M., Hitchman, B., & Lennan, M. (1997). Social support and psychological distress before and after childbirth. *Health and Social Care in the Community*, 5 (5), 296-308.
- Kenney, C. (2011). Midwives, women and their families: A Maori gaze towards partnerships for maternity care in Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, 7 (2), 123-137.
- Kitzinger, S. (1992). *Ourselves as mothers*. London: Doubleday.
- Klima, C. S. (2001). Women's health care: A new paradigm for the 21st century. *Journal of Midwifery and Women's Health*, 46 (5), 285-291.
- Kralik, D., & van Loon, A. M. (2008). Feminist research. In R. Watson, H. McKenna, S. Cowman, & J. Keady (Eds.), *Nursing Research: Designs and Methods* (pp. 35-43). Philadelphia, USA: Churchill Livingstone Elsevier.
- Kukla, R. (2005). *Mass hysteria: Medicine, culture and mothers' bodies*. Lanham, Maryland: Rowman & Littlefield Publishers Inc.
- Kulkarni, J. (2007). Women's mental health. *Psychiatry*, 6 (9), 377-380.
- Leckliter, I. N., & Matarazzo, J. D. (1994). Diagnosis and Classification. In V. D. Van Hasselt, & M. Hersen (Eds.), *Advanced abnormal psychology* (pp. 3-18). New York: Plenum Press.
- Leverton, T. (2005). Advantages and disadvantages of screening in clinical settings. In C. Henshaw, & S. Elliott (Eds.), *Screening for perinatal depression* (pp. 34-46). London, UK: Jessica Kingsley Publishers.
- Lorber, J., & Moore, L. J. (2011). *Gendered bodies: Feminist perspectives*. New York: Oxford University Press.
- Luyben, A. G., & Fleming, V. E. (2005). Women's antenatal care in three European countries. *Midwifery*, 21 (3), 212-223.

References

- Mardorossian, C. M. (2003). Labouring women, coaching men: Masculinity and childbirth education in the contemporary United States. *Hypatia*, 18 (3), 113-134.
- Marecek, J., Kimmel, E. B., Crawford, M., & Hare-Mustin, R. T. (2003). Psychology of women and gender. In *Handbook of psychology, Volume 1: History of psychology* (D. K. Freedheim, Trans., pp. 249-268). Hoboken, NJ: Wiley.
- Marshall, H., & Woollett, A. (2000). Fit to reproduce? The regulative role of pregnancy texts. *Feminism and Psychology*, 10 (3), 351-366.
- Matlin, M. W. (2012). Pregnancy, childbirth and motherhood. In M. W. Matlin, *The Psychology of Women* (pp. 318-349). Belmont, CA: Wadsworth Cengage Learning.
- Maynes, M. J., Pierce, J. L., & Laslett, B. (2008). *Personal narrative research as intersubjective encounter*. Ithaca, NY: Cornell University Press.
- McCauley-Elsom, K., Cross, W., & Kulkarni, J. (2009). Best practice when working with women with serious mental illness in pregnancy. *Mental Health and Learning Disabilities Research and Practice*, 6, 185-203.
- McCauley, K., Elsom, S., Muir-Cochrane, E., & Lyneham, J. (2011). Midwives and assessment of perinatal mental health. *Journal of Psychiatric and Mental Health Nursing*, 18, 786-795.
- McCool, W. F., & McCool, S. J. (1989). Feminism and nurse-midwifery historical overview and current issues. *Journal of Nurse-Midwifery*, 34 (6), 323-334.
- McCrae, H., & Crute, V. (1991). Midwife/client relationship: Midwives' perspectives. *Midwifery*, 7, 183-192.
- Mein Smith, P. (2002). Blood, birth, babies, bodies. *Australian Feminist Studies*, 17 (39), 305-323.
- Mein Smith, P. (2012). *A Concise History of New Zealand*. Cambridge: Cambridge University Press.
- Ministry of Health. (2000). *The New Zealand health strategy*. Wellington: Ministry of Health.
- Ministry of Health. (2002a). *Building on Strengths - A new approach to promoting mental health in New Zealand/Aotearoa*. Ministry of Health. Wellington: Ministry of Health.
- Ministry of Health. (2002b). *Family violence intervention guidelines: Child and partner abuse*. Wellington: Ministry of Health.
- Ministry of Health. (2007). *New Zealand Smoking Cessation Guidelines*. Wellington: Ministry of Health.

- Ministry of Health. (2011). *Healthy beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health.
- Ministry of Health. (2012a). *Your lead maternity carer*. Retrieved October 13, 2012 from Ministry of Health: <http://www.health.govt.nz/yourhealth-topics/maternity/pregnancy/your-lead-maternity-carer>
- Ministry of Health. (2012b). *Report on Maternity, 2010*. Wellington: Ministry of Health.
- Ministry of Health. (2012c). *Guidelines for consultation with obstetric and related medical services (Referral guidelines)*. Wellington: Ministry of Health.
- Moore, F. (2013). Governmentality and the maternal body: infant mortality in early twentieth-century Lancashire. *Journal of Historical Geography*, 39, 54-68.
- Morales, M. F. (2006). Foucauldian biopower in contemporary Anglo-American theatre: Margaret Edson and Nell Dunn. *Barcelona English Language and Literature Studies*, 15 (6), 54-65.
- Morawsky, J. G. (1997). Feminisms and psychologies. In *Practicing feminisms, reconstructing psychology. Notes on a liminal science* (pp. 9-51). Ann Arbor: University of Michigan Press.
- Morgan, M. (1999). Discourse, health and illness. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 69-75). London: Sage.
- Morgan, M. (2005). Remembering embodied domination questions of critical/feminist psych-discourse on the body. *Theory and Psychology*, 15 (3), 257-372.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1 (2), 1-19.
- Mothers Matter. (2013). *Mothers Matter*. Retrieved June 19, 2013 from Mothers Matter: Postnatal depression and family/whanau New Zealand trust.: <http://www.mothersmatter.co.nz/Support/North-Island/Wellington/>
- Murray, M. (1997). Narrative health psychology. *Visiting Scholars Series (7)*. Palmerston North, NZ: Massey University.
- Murray, M. (2000). Levels of Narrative Analysis in Health Psychology. *Journal of Health Psychology*, 5 (3), 337-347.
- New Zealand Bill of Rights Act*. (1990). Retrieved May 15, 2013 from <http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html>
- New Zealand College of Midwives. (2011). Media release: Midwifery system hailed as world leader.

References

- New Zealand College of Midwives. (2013). *Scope of practice of the midwife*. Retrieved May 29, 2013 from New Zealand College of Midwives: <http://www.midwife.org.nz/in-new-zealand/definition-and-scope-of-practice>
- NICE. (2007). *National Institute of Clinical Excellence guidelines on antenatal and postnatal mental health*. London: NICE.
- Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998). Focus on women: Mothers with mental illness: II. Family relationships and the context of parenting. *Psychiatric Services, 49* (5), 643-649.
- O'Hara, M. W. (2009). Postpartum Depression: What We Know. *Journal of Clinical Psychology, 65* (12), 1258-1269.
- Pairman, S. (1998). Women-centred midwifery: Partnerships or professional friendships? *New Zealand College of Midwives Journal, 19*, 5-10.
- Pairman, S. (2005). From autonomy and back again: Educating midwives across a century. Part 1. *New Zealand College of Midwives Journal, 33*, 4-9.
- Pairman, S. (2006). From autonomy and back again: Educating midwives across a century. Part 2. *New Zealand College of Midwives Journal, 34*, 11-15.
- Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Berkshire: Open University Press.
- Parry, D. C. (2008). "We wanted a birth experience, not a medical experience": Exploring Canadian women's use of midwifery. *Health Care for Women International, 29*, 784-806.
- Paterson, S. (2010). Feminizing obstetrics or medicalizing midwifery? The discursive constitution of midwifery in Ontario, Canada. *Critical Policy Studies, 4* (2), 127-145.
- PMMRC. (2013). *Seventh annual report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2011*. Wellington: Health and Quality Safety Commission.
- Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education, 8* (1), 5-23.
- Price, J., & Shildrick, M. (1999). Openings on the body: A critical introduction. In J. Price, & M. Shildrick (Eds.), *Feminist theory and the body: A reader* (pp. 1-14). Edinburgh: Edinburgh University Press.
- Raynor, M., & England, C. (2011). *Psychology for Midwives*. Berkshire, England: Open University Press.
- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA, USA: Sage Publications.

- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Boston, MA: SAGE Publications, Inc.
- Ross-Davie, M., Green, L., Sarkar, A., & Elliot, S. (2006). A public health role in perinatal mental health: Are midwives ready? *British Journal of Midwifery*, *14*, 330-335.
- Rothera, I., & Oates, M. (2011). Managing perinatal mental health: A survey of practitioners' views. *British Journal of Midwifery*, *19* (5), 304-313.
- Rothman, B. K. (1989). *Recreating motherhood: Ideology and technology in a patriarchal society*. New York: Norton & Company.
- Rothman, B. K. (1991). *In labour: Women and power in the birthplace*. New York: W.W. Norton & Company.
- Rutherford, A., & Granek, L. (2010). Emergence and development of the psychology of women. In J. C. Chrisler, & D. McCreary (Eds.), *Handbook of gender research in psychology* (pp. 19-42). New York: Springer.
- Sanchez, M. (2011). *Words from the womb*. Miami, FL: xobebe.
- Sareef, S. (nd). *What the Experts Say*. Retrieved January 11, 2013 from American Association of Birth Centers: <http://www.birthcenters.org/history-blog/know-about-birth/sameerah-shareef>
- Sawicki, J. (1999). Disciplining mothers: Feminism and the new reproductive technologies. In *Feminist theory and the body: A reader* (pp. 190-202). New York: Routledge.
- Seagal, S. (2010). The unassisted childbirth movement: Questions of autonomy, intuition, and empowerment in the familial and communal context. *MP: An online Feminist Journal*, *2* (6), 84-100.
- Seefat-van Teeffelen, A., Nieuwenhuijze, M., & Korstjens, I. (2011). Women want proactive psychosocial support from midwives during transition to motherhood: A qualitative study. *Midwifery*, *27*, e122-e127.
- Seibold, C., Licqurish, S., Rolls, C., & Hopkins, F. (2010). 'Lending the space': Midwives perceptions of birth space and clinical risk management. *Midwifery*, *26*, 526-531.
- Seng, J. S., Sparbel, K. J., Low, L. K., & Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery and Mental Health*, *47* (5), 360-370.
- Sixsmith, J., & Boneham, M. (2004). Narrating women's health identities in the context of community living. In *Narrative, memory and identity: Theoretical and methodological issues* (pp. 233-246). Huddersfield: University of Huddersfield.

- Skinner, J. (2011). Being with women with risk: The referral and consultation practices and attitudes of New Zealand midwives. *New Zealand College of Midwives Journal*, 45, 17-20.
- Spivak, G. C. (2004). The politics of translation. In L. Venuti (Ed.), *The translation studies reader* (pp. 369-388). New York: Routledge.
- Stapleton, H., Kirkham, M., & Thomas, G. (2002). Qualitative study of evidence based leaflets on maternity care. *British Medical Journal*, 324 (7338), 639-644.
- Stephens, C., & Breheny, M. (2013). Narrative analysis in psychological research: An integrated approach to interpreting stories. *Qualitative Research in Psychology*, 10 (1), 14-27.
- Stewart, A. J., & McDermott, C. (2004). Gender in psychology. *Annual Review of Psychology*, 55 (1), 519-544.
- Stojanovic, J. (2010). Midwifery in New Zealand, 1904-1971. *Birthspirit Midwifery Journal*, (5), 53-60.
- Sullivan, C., & Riley, S. (2012). Planning and ethics. In C. Sullivan, S. Gibson, & S. Riley (Eds.), *Doing your qualitative psychology project* (pp. 37-64). London, UK: SAGE Publications Limited.
- Szabo, C. P., & Coryell, W. H. (2004). Illness prediction in psychiatry. *Acta Psychiatrica Scandinavica*, 109, 323-324.
- Taha Advisory Group. (2013). 1st New Zealand Pacific Maternal and Infant Health Conference. Auckland, New Zealand: Taha Advisory Group.
- Thachuk, A. (2007). Midwifery, informed choice and reproductive autonomy: A relational approach. *Feminism and Psychology*, 17 (1), 39-56.
- The Poverty Bay Herald. (1912, July 27). Foundation of patriotism: Care of the rising generation. *The Poverty Bay Herald*, XXXIX (12826), p. 4.
- Thompson, L. (1992). Feminist methodology for family studies. *Journal of Marriage and the Family*, 54 (1), 3-18.
- Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness*. New York: Harvester Wheatsheaf.
- Ussher, J. M. (1997). Towards a material discursive analysis of madness, sexuality and reproduction. In *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 1-9). New York: Routledge.
- Ussher, J. M. (2010). Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism and Psychology*, 20 (1), 9-34.

-
- Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism and Psychology, 23* (1), 63-69.
- Warriner, S., Byrne, G., & Graham, D. (2011). Maternity and mental health services working collaboratively with women. *British Journal of Midwifery, 19* (11), 729-733.
- West, C., & Zimmerman, D. (1991). Doing Gender. In J. Lorber, & S. Farrell (Eds.), *The social construction of gender* (pp. 13-37). London: Sage Publications.
- Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Berkshire, England: Open University Press.
- Woliver, L. R. (2002). *The political geographies of pregnancy*. Urbana: University of Illinois Press.
- World Health Organisation. (1992). ICD-10 Classifications of mental and diagnostic guidelines. Geneva.
- World Health Organization. (2011). Strengthening Midwifery: A background paper. Geneva, Switzerland: World Health Organisation.
- Yelland, J., McLachlan, H., Forster, D., Rayner, J., & Lumley, J. (2007). How is maternal psychosocial health assessed and promoted in the early postnatal period? Findings from a review of hospital postnatal care in Victoria, Australia. *Midwifery, 23*, 287-297.

Appendix A



MASSEY UNIVERSITY
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TE KURA PŪKENGA TANGATA

Midwifery and Mental Health: Experiences of New Zealand Midwives Caring for Pregnant Women with Mental Health Needs

INFORMATION SHEET

My name is Karen Hielkema, and I am a student at Massey University enrolled in a Master of Science in Psychology. As part of this qualification, I am undertaking a qualitative research project, which will culminate in a thesis. This project is going to be conducted using Narrative Inquiry, and will look at midwives' experiences of working with women who experience mental health problems during their pregnancies.

While a lot of research has focused on postnatal depression and related conditions, and looked into pregnant clients' needs from midwifery care, the experiences and perspectives of midwives themselves and how they provide care for such clients have not been studied in depth. The purpose of this research is to investigate an area that has not been well researched, and of particular interest is how midwives experience, identify and manage mental health issues with pregnant clients - and how this experience, perception and expertise informs case planning, treatment and practice. From the discoveries made in this study, it is hoped that there will be benefits to psychology and the mental health area, especially in the relationship between maternity service providers and mental health. In addition, there are potential benefits to midwifery as a profession in terms of highlighting particular issues that are relevant for midwives in practice, and through this process giving a voice to midwives who live these experiences with clients on a daily basis.

I invite you to participate in my research to explore midwives' experiences with mental health in their pregnant clients. Your stories will be used to engage with relevant literature and to highlight specific areas as they are identified.

The goal for this project is to obtain stories from between 6 and 12 independent midwives who have experience practicing as a Lead Maternity Carer (LMC). As LMCs are the primary maternity health providers for the majority of pregnant women in New Zealand they are most likely to develop on-going, partnership-style relationships with clients throughout the

duration of pregnancy and a period post birth, and as a result will be in a position to talk about this in-depth. This number of participants has been chosen in order to ensure varied stories and capture a range of individual experience, to enable identification of recurrent themes, and for the richness of this data to be represented in the final thesis.

Recruitment for this research will be undertaken on a convenience sample basis, and this is expected to be through direct contact with independent midwives and through referral. It is not expected that participants will experience discomfort or risk in their participation with this research, and your participation in this project is entirely voluntary.

The data for this research will be obtained through conversational style interviews that will be digitally audio-recorded. It is anticipated that the interview should take approximately one hour, or as long as it takes for you to tell me your story. This interview will take place at a location and time that is convenient for you. I will personally transcribe these digital recordings in detail so that confidentiality is protected, and to permit me a high level of familiarity with the contents as I conduct the analysis and write my thesis.

I will make a copy of your transcript available to you in order to give you an opportunity to reflect on the contents. I will follow-up with you to discuss your reflections, thoughts and possible amendments/additions so these can be considered and included in the final analysis. This follow-up can either be done by phone call, email, or another face-to-face appointment; whichever is more suitable for you. Once this process is complete, the digital recordings will be destroyed. In addition, a summary of themes and findings will be made available to you after the final analysis has been completed.

All your information and data will be kept confidential, stored securely, and password protected. Your identity will be safeguarded and your details will not be discussed with any unauthorised individual. Identifying features, such as your name, age, or place of work, will not be disclosed and a pseudonym will be allocated to you in the writing process to maintain confidentiality.

As above, even though the purpose of the project is not to talk about particular clients, if for any reason any client information should inadvertently be discussed, all identifying features of that client including her name, dates, and so forth will be removed for the purposes of confidentiality, and to support your adherence to your own professional code of ethics which includes clauses for non-disclosure.

After the completion of the interviews and analysis, this project and its results will be written about by me and submitted to Massey University for evaluation and marking, and published as the final requirement for completion of my Master of Science Degree in Psychology. A copy of the final thesis will be placed and held in the Massey University Library catalogue.

You are under no obligation to accept this invitation to participate. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time prior to the analysis being conducted;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Should you have any queries related to this research project, I can be contacted at any time by telephone: 021 99 99 44, or by email: karen_h@orcon.net.nz or alternatively my supervisor, Dr Leigh Coombes, can be contacted by telephone: 06 3569099 ext. 2058 or by email: L.Coombes@massey.ac.nz

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 350 5249, email humanethics@massey.ac.nz.

Appendix B



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Midwifery and Mental Health: Experiences of New Zealand Midwives Caring for Pregnant Women with Mental Health Needs

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

Full Name - printed

Appendix C



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Midwifery and Mental Health: Experiences of New Zealand Midwives Caring for Pregnant Women with Mental Health Needs

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research, with the understanding that identifying features have been removed.

Signature:

Date:

Full Name - printed
