Perspectives on Midwifery and Parenthood

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Foreword

It is with great joy that I have learned of this impressive new publication to guide midwives, and other health professionals, in providing compassionate care and support to new mums and dads in their transition to parenthood. Pregnancy is the beginning of a journey, a time of preparation and adaptation to a new way of life, and yet information on this critical topic has been lacking for too long. This book will enable the transition to parenthood to become a core part of the education of all midwives. This helpful resource carefully explores parents' own experiences of pregnancy under diverse physical, psychosocial, spiritual and emotional situations. It calls on midwives and health professionals to be culturally competent through greater awareness of attitudes, behaviours and cultural differences that need to be considered when caring for new parents and their families.

The transition to parenthood is a major life event in the lives of women and men. It is a life-changing experience, which irreversibly confers parenthood, with new tasks, roles and responsibilities. The transition can be empowering, a truly positive experience. But for many who do not get the physical and emotional support needed, becoming a new parent can be exhausting and stressful. Midwives and other healthcare professionals who work alongside women and men, through pregnancy and early parenthood, are in a unique position to support parents in achieving a positive experience during the transition to parenthood.

Midwives, when educated and regulated to international standards and integrated into the health system, have the competencies to provide help, care, support, education and, where needed by parents, supportive interventions. This includes the dissemination of knowledge about keeping well in pregnancy, preparation for childbirth and parenthood, parenting and child development, and development of social networks. Being mindful of the pragmatic, realistic and emotional needs of parents and supporting them in navigating this new experience can help parents embark positively on parenthood, which in turn supports early childhood development.

Each chapter addresses diverse psychosocial challenges that women and men may face during their transition to parenthood. These include poor perinatal mental health of mothers and fathers, preterm birth, infertility, repeated baby loss, surrogacy, adolescent pregnancy, migrants, intimate partner violence, excessive use of alcohol and drugs during pregnancy, unique experiences of LGBTQ+ parents, as well as breastfeeding and spirituality. The chapters highlight the importance of respecting parents' own experiences and the humanness of each situation. The

human aspects of empathy and compassion and the ability to see things from parents' perspective, to ensure the holistic well-being of parents, are very well illustrated.

The authors are highly experienced midwives, health professionals and researchers who have focused on women and men during the transition to parenthood. They have provided both evidence and theory to provide an insightful way to enhance the provision of an optimal person-family-centred support service during the all-important transition to parenthood.

I hope that all midwives, and other health professionals, can benefit from this book and improve quality compassionate care for all new parents everywhere.

Professor Fran McConville
World Health Organisation

Contents

Midwifery and the Transition to Parenthood

Rita Borg Xuereb

1 Introduction

The transition to parenthood (TtoP) is considered as a highly demanding, yet unique, period in the life of women and men. As they traverse from woman to mother, man to father, new parents face a myriad of reactions such as joy, happiness, fear, stress and anxiety while embracing the addition of a new member within their family (McGoldrick et al. 2013; Borg Xuereb 2008). The TtoP results in an internal and external reorganisation of the parents' lives (Balfour et al. 2012).

Parenting is a role which demands skills, often unknown or unfamiliar to the prospective parents; they hardly receive information about the impact a child will have on mothers' and fathers' lives, yet they are expected to undertake the task, often with very little help or support, and their mistakes are expected to be few (Borg Xuereb 2008; Baldwin et al. 2018; Borg Xuereb et al. 2012). Not all parents feel ready for the transition, and the fear of losing control could affect their self-confidence and self-esteem (Solmeyer and Feinberg 2011).

Additionally, as mothers and fathers are passing through the transition, a mismatch can arise between their expectations and the actual experiences, potentially leading to emotional and psychological ill-health (Webb et al. 2021; Delmore-Ko et al. 2000). Hence, the TtoP may be a positive or negative experience for the parent, which could possibly increase or decrease the closeness between the partners (Doss and Rhoades 2017; Walker 2014).

O'Connor (1993, p. 201) recognised the importance of raising public awareness about the relevance of "*being adequately prepared for parenting, to create a realistic view of parenthood and childbirth and to firmly reject the notion that it is easy to*

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adjust to parenthood and that all babies are either happy or asleep", almost three decades ago. This is still highly topical today.

Literature identifies the midwife as having an educational and supportive role in the pregnant and the postnatal women's physical, psychosocial, emotional, spiritual and mental health (Borg Xuereb 2008; Crowther et al. 2021; Dahl et al. 2020; Petch et al. 2012; Deave et al. 2008; Riley 2004; Harrison 2003). Similarly, the International Confederation of Midwives' (ICM) definition of the midwife (2017), and the State of the World's Midwifery report (UNFPA 2021), acknowledges the midwife as a practitioner, educator and counsellor of the woman and her family during the TtoP.

Midwives do more than care for the pregnant womb, birthing woman, neonate and infant. Midwives provide respectful, humanistic and holistic care, which includes the psychological, spiritual, cultural and social dimensions of the health and well-being of the woman, her partner, the unborn child and neonate, during pregnancy, birth, postnatal and early parenting. Hence, midwives are tangibly present in the lives of parents, as they journey through the transition.

As stated in the abstract, diverse situations concerning the TtoP are presented in each chapter where midwives together with nurses, obstetricians, psychiatrists, psychologists, and social and community workers, amongst others, could make a difference through the provision of holistic and seamless care contingent to the needs of women, partners and families.

2 Transition to Parenthood

According to Parke (1996, p. 17), the TtoP starts with the decision about "when and whether to have a child and try to become pregnant" and extends from pregnancy to the first year or two after birth (Deave et al. 2008; Deave and Johnson 2008; Polomeno 2000, 2006). It is also considered as the "birth of the family" (Lewis 1989). The transitions from a woman to a mother, a man to a father and partners to parents are considered as major developmental stages with a multitude of challenges (Gameiro et al. 2011). It is a life event that influences the psychological and social functioning as well as the well-being of individuals, partners and families (Meleis 2010). It also seems to be a promising time for learning, as parents want to do what is best for their child.

Transition to and early parenthood include the infant's health and psychosocial development (Dahl et al. 2020; Barimani et al. 2017; Cowan and Cowan 2000, 2012; Scrandis 2005; Knauth 2000). Besides providing food and shelter, parents shape the values, goals and self-worth of their children. Parental example lays the framework for their child's future relationships, aspirations and accomplishments. Therefore, the family environment is critical for the parents, the development of the child and the whole family as a unit (Scrandis 2005; Knauth 2000; Hall et al. 1996; Cowan and Cowan 1995). No wonder the addition of a child to a new family is considered as one of the most challenging transitions in women's and men's lives (Cowan and Cowan 2000).

Attention also needs to be given to this role of historical change in accounting for current perceived experiences of parenting, couple's relationships and family responsibilities. The family aided by the community used to prepare its members with parenting and social skills. Girls learnt mothering through role modelling on their own mothers. Boys, like their fathers, were expected to grow up and become the breadwinners of their future family.

The past decades, however, have witnessed major shifts in work and family patterns, with changes in the family concerning size and structure. Many women are gainfully employed outside the home and subsequently return to their career after childbirth (Gambles et al. 2006; Alvesson and Due Billing 1997). Mothers are now returning home from their gainful activities to start another full day's work of housework and childcare, considered as the "double day" or "dual job" (Gambles et al. 2006; Cranny-Francis et al. 2003). Although it is being recognised that fathers are giving more time to childcare, many mothers are consistently involved more than fathers in all facets of caregiving and across all time points (Cowan and Cowan 1995; Gambles et al. 2006; Cranny-Francis et al. 2003; Levesque et al. 2020).

Hence, shifts in gender-role ideology, shifts in work patterns for women and men, shifts in timing/age of first-time parenthood as well as significant changes in medical practices have altered the climate in which women and men are actively involved as they navigate the transition to motherhood and fatherhood. Societal trends have thus converged to create a situation in which fathers have to share household tasks and childcare (Borg Xuereb 2008).

Nonetheless, most parents expecting their first child anticipate parenthood with enthusiasm and excitement. However, some parents struggle to adapt to the stresses and joys of parenthood while concurrently trying to establish a healthy work-family balance with minimal support from the cultural and social systems that place demands on parents. Families do not exist as units independent of other social organisations within the society. Symonds and Hunt (1996, p. 83) consider "*pregnancy and childbirth as social events in that they take place within a surrounding economic and social system, and are understood within a cultural value system*". Hence, women and men who are passing through the TtoP also need to be viewed within their social context.

The TtoP contributes to a "*multiplicative range of expectations, attitudes, beliefs and competencies, as well as physical and psychological demands*" (Durkin et al. 2001, p. 122). Consequently, the actual experience may be different from women's and men's expectations. Women's knowledge of motherhood is contingent to their motivation for becoming mothers, their experiences as mothers and the contexts in which they become mothers. Expectations and ideologies are highlighted in the media such as television, magazines, internet, Twitter and Facebook, together with government reports that inform health, social and educational policy. Motherhood is revered, yet it tends to reduce women to one dimension and ignores the fact that mothers have activities, interests, needs and relationships apart from mothering (Borg Xuereb 2008; Borg Xuereb et al. 2012; Spiteri and Borg Xuereb 2012).

The transition can likewise be stressful for men as they must face a period of change and uncertainty. Moreover, society does not recognise or prepare fathers for

parenthood as fatherhood is construed as "optional". Although men gain identity and status from fatherhood, they still retain a positive identity of themselves as men without becoming a father (Woollett and Nicolson 1998). The socially constructed nature of fatherhood images includes that of a breadwinner role, a moral overseer, sex role model and nurturer (Marsiglio 1995). The culture of fatherhood may have changed; however, the conduct of fatherhood has been rather slow to change (Cowan and Cowan 1995, 2000).

Fathers' involvement in parenting varies considerably, in terms of physical and emotional commitment (Woollett and Nicolson 1998; Marsiglio 1995). Baafi et al. (2001) studied the functional status of fatherhood in Australia. They found that a few fathers increased their level of active participation in the routine tasks associated with home and family. Other fathers, however, found it easier to cope, by simply being absent from home (Baafi et al. 2001). Fathers seem to be less involved in the more demanding and continual tasks of parenting, which require parents to respond to their children's needs (Marsiglio 1995). Although some men may be inadequately prepared for fatherhood and may experience postnatal anxiety and role confusion, many remain on the fringes of parenthood (Barclay and Lupton 1999), especially when the mother stays at home after the birth of the child (Borg Xuereb 2008). The chapter "Midwives and the Transition to Fatherhood" focuses on the transition to fatherhood; however, more research about the evolving needs of fathers is needed.

The TtoP is a time when parents' role expectations are being challenged, new roles must be learnt and new relationships are developed. They must adjust to the personality of their child, and their present relationships with partners and relevant others must also be readjusted. Health could, therefore, be compromised when the dynamic balance of a person's actions and personality fails to adapt to the circumstances of a changing environment.

3 Changes in Parents' Relationships

The quality of the relationship between the parents has a direct influence on the development of the parent-child relationship (Cowan and Cowan 2000; Hay and Kumar 1995; Gloger-Tippelt and Huerkamp 1998; Belsky 2006). Knowledge of the relationships between marital or partner satisfaction and parental functioning increases the understanding of how family functioning changes with the birth of a child.

New parents often subordinate their own needs to prioritise the child's needs, with potential negative consequences to the well-being of the partners (Delicate et al. 2018). New parents also speak about the loss of freedom and the lack of flexibility in their lives (Borg Xuereb 2008). Cowan and Cowan's (1995), and Gottman and Notarius' (2002), reviews on the TtoP show that findings from longitudinal studies are consistent in suggesting that there is a drop in marital quality in approximately 40–70% of couples. Findings from these studies are comparable to one another even though they have relied on convenient samples, which limit

generalisability. Longitudinal studies of marital relationship*s* and family functioning demonstrate that most decreases in marital satisfaction occur during the first year of postnatal period (Lewis 1989; Cowan and Cowan 1995; Gloger-Tippelt and Huerkamp 1998; Cox et al. 1999).

The birth of the baby initiates changes, which could undermine partners' relationship with less time for couple communication, increase in conflicts especially about child rearing, increase in financial concerns and lack of quality time for each other (Borg Xuereb 2008; Atkinson et al. 2000; Petch and Halford 2008). The TtoP can also amplify prior existing problems in the relationship (Borg Xuereb 2008; Doss and Rhoades 2017; Bronte-Tinkew et al. 2009). Conversely, Belsky and Kelly's (1994) longitudinal study also highlighted that 30% of parents identified no change and 19% reported greater closeness, less conflict and an improvement in communication. Researchers have, nonetheless, reported that the parents who were most satisfied in the antenatal period were again the most satisfied during the postnatal. Therefore, antenatal conditions contribute significantly to variances in parents' level of functioning (Knauth 2000, 2001; Cowan and Cowan 1995; Belsky and Kelly 1994), implying the need for increased support to pregnant women and their partners in the preparation for a realistic transition and the promotion of positive parenting.

4 Mother-Father-Child Interactions

The family's social conditions have a profound effect on the roles of the father and mother and affect their child. In addition, the quantity and quality of parents' interactions are modified and influenced by the direct and indirect effect of both parents on one another and their child, as they redefine their roles, expectations and interactions with each other during pregnancy (Borg Cunen 2021) and following childbirth (Doss and Rhoades 2017). The interrelationships within the mother-father-infant triad emphasise the importance of both mother's and father's role in child development; however, social and work institutions and traditions have pushed the father out of the picture at a time when mothers are expecting an increase in father's involvement (Dickie 1987).

Researchers have identified areas of differences between mothers' and fathers' interactions with their child; for example, fathers tend to play with the infant more than mothers, while mothers tend to take responsibility for the everyday care of the infant (Borg Xuereb 2008; Cowan and Cowan 1995; Belsky 2006; Belsky and Kelly 1994); others identified variables on which mothers and fathers by and large did not differ from each other in their interactions with the child (Dickie 1987). Intervention studies focusing on fathers show an interrelationship between parenting roles and partners' relationships (Dickie 1987), which may likewise be linked to the child's outcomes (Goldberg and Carlson 2014).

This could imply that the partners' relationship affects the parent-child relationship, and it also impacts the child development (Goldberg and Carlson 2014; Kouros et al. 2014). Hence, sensitive or responsive parental caregiving is associated with

parent-child attachment security and plays an important role in the social development of the child (Brooks 2011; Hoghughi and Long 2004; Bowlby 1988). In fact, Belsky (2001, p. 845) points out that "*early, extensive and continuous non-maternal care is also associated with less harmonious parent-child relations*". Studies also highlight the long-term effect of maternal depression on child rearing and on the whole family (Brockington 2004; Ramchandani et al. 2005). Maternal depression can influence the bonding between the mother and her child (Nath et al. 2019) and reduce the quality of mother-child interactions during the first 2 years after childbirth, possibly with long-term outcomes on the physical, emotional and cognitive development of the child (Stein et al. 2014).

In a meta-analysis of 42 studies, Barnes and Theule (2019) found that the rate of non-attachment security in the infants of depressed mothers was approximately 20% higher than that in non-depressed mothers and only 43% of infants of depressed mothers were securely attached. Consequently, impaired mother-infant interaction could lead to insecure attachment with substantial consequences for the mental health outcomes of the child (Fatori et al. 2020; Burger et al. 2020).

The difficulties faced by the families of depressed mothers could potentially result in increased rates of child mental ill health (Goodman et al. 2011), increased vulnerability in parent-child relationships (Lee et al. 2013) and increased family conflict (Foster et al. 2008). Similar findings were, likewise, observed in the families of depressed fathers (Cheung and Theule 2018).

5 Parents' Antenatal and Postnatal Mental Health

The nature, prevalence and determinants of mental health and ill health in women and partners during pregnancy and in the first year following childbirth have been widely searched and documented (Cankaya 2020; Fisher et al. 2012; Pataky and Ehlert 2020; Tokumitsu et al. 2020). Literature has suggested that the stress of the adaptation to motherhood, fatherhood and parenthood on a physical, social and psychological or emotional level could lead to mental ill health in women during the perinatal period, calling the need for tangible help and support (Yasumaa et al. 2020; Roberston et al. 2004; Shaw et al. 2006).

Studies have identified several risk factors as being potential antecedents for emotional problems during the TtoP. Major life events around childbirth, fear of childbirth and traumatic births are considered as primary risk factors for postnatal depression and/or traumatic birth disorders (Astbury et al. 1994; Halperin et al. 2015). Both women and men can experience postnatal depression (Soliday et al. 1999; Ramchandani et al. 2011).

Meighan et al. (1999) found that men were quite concerned when they could not help their wives to overcome postnatal depression and some men also ended up suffering from postnatal depression themselves. Ballard et al.'s (1994) study of 200 British couples also found that the partner was more likely to be depressed if the mother had postnatal depression. Another large study of 7018 men to estimate the rates of depression, and to explore the role of stressful life events and social and

emotional support during pregnancy and 8 weeks postnatal, suggested similarities in the patterns and correlates for men and women (Deater-Deckard et al. 1998). Lutz and Hock's (2002, p. 419) study suggested that men whose "*personalities reflected high fear of loneliness*" may be more at risk for depressive symptoms. Conversely, Condon et al.'s study (2004) observed that men were mainly distressed in the antenatal period. It seems that culture and possibly the way men construe fatherhood could play a role in their emotional well-being during the TtoP.

Concerning migrants, Fellmeth et al.'s (2017) systematic review proposed that migrant women are more liable to develop perinatal mental ill health than non-migrant women, calling the need for health and social services to provide the much-needed support to these vulnerable women. Moreover, the provision of interpretation services to all migrant women could facilitate communication issues, enhance care and support (Rapa 2015), uphold the mother and her partner's self-esteem and possibly contribute to a better perinatal experience. The chapter "Migrants, Midwives, and the Transition to Parenthood" focuses on migrants and the transition to parenthood.

Perceived and received social support could, therefore, moderate the effects of a variety of stressors on health and couple relationships. Borg Xuereb et al. (2012) noted that wherever the partners perceived themselves as being highly supported by their own parents or friends, they seemed more serene and less distressed than parents who were not supported. In addition, when support was lacking, fatigue, exhaustion, psychological distress and stress were more pronounced in women (Hamelin-Brabant et al. 2015), thus strengthening previous findings that a strong support system is critical during the TtoP (Cowan and Cowan 2000; Durkin et al. 2001). Midwives are in an optimal position to make a difference to so many individuals during this transition. Perinatal mental health is discussed in detail in chapter "Midwifery and Perinatal Mental Health".

6 Midwifery and Parenthood

The support that is presently being offered by midwives during the TtoP is primarily woman-child focused rather than family focused (Borg Xuereb 2008; Cowan and Cowan 2000). Midwives offer routine care, advice and support preconceptionally, in the antenatal period, and supervise the birth and care for the physical and emotional well-being of the mother and child during the postnatal period. Other health dimensions such as the impact of having a baby on the marital and family relationships are largely ignored. Singh et al. (2002) underline the need to move away from the routine assessment and activities to also include the wider public health roles. Thus, if midwives are to provide social and emotional support to parents in the TtoP, they must embrace a more holistic role in supporting the family, through the provision of competent, respectful and culturally sensitive antenatal and postnatal care, including health promotion and education and preparation for childbirth *and* parenthood (Dahl et al. 2020).

Parenthood education could include aspects of intimacy between the partners (Polomeno 2007, 2014), skills in coping, time and stress management and

teamwork (Borg Xuereb 2008). Education for parenthood in pregnancy can start during the first meeting between the midwife and the couple at the booking visit, through an assessment of the parenting education needs while prioritising individualised care to the partners. Midwives could also support the family of new parents through focusing and recognising the importance of relationships between mothers, fathers and their children and other members of the family and community.

7 The Provision of Learning Opportunities

The provision of learning opportunities to help parents who are facing the TtoP is considered as a relatively recent phenomenon. Parents do seem to value the help, support, advice and feedback they get from health professionals (Polomeno 2000, 2006; Svensson et al. 2006) and from non-experts including their peers (Borg Xuereb 2008). Antenatal programmes are, nevertheless, criticised for not giving adequate attention to the different needs of women and men during the TtoP (Matthey et al. 2002).

Midwives in many countries organise antenatal programmes as part of the parents' preparation for childbirth and the postnatal period. The programme generally includes information on nutrition during pregnancy, preparation of the mother and partner for childbirth, breastfeeding, emotional problems and immediate care of the mother and child after childbirth. Preparation for parenthood is considered as a prime activity of midwifery education and practice as stipulated in EU directives (European Union Midwives Directives 2005) and ICM's definition of the midwife (International Confederation of Midwives (ICM) 2017).

There is, however, a huge variation in the provision of antenatal education, with variations in the way classes are delivered, the teaching-learning methods used and the contents of these classes (Gagnon and Sandall 2007). Several studies noted that retrospectively, first-time parents felt that the postnatal area is not sufficiently addressed in the antenatal classes (Borg Xuereb 2008; Deave et al. 2008; Barnes and Theule 2019; Svensson et al. 2007), contradicting midwives' anecdotal reports that women cannot focus on parenthood issues during pregnancy as women have a "tunnel vision" and therefore they do not think beyond birth (Svensson et al. 2007, p. 11).

Cowan and Cowan (2000) also criticise midwives and doctors by stating that they do not provide opportunities for expectant parents to discuss concerns or for couples to talk about marital issues raised during pregnancy. The increase in involvement of parents during preparation for parenthood programmes is mainly to prepare for the day of their baby's birth even though childbirth brings major psychological upheaval (Cowan and Cowan 2000). They further add that medical practice is congruent with the medical model of care, which endorse*s* the tendency to separate the concerns of women from those of men, "thereby attributing to men's and women's separation from each other, a separation that grows wider during their early child-rearing years" (Cowan and Cowan 2000, p. 70). In his review of evidence of the causes of marital breakdown, Simons (1999) calls for future research to target

parenthood programmes to the specific needs and interests of couples becoming parents.

Literature shows that antenatal education does not give adequate attention to the different needs of women and men during the TtoP (Borg Xuereb 2008; Borg Xuereb et al. 2012; Matthey et al. 2002) and underlines the importance of preparing parents for the adjustment they need to make with regard to their relationship with each other (Borg Xuereb et al. 2012; Cowan and Cowan 2000; Svensson et al. 2006; Matthey et al. 2002). Preparation for parenthood must be understood with reference to the prevailing social environment, understand the experiences of how parents prepare for parenthood and explore effective and efficient ways in the provision of health promotion and education (Borg Xuereb 2008; Borg Xuereb et al. 2012; Cowan and Cowan 2000; Svensson et al. 2006; Spiteri 2018). The chapter "Preparation for Parenthood" comprehensively covers preparation for parenthood.

8 Conclusion

This chapter explored how contemporary parents are facing the TtoP. Studies showed that parents are often ill-equipped to face the challenges of parenthood given the social and cultural changes the family has experienced during the past decades. Parents' adjustment to parenthood depends on how the couple negotiates specific domains that include their own individuality, marital relationships, gender ideology, emotional well-being, lifestyles, and social, spiritual and cultural issues including the partners' expectations and actual experiences during the TtoP.

The social shifts in work and family patterns warrant the need for the sharing of family responsibilities between women and men. Studies however have shown that many women still assume the main responsibility for household tasks and childcare, with men being more supportive. Issues about equity are a concern and a potential source of tension between the partners during the TtoP.

Social support can moderate the effects of stressors on the health of the parents. Women and men feel the need to have someone to turn to especially during pregnancy and the early post-partum period. Each of the following chapters presents the readers with diverse family-life situations during pregnancy and early postnatal period, whereby midwives can inspire and positively affect the lives of individuals, couples, infants and families.

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Preparation for Parenthood

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1 Introduction

Preparation for parenthood is defined as a process of active, conscious and positive participation that transitions towards motherhood and fatherhood (Spiteri 2018; Spiteri et al. 2014). During the transition to parenthood, maternity care aims to offer women and their partners an opportunity to feel supported and guided by their midwives. Traditionally, this has been offered through antenatal education programmes. The information delivered during these courses, however, tends to primarily focus on labour and birth processes. Discussions about preparation for motherhood, fatherhood, parental role and identity, self-confidence and relationships are amongst many of the untouched topics in such courses. In fact, many new parents have reported feeling unprepared for the reality of first-time parenthood (Spiteri 2018; Borg Xuereb 2008; Barimani et al. 2018). Despite this lack of preparation, most individuals qualify as parents. While some parents prepare and plan for pregnancy months in advance, others stumble upon this experience without having had any plans for it to happen. Some individuals buy books, download apps or surf the internet to help them understand the processes of childbearing. This, however, has implications on the quality of information acquired as some men and women might not be able to afford such resources, hence relying on lay advice (Spiteri 2018). Despite the widespread academic literature surrounding parenthood, little is known about the preparation for this life course journey. Much of what is available appears to

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apply to high-risk or 'problematic groups' rather than for the low-risk scenarios (Borg Xuereb 2008; Robling et al. 2016). Also, preparation for parenthood may take on different meanings for different situations. For example, preparation for parenthood of subsequent children may be different from preparation for the first-time experience of parenthood, and indeed, preparation may be different in the planned or unplanned pregnancy context as well as with individuals who may have underlying medical conditions. The same can be said for parenthood through adoption, surrogacy or artificial reproductive technologies. Planning for parenthood has implications for the well-being of both the parents and their offspring. Hence, preparing individuals for parenthood is an essential role of midwives, and this needs to be further embedded in their practice.

The knowledge about preparation for parenthood presented in this chapter originates from various sources, predominantly a PhD study which was designed to explore the experience of preparation for first-time parenthood amongst biological parents based in Malta (Spiteri 2018). Twelve couples participated in the study and took part in a face-to-face interview. Four couples were actively planning for a pregnancy, four couples were expecting their first child and another four couples were interviewed between 6 weeks and 1 year post-partum. The interviews were transcribed verbatim and analysed using interpretative phenomenological analysis as described by Smith et al. (2009). Pseudonyms are used throughout to provide anonymity.

2 Preconception Preparation for First-Time Parenthood

The preconception period can be viewed as a critical time where preparation for parenthood may be achieved through support and education, which may result in both immediate and long-term benefits for women, men and their offspring (Frey et al. 2012; World Health Organisation 2013a). Our qualitative study indicated that an integral component of preconception preparation was mental preparation. In the planned context, men and women anticipate changes in their lifeworlds and have discussions about personal parental readiness and commitment (Spiteri 2018). Conversations between men and women involve complex interactions between long-time personal goals and values, which feature as preconception motivating factors for pregnancy. The first-time experience of preparation for parenthood changes through time as individuals relate to their current life circumstances and use these as inhibitors or motivators for this experience. This idea confirms one of the critical attributes of preparation for parenthood as revealed in a concept analysis about preparation for parenthood, which indicated that preparation for parenthood was indeed time specific (Spiteri et al. 2014). In the planned pregnancy context, many of the preconception desires for approaching parenthood have in fact a strong time relatedness. For many women, this is generally associated with their ages as they fear decreasing fertility with advancing maternal age as suggested in the literature (Lemoine and Ravitsky 2015; Perheentupa and Huhtaniemi 2009; de la Rochebrachard and Thonneau 2002). Indeed, many women appear to hold their ages as contributory factors to start preparing for first-time parenthood.

> *Since we are over 30, we don't think it's a good idea to delay parenthood any longer. We can't wait that long because Max would be nearing 40 and I would be approaching 35, so I don't think that would be a good idea because we could end up having problems then.* (Spiteri 2018, Martina—Martina and Max).

Despite the concern associated with age, the Western world has seen an increase in women having their first child over the age of 35. The female participants in our study, however, appeared to be more concerned with the association between increased maternal age and risk of adverse outcomes of the pregnancy and compromised health when compared to their male counterparts (Spiteri 2018). This heightened concern may indeed influence reproductive decisions, particularly in the planned scenario. This has important implications for preconception care, especially given the global increase in women pursuing an education and personal career goals before starting a family.

Research has shown that women's stable employment situations are a prerequisite for forming families (Spiteri 2018; Andersson 2000; Hoem 1990; Kreyenfeld 2010). Employment aspirations, as well as the chances to combine work and family life, vary by a woman's socio-economic background (Kreyenfeld 2010). Highly educated women seem to be better able to balance work and family life than others, and it has been noted that they return to work soon after childbirth (Drobnic 2000; Spiteri and Borg Xuereb 2012). Employment uncertainties may indeed act as a hindrance for the postponement of parenthood, especially amongst highly educated women (Kreyenfeld 2010).

Another important tenant of preconception preparation within a planned context is financial stability. Economic stability allows individuals to actively consider parenthood. In the coupled scenario, most described how in preparation for parenthood they were financially saving up in an attempt to be ready for the impending experience (Spiteri 2018; Spiteri et al. 2014):

> *We would like to settle in first and maybe save some money because we wouldn't want to have a baby and be struggling financially. You have to be ready from that aspect too.* (Charlie)

> *Yes, we are saving up for the experience. It wouldn't be the most responsible thing to enter parenthood without an element of financial stability*. (Spiteri 2018, Lara—Lara and Charlie).

Within the Maltese context, spiritual preparation also featured as an important domain in the preparation for first-time parenthood (Spiteri 2018; Spiteri et al. 2014):

> *You have to allocate a place in your mind for this experience. I feel like I am spiritually preparing for how I will be as a father. I will be entrusted with this child of God, and I need to understand my mission and my calling in this experience with my wife and with my baby.* (Spiteri 2018, Mitch—Amy and Mitch).

Religious connotations also featured in the narratives of the couples in the study being presented here (Spiteri 2018). During the pre-pregnancy and pregnancy phases, some women revealed their negotiating tactics with God; they prayed to get

pregnant and to have a healthy baby (Spiteri 2018). These can be viewed as spiritual-positive coping mechanisms (Hamilton and Lobel 2008). Many couples also displayed a reliance on God, with some exhibiting fatalistic attitudes, and this is particularly interesting and relevant within more traditional cultural contexts (Spiteri 2018; Jones et al. 2016). Researchers have described fatalism as the belief that life events are predetermined or controlled by outside forces such as God or fate (Bell and Hetterly 2014). This fatalistic approach goes against the preconception care policy brief put forward by the WHO, which encourages individuals to engage in healthy behaviours and change unhealthy ones or to act with agency (World Health Organisation 2013b). Despite this, research has also shown how pregnancy planning might be particularly vulnerable to fatalistic thinking and that some degree of fatalism actually informs how women view their fertility (Jones et al. 2016; Woodsong et al. 2004).

Most interviewed women in our study acted with agency, especially when it came to potentially modifiable risk factors which are associated with poor pregnancy outcomes as most tried to optimise their health during the preconception phase. Many women start taking folic acid and vitamin supplementation pre-pregnancy, heavier women try to lose weight, some start eating healthier foods and others stop smoking and drinking alcohol all in preparation (Spiteri 2018; Stephenson et al. 2014). It needs to be acknowledged, however, that some women have less agency and that our study participants were all in settled relationships, which may have influenced our findings.

Preconception preparation also involves engaging with formal and informal sources of information, especially amongst women (Spiteri 2018; Spiteri et al. 2014; Nolan 1997). Many females independently read about certain aspects of parenthood, which in turn helps them with knowing what to expect in pregnancy (Spiteri 2018). Unlike women, male participants from our study explained how during the preconception phase their engagement was not very personal, despite acknowledging that reading could help a person in preparation. Most men felt that the preconception period was too early for them to start to actively prepare for the first-time experience of parenthood. It was as if most of the men relied on their partner's engagement during the preconception phase (Spiteri 2018).

3 Preparation for First-Time Parenthood During Pregnancy

The pregnancy period offers parents-to-be unique yet different experiences, which in turn help to enhance their preparation for parenthood. Many females seek antenatal care as soon as they find out they are pregnant as a form of preparation. Most continue to optimise their health for the benefit of their unborn child:

> *You start taking your vitamins and folic acid, you pay attention to lifting and handling, you try to rest more, exercise, stretch mark prevention oil, circulatory stockings. These all helped me with the physical aspect of preparation*. (Spiteri 2018, Mollie—Mollie and Dan).

Within a coupled context, relationship preparation also featured as an integral part of the preparation for parenthood during the pregnancy period. Pregnancy allowed the couple to start transitioning from dyad to triad. Acknowledging the unborn during pregnancy helps to decrease the impact of new parenthood postnatally (Spiteri 2018). Many parents-to-be rearrange their homes to accommodate the new baby. The setting up of a space for the unborn baby can be viewed as a venture into the future, a space ready to be filled with the desires and imaginative plans of becoming mothers and fathers. This, however, might not apply in all instances of new parenthood as access to space and socio-economic circumstances may constrain this possibility (Kehily 2014).

In an attempt to engage with formal sources of information, expectant couples may often attend antenatal education as a means of pregnancy preparation. Antenatal education in health systems is also a very common means of pregnancy preparation for parenthood (Spiteri 2018; Nolan 1997; Borg Xuereb et al. 2012). Individuals however also acquire information by reading various types of literature or searching the internet and through conversations with people who have experienced first-time parenthood already (Spiteri 2018):

> *If you are preparing for parenthood, go and search about it, become knowledgeable. Read and study all about it. Plan it well. Read books, use the internet, and become knowledgeable*. (Spiteri 2018, Dan—Mollie and Dan).

Couples can also call on the support and information from their immediate family and close friends as well as from their midwives. Family and friends with young children tend to be considered a great source of contemporary information and advice by many preparing for first-time parenthood. Research has shown however that advice from one's own parents is sometimes unwelcomed, especially in situations where relationships are strained or when there is value divergence (Spiteri 2018). While some consider their parents' advice to be invaluable, others may consider it to be out of date and unhelpful given changing times:

> *And you need to talk to people about things. We've talked to some people about certain things, and they told us this and that which helped us I think*. (Peter)

> *People with experience are our main source of reference*. (Spiteri 2018, Jessica—Jessica and Peter).

The pregnancy period further contributes, where relevant, to making working arrangements, especially amongst females. In an attempt to work in a healthy environment, some women make work arrangements or quit work altogether because their place of work is deemed to be hazardous (Spiteri 2018). Research has shown that upon disclosing their pregnancies at their place of work, some women are faced with unsupportive reactions, with some even feeling that they were discriminated against (Spiteri 2018; Spiteri and Borg Xuereb 2012). In pregnancy, decisions with regard to maternity and paternity leave are often taken with some parents even making arrangements to return to work post-leave. This return

to the workforce is considered to be a complex and multifaceted process (Coulson et al. 2010). Planning in advance tends to put parents' minds at ease, especially the females, as they are generally more likely to stay at home with their children post-birth (Spiteri 2018; Spiteri and Borg Xuereb 2012). While the planning process starts early on, it continues after childbirth with parents adapting gradually to their everyday experiences. Indeed, the planning process may be viewed as a continuous process (Scholnick and Friedman 1993). Moreover, planning with regard to childcare seems to be associated with parental stress. When the family of origin is available to support with childcare needs, parents have described feeling grateful for this opportunity, especially with respect to returning to gainful employment (Spiteri 2018; Spiteri and Borg Xuereb 2012). This may not be the case for all parents as many grandparents may live far away and hence may be unable to watch their grandchildren.

4 Preparation for First-Time Parenthood During the First Postnatal Year

Despite having tried to prepare for their first-time experience of parenthood, globally, many parents have reported a difficult and stressful transition into parenthood, especially in the beginning (Spiteri 2018; Borg Xuereb 2008; Borg Xuereb et al. 2012; Deave and Johnson 2008; Sanders et al. 2014; Woolhouse et al. 2012; Craig and Mullan 2011). New parents have to deal with unrealistic expectations of new parenthood, which sometimes leaves them feeling disappointed and even guilty (Spiteri 2018; Borg Xuereb 2008). During this transition, new parents need to reorganise their lives, with women often taking up the greatest share of domestic and childcare work in many communities, which reflects broader cultural norms about gender (Spiteri 2018; Borg Xuereb 2008; Borg Xuereb et al. 2012; Craig and Mullan 2011; Horchschild and Machung 1989).

While many parents try to equip themselves with professional knowledge during pregnancy by attending antenatal education, postnatally, many of them realise that while they felt that these courses had somewhat helped them to prepare for the labour and birthing experience, they were not adequately prepared for the realities of new parenthood which include increased roles, financial hardships and even relationship challenges (Spiteri 2018; Borg Xuereb 2008). The importance of delivering parenthood information during antenatal classes has been raised in the literature (Spiteri 2018; Borg Xuereb 2008; Nolan 1997). While some midwives believe that during pregnancy parents are too consumed by the pending birth of their child to engage with information relating to the postnatal period (Weiner and Rogers 2008), many new parents have suggested otherwise (Spiteri 2018; Borg Xuereb 2008; Borg Xuereb et al. 2012). Research has shown how parents who receive information relating to parenthood during the antenatal period are less likely to experience anxiety or depression and coped better with the stressors associated with new parenthood (Milgrom et al. 2011):

> *At around my seventh month I was reading an article about baby's first hours at home, and I realised that I wasn't prepared at all in that sense. I was so focused on pregnancy and labour that I didn't think about what was going to happen once we got home. It's like everyone is focused on pregnancy and the birth and nobody really tells you about what happens afterwards. Even though we attended the course, I think we were selective in our hearing. You will only hear or pay attention to what you think is relevant to you at that particular moment in time, whatever is worrying you at that time and not really focusing on what is yet to come*. (Spiteri 2018, Dina—Dina and Remy).

During the first postnatal year, most parents have reported difficulty in engaging with parenthood resources, advice and support (Spiteri 2018; Spiteri and Borg Xuereb 2012; Borg Xuereb et al. 2012). Retrospectively, parents have been seen to express a desire for adequate preparation for the first-time experience of parenthood (Spiteri 2018; Borg Xuereb 2008). Moreover, postnatal parents have reported their depreciation of receiving unsolicited advice after the birth of their firstborn (Spiteri 2018). Congruent with other studies, the participants from our study preferred to access information on their own terms, generally from books, the internet and peers, but most importantly they valued information from health professionals (Spiteri 2018; Sanders et al. 2014):

> *I personally think that advice should come from someone professional. I'd prefer a professional's comment or opinion. I think a professional can really impact on the person's journey. They have the ability to calm a person in distress with the information they provide. I actually think that other people's opinions or suggestions are more intrusive rather than helpful*. (Spiteri 2018, Remy—Dina and Remy).

During the postnatal period, looking up information and answers online for any queries parents might have is often deemed as a very straightforward process, especially given recent technological advancements (Sanders et al. 2014; Khoo et al. 2008; Moseley et al. 2012). Parents report using reliable resources, which include governmental websites and those of health-related agencies (Spiteri 2018). However, search engines like Google are also used (Spiteri 2018; Sanders et al. 2014; Grimes et al. 2014). Parents often only consider what makes sense to them at that particular moment in time, and they are the ones who decide what information most suits them (Spiteri 2018; Khoo et al. 2008):

> *You need to make sure your source is reliable though. It's one thing to be getting information off the WHO website but if you are using some weird site that's another story and I wouldn't be so sure*. (Spiteri 2018, Mollie—Mollie and Dan).

> *I read everything that was available online, and then I told him about it. I tried to read reliable sources like the NHS and the American Association of Paediatrics and stuff like that, even some Australian ones which were also really good. So, I had my little pile of information which made sense to me and suited my need, our needs, so we worked with that. That is how I prepared really*. (Spiteri 2018, Samantha—Samantha and Shaun).

Peers have also been deemed as an important source of support and social interaction for many new parents (Spiteri 2018). This is congruent with other research that has shown that peers can offer informational support to new parents in their

transition to first-time parenthood (Sanders et al. 2014). Some parents disclosed wanting to meet up with people also experiencing first-time parenthood (Spiteri 2018). Playgroups, library services and other activities that cater to children's needs should be reorganised to create opportunities for adult-oriented interactions too (Sanders et al. 2014). These may help enhance parental psychological well-being, which in turn has implications for the child as well. Parfitt and Ayers (2013) also recommended re-evaluating opportunities available for new parents with regard to social interaction given the association between the mental health of the primary caregiver and children's development. Parenting stress may cause suboptimal parent-child interactions, insecure child attachments and child abuse or neglect (Crnic et al. 2005; Guterman et al. 2009):

> *We used to go to an infant massage class. We used to be really looking forward to them not because we would give a massage to our daughter but because it provided us with an opportunity to meet and discuss things with other parents who were basically experiencing similar things we were. We used to end up staying there after the session ended to talk about experiences and challenges*. (Dina)

> *Yes, it was nice to meet other parents going through a similar experience. It was an opportunity to share our experiences*. (Spiteri 2018, Remy—Dina and Remy).

Despite the transitioning difficulties often faced in the post-partum period, most parents accept their changing identities bringing with it a deep sense of accomplishment despite all their hardship (Spiteri 2018). The post-partum period further allows individuals an opportunity for transformation into mothers and fathers. This involves a process of growth and adaptation, which renders them more flexible and resilient as individuals. Adaption is an important facet in preparation for first-time parenthood (Spiteri 2018; Spiteri et al. 2014). Acknowledging a change in their lifeworld is inevitable, and parents have expressed that the sooner this realisation is made, the easier the transition would be (Spiteri 2018):

> *I think that a parent must understand that change is inevitable, and they shouldn't fear the unknown. They need to accept that their lives will change, and they need to move forward and adapt*. (Dan)

> *Yeah, and you need to forget about how your life was before the change too*. (Spiteri 2018, Mollie—Mollie and Dan).

Adapting into this new lifeworld sometimes brought with it self-sacrifice (Spiteri 2018). Parents need to be able to let go of their previous selves to a certain extent to be able to move forward in their new roles (Spiteri 2018). Most postnatal parents acknowledged how becoming a parent has made them more resilient and prouder of their achievements:

> *Even the routine that we both had before, it has changed. Now she's the boss. You have to adapt for the sake of yourself and for your baby. The baby won't adapt to accommodate the parents. Until you realise and accept that you aren't as independent as you were before you'll be stuck in this stage of not being able to move on with your life*. (Dina)

Speaking for the both of us I think we were both ready to sacrifice everything for her. We moved countries, sacrificed our careers. I think people need to be aware of what the experience is really like. We were ready to sacrifice everything, but I don't know if everyone else is. Yes, it is a difficult experience, but you will come out of it stronger than ever and so proud of your accomplishments. (Spiteri 2018, Remy—Dina and Remy).

5 Improving the Support Available to Couples in Preparation for First-Time Parenthood

In more traditional communities, the influence of gender roles, where the male partner is identified as the breadwinner and the female partner as the child carer and homemaker, needs to be acknowledged and further supported. This mentality seems to create a contradiction for many women who are highly educated and established in their careers. Mixed messages put forward in traditional societies make it difficult for women to decide with regard to returning to paid employment or not. Stacy's excerpt below highlights a somewhat apprehensive stance on her part. It was as if she was already feeling pressured to be a stay-at-home mum:

I have been studying all my life, so I am not sure if I will be able to stay at home and just be a mother. On the other hand, I feel as though I am expected to be with our baby all the time while my husband goes out to work. What happens if I want to work too? (Spiteri 2018, Stacy—Stacy and Michael).

Moreover, some couples credited their work orientation as having helped them gain a sense of achievement. Having the opportunity to work from home through telework, having flexible hours, and decreasing their working hours or working part-time seemed to be beneficial to these new parents or parents-to-be:

I wish employers could realise that fostering family-friendly measures would be so helpful for working parents. Having this type of support at your place of work would be ideal and not just for the mothers but for the fathers too. (Spiteri 2018, Michael—Stacy and Michael).

6 The Role of the Midwife in Preparation for Parenthood

The preconception period is a time where midwifery support has traditionally often been lacking, and this has implications on expanding the role of the midwife in this regard:

Pre-conceptionally there is no support or information whatsoever. You do not know what to do. I feel this is something that should be taken up by midwives. I think there is a lack of awareness and knowledge. (Spiteri 2018, Amy—Amy and Mitch).

Also, parents have highlighted that the content of current antenatal education should be revised to better equip parents-to-be for the realities of new parenthood:

> *The course (antenatal education) was good, but the focus was on the delivery, and nobody tells you what will happen after the baby arrives. It's like everyone helps you throughout the pregnancy, and there are loads of support, but then you end up alone once the baby arrives. I think teaching new parents about the realities of parenthood would be very helpful.* (Spiteri 2018, Kylie—Kylie and Chris).

Another essential recommendation put forward by new parents was the need for midwives to provide consistent and research-based information to expectant and new parents (Spiteri 2018). Conflicting advice is confusing to new parents, and this has implications for midwives and their continuing professional development.

7 Conclusion

While most of the data presented here is specific to a particular context, some of the findings may be transferred to different cultures and communities elsewhere. From a midwifery perspective, the preconception and antenatal periods should be viewed as an opportunity to strengthen the family unit or support networks where the family may not be available by encouraging prospective parents to talk about the changes they will face during the transition to first-time parenthood. This can be achieved through the implementation of preconception care clinics or units within the community to offer advice and support to prospective parents regarding diet and nutrition, healthy lifestyle behaviours and fostering healthy relationships. There is the potential for these preconception clinics to be run by midwives but may also engage other professionals such as family therapists, psychologists and nutritionists. Engaging other new parents could also be beneficial as these can offer practical and realistic advice. Our research suggests that prospective parents should have the opportunity to speak about their concerns regarding parenthood before embarking on this life-changing journey as a form of preparation (Spiteri 2018). Assessments for parental readiness may also be done via informal discussion with midwives during the preconception and antenatal stages so that support can be offered to individual parents accordingly. The current provision and delivery of antenatal education should be revised to better prepare parents for the first-time experience of parenthood. Moreover, these courses have the potential to continue well into the first postnatal year. This would allow for issues around new parenthood, child rearing and psychosocial aspects to be discussed.

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The Parental-Fetal Tie During Pregnancy

Nicole Borg Cunen, Julie Jomeen, and Rita Borg Xuereb

1 Introduction

The parental-fetal tie (PFT) refers to the emotional affiliation that expectant parents develop towards the unborn child over the gestational period, as influenced by their evolving conceptualisations of the fetus (Borg Cunen 2021; Doan and Zimerman 2002). The degree to which parents feel connected to the fetus varies widely both between individuals and over the gestational period and is intertwined with other processes that occur during this time, such as a transformation in self-concept to identify with the parental role (Doan and Zimerman 2003; Fenwick et al. 2012; Modh et al. 2011) more closely. How the fetal tie forms for each expectant parent is believed to be determined by a unique combination of influences (Bouchard 2011), including their personality (Sjögren et al. 2004), their history of attachment experiences (Doan and Zimerman 2003), and the amount of social support they have access to (Diniz et al. 2015; Krause 2013).

Over the past decades, research interest looking into how expectant parents think and feel about the unborn child has been relatively strong. Early researchers, such as Cranley (1981), Müller (1993), and Condon (1993), worked towards conceptualising the phenomenon and developing tools to quantify it using self-report measures. Much of the research that followed used those tools in attempts to identify the predictors and correlates of the PFT (Van den Bergh and Simons 2009). Each of the

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original conceptualisations, however, focused on different aspects of the phenomenon, with the resultant tools measuring somewhat different concepts (Yarcheski et al. 2009; Shieh et al. 2001). This has likely contributed to the inconsistent results of research attempting to establish links between the PFT and other variables. For instance, while some studies have identified a link between antenatal depression in the expectant mother and a lower quality maternal-fetal tie (Ossa et al. 2012), other studies have failed to establish such an association (Haedt and Keel 2007).

2 The Significance of the Parental-Fetal Tie

Investigating the PFT allows for an understanding of how expectant parents envision their children before this perception is complicated by influences such as infant temperament and early parenting experiences (Condon 1993; Dayton et al. 2010). Primarily, the value of acquiring information about the PFT lies in its surmised longitudinal associations (Siddiqui and Hagglof 2000; Mercer 2004). There is evidence that the PFT is, to some degree, a precursor to the parental-infant attachment that occurs after birth (Condon et al. 2013; Hjelmstedt and Collins 2008) and that is modestly but significantly associated with postnatal parent-child interaction quality (Foley and Hughes 2018). Through such associations, the PFT is thought to be linked to the child's cognitive and emotional well-being in the post-partum period and beyond (Siddiqui and Hagglof 2000). Although these correlations may indicate that the postnatal parental-child relationship is a continuation of the PFT, one must be cautious about making such suppositions. Such links may, alternatively, be a result of a mediating variable, such as an individual's overall ability to form emotional bonds, which would affect one's ability to both develop perceived emotional proximity to a fetus during pregnancy and form a reciprocal relationship with a child in the post-partum period (Condon et al. 2013).

The PFT is thought to have short-term consequences as well, with expectant mothers' feelings about the unborn child being associated with their health-related behaviour over the gestational period (Lindgren 2001, 2003; Alhusen et al. 2012).

3 Relevance of the Parental-Fetal Tie to Midwives

Acting as the primary caregivers to women and their families during the perinatal period places midwives in a unique and privileged position to observe how expectant parents talk about the unborn child and to note any serious issues that may interfere with the later parental-child relationship. This, in turn, may allow for early intervention, either by midwives themselves or through referral to appropriate healthcare professionals, to ameliorate these risk factors even before the child's birth, thus promoting healthy family bonds.

Knowledge of the PFT and how it develops also gives midwives insight into opportunities to promote a sense of emotional proximity to the unborn child in all expectant parents, encouraging mothers and fathers-to-be to engage with their

unborn child earlier during the gestational period, or to a greater degree than they otherwise might have. Suggestions as to how midwives can encourage the parental-fetal tie are given later in the chapter.

Finally, an understanding of the processes involved in the PFT and an appreciation of the individuality involved in its development will help midwives to better comprehend, and cater for, the varying reactions that expectant parents in their care may have in reaction to fetal loss or compromise, depending on, amongst other factors, their interpretation of their emotional proximity to the unborn child at that point in time (Condon 1985).

4 The Formation of the Parental-Fetal Tie over Pregnancy

The knowledge about the PFT presented in this chapter originates from various sources but is illustrated by participant excerpts extracted from a longitudinal study done using constructivist grounded theory (Charmaz 2014) whose purpose was to construct substantive theory of expectant parents' fetal conceptual and relational experiences over the gestational period (Borg Cunen 2021). For the study, 18 first-time expectant mothers and fathers were interviewed individually in early, middle, and late pregnancy (Borg Cunen 2021). Pseudonyms are used to protect the participants' confidentiality. The theoretical framework that was constructed through that research has been reported elsewhere (Borg Cunen et al. 2022).

The chapter continues by detailing key processes that occur during the gestational period in relation to the formation of the PFT. These processes are referred to as internalisation, emotional engagement, familiarisation, and yearning (Borg Cunen 2021). While the processes described are universally applicable, there is an extent of variability in the way that each expectant parent experiences them, with some ascribing more importance to, or being more intensely affected by, some processes over others. The timing at which each experiences elements within the processes also varies.

4.1 Internalisation

The initial weeks of pregnancy are a surreal time for expectant parents (Draper 2002a). Although they are cognitively aware of the pregnancy, they have few ways to substantiate the reality of fetal presence, making it difficult to internalise (Draper 2002a), "*… at the moment it hasn't quite sunk in*" (Borg Cunen 2021, Rocco, T1). This is particularly evident in cases where the mother does not experience many physical symptoms of pregnancy (Borg Cunen 2021). Optic, haptic, or audial evidence of the unborn child is needed to authenticate the reality of the fetus.

> *… at the moment I don't feel anything … so sometimes … I wouldn't even know I was pregnant*. (Borg Cunen 2021, Lydia, T1)

Gradually, as the pregnancy advances, these feelings of incredulity decrease. The process of internalisation is driven by increasing access to tangible evidence of fetal presence (Fenwick et al. 2012; Draper 2002b). Corroboration is gained through experiences such as viewing fetal ultrasounds, hearing the fetal heartbeat, recognising changes to the maternal body, and, in particular, becoming able to palpate fetal movements (Lumley 1982; Heidrich and Cranley 1989). Through these experiences, the existence of the fetus within the maternal body gains a degree of consolidation in the expectant parents' minds, and this sense continues to be reinforced throughout the gestational period (Yarcheski et al. 2009; Müller and Ferketich 1992; Chang et al. 2010):

> *At the beginning, in the first two months or so, it's like you're in a dream. Then you start seeing her tummy growing. You say, "It's really happening." It's strange - it's not enough knowing she's pregnant. Before you see it, this thing … it's when you start seeing him that it becomes confirmed. At least that's how I felt.* (Borg Cunen 2021, Alfred, T3)

Assimilation of the presence of the unborn child encourages the expectant parents to shift their focus to centre on the pregnancy, eliciting feelings of excitement and trepidation as they come to terms with what pregnancy means for them as individuals and as a family unit (Finnbogadóttir et al. 2003; Hilfinger Messias and DeJoseph 2007). During this reflective period, women and men begin to picture themselves in the parental role and to slowly internalise this version of themselves (Doan and Zimerman 2003; Fenwick et al. 2012; Modh et al. 2011):

> *… you mature involuntarily, the way you think about certain things. You start thinking like a parent …* (Borg Cunen 2021, Tara, T2)

4.2 Emotional Engagement

The gradual process of internalisation means that, during the initial stages of the pregnancy, expectant parents often do not feel a strong emotional connection to the fetus (Sandbrook and Adamson-Macedo 2004), with Müller and Ferketich (1992) suggesting that the PFT begins with a sense of curiosity rather than affection. It is the growing internalisation of fetal presence that enables the beginnings of a sense of intimacy in the PFT (Borg Cunen 2021). Research has established a robust link between maternal awareness of the unborn child and development of fetal attachment (Siddiqui et al. 1999; Della Vedova et al. 2008):

> *I don't think [I developed a sense of affection] straight away … at the beginning, it's still a bit surreal. Because [in the initial weeks] you don't have any side-effects … you just know [about the fetus] because of the ultrasound, but again it's just a dot. So, it's like it grew, it grew for me … it came gradually.* (Borg Cunen 2021, Catherine, T1)

Emotional investment in pregnancy then leads to increasing concerns about the possibility of fetal loss or disability (Gourounti et al. 2012; Sandbrook 2009). The unborn child is perceived to be acutely "*vulnerable*" (Borg Cunen 2021, Matteo,

T1) in early pregnancy, and protecting him/her from harmful influences becomes a priority for expectant parents (Condon 1993; Shieh et al. 2001; Sandbrook 2009), an aspect of the PFT labelled as altruistic attachment by Shieh et al. (2001). Thus, expectant mothers modify their routines and behaviour to carefully adhere to recommendations for safeguarding fetal welfare (Sandbrook 2009), and expectant fathers often willingly take on additional household roles to support their partners' well-being (Johnsen et al. 2017):

> *Mostly I've been thinking about Lydia, obviously. That she is, every day, safe first of all. I help her to do the housework. Where before she used to do everything herself, I have now begun to help out … The pregnancy requires input from the man too. You can't leave everything in the woman's hands.* (Borg Cunen 2021, Kurt, T1)

Worry about the unborn child is often an "*overwhelming*" (Borg Cunen 2021, Anna, T1) feature of early pregnancy. This sentiment has two somewhat opposing connotations, on the one hand being regarded as a sign of commitment to the unborn child (Borg Cunen 2021): "*You worry a lot about something because you really want it*" (Borg Cunen 2021, Rocco, T1). On the other hand, however, worry can also cause expectant parents to consciously constrain the intensity of their feelings to limit the emotional impact of a possible loss (Sandbrook 2009; Ohman and Waldenstrom 2010). As Raphael-Leff (2005) suggests, expectant parents initially find difficulty in trusting their own or their partner's ability to sustain the precarious embryo. This phenomenon has been referred to as "tentative pregnancy" (Rothman 1986):

> *… the consciousness that there could be a miscarriage … that was holding me back a bit.* (Borg Cunen 2021, Catherine, T1)

Parental worries tend to decrease by mid-pregnancy as the unborn child becomes more vigorous in their minds (Côté-Arsenault et al. 2006). Apart from reassurance received from healthcare professionals, it is the onset of perceivable fetal movements which does most to dispel parental fears (Smith et al. 2021). Quickening gives the expectant parents access to a consistent method to ascertain fetal life (LoBiondo-Wood 1985), without the need for input from an external other (Borg Cunen 2021). This reassurance allows the fetal tie to blossom further:

> *… the worries have disappeared to a certain point. You can never be sure … [but] I don't think about it anymore, it's over now … there are two things that [reassure me]. Her [growing] body and the fact that she feels him moving. That gives me a sense of serenity.* (Borg Cunen 2021, Julian, T2)

4.3 Familiarisation

The way that expectant parents envision the fetus evolves considerably over the pregnancy (Yarcheski et al. 2009; Müller and Ferketich 1992; Della Vedova et al. 2008; Sandbrook 2009). Early in the pregnancy, women and men only have

vague ideas about what the fetus looks like, imagining him/her to be part of the maternal body and describing him/her as "*transparent*" (Borg Cunen 2021, Valentina, T1), a "*bump*" (Borg Cunen 2021, Marc, T1), and a "*ball*" (Borg Cunen 2021, Radha, T1 and Krishna, T1). They find it challenging to identify with an entity that seems to lack human form when viewed on initial ultrasounds (Ekelin et al. 2004):

> *… in the beginning, it's very, very difficult to relate because he wasn't even a … He was cells, he was [just] starting to grow, so small that you almost can't recognise anything.* (Borg Cunen 2021, Matteo, T1)

This ambivalent perception of the fetus does not lend itself to the development of emotional proximity in the PFT (Borg Cunen 2021). Thus, the importance of events and actions that encourage a vision of the fetus as a person and as an individual is emphasised (Shieh et al. 2001). The gradual development of a "*mental image*" (Borg Cunen 2021, Chris, T2) of the unborn child with these qualities is achieved through various means, including viewing detailed ultrasounds, particularly images of the fetal face, assigning and referring to the fetus by a nickname or name, finding out the fetal gender, deducing meaning from distinct fetal movements, and preparing the nursery (Borg Cunen 2021):

> *We've already named him, our [baby] is called Tiny … So, he already has a name … it's not like [he's just any] baby … I feel that it has helped.* (Borg Cunen 2021, Lily, T1)

Shieh (2001) refers to this aspect of the PFT as cognitive attachment, the desire to know and understand the fetus. Expectant parents seek to gain as much information as they possibly can about the unborn child, cling onto this knowledge, and use it to conjure up more detailed ideas about the baby (Condon 1993). The use of their imagination is thus key to the development of a detailed mental image of the child and to picturing what life with the child will be like (Müller and Ferketich 1993). Through these means, expectant parents gradually develop an understanding of the unborn child as a familiar other and as a cherished member of their intimate family unit (Borg Cunen 2021). In this way, the PFT seems to be primarily built with a conjectured image of the child (Condon 1993). This process of fetal personification and mental representation is a well-established path through which expectant parents build a sense of affiliation with the fetus (Doan and Zimerman 2003; Siddiqui et al. 1999; Leifer 1977; Shieh and Kravitz 2002), with Benedek (1959) cited in Condon (1993) referring to this concept as "the gestation of a person" and Raphael-Leff (2005) talking about the shaping of an "imaginary friend".

> *I think [finding out the fetal gender] massively helped … that kind of bonding with the baby … I can picture things now. Before you'd kind of picture something and then you'd go "oh that's what I do if it was a boy," and then you'd sort of flip and go "oh if it was a girl, I'd been doing this." You kind of linger on those thoughts for longer now you know it's actually gonna be a boy, "oh we're gonna probably be playing football together in the park.* (Borg Cunen 2021, Marc, T2)

4.4 Yearning

In a conscious effort to reduce the sense of distance from the unborn child, expectant parents often use contact bids to connect to the fetus (Cranley 1981). These involve talking to or touching the unborn child through the maternal abdomen (Sandbrook 2009; Stainton 1985). However, these gestures often feel hollow and ineffective in early pregnancy (Borg Cunen 2021):

> *He's still too small, so it's limited what you can do. For example, if I were to play some music; if he's not going to hear it, then what's the point?* (Borg Cunen 2021, Lily, T1)

As the gestational period progresses, and the image of the unborn child held in the mind of expectant parents matures, they become somewhat more confident in his/her ability to perceive their contact bids (Borg Cunen 2021). Women and men start to put more effort into their communications, and the bids gain an element of spontaneity (Borg Cunen 2021). Condon (1993) highlights interaction with the fetus to be one of the core subjective experiences required for the development of a sense of love towards the unborn child:

> *I start imagining that he's responding … through that, I start feeling that there is a connection, a small relationship that I've started … we try talking to him … maybe he'll give some kind of response … when I see him moving, it seems like he's giving you feedback … I don't feel like I'm talking to the wall …* (Borg Cunen 2021, Alfred, T2)

However, even in the latter gestational weeks, not all expectant parents share the view that contact bids are beneficial to the unborn child (Borg Cunen 2021). Not being able to clearly perceive a fetal reaction to their efforts is frustrating for women and men, and some continue to express doubts that fetal movement during these occasions truly signifies that the unborn child is responding to them (Borg Cunen 2021). Expectant parents continue to view the fetus primarily as a perceiver rather than a communicator (Borg Cunen 2021):

> *I do try [to talk to the baby] but you start and then … you don't have anything that you can call a response. You try but … [I feel] like I'm talking to myself. They tell you that he can hear, but you don't receive anything back.* (Borg Cunen 2021, Chris, T3)

Reciprocity, the back-and-forth flow of social interaction (Autism Society of Baltimore-Chesapeake (ASBC) 2021), is considered to be a critical component of a genuine relationship (Buunk and Schaufeli 1999):

> *When you see her in your arms … maybe because you can caress her, talk to her face-to-face, you feel that she can hear you more or make more contact - that's why the bond grows suddenly. At the moment … I think it's still a bit limited … no one is talking [back] to you … no one is answering you …* (Borg Cunen 2021, Lydia, T3)

Expectant parents thus yearn to establish true visual and tactile contact with the unborn child. Having the baby within the maternal body, beyond reach, can never

fully satisfy their desire to connect to him/her (Kao and Long 2004). During the gestational period, the fetus remains "a curious mix of fantasy and reality" (Condon and Corkindale 1997, p. 360):

> *I expect it to change when he's born. In the sense that at this point I know I'm the father, I'm happy …. you're protective - fine. But the bond still needs to happen. Towards the baby itself… I mean I love him but I think I still need to gear up… you love them, you think about them, but once you see him I think it's more!* (Borg Cunen 2021, Julian, T3)

Given the lack of fulfilment related to fetal reciprocity, expectant parents perceive the PFT to remain primarily uni-directional, from the parental side, during the gestational period, achieving gradual actualisation in the post-partum period when it can be considered a reciprocal relationship (Walsh 2010).

5 Influence of Parental Gender on the Parental-Fetal Tie

While comparatively little research concerning the PFT has been done with expectant fathers (Condon et al. 2013; Della Vedova and Burro 2017), the few studies that have included parents of either gender have suggested that they form fetal conceptions and develop emotional ties to the fetus, in remarkably similar ways (Borg Cunen 2021; Condon 1993; Weaver and Cranley 1983; Armstrong 2000). Both women and men connect with the unborn child on both a conceptual and a sensual level through the processes described within this chapter. However, it is salient to acknowledge that there are a few notable gender differences that influence fetal conception and connection. These differences are rooted in physical gender disparities in pregnancy (Draper 2002b), in terms of the level of contact with the unborn child, as well as in pre-existing ideas about parental gender roles (Condon 1985). To avoid repetition across chapters, the distinction between how men and women think and feel about the unborn child will be discussed in the chapter "Midwives and the Transition to Fatherhood", which focuses on the transition to fatherhood and, in doing so, juxtaposes this against maternal experiences during this period.

6 Supporting the Development of the PFT in Expectant Parents

Midwives and other healthcare professionals can help to support expectant parents as they develop ways of thinking about the unborn child. Given the conspicuous individuality that exists in both the intensity and timing that expectant parents express aspects of the PFT, the most crucial recommendation is for the tie not to be pathologised without due cause (Borg Cunen 2021). Ways of thinking about the fetus vary widely, but this is not to say that there is a right or wrong way to feel at any particular point during the gestational period.

Thus, measuring the PFT, to try to identify expectant parents with a "substandard" tie, particularly through brief and superficial self-report measures, is not recommended (Borg Cunen 2021). Such measurement is unlikely to provide valuable

results, in terms of identifying individuals at risk of a dysfunctional postnatal relationship. Furthermore, bracketing an antenatal tie as flawed based on such tools could result in undue negative categorisation for expectant parents who would have otherwise spontaneously caught up with their peers in their ways of thinking about the child, either later in the pregnancy or early in the post-partum period. Shaming a parent by assigning them a negative categorisation could affect their perception of their ability to relate to the child, which could, in turn, affect their future relationship. Instead, it is suggested that midwives take the time to talk to expectant parents about their feelings towards the unborn child, allowing them to open up and express any concerns. It is only if these concerns raise safeguarding issues would they warrant further action, such as referral to mental health or social services.

The development of a sense of familiarity with the unborn child is critical in building emotional proximity to him/her (Doan and Zimerman 2003; Siddiqui et al. 1999; Leifer 1977; Shieh and Kravitz 2002). It is thus proposed that midwives and other healthcare professionals caring for expectant parents should take opportunities to enhance perceptions of fetal familiarity wherever possible. For instance, there is a growing amount of evidence that suggests that undergoing ultrasounds during pregnancy helps to promote the PFT, particularly in the period prior to the onset of perceivable fetal movements (Borg Cunen et al. 2017). Fetal familiarity could also be promoted through evidence-based education about fetal development and, in particular, about the perceptive abilities of the unborn child and his/her capacity to respond to parental actions at different stages of gestation. Such knowledge, in turn, could give expectant parents more confidence in the efficacy of their fetal contact bids.

7 The Need for Further Research

Much of the research done to understand the PFT has made use of samples of expectant parents of primarily Caucasian ethnicity, middle- or upper-class background, and who identify as heterosexual. Thus, little is known about how the PFT develops in more diverse populations. In particular, the building of the PFT may differ significantly in cases where expectant parents are not in a conventional partnership or marriage with one another, especially for expectant fathers. Other scenarios in which the development of the fetal tie may take on a different trajectory include pregnancies involving same-sex parents, surrogates and intended parents, unwanted pregnancies, twin pregnancies, and cases where fetal disability is diagnosed during the gestational period.

8 Conclusion

The PFT is a phenomenon that evolves over the pregnancy, that is largely equivalent between expectant mothers and fathers, and that exists on a continuum rather than being static or homogeneous amongst individuals.

As the fetus becomes increasingly tangible, expectant mothers and fathers are increasingly able to come to terms with his/her presence and, through a process of familiarisation, gain a sense of emotional proximity to the unborn child. The intensity of PFT, however, continues to be restricted by limits in fetal tangibility and reciprocity, which prevent it from being conceived as a genuine relationship.

This knowledge will be valuable to all midwives, with an understanding of the processes that drive the PFT facilitating discussion around this phenomenon with expectant parents. Knowledge of the topic will enhance midwives' ability to empathise with individualised parental reactions to different circumstances affecting the unborn child, such as threatened or actual fetal loss or compromise.

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Well-Being and Early Motherhood

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1 Introduction

While there are variations in definition, the perinatal period incorporates the time from conception until at least 1 year post-partum. The focus of this chapter is predominantly the period from birth to 12 months post-partum; however, women's postnatal experiences do not exist in a vacuum; they are shaped by previous experiences, indeed by a whole biography, relationships, current circumstances and wider context of their lives. The perinatal period can, and arguably should, be considered a continuum, which inherently includes the post-partum. Feelings, concerns and fears during pregnancy may continue into the postnatal period, as, for example, is the case with depression (Underwood et al. 2016). A woman's well-being during pregnancy can be affected by thoughts and feelings about birth and early motherhood—or by previous experiences of pregnancy, birth and early postnatal period (Beck and Watson 2010; Cŏté-Arsenault and Mahlangu 1999), but also by earlier life experiences, such as childhood trauma (Garon-Bissonnette et al. 2022). Therefore, while the focus in this chapter is the postnatal period and transition to motherhood, specifically well-being across that period, we will refer to the full spectrum of the perinatal period in order to contextualise women's

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experiences and highlight continuities across the period. We are aware of the importance of paternal well-being in the postnatal period; this is, however, beyond the scope of this chapter.

Traditionally, well-being has been researched in a fragmented manner. The psychological side of the post-partum, in postnatal depression and anxiety, has received much research attention (Rallis et al. 2014; O'Hara and McCabe 2013; Jomeen 2004). The subject of well-being is, however, usually explored through the absence of distress rather than as a concept in its own right. The psychological facet of well-being is often separated from physical aspects of women's experiences and other factors (economic, environmental, relational) that influence well-being (Wadephul et al. 2020). In the following, we share a more holistic understanding of the subject with facets of the concept of well-being *not* separated out, with a mother as an individual and her well-being as part of her whole person including her past experiences. Our exploration of postnatal well-being is illustrated with findings from two studies investigating how women use a practical and holistic self-management approach (the Alexander Technique) in this potentially challenging phase of life (Hanefeld et al. 2021). This technique has been shown to improve well-being in other populations (Kinsey et al. 2021).

2 What Is Well-Being?

Perinatal well-being is complex and multidimensional with subjective whole-person experience (Wadephul et al. 2020). Further, two models of well-being illustrate a dynamic nature of this difficult-to-pin-down concept.

Dodge and colleagues (2012) balance resources with challenges in a see-saw model with resources on one side and challenges on the other, whereby both sides involve psychological, social and physical elements. The authors view the see-saw as representing the drive of the individual to return to a well-being set point and the person's need for equilibrium and homeostasis. *Skills* as resources to re-establish well-being play a central role in the model.

White's model (2010) proposes that *relationship* is central to well-being: between individual and collective, between local and global and between people and state. One could possibly add 'the relationship to oneself' and between woman and partner. White (2010) suggests that the attraction of this concept of well-being is its holistic outlook, connecting a person's various levels of being: mind, body and spirit. This understanding of well-being integrates the aspects of time and life phases, recognising that life takes place in space and is hence '3D', and above all, it is a dynamic process.

Both these well-being concepts are holistic as well as dynamic, and they have relevance to the perinatal period, especially post-partum, because they allow for fluctuating well-being states which could result, for example, from experiencing a day with tiredness after a night with sleep disruption and activities, which might be

undertaken to regain well-being in such a situation. Both models also avoid trying to define what well-being *is* but leave space for a conceptualisation of it as a fluctuating state, which can be influenced by multiple variables.

3 The Perinatal Continuum and Post-partum Maternal Well-Being

When compared with other periods of life, profound mind-body changes occur in the perinatal phase; women's roles, identities and relationships also transform. It is feasible to suggest, therefore, that some characteristics of the perinatal period can pose particular challenges to well-being, as well as present opportunities. Rapid physical changes take place during this time, especially during labour and birth. For many women, pregnancy and labour may be the first time they have such extreme experiences, including experiences of physical limitation. Along with physical changes, women often experience emotional and psychological shifts in the transition to motherhood (Redshaw and Martin 2011). These may be profound and linked to extensive changes in women's roles and expectations, particularly for first-time mothers. Baby responsibility is often 24 hours a day, and adapting from working to being a mother is a process that is intricately linked to sociocultural expectations and discourses; this can also have a significant impact on women's sense of identity and self-worth (Laney et al. 2015). The transition to motherhood often brings with it fundamental relationship changes with partners, family members and friends. In addition, a new relationship with the baby develops during this time (Walsh et al. 2013). Furthermore, healing after birthing can be an issue and is another unique experience, potentially influencing well-being in this phase of life. The physicality of the post-partum involves carrying, holding and feeding, which can lead to musculoskeletal tension pain, which along with all the above elements can influence maternal well-being (Fraser and Cullen 2009). Well-being is likely to fluctuate considerably during this period, especially the post-partum period, due to sleep disruption and tiredness. New mothers tend to experience a range of competing demands on their time and energy, and the post-partum period can be a time in which women's well-being receives less attention.

4 Perinatal Well-Being Framework

Our development of the perinatal well-being framework (PWB) is based on three iterative elements: a theoretical review on the topic of perinatal well-being (Wadephul et al. 2020), a second review which synthesised women's experiences of lumbo-pelvic pain in the post-partum (Wadephul et al. 2021) and, thirdly, a qualitative study.

The theoretical review (Wadephul et al. 2020) used thematic synthesis (Thomas and Harden 2008) to synthesise theoretical discussions of perinatal well-being from seven academic papers. This review led to domains of life relevant to well-being (society and culture, community, immediate environment, individual) being identified. It is suggested that well-being is subjective and individual and is experienced physically, emotionally and psychologically, as well as is dynamic and fluctuating over time.

The second review (Wadephul et al. 2021) synthesised qualitative studies of women's experiences of lumbo-pelvic pain (non-specific lower back pain and pelvic girdle pain) to test and further refine the initial framework in the context of a real perinatal problem. Using framework synthesis (Carroll et al. 2011, 2013), data extracted from the qualitative studies were mapped against the framework; additional themes were noted, and themes and subthemes were developed. This review largely confirmed the original framework but led to some changes in the domains of life, including inclusion of a domain of *structures, policies and laws* (such as maternity leave and sick leave). The community and immediate environment domains were altered to a *relationships domain* to include a range of relationships (family, friends, colleagues, health professionals) with varying degrees of closeness and significance.

The final step in the development of the perinatal well-being framework drew on a qualitative study of women's and health professionals' experiences and understanding of well-being in the perinatal period (currently unpublished). Women's responses highlighted the often-challenging nature of the perinatal period, sense of immense responsibility for the baby's well-being, competing demands on women and close relationship between maternal well-being and baby's well-being. Becoming a mother also had a profound impact on women's sense of self and identity. Furthermore, women made efforts to maintain or regain well-being, and the importance of supportive relationships and past experiences was identified. Many of these findings were reflected by health professionals caring for women in the perinatal period, which characterised the period as a uniquely stressful and risky time. The health professionals emphasised the importance of sensitive support for women. Based on the findings of the qualitative study, we added a core element 'denoting the self' to the conceptual framework. We also added an element representing the often-overwhelming nature of motherhood: responsibility for the baby, competing demands on mothers' time, lack of time for oneself and profound changes to women's sense of identity and purpose (see below). Following Daly and colleagues (2022), we called this 'the magnitude of motherhood'. The proposed framework of PWB is shown in Fig. 1.

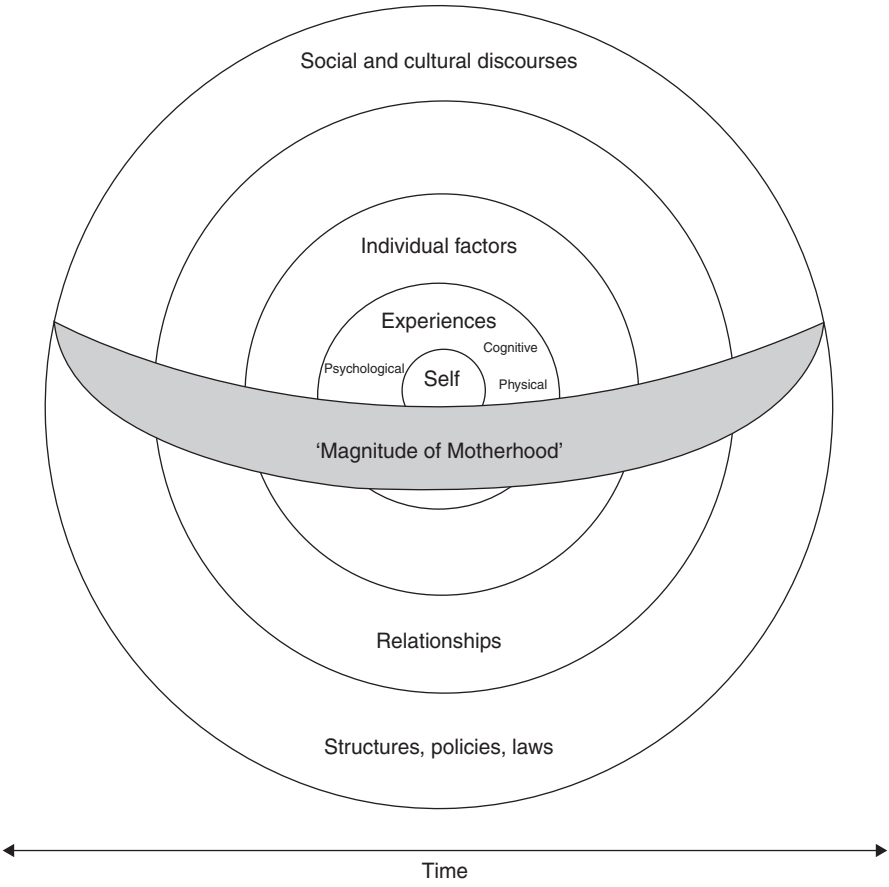

Fig. 1 Framework of perinatal well-being

5 The 'Magnitude of Motherhood'

Women's responses in the qualitative study conducted as part of the development of the framework illuminated aspects of well-being, which had not yet become apparent in the two preceding reviews. These include the impact of the transition to motherhood on women's self and sense of identity; often-overwhelming nature of this transition including women's longing, and need, for time for themselves without the infant; and the efforts women make to maintain or regain well-being.

The phrase 'magnitude of motherhood' was proposed by Daly and colleagues (2022) who used it to identify one of the themes developed in their qualitative study of maternity care experiences. It is reflected in women's narratives in our qualitative study; they talked about how overwhelming motherhood could be, particularly the responsibility for the baby's well-being. Several women used the phrase '*there is so much at stake*'. Consequently, the baby's well-being was usually their priority, while their own well-being was, as some women put it, at the '*bottom of the pile*'. In addition, women also talked about the responsibility for older children and other family members, which often conflicted with their own needs. It was clear from women's responses that many felt that they lacked quality time for themselves. This was often described as '*me time*'—a time just for themselves when they would not be interrupted and could focus on themselves.

Self-care was a core element of women's efforts to experience a sense of well-being. Yet, it seems illusive for many that the sense that women have of their responsibility for their baby's well-being often overrides their own capacity to engage in focused self-care, even though the two are intrinsically linked. Women's approaches to maintaining their well-being varied. What seemed important to all though was having time for themselves to facilitate well-being, but also a sense of wondering how that might be achieved.

Perinatal well-being reaches beyond the absence of pathological issues. Developing skills and using them require a sense of agency. Hurault and colleagues (2020) suggest that a sense of positive agency (SoPA) is about personal autonomy and responsibility for our actions, while a sense of negative agency (SoNA) is about fatalism and existential helplessness. The SoPA represents the level of control over the body, mind and environment felt by an individual. Conversely, the SoNA represents the lack of control over the body, mind and environment felt by an individual (Hurault et al. 2020). The potential for increasing a SoPA regarding self-care is worthy of more attention for practitioners working with pregnant and postnatal women, when evidence illustrates that mothers tend to ignore their universal self-care needs by prioritising their baby's needs (Lambermon et al. 2020).

The following studies describe one potential approach to effectively promote women's ability to engage in self-care and enhance well-being in the post-partum.

6 Two Studies on Using the Alexander Technique (AT) in the Post-partum

The Alexander Technique is a well-established approach based on becoming aware of maladaptive self-management habits and then modifying them by using skills learnt in lessons. It does not subscribe to exercises or treatment, but it is taught by qualified teachers. Stallibrass and colleagues (2005, p. 151) describe practically:

> *Pupils of the Alexander technique learn how to change their unconscious habitual responses to stimuli by applying a set of conscious strategies. They learn to consciously inhibit rushing into action (called inhibiting). They also learn how to consciously organise themselves prior to action and during action (called directing) so that movement is led by the head. In*

particular, they learn how to re-organise the balance of the head in relation to the rest of the body in order to lessen the effort needed to stay upright in gravity.

A study using interpretative phenomenological analysis explored how women with differing levels of experience of learning the AT used the method in the post-partum period (Hanefeld 2021). The results demonstrated that participants used a range of self-care strategies and 'Alexander skills' to consciously modify their self-management via awareness. Participants monitored their self-management consciously, and when they felt tension coming on, caused, for example, by inappropriate holding habits during carrying or feeding, they changed what they were doing. Using the AT led to a range of well-being benefits through a sense of agency regarding the participants' self-care (Hanefeld 2021). Taking time to apply the AT while lying in semi-supine to rest was important to their lives as was recognising maladaptive habits (Hanefeld et al. 2021). The latter finding is of interest as participants shared that although they had a maternal sense of duty which meant they sometimes struggled to prioritise for themselves, they also had the skills to be *aware* of such habits and then decide to consciously look after themselves.

The second study informed by the IPA recruited post-partum women with babies 4–10 months old, who were given access to an online self-care package based on the Alexander Technique. These women had had no prior practical experience of the method. The package included five online videos on the Alexander Technique (viewing time 35 min), written information and 'postural instructions' (Cohen et al. 2015) and an audio recording for lying 10–15 min in semi-supine to practise the Alexander Technique. Participants were asked to practise the AT in semi-supine ('constructive rest') 14 times, not necessarily on consecutive days. Women completed this practice over a span of time, and findings of the post-intervention survey indicated that the package positively impacted participants' self-care, changed their post-partum experience and had a positive effect on their well-being. Taking time for 'constructive rest' was surprisingly challenging for the participants, but the value of it was a finding that all participants shared having progressed with this practice. The change in well-being could be related to the mindful aspects which the AT initiates, and the change in the type of attention that then occurs which is broad, not focused. The marked difference to mainstream approaches for self-care is that the AT did not require women to *do* anything; they only had to create space and take time for themselves to lie in semi-supine and apply the principles of inhibition and direction. This seemed to enable the women to come more into contact with themselves and sense their needs; this was experienced in both studies by participants as leading to an increase in well-being.

7 The Alexander Technique as One Potential Solution

Taking Alexander Technique lessons promotes self-care and self-efficacy (Woodman et al. 2018), which women identify as important but difficult to achieve. Research in this area in perinatal women remains in its infancy, but the AT shows promise in

terms of its ability to support women's well-being in the post-partum. Empowerment through personal skills and a heightened sense of agency is a different approach to promoting well-being. That is not to diminish the value of other active interventions (Stuge et al. 2004) that have demonstrated efficacy, including a trial with results suggesting alleviation of pelvic girdle pain when utilising a multidimensional treatment concept. The intervention included training of global and local muscles, ergonomic advice, raising body awareness and, when indicated, massage, mobilisation and exercises (Stuge et al. 2004). On the practical, physical side of well-being and the lifeworld of post-partum women, the AT is significant because of its concern with an aligned, flexible and free neck and spine relationship. Women look down at their babies during many activities, and the potential for developing habitual forward head posture seems real along with the tension consequences and loss of physical well-being due to that habitual forward head posture. These AT benefits were articulated by participants in the studies outlined above. In addition, the broader evidence base also suggests the value of the AT in back and neck pain (Woodman et al. 2018; Wenham et al. 2018; Little et al. 2008; MacPherson et al. 2015), with the former being a common complaint in perinatal women. The AT appears to offer a path towards conscious self-care, which, when taken alongside evidence indicating that the AT improves posture and general well-being and increases confidence in the ability to address current and future challenges (Kinsey et al. 2021), feels persuasive of its benefits.

8 Role of Healthcare Professionals (HCPs)

The role of HCP in supporting *well-being* has not been widely researched. While there are studies looking at their role in the treatment of not just physical issues but also perinatal mental health problems (Noonan et al. 2017, 2018), there is little which addresses their role in supporting well-being as we have outlined it. Findings from our online survey of nine UK-based HCPs' views on well-being in the perinatal period (currently unpublished) enable us to also identify some of the barriers facing HCPs in this area. Our findings suggest that HCPs are very aware of the range of elements which contribute to women's well-being in the perinatal period; they identified factors influencing well-being including pressures on women from society and from their life circumstances whether that be relationship, financial or environmental. The HCP themes concorded quite strongly with women's own views from the women's survey, described above. In particular, HCPs were aware of women's own immediate context and the need for them to feel safe and secure (Charitou et al. 2019).

This survey requires care in making generalisations, due to small numbers; however, it seems significant that the HCPs who took part tended to characterise the perinatal period as risky, and their responses suggested a focus on seeking to reduce risk and to avoid harm rather than actively promoting well-being. This is understandable given that HCPs work within structures which tend to fragment women's experiences, with services being specialty based and focused on treating specific issues.

However, when identifying what would help women, the HCPs responded with a sense of considering the whole woman. In terms of the support which HCPs identified, the provision of good, accurate and trustworthy information was seen as extremely important. They highlighted the need for a firm foundation as the basis for well-being, with women having access to good information that allows them to approach the perinatal period and early parenthood with accurate knowledge and realistic expectations. Good communication, as often identified (Goodwin et al. 2018), was central with the need for women to be listened to, heard and responded to as individuals with a range of challenges and strengths and with individual needs. HCPs talked about the need for an individual, person-centred focus, ideally following the woman's lead and enacting her wishes, which has been demonstrated elsewhere to be central to women's feelings of control (Greenfield et al. 2019). Implicit in this is a need for flexibility in the system and for women to be able to trust professionals and services and ideally develop relationships with them; this is not necessarily the case.

HCPs also talked about the need for support across the perinatal period to come from wider networks including partner, family, friends as well as health professionals. However, there was a tendency for HCPs to focus on factors which negatively impact well-being rather than those which enhance it reflecting the risk management and damage limitation approach.

While HCP views in this survey align with the framework, professionals are hampered by time and by the structures and systems which are in place and under pressure in the UK and elsewhere (Wadephul et al. 2018). This situation has been made significantly worse by the coronavirus pandemic (Reingold et al. 2020; Sanders and Blaylock 2021). While there appears an understanding and a willingness amongst health professionals to provide support for women's well-being, a move towards a well-being-focused approach will need a major paradigm shift in both training and services, and we need to consider whether and how this might be possible.

9 Conclusion

Well-being is clearly of significance for perinatal women. Our work indicates that well-being requires a broader definition than has traditionally been the case; accepting the more holistic definition presented in this chapter requires us as midwives and HCPs caring for perinatal women to consider the implications for practice, what we can and cannot influence in the differing aspects of the well-being frame.

A key challenge is whether our current maternity service systems and processes enable us to promote a well-being-focused approach, or if it is a construct important to women themselves. A key focus of well-being appears to be the concept of self-care, which is something that can be supported and encouraged in our encounters with women throughout their maternity journeys. Women clearly highlight the importance of genuine understanding relationship, being listened to, feeling understood and empathy, approaches which are possible within any care encounter, as

found in previous studies (Lewis et al. 2017). As other authors point out, however, empathy is a complex variable and there remains a necessity to investigate the long-term effects of health professional empathy on patient satisfaction and clinical outcome (Charitou et al. 2019). Midwives and HCPs need to recognise how the current paradigm influences how they respond to women and how that might influence the way they both conceptualise but also address well-being in a clinical context. Many of the things that women want are core midwifery skills, which may just need a slightly different orientation.

Further, it is clear that there is potential in approaches which traditionally sit outside maternity service provision but that may enable women to develop skills and strategies to focus on their own well-being but more importantly give permission for women to focus on their own needs and make space for self-care. The AT is clearly one such intervention, amongst others (such as the approach by Stuge and colleagues (2004) as described above), which would benefit from future research.

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Midwifery and Perinatal Mental Health

Maria Noonan, Owen Doody, and Julie Jomeen

1 Introduction

Perinatal mental health conditions have a long history and have been recognised since the time of Hippocrates. However, interest in perinatal mental health accelerated in the nineteenth century with Marcé (1858) publishing a series of case studies of women with a variety of perinatal mental health conditions over 150 years ago (Marcé 1858). Since then, there has been a focus on prevalence, determinants of perinatal mental health and ill health, detection, consequences to the family unit and evidence-based treatment interventions. Internationally, perinatal mental health has become a significant focus of research, policy and practice development, and government agencies and professional groups have published guidelines to guide healthcare providers (Howard and Khalifeh 2020). In addition, there has been investment in and establishment of new specialist perinatal mental health services and availability of inpatient mother and baby units in some high-income countries (Howard and Khalifeh 2020). The ambition of healthcare services is to provide care in line with approved standards and guidelines such as that produced by the National Institute for Health and Care Excellence, in the UK (2014). The chapter explores how midwives are in a critical position to make a difference in potentially identifying women with perinatal mental health needs and connecting them to appropriate supports. Early intervention and treatment may reduce long-term effects of perinatal mental ill health on the women, their partners and notably their infant.

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2 Understanding Perinatal Mental Health

Pregnancy and parenting are generally a happy and exciting time and a positive and affirming experience; however, this is not the case for all and not every woman feels this way. For many women, the perinatal period is a time of great social, physiological and psychological transition and adaptation that can profoundly impact the woman's sense of identity and their perinatal mental health and well-being (Coates and Foureur 2019). A woman may have a variety of feelings about being pregnant. Some women may find it more challenging than others to optimally respond to the changes and uncertainties a pregnancy brings. Many factors can affect how a woman feels in pregnancy including physical symptoms, presence of a support network and stressful events. An understanding of the psychological context of the perinatal period supports midwives to appreciate the complexity of a woman's experience within a cultural context and facilitates a more informed consideration of her emotional and psychological needs (Jomeen 2017).

The classifications of perinatal mental conditions are complex, reflecting the debate as to whether these conditions are unique in terms of their causes and psychopathology, or the same as mental health conditions occurring at other times of a woman's life. Mental health concerns experienced in the perinatal period can be new-onset conditions or relapses, continuation or deterioration of preceding conditions in women who were well for a period of time. Perinatal depression and anxiety are the most common mental health conditions that frequently begin before or during pregnancy and represent a significant component of treatment need in the postnatal period (Howard and Khalifeh 2020). However, women can experience the spectrum of mental health including the less common and severe conditions such as obsessive compulsive disorder (OCD), post-partum or puerperal psychosis, bipolar disorder, psychosis and various eating disorders (Howard and Khalifeh 2020; Viveiros and Darling 2019). Fear of childbirth (FOC) in pregnancy and post-traumatic stress disorder (PTSD) are two less recognised perinatal mental health conditions. These conditions are particularly important to midwives because they directly affect women's perinatal experiences, develop mainly in response to a birth experience and impact women's birth preferences; both conditions are potentially preventable through the provision of appropriate midwifery and perinatal mental health care (Ayers 2014; O'Connell et al. 2021).

Fear of childbirth or tocophobia (tokophobia) or severe childbirth anxiety is defined as a profound unreasoned pathological fear of childbirth, which can be primary tocophobia that develops in adolescence, precedes conception and leads women to avoidance of pregnancy or natural childbirth (tokos: Greek for childbirth) or secondary tocophobia that occurs in multiparous women usually after a previous birth experience that is perceived to be distressing or traumatic by the woman and may influence a woman's avoidance of pregnancy and birth preferences (Hofberg and Brockington 2000; O'Connell et al. 2017). It is normal for pregnant women to feel some level of fear in response to the uncertain nature of childbirth (O'Connell et al. 2021), which may be protective, as women may seek help based on a response to fear (O'Connell et al. 2021; Jomeen et al. 2021).

However, fear exists on a continuum from low to severe, and an increasing number of women have sufficiently elevated levels of anxiety and fear, which may interfere with their ability to have a fulfilling childbirth experience (O'Connell et al. 2021; Jomeen et al. 2021). A lack of consistency over the way fear of childbirth or tocophobia is defined has been noted with both terms used interchangeably (Jomeen et al. 2021). The current discussion in the literature guides healthcare professionals to use the term 'tocophobia' with caution because of the limited understanding of the aetiology of tocophobia and the potential for the term to be interpreted negatively. Furthermore, in some circumstances, labelling women as 'tocophobic' may disempower women rather than offering support (O'Connell et al. 2021). An interrelationship between fear of childbirth and post-partum PTSD (PP-PTSD) is recognised as fear of childbirth can emerge in response to a previous traumatic birth experience (Ayers 2014). Recent research has focused on the importance of recognising and treating women with perinatal PTSD (Ayers 2014). PTSD diagnosed in pregnancy is mainly caused by non-obstetric events such as abuse or other trauma but may also be caused by witnessing a traumatic birth or watching a video on childbirth without adequate explanation. The majority of women experience PP-PTSD, which develops in response to a traumatic childbirth experience (Ayers 2014). This may occur after a birth without complications as reflected in the following definition where fear of childbirth is defined as 'the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but results in psychological distress of an enduring nature' (Greenfield et al. 2016, p. 265). Perinatal PTSD has a high comorbidity with depression (Howard et al. 2014). Being aware of the complexities of specific perinatal mental health conditions such as fear of childbirth and PTSD offers midwives an opportunity to respond with comprehensive emotional support (O'Connell et al. 2021).

3 Prevalence

Perinatal mental health problems are common being the most frequent complication of childbearing, with between 15% and 25% of women experiencing the spectrum of perinatal mental health conditions, most commonly depression and anxiety (Austin et al. 2017; Stein et al. 2014). Severe perinatal mental health conditions are rare with post-partum psychosis affecting around 1 in every 1000 women. Approximately 3.1–6.3% of women experience PP-PTSD, which rises to 15.7–18.9% among women with risk factors (Caparros-Gonzalez et al. 2021). A meta-analysis of severe fear of childbirth/tocophobia's global pooled prevalence rate was estimated to be 14% (O'Connell et al. 2017). Younger women (Howard and Khalifeh 2020) and women from socio-economically vulnerable groups, ethnic minorities, recent immigrants and refugees (Howard et al. 2014; Viveiros and Darling 2018) are identified as being at higher risk of experiencing perinatal mental health conditions.

4 Factors That May Influence a Woman's Perinatal Mental Well-Being

An understanding of the aetiology of perinatal mental health conditions can increase awareness of the profiles of vulnerable women (Jomeen 2017) and enable midwives to identify women and their partners that require further support (Jomeen 2017; O'Connell et al. 2021). Causes of psychological problems are multifactorial, are not specific to the perinatal period or specific conditions and include early adverse life experiences, such as trauma. The most common traumatic events which may impact a woman are childhood sexual, emotional or physical abuse; having a close friend or family member experience violence; and unexpected death or illness of someone close (Kendall-Tackett 2017). Women exposed to trauma were found to be up to four times more likely to experience antenatal depression (Kendall-Tackett 2017). Women with a history of depression, anxiety, PTSD, substance use and infertility, and those who have chronic diseases and medical illness, are at increased risk of developing perinatal mental health conditions (Howard et al. 2014). There is evidence for a reproductive subtype of depression, characterised by a particular sensitivity to changes in reproductive hormones and subsequent increased risk of postnatal depression (Howard et al. 2014). Perinatal mental health conditions are linked to low socio-economic status, poverty, birth in a foreign country, physical health and pregnancy complications, interpersonal violence, substance and alcohol use and other forms of disadvantage (Jomeen 2017; Howard et al. 2014). Poor relationships and lack of family and social support may lead to isolation and loneliness and are risk factors for mood disorders (Howard et al. 2014). Limited published research suggests that there may be a higher incidence of perinatal depression in lesbian women (Ross et al. 2007). While predisposing factors are similar across perinatal mental health conditions, they may vary depending on the disorder; for example, women who have a negative or traumatic birth experience are nearly five times more likely to report FOC in a subsequent pregnancy (O'Connell et al. 2017; Størksen et al. 2013). PP-PTSD usually develops in response to a birth experience a woman perceives as life threatening for her baby or herself, and other risk factors include an unplanned or emergency caesarean section, premature birth, unexpected complications such as prolapsed cord, vacuum/forceps birth, pre-eclampsia/eclampsia, baby with health complications, and admission of baby to neonatal intensive care unit or in response to an experience of stillbirth, miscarriage or termination of pregnancy. PP-PTSD has also been associated with women experiencing feelings of powerlessness, loss of control and autonomy, poor communication particularly around clinical interventions and/or lack of support and reassurance during labour and birth (Thomson et al. 2021; Patterson et al. 2019). Risk factors may emerge or pass during the perinatal period; therefore, a woman's perinatal mental health may change over time.

5 Perinatal Mental Health Consequences

In recent times, the active combination of biological, socio-environmental and psychological factors that affect the expression of illness/and health across the lifespan has come into focus. This focus acknowledges that levels of stress associated with perinatal mental health conditions may affect maternal and foetal outcomes and the long-term health of offspring into adulthood. Midwifery knowledge of the obstetric and neonatal outcomes of a maternal experience of perinatal mental health conditions may motivate midwives to identify women who require support and referral. The unique aspect of perinatal mental health conditions is their potential to affect the relationship between the mother and family unit. Women who continue to experience perinatal mental health concerns may be at increased risk of impaired maternal-infant bonding, relationship dissatisfaction, continued maternal psychological distress that extends beyond the perinatal period, and rarely maternal suicide and infanticide (Howard and Khalifeh 2020; Stein et al. 2014). Furthermore, women with severe mental illness are less likely to attend for antenatal care and are at increased risk of pre-eclampsia, antepartum and post-partum haemorrhage, placental abruption, preterm birth, foetal growth impairments and stillbirths regardless of pharmacotherapy suggesting causality beyond medication (Howard and Khalifeh 2020; Howard et al. 2014). In addition, women, particularly those with pre-existing severe mood conditions, are 22 times more likely to require inpatient treatment in a psychiatric unit in the month following birth than in the pre-pregnancy period (Howard and Khalifeh 2020). There is some evidence that physical symptoms of life-threatening complications are attributed to mental health conditions in women with for example anxiety disorders or psychosis (Howard and Khalifeh 2020) even though research recognises that these women are more likely to experience life-threatening complications (Howard and Khalifeh 2020). Suicide continues to be the leading cause of maternal death (Howard and Khalifeh 2020). Suicide risk is particularly related to perinatal depression and may occur in any trimester of pregnancy; however, it is most likely to occur in the second half of the first post-partum year, and women may not be receiving active treatment at the time of death (Howard and Khalifeh 2020). Social and cognitive developmental delays for the infant have been reported (Howard and Khalifeh 2020). Children at risk of poorer psychosocial and psychological outcomes are generally those whose mothers have a combination of psychiatric, psychosocial and physical concomitant conditions (Howard and Khalifeh 2020). Importantly, most children remain unaffected even if exposed to significant antenatal and postnatal severe maternal illness (Howard and Khalifeh 2020). Outcomes may be specific to mental health conditions where an experience of severe fear of childbirth and PTSD may influence the woman's pregnancy and birthing decisions, including requests for epidural analgesia and caesarean birth. Furthermore, severe fear of childbirth during pregnancy has been identified as a

significant risk factor for PP-PTSD symptoms 1 month after birth (Ayers 2014; O'Connell et al. 2017; Jomeen et al. 2021). However, the most significant impact for women may be the feeling that they somehow 'lost out' or were not able to fully engage with the experience of pregnancy, birth and parenting and the impact their perinatal mental ill health may have had on their child (Noonan et al. 2017). Howard and Khalifeh remind healthcare professionals of the importance of recognising the risk of 'blaming' women for the health of future generations when perinatal mental health conditions may have aetiology linked to the socio-environmental context and the onset of the condition signals a need for family- and system-level interventions (Howard and Khalifeh 2020).

6 Presentation of Perinatal Mental Health Conditions

No two women experience exactly the same symptoms of mental health conditions. Symptoms of depression include psychological and somatic symptoms (Howard et al. 2014). Somatic symptoms need to be carefully assessed as they are more common in women who experience depression and can result from normal physiological changes in pregnancy and early post-partum period (Howard et al. 2014). Anxiety conditions have different presentations; for example, women with OCD may experience ruminations of harm, which are not associated with actual harm and are distressing for the woman. Women may be reluctant to disclose ruminations, making it more difficult for healthcare professionals to distinguish obsessive ruminations from delusions (Howard et al. 2014). Women with fear of childbirth may report fears of being abandoned and alone, fears of harm to herself or to her baby and fears of not being able to cope with labour pain. Other signs characteristic of severe fear of childbirth include nightmares; psychosomatic symptoms; lack of concentration; recurring, aggravating and painful thoughts during the day or night, which make the woman feel tense, nervous or restless; and request a caesarean birth (O'Connell et al. 2021; Slade et al. 2019; Wigert et al. 2020). Symptoms of PP-PTSD include anxiety, panic attacks, agitation, sleep disturbances, nightmares, flashbacks, hypervigilance, fear, irritability, detachment, withdrawal from relationships and intrusive thoughts/images and avoidance of any reminders of the traumatising events (James 2015). A knowledge of symptoms of specific perinatal mental health conditions can support midwives to recognise women that require additional support with their mental health.

7 Assessment of Psychological Health

Midwives are uniquely positioned to engage in perinatal mental health and wellbeing conversations with women, their partners and family members; provide information on the symptoms of perinatal mental health conditions; assess the woman's psychological health; and to identify, support and refer women with perinatal mental health needs (Jomeen 2017; Viveiros and Darling 2019; Noonan et al. 2017,

2018). Despite the fact that midwives have frequent contact with women during the perinatal period, identification of women with perinatal mental health needs remains lower in pregnant than in non-pregnant populations (Jomeen 2017; Howard et al. 2014). Consideration needs to be given to how midwives communicate and interact with women as this may impact the disclosure of psychological distress and may have lasting consequences for the woman and her family (Jomeen 2017). The aim is to normalise conversations about mental health through creating an open and honest environment in which women feel comfortable talking about their mental health. Disclosure of perinatal mental health concerns is more likely to occur if the midwife's approach is non-judgemental and characterised by openness, sensitivity, compassion, kindness, encouragement and a willingness to listen.

Screening of women for current or potential mental health conditions to identify perinatal mental health needs and facilitate early access to care has become routine practice in maternity and community settings (National Institute for Health and Care Excellence 2014; Austin et al. 2017). International guidelines recommend depression and anxiety screening and psychosocial risk assessment (National Institute for Health and Care Excellence 2014; Austin et al. 2017). Midwives conduct routine screening of women for psychosocial vulnerabilities, depression and anxiety at the first booking-in visit and inquire about the woman's perinatal mental well-being at subsequent visits as women may not necessarily disclose their mental health needs immediately (Reilly et al. 2020). Identification and assessment of a woman's personal context, changes in interpersonal relationships and support structures can increase awareness of the profiles of vulnerable women. The objective of a midwife's assessment is to provide a holistic integrated woman-centred approach by placing perinatal mental well-being in the context of a woman's life circumstances (Jomeen 2017).

Psychosocial assessment, depression and anxiety screening tools such as the Whooley or Edinburgh Postnatal Depression Scale (EPDS) may support midwives to open the conversation and offer women the opportunity to have their concerns heard and validated and promote access to appropriate care (National Institute for Health and Care Excellence 2014; Austin et al. 2017; Viveiros and Darling 2018; Reilly et al. 2020). Furthermore, a knowledge of available screening tools and screening criteria may support midwives to recognise the symptoms of specific perinatal mental health conditions. Screening measures with high sensitivity and specificity should be acceptable to women and robustly evaluated (O'Connell et al. 2021). Screening tools give an indication that women may require further psychosocial and clinical assessment and support with their mental health and aid a diagnosis (O'Connell et al. 2021).

While routine screening for depression and anxiety is embedded in current practice in high-income countries, some conditions such as PP-PTSD continue to receive insufficient attention in maternity services with women who experience this condition rarely assessed and treated (Ayers et al. 2018). Furthermore, women may not realise that they are experiencing the symptoms of PP-PTSD due to being overwhelmed with the transition to motherhood or due to onset of symptoms after discharge from maternity services (Ayers 2014). Assessment tools are available for

conditions such as the use of the Wijma Delivery Expectancy Questionnaire (W-DEQ-A) (Wijma et al. 1998) to support the early identification of fear of childbirth and distinguish between manageable fear and fear that requires early interventions, which may reduce the negative impact of this fear (O'Connell et al. 2021; Wigert et al. 2020). The City Birth Trauma Scale (City-BiTS) (Ayers et al. 2018) has been developed to evaluate and diagnose PP-PTSD. However, O'Connell et al. caution against introducing yet another antenatal screening tool, which runs the risk of reducing screening to a 'tickbox' exercise, and suggest that a more general emotional health and well-being assessment may bring perinatal mental health concerns to the surface such as fear of childbirth that require further assessment (O'Connell et al. 2021). If PP-PTSD or FOC is suspected, the midwife may refer the woman to the specialist's perinatal mental health midwife, psychologist or consultant for diagnosis and treatment.

Psychosocial risk assessment, depression and anxiety questionnaires are computerised, incorporated into the electronic clinical information systems in some maternity units, and midwives have adapted assessment strategies in response to individual women's preferences to optimise engagement (Reilly et al. 2020). One of the risks with digital or paper-based questionnaires is that in the context of time-pressured environments, midwives will complete assessment as a 'checklist exercise', which may impede women's ability to engage with the midwife and act as a barrier to disclosure of her perinatal distress; therefore, screening tools should be used as a means of facilitating conversation and engagement with women as opposed to form-filling (Viveiros and Darling 2018).

Critically, to enable effective clinical decision-making, midwives need to have confidence to identify women who require support based on clinical judgement even when no risk is detected through the questionnaire assessment items alone as women may not disclose or be aware of predisposing factors or symptoms (Reilly et al. 2020). Furthermore, the way in which the midwife approaches the conversation is important as questions on psychosocial risk factors and perinatal mental health conditions are sensitive (Reilly et al. 2020). In addition, the midwife needs to be able to respond in an appropriate way, and there is evidence that midwives tailor their approach to build rapport and trust (Reilly et al. 2020; Rollans et al. 2013). Midwives also need to be aware of women who are the least likely to have their perinatal mental health needs met including women from vulnerable populations, for example refugee and asylum-seeking women (see chapter 'Migrants, Midwives, and the Transition to Parenthood') who may not divulge their perinatal mental health needs for a variety of reasons including fear that their baby will be taken from them and stigma. Furthermore, women are more likely to reveal their psychological distress in the context of a trusting relationship with a healthcare professional, which is more likely to occur in models of maternity care that support continuity of care (Coates and Foureur 2019; Sandall et al. 2016). However, the assumption around the view that women need to be seen frequently by the same midwife to optimise perinatal mental health disclosures has been challenged because in the absence of this model of care, there is a risk that midwives may not engage in

conversations around perinatal mental health until they perceive sufficient rapport or trust is established (Carroll et al. 2018).

Some authors have questioned the value of screening and referral by midwives suggesting that there is little evidence for improved outcomes (Coates and Foureur 2019; Matthey 2010) and caution against the potential for over-pathologising distressed but not clinically distressed women (Matthey 2010), which in turn can place additional burden on limited perinatal mental health services (Jomeen 2017; O'Connell et al. 2021). The importance of midwives being able to make the distinction between normative and pathological psychological adjustments to avoid over-medicalisation and potential stigmatisation of women has been acknowledged (Jomeen 2017).

8 Referral

Midwives can enhance access to perinatal mental health support through creating a safe space for women to disclose their psychological distress and having the knowledge to provide information on the mental health services available to support women. This process involves working with women to find out what they would like to happen and empowering them to take a course of action that meets their individual psychological needs. Organisations guiding healthcare professionals to inquire about perinatal mental health needs must ensure that appropriate referral pathways are available to practitioners (Noonan et al. 2017). Midwives also require a knowledge of other services that may be important in creating a support structure for this woman and her family; for example, migrant women may benefit from connections with migrant supports (Viveiros and Darling 2018).

Commonly reported barriers to implementing routine screening are the limited knowledge of and the variable availability of appropriate referral pathways (Viveiros and Darling 2019; Megnin-Viggars et al. 2015), with some maternity units having clearly defined pathways and specialist perinatal mental health services (Reilly et al. 2020) and others offering referral to non-perinatal or generic community mental health services. Ideally, women are referred to specialist's perinatal mental health services developed in response to arguments that generic mental health services are not appropriate to meet the needs of women in the perinatal period. The establishment of mother and baby units for women who require inpatient treatment in some countries has been well evaluated (Connellan et al. 2017).

Women may be reluctant to engage with mental health services for various reasons, including fear of mental health stigma and that her baby will be taken into care, personal values and beliefs around mental health services and a belief that pharmacological treatment is the only treatment option available (Viveiros and Darling 2018). Midwives can address these barriers in conversations with women. There is limited evidence that midwives may be reluctant to refer women to perinatal mental health services because they perceive that pharmacology treatment is the only treatment offered by these services. It is important therefore that midwives link

in with specialist or generic perinatal mental health services to gain understanding of the range of treatment options available for women.

Restrictive eligibility criteria for accessing perinatal mental services have been identified as a barrier to care provision (Viveiros and Darling 2018). On the other hand, the potential for over-referral of women to perinatal mental health services has also been flagged, which may have resource implications and increase anxiety for women incorrectly referred (Schmied et al. 2016). A follow-up process where midwives receive feedback on outcomes of referrals may support knowledge development and more appropriate referral practices. Multilevel strategies that address individual, organisational, sociocultural and structural-level barriers at different stages of the care pathway are required to improve access to perinatal mental health care (Smith et al. 2019).

Providing a surveillance style of support was identified as a factor that negatively impacted the appropriateness of services (Viveiros and Darling 2018). In addition, an important area to consider is the language a midwife uses when discussing perinatal mental health with women. The use of terms such as 'at risk' or 'high risk' can be unhelpful and anxiety provoking, and women may interpret such terms to mean that they are identified as a risk to their baby, and this can act as a barrier to help seeking. Terminology such as increased support needs may be more acceptable, and research needs to determine women's views on acceptable perinatal mental health terminology (Dolman et al. 2016).

Internationally, midwife perinatal mental health specialist's roles have been created to act as a primary resource for colleagues and women experiencing perinatal mental health needs to improve access to care. The appointment of midwife specialists has the potential to counter some of the barriers to access such as time constraints, limited referral pathways and lack of perinatal mental health knowledge and expertise. Furthermore, in the UK, 'social prescribers', who are link workers familiar with local population needs and services, are available to advise healthcare professionals, women and their support networks on the availability of local or online interventions relevant to a woman's perinatal mental health needs (Howard and Khalifeh 2020). One of the developments in the area of referral is the establishment of community perinatal mental health services, which is a model unique to the UK, and calls have been made for the establishment of a community-based equivalent of a mother-baby unit (Lever Taylor et al. 2021).

9 Interventions in Perinatal Mental Health

Midwives may be more likely to refer women to mental health services if they know that effective evidence-based treatment interventions are available. Evidence from systematic reviews confirms that psychological and psychosocial interventions for perinatal depression and anxiety are effective (Howard and Khalifeh 2020). Interventions may include and are not limited to cognitive behaviour therapy, interpersonal therapy, counselling, mindfulness, guided self-help, other

psychotherapies, community groups, physical exercise, peer support and parenting classes (Howard and Khalifeh 2020; Ayers et al. 2020).

Interventions have been developed based on an understanding of the specific perinatal mental health condition; for example, cognitive behavioural therapy, antenatal education, enhanced midwifery care and interventions during labour have been identified as effective treatment options in reducing fear of childbirth, regardless of the approach (Webb et al. 2021a). Eye movement desensitisation and reprocessing (EMDR) is used to treat PP-PTSD (Ayers 2014). In practice, women with perinatal mental health conditions may experience multiple comorbid problems and may need to be referred to separate services, such as smoking cessation, weight management and substance use services (Howard and Khalifeh 2020). Integrated interventions are identified as essential for holistic perinatal care; however, relatively few have been developed and evaluated (Howard and Khalifeh 2020). Calls have been made for a move away from offering women a single intervention in a 'one-size-fits-all' approach to the provision of a personalised approach based on the principles of women's choice and shared decision-making, which offers a variety of evidence-based, acceptable interventions, in a range of settings to reflect the extent and severity of symptoms and perinatal mental health needs women may experience (Howard and Khalifeh 2020; Ayers et al. 2020). This approach may be particularly important for women who do not normally access or respond to usual recommended care (Ayers et al. 2020). Flexible innovative designs are required to evaluate the outcomes of targeted personalised interventions (Ayers et al. 2020). Furthermore, women who experience perinatal mental health concerns are primarily supported by their partner/spouse, and calls have been made for more co-designed evidence-based interventions that include couples therapy and support for women's partners and family members where appropriate (Noonan et al. 2021).

Pharmacological treatment is an appropriate and acceptable option for some women. Current guidance reflects the need for individual risk-benefit analysis and informed and shared decision-making with regard to the use of psychotropic interventions in pregnancy (Howard and Khalifeh 2020). Preliminary evidence of efficacy of decision aids to support women's decision regarding the use of antidepressants in pregnancy has been published. Midwives need to be aware of the side effects of antenatal antidepressants to inform care provision (Howard and Khalifeh 2020).

While the main role of the midwife is to refer women to the appropriate perinatal mental health professionals, calls have been made for midwives to provide perinatal mental health interventions. Midwives are well placed to provide interventions, and positive outcomes have been reported for the effectiveness of midwife-led counselling interventions primarily in relation to interventions for women with fear of childbirth rather than a diagnosed mental health condition (Coates and Foureur 2019). Evidence is inconclusive for midwife-led debriefing to reduce PTSD symptoms (Howard et al. 2014). Ongoing research is required to establish the efficacy of midwife-led interventions for women with perinatal mental health conditions (Coates and Foureur 2019). Finally, current discourse recognises that perinatal mental health is influenced by external conditions such as financial and housing

stability, and interventions that target social factors are required to impact long-term mental health outcomes (Lucas et al. 2019).

10 Education of Midwives

Training and education can prepare midwives to identify women who have perinatal mental health needs (Noonan et al. 2018). Evidence suggests that while midwives are interested in providing mental health support, some lack the confidence, competence and training to optimise their role in perinatal mental healthcare provision (Coates and Foureur 2019; Noonan et al. 2017, 2018). There is often a disproportionate focus on depression in midwifery curricula to the exclusion of less common and more severe perinatal mental health conditions, which has implications for midwives' ability to promptly detect and facilitate treatment of other specific conditions in order to prevent adverse outcomes (Viveiros and Darling 2018). Furthermore, a lack of knowledge of severe mental health conditions, e.g. personality disorders, can create fear and avoidance behaviour among midwives. The need for a validated, specialised and recognised training programme to prepare healthcare professionals to care for woman after a traumatic birth has been identified (Thomson et al. 2021). In addition, education is required to prepare midwives to meet the specific perinatal mental health needs of lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning (LGBTIQ) families (Ross et al. 2007) (see chapter 'Diversity of Family Formation: LGBTQ+ Parents'). A midwife's individual life experiences, psychology and sociocultural influences may shape personal beliefs about mental health, which can potentially create tensions in practice (Jomeen 2017). The development of self-awareness and sensitivity to those influences in education programmes are essential to ensure that midwives provide truly non-judgemental, woman-centred care (Jomeen 2017; Noonan et al. 2018). A component that explores how healthcare professionals can care for their own mental health and optimise resilience has also been suggested, which could in turn increase midwives' knowledge and skills to support women's mental well-being. Access to regular education and training integrated into pre- and post-registration training with service user input and facilitated through a variety of strategies including clinical supervision has the potential to effect higher knowledge and confidence levels and more positive attitudes towards mental health (Coates and Foureur 2019; Viveiros and Darling 2018; Noonan et al. 2017). Confidence in the area of perinatal mental health will be influenced not just by training but also workplace culture, practice, availability of referral pathways and a midwife's experience (Reilly et al. 2020).

11 Partners' Perinatal Mental Health

Recently, the perinatal mental health of the woman's partner has gained greater attention as a couple's mental health is interrelated and family health depends on optimising the woman and her partner's mental well-being. International reviews

suggest that up to 10% of male partners may experience depression and anxiety. There is limited research documenting an increased risk of postnatal depression for lesbian co-mothers (Ross et al. 2007). There is also growing evidence on the adverse impact of untreated paternal mental health conditions on the woman's perinatal mental health and its association with adverse child development, particularly when children are exposed to a combination of parental mental ill health (Howard and Khalifeh 2020). A father's experience of severe fear of childbirth may impact their engagement with the pregnancy and influence the woman's birth decisions (Moran et al. 2021), while calls have been made for a family-centred approach to respond to PP-PTSD in acknowledgement that trauma can be transmitted within the family system (Ayers 2014). Furthermore, partners and family may act as both a support and barrier for women accessing perinatal mental health support. The role of midwives in responding to paternal perinatal mental health needs requires further exploration and development coupled with training.

12 The Midwives' Role in Prevention

Midwives have a central role in optimising perinatal mental well-being through maximising every perinatal encounter with the woman and her family to provide education and information on the strategies that women can integrate into their lives to optimise perinatal mental health, e.g. physical exercise, dietary changes, relaxation techniques, mindfulness, meditation and hypnobirthing. Midwives have opportunities throughout the perinatal period to raise awareness of the spectrum of perinatal mental health, thereby creating a context in which women might recognise symptoms and seek timely treatment (O'Connell et al. 2021). The need to provide further information to raise awareness of specific conditions, e.g. PP-PTSD symptomatology, to encourage help seeking has been identified (Thomson et al. 2021). Midwives also have a role in dispelling myths and normalising conversations around mental health and opening a conversation about specific conditions; for example, fear and childbirth, and this may be enough to prevent anxiety and rumination for some women (O'Connell et al. 2021).

Furthermore, midwives have a key role in optimising the quality of women's experiences across the perinatal period and hence can be central to women's perinatal mental well-being (Jomeen 2017). Women who have experienced trauma are at risk for being re-traumatised in maternity settings, which is why midwives must be particularly mindful of their needs (Kendall-Tackett 2017). Preparing women and their partners to have realistic expectations around birth is one aspect of a midwife's role as an incongruity between birth expectations and actual experiences may increase the risk of the woman developing PP-PTSD (Webb et al. 2021b). A woman's right to give birth in a clinically and psychologically safe environment and to receive respectful and dignified perinatal care is internationally accepted best practice (O'Connell et al. 2021). The provision of sensitive care that acknowledges the woman's preferences through open and clear communication from the onset of perinatal care and encourages the woman to be involved in informed shared

decision-making from an approach which views the woman as equal may optimise her perinatal care experiences (O'Connell et al. 2021; Webb et al. 2021c). Furthermore, there is evidence that healthcare professionals can improve and shape the woman's birth experience, buffer against adverse events and reduce or prevent fear of childbirth and PP-PTSD. This can be achieved through optimising the birth environment, responding with appropriate high-quality midwifery care and positive interactions that value clear and open communication particularly around interventions and listening to women and their partners' needs throughout the continuum of pregnancy, birth and post-partum (Ayers 2014; O'Connell et al. 2021; Webb et al. 2021b). To achieve this goal, maternity organisations are called on to 'create a midwife-centred system' to enable and support midwives to optimise care provider interaction within a relationship-based care model (Patterson et al. 2019).

13 Conclusion

A midwife's role in perinatal mental health spans prevention and optimising a woman's perinatal mental well-being, educating the woman and her family on the spectrum of symptoms, undertaking psychosocial assessment and screening at booking and subsequent visits, and referring women to perinatal mental health services and supports. Midwives need to seek out all education and training opportunities to prepare for this role, liaise with available mental health services to understand the range of treatments available to women and develop a knowledge of the network of supports available to meet women's individual needs. Further research is required to explore the role of midwives in providing perinatal mental health interventions.

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Infertility, Repeated Loss, and Surrogacy

Andee Agius and Jean Calleja-Agius

1 Introduction

Recurrent miscarriage and infertility are two common major problems that healthcare professionals working in the field of women's health need to face on a routine basis. There is a lot of overlap with miscarriage and fertility in terms of the holistic management of patients (Kuroda et al. 2018; Wyrwoll et al. 2021).

Whether having a baby is a right or not has been hotly debated, especially in the light of the advances which have been made in recent years in the field of assisted reproductive technology (Stirrat 2005). However, midwives together with all healthcare professionals who work closely with women experiencing infertility and/or recurrent miscarriage, should be aware of risk factors, types of investigations, evidence-based treatments, psychological sequelae, and impact on relationships (Wilson and Leese 2013). Midwives therefore have a potential role as advocates and points of referral for patients who are caught up in these very distressing and challenging clinical situations (Keitel et al. 2021).

This chapter gives an overview of recurrent miscarriage and infertility, together with one of the most controversial forms of assisted reproduction: surrogacy.

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2 Recurrent Miscarriage

2.1 Definition

Pregnancy loss is defined as the spontaneous demise of a pregnancy that has been confirmed by at least two positive β-hCGs in the serum or urine (Kolte et al. 2015).

There is a lack of consensus on the definition of recurrent pregnancy loss, ranging from two clinical miscarriages, not necessarily consecutive (American Society for Reproductive Medicine 2013), to three consecutive pregnancy losses (not necessarily intrauterine) (Jauniaux et al. 2006). This lack of consensus on the definition of recurrent miscarriage is one of the main contributors as well as consequence of limited evidence related to the management of recurrent miscarriage (Kolte et al. 2015).

2.2 Prevalence

Worldwide, 23 million miscarriages occur every year. Of all recognised pregnancies, the risk of miscarriage is 15.3% (95% CI 12.5–18.7%) (Quenby et al. 2021). There is a population prevalence of 10.8% (10.3–11.4%) among women who have had one miscarriage, 1.9% (1.8–2.1%) with two miscarriages, and 0.7% (0.5–0.8%) having suffered from three or more miscarriages (Quenby et al. 2021). Recurrent miscarriage affects around 1–2% of couples trying to conceive (Ravneet 2020).

2.3 Risk Factors

Risk factors for miscarriage include age (female younger than 20 years and older than 35 years, males older than 40 years), extremes of body mass index, Black ethnicity, and lifestyle factors such as stress, smoking, alcohol, air pollution, and exposure to pesticides (Quenby et al. 2021). Uterine malformations, infections, metabolic disorders, endocrine factors, and genetic factors have also been implicated as causative factors of recurrent miscarriage (Ravneet 2020). The balance between coagulation and fibrinolysis is essential for a successful pregnancy, and thrombophilia, whether congenital or acquired, is associated with recurrent miscarriage (Fang et al. 2021).

The establishment of a successful pregnancy depends upon implantation, which is a complex process involving interactions between the blastocyst and the receptive endometrium. Embryos are estimated to account for one-third of all implantation failures, while the other two-thirds are caused by suboptimal endometrial receptivity and altered embryo-endometrial crosstalk (Craciunas et al. 2019). In recurrent miscarriages, a chromosomal error in the embryo is responsible for 50–60% (Tur-Torres et al. 2008). However, it can be very frustrating for both clinicians and patients, especially because in up to 50% of women, no clear underlying pathology is found despite intensive workup (Ravneet 2020).

2.4 Long-Term Effects

Miscarriage comes at a high cost, affecting individuals, healthcare systems, and society in general. There are both physical and psychological consequences of miscarriage, including bleeding, infection, risk of anxiety, depression, post-traumatic stress disorder, and even suicide (Quenby et al. 2021; Coomarasamy et al. 2021).

Recurrent miscarriage is also an important risk factor for obstetric complications, such as fetal growth restriction, placental abruption, preterm birth, and stillbirth in future pregnancies. In addition, recurrent miscarriage is a predictor of cardiovascular disease and venous thromboembolism in the long term (Quenby et al. 2021).

2.5 Investigations

Many investigations and treatments are offered to women with recurrent miscarriage, but the majority have not been well studied (Kolte et al. 2015). The essential investigations which need to be carried out on women suffering from recurrent miscarriage include a transvaginal pelvic ultrasound scan and measurement of lupus anticoagulant, anticardiolipin antibodies, and thyroid function (Coomarasamy et al. 2021). A transvaginal ultrasound is important to reveal any uterine malformation, whether congenital (e.g. uterine septum) or not (e.g. submucosal fibroids). Antiphospholipid syndrome is an autoimmune systemic disorder where the patient has persistent antiphospholipid antibodies including the lupus anticoagulant, or moderate-high-titre anticardiolipin, or anti-β2-glycoprotein I antibodies. This condition is commoner in women and is characterised by arterial, venous, or capillary thrombosis and/or recurrent early pregnancy loss, fetal loss, or pregnancy morbidity such as pre-eclampsia and intrauterine growth restriction (Sammaritano 2020). Women with recurrent miscarriage should be screened and treated for overt thyroid disease (Dong et al. 2020; Amrane and McConnell 2019).

Numerous endometrial receptivity markers have been associated with clinical pregnancy. These include endometrial thickness, Doppler indices, endometrial pattern, endometrial wave-like activity, and various molecules such as cytokines, angiogenic mediators, and hormones (Craciunas et al. 2019). Investigations into the genetic and epigenetic polymorphisms related to maternal immune response and inflammatory mediators have shown a significant relationship between recurrent miscarriage and immune mechanisms. Thus, unknown causes in unexplained recurrent miscarriage (which account for up to 40% of cases of recurrent miscarriage) could be due to an immune imbalance brought about by T-helper Th1/Th2/Th17 cytokines and regulatory T cells (Tur-Torres et al. 2008). While most healthcare settings treat miscarriage as a problem of subfertility in gynaecological and assisted reproduction units, it has also been shown that recurrent miscarriage occurs in super-fertile women. In this case, it has been shown that the endometrium is unable to perform its natural 'quality control' in selecting which embryos manage to implant and allows the implantation of embryos with aneuploidy (Salker et al. 2010).

In a study where UK-based clinicians' views of managing women with first-trimester recurrent miscarriage were evaluated, the majority of clinicians screened

women for antiphospholipid antibodies, conducted karyotyping for subsequent miscarriages, and carried out a pelvic ultrasound (Manning et al. 2021). Other routine investigations included inherited thrombophilia, thyroid function tests, diabetes mellitus screening, parental karyotyping, androgen profile, vitamin D, 3D ultrasound, hysteroscopy, hysterosalpingogram, and peripheral and uterine natural killer cells. This highlights the considerable deviation from current international treatment guidelines (Bender Atik et al. 2018; Vomstein et al. 2021).

2.6 Treatment

Progesterone deficiency is associated with recurrent miscarriage. The key treatments to consider include first-trimester progesterone administration, in particular vaginal micronised progesterone (Devall and Coomarasamy 2020). The benefits of the application of first-trimester vaginal micronised progesterone at a dose of 400 mg twice daily have been confirmed in two large, high-quality, multicentre placebo-controlled trials: the PROMISE [PROgesterone in recurrent MIScarriagE] trial, targeting women with unexplained recurrent miscarriages, and the PRISM [PRogesterone In Spontaneous Miscarriage] trial, targeting women with early-pregnancy bleeding (Coomarasamy et al. 2020). Other important treatments are levothyroxine in women with subclinical hypothyroidism, and, in women with antiphospholipid antibodies, the combination of aspirin and heparin (Coomarasamy et al. 2021; Shields et al. 2020). Interestingly, the combination of aspirin with metformin can enrich the vaginal microbiome by enhancing the *Lactobacillus*. This is beneficial, especially since an altered vaginal microbiome with reduced beneficial flora such as *Lactobacillus* has been shown to be linked with recurrent miscarriage (Fan et al. 2020; Jiao et al. 2021).

A promising treatment option for recurrent miscarriage is investigating immune checkpoints on T-lymphocytes, which are molecules that regulate the function of immune cells and control inflammation processes (Keller et al. 2020). 'Decidualisation scoring' measuring differential expression of six factors associated with decidualisation, tissue homeostasis, and immune regulation, FOXO1, GZMB, IL15, SCNN1A, SGK1, and SLC2A1, was shown to determine whether the endometrium is implantation-friendly. However, more evidence is required for them to be included in the clinical setting to determine a particular patient population, who would benefit from therapeutic actions to improve endometrial conditions, especially prior to the in vitro fertilisation procedure in patients with recurrent IVF failures, particularly in cases of recurrent implantation failure of top-grade embryos (Dambaeva et al. 2021).

2.7 Overall Management

Women with a history of recurrent miscarriage should receive care in preconception and obstetric clinics specialising in high-risk patients in view of the increased risk of preterm birth, fetal growth restriction, and stillbirth.

The management of recurrent miscarriage would be expected to be cause specific. However, since in the majority of the cases no cause is identified, and the factors associated with recurrent miscarriage may not be causally related with the condition, this can lead to a lot of frustration and even despair among patients. Due to the high incidence of psychological morbidity following pregnancy loss, there needs to be effective screening and treatment options for mental health consequences (Elsharkawy et al. 2021). Self-reported emotional distress has not been shown to affect future chances of having a live birth, but certainly, a live-born child decreases emotional distress (Kolte et al. 2019).

It is recommended that a graded model is used within healthcare services where, according to clinical needs, women are offered online healthcare advice and support, care in a nurse or midwifery-led clinic, or care in a medical consultant-led clinic (Coomarasamy et al. 2021). Midwives are particularly well placed in directing couples towards coping interventions, which target reappraisal of the stress involved around the waiting period. Positive reappraisal is a cognitive strategy which could help women to cope as they brace themselves and wait 'for the worst', as a subsequent pregnancy is confirmed as ongoing (Ockhuijsen et al. 2013). As part of a multidisciplinary team, midwives can be involved in tailoring coping interventions to women who are undergoing recurrent miscarriage or are expecting news in a subsequent pregnancy.

3 Infertility

3.1 Definition

Infertility is defined as 'a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse' (WHO 2020). Up to 15% of couples have difficulties in conception, and the rate appears to be on the increase. Investigation of female factors leading to infertility has traditionally been the starting point for the infertility workup. Women are more likely to seek earlier medical attention regarding their reproductive health (Chu et al. 2019). While ovulatory defects and unexplained causes affect >50% of infertile couples, male factor is estimated to play a role in 50% of cases, being the sole contributor in 20% (Talmor and Dunphy 2015; Agarwal et al. 2021).

It is crucial to ensure appropriate investigations and possible treatment of both partners in order to exclude potentially reversible causes of infertility and thus improve the chances of natural fecundity (Talmor and Dunphy 2015). While significant medical advances have taken place since the birth of Louise Brown in 1978 following in vitro fertilisation (IVF), the cost of assisted reproductive technology (ART) is high, both financially and psychologically (Bahadur et al. 2020). Therefore, health literacy related to reproductive issues and identification of reversible causes of infertility should be the starting point when managing an infertile couple (Kilfoyle et al. 2016).

3.2 Causes of Infertility

In general, causes of infertility can be divided into issues related to the hypothalamic-pituitary-gonadal axis, structural issues, and external factors. However, in up to 20% of cases, the cause of infertility is unexplained.

3.3 Female Factor Infertility

Ovulatory dysfunction, especially anovulation, is characterised by a disturbed frequency and duration of the menstrual cycle. Instead of having the typical menstrual cycle every 21–35 days, some women have primary amenorrhoea (never menstruate), some have secondary amenorrhoea (can menstruate but have prolonged episodes of >6 months without a period), or others have oligomenorrhoea (an irregular menstrual cycle).

Primary amenorrhoea can result from failure of normal gonadal development, which can be idiopathic or associated genetic conditions such as Turner syndrome (45, XO karyotype), or hypothalamic problems secondary to a spectrum of disorders (such as chronic disease such as coeliac disease, extremes of body weight including anorexia nervosa). Structural anatomical conditions can also lead to primary amenorrhoea. These include imperforate hymen and complete absence of the reproductive organs due to the lack of normal gonadal development, such as in testicular feminisation syndrome (Farquhar et al. 2019).

Secondary amenorrhoea and oligomenorrhoea can be caused by endocrine disorders involving the hypothalamus, pituitary gland, and ovary, as well as the thyroid and adrenal glands.

The most common cause of anovulation in women of reproductive age is polycystic ovary syndrome (PCOS). Women with PCOS have an increased frequency of pulsatile release of GnRH from the hypothalamus, leading to an increase in the LH/FSH ratio, which raises the androgen levels, disrupting follicle maturation and causing anovulation (Witchel et al. 2020). Although women with PCOS have high rates of subfertility compared with women without PCOS, the majority do usually conceive following lifestyle interventions such as weight loss following physical exercise and healthy diet, and even those who do eventually need fertility treatment tend to overall have a higher take-home baby rate compared to other causes of infertility (Hoeger et al. 2021).

Advanced maternal age is associated with a reduction in ovarian reserve and increased risk of lower quality oocytes (Bernstein and Treff 2021). Decreased ovarian reserve may even occur earlier in life, leading to primary ovarian insufficiency (POI), premature ovarian failure (POF), and therefore premature menopause. Causes of POF and POI include a low initial number of ovarian follicles during development, which can be idiopathic or genetic (for example, Turner syndrome or Fragile X syndrome) or can be caused by cytotoxic therapies including chemotherapy and/or radiotherapy (Lew 2019). Serum levels of anti-Müllerian hormone (AMH), which is produced by the granulosa cells of follicles growing in the ovary,

are currently one of the main biomarkers for ovarian reserve (Moolhuijsen and Visser 2020).

Pituitary prolactinomas can inhibit gonadotropin-releasing hormone (GnRH) secretion and production of gonadotropins (follicular stimulating hormone and luteinising hormone), leading to suppression of ovulation. Sheehan syndrome can occur following massive post-partum haemorrhage, leading to anterior pituitary failure and hypopituitarism, with low levels of gonadotrophins and prolactin. Women with ovarian and unexplained causes of infertility tend to have a higher prevalence of thyroid autoimmunity (Poppe 2021). Any deranged thyroid function also needs to be corrected; otherwise, this can have implications on fertility outcomes and fetal development (Dosiou 2020).

Abnormalities of the fallopian tubes range in severity from scarring and mild adhesions to complete blockage or even complete absence. Tubal blockage including hydrosalpinx (distal end blocked and proximally filled with fluid) can be caused by sexually transmitted diseases such as chlamydia and gonorrhoea; endometriosis; peritoneal infections; previous surgeries; and, rarely, genetic defects. Hysteroscopy and tubal reconstructive surgery play a role in the management of infertility; very often in such cases, women need to resort to IVF (Vitale et al. 2021; Norris et al. 2020).

Endometriosis is a common condition in which endometrial tissue, the lining of the uterine cavity, is aberrantly located outside the uterus and deposited in the fallopian tubes, ovaries, and anywhere in the peritoneal cavity, with the risk of causing adhesions, leading to distorted and abnormal anatomy (Filip et al. 2020).

Uterine abnormalities can also lead to infertility. Examples include submucosal uterine fibroids, polyps, adenomyosis, as well as congenital malformations. Defects in the development of the Müllerian ducts, which form the fallopian tubes, uterus, cervix, and part of the vagina, can lead to infertility and/or recurrent pregnancy loss, but, depending on the type of defect, some women can be completely asymptomatic and have normal pregnancies. Such defects include unicornuate uterus (only half of the uterus with a single fallopian tube is present), a bicornuate uterus (an indentation in the fundus of the uterus, leading to an approximately heart-shaped uterus), or a septate uterus (the uterine cavity is partly partitioned by a longitudinal septum). Other uterine abnormalities can be acquired either through prenatal exposure to diethylstilbestrol or following intrauterine surgery leading to adhesions (Asherman syndrome), thus reducing the likelihood of implantation (Farquhar et al. 2019).

3.4 Male Factor Infertility

Male infertility affects approximately 7% of the male population. Causes of male infertility include congenital, acquired, or idiopathic factors that negatively impair spermatogenesis. Key male lifestyle factors, especially obesity, heat, and tobacco smoking, have an adverse effect on fertility. A history of cancer and related treatments in the male impact the reproductive health options (Barratt et al. 2017). It is important that all infertile men undergo a thorough evaluation especially to identify

treatable or reversible lifestyle factors or medical conditions, which can also be impacting the overall health of the individual.

Semen analysis is the cornerstone for evaluating male infertility. According to the WHO criteria, the sperm count needs to exceed 15 million/mL, with a progressive motility of more than 32% and a normal sperm morphology of more than 4% (Barratt et al. 2017). Advanced diagnostic tests, including genetic testing, have been developed to investigate sperm quality and function (Krausz and Riera-Escamilla 2018). Genetic screening is especially important not only for its diagnostic value, but also for appropriate genetic counselling. Anomalies in sex chromosomes and autosome-linked gene mutations have major roles in severe azoospermia and other types of spermatogenic impairment (Krausz and Riera-Escamilla 2018).

3.5 Management of Infertility

The clinical and diagnostic approach for the male and female partners of an infertile couple needs to be individually tailored. The rationale is based on the history and physical examination followed by initial investigations and procedures using a gradual step-by-step approach to both partners. The aim is to obtain a precise diagnosis in order to choose the most effective therapeutic option, thus reducing invasive and occasionally redundant procedures (Garolla et al. 2021). Treatment of infertility does depend on the underlying cause, unless it is unexplained. However, if this cannot be corrected or improved through the use of fertility medication, assisted reproductive technologies (ART) including intrauterine insemination or in vitro fertilisation (IVF) with/without intracytoplasmic sperm injection (ICSI) can be offered. Depending on the legislation of the country and the licences of the ART laboratories involved, it is also possible to use donor gametes and embryos in couples (hetero- and/or homosexual) and even single women (Association of Women's Health, Obstetric and Neonatal Nurses 2021).

Infertile women undergoing assisted reproduction tend to be at increased risk of having a miscarriage compared with women with a spontaneous conception, especially in older age (Podzolkova et al. 2020). Infertility, same as recurrent miscarriage, has a negative impact on the sexuality of individuals involved. Since lower sexual satisfaction and dysfunctions are closely associated with reproductive issues and their treatment, couples do benefit from psychological and sexual therapy during the treatment process (Starc et al. 2019). This is especially important because, given the vulnerable situation that they find themselves in when trying to achieve a pregnancy, patients with infertility, like those suffering from recurrent miscarriage, need to be guided professionally and compassionately throughout their care pathways whether in their country of residence or when accessing cross-border care (Lasheras et al. 2020). This particularly applies when seeking treatments such as surrogacy.

4 Surrogacy

An increase in the global prevalence of infertility has led to searches of alternative reproductive techniques, one of which is surrogacy (Patel et al. 2018). Despite the fact that in various countries surrogacy is often not seen as a publicly popular choice to overcome involuntary childlessness, it is now recognised as a possible treatment choice. Surrogacy encompasses multifaceted issues including social, ethical, moral, and legal implications (Piersanti et al. 2021). Indeed, it is considered as a highly debatable procedure in the domain of assisted reproduction.

4.1 Definition

The term 'surrogate' emerges from the Latin word 'subrogare' (to substitute). In other words, it entails appointing someone to act on one's behalf. In this context, the surrogate mother is the woman who agrees to be impregnated and carries the child in utero with the intention that when she delivers, the child will be taken care of by the 'intended' or 'commissioning' parents (Crockin et al. 2020).

Gestational (host/full) and genetic (traditional/partial/straight) surrogacy are the two types of surrogacies. In the former, the intended couple utilise their gametes and the genetically linked embryo is transferred into the uterus of the surrogate mother via in vitro fertilisation. In genetic surrogacy, the embryo is genetically related to the intended father and the surrogate mother (Crockin et al. 2020). Surrogacy may be altruistic or commercial. This depends on whether the surrogate mother is paid for carrying the child or on whether she does it without any remuneration beyond the pregnancy-related costs (Piersanti et al. 2021).

4.2 Social, Legal, and Ethical Implications

One of the ethical issues concerning commercial surrogacy is the danger of taking advantage of deprived women, contrasted with the possibility of providing women with the prospect of becoming mothers when they are unable to conceive themselves. The risk of exploitation of women is increased in the case of transnational surrogacy, where women from impoverished countries resort to surrogacy to run away from poverty and often end up mistreated due to absence of regulations in such nations, making commercial surrogacy a form of slavery (Zervogianni 2019). Hence, legal contracts and agreements between the surrogate mother and the intended parents are paramount to safeguard both parties and the welfare of the unborn child (Klock and Lindheim 2020). When such agreements take place, documentation should clearly indicate what will happen in cases when the intended couple separate or divorce one another and in cases of unexpected outcomes in the child, for example, a baby born with disability or unexpected sex (Deonandan 2020).

4.3 Indications and Risks Associated with Surrogacy

The absence of a uterus (either congenital or acquired) and women with serious medical conditions (cardiovascular and/or renal disease) are among the indications for surrogacy. Moreover, women who had repeated failed implantations and recurrent pregnancy loss are also amid the candidates where surrogacy may be a plausible solution. Another indication for surrogacy is same-sex couples or single men where biological pregnancy is not a viable option (Kim 2017).

Obstetric risks in the surrogate mother are overall similar to those experienced by women who become pregnant naturally (Klock and Lindheim 2020). However, obstetric outcomes for surrogate mothers have been reported mostly from case series, and more research in this area is needed.

4.4 Psychological Implications on the Surrogate Mother, the Infertile Couple, and the Child

Surrogate mothers are exposed to more psychological distress, especially after having to give away their child (Söderström-Anttila et al. 2016). Although it has been shown that emotional trauma was found to decrease in the weeks following childbirth, surrogate mothers are at increased risk of facing negative experiences (Tehran et al. 2014). Therefore, surrogacy pregnancy should be considered as high-risk emotional experience. Trained mental health professionals need to provide professional counselling to new surrogates for the potential challenges along the surrogacy pathway, prior to, during, and even following pregnancy, whether conducive to a live birth or not.

In contrast to donor egg techniques where the intended parents have no relationship with the donor, in surrogacy practice, the intended parents and surrogate mother have a dynamic rapport. As a result, some studies sought to explore the experiences and psychosocial implications of the surrogate mother both during and after giving birth (Riddle 2020).

It has been reported that in general, surrogate mothers view the journey of surrogacy as a positive one including feelings of self-worth (Yee et al. 2020; Jadva et al. 2015). A study by Teman (2008) revealed that the participants' the main reason for embarking on the surrogacy journey was to help other childless couples. It is noteworthy that most women who decided to carry out surrogacy had their own family (Teman 2008). Pizitz et al. (2013) in their study on the psychological and personal characteristics of surrogate mothers outlined that to embark on surrogacy, the individual needs to have a robust sense of fortitude and the capacity to avoid emotional connection from the unborn child. Furthermore, Teman (2008) maintained that the majority surrogate mothers did not form ties with the child and most gave the child to the intended parent without any hesitation. In a prospective longitudinal study, Jadva et al. (2015) followed 20 surrogate mothers up to 10 years after giving birth. They were interviewed at two time points at 1 and 10 years post-partum. The Beck Depression Inventory revealed that surrogate mother denied signs of

depression. They remarked that the quality of their marital relationship continued to be positive throughout the years. None of the participants regretted acting as a gestational carrier. Moreover, their rapport with the intended parents was optimistic. Most participants expressed that they would be available in case the child wanted to make contact.

Research into the recipient's psychological implications is currently limited (Gunnarsson Payne et al. 2020). A qualitative study exploring the experiences of infertile couples who resorted to surrogacy revealed that there is a lot of secrecy about disclosure, due to worry over societal negative views regarding surrogacy (Hadizadeh-Talasaz et al. 2015). This deprives the recipients from support from family, resulting in having to tolerate psychological pressure all alone in secrecy. Another study exploring the experience of transnational surrogacy in gay father families calls for the urgent need to offer professional psychological counselling in the recipients' resident countries to facilitate informed decisions before starting surrogacy abroad (Carone et al. 2017). This is especially important regarding potential difficulties related to surrogacy after the child's birth and recipient-child bonding, which has been further highlighted when there are restrictions in travel, such as those brought about by the COVID-19 pandemic (Carone et al. 2021).

Surrogacy can be a highly risky practice and, when unregulated, is likely to end up badly (Kartzow 2016). In contrast, other studies reported that the infertile couple perceived the surrogacy arrangement as an optimistic one. Jadva et al. (2012) studied 42 families who experienced the journey of surrogacy. The intended couples were followed up for 10 years and interviewed at four time points. Most parents claimed that the quality of their married life was not negatively affected by the journey of surrogacy. Indeed, 93% of the participants were still together. Moreover, studies have reported that children conceived through surrogacy did not experience adverse effects, and their psychological well-being and developmental process were not negatively affected (Jadva et al. 2015; Teman 2008).

Midwives play a crucial role in the day-to-day care of surrogates and recipients. They also have a key role in getting involved in the set-up of local, national, and international guidelines for surrogacy. International guidelines for cross-border surrogacy need to be established, for tailored and ongoing psychological and legal support for intended recipients to ease their strain and anxiety, especially when considering having a child through cross-border surrogacy.

5 Conclusion

Infertility and recurrent miscarriage, especially when unexplained, can lead to patients' distress and leave clinicians at a loss for how to help. This can lead to the risk of promoting the uptake of investigations and interventions of unproven benefit. Research has shown the importance of recurrent miscarriage linking infertility and late-pregnancy complications and has permitted the advancement of evidence-based

management with rejection of practice based on anecdotal evidence (Rai and Regan 2006).

Infertility data is collected via the International Committee for Monitoring Assisted Reproductive Technologies (ICMART), receiving data from all continents, including the European IVF Monitoring Group (De Geyter et al. 2020). It is recommended that miscarriage data is also gathered and reported on a national level to facilitate comparison among all countries, accelerate research, and improve patient care. Lastly, it has been shown that there is an overlap in the underlying causes and management between recurrent miscarriage and infertility (Wyrwoll et al. 2021).

Gathering this data helps to influence policymakers and healthcare providers to ensure that there is a minimum set of investigations and treatments which are offered universally to couples who have had recurrent miscarriages or are suffering from infertility. Thus, this paves the way for the more debateable ethical issues involved around surrogacy and other forms of assisted reproductive technologies.

Midwives play a crucial role in promoting the health and well-being of patients along their journey of fertility treatment (Keitel et al. 2021). People seeking fertility treatment must endure many stressors and face many professionals who are involved in their care. The midwife has a key role in the multidisciplinary team looking after these patients and is the main navigator of holistic care. The provision of continuity of care and support throughout all stages of treatment, particularly prior to pregnancy testing, antenatally, and following unsuccessful treatment, is especially important.

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Supporting Early Parenting Following Preterm Birth

Rita Pace Parascandalo and Kevin Hugill

1 Introduction

Parents' experiences after preterm birth (before the 37th week of gestation) have undergone remarkable changes. In the past, parents were largely excluded or confined to passive roles (Christie et al. 2001; Henderson 2021). These changes were influenced by groundbreaking work by Robertson (1970) and Robertson and Robertson (1989) building upon work by Bowlby (1951, 1965, 2005) and Ainsworth (1979). These studies demonstrated the emotional and psychological harm affected on children when they were separated from their mothers (later amended to parents). Influential publications (Harrison 1993; Als and Gilkerson 1997) in the 1990s marked a key juncture in the transition amongst neonatal practitioners internationally to more inclusive ways of working. The central tenet that parents are essential for the provision of high-quality care and optimal infant and family outcomes informs many of the care models and endeavours in contemporary neonatal care. However, agreement about which approaches best support greater parental engagement lacks consensus.

The chapter draws upon a hermeneutic phenomenological study (Pace Parascandalo 2016), which explored parents' lived experiences in a neonatal intensive care unit (NICU) and their transition to home. We used a hermeneutic phenomenological approach (Gerrish and Lathlean 2015; Smythe 2011) to address key gaps in the literature and aimed to generate a deeper understanding of the meanings and lived experiences of NICU-to-home transition from multiple perspectives of mothers, fathers, and staff. The study used purposive sampling, and open interviews were

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conducted with 9 mother-father dyads of preterm infants and with 12 staff (midwives, nurses, and doctors) working on a NICU in Malta. A longitudinal design was adopted for data collection from the parents: at 1, 3, and 6 months after discharge of their baby from the unit. We compare these experiences with those in other internationally published research together with health professionals' perspectives, to consider some of the key challenges parents face and how they might be better supported.

2 Coping Through Hope

Becoming a parent is a significant life event impacting individuals' sense of identity and relationships with others. It is well documented by a large body of empirical evidence worldwide that premature birth of an infant and his/her hospitalisation in a NICU are key sources of acute and enduring emotional and psychological distress for parents (Redshaw 1997; Jackson et al. 2003; Lee et al. 2005; Olshtain-Mann and Auslander 2008; Hugill et al. 2013; Hagen et al. 2016; Ionio et al. 2016; Provenzi et al. 2016; Gonçalves et al. 2020; Breivold et al. 2019a; Brunstad et al. 2020; Stefana et al. 2018; Hutchinson et al. 2012; Lakshmanan et al. 2017; Spinelli et al. 2016). One mother recollected:

> *Initially I took it really badly the way it happened, ……., they (staff) took him away, not even giving me a chance to cuddle him. It's like I didn't realise I just had a baby of my own. I felt as if they had taken something from within me.* (Pace Parascandalo 2016)

Unfamiliarity with the NICU environment, medical technology, and terminology and fears over infant survival feature in parents' accounts. Petty and colleagues (2020) report that parents widely use emotionally compelling metaphors when describing their experiences. For staff, understanding why they are used by parents to express difficult experiences and emotions can be helpful in establishing a common language or frame of reference through which to communicate with parents. Speculatively, it might be possible to track parents changing use of metaphors to express their inner thoughts and use this insight to inform better parent-staff interactions.

Studies have compared mothers' and fathers' experiences. Most reveal commonalities, but often men and women use different related words and place different emphasis on the relative importance of different enablers and impediments (Jackson et al. 2003; Hagen et al. 2016; Ionio et al. 2016; Provenzi et al. 2016; Gonçalves et al. 2020). Individual life experience and personality affect parents' coping styles. There is some evidence that mothers and fathers use different coping strategies. Research over time has consistently shown that fathers invariably try, with varying degrees of success to be emotionally strong and supportive of their partner during their time in the NICU (Hugill et al. 2013; Hagen et al. 2016; Provenzi et al. 2016; Stefana et al. 2018). Interestingly, mothers report greater stress when the father is not present (Hagen et al. 2016). However, whether this observation is attributable to

the fathers' physical presence alone or his physical proximity and emotional support is uncertain and requires further research.

In Pace Parascandalo's study (2016), parents' emotional responses were accentuated by profound and shifting uncertainties about the well-being of their infant, a finding which resounds with other studies (Jackson et al. 2003; Hutchinson et al. 2012; Bissell and Long 2003). However, the longitudinal design of this study (Pace Parascandalo 2016) allowed for an understanding as to how these complex emotions shift over time. This included the crisis of the preterm birth itself, followed by the process of settling into the rhythms of the NICU, the new unknowns generated by the homecoming of the infant, and the shift from an initial focus on the uncertain survival of the baby to the possibility of future developmental repercussions of prematurity.

Additionally, findings revealed that shifting concepts of 'hope' over time (hope of survival, hope of absence of disability, hope for weight gain/growth, hope for discharge, and hope of normality) helped parents to cope at each unfamiliar new stage in the process, and this ultimately led them to have a more positive outlook on life. However, staff did not seem to have identified with such means of parental coping (Pace Parascandalo 2016). This highlights that staff need to be more attuned active listeners in their dealing with parents. The importance of becoming progressively hopeful and looking forward to a positive future as the child's condition improved has also been expressed by other parents (Jackson et al. 2003). However, the role of effective trustworthy information and advice as a means of helping parents connect with their infant was particularly evident (Pace Parascandalo 2016) and resonates with Finlayson et al. (2014).

3 Making the Unreal Real

Preterm birth brings about a disconnect from parents' usual reality and a dramatic shift in their anticipations of pregnancy. Spinelli et al. (2016) suggested that the sudden interruption of pregnancy due to preterm birth meant that mothers had to reorganise the process of transition to motherhood. They suggest that if done poorly, these transitory experiences can adversely affect motherhood identity and attachment to their infant. Indeed, others postulate that preterm birth can be a source of psychological trauma and a possible mediator for symptoms of PTSD, which can inhibit normal transition to parenthood (Ionio and Di Blasio 2014; Thomas and Anderton 2021). As one father said:

> *It all happened so suddenly; we weren't expecting it … I couldn't be happy.* (Pace Parascandalo 2016)

Almost universally, mothers and fathers report feelings of alienation from their baby, feelings which impact the formation of emotional attachments (bonding) (Jackson et al. 2003; Lee et al. 2005; Olshtain-Mann and Auslander 2008; Hugill et al. 2013; Hagen et al. 2016; Provenzi et al. 2016; Gonçalves et al. 2020; Lakshmanan et al. 2017). Partially, this situation might arise from interruptions in individual and family preparations for pending parenthood as well as their NICU

experiences. These findings and the words parents use emphasise that separation is not purely physical but emotional as well.

Early physical and emotional closeness between parents and their infant is believed to be crucial for bonding and formation of positive attachment relationships (Bowlby 1951, 1965, 2005; Ainsworth 1979; Harrison 1993; Flacking et al. 2013). Once in the NICU, parents expressed how they craved connection to their baby both physically and emotionally (Pace Parascandalo 2016). They longed to touch and hold their baby and to participate in caregiving. At birth, expectant parents usually have great anticipations to meet and hold their baby for the first time. However, with a preterm birth, parents revealed that they were faced with the opposite; the baby was drawn away from them as it was taken to intensive care. Parents very vividly expressed feeling distant and disconnected from their baby at birth (Pace Parascandalo 2016). Additionally, mothers felt empty and disembodied as the baby was taken away from them (Pace Parascandalo 2016). Hutchinson et al. (2012) found similar disconnected feelings of emptiness in parents of preterm infants. Parents talked about the sense that the birth of their baby was unreal. Some mothers tried to cope with this situation by putting their sense of becoming a parent and celebrating the birth of their baby 'on hold' (Pace Parascandalo 2016). Finlayson et al. (2014) found that mothers in their study expressed 'not feeling like a mother' or not being the mother, feelings that continue to resonate with more recent studies (Spinelli et al. 2016) and this one.

In Pace Parascandalo's study (2016), it was possible to explore what parents did to feel involved and emotionally closer to their baby, to make him/her appear more real, and, in the process, to regain their sense of being parents. One ubiquitous behaviour was the taking of photographs. Photographs can evoke powerful emotional responses (Yang et al. 2019) and help to document events and changes over time. Through these images, parents can capture the changes in their baby and ultimately have a more complete story of their early life, as well as provide a means of sharing the birth and the baby with family and friends, who could not see and hold the new family member. Fathers, especially, sought to create both current realities and future memories through photography (Pace Parascandalo 2016), though sharing these images with others was not without risk and emotional consequences, as one father recalled:

> *…. relatives don't know what's going on and you can't blame them for it, …. I showed them (relatives) a photo and they started crying and I told them, 'Don't cry, that's my child, don't cry', they really put me down, crying like that as if my daughter was dying. I knew what was going on and I knew it wasn't so bad. So, then I stopped showing photos and I stopped talking and if they asked whether everything was ok, I used to say 'yes of course it is' and that's it.* (Pace Parascandalo 2016)

Taking photographs during early parenthood is filled with cultural meaning. For some parents, if the life of the baby was not captured visually, it had never happened for them. Beyond the usual social impulse to take pictures, the imperative amongst many parents was to record what they felt were important transitions such as skin-to-skin contact, discontinuation of supplemental oxygen or tube feeding, and getting ready for discharge. The ways in which parents use photography can be seen as

an important activity that serves to make things real and maintain hope for a time when their time in the NICU becomes a memory.

For parents, 'going home' marks an important transition to the anticipation of normal parenthood (Lee et al. 2005; Olshtain-Mann and Auslander 2008; Breivold et al. 2019a; Brunstad et al. 2020; Hutchinson et al. 2012; Lakshmanan et al. 2017; Spinelli et al. 2016; Bissell and Long 2003). Many mothers expressed how they interpreted being home as the birth-made-real (Pace Parascandalo 2016). Having the baby at home beyond the gaze of health professionals also meant that parents could claim their child as being their own (Deeney et al. 2012).

4 Transitioning to Home

The benefit of skill transference with pre-discharge teaching activities was favourably viewed by all parents (Pace Parascandalo 2016). This is a view that has longevity in the neonatal parenthood literature and is a subject of considerable research attention aiming to develop robust interventions to support parental engagement and competence (Breivold et al. 2019a; Spinelli et al. 2016; Bissell and Long 2003; Williamson et al. 2021; Puthussery et al. 2018; Broedsgaard and Wagner 2005; Burnham et al. 2013; Smith et al. 2012; Sheikh et al. 1993; Sneath 2009; Benzies et al. 2013).

In the unit, structured and unstructured pre-discharge activities helped parents gain confidence in infant caregiving activities and helped prepare them for home life. However, parental needs, as expressed by parents themselves, were not wholly met. Key gaps, from parental perspectives, were insufficient information about expectations of their baby's behaviour, how to optimise interactions with their baby, and deciding when to seek help about concerns regarding illness or developmental delays (Pace Parascandalo 2016). These information gaps were a source of anxiety and disquiet once home, a finding which resonates with previous studies (Sheikh et al. 1993; Staniszewska et al. 2012). The need for a more individualised and culturally nuanced approach to providing support and information during admission, preparing for discharge and afterwards at home, is supported by parents in several studies (Pace Parascandalo 2016; Olshtain-Mann and Auslander 2008; Sheikh et al. 1993; Sneath 2009; Benzies et al. 2013; Staniszewska et al. 2012).

Going home and moving away from constant medical surveillance were viewed with mixed emotions. Leaving the NICU was a joyous moment for most parents, but some felt anxiety about the loss of security they gained from health professionals' constant presence (Pace Parascandalo 2016). Consequently, as reported elsewhere (Jackson et al. 2003; de Souza et al. 2010; Griffin and Pickler 2011), many parents sought to replicate in some way the monitoring of vital signs and physiology by neonatal staff by adopting similar practices at home (Pace Parascandalo 2016).

Letting go of technical and routine NICU practices posed difficulty, sometimes for many months for most parents in Pace Parascandalo's study (2016). Regular check-ups with a private paediatrician reassured many about adequate growth and development of their baby. This reassurance also seemed to be seen as confirmatory

of their parenting abilities and increased their confidence. It is possible that NICU staff might not realise the influence that regimented, routinised technical care has upon parents at home (Pace Parascandalo 2016). How this parental mindset might be nullified requires further study but supports the premise that parents of preterm infants need to be prepared to go home and continue to need support after discharge is also advocated elsewhere (Staniszewska et al. 2012; Brett et al. 2011; Breivold et al. 2019b).

5 Rooming-In in the Neonatal Intensive Care Unit

Rooming-in is considered by many NICUs to be a key step in the process of NICU-to-home transition. However, considerable variations in polices and practice exist internationally, and the activity has received limited research attention (Pace Parascandalo 2016; Flacking and Dykes 2013). In the context of Pace Parascandalo's study (2016), rooming-in refers to the practice of parents caring for their baby in a less clinical, more domestic room (located in the NICU). Staff provide some educational input but minimal direct supervision. The activity usually lasts one or two day/s and night/s. Proponents argue that rooming-in can enable parents to experience a sense of ownership, enhanced connection and closeness between them and their baby, opportunity to practise essential care skills, and time to become more attuned to their baby's behavioural communication signals.

Some parents felt that rooming-in was a positive experience providing them the opportunity to care for their baby on their own, but with the reassurance of staff nearby (Pace Parascandalo 2016), a view expressed in other studies (Staniszewska et al. 2012; Bennett and Sheridan 2005). However, some parents were less positive, a feature less overtly reported. These parents questioned the benefit of spending a day and night in a room with their baby doing what they had been doing in the NICU. Parents questioned the imperative to room in and felt that it was almost as if this was a test they had to pass before they were judged to be fit to be 'allowed' to take their baby home (Pace Parascandalo 2016):

> *I don't know why we did rooming-in; I mean because ok they (staff) tell you to do it so that they see how you (parents) get along on your own, but I don't know really what difference it would have made if I came home not having done it (rooming-in), we were pressured to do it.* (Pace Parascandalo 2016)

The room layout, its décor, and lack of everyday living facilities were felt to be restraining and not at all home-like. Indeed, the overall experience was stressful for some parents, especially fathers, and hindered their connection with their baby. These findings highlight the need to individualise policies and interventions aimed at supporting parents as they move from hospital to home (Pace Parascandalo 2016). Furthermore, they support the view expressed by Flacking and Dykes (2013) of the need to ensure that such interventions, if used, need to facilitate, through design, feelings of 'at-homeness' to be 'enabling a family-life'.

Views about rooming-in were also sought from neonatal staff (Pace Parascandalo 2016). On reflection, staff expressed insight into and empathised with the difficulties and concerns parents expressed with the routinisation of this practice in their unit. Furthermore, staff expressed that although the service was portrayed as being optional, in practice the decision ultimately rested on doctors and ward managers, with parents not having much say or choice in the matter. Influenced by past negative experiences of having to readmit infants when rooming-in was not done, doctors favoured mandatory rooming-in for all parents. However, such a catch-all policy denies parents' collaboration in decision-making and is based on scant empirical data of the impact of rooming-in on hospital readmissions (Pace Parascandalo 2016).

Rooming-in was perceived by many of the staff as confirming the parents' abilities to manage the infant's care before they hand over the baby to them completely. In contrast, others, particularly midwives and nurses, recognised that an autocratic attitude did not address parents' unique needs. They perceived that rooming-in was unlikely to be beneficial for parents who felt compelled. Rooming-in, in its various guises, is at times controversial amongst staff and parents alike. Results of this study have brought forth unresolved issues of collaboration and decision-making whilst highlighting issues of power of staff over parents. Additionally, these findings suggest that it is erroneous to assume that rooming-in only offers benefits to parents, as staff expressed the reassurance of the practice it offered them. The underlying intent and rationale for, and practice of, rooming-in require further, more comprehensive research from a range of perspectives, particularly when this is the last contact that parents have with the NICU and the staff prior to discharge home (Pace Parascandalo 2016).

6 Partner-to-Partner and Grandparents' Support

Each mother-father dyad provided each other mutual emotional support during admission and afterwards at home (Pace Parascandalo 2016). Sharing the same experience with their own child seems to have provided the parents' understanding of what each partner was experiencing. The interconnectedness between partners supported each other's emotional well-being and seems to have enhanced their adaptation to family functioning throughout their experience. This mutual support has not been so evident in previous studies, despite advocates of family-centred care emphasising the need to be inclusive (Harrison 1993; Als and Gilkerson 1997; Staniszewska et al. 2012; Brett et al. 2011).

Coping with home transition was facilitated when both partners supported each other and shared their responsibilities at home, including the care of the baby and that of any other siblings (Pace Parascandalo 2016). This finding seems to differ from past explanations of gendered roles within the family, which stereotypically associated childcare with mainly mothers (Dermott 2008). This study (Pace Parascandalo 2016) supports notions reported internationally about the continued

shift from traditional uninvolved fathers towards an expectation of equal co-parenting (Hugill et al. 2013; Brunstad et al. 2020; Deeney et al. 2012).

Including relatives in neonatal care is advocated as being important in supporting the whole family and aiding family life adjustment post-discharge (Als and Gilkerson 1997; Puthussery et al. 2018; Benzies et al. 2013; Staniszewska et al. 2012). Whilst neonatal staff agreed with these benefits in principle, they also expressed concerns about increased risk of infection with more liberal visiting (Pace Parascandalo 2016). Such attitudes have informed NICU visitation polices and been previously reported (Christie et al. 2001; Henderson 2021; Finlayson et al. 2014; Puthussery et al. 2018; Greisen et al. 2009). Interestingly, staff also considered grandparent visiting and involvement in care as essential for them to become acquainted with preterm infant caregiving skills (Pace Parascandalo 2016). This view seemingly reflects prevailing cultural norms regarding the roles of grandparents in family life in Malta, a country characterised by its small geographical area and the interconnectedness of familial relationships (Pace Parascandalo 2016).

Parents revealed multiple ways in which grandparents supported them, physically and emotionally, both during hospitalisation and increasingly so afterwards once at home (Pace Parascandalo 2016). This finding, whilst not unique, extends the importance of grandparents on parenthood experience beyond that previously documented (Griffin and Pickler 2011; Greisen et al. 2009; Levick et al. 2010). Ultimately, parents interpreted having a premature baby as unifying the family and strengthening family cohesion (Pace Parascandalo 2016). This included the parental dyad but extended to other family members, especially grandparents. The involvement of grandparents in the NICU, and in the early days in the family home, seems to be a neglected area of research which requires in-depth exploration.

7 Staff-Parent Relationships and Information-Giving

Effective communication and ongoing information-giving to parents have been repeatedly emphasised as a foundational issue for high-quality neonatal care. Despite this, poor communication and lack of timely appropriate information are often highlighted as problematic in many studies (Redshaw 1997; Jackson et al. 2003; Hugill et al. 2013; Gonçalves et al. 2020; Breivold et al. 2019a; Spinelli et al. 2016; Petty et al. 2020; Bissell and Long 2003; Finlayson et al. 2014). Consequently, interventions to improve communication often feature prominently in parent support interventions (Puthussery et al. 2018; Benzies et al. 2013; Staniszewska et al. 2012; de Souza et al. 2010; Brett et al. 2011). In contrast, staff perspectives on parental communication have been sparingly explored.

Establishing trusting relationships with parents is an essential component of contemporary neonatal practice (Benzies et al. 2013; Staniszewska et al. 2012). However, several organisational factors present barriers, which impact NICU staff's opportunity to communicate with parents and optimise relational aspects of care in everyday practice. These include workload, staff turnover, staff shortages, and work practices that limit continuity of care (Trajkovski et al. 2012; Friedman et al. 2017).

Family-centred models of care emphasise partnership working through building trusting relationships between staff and parents (Als and Gilkerson 1997; Staniszewska et al. 2012; Brett et al. 2011). The mutuality of such relationships remains contestable, particularly as staff often retain the 'expert role'. Consequently, unbalanced power dynamics can operate between staff and parents, which can lead to staff making judgements about parents' behaviours and motives. For example, Friedman et al. (2017) observed that parental suspicion and repeated questioning of staff, together with a reluctance to engage in daily infant care, or involvement of statutory child safeguarding agencies were viewed by staff as facets of challenging parental behaviour rather than as an indication of the need for greater support.

NICUs remain environments where staff maintain most of the control. The situation can lead to 'power struggles', conflict between staff and parents emerging, or staff experiencing tension as they seek to advocate for parents within their professional, inter-professional, and organisational power structures (Trajkovski et al. 2012; Friedman et al. 2017; Valizadeh et al. 2013; Higman and Shaw 2008).

It is not possible to condense early preterm parenthood experience into a single explanatory version in a single chapter, or book. Parenthood experience exists in a multitude of forms, each unique to the infant and his/her family. Nevertheless, there are key messages that midwives, neonatal nurses, and health practitioners can take from this chapter. Firstly, having an awareness of how parents' experiences and ideas about their needs are driven by organisational policies and values and our own perspectives, behaviours, and attitudes is essential. Secondly, spending time listening to parents' stories and their lived experiences in research and in everyday practice is an important step when seeking the best ways to support parents in their early parenting after preterm birth.

8 Concluding Remarks

In this chapter, we have considered the experiences of parents in NICUs, their thoughts on what they considered helpful and less supportive behaviours by health professionals, and what health professionals themselves thought about their interventions to support parents.

Encountering preterm parenthood is an unplanned for and novel situation for most parents. Parents of preterm infants seem to have a different experience compared to those with healthy term infants. Reviews of neonatal parenthood study worldwide consistently highlight the relationship between preterm birth and increased and enduring levels of parental stress. These stresses can have long-lasting effects on psychological well-being, infant development, transitions to parenthood, family relationships, and parent-infant attachments.

The study (Pace Parascandalo 2016) we have discussed in this chapter has held up a mirror to practice, reporting on both staff and parents and views about approaches health professionals use whilst attempting to support parents in the NICU. Furthermore, we have highlighted the supportive and confounding effects of influences from culturally contextual wider social and family structures on the

effectiveness of parenthood support interventions and overall family experiences of preterm birth and neonatal care. Importantly, we conclude that preterm parenthood cannot be considered in isolation from parenthood in a wider society. These findings must be incorporated into more culturally sensitive and nuanced interventions designed to meet parents' needs and desires, support their early parenting, and optimise individual and family health and developmental outcomes.

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Adolescent Pregnancy and Early Parenting

Christian Borg Xuereb, Rita Borg Xuereb, and Julie Jomeen

1 Introduction

Adolescent pregnancy and parenting are considered a worldwide public health and social challenge (WHO 2020). Adolescents (boys and girls, aged 10–19 years) constitute approximately 18% (1.25 billion) of the world population with variations between regions ranging from 12% in high-income countries to 23% in low-income countries (Vogel et al. 2015; UNFPA 2021).

Although adolescent pregnancies and births have declined in the past three decades globally, approximately 12 million girls (15–19 years) still give birth each year, that is, an estimated 11% of all global births; 95% of these births occur in low- and middle-income countries (WHO 2020; UNFPA 2021). Maternal settings are considered as the second leading cause of mortality among adolescent pregnancies (UNFPA 2021). Additionally, according to Neal et al. (2012), about 2.5 million births occur to girls under 16 years of age in low-income countries and it is this age group (12–15 years) that are exposed to the highest health risk (Neal et al. 2012). The chapter reviews adolescent pregnancy and its effects on health, social and environmental challenges; consequences of early parenting; transition to parenthood; supporting of adolescent parents; and health professionals' contribution to preventing adolescent pregnancies.

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2 Multifactorial Challenges of Adolescent Pregnancy

The global adolescent fertility rate has declined in the past decades. However, the number of childbirths to adolescents has increased, given that the population of young women in the 15–19-year age group is increasing in some countries, for example Eastern Asia and Western Africa (WHO 2020). Adolescent mothers are also more likely to face numerous relational, environmental and health challenges.

Adolescent pregnancies may result in major adverse health consequences for the mothers and their babies. In fact, complications arising during pregnancy and childbirth are the principal cause of death among girls aged 15–19 years worldwide; 99% of these maternal deaths occur in low- and middle-income countries (Neal et al. 2012). A study from Bangladesh found that girls aged 15–19 years had a maternal mortality rate nearly twice that of women aged 20–24 years while the maternal mortality rate for girls aged 10–14 was nearly five times higher (Neal et al. 2012). Examples of adolescent pregnancy complications during the perinatal period include higher risk for eclampsia, puerperal endometritis, increased risk for obstetric fistula and general infections (WHO 2020). Younger adolescents may also be at an increased risk for obstructed labour as their pelvic bones are still developing (Neal et al. 2012).

Approximately, there are 10.2 million unplanned pregnancies each year among 15–19-year-old adolescents in the developing world, resulting in 3.3 million births, 1.2 miscarriages and 5.6 million abortions, 3.9 million of which are unsafe, which further increases the maternal mortality, morbidity and lifelong health problems of these adolescents (Darroch et al. 2016). Infants of adolescent mothers are at higher risks for low birth weight and preterm birth (WHO 2020).

In addition, adolescent pregnancy has also been linked with reduced parent-infant bonding, poor parental support and supervision, more lenient parental viewpoints concerning adolescent sexual activity, community and family instability and disruptions, lack of positive peer exemplars and low partner support to the use of contraceptives (Bhana and Nkani 2016; Raneri and Wiemann 2007; Savio Beers and Hollo 2009).

Possible factors contributing to adolescent pregnancy include pressure to marry and bear children prior to 18 years of age, as motherhood in some societies is valued with marriage or union being the best opportunity (WHO 2013; Kozuki et al. 2013; Parsons et al. 2015) and sometimes before the age of 15 (UNFPA 2021; World Bank 2017). Furthermore, access to contraceptives in some countries may be insufficient (Bendavid et al. 2021).

Adolescent pregnancies are also more likely to happen in marginalised communities, frequently driven by poverty and low socio-economic status, lack of education and low literacy, and absence or shortage of employment opportunities (UNICEF 2013). In addition, adolescent pregnancy may also be the result of sexual abuse and violence (Raj and Boehmer 2013). According to Raj and Boehmer (2013), many girls in several countries stated that their first sexual encounter was ‘non-consensual’.

Pregnant adolescents need additional healthcare monitoring during the perinatal period. However, they are less likely to be able to afford the financial costs of pregnancy and childbirth. Therefore, they are less able to access good antenatal care and competent midwifery and healthcare services, hence potentially contributing to the increased risk of mortality and morbidity during pregnancy, childbirth and postnatal period (Vogel et al. 2015).

Concerning adolescent fatherhood, Bamishigbin et al. (2019) conducted a systematic review of 39 studies to examine its antecedents and consequences. They found that adolescent fathers are more likely to come from single-parent households, and their parents have lower income and lower educational achievement. Additionally, Bamishigbin et al. (2019) stated that there is some evidence, which shows that adolescents who participate in more delinquent behaviour and have lower academic achievement are more likely to become adolescent fathers. Moreover, many of the adolescent fathers' parents also became parents during their adolescence (Bamishigbin et al. 2019).

3 Outcomes of Adolescent Parenthood

Early parenthood contrasts to planned parenthood for several reasons. Adolescent pregnancy is frequently unintended, the family unit is rarely established at the time of conception and the young parents are at a critical developmental stage in their life having to traverse two transitions, as adolescents and as parents (Johansen et al. 2020).

Adolescent pregnancy and childbearing could result in girls dropping out of school, thus possibly undermining the girl's future educational achievements (Ashcraft et al. 2013; Holmlund 2005; Lee 2010) and employment opportunities (Chevalier and Viitanen 2003). Moreover, mothers also suffer the repercussions for the loss of skills and earning opportunities once they must put on hold their education or careers to rear their child (Adda et al. 2017; Kleven et al. 2019). In addition, adolescent mothers tend to underachieve economically when compared to peers who can plan and decide to postpone childbearing (Johansen et al. 2020). Therefore, adolescent mothers face increased risk of falling under the poverty line as, apart from being the main carers of children, they are at a higher risk of facing systemic gender discrimination (Bhana and Nkani 2016).

Social outcomes for pregnant adolescents may include stigma, rejection or violence by partners, parents and peers. Girls who become pregnant prior to 18 years of age are more likely to experience violence within a marriage, partnership or cohabitation (Raj and Boehmer 2013).

Family background also plays a role in how norms are explicitly or implicitly considered regarding early parenthood (Johansen et al. 2020). In families or communities where early parenthood is socially accepted, early parenthood may have less serious consequences; it may also motivate the adolescent to return to school or to search for employment (Johansen et al. 2020).

Contrary to studies on the effects of adolescent pregnancy and motherhood, there is paucity of research with regard to adolescent fatherhood. Nonetheless, adolescent fathers also seem to underachieve, yet the differences are less marked and less strong (Assini-Meytin and Green 2015). A possible reason that adolescent fathers may be understudied is because adolescent mothers are less likely to put fathers' information on the birth certificate or because adolescent fathers are less likely to affirm paternity than older fathers. Nonetheless, according to Martinez et al. (2012), it is estimated that there are approximately 1.28 million adolescent fathers in the USA alone.

Concerning the consequences of adolescent fatherhood, Bamishigbin et al.'s (2019) systematic review also found that babies of adolescent fathers have more adverse birth outcomes, for example low birth weight and preterm birth, than babies of older fathers. Additionally, they stated that there is evidence that children of adolescent fathers are at a greater risk for psychological ill health than children of adult fathers. Shifting the community's view of adolescent fathers to a less judgemental and more empathic perspective could assist in addressing the many challenges and consequences these fathers face during their transition from adolescence to adulthood and parenthood.

4 Adolescent Pregnancy and the Transition to Parenthood

The transition to parenthood is considered as stressful for men and women who are passing through the experience (Cowan and Cowan 2000; Condon et al. 2004). Adolescence is regarded as a transitional life stage; hence, the transition to parenthood becomes more intense for pregnant adolescents as it involves further rapid changes in emotional, relational and cognitive tasks shifting from being an adolescent to becoming an adult parent (Elder et al. 2003; Settersten 2004). Transition to parenthood, therefore, echoes a critical life change coinciding with the developmental stage of adolescence, which presents several challenges for the adolescent parent related with developmental issues, for example identity, independence, and cognitive and sexual development (Erikson 1968; Lerner et al. 2001; Moriarty Daley et al. 2013; Coleman 2006).

Consequently, this could exponentially increase stress and anxiety arising during the adolescents' transition to parenthood, since the adolescent must shoulder an adult role in making life choices that could bear long-term implications for themselves and their child, concerning social resources and future positions in life (Coleman 2006; Arnett 2000). Furthermore, adolescents' pregnancy and parenting are at an increased risk for challenging physical and psychological outcomes compared to older parents, including medical difficulties for both mother and infant (Hodgkinson et al. 2014).

In addition, adolescent mothers seem to be at an increased risk for post-partum depression (PPD) during early parenting (Easterbrooks et al. 2016; Mollborn and Morningstar 2009; Figueiredo et al. 2007). Studies noted that adolescent mothers

have a higher prevalence of PPD than adult mothers ranging from 14% to 32% and 10% to 16%, respectively (Mollborn and Morningstar 2009; Figueiredo et al. 2007; Kim et al. 2014). Hymas and Girard's (2019) systematic review of 14 studies to identify risk factors for PPD noted that a preceding depression, lack of social support, socio-economic difficulties and younger maternal age were significant risk factors for PPD in adolescent mothers. PPD could intensify the mother's emotional, behavioural and relational problems with the possibility of negatively affecting her interactions with and the provision of care for her infant (Hill et al. 2013; Morrell 2006), thus emphasising the importance of antenatal screening for both risk factors and PPD among adolescents (Hymas and Girard 2019).

Sangsawang et al. (2018) conducted a systematic review of 13 psychological and psychosocial intervention studies to identify and evaluate the effectiveness of the intervention programmes to prevent PPD in adolescent mothers. They found that three psychosocial (home-visiting; prenatal and postnatal educational programmes; and infant massage training) and two psychological (psycho-educational and cognitive behavioural therapy (CBT) as well as the Relaxation, Encouragement, Appreciation, Communication, Helpfulness (REACH) programme based on interpersonal therapy (IPT)) types of interventions were effective in preventing PPD among adolescent mothers. The authors remarked that the cost-effectiveness of the interventions when compared to normal care was not measured and the interventions may not be applicable to non-Western countries. It seems that a supportive environment is essential to support adolescent parents during their transition to parenthood. Hence, it is proposed that similar interventions could be considered for pregnant adolescents together with their usual care (Sangsawang et al. 2018).

5 Midwives and Health Professionals Supporting Adolescent Parents

It transpires that the transitional challenges of pregnant adolescents represent a key characteristic of adolescent parenthood, which are interlinked between adolescent development and transitions to parenthood and adulthood (Wahn et al. 2005; Breheny and Stephens 2007). The midwife is thus a crucial player in providing educational and supportive roles to the pregnant and post-partum adolescent women's and men's physical, social and mental health (MacArthur et al. 2002; Harrison 2003).

Becoming an adolescent parent stimulates the adolescents into enacting a similar role to that of the nascent adult in making life choices, which ensures social resources and future positions for both the parents and their child (Arnett 2000). Parenting demands skills that are often unknown or unfamiliar to the new parent (Hudson et al. 2001). However, to become competent, the new parent depends on the experience, support and encouragement of relevant others such as relatives, midwives, nurses and community workers (Hudson et al. 2001; Deave et al. 2008).

Lim et al. (2012) argued that some adolescents linked professional care with negative experiences such as long waiting times and a feeling that health

professionals are too busy for them. Moreover, adolescents may decide to hold back from divulging sensitive information to health professionals out of concern for being judged (Harrison et al. 2017; Redshaw et al. 2014) and/or anxiety about the possibility of infringing confidentiality (Ford et al. 2004). Consequently, some adolescent mothers delay seeking access to antenatal services, possibly resulting in adverse maternal, obstetric and neonatal outcomes (Fleming et al. 2013).

Harrison et al.'s (2017) qualitative study explored pregnant and adolescent mothers' healthcare experiences. Participants commented on both positive and negative experiences; however, the negative experiences left a bigger impact on the adolescents. The authors noted that the perceived judgemental attitudes of healthcare professionals during their antenatal, intranatal and postnatal encounters contributed to a general sense of mistrust and fear in the adolescents. Adolescents also felt that health professionals at times questioned their ability to become skilled parents and seemed to consider the adolescent parents as being unprepared or indifferent for parenthood. Hence, for fear of being judged by health professionals, adolescents sometimes hesitated or delayed to access health services (Harrison et al. 2017) and were more likely to decline nursing care and/or left hospital prior to discharge (Peterson et al. 2007).

Maternity care providers, especially midwives, are in a pivotal position to positively influence pregnant women about positive health choices (McNeill et al. 2012). Yet, Harrison et al.'s (2017) findings imply that there is the possibility of a gap in knowledge and skills of how healthcare professionals address the holistic or psychosocial needs of the adolescent parent. It seems that there is a need to include a theoretical and practical component about adolescents' pregnancy and parenthood in undergraduate curricula. Another option could be that continuous professional development programmes are offered to midwives, nurses and other maternity care providers specifically focusing on the needs of adolescent pregnancy, adolescent father and early parenting. Furthermore, Harrison et al.'s (2017) qualitative study has shown that midwives and other professionals must be competent in addressing the informational, physical, psychological, social and cultural needs of the adolescent parent (Kelly and Millar 2017). Health professionals must also recognise and understand the multiplex transitional challenges adolescent parents are facing during their transition to parenthood and adulthood. Hence, it seems essential that professionals working with adolescent parents are competent and well prepared to provide sensitive, effective, efficient, respectful and non-judgemental care during this life-changing experience.

Midwives and other health professionals are also able to work with parents on the development of the new parents' self-confidence and self-worth. Using a collaborative approach with the adolescent parents, health professionals are in a good position to help the parents in achieving a positive transition to parenthood and to become more aware and competent in preventing future pregnancies (Conn et al. 2018). Therefore, health professionals' experiences, aptitude and encouragement are essential to support adolescent parents to become confident and competent in their new role (Condon et al. 2004; Hudson et al. 2001; Deave et al. 2008). A good referral system under these circumstances is an asset, and a multidisciplinary collaborative support system seems central to further develop their self-efficacy through the provision of social and health services.

6 Intervention Programmes to Support Pregnant Adolescents and Early Parenthood

As discussed earlier in this chapter, pregnant adolescents have an increased risk of maternal and infant complications and mortality (UNFPA 2021). Pregnancy can also affect the adolescent mothers' social and economic life situation, especially single mothers. Adolescent parents related experiences of shame, stigma and discrimination concerning their ability to parent (Conn et al. 2018). All this could result in the adolescent parent experiencing a cascade of consequences, including falling out from formal education, social privation, marginalisation, lack of family support, lack of employment opportunities and poverty (Vogel et al. 2015). Therefore, adolescent pregnancy and childbearing also impact society at large due to their long-term economic and social expenditures (Minnick and Shandler 2011).

Beyond doubt, adolescent parents need support to address these challenges; consequently, several types of intervention programmes were initiated in various countries with the aim of helping adolescent parents achieve long-term socio-economic stability, ensure a healthy start to their children's lives and prevent further pregnancies (Minnick and Shandler 2011; Robling et al. 2016). Examples of intervention programmes include 'the Teens and Toddlers' pregnancy prevention intervention programme, UK (Sorhiando et al. 2015); the Family Nurse Partnership programme, USA and UK (Robling et al. 2016); 'Teen Voices/Teen Choices', USA (Minnick and Shandler 2011); and the Massachusetts Pregnant and Parenting Teen Initiative (Egan et al. 2020) among others.

Harding et al.'s (2020) comprehensive systematic literature review involved 23 studies about 20 intervention programmes. The 23 studies used mainly randomised designs and relatively large samples, which offered insights into how vulnerable adolescent mothers from several ethnic groups can be supported. The systematic review found robust evidence that different types of intervention programmes can enhance adolescent parents' education outcomes and healthy birth spacing or fertility control, thus contributing to a better socio-economic stability (Harding et al. 2020). Increasing education and contraception use and decreasing repeated pregnancies are considered key aspects of fostering teen parents' self-reliance (Lee 2010; Assini-Meytin and Green 2015).

Harding et al. (2020) identified 4 studies out of the 23 studies, which included teen fathers; however, the adolescent fathers comprised only a small percentage of participants in these 4 studies. This highlights the dearth of research about adolescent fathers and emphasises the need for more studies about intervention programmes with teen fathers. Additionally, there is also the need for more research to demonstrate whether the effects of intervention programmes can be replicated with different populations (Harding et al. 2020).

Understanding the cultural nuances of adolescents' experiences during pregnancy, birth and postnatal period could provide a platform to more personalised intervention programmes, potentially resulting in better support at strengthening the well-being of young parents and their children.

7 Conclusion

Adolescence is a phase of life during which young people transition from childhood to adulthood, a time of major physiological and psychological changes and development, and a time of opportunities, risks and possibilities. Many adolescents become sexually active, possibly without having adequate educational information and services to protect their health and to delay childbearing.

Literature shows that becoming pregnant during adolescence may greatly alter the adolescent's life prospects and those of their children. Adolescent childbearing is associated with lower educational attainment and increased possibility of poverty. Furthermore, complications of pregnancy and childbirth are the second leading cause of death among 15–19-year-old women (WHO 2020).

Midwives are in a pivotal position to provide culturally sensitive, respectful and non-judgemental care and support to adolescents during pregnancy, birth and early parenting period. However, midwives need to be cognisant about the implicit and explicit needs of adolescents. Midwives also have a window of opportunity to initiate and encourage open communication with the adolescent parents and enhance adolescents' confidence and competence in childcare, childrearing, fertility control, competent use of contraceptives and parental responsibilities.

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Drug and Alcohol Use in Pregnancy and Early Parenthood

Claire Smiles, Ruth McGovern, Eileen Kaner, and Judith Rankin

1 Introduction

Drug and alcohol use during pregnancy can cause significant physical and psychological harm to both mother and baby. The aim of this chapter is to explore the experiences and perspectives women who use drugs and alcohol have of pregnancy. The chapter begins with an overview of women who use drugs and alcohol, framing and contextualising the current situation. We then explore topics of importance for antenatal care: the impact substance use can have on reproductive health, fertility and contraceptive care. Alcohol and drug use in pregnancy is explored in detail, including the risks and adverse effects of intrauterine substance exposure. After this, motherhood from the perspective of women who use drugs and alcohol is presented. The chapter concludes with barriers and facilitators to care and recommendations for improving practice.

2 Women Who Use Drugs and Alcohol

Health inequality and drug use are inextricably linked, with the most deprived local authorities having the highest prevalence of problematic substance use[1] (Public Health England 2020). However, the structure of this relationship is complex and multifaceted. Gender, socio-economic deprivation, family history of addiction, poor

[1]Defined as substance use, which significantly impacts an individual's health and well-being, including dependent, recreational and occasional use.

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mental health, unemployment and homelessness are considered to be the main factors that contribute to deprivation (Galea 2004). These factors are recognised as the biggest challenges faced by individuals with problematic substance use, making this population one of the most vulnerable in modern society.

Women who use illicit[2] drugs and drink alcohol on a regular and/or heavy basis have poor reproductive health, poor contraception use and general health impairment (Black et al. 2012). Low self-regard, traumatic experiences, drug and alcohol use and its associated lifestyle appear as mutually sustaining factors that dominate the daily lives of women who use drugs (Edelman et al. 2013). A 2011 qualitative study, researching pregnant and post-partum women in maternity services in the Southeast of England, found that more than half of the women who participated ($n = 24$) had funded their substance use by shoplifting, sex work or pickpocketing and had received custodial sentences, probation or drug treatment rehabilitation orders (Edelman et al. 2013). This highlights the adverse, difficult and often complex lifestyles women who use drugs have to navigate.

Women represent just under one-third of all patients accessing drug treatment in the UK, averaging 27.5% of the overall treatment population (Public Health England 2019, 2021). This increases substantially to 40% for alcohol treatment (Public Health England 2019). Problematic drug use is cited by 41% of women on arrival at prison, wherein incarceration is often a consequence of the burdensome lifestyle associated with acute substance use (Public Health England 2019). Traditionally, substance misuse programmes are designed for men and are not readily available for women, particularly pregnant women (Sun 2004). Research indicates that mitigating circumstances such as homelessness, heavy drug and alcohol use or transient lifestyle limit some women's use of services, and pregnant women have a higher dropout rate than other individuals in treatment (Hathazi et al. 2009; Milligan et al. 2010). In summary, women are less likely to use drugs than men, but are confronted with more barriers to care than their male counterparts.

3 Reproductive Health and Fertility

Around one-third of women who use drugs and almost 60% of current drinkers are of childbearing age (Rehm et al. 2013; World Health Organization 2006). Women who use substances are considered to be at very high risk of contracting sexually transmitted infections (STIs) and at an increased risk of sexual violence and trauma (Vanthuyne et al. 2016). A 2002 study by Tyndall et al., researching risky sexual behaviours of injecting drug users with HIV, found that women who participated in the study had in excess of 100 lifetime partners and were more likely to have contracted a sexually transmitted disease (STD) than men who use drugs (Tyndall et al. 2002).

[2]Defined as the use of illegal substances such as heroin and cocaine and/or non-prescribed/prescribed medication abuse.

Drug and alcohol use can impact women's fertility and ovulation. Many studies have found that women who use drugs have irregular periods or none at all, with many believing that they are infertile (Black et al. 2012; Olsen et al. 2014; Lewis et al. 1995). Research suggests that women who use drugs and alcohol have a 'misperception of their fertility' due to their substance use, and because of this, they use contraception sporadically (Oliva et al. 1999; Black and Day 2016). Having irregular menstruations or believing that their substance use (including prescribed methadone) makes them incapable of conceiving or infertile, places women who are sexually active and use drugs at the highest risk of unplanned pregnancy, as well as sexually transmitted infections STIs/STDs (Olsen et al. 2014; Lewis et al. 1995). This misplaced perception of fertility underscores the urgent need to address the myths that surround fertility for individuals that use drugs.

4 Contraceptive Care

In 2019, the United Nations estimated that around 1.1 billion women in the world have an unmet need for family planning (United Nations, Department of Economic and Social Affairs, Population Division 2019). Globally, female sterilisation is the most commonly used contraceptive method, with over 219 million relying on this method (United Nations, Department of Economic and Social Affairs, Population Division 2019). The male condom, intrauterine device (IUD) and pill were the other methods used, respectively (United Nations, Department of Economic and Social Affairs, Population Division 2019). To date, little qualitative research has been undertaken to establish the uptake and attitudes women who use drugs and alcohol have towards contraceptives.

Research into family planning provision in rural Britain found that women attending contraceptive and counselling services had high rates of alcohol and drug use and those who used substances daily attended these services more frequently than other patients (Tolland et al. 2003). A UK survey study (n = 77) researching sexual risk-taking and health-seeking behaviours among substance-using women found that 53% of their respondents were sexually active in the 4 weeks prior to taking part and 66% of them engaged in sexual intercourse that could lead to pregnancy (Edelman et al. 2013).

The most common method of contraception for women who use drugs is the male condom, giving male partners the responsibility and, in some cases, control over contraception use (Black et al. 2012; Clergue-Duval et al. 2017; Sharma et al. 2017). A study by Sherman and Latkin found that drug-using partners who lived together were less likely to use condoms consistently, compared with partners who do not live together (Sharma et al. 2017). Trust and financial interdependence also played a role in condom use, with inconsistent condom use inversely linked with financial dependency and relationship security (Sherman and Latkin 2001). Similar research indicates that women who engage in sex work are 80% more likely to use condoms with paying partners/clients than casual or regular partners (Tyndall et al. 2002). Although condom use may offer protection against HIV and STIs/STDs,

maintaining sexual relationships and obtaining drugs were higher priorities for women who use drugs (Gutierres and Barr 2003). As such, the sexual and reproductive health of women who use drugs is dominated by their partner's attitude and willingness to use contraception.

An Australian survey by Black et al. found that of the 116 participants who were of reproductive age, 74 (55%) reported using contraceptives to avoid pregnancy (Black et al. 2012). Of the women who used contraceptives to prevent unplanned pregnancy, 37.5% (n = 24) used long-acting reversible contraceptives (LARCs) or had been sterilised (Black and Day 2016). LARCs such as intrauterine devices (IUDs), implants and injectables could give women who use drugs the best chance at avoiding pregnancy with the least maintenance. Gutierres and Barr (2003) advise that dual birth contraceptive methods such as birth control pills for unplanned pregnancy, alongside condom use for disease protections, should be encouraged by healthcare professionals who offer sexual and reproductive healthcare, education and advice (Gutierres and Barr 2003).

5 Pregnancy

Globally, between 2015 and 2019, there were approximately 121 million unintended pregnancies annually (Bearak et al. 2020). Forty-six per cent of pregnancies in Europe and North America are unintended (Bearak et al. 2020). In the UK, it is estimated that one-third of unintended pregnancies are unwanted, mistimed and ambivalent (Heil et al. 2011; Nordenfors and Hojer 2017). In the UK, it is estimated that women who access treatment for drug and alcohol misuse will average 3.2 episodes of pregnancy during their lifetime (Edelman et al. 2013). There are many risk factors in unplanned pregnancy, which include adverse maternal and neonatal risk, particularly in relation to parental substance use (Lui et al. 2008). In the context of alcohol, unplanned pregnancies can put embryos at risk of being unintentionally exposed to alcohol in the earliest stage of pregnancy, when brain and facial development are particularly vulnerable to its effects (Popova et al. 2017).

6 Alcohol Use and Pregnancy

The Chief Medical Officer for England advises that women who are pregnant or planning pregnancy should not consume alcohol (Department of Health 2016). Notwithstanding this guidance, the UK has the fourth highest prevalence of prenatal alcohol use in the world, with around 41% of women reporting alcohol consumption during pregnancy (McQueen et al. 2015). The five countries with the highest estimated prevalence of alcohol use during pregnancy are Russia, the UK, Denmark, Belarus and Ireland, all of which belong to the World Health Organization, Europe (McQueen et al. 2015). A large European study by Mårdby et al. found that 16% of their participants (n = 7905) drank alcohol during pregnancy, with 39% consuming at least one unit per month (Mardby et al. 2017).

6.1 Foetal Alcohol Spectrum Disorder

The developmental process of the foetus begins from conception and can be impaired or altered by alcohol. For women who had consumed small amounts of alcohol before being aware of their pregnancy, the risk of harm to the baby is likely to be low (Brown and Trickey 2018). There is a paucity in evidence regarding low levels of consumption during pregnancy; however, the limitation of evidences does not mean that there is an absence of harm (Brown and Trickey 2018). Mothers who continued to drink throughout their pregnancy and averaged 1–2 units daily are more likely to have children born preterm, with lower birth weight and small for gestational age (Department of Health 2016). Heavy[3] or dependent drinking[4] during pregnancy increases the risk of adverse outcomes to the unborn child (Popova et al. 2017). Advances in research have shown that any alcohol use (not limited to alcohol dependency) impacts foetal development and increases the risk of foetal alcohol spectrum disorder (FASD) (McQuire et al. 2019). FASD is not a diagnosis, but a collective term used to describe a range of conditions associated with antenatal alcohol exposure (McQuire et al. 2019). Babies born with FASD may have higher rates of prematurity and growth retardation resulting in small-for-gestational-age babies; premature birth; spontaneous abortion and stillbirth; deficits in behaviour, attention and cognition; and neonatal morbidity and mortality (Popova et al. 2017). One of the most serious and disabling outcomes of drinking during pregnancy is the risk of developing foetal alcohol syndrome (FAS). FAS is associated with a wide range of effects including damage to the brain and central nervous system, growth impairment and facial abnormalities as well as behavioural, emotional and adaptive functioning deficits (Popova et al. 2017). Children with FASD are often confronted with 'difficult life trajectories', and some may experience psychiatric problems, disruption to their education and substance use disorders (Aspler et al. 2021, p. 1).

A systematic review by Popova et al. collated data from seven countries (Australia, Canada, Croatia, France, Italy, South Korea and the USA) and estimated that 1 in every 67 mothers who consumed alcohol during pregnancy delivered a child with FAS, which translates to approximately 119,000 children born with FAS in the world each year (Popova et al. 2017). This figure is likely to be higher given the limitation of global predictions using only eight countries, the delay in diagnosis of FAS and the varying social and cultural attitudes to alcohol consumption during pregnancy. A recent population-based sample study ($n = 13{,}495$) from the UK found that 7.2% ($n = 223$) screened positive for FASD (McQuire et al. 2019). Children from unplanned pregnancies and from lower socio-economic backgrounds were most likely to screen positive for FASD (McHugh et al. 2014). In contrast to this, Aspler et al. and Mårdy et al. proposed a counter-narrative to the stereotype to disadvantaged drinking pregnant women and found that women from middle-class backgrounds were more likely to drink alcohol during pregnancy, exposing their unborn child to the risk of FASD (Mardby et al. 2017; Aspler et al. 2021). Both

[3]Defined as an average of two or more drinks per day, or five to six drinks per occasion.

[4]Defined as a physical and/or psychological dependence on alcohol.

narratives underscore the need to raise awareness of the harm that alcohol consumption can have during pregnancy and prioritise alcohol screening for all pregnant women as routine practice, regardless of socio-economic status.

7 Drug Use in Pregnancy

The global prevalence of illicit drug use among pregnant women is unknown. A US study found that 1 in 20 women reports drug use during pregnancy and 1.6% of all pregnant women in the USA meet the criteria for substance use disorder (McHugh et al. 2014). In the UK each year, it is estimated that about 6000 (1%) children are born to women with problematic substance use (Advisory Council on Misuse of Drugs 2011). Like alcohol consumption, drug use during pregnancy and the associated lifestyle are both harmful to mother and baby. Opiates, cocaine, benzodiazepines, amphetamines and cannabis all pose significant risks to the physical, psychological and social well-being of both the mother and her unborn child, and like alcohol, the continuum of harm varies from person to person dependent on their pattern of use, physical and mental health and social capital.

7.1 Neonatal Abstinence Syndrome

An identified physiological implication to intrauterine exposure to substances (most often opioids) is neonatal abstinence syndrome (NAS). NAS is a group of conditions whereby a newborn withdraws from substances their mother has used during pregnancy. Signs of NAS include tremors, excessive crying, poor feeding, breathing problems, fever, sweating, difficulty sleeping, vomiting and diarrhoea and flu-like symptoms (McQueen et al. 2015). Often infants get better within a few days or weeks; however, there may be long-term health and development impairments including hearing and/or vision problems and behavioural and learning problems (Ross et al. 2015). The optimal care for the management of NAS includes nonpharmacologic management of infants from birth, continuing after discharge (which includes skin-to-skin care, low lighting and soothing care); pharmacologic intervention for infants who cannot thrive with nonpharmacologic care alone; and comprehensive care of mother (Jansson and Patrick 2019).

Opioid substitute treatment (OST) is an effective way to manage withdrawal, reduce physical and social harms of opiate use and connect individuals with psychosocial and peer support. OST is safe to use during pregnancy under a clinical care team and tailored to the patient's needs (Ecker et al. 2019). The use of methadone in combination with comprehensive clinical and psychosocial care is associated with less pregnancy complications, higher birth weights, decrease in foetal mortality and improved engagement with antenatal care compared with those who have no treatment (Ecker et al. 2019). The prescribing of methadone in comparison to buprenorphine indicated fewer relapses and better engagement with treatment (Ecker et al. 2019). Women in receipt of medications to treat opiate use disorder (such as

methadone) can choose to breastfeed; however, this is not recommended for women who are not in active patterns of illicit substance use (Jansson and Patrick 2019). For women who use opioids, OST is a viable way to recover from substance use and improve the health and well-being of themselves and their children.

8 Pregnancy Care for Women Who Use Drugs and Alcohol

Antenatal care is a key factor in determinants of birth outcomes, such as maternal nutrition and physical health. The National Institute for Health and Care Excellence (NICE) recommends ten antenatal care appointments for women without pregnancy complications, with the first appointment booking before 10 weeks (National Institute for Health and Care Excellence 2021). Pregnancy among substance-misusing women is often only detected after the first trimester, where the mother feels foetal movement or other physical changes (Boyd 1999). Substance use may mean that a pregnancy is detected later than usual, and on occasion, a pregnancy may be concealed due to the associated lifestyle constraints of substance use. Late identification of pregnancy impacts antenatal care, meaning that some women may fall short of these recommendations. Substance-exposed pregnancies and delayed antenatal care can cause physical and psychological impairments for both mother and child.

Half of all unplanned pregnancies in the UK end in a termination; however, there is no data available that relates specifically to women who use drugs and alcohol (Black and Day 2016; Finer and Henshaw 2006). Some research has surmised that whilst some drug-using women 'plan pregnancies', they also 'practise abortion de facto' (Sun 2004; Black and Day 2016, p. 30; Tolland et al. 2003, p. 4). A large study (n = 1020) by Coleman et al., published in 2005, found that women with a history of abortion had a delayed onset of antenatal care (Coleman et al. 2005). This study also found an association between a history of abortion(s) and substance use (excluding alcohol) during pregnancy (Coleman et al. 2005).

Pregnancy among women with substance use disorders can be used as an opportunity to stabilise or reduce drug use and address other complex issues such as trauma, housing and mental health. Drug and alcohol services often encourage women to utilise this 'unique opportunity' by connecting them with psychosocial and clinical intervention and peer support networks, to help them maintain recovery from substance use (Black et al. 2012, p. 149; Milligan et al. 2011; Chou et al. 2018). This engagement with health and social care services relies on the early detection of pregnancy and women's willingness to engage with support (Chou et al. 2018). For this reason, it is important that healthcare professionals discuss family planning, contraceptive care and pregnancy with all women regardless of their drug and alcohol use disclosure. Health and social care practitioners, including midwives, who are in contact with women in early pregnancy, have an opportunity to engage women who use drugs and alcohol (where level of consumption is warranted) with support services and reduce harm for both mother and baby.

A meta-analysis by Milligan et al. supported the hypothesis that women who participate in integrated drug treatment programmes have better birth outcomes, including having infants with higher birth weights, larger head circumferences, fewer birth complications and fewer positive infant toxicology screens (Milligan et al. 2011). A study by Best et al., in a specialist mother and baby treatment team in the UK, found that pregnancy reduced the frequencies and quantities of heroin use that continued after the birth of the child (Best et al. 2009). To adequately support women and their children, a multiagency approach is necessary. Where relevant, a multiagency approach could include providers of health services (including sexual and reproductive), obstetric pharmacotherapy and drug treatment services, behavioural health, housing, employment, community services (e.g. childcare), social and legal services, paediatric care, peer support groups and breastfeeding support (Boyd 1999; Chou et al. 2018). Offering women a network of health and social care support in early pregnancy will better prepare them for parenthood.

9 Motherhood

Mothers are disproportionally considered to be the sole actors, responsible for a child's well-being (Racine et al. 2018). Mothers who use drugs and alcohol experience shame and stigma having '… been constructed as deviant and dangerous' (Holt and French 2020, p. 297). To avoid the stigmatised figure of 'drug addict', many parents attempt to manage their identity, often creating and managing a lifestyle aimed at avoiding detection as drug users, and juggle parental responsibilities in parallel to this (Holt and French 2020; Klee 1998). According to Radcliffe, '… women are generally held differentially responsible for the outcome of their children's health and wellbeing in a process through which mothers are to blame for their own circumstances, be they the breakdown of relationships, or poverty' (Radcliffe 2011, p. 985). Women who use drugs and alcohol during pregnancy and as parents often fall short of what is considered 'good motherhood' and often face 'serious moral disapprobation' (Racine et al. 2018; Broadhurst and Mason 2013, p. 295). Policy and practice partners and indeed the wider public focus on the failings of women who use drugs to prevent pregnancy, stopping their drug use for the sake of their (unborn) child/children and the irresponsibility of continuing to use substances that may harm them. This agenda continues to generate narratives of stigma and shame and discounts their experience of motherhood.

Qualitative research indicates that many women who use drugs value motherhood (Lewis et al. 1995; Klee 1998). A study by Lewis et al., which explored illicit drug users' experience of pregnancy, found that women were 'resigned, happy or even excited about the prospect of having a baby', and all of the women involved in their study intended to keep their child (Lewis et al. 1995, p. 223). A study by Holt and French found that all the women who participated in their research wanted to become mothers, all the women loved their children and all had a maternal nature (Holt and French 2020). A systematic review into facilitators to substance use

treatment found that women who were pregnant wanted to be 'good mothers' who enhanced their children's lives and kept them safe (Barnett et al. 2021). Women whose children were no longer in their care reported that the loss of their children facilitated higher drug use and a sense of a loss of purpose (Hathazi et al. 2009; Holt and French 2020). Pregnancy and motherhood often place women who use drugs in an arduous position, often faced with the grave ultimatum of their children or drugs.

10 Barriers and Facilitators to Care

The most discernible barriers to reproductive and antenatal health and social care for women who use drugs are stigma and shame. Pregnant women who use drugs are often reluctant to engage in treatment due to shame, denial and family responsibilities (Jackson and Shannon 2012). A meta-summary by Renberger et al. found that pregnant and post-partum women who use drugs and who engaged with healthcare professionals found that encounters were adverse, unhelpful and detrimental to their health or well-being and were difficult and contentious interactions (Renbarger et al. 2020). Some vulnerable birth mothers who used substances reported that they were poorly understood by service providers, further compounding their 'sense of isolation and despair' (Broadhurst and Mason 2013, p. 293). This, in conjunction with perceived judgemental attitudes, was the single biggest '… deterrent for parents seeking help' (Klee 1998, p. 447). Additional barriers to care for substance-using women included misperception of fertility, intimate partner violence with reproductive coercion, fear of losing custody of children and denial or embarrassment regarding their substance use (Lewis et al. 1995).

Studies into healthcare professionals' (including midwives) attitudes to reproductive health of women who attend substance misuse treatment services suggest that their beliefs, personal values and experience of childhood and parenting could be significant barriers to addressing reproductive health in women who use drugs (Broadhurst and Mason 2013; He et al. 2014; Whittaker et al. 2016). A study by Klee found that some health professionals did stereotype drug-using women referring to them as 'selfish and uncaring', 'irresponsible', distracted', 'neglectful', 'intolerant', 'irritable and aggressive', 'one who engages in no-child-centred activity' and 'one who puts drugs before child' (Broadhurst and Mason 2013). Another study of healthcare professionals provided similar accounts of drug-using parents, whereby they described them as 'risky', 'dishonest', 'damaged', 'inadequate' and 'reluctant' (Whittaker et al. 2016). This language not only evidences a focus on the failures of women who use drugs but also validates women's 'perceived' experience of judgement and bias experienced by these women, when engaging with healthcare professionals. These words produce narratives of worthlessness, shame, guilt and self-deprecation. Cook et al. stated that healthcare practitioners who treat their patients through these bias stereotypes are not contributing to '… their mental or social wellbeing, or therefore their health' (Cook et al. 2010, p. 258). The attitudes and bias perceptions some healthcare workers have towards women who use drugs are legitimate barriers to why women may not access their service; it is also likely

to contribute to high STI and unintended pregnancy, increasing their risk and vulnerability even further.

Health and social care professionals are confronted with additional challenges and complexity when caring for women who use drugs and alcohol during pregnancy. A 2021 study by Scholin et al. found that midwives who participated in their study were not aware of the alcohol guidelines or reported a conflict in the information being shared (Scholin et al. 2021). At present, there is no standardised alcohol screening tool designed specifically for pregnant women, impeding research on this topic (Scholin and Fitzgerald 2019). Midwives report that the lack of validated screening tools, inadequate support and training, lack of multidisciplinary team and specialised treatment, workloads and limited consultation time, and discomfort in screening were some of the biggest barriers (Scholin and Fitzgerald 2019; Howlett et al. 2019; Oni et al. 2020). Some midwives found discomfort in blanket screening all patients for drug and alcohol use, particularly those from minority and certain religious backgrounds (Oni et al. 2020). Health and social care practitioners require the knowledge, skills and training to successfully engage, communicate with and support women about the risks and potential outcomes of consuming alcohol during pregnancy (Sun 2004; Scholin and Fitzgerald 2019).

A systematic review conducted by Barnett et al. (2021) describes motherhood as a 'double-edged' sword with access promoted and hindered by relational and structural support (Barnett et al. 2021, p. 8). Whittaker et al. described the 'burden of care' these families pose for healthcare professionals including capacity, service capacity, time constraints, lack of services and competing priorities (Whittaker et al. 2016, p. 74–75). Continuity of care was recognised by midwives as important for building rapport and encouraging drug and alcohol use disclosure (Oni et al. 2020). Research undertaken in an integrated maternity drug and social care service for drug-using women found that the most important aspects of the clinic were the non-judgemental attitude of staff, consistent staff, high level of support, reliable information and multiagency integrated care (Vanthuyne et al. 2016; Hall and van Teijlingen 2006). Treatment programmes which valued and included the importance of motherhood and mothering in recovery also increased engagement (Jackson and Shannon 2012). Motherhood is a valued life trajectory for many women who use drugs, and they should be supported by services in the same way as non-substance-using women.

11 Conclusion

Reproductive healthcare, contraceptive availability and family planning are integral to the health and social outcomes for women who use drugs and alcohol. The ability to choose whether and when to bear children is a fundamental aspect of reproductive health, but the unmet reproductive healthcare needs of women who use drugs and alcohol are unambiguous (Finer and Henshaw 2006). Treatment designed to support the needs of pregnant women who use drugs and alcohol and alcohol which incorporates their voices into care could be an attributable factor for improving

outcomes (Best et al. 2009; Grant et al. 2005; Stone 2015). The real challenge for this population is to ensure that health and social care provision is accessible without the barriers or constraints of stigma and shame for themselves or others. Integrating health and social care provision for women who use drugs and alcohol is an opportunity to address these barriers, improve engagement and reduce harm. Women who use drugs and alcohol have the same reproductive health rights as the rest of the population and must be given the agency and autonomy to exercise these rights at a time that is best for them.

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Violence, Abuse and Coercive Control in Pregnancy and Early Parenting

Parveen Ali and Julie McGarry

1 Introduction

The World Health Organization (WHO) defines violence as '*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'* (Krug et al. 2002, p. 4).

The definition is broad and encompasses interpersonal violence, suicidal behaviour and armed conflict. However, the most common or prevalent form of violence is intimate partner violence (IPV). It affects millions of individuals, mainly women, across the world and is a major public health problem. While women experience violence and abuse at any age, for many women, the risk of experiencing IPV increases in certain circumstances and pregnancy is one such time. It is a significant time in a woman's life, when she is going through a lot of physical, emotional as well as hormonal changes. This is a time when she has to take care of not only herself but also her unborn baby. Unfortunately, IPV does not stop in pregnancy, and in fact, for many women, IPV either starts or escalates during pregnancy. While IPV can take many forms (as discussed later in the chapter), psychological abuse and coercive control are one such form that does not leave any scars or physical signs on

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the body of victim, and therefore, it is often difficult to see and spot. In addition, at times, it is difficult to recognise signs of IPV if the person does not appear to be submissive, anxious or vulnerable. Pregnant women come in close and regular contact with midwives not only during pregnancy but also in the post-partum period. Midwives can play an important role in identifying, reporting and preventing IPV. They need to have appropriate understanding of IPV and domestic violence, various forms of abuse that pregnant women may experience and its impact on their physical, psychological and emotional health. This chapter explores the concepts of IPV, domestic violence and abuse and coercive control and how it can affect women generally, during pregnancy and early parenting. The chapter also explores the role, midwives can play in supporting women experiencing abuse.

Before concentrating on IPV, it is important to explore the concept of violence against women (VAW)/gender-based violence (GBV) and domestic violence. As mentioned earlier, while violence can affect anyone, girls and women remain to be major victims of violence in public as well as private sphere and therefore violence is considered a gendered issue. Both terms (VAW and GBV) refer to 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (United Nations 1993). VAW can take many different forms, including female infanticide, female genital mutilation, child marriage, grooming, trafficking, forced marriage, dowry-related abuse, honour-based violence, rape, sexual assault, stalking, harassment, street violence, domestic abuse (DVA) and intimate partner violence (IPV). While GBV and VAW encompass every form of violence and abuse against girls and women, a major portion of such abuse happens in the context of private life and individual relationships such as intimate relationships and therefore is known as IPV. Over the years and depending on the geography, country and culture, many other terms have been used to refer to IPV and these include domestic violence and abuse, intimate partner violence, family violence, domestic abuse, domestic violence, intimate partner abuse, partner violence, partner abuse, etc. While these terms are used interchangeably to refer to the same phenomena, there are distinctions between them. For instance, domestic violence and abuse is a broad term referring to a range of abuse and violence that occur within a domestic context. The perpetrator might be a partner or other family member, whereas IPV, as the name suggests, refers to violence between intimate partners.

IPV affects a significant number of individuals and families worldwide and intersects cultural, religious, gender and ethnic boundaries. It can occur in marital, cohabiting, heterosexual as well as same-sex relationships (Ali et al. 2016; Baker et al. 2013). While it is acknowledged that IPV can be experienced and perpetrated by men, women as well as transgender people in straight, gay or lesbian relationships, IPV is experienced disproportionately by women and perpetrated predominantly by men. The abuse that women experience is repeated, systematic, severe and more likely to result in injury or death. Men, as current intimate partners, or ex-partners, remain the most common perpetrators of IPV. Many women, especially

those living in patriarchal societies and extended families, may also be exposed to domestic violence at the hand of husband's family members.

2 Forms of IPV

IPV can take many forms as stated earlier and showed in Fig. 1. It can take the forms of physical, sexual, psychological and financial abuse (Krug et al. 2002). ***Physical*** abuse refers to the use of physical force to inflict pain, injury or physical suffering to the victim. Examples of acts include slapping, beating, kicking, pinching, biting, pushing, shoving, dragging, stabbing, spanking, scratching, hitting with a fist or something else that could hurt, burning, choking, threatening or using a gun, knife or any other weapon (García-Moreno et al. 2005). ***Sexual*** abuse refers to 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting, including but not limited to home and work' (Jewkes et al. 2002). In the context of IPV, sexual abuse refers to physically forcing a partner for sexual intercourse, forcing partner to do something they find degrading or humiliating (García-Moreno et al. 2005), harming them during sex or forcing them to have sex without protection (World Health Organization 2014).

Psychological abuse refers to humiliating and controlling another individual in public or private. Examples of psychological IPV include verbal abuse,

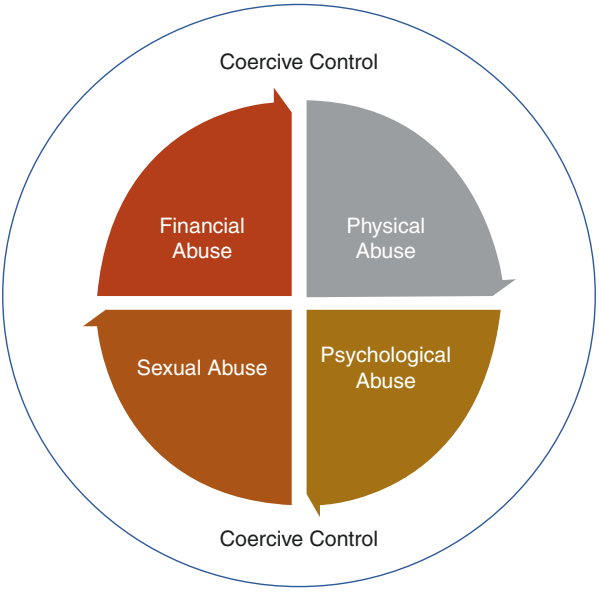

Fig. 1 Forms of domestic violence and abuse

name-calling, criticizing, blackmailing, saying something or doing something to make the other person feel embarrassed, threatening to beat women or children, monitoring and restricting movements, restricting access to friends and family, and restricting economic independence, access to information, assistance or other resources and services such as education or health services (Krug et al. 2002; Follingstad and Dehart 2000). ***Financial or economical abuse*** refers to controlling a person's ability to acquire, use and maintain their own money and resources. An abuser may prevent a woman from working to earn her own money (not letting her go to work, sabotaging job interviews, taking the welfare benefits she is entitled to), use their money without consent, build up debts in her name, damage her property and possessions, withhold maintenance payments, etc.

Coercive control is another form of IPV defined as any act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim (UK Home Office 2015). Coercive control can be a regular feature of a visibly abusive relationship but can also be used in the absence of physical and sexual abuse and therefore can be more difficult to spot. Coercive control is now a criminal offence in some countries such as the UK and parts of Australia. In the UK, for example, the perpetrator can be sentenced up to 5 years in prison, made to pay a fine or both. Usually, victims may experience more than one form of IPV (World Health Organization 2013; Devries et al. 2013). In the UK, coercive and controlling behaviour is defined as 'a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another' (UK Home Office 2015). It is often a pattern of abusive and controlling behaviour used by one person against the other over a long period of time.

Midwives stay in close contact with women during pregnancy, childbirth and post-childbirth and therefore develop a good rapport and trusting relationship with, and are best placed to spot signs and consequently provide, women with appropriate opportunities to disclose their experiences. This aspect is later discussed in this chapter; however, let us first learn a little bit more about the prevalence of the IPV/DVA in the community generally as it is essential in understanding the extent of the problem.

3 Prevalence of IPV

Knowing the exact prevalence of IPV within and between countries is challenging; however, data collection is improving day by day due to increasing focus on the issue by national and international organisations. What we already know is that IPV/DVA is a common experience for many women across the world. Available evidence suggests that one in three women is physically or sexually

abused by an intimate partner during their lifetime (World Health Organization 2013; Devries et al. 2013). Let us look at some specific examples. According to the Crime Survey for England and Wales, UK (2021), an estimated 2.3 million adults aged 16–74 years experienced domestic abuse in the year ending March 2020 (Office of National Statistics 2021). Women were approximately twice as likely to have experienced domestic abuse than men (Office of National Statistics 2021). A few years ago, another study conducted by the European Union Agency for Fundamental Rights (2014) gathered evidence from 28 member states by interviewing 42,000 women (FRA-European Union Agency for Fundamental Rights 2014). The findings suggested a lifetime prevalence of physical and/or sexual abuse of 33%. Another extreme form of IPV, domestic homicide, is not uncommon as an average of two women are killed each week in the UK (Office for National Statistics 2019) by a current or ex-partner and one woman is killed per week in Australia (Australian Bureau of Statistics 2017). Similarly, data for 2019, from Canada, reveals that 47% of women who were victims of homicides were killed by an intimate partner (Cotter 2021). Data from the USA shows that women are more likely to be killed by an intimate partner or ex-partner than by anyone else (Catalano 2013; Violence Policy Centre 2015). The findings of Demographic Health Survey (DHS) suggest that 35% of women, worldwide, have experienced physical and/or sexual violence at some point in their life. However, some national studies maintain that up to 70% of women have experienced physical and/or sexual IPV in their lifetime (United Nations 2015). Figures from DHS suggest that the proportion of women experiencing physical and/or sexual IPV in their lifetime ranges from 6% to 64%. Prevalence, generally, was higher in Africa than in other regions, with one-quarter of countries in the region reporting a lifetime prevalence of at least 50%. Prevalence was lower across Asia, Latin America and the Caribbean and Oceania with maximum prevalence levels of around 40%. For physical and/or sexual abuse experienced in the 12 months prior to the survey, prevalence ranged from 5% to 44%. The life prevalence of economic abuse was 25%, whereas prevalence of economic abuse in the last 12 months, prior to the survey, was reported to be 17% (United Nations 2015). We also know that women who experience physical and sexual abuse are more likely to experience economic abuse. This could take the form of the husband taking their wife's earned or saved money from them or refusing to financially support them (United Nations 2015).

Men can also be victims of IPV perpetrated by their female partner. The findings of the CSEW (Office of National Statistics 2021) suggest that an estimated 757,000 men aged 16–59 had experienced DVA since the age of 16. However, available evidence from around the world clearly highlights that the number of women experiencing IPV is much higher than the number of women perpetrating IPV. More

research is needed to explore the true extent of violence against men and violence perpetrated by women against men.

4 IPV During Pregnancy

This brings us to the specific issue of IPV or DVA during pregnancy. Evidence shows that violence during pregnancy is widespread and that pregnancy significantly increases a woman's risk of becoming a victim of IPV and domestic homicide as men who abuse their pregnant partners are more likely to kill them (Campbell et al. 2004; Spencer and Stith 2020). IPV commonly begins or increases in severity and frequency during pregnancy and in the early childhood period (García-Moreno et al. 2005; James et al. 2013). In Australia, 68% (or 188,000) of women who experienced IPV reported that they were pregnant during the relationship and 34,500 were abused during their pregnancy. More women (326,000) reported being abused during pregnancy by a previous rather than the current partner (Australian Bureau of Statistics 2017). According to the findings of the WHO multi-country study on women's health and domestic violence against women, the prevalence of physical violence during pregnancy ranged between 1% in a Japanese city and 28% in a province of Peru, with most sites ranging between 4% and 12% (García-Moreno et al. 2005). Similar findings were reported from DHS and the International Violence Against Women Survey, which reported prevalence rates for IPV during pregnancy between 2% in Australia, Denmark, Cambodia and the Philippines and 13.5% in Uganda, with the majority ranging between 4% and 9% (Devries et al. 2010). Other evidence suggests a higher prevalence of DVA in various countries, including Egypt (32%), India (28%), Saudi Arabia (21%) and Mexico (11%) (Campbell et al. 2004). A review of clinical studies from Africa reported prevalence rates of 23–40% for physical, 3–27% for sexual and 25–49% for psychological violence during pregnancy (Shamu et al. 2011). Figure 2 shows DHS data about women's experience of DVA in pregnancy. It shows 17 countries with higher rates of DVA reported during pregnancy, ranging from 7.4% in Chad to 15.7% in Afghanistan.

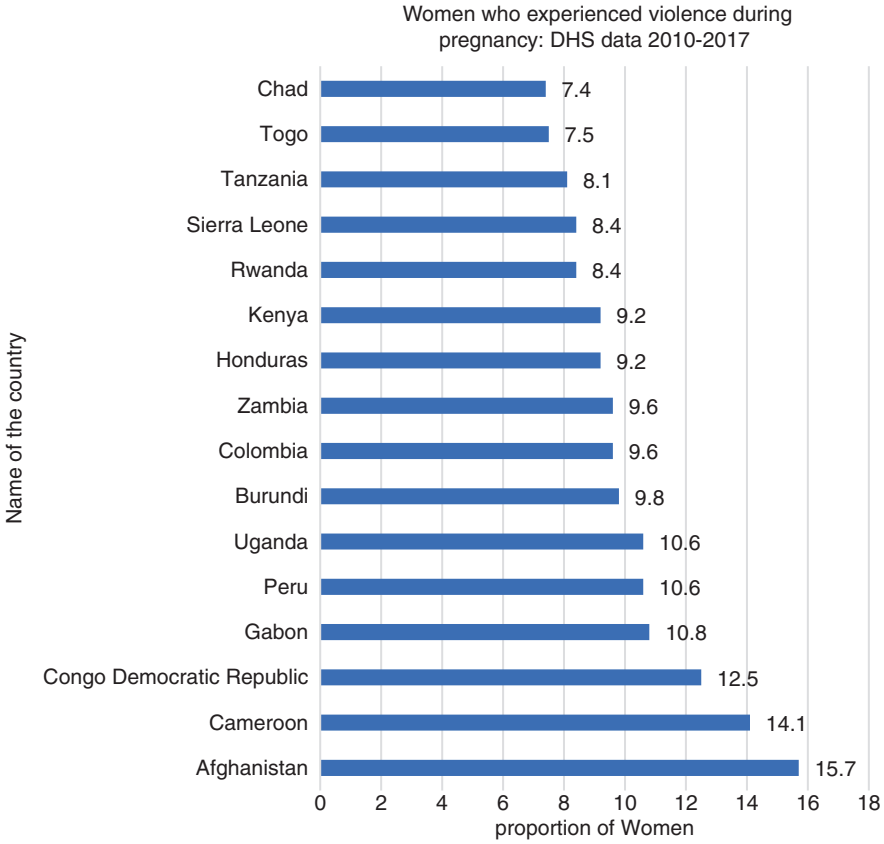

Fig. 2 Proportion of ever-partnered women aged 18–74 years experiencing DVA during pregnancy: data obtained from Demographic Health Survey

5 Health Impacts of IPV

IPV is associated with serious psychological as well as physical consequences for not only the victim, but also others in the family such as children or an unborn baby. We know that approximately 42% of women who experience physical or sexual IPV

sustain injuries (World Health Organization 2013). The examples of minor physical impact may include cuts, punctures, bruises and bites. Severe injuries may result in permanent disability such as loss of limb, hearing loss and damage to teeth. IPV victims report higher rates of poor health, compromised ability to walk, pain, vaginal discharge, loss of memory, dizziness and self-harm compared to those who do not. Other examples of the impact of sexual abuse include unwanted pregnancy, miscarriage, sexually transmitted infections (STIs) and other gynaecological problems.

Psychological effects of IPV may include fear, depression, low self-esteem, anxiety disorders, depression, headaches, obsessive-compulsive disorder, post-traumatic stress disorder, low self-esteem, disassociation, sleep disorders, shame, guilt, self-mutilation, drug and alcohol abuse and eating disorders. Psychological consequences may also manifest through psychosomatic symptoms, sexual dysfunction and eating problems. In addition, IPV can have fatal consequences for victims resulting from homicide or suicide (Black 2011).

IPV in pregnancy is also associated with adverse pregnancy outcomes. As mentioned earlier, pregnancy significantly increases a woman's risk of becoming a victim of domestic homicide and men who abuse their pregnant partners are very dangerous and more likely to kill them (Campbell et al. 2004; Spencer and Stith 2020). Clearly, the health outcomes of abuse can be both fatal and non-fatal for pregnant women and their children. Non-fatal impacts result from the impact of trauma to a woman's body as well as the physiological effects of stress from current or past abuse on foetal growth and development (Allen and Raghallaigh 2013). Pregnant women experiencing abuse are at risk of experiencing additional impacts, including but not limited to higher rates of preterm labour and stillbirth; placental abruption; low birth weight; and other infections and complications (Allen and Raghallaigh 2013; Coker et al. 2002). In addition, the strongest risk factors for developing antenatal mental illness have constantly been found to include the existence of IPV as well as other factors, including a history of psychiatric illness, low socio-economic status and insufficient social support (Howard et al. 2013, 2014; Moncrieff 2018).

6 Recognising IPV

Midwives can play an important role in identifying and supporting women and especially pregnant women and post-partum women as they regularly meet these women during pregnancy and in postnatal period (Ali and McGarry 2018). The nature of contact between a woman and midwife means that there are opportunities for a woman to be seen alone and to make a disclosure of IPV. Moreover, in many countries, including the UK, midwives are required to carry out routine enquiry during the antenatal period. Therefore, an understanding of IPV, its presentations and its effects is needed to effectively identify and support women who are experiencing IPV. A working knowledge of IPV and its effects will assist midwives in distinguishing between injuries resulting from IPV and other causes, as well as providing person-centred care to women.

Understanding of the complexity of IPV, for example coercive control, can also help midwives to exercise professional curiosity and to begin to hold conversations that can lead to a disclosure and support, including safety planning. However, midwives are not always adequately prepared to support women who experience IPV. For example, some may find it challenging to be empathetic and may blame the individual for becoming a 'victim' of abuse (Ali and McGarry 2018; Sundborg et al. 2012). Some women who have experienced IPV have claimed that healthcare professionals did not demonstrate concern for their situation and missed opportunities to investigate IPV during healthcare encounters, even where it was obvious that they had experienced IPV (Ahmad et al. 2017). Midwives have also reported that they lack the education, training and professional confidence to approach IPV during consultations with women for fear of causing offence or not knowing what to do if a disclosure is made.

7 Conclusion

This chapter aimed to provide an overview of IPV, forms of IPV, its prevalence and health impacts both broadly and within the context of midwifery. The important points from the chapter are that IPV is a major social and public health issue and millions of women regardless of income, education, age or other characteristics experience DVA in its various forms. We also learned that IPV has serious consequences for the victims, and these include short- and long-term physical, mental and emotional health problems. In addition, we have also highlighted that disclosing experiences of IPV and seeking help from appropriate sources are not easy for women for a number of reasons. Alongside other healthcare professionals, midwives are in a pivotal position—through their specialist role and professional relationship with women—to support women who disclose IPV, to utilise their skills of professional curiosity and to offer a safe space for enquiry.

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Migrants, Midwives, and the Transition to Parenthood

Christie Hili, Rita Borg Xuereb, and Charles Savona-Ventura

1 Introduction

Human migration has existed since the prehistoric times, and it will certainly remain a feature of human society throughout the coming decades (International Federation of Red Cross and Red Crescent Societies 2012). After births and deaths, migration is the third important demographic factor that controls the structure and size of a population. It is a complex phenomenon because it encompasses the movement of individuals over time, oftentimes across international borders (United Nations 2012). This chapter targets migration from a different perspective other than demography. It addresses the psycho-social challenges that migrant women and their families face in host countries during pregnancy, childbirth, and post-partum period. An overall picture of the perinatal outcomes of migrant women will be provided and discussed from a medical and sociocultural standpoint. Subsequently, this chapter further explores the significant role of midwives, in providing culturally competent maternity care to migrant women and their families. It also highlights how midwives support and facilitate the transition to parenthood in migrant women and enables them to successfully adapt to this life-changing experience.

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2 Migration: A Global Phenomenon

Over the course of human history, migration has played a crucial role in shaping societies, cultures, and the world we live in today (International Federation of Red Cross and Red Crescent Societies 2012). Migration refers to the movement of people away from their habitual residence, either within a country (internal migration) or across an international border (International Organization for Migration 2019). Recent estimates indicate that currently there are 1 billion migrants in the world, suggesting that about one in every seven individuals is a migrant (World Health Organization 2021). Highlights on migration in the 2020 United Nations publication imply that, in 2020, the world region hosting the largest number of international migrants was Europe with the number of migrants reaching 87 million, followed by Northern America (almost 59 million). Northern Africa and Western Asia account for nearly 50 million migrants. The disruptions brought about by the COVID-19 pandemic situation appear to have had a major impact on migration trends because of travel and mobility restrictions together with many migrants returning to their home countries (Chamie 2020). Indeed, so far, evidence suggests that globally, by June 2020, the number of international migrants may have decreased by two million. This translates to a reduction of 27% in the migration growth expected between July 2019 and mid-June 2020. Moreover, while the decline in migration flows has been observed in all world regions, the effect of the COVID-19 pandemic on migration was more evident in the European region (United Nations 2020).

The factors driving migration are diverse, ever-changing, and highly dependent on a complex interaction of personal, societal, environmental, political, and economic factors. People are forcibly displaced or flee their home to seek refuge in host countries out of choice due to wars, political instability (Kühlmeyer et al. 2019), persecution (United Nations 2020), and human rights abuse in their homeland (Roman et al. 2010). Other individuals migrate for educational purposes, family reunification, economic improvement, poverty, healthcare needs, social and cultural discrimination (Roman et al. 2010), and environmental causes, such as rising sea levels (Hauer et al. 2020).

2.1 Migrant: Refugee Definitions

Considering that international migration is one of the leading items on the global development agenda, the United Nations (2012) emphasizes on the need to collect and analyse reliable, comparable, and timely migration data to enable a more thorough understanding of the consequences of human migration and to address these issues on a national, regional, and international level. Although it is recommended to gather data on who the migrants are, when and why they migrated, and the countries from which they come from United Nations (2012), this is problematic in the absence of a universally acceptable definition of the word ‘migrant’ (International Organization for Migration 2019). Consequently, different entities have developed different definitions for the same term. In view of this heterogeneity, it may be

challenging for researchers to study particular aspects of migration, especially sensitive issues from the health and the social perspective. A consensus on a single definition of the term 'migrant' is therefore of utmost importance as it enables consistency in data collection and representation (Anderson and Blinder 2019).

The International Organization for Migration (IOM) has provided a broad definition of the term 'migrant'; it refers to a person who moves away from his/her habitual residence for various intentions, either for a limited time or permanently, within a state or across different countries (International Organization for Migration 2019). This definition does not differentiate between the different types of migrants and includes also certain categories of individuals such as smuggled migrants, migrant workers, and international students. Anderson and Blinder (2019) argue that the word 'migrant' can be defined in terms of country of birth, nationality, and length of stay in foreign country; yet each of these aspects poses several challenges. In case of the latter factor, for instance, although it may be instinctive to define migrants as 'foreign-born', some 'foreign-born' individuals may still be citizens of the host country. Further difficulties may arise when the definition of migrant is based on persons' nationality, simply because nationality can change over time. Moreover, when nationality is self-reported, it may be influenced by individuals' personal feelings, as well as their social and cultural affinity, rather than the legal status (Anderson and Blinder 2019). Additional complications may surface in cases where individuals have multiple citizenships, since many a time, data sources represent only one citizenship. It is also difficult to know how long a person intends to stay in the host country, making it problematic to base the term 'migrant' on people's length of stay (Anderson and Blinder 2019).

There is a common misconception that the terms 'migrant' and 'refugee' can be used interchangeably. Yet, the incorrect usage neglects the distinctiveness of each term (see Fig. 1) and presents further challenges to researchers and policy makers who are trying to understand and act upon issues brought about by migration. In fact, as previously mentioned, while a formal definition of 'international migrant' does not exist, the term 'refugees' refers specifically to persons who are outside of

MIGRANT: *An umbrella term, referring to an individual who moves away from his/her habitual residence for various intentions, either for a limited time or permanently, within a state or across different countries. This term includes well-defined legal categories of persons, for example migrant workers. It also refers to persons whose specific means of movement is legally defined (smuggled migrants), and those whose status is not particularly defined under international law (international students) (developed by the IOM but not defined under international law) (International Organization for Migration 2019).*

REFUGEE: *A person who is outside the country of his/her nationality because of a justifiable fear of persecution based on his/her race, religion, affiliation with a particular social group, political opinion,or nationality, and as a resultof these aspect is reluctant to, or unable to benefit from the protection of that country. The term also refers to a stateless individual who is outside the country of his/her previous place of habitual residence and due to fear of such events, he/she is unable or does not wish to return to his/her country (Adapted from 1951 Convention relating to the Status of Refugees) (UNHCR 2019).*

Fig. 1 Commonly used definitions of the terms 'migrant' and 'refugee'

their country of origin and are seeking international protection as a consequence of a justifiable fear of persecution in their home country based on their race, religion, political opinion, violence, conflict, or situations that have disturbed public order (United Nations 2021).

These definitions continue to bring to light the diversity that exists within migrant populations and, consequently, the importance of using the correct terminology when addressing issues pertaining to migration, especially in the context of healthcare. This is because the needs, particularly health needs, and the social determinants of health of individuals moving for economic or educational purposes may be considerably different than the needs of people who are forced to leave their home country or flee their habitual residence to seek protection.

2.2 Women and Migration

From a gender perspective, data on migration suggests that since the 1960s, the trend of female migration has remained stable (Migration Data Portal 2021). In the year 2020, almost half of all forcibly displaced individuals across national borders were women and girls (United Nations 2020). Being a migrant, irrespective of the gender, places individuals vulnerable to physical and/or economic abuse and ill-treatment (United Nations Population Fund 2018). However, women and girls have an increased risk of sexual abuse, violence, and trafficking; in fact, almost three-quarters (71%) of all human trafficking victims are women and girls (United Nations Population Fund 2018). This alarming figure requires immediate action on an international scale. The displacement of female migrants because of natural disasters or conflict places the health of women and girls in jeopardy as the collapse of protection systems gives perpetrators the impunity for violence (United Nations Population Fund 2018). Poverty, overcrowding of migrants in camps, poorly lit toilets, as well as lack of suitable shelter further predispose females to physical and sexual abuse, in some instances driving them to forced child marriage as a means of coping with extreme poverty (United Nations Population Fund 2018). In addition, seeking help in such situations is challenging for females due to their lack of knowledge related to support systems and/or the unavailability of adequate support resources and systems.

Nowadays, more women are migrating independently for educational purposes and to seek job opportunities. Even these female migrants, when compared to males, can experience discrimination in host countries: discrimination arising from the fact that these women are migrants and simply because they are females (Migration Data Portal 2021). This, consequently, leaves them susceptible to maltreatment and sexual exploitation in various aspects of their lives, even during their most vulnerable state, such as when using healthcare services (United Nations Population Fund 2018). Along with the psychological trauma that this chaos brings with it, one must not disregard the possibility of pregnancy (United Nations Population Fund 2018) and sexually transmitted infections (WHO Regional Office for Europe 2018a) as a consequence of sexual assault. In addition, during the migration process, women

often lose access to healthcare, particularly safe antenatal and intrapartum care, which puts them at significant risk of morbidity and mortality (United Nations Population Fund 2018). Indeed, the absence of safe maternity care is one of the leading causes of death among migrant females of childbearing age (United Nations Population Fund 2018).

3 The Social Determinants of Migrant Women's Health

Resettlement in a new country brings with it hope for a promising future; yet, the difficulties that migrant women experience in transit do not end upon reaching the host countries (United Nations Population Fund 2018). Migrant women are faced with an endless list of adjustment challenges in the host country that inhibits their integration into the community and makes them susceptible to several adverse reproductive health outcomes.

Evidence suggests that in host countries, migrant women experience poor living conditions particularly in asylum centres (Vervliet et al. 2014) and difficulties finding employment (Robertson 2015) or at times are forbidden to work (Briscoe and Lavender 2009). The financial burden brought about by these challenges along with the remittance expected by migrants' families back home (Rapa 2015) often results in difficulties covering living costs (Phillimore 2015) and transport to access healthcare services (United Nations Population Fund 2018). It also restricts migrants from communicating with their families (Ny et al. 2007). Furthermore, settling in a new country is often accompanied by feelings of isolation, cultural shock, different policies and social norms (Connor 2012), racial discrimination, social oppression (Murray et al. 2010), and stigma when lacking understanding of the host country's language (Phung et al. 2020), all of which may potentially impact their health negatively (Menke et al. 2003). These are some of the social determinants of health responsible for the health inequalities and inequities in migrant women (International Organization for Migration 2021) that impact not only their health and well-being, but also their functioning capabilities and quality of life (Social Determinants of Health 2021).

Along with these challenges, a major social determinant of health faced by migrant women in host countries is communication problems (Rapa 2015). This not only inhibits women's interaction with the community, but also puts them in a more vulnerable position in terms of their health when this challenge is experienced during clinical encounters. This is further exacerbated by migrants' lack of knowledge on the structure and functionality of the healthcare system in host countries (Almeida et al. 2014). In such instances, migrants often resort to relatives or friends to translate communications with health providers and assist them in navigating the healthcare system (Phung et al. 2020). Despite its practicality, the use of relatives as interpreters is strongly discouraged (The Royal College of Obstetricians and Gynaecologists 2008) because the latter may not be able to accurately translate the conversation due to their lack of medical knowledge and the emotional connection they share with women (Cantwell et al. 2011). Moreover, women may fear sharing

personal concerns due to confidentiality issues (Rapa 2015), particularly in cases of domestic violence, where reliance on the husband or family members will undoubtedly inhibit disclosure of abuse (Phillimore 2015).

These limitations affect the delivery of effective maternity care (Cantwell et al. 2011) and may unintentionally threaten migrant women's health (Jonkers et al. 2011). Consequently, evidence suggests that women encountering language barriers during medical encounters should be provided with the service of professional interpreters to ensure effective two-way communication between women and health providers. Yet, despite their obvious need, migrant women are not always offered appropriate interpretation services. Several logistic factors may make the availability of interpreter facilities inconsistent. Some apparent barriers include the shortage of and inaccessible interpreters (WHO Regional Office for Europe 2018b), difficulties organizing a session (Bell et al. 2019) and contacting interpreters, non-attendance to appointments, and professionals failing to book for such services (Phillimore 2015). The provision of unreliable services is one of the reasons why migrant women report negative experiences when using the assistance of an interpreter (Crowther and Lau 2019). This may potentially explain why at times, when given the option, women object to using this service. Furthermore, research indicates that women distrust interpreters due to fear of breach in confidentiality (Mohale et al. 2017) and are sceptic about their ability or willingness to accurately translate the communication (Missal et al. 2016). These barriers limit migrant women from expressing their needs and concerns, which may be indicative of a potential obstetric complication (Phillimore 2015) and hinder understanding of the medical procedures being proposed and the risks involved (Hunter-Adams and Rother 2017). This often leads to non-attendance to medical services (Phung et al. 2020). The use of interpretive facilities is also adversely viewed by healthcare professionals since the involvement of interpreters interferes with the person-to-person communication process so essential to building trust and understanding. There may also be the feeling that what is said during the consultation is paraphrased.

3.1 Psychological Issues Faced by Migrant Women

The life-changing experience of becoming a mother is an emotionally and physically taxing experience for all childbearing women. Yet, amidst all the social adaptations and difficulties that migrant women experience in host countries, the absence of a family and social support system (Ny et al. 2007) makes the adjustment process of the transition to parenthood a hurdle. Migrant women report experiencing deep distress due to hopelessness (Fair et al. 2020) and isolation and, consequently, long for instrumental and emotional support (Rapa 2015), particularly from their own mother during critical moments of the childbearing period (Ny et al. 2007). Along with this, the literature recognizes that migrant women, particularly those seeking asylum, may also experience insecurity of personal identity (Straus et al. 2009), worries concerning the outcome of their asylum application, and fear of the possible impact that rejection may have on their children (Vervliet et al. 2014).

These social support challenges are not the only psychological and emotional issues faced by migrant mothers in the host countries. A multiple case study research reported that past traumatic experiences of both physical and psychological violence witnessed in their country of origin created emotional difficulties that continued to exacerbate the difficulties that migrant women faced during the perinatal period in host countries (Vervliet et al. 2014).

4 The Perinatal Outcomes of Migrant Women

Research indicates that the perinatal outcomes of migrant women are oftentimes worse than those observed for host country nationals (WHO Regional Office for Europe 2018a) despite their interaction with highly complex healthcare systems in most host countries (Bollini et al. 2009). In fact, there is ample evidence suggesting that during pregnancy, migrant women originating from underdeveloped countries are more likely to commence antenatal care later, have less visits during pregnancy (Råssjö et al. 2013), and experience more infections, hyperemesis gravidarum (Råssjö et al. 2013), pre-eclampsia (Urquia et al. 2017), oligohydramnios (Salim et al. 2012), diabetes (Bakken et al. 2015), anaemia (Råssjö et al. 2013), severe life-threatening complications (Urquia et al. 2017), and hospital admissions (Råssjö et al. 2013). Yet, despite these complications, they have fewer medical interventions during pregnancy (Malin and Gissler 2009). This negative trend extends to the intrapartum and post-partum period, wherein the risk of giving birth by caesarean section is higher (Savona-Ventura et al. 2009). Experiencing early post-partum haemorrhage (Salim et al. 2012) is likewise significantly higher for migrant populations. Moreover, when compared to host country nationals, migrant women who give birth by vaginal delivery are also more at risk of suffering from perineal tears (Michaan et al. 2014).

In addition to these adverse maternal outcomes, studies identified that infants born to migrant women have a significantly higher risk of being born premature (Savona-Ventura et al. 2009) or post-term (Bakken et al. 2015), with a low birth weight (Savona-Ventura et al. 2009), small for gestational age, and a low Apgar score (Bakken et al. 2015), and may require more admission to intensive care (Michaan et al. 2014). Besides these complications, the perinatal mortality rate is evidently higher in infants born to migrant women in various countries all over the globe (Råssjö et al. 2013).

4.1 Why Do Migrant Women Have Worse Perinatal Outcomes?

The consequences of these adverse perinatal outcomes are multifaceted and influenced by various personal, social, cultural, and institutional factors and social-health disparities that migrant women experience in host countries. Evidence clearly indicates that poor antenatal care attendance is one of the reasons contributing to the above-mentioned complications among migrant populations (Flenady et al. 2016).

Moreover, language difficulties (Kopin and Integra Foundation 2016), migrants' lack of knowledge regarding their entitlement for prenatal care (Schoevers et al. 2010), and differences that exist in maternity healthcare systems between originating and host countries may be additional factors inhibiting migrant women from accessing antenatal care. One must not overlook the possibility that women's cultural norms, their perception to maternity care, as well as the attitudes of healthcare staff may be other subtle but deeply ingrained factors limiting migrant women from seeking and availing themselves of the available prenatal services. Indeed, migrant women coming from countries where multiparity is perceived to be a cultural norm and therefore where pregnancy is considered to be a natural event in a woman's life may not perceive the need to seek antenatal care (Feldman 2013). Additionally, migrant women may be reluctant to access maternity care fearing that they may lose their job, have their children taken away, or be deported (Schoevers et al. 2010). Furthermore, migrant women originating from countries with a strikingly high maternal mortality rate and where healthcare is provided by low-skilled health providers lacking proper medical equipment and supplies (UNICEF 2019) may be unwilling to seek healthcare in a foreign land, having unfamiliar customs, language, and people.

In addition to poor antenatal care, Flenady et al. (2016) argued that being a migrant, in itself, doubles women's risk of experiencing a stillbirth. Moreover, certain socio-demographic characteristics observed predominantly in migrant populations, such as young age (Savona-Ventura et al. 2009), low educational level (Bakken et al. 2015), unemployment (Råssjö et al. 2013), low socio-economic status (Calderon-Margalit et al. 2015), and low BMI (Salim et al. 2012), have been linked to premature birth (Taylor and Rundle 2016) and its aftermath, particularly, neonatal mortality (Lassi et al. 2014). Likewise, migrant women's medical and obstetrics history plays another fundamental role in determining the outcomes of their pregnancy. In particular, this is evident in the high rate of sexually transmitted infections reported for migrant women, mainly genital herpes, syphilis (Salim et al. 2012), HIV, hepatitis B, and hepatitis C (Savona-Ventura et al. 2009). One must also acknowledge the impact that female genital mutilation or cutting has on women's intrapartum outcomes and post-partum recovery, especially considering that many migrant women are fleeing from countries with a high prevalence rate of this human right violation (World Health Organization 2018).

4.2 Satisfactory Perinatal Outcomes in Migrant Women

Migration flow is a rather dynamic process, typically influenced by the amendments in migration policies, and political systems, and the changes in legislation that occur through the years in host countries. Roman et al. (2010) argued that in addition to economic factors and educational opportunities, other political and social precarious factors such as poor governance, poverty, lack of basic health, human

trafficking, and human rights abuse have influenced migration from the Central and Eastern European region. Considering this diversity in the consequences leading to migration, it is intriguing to note that migrant women originating from this region, who are typically referred to as 'economic migrants', had better obstetric outcomes than host-country women despite having less antenatal check-ups (Martínez-García et al. 2012) and less prenatal ultrasound scans (Malin and Gissler 2009). In fact, research identified that this migrant population experienced fewer complications during pregnancy (Urquia et al. 2017) and had more spontaneous vaginal births (Walsh et al. 2011) and fewer caesarean sections when compared to host countries' nationals (Malin and Gissler 2009).

These pregnancy outcomes can be looked at from the perspective of the healthy migrant effect hypothesis. This hypothesis implies a health selection on migration. It suggests that since only healthy individuals succeed to migrate, these populations have better health status than host-country nationals (Moullan and Jusot 2014). In addition to this, migrants facing language difficulties and lacking familiarity with how the healthcare system operates in the host country often return home to seek medical treatment (Phung et al. 2020). Consequently, this migrant group may receive the recommended prenatal visits back home as reflected in their satisfactory perinatal outcomes.

5 Addressing the Problem

The movement of people impacts all aspects of society and all countries around the globe (United Nations 2020). It presents both challenges and opportunities to host countries (World Health Organization 2021). The healthcare system, particularly maternity healthcare, is one of the sectors that have been greatly affected by migration. Due to the inherently different perceptions towards life, health, and maternity care, the delivery of perinatal care becomes problematic when society becomes increasingly ethnic and culturally diverse (Small et al. 2002), especially when midwives and other healthcare providers practise within highly developed and organized maternity services (Savona-Ventura et al. 2009). Furthermore, the social determinants of health described earlier often lead to misunderstandings and missed antenatal appointments, which frustrate both pregnant women and practitioners (Kopin and Integra Foundation 2016). Additionally, the management of complicated obstetric cases poses challenges to health professionals whose sole purpose is to prevent morbidity and mortality and ensure safe high-quality care (Savona-Ventura et al. 2009).

In view of these burdens, the WHO (2018a) argued that the implementation of strong integration policies in host countries can safeguard migrant women against adverse perinatal outcomes. In fact, a systematic review by Bollini et al. (2009) found that after controlling for maternal age and parity, in countries having a strong integration policy, migrant women had an evidently reduced risk of preterm birth, low birth weight, perinatal mortality, and congenital malformations.

5.1 Supporting Migrants During the Transition to Parenthood: The Role of the Midwife

Midwives play a pivotal role in ensuring that migrant women are provided by the necessary support during the transition to parenthood. The International Confederation of Midwives (ICM) (Migrant and Refugee Women and Their Families 2017) emphasizes the importance of protecting and respecting the rights of migrant women. It advocates for the provision of culturally sensitive care and equity in accessing midwifery services to all childbearing women, in all countries, regardless of their situations, status, and the country from which they originated. The role of midwives goes beyond the physical aspect of the perinatal period. The social determinants of migrant women's health outlined throughout this chapter may potentially compete with antenatal care (WHO Regional Office for Europe 2018b), since the struggles brought about by resettlement in a new country, such as financial issues, may put pregnancy at the bottom list of priorities. Hence, the WHO (2018b) proposes the provision of a complete maternity care package for migrant women. This model of care, however, needs to be addressed from a multidisciplinary perspective in collaboration with governmental health and social care agencies and communities.

A Cochrane review in 2016, involving more than 17,000 women, found that women had better perinatal outcomes when provided by continuity of midwifery care in contrast to those being provided by fragmented models of maternity care (Sandall et al. 2016). Research also indicates that not only migrant women are dissatisfied by the involvement of multiple health providers during pregnancy (Crowther and Lau 2019), but also the fragmented care models affected their prenatal care attendance (Phillimore 2015), as it hindered the establishment of a trustful relationship (Straus et al. 2009) and women's ability to express their needs (Crowther and Lau 2019). This is further exacerbated in the presence of communication difficulties, which continues to delay the acquisition of care migrant women may require. In view of the advantages associated with continuity of maternity care, the implementation of the continuity of midwifery models of care for migrant populations should be on the agenda of midwifery organizations and global associations for maternal and child health and well-being.

Struggles with communication are one of the major difficulties faced by migrant women, midwives, and other health providers during maternity care encounters. Literature suggests that the initial feelings of embarrassment and vulnerability felt by migrant women are counterbalanced by feelings of safety especially during childbirth when healthcare providers adapt to women's communication needs (Crowther and Lau 2019). Consequently, Hayes et al. (2011) suggest that women's requirements for interpretation services should be determined at an early stage during the pregnancy so that the use of these facilities would be organized for subsequent appointments up until childbirth. This is also in line with the ICM (Migrant and Refugee Women and Their Families 2017) position, which supports the use of translators when necessary. Healthcare providers caring for migrant mothers should endeavour to provide relevant literature in the women's vernacular language

outlining the services available together with an outline plan of routine antenatal care generally provided. This literature resource should include information on the range of antenatal, intrapartum, and post-partum services available. In addition, information should be provided in respect to other available social and support services.

Midwives' attitudes are significant in shaping migrant women's perinatal experiences. The ICM (Migrant and Refugee Women and Their Families 2017) strongly suggests midwives to provide humanized care for migrant women. A large body of literature suggests that migrant women value health providers' respect (Mohale et al. 2017) and culturally sensitive care (Carolan and Cassar 2010) as this leads to a more meaningful perinatal experience (Crowther and Lau 2019). Moreover, professionals' presence and emotional support (Missal et al. 2016), explanations (Siad et al. 2018), advice, and reassurance (Glavin and Sæteren 2016) enable the establishment of a trusting relationship (Missal et al. 2016), which makes women feel safe especially during childbirth (Crowther and Lau 2019). These positive experiences signify the importance of the midwife's role in providing culturally competent continuity of maternity care (Fair et al. 2020).

5.2 Future Directions

The disparity in perinatal outcomes observed in migrant populations raises several questions and concerns about the quality of maternity care being offered to migrant women in host countries. In view of this, it is necessary that further studies are undertaken from the clinical perspective to observe the quality and effectiveness of the current maternity services. Studies are also needed to identify whether the current maternity services are actually being reached by all migrant women and, if not, identify other more effective models of care particularly in the community. Moreover, it is significant to conduct research to determine how the delivery of perinatal care can be improved to address migrant women's needs and promote attendance. Future research also needs to address service providers by exploring the viewpoints, experiences, and challenges that midwives and maternity healthcare professionals encounter when caring for migrant women.

In addition to these recommendations, it would be of great value to gather disaggregated data such as migrants' year of arrival in the host country; their socioeconomic, behavioural, and environmental determinants of health; and inputting this data into pre-existing health databases (WHO Regional Office for Europe 2020). This will enable researchers to conduct in-depth retrospective analysis on migrant women's health, pregnancy outcomes, and risk factors predisposing women and infants to certain complications. Furthermore, this will ultimately inform policymakers to ensure that the maternity healthcare systems currently in place are inclusive to all migrant women.

Although this chapter provided a brief overview of the social determinants of health faced by migrant women in host countries, the diversity in migrant groups and integration policies in host countries merits investigation of the risk factors that

place certain migrants at increased risk of adverse complications during pregnancy. Moreover, in-depth qualitative studies need to be carried out to understand migrant women's views towards maternity care and their experiences of pregnancy and childbirth in host countries. Yet, it is imperative that conclusions drawn from these studies should bear in mind the socio-cultural diversity in migrant populations, especially if the study sample is significantly heterogenous in terms of nationality and socio-cultural background.

6 Conclusion

Migration is far from a recent phenomenon. The movement of people across international borders has been part and parcel of human history and will remain evident throughout the decades which follow. Although migration presents challenges to the health, social, and economic sectors, migration can provide a valuable contribution to the development of both originating and host countries when migrants are supported by the appropriate policies (United Nations 2020).

This chapter introduced some of the social aspects brought about by migration. It centred its focus on the vulnerabilities associated with being a woman and a migrant and outlined how the social determinants of migrant women's health brought about by migration can have a major impact on their perinatal outcomes. The significance of the midwife's role in supporting migrant women during the transition to parenthood has been emphasized, particularly in ensuring that all migrants have access to person-centred, culturally sensitive continuity of maternity care. In conclusion, future directions for the improvement of maternity care services have been outlined and recommendations for additional research were put forward.

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Midwives and the Transition to Fatherhood

Georgette Spiteri, Nicole Borg Cunen, and Rita Borg Xuereb

1 Introduction

Fathers are increasingly taking on a more active role in both partner support and rearing of their children due to an increase in maternal gainful employment and due to the emergence of more isolated families (Lamb 2010). Increasing support and involvement from fathers have expanded the literature exploring issues relating to fatherhood (May and Fletcher 2013). However, when this is compared to the research done around motherhood, fathers feature much less. Despite this, evidence has highlighted the significant role fathers have in enhancing maternal well-being and improving the quality of their children's physical, emotional and social development, which in turn is associated with a reduction in criminality, antisocial behaviour and substance abuse (Lamb 2010).

This chapter draws on the qualitative findings elicited amongst male participants from two PhD studies (Spiteri 2018; Borg Cunen 2021), which were carried out in Malta. The study by Spiteri (2018) explored how men prepared for first-time parenthood, from the preconception period to the first post partum year. Borg Cunen's study (2021) looked at men's experiences of conceptualising and relating to the unborn child across pregnancy.

Midwives are at the forefront in supporting women and their partners in their transition towards parenthood. Despite this, first-time fathers describe minimal or no support during this process (Spiteri 2018; Deave and Johnson 2008; Fenwick et al. 2012; Borg Xuereb 2008). Research has shown that men require more support and guidance in their role as fathers (Lamb 2010; Spiteri 2018; Borg Xuereb 2008). This chapter aims to shed light on the experiences of men as they navigate through

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parenthood to inform midwives and other health practitioners in ways in which men require their support to facilitate their transition.

2 Men's Experiences of the Preconception Period

The preconception period can be viewed as a time in which couples optimise their health to improve reproductive outcomes. However, this notion does not come naturally to all parents in preparation for parenthood. Research has identified precursors that need to be in place for men to actively start preparing for parenthood (Spiteri 2018). Men describe needing to feel ready for parenthood and associate this readiness with a broader sense of stability. This stability is related to relationship and financial security. Many a time, men take up the responsibility for their new role as a parent by preparing financially to have a baby by working overtime or taking on extra shifts (Spiteri 2018). During the preconception period, men view themselves and their partners as being responsible for different aspects of preparation, which are equally important (Spiteri 2018). Financially contributing to their families has been shown to result in enhanced psychological well-being amongst men (Schindler 2010):

> *I cannot prepare to have a baby without having the financial stability for the experience*. (Spiteri 2018, Roger).

Many men's desire for parenthood stems from this innate need to contribute to the world by leaving their mark through having their own children. The prospect of parenthood offers men a sense of personal achievement, which can be viewed as an emotional positive childbearing motivator (Spiteri 2018; Borg Xuereb 2008):

> *It's a wonderful experience to get to say that you are going to have a child and that you are going to give him or her your best. It is like you get to make someone better than you are for future generations so that the world will be a bit better than it is today, it's something amazing*. (Spiteri 2018, Jamie).

Men expressed social positive childbearing motivations in the form of continuity as parenthood would allow for familial lineage and a sense of immortality (Spiteri 2018). The desire of having a biological link with a child has been described as another motivator for fatherhood (Spiteri 2018). This is similar to the personal fulfilment factor, which focuses on the intrinsic motivations related to the inherent satisfaction of having a child (Borg Xuereb 2008; Miller and Jones 2009). In Spiteri's study (2018), Ricky, an expectant father, referred to his unborn child as the "*fruit*" of his "*loins*" [p. 16, 356]. The use of Biblical terms in the context of parenthood sheds light on the spiritual and religious meanings placed on the experience by many of the participating men in her study. The unique context of the study may have influenced men's views in relation to this context. Within more traditional and religious communities, men also attribute their religious and moral obligations as a driving force for seeking parenthood (Spiteri 2018).

In the preconception period, men have expressed fearing the unknown, especially with regard to the possibility of the inability to conceive but also in relation to pregnancy outcomes (Spiteri 2018). Acknowledging these difficult situations was a means by which men achieved an element of preparation in this regard (Spiteri 2018):

> *I am prepared for everything and anything. I am also ready for the eventuality of not being able to conceive because that is also important, I think*. (Spiteri 2018 Ken).

Research with men has also identified that most do not prepare for parenthood from a lifestyle point of view during the preconception phase (Spiteri 2018) despite the recommendations that men should aim to reach and maintain a healthy weight during this time (Centres for Disease Control and Prevention (CDC) 2018). Men who are either underweight or obese are at risk of developing serious health issues, and obesity is also directly related to male infertility (Moos et al. 2008; Sallmén et al. 2006). Preconception recommendations for men include engaging in behaviours that do not harm male sperm as recommended by the CDC (2018). Alcohol consumption, drug use and cigarette smoking all contribute to changes in male sperm, which in turn results in infertility (O'Brien et al. 2018). From an ethical point of view, men have a moral responsibility to engage in healthy lifestyle behaviours during the pre-pregnancy phase to optimise a safe environment to bring up their children (O'Brien et al. 2018).

3 Transition to Fatherhood

While research has documented the important supportive role men have during pregnancy and childbirth, their own experiences and development towards fatherhood appear less explicit. During pregnancy, many men accompany their partners for hospital appointments and ultrasound scans. Pregnancy scans offer men a visual confirmation and an opportunity to register the changes that occur within the female body (Spiteri 2018). This is crucial in helping men come to terms with impending fatherhood. Research has shown that one of the best access points to the unborn baby for men was indeed through ultrasound scans (Poh et al. 2014). These appointments and images increase men's awareness of the baby and trigger a realisation that within their partner's body was a real baby, a human being and not an abstract concept (Poh et al. 2014):

> *The hospital visits and the ultrasound scans were also a very important part of how I prepared even when we went for the 4D scan. I think that was the first time I really understood that we have a baby already, that it is really happening. I got to see him move, it was amazing*! (Spiteri 2018, Ricky).

Dissimilar to the preconception period, some men accompany their partners during pregnancy with regard to engaging in healthy lifestyle behaviours such as healthy eating and exercise (Spiteri 2018). Men who view themselves and their partners as being two unrelated and separate entities do not engage in this type of

preparation as it is not deemed as necessary by them. In fact, these men do not feel the need to quit smoking or drinking because of their lack of biological and physical connectedness to the unborn child. These men appear to separate themselves from the pregnancy and are less thorough in their pregnancy preparations for fatherhood (Spiteri 2018):

> *Unlike myself, she is carrying the baby, so for sure the relationship that we have with our baby is already different. For example, I've never threw up throughout the pregnancy. She quit smoking, but I continued. Had I been the one carrying the child, maybe I would have quit. So, with regards to our lifestyle preparation, there are things that obviously were different for us because she is carrying the child*. (Spiteri 2018, Joey).

Research has shown how some men modify their social behaviours to adhere to what would be perceived as good and socially acceptable (Spiteri 2018; Poh et al. 2014). In a qualitative study conducted with seven first-time expectant fathers in Sweden (Finnbogadóttir et al. 2003), findings highlighted how men experienced some psychological, social and/or physical changes during the pregnancy with some expressing feeling socially isolated during this time.

Most men become highly protective of their partners during the pregnancy, ensuring that they are left comfortable (Spiteri 2018; Borg Xuereb 2008). This can be described as one of their main responsibilities during the pregnancy period. This protectiveness is in fact a form of their preparation for fatherhood which can, in turn, be linked to their masculine characteristics. Similar findings were elicited in other research as participants experienced feelings of heightened responsibility about taking greater care of their partners during the pregnancy phase (O'Brien et al. 2018; Finnbogadóttir et al. 2003).

During pregnancy, men also take on the role of ensuring that the home environment is welcoming for the new baby (Spiteri 2018). This type of preparation is particularly important to men as it allows them to exercise an element of control over an experience that most of the time leaves them feeling like a bystander (Spiteri 2018; Finnbogadóttir et al. 2003). This type of preparation allows them to be in charge of all the strenuous physical labour that is involved while getting their homes ready to welcome a new child. Despite this, research has shown how some men are apprehensive about getting things in order too early because they fear something may happen to the unborn child (Spiteri 2018). Evidence suggests a twofold explanation as to why men feel sidelined during pregnancy. Firstly, men report feeling invisible to the experience when compared to their partners whose bodies were changing and showing very obviously that they were pregnant. Secondly, men also feel disregarded by most health professionals they meet during the pregnancy (Spiteri 2018; Finnbogadóttir et al. 2003).

Many expectant fathers have also expressed feeling anxious and afraid about what the future held for them, especially concerning the impending birth (Spiteri 2018). New fathers expressed feelings of relief upon seeing a healthy child and partner post-birth (Spiteri 2018; Poh et al. 2014). Many men around the world have viewed the pregnancy and birthing experiences as epoch moments (Spiteri 2018; Finnbogadóttir et al. 2003; Roberts 2016). These instances offer men visual

confirmation of how and why their lives were changing. Childbirth has a significant impact on many men's feelings of becoming fathers (Spiteri 2018; Iwata 2014). Meeting their child for the first time has an unparalleled effect on experiencing the reality of the child as men transition from a hypothetical situation to an actual one during the actual birth (Iwata 2014).

Men have also confessed to having kept negative emotions like fear and anxiety to themselves during the pregnancy period because they did not want to worry their partners (Spiteri 2018). The extent to which men share their feelings, concerns and worries with others is unknown (Poh et al. 2014). This may be associated with their masculinity (Dolan and Coe 2011). In traditional communities like Malta, society sends both indirect and direct messages about men's emotional expression (Christie 2013). The study by Christie revealed how society portrayed men as individuals whose emotions should be under control and there appeared to be an association between emotional expression and weakness (Christie 2013). Hence, when faced with negative emotions such as fears or anxiousness related to the pregnancy or the impending birth, some men might not verbalise their worries but suffer in silence. This corresponds with the "stereotype masculine display rule" described by Polce-Lynch et al. (1998, p. 1038) and has implications for health professionals who work with men in preparation for parenthood. Anticipating any negative emotions in men by educating and discussing relevant issues may offer a step in the right direction (White 2007).

Similarly, in other research studies, men have been expected to be manly, physically strong and, therefore, able to defend their families (Perälä-Littunen 2007). Moreover, evidence has shown that fathering a child is a symbol of sexual virility, an important masculine marker as are other important fathering roles, namely being the financial provider and moral protector as previously explained (Hunter 2006; Marsiglio et al. 2000). Good fatherhood has also been associated with discipline (Spiteri 2018; Marsiglio et al. 2000). Mkhize (2006, p. 186) explained that "fatherhood is intertwined with the process by which men come to an understanding of who they are … [it] does not occur in a vacuum … [but] is informed by the dominant discourses of what it means to be a man in one's society". He described fatherhood as being "interconnected with the social production and reproduction of masculinities" (Mkhize 2006, p. 186). It needs to be acknowledged, however, that the standards of masculinity and how men relate to their offspring vary across different cultures and historical periods.

4 Fathers' Affiliation with the Unborn Child

During the gestational period, expectant fathers, like their female counterparts, develop a degree of emotional affiliation with the unborn child (Borg Cunen 2021). However, their experience of relating to the foetus necessarily differs from that of their female counterparts in certain ways, with a major factor in this being the comparative paucity of physical contact they have with the unborn child (Draper 2003a).

While expectant parents of either gender struggle to internalise the reality of foetal presence in the initial weeks of pregnancy (Della Vedova et al. 2008),

experiencing physical symptoms often serves to authenticate the gestation in the expectant mothers' minds (Borg Cunen 2021). Men, however, require access to directly observable physical manifestations of the unborn child's existence for their feelings of incredulity to diminish, something that only becomes possible later in the gestation (Habib and Lancaster 2006, 2010). These signs include obvious bodily changes in the expectant mother, externally palpable foetal movements and an easily recognisable foetal image on ultrasound scans (Habib and Lancaster 2006, 2010). A delay in internalisation means that men are often slower than their female partners to become immersed in the pregnancy and emotionally engaged with the unborn child (Borg Cunen 2021; Habib and Lancaster 2010).

Men's "*disembodied*" (Draper 2003a, p. 746) experience of pregnancy continues to put them at a disadvantage in developing emotional proximity to the foetus as the gestation progresses. By mid-pregnancy, gaining the ability to feel the foetus moving within herself often facilitates a sense of intimate interconnectedness with the unborn child for women (Borg Cunen 2021; Berryman and Windridge 1996). However, expectant fathers are often on the other end of this spectrum and frequently feel somewhat disengaged (Ustunsoz et al. 2010). For men, cues about the unborn child's existence are far and in between, and it is easy for them to leave behind thoughts related to the foetus when engaged in other activities, such as work (Borg Cunen 2021; Draper 2003a). They are less consistently immersed in the experience, and their feelings of emotional proximity to the unborn child tend to vacillate in intensity, being stronger when they are close to their female partner, who serves as a reminder of foetal presence (Borg Cunen 2021):

> *I'll be at work, all the hectic day, 9 till 6 … then in the evening when we're sitting on the sofa, I sort of realise like, "Hey, we are three people now, is that real?" You know? Sometimes you've got to go and feel her*. (Borg Cunen 2021, Julian).

Apart from gender disparities in the physical experience of pregnancy, expectant fathers' interpretations of their relations with the unborn child are influenced by the competing discourses around fatherhood that exist in contemporary Western society (Condon 1985). Men's attitudes towards the unborn child often fall within a range of two contrasting attitudes (Borg Cunen 2021), with Raphael-Leff (2005) terming these as "participator" and "renouncer".

During the gestational period, some men are predominately content to exist on the periphery, allowing their female partners to nurture the unborn child without much input from their end (Borg Cunen 2021). These men rationalise that it is natural for the mother to develop the predominant tie to the foetus and often expect that these distinct parenting roles will persist even after the infant's birth (Maushart 2008; Dermott 2008). They tend to belong to a school of thought that suggests that it is genetic differences that primarily determine parental gender roles (Cassidy 2008; George and Solomon 2008). Condon (1985) suggests that some men do not regard feelings of affinity to the unborn child as being compatible with their notions of masculinity and may thus suppress such emotional reactions or avoid their external expression.

In contrast, other expectant fathers are eager to be involved in the pregnancy at every stage, expressing an extent of envy of their female partner's physical immersion in the experience (Draper 2003a), a phenomenon which has been termed "womb envy" (Bayne 2011). Their vicarious access to the unborn child is not enough, and they yearn to achieve the same level of "oneness" with the foetus that they perceive their partner to effortlessly have (Borg Cunen 2021). They seek opportunities to connect to the unborn child whenever possible, determined to overcome their disadvantage through effort (Borg Cunen 2021).

Contemporary discourses about "involved" fatherhood may be influencing these men's drive for foetal engagement to an extent that was uncommon in previous generations (Draper 2002). Raphael-Leff (2005) argues that sex-role expectations are gradually changing and that both men and women are, in many Western societies, now at liberty to adopt, fluidly, traits habitually associated with the opposite gender, such as, in the case of men, the "expressive" function.

Thus, while an emotional tie to the foetus may develop naturally and spontaneously for many women over time, for men, the foetal tie is somewhat more optional (Borg Cunen 2021). Widarsson et al. (2015) aptly use the term "paddling upstream" to describe the barriers that expectant fathers face to feel involved. While achieving a sense of intimate proximity to the foetus is entirely possible for men, the strength of the tie is primarily determined by the amount of effort he chooses to put into nurturing it (Borg Cunen 2021).

The energy men choose to put into the endeavour of forming an emotional tie to the unborn child largely depends on their interpretation of their role within the family unit. Habib and Lancaster found that men who assigned importance to caregiving and emotional support scored higher on a foetal attachment measure than those who did not (Habib and Lancaster 2006). In the same study, seeing oneself as a "breadwinner" was not associated with the strength of the antenatal tie (Habib and Lancaster 2006).

Dermott (2008) and Miller (2011) talk about contemporary fatherhood being characterised by inconsistencies, one of which centres on the ever-increasing cultural representation of fathers as nurturing and intimately involved, contrasted with ongoing inequality in actual child-related domestic division of labour. While many fathers long to increase the time they spend with their children at home, deeply embedded gendered stereotypes about men's primary role as breadwinners, and a failure of systems to encourage the male caregiving role, restrict their ability to do this (Dermott 2008; Gatrell 2005; Giddens and Sutton 2017).

Aside from their physical separation from the pregnancy, expectant fathers' access to, and influence over, the unborn child is further complicated by the expectant mother's agency in acting as a gatekeeper to the foetus residing within her (Borg Cunen 2021), a phenomenon noted to continue even in the post-partum period (Gaunt 2008). During the gestational period, expectant fathers are forced to connect to one person through another. Therefore, the paternal tie to the foetus depends somewhat on another person's cooperation and, in this instance, the quality of their relationship with their significant other (Borg Cunen 2021).

The presence of the woman as an intermediary affects the expectant father's experience with the unborn child in several ways. For instance, while expectant parents of either gender feel protective over the unborn child (Sandbrook 2009; Hallgreen et al. 1999), men need to tread carefully when putting safeguarding efforts into practice. If their protective efforts involve setting limits to their partners' activities, this may be interpreted by the women as paternalistic and overbearing (Borg Cunen 2021). In a patriarchal society, pregnancy is often perceived as a period of empowerment for women, when they feel like they have ownership over the foetus and thus a right to exert control over him/her without interference (Gatrell 2005; Higginbottom et al. 2013).

In her agency as a gatekeeper, the expectant mother also influences the extent of foetal interaction that the expectant father engages in (Borg Cunen 2021). Thus, when a man solicits intimate access to the unborn child, through attempting to palpate foetal movement through the maternal abdomen, for instance, the woman controls whether to allow him to move closer or to push him away, protecting her bodily boundaries (Borg Cunen 2021; Draper 2003a). On the other hand, when the expectant father is not perceived to be exhibiting enough investment in the pregnancy, women may try to draw them further into the experience through encouraging foetal contact bids (Borg Cunen 2021; Schwerdtfeger et al. 2013).

In the male mind, this arrangement means that their connections to the partner and the foetus are somewhat intertwined, with the expectant mother necessarily an enmeshed participant in the development of the paternal-foetal tie (Draper 2003a). This way of thinking is exhibited, for example, in instances where expectant fathers describe feeling close to the child when connecting to their partners, either physically or emotionally.

> *Even while hugging her maybe and hugging him at the same time. It's not the first time that I hugged her, and I imagined that we're already the three of us*. (Borg Cunen 2021, Matteo).

The indirectness of their tie to the foetus, and their limited ability to connect one-to-one with the unborn child, is experienced as frustrating by some expectant fathers, who long for a time after the birth when they can spend time alone with the infant in the absence of the mother, nurturing an individual relationship (Borg Cunen 2021). The emphasis that men place on limited examples of this individual tie achieved during pregnancy highlights the importance they ascribe to being able to connect to the baby directly, in a sense cutting out the middleman (Borg Cunen 2021):

> *I feel closest to the baby] in the evening when the mother is sleeping, and I touch her tummy and [the baby] starts moving. I say, "It's just the two of us awake, and the other one [is] asleep*. (Borg Cunen 2021, Kurt).

Thus, the man's foetal tie is largely vicarious and regulated by the female partner (Borg Cunen 2021). In this way, pregnancy is a period where motherhood is promoted and fatherhood is somewhat relegated (Draper 2003b).

During the gestational period, expectant fathers often experience an uncertainty about how the arrival of the child will affect their lives (Borg Cunen 2021; Baldwin et al. 2018). Fears about disruption to their established routines and relationships sometimes overshadow otherwise positive perceptions of the foetus (Borg Cunen 2021). One of the men's primary concerns relates to the potential influence of the child's arrival on the couples' dyadic bond (Baldwin et al. 2018). Expectant fathers tend to worry that their female partner's attention will shift away from them and onto the unborn child upon the birth, resulting in them being sidelined (Gatrell 2005):

> *The attention she used to give me now has shifted towards the baby, but I can understand that, and I expect it to continue once the baby is born with me being left out of the picture. I know that will happen, but I don't know how it will make me feel. Hopefully, knowing that it will happen will help me prepare for it.* (Spiteri 2018, Jamie).

This fear of being downgraded in their partner's eyes is likely related to wider feelings of exclusion during the pregnancy, as well as the tendency for the dyadic sexual relationship to decline in quality during the transition to fatherhood (Baldwin et al. 2018).

5 Fathers' Postnatal Experiences

New fatherhood presents itself with many contradictions for men. Some struggle with the idea of their expanding roles (Spiteri 2018; Iwata 2014). For men, the reality of new parenthood requires a mental shift to manage all their new responsibilities (Spiteri 2018; Iwata 2014). Many new fathers are presented with a dilemma as they feel as if they are expected to be present at home, to be able to care for their child and partner, but also need to go to work to contribute financially to their growing families (Spiteri 2018). Some find it difficult to strike a balance with their new responsibilities and retaining a bit of their pre-father self.

Although most fathers experience the transition to parenthood positively, around 10% of new fathers may experience depression and/or anxiety, antenatally and/or postnatally (Condon et al. 2004; Nazareth 2011; Leśniewska et al. 2021). Potential risk factors that can contribute to the development of perinatal depression in men include a history of depression, high expectations antenatally, maternal depression, low levels of social support and relationship dissonance (Paulson and Bazemore 2010; Schipper-Kochems et al. 2019). Leach et al.'s (2016) systematic review of 43 international studies reported that anxiety was common during the perinatal period with approximately 16% of men reporting high levels of anxiety after the birth of their child. However, since many of the studies lacked a control group, it could not be classified as a specific anxiety disorder (Leśniewska et al. 2021).

Studies highlight that fathers' perinatal mental health plays an important role in their children's behaviour and development (Nazareth 2011; Eddy et al. 2019). Therefore, raising awareness through the availability of information concerning men's perinatal mental health and its implications for the whole family is beneficial for fathers, the family and society at large. It also seems judicious for fathers to be

screened for perinatal mental health alongside mothers. Education of health professionals about men's perinatal mental health and its implications for the health of the whole family is needed.

Flexibility and adaptation are characteristics that are warranted so that new fathers can transition to fatherhood better (Spiteri 2018; Iwata 2014). Acknowledging how vital their presence is in the post-partum period enhances their well-being (Spiteri 2018). The first post-partum year offers men a sense of achievement, having managed to get through it despite all their worries leading up to it (Spiteri 2018; Deave and Johnson 2008). This is made possible as they learn to adapt in times of change, becoming resilient in the process (Spiteri 2018; Spiteri et al. 2014). Being able to manage their stress to function well even when faced with the challenges of new parenthood is an admirable quality amongst men during their transition to fatherhood. Using their inner strength, men push forward to meet all the new demands put on them in the post-partum period, which has been described as self-sacrificing by some fathers (Spiteri 2018):

> *My life changed completely. With regards to personal time for myself definitely, it is much less, but I wouldn't have it any other way. Despite it being a difficult, hard, self-sacrificing experience, at the end of the day, when I put my head on the pillow at the end of the day, exhausted, tired and beat I think to myself I am a father, and it is definitely worth it. So, if I had to go through this process all over again, I definitely would*. (Spiteri 2018, Jan).

6 Midwives' Role in Supporting Men During Their Transition to Parenthood

Irrespective of their parenthood status, men acknowledge the important role of midwives in supporting and educating them in their transition to fatherhood. In the qualitative study by Spiteri (2018), many men, however, put forward multiple suggestions for midwives and their services intending to improve the support given to expectant and new fathers. Firstly, many identified the preconception period as an area that needed much improvement. They also perceived informal discussions with midwives as being an effective means of gaining insight into a person in preparation for parenthood. This may help to identify their needs and offer support as necessary. They felt as if through conversations with midwives, they would have the opportunity to be informed about issues relating to preparation for first-time fatherhood and would be allowed to voice any concerns they might have during that time (Spiteri 2018):

> *Maybe something can even be organised for the preconception phase too because I feel there isn't any form of support in that regard … Maybe there can be somewhere within the hospital or in the community that caters for people who have any type of question relating to the experience so that they can feel better prepared and supported for the experience. When a person gets to talk about certain issues that might be worrying him, I think he will be better prepared for the impending experience. So, I think having a chat is the best way*. (Spiteri 2018, Jan).

Men from Spiteri's study also suggested that antenatal education should commence earlier on as presently most courses commenced halfway through the pregnancy, so the first few lectures were deemed to be too late for them (Spiteri 2018). This suggestion might help men who appear to be in denial of the experience until the birth of the child as it might help them to actualise the changes that occur during pregnancy. Group size recommendation was also put forward by men whereby they suggested that these should be kept small so that individuals would feel comfortable talking about sensitive and private issues (Spiteri 2018):

> *Maybe midwives can create more awareness through education. I think the educational classes they provide are very useful, but I think ideally, they should be conducted in smaller groups. I think this will actually help both the midwife and the attendees because I think they will feel more comfortable in a smaller group setting. I think men might be a bit apprehensive in discussing at group level so maybe having smaller groups or even one-to-one sessions would help.* (Spiteri 2018, Roger).

Moreover, the psychological impacts and men's mental health during the transition to fatherhood need to be taken into account. Men from Spiteri's study (2018) confessed that they would worry about the impending changes without disclosing their true feelings to their partners:

> *Then, she'll go to bed, I'd always stay pondering on what will happen, how are we going to get by and all these types of things. I worry, but I don't show her*. (Spiteri 2018, Ricky).

Ricky's experiences of keeping his worries to himself stress the importance of offering adequate support to men as some risk their own mental well-being to protect their partners. Concealing one's true feelings may also contribute to heightened anxiety, which has further implications for the health and well-being of men during the transition to fatherhood.

7 Conclusion

The chapter sought to gain insights into the father's experiential relationship with the foetus, reflect on how men transition to fatherhood and consider ways how midwives could support both the mother and her partner during this challenging transition. The transition to fatherhood is a physical, emotional, psychological and spiritual journey; however, it is often poorly defined. Fathers endorsed their desire to be more involved during their partners' pregnancy, birth and postnatal period, yet they felt excluded and unsupported by maternity services. While women and their infants are at the centre of care, it seems that there are opportunities for better engagement with fathers. Midwives and other healthcare professionals have an active role in supporting and facilitating this by encouraging fathers to attend appointments and antenatal/postnatal classes with their partners and, where possible, to focus some parts of antenatal education specifically on fathers.

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Diversity of Family Formation: LGBTQ+ Parents

Zoe Darwin and Mari Greenfield

1 Introduction

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) people have been parents throughout history, in various cultures around the world. Many terms are used in describing sexuality and gender diversity, and whilst this language continues to evolve rapidly, we have provided current terms in Appendix 1 which may offer helpful orientation and some shared understanding. Growing interest and awareness in LGBTQ+ people pursuing parenthood may reflect increasing numbers but also increasing *visibility*, which—in some countries—may be linked to changing social and legal recognition of sexual minority and gender minority people as parents. Routes to parenthood for LGBTQ+ people (and indeed anyone) may include fostering, adoption and surrogacy. This chapter concerns LGBTQ+ people's routes to parenthood where one of the parents is pregnant, reflecting this book's focus on the unique relationships that midwives, nurses, doctors and other healthcare professionals enjoy with parents during their transition to parenthood.

In most countries, we do not know how many LGBTQ+ people use perinatal services, because neither gender nor sexual orientation is routinely recorded. Some data is available through birth records and through assisted conception clinics; however, these do not provide the complete picture for various reasons, including perinatal loss and conception outside of formal clinic arrangements. In addition, the data focuses on female couples, with other LGBTQ+ people being more difficult to

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identity in many data sets: for example, LGBTQ+ people who are in (or assumed to be in) opposite-gender/cishet relationships and LGBTQ+ people who are lone parents, as well as any LGBTQ+ people becoming parents using surrogacy. The small amount of evidence we do have suggests that the numbers of both lesbian parents and trans men gestational parents are increasing. Available data in the UK suggests that the number of lesbian parents has been increasing by around 15–20% a year (Darwin and Greenfield 2019).

Because we do not have cohort data about the gender or sexual orientation of expectant parents, we do not know if there are different outcomes for parents or babies in terms of mortality, physical morbidity or perinatal mental health difficulties. In addition, most perinatal research is 'centred within a heteronormative framework' (Charter et al. 2018) and rarely asks demographic questions about parents' gender or sexual orientation, meaning that there is very little evidence that we can rely on when thinking about the relationship between a midwife and an LGBTQ+ family. The small amount of evidence that does exist suggests that LGBTQ+ people face unique challenges on their journeys to parenthood. We note too that this evidence is taken from countries where it is deemed sufficiently safe to ask about and record people's sexual and gender identities and that there will likely be different/further challenges elsewhere. In this chapter, we examine this evidence using the journey from preconception to the early postnatal period as a guide.

Where available, we consider evidence concerning both birthing and non-birthing parents. This is consistent with wider calls for attention to transition to parenthood for fathers. Furthermore, it recognises that more than one parent may be pursuing gestational parenthood and may therefore have contact with midwives and other professionals in multiple capacities, between (and potentially within) pregnancies. There has been a policy shift in several countries towards recognising fathers as *parents*, not solely as *partners*, as part of supporting transition to fatherhood and addressing fathers' experiences of feeling excluded (Steen et al. 2012). Currently, the same recognition is not consistently afforded to non-male co-parents, with the status of 'parent' usually only given to male partners. Language that adopts the assumption that all birth parents are women and that all mothers are birthing parents is problematic in several ways (Darwin and Greenfield 2019). Within practice, this stance may prevent a complete family history being taken by a midwife, for example, by focusing on the reproductive history of the individual that is the focus of the current maternity care. Language (in practice and in research) that focuses on established pregnancies and births in one cis birth mother will fail to fully capture a family's journey to parenthood, for example, previous perinatal loss and pregnancies relating to a non-birth mother (Box 1).

Box 1 Developing Self-Awareness
This chapter may help you to:

- Develop your awareness of the diversity of family forms, specifically in relation to sexual and gender diversity
- Gain insights into the experiences of LGBTQ+ individuals in the perinatal period and how these may vary within and across sexual and gender minority groups
- Consider some of the potential vulnerability factors facing LGBTQ+ people in the perinatal period
- Develop self-awareness through reflecting on your own assumptions, attitudes and beliefs
- Consider what this means for your own midwifery practice and for your own organisation

2 Conception

LGBTQ+ people will often need to make choices about how to conceive; however, whilst assisted conception is more likely amongst LGBTQ+ people, there is also evidence of increased numbers of adolescent unwanted pregnancies (Hodson et al. 2017). This may be relevant both to pregnancies that are continued and to care in subsequent pregnancies, both concerning the parents' experiences and the assumptions made by midwives and other practitioners concerning reproductive history. We focus here on options concerning assisted conception, implications for antenatal care and birth choices, legal recognition as parents and, lastly, perinatal loss.

Some LGBTQ+ people will be able to conceive at home, via either sexual intercourse or home insemination using their partner's sperm. Other LGBTQ+ people will need to use a donor or third party. This may be someone who is known to them or could be an unknown donor arranged via a fertility clinic. Unknown donors may vary in the level and length of anonymity, and rules governing anonymity differ in different countries/localities. Third-party reproduction using a sperm donor may be done at home or may involve procedures conducted at a clinic, with varying levels of medical intervention, for example intrauterine insemination (with or without medication) or IVF. Where IVF is used, the gestational parent may not be genetically connected to their baby; for example, their partner's eggs may have been used and this could be for various reasons. Because there is not yet shared acceptable language in describing these families, in some places the pregnant person may be described as having received egg donation, and in others, they may be described as

being a surrogate, neither of which may be accurate and both of which may cause distress to the parents.

Some LGBTQ+ people will experience fertility issues and will need to use assisted conception services to conceive. The research evidence that exists shows that LGBTQ+ people may face difficulties when accessing fertility services. In the UK, interpretation of guidance and commissioning decisions can vary locally, and heterosexism within NHS services may mean that funding is only available for those who have been trying to conceive via sexual intercourse. Indeed, research evidence repeatedly offers examples of poor interactions with healthcare providers. This includes both obtaining an initial referral within primary care and poor treatment within specialist services, for example, uninformed practitioners in primary care who may simply lack relevant knowledge about access for LGBTQ+ people (Charter et al. 2018), but there is also evidence of direct discrimination with individual clinicians refusing to provide fertility services to LGBTQ+ people entirely (de Carvalho et al. 2019; Dempsey et al. 2022).

Where an LGBTQ+ person has used a fertility clinic solely to access sperm, without subfertility or infertility, they may be subjected to unnecessarily invasive procedures in preparation for or as part of conception (de Carvalho et al. 2019; Dempsey et al. 2022). Once under the care of a midwife, their pregnancy is considered 'high risk', with implications for antenatal care and birth choices. Whilst there is evidence that outcomes for pregnancies after IVF are worse than naturally occurring pregnancies (Qin et al. 2017), there are no studies which separate the outcomes for LGBTQ+ or single people who simply need access to gametes. Thus, recommendations are used that are based on pooled data which may be inaccurate for these groups. An example of this occurred in the recently proposed controversial new guidelines for the induction of labour in the UK, which recommended considering induction at 39 + 0 weeks' gestation for any 'woman … after assisted conception' (NICE 2021). Furthermore, having an induced labour may mean that people have to give birth in an obstetric ward, may not have access to a water birth and have an increased risk of an assisted delivery, with the concomitant risks of life-changing severe perineal injuries (NICE 2021). This in turn may pose vulnerabilities for their future mental health given the association between interventions in birth, maternal birth injuries and birth trauma, and perinatal mental health difficulties such as post-traumatic stress disorder (Greenfield et al. 2016).

2.1 Legal Recognition as Parents

Depending on the local legal position, conceiving through assisted conception services may be required to allow a non-gestational female parent to have legal recognition as parent. Within the UK, the ability for both female parents to be named on a birth certificate (as 'mother' for the birthing parent and as 'parent' for the

non-birthing parent) is a relatively recent development, with the previous arrangement requiring 'step-parent adoption' or 'second-parent adoption' by the non-birthing parent despite a similar process not being required for cishet couples who became parents using donor conception. In countries where birth identification documentation is a requirement, legal challenges continue for trans people, with a recent UK case rejecting a birthing trans man's application to be registered as his child's father or parent, ruling that motherhood is defined as being pregnant and giving birth, regardless of the birthing person's legal gender (Royal Courts of Justice 2019).

2.2 Perinatal Loss

Turning to perinatal loss (i.e. pregnancy loss or baby loss), evidence both from the more sizable literature on assisted conception with assumed-to-be cishet couples and the emerging literature with LGBTQ+ people names the role of 'investment' in pregnancy (i.e. time, financial, emotional) and its potential to amplify grief (Harris and Daniluk 2010; Peel 2010). This resonates with theory concerning the psychological adaptation involved in the transition to parenthood, including the development of the parent's relationship with their unborn child, which can be shaped by events including planning the pregnancy (Peppers and Knapp 1980). In addition, research with assumed-to-be cishet couples finds that unsuccessful assisted conception may be followed by grief reactions (Volgsten et al. 2010) and our own public engagement with LGBTQ+ parents has indicated the need for future research in this area, potentially expanding perspectives on perinatal loss. Further, perinatal loss amongst LGBTQ+ people can be experienced as 'disenfranchised grief' through invisibility as potential parents and not having their relationships recognised, intensifying isolation during bereavement and reducing the support available (Cacciatore and Raffo 2011). This history of loss and consequent grief may carry impact for LGBTQ+ couples engaging with midwives in future pregnancies but may not be known by the midwife if attempted conceptions are not enquired about, or if only the gestational parent's history is recorded.

3 Pregnancy

During pregnancy, LGBTQ+ expectant parents may experience issues that may be common to any expectant parent. However, they may also experience distinct challenges that cishet expectant parents do not. We will consider three examples:

- Trans men's and non-binary people's pregnancy experiences
- Non-gestational mothers lactating
- Lack of inclusion within health service records

3.1 Trans Men's and Non-binary People's Pregnancy Experiences

Pregnancy and womanhood are concepts which are strongly linked within our society. The authors' scoping review identified that some trans men and non-binary people experience dysphoria in pregnancy, connected to hormonal changes, changes to the chest and being socially read as pregnant, and some experienced disconnection from their bodies at this time; some found bodily changes distressing whilst others enjoyed them—however, this too could be challenging for individuals to process (Greenfield and Darwin 2021). We identified that being visible as a pregnant man or non-binary person could be uncomfortable and even dangerous and that people's attempts to negotiate visibility could feel unsafe in different ways—both physically (e.g. being at risk of violence) and emotionally (e.g. the personal cost linked with not being visible as both pregnant and trans). Similarly, isolation and exclusion were commonly experienced and increased by midwifery being viewed as a service for (cis) women. Further, we found that pregnant non-binary people were often directly excluded from research or assumed to have the same needs and experiences as trans men. We also found that no research had explored the experiences of non-gestational parents who were themselves trans or the partner of a pregnant trans man or non-binary person.

3.2 Non-gestational Mothers Lactating

In lesbian couples, the non-gestational mother may wish to breastfeed their baby. If she has already been pregnant, depending on the timing, she may still be able to lactate or to (relatively) readily resume lactation. If not, she may induce lactation. Inducing lactation often includes a regime of using a breast pump every few hours for some weeks or months and may be supported by the use of prescription galactagogues (drugs which induce lactation).

Heterosexism in maternity and neonatal services means that infant feeding policies assume that the gestational parent will be the only lactating parent (Chetwynd and Facelli 2019). During the COVID-19 pandemic, with significant restrictions on who could visit postnatal or neonatal wards, this became a real difficulty for several lesbian non-gestational parents, as the case study in Box 2 shows.

Non-gestational mothers who are lactating or who wish to lactate are outside of the midwifery scope of practice and are not an obstetric patient. Whilst some midwives are knowledgeable about non-gestational mothers lactating, others are not. The support these mothers receive in achieving their breastfeeding goals is therefore significantly less than the support lesbian gestational mothers receive, even though the physiological challenges they experience may be greater. There are accounts of individual midwives, doctors and nurses telling non-gestational lesbian mothers that they are considered 'milk donors' rather than mothers, because policies do not include the possibility of lesbian mothers. As they do not fit within the heterosexist policy assumptions, they may even be told that they are not permitted to feed their

baby, even though preventing a mother from breastfeeding is against the law in many countries. An example case study is provided in Box 2.

Box 2 Case Study

Jane and her wife Joanne have a 6-year-old, who Jane gave birth to. Joanne is currently pregnant with their second child. They intend to co-feed their baby from birth, and Jane may be the main breastfeeding parent once Joanne returns to work (planned for a few weeks post-partum). A hospital birth and a short postnatal stay are medically advised. Their midwife has told them Jane can only visit for 1 h a day, due to the COVID-19 pandemic, causing significant distress to both women.

Following a complaint, a meeting is held with senior midwives. Here, Jane is told that her breastmilk will not be as beneficial to her baby as Joanne's, and her behaviour and wish to breastfeed are negatively commented upon. It is however arranged that Joanne will be allocated a single room after birth and that Jane will be allowed to remain with her and their baby.

Joanne gives birth in hospital before 37 weeks, while Jane is outside waiting to be admitted to join her. Jane is admitted shortly after the birth but is then told that if she leaves the side room to go to the canteen, she will not be readmitted due to the potential COVID risk.

Their baby is later admitted to the neonatal unit. Jane is told that she is not allowed to breastfeed the baby during his neonatal care, as under their policies she is a donor, not a mother. The mothers are told that their agreement with maternity services does not extend to cover the neonatal unit.

3.3 Lack of Inclusion Within Health Service Records

Most maternity services' records continue to have a space for one mother's details to be recorded and one father's details to be recorded (albeit sometimes stating 'father/partner'). Many LGBTQ+ families will not fit this model. Research into lesbian women's encounters with midwives has established that such heteronormativity in written communication and verbal dialogue impacts the experiences of care (Dahl et al. 2013). In addition to impact on experiences, it can affect care that is offered. Details collected by the midwife about the (non-birthing) father may include genetic information and information about the social situation the baby will be born into. Adding in a non-gestational mother's details here may provide inaccurate details about genetic factors that might affect perinatal care (unless the baby was conceived using her eggs), for example, unnecessary referrals based on a non-gestational mother's family medical history. It is therefore necessary to be specific: Is the information needed because of genetic connection or to form a picture of the family's psychosocial circumstances?

If a trans man has changed his gender marker within the healthcare system (which may or may not be possible, depending on local legal position), it may be

difficult to register his pregnancy. If he requires antenatal tests, it may be difficult to order maternal tests for him. He and his baby may receive suboptimal or delayed care as a result. Data from trans men may also be removed from quantitative research during the cleaning process, as a male gender marker in someone who has given birth will be assumed to be a mistake. Further, health service records in most countries do not offer gender markers outside of the binary.

4 Birth

Research shows that whilst many LGBTQ+ people will experience the same intrapartum care as their cishet peers, some will experience poor care as a direct result of homophobia and transphobia. Such care includes midwives giving deliberately rough vaginal examinations (Spidsberg 2007), their unwillingness to physically check a lesbian woman's perineum after giving birth and unwillingness to provide breastfeeding support (Lee et al. 2011). In one case, a lack of trans awareness led to a potentially preventable traumatic baby loss, when a cord prolapse happened to a man who presented at the emergency clinic with acute stomach pain (Stroumsa et al. 2019). Here, labour was not considered as a possibility for some time, despite him identifying himself as a trans man who had had a positive pregnancy test. Poor care during birth can affect both the gestational and non-gestational parent and has a number of enduring consequences.

4.1 Birth Trauma and Fear of Birth

LGBTQ+ birthing parents may have a greater vulnerability to birth trauma. Pre-existing factors such as childhood sexual abuse make experiencing birth a traumatic event more likely, and research shows that there are higher rates of childhood sexual abuse (CSA) in sexual minority women (Eliason 2017). Poor care is also a major risk factor for traumatic birth (Greenfield et al. 2016). The negative sequelae of traumatic birth can be significant for all parents, the new baby and other children within the family. Experiencing birth as a traumatic event is associated with the development of a number of perinatal mental health conditions, including postnatal depression, anxiety, post-traumatic stress disorder and tokophobia (severe fear of childbirth) (Greenfield et al. 2016). Conversely, experiencing good care can be a protective factor against experiencing birth as psychologically traumatic, even if there are physical complications during birth.

There are fewer studies examining birth trauma in non-gestational parents, and those that do exist have focused almost exclusively on fathers (Daniels et al. 2020; Inglis et al. 2016). For couples who both have the physical ability to become pregnant, experiencing birth as traumatic as a non-gestational parent may create additional difficulties. Research with lesbians, trans men and non-binary people who had the ability to become pregnant showed that one cause of tokophobia (a severe fear of childbirth) was being present during their partner's traumatic birth (Malmquist

et al. 2019). This links to the case study presented above, where the gestational mother is treated as a primiparous woman, which is physically appropriate, but psychologically inappropriate. Malmquist's research also showed that a fear of receiving 'insufficient care' from midwives and other practitioners because of homophobia or transphobia could cause tokophobia amongst LGBTQ+ people. Therefore, the existence of homophobic or transphobic perinatal care can have negative consequences for LGBTQ+ people, even if they did not experience that care themselves.

4.2 Invalidation for Lesbian Non-gestational Mothers

A review of lesbian women's experiences with midwives and other healthcare providers in the birthing context (Dahl et al. 2013) which drew on 13 studies across Europe and North America found that non-gestational mothers were frequently not acknowledged or viewed as an equal parent. This coheres with the evidence on fathers' experiences of birth, including feeling 'merely a passenger' and lacking control at birth (Daniels et al. 2020) and feeling invisible to and excluded by midwives and perinatal services more broadly (Steen et al. 2012; Hodgson et al. 2021). However, some non-gestational mothers further linked their discomfort in hospital settings to feeling that they were treated differently to heterosexual parents and welcomed opportunities for recognition of their relationship through acts such as cutting the cord (Dahl et al. 2013; Howat 2021).

Within the context of the pandemic and services' infection control efforts, involvement of co-parents has been reduced further, including in relation to presence at induction, at birth and in postnatal settings. Whilst this applies to all co-parents, we have found examples of services not recognising non-birthing parents in LGBTQ+ families in the same way that fathers were recognised. This has included midwives making assumptions that women seeking access to the ward could not be the baby's parent, and women therefore not being allowed onto the ward to collect their partner and child at discharge, which a participant contrasted with the treatment of fathers that they had observed (Stacey et al. 2021). Thus, the phrasing of hospital policies and midwives' assumptions may further compound the impact of infection control measures, deepening inequalities.

4.3 Birth Preferences

There is a significant body of evidence that trans men's birth choices are influenced by a number of factors that cis women's birth choices are not influenced by, such as physical and social gender dysphoria. It should not be assumed that these factors result in all trans men wishing to make the same birth choices though. The evidence suggests that this may lead to some trans men choosing to have an elective caesarean birth (Ellis et al. 2015), and others choosing to have a home birth (Hoffkling et al. 2017). All birth choices should be supported (as they should for any pregnant

person), but midwives should bear in mind that psychosocial factors may play as significant a part in decisions as medical factors.

There is little evidence about the birth choices of non-binary people or pregnant lesbian and bisexual women. During the COVID-19 pandemic, research conducted by one of the authors showed that a significantly higher proportion of LGBTQ+ women had seriously considered freebirth than heterosexual women (Greenfield et al. 2021). This is the first research to make this association, and the reasons behind this difference are unclear. It may be that LGBTQ+ women have less satisfactory interactions with maternity care providers, which was indicated by surveys in maternity services during the COVID-19 pandemic (Stacey et al. 2021).

5 Postnatal Care

In considering postnatal midwifery care, we focus on two areas—infant feeding and perinatal mental health—whilst also recognising that support for these is not restricted to the postnatal period.

5.1 Infant Feeding

Underlying infant feeding support policies and practices is a cis-heteronormative model of how infant feeding decisions are made (see Fig. 1). Whilst real decisions about infant feeding may be more complex than this (for example including cup feeding or exclusive pumping), they all rely on the idea that there will be one mother, who gives birth and who will be the one to provide human milk in the long term if the baby is to receive human milk. In LGBTQ+ families, there may be no mother,

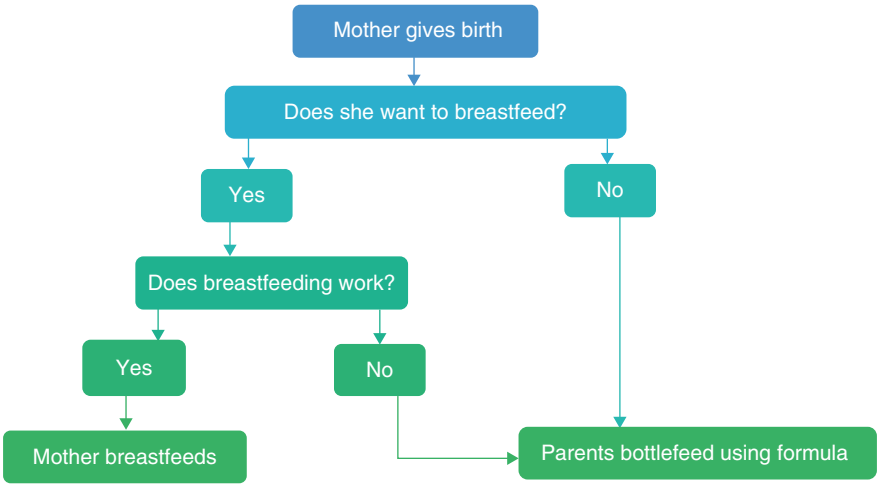

Fig. 1 Assumptions behind infant feeding policies

or more than one mother. The designation of mother may be irrelevant to who will feed the baby.

In the case study earlier in this chapter, we saw the difficulties that this underlying cis-heteronormative model caused for a non-gestational mother. As discussed earlier, where a non-gestational parent intends to feed their baby, midwifery infant feeding support must be put in place antenatally. Postnatally, having joint policies between maternity and neonatal services is essential to avoid discriminating against non-gestational mothers and to avoid the invalidation that the mother in the case study experienced when she was referred to as a donor.

The cis-heterosexist model can also cause problems for trans men and non-binary birthing people. Whilst some may receive appropriate care, research shows that many transmasculine people receive midwifery support, which is inappropriate in one of the three ways—too much pressure, inappropriate support and too little support (MacDonald et al. 2016). Some trans men and non-binary people feel pressured to feed their baby themselves. They describe midwives ignoring the potential for chestfeeding to increase the dysphoria they might experience, or not seeing dysphoria as a serious perinatal mental health difficulty. Others describe receiving inappropriate support, where midwives and other practitioners used terminology or resources that increased dysphoria, causing iatrogenic harm. Yet another group receive no support, either because midwives have assumed that they will choose to feed their baby infant formula or because they feel unqualified to offer chestfeeding support, perhaps because they have little or no training in caring for LGBTQ+ clients.

5.2 Perinatal Mental Health

Mental health difficulties in the perinatal period (conception to 1 year post-partum) are common and can be experienced by any parent, regardless of gender or status as a birthing or non-birthing parent. Maternal mental health and paternal mental health are established terms within research, policy and (increasingly) midwifery practice. Current usage appears to position maternal with gestational parenthood and paternal with non-gestational parenthood, and we argue the need to explore these further and to have open conversations about who they refer to and whose experiences are missed or indeed silenced. It is also vital to be explicit about who is eligible to receive support offered by services; for example, in-patient perinatal mental healthcare provided in mother and baby units is available to gestational parents. We are also seeing growth in 'dads' groups' and male peer support workers in relation to perinatal mental health, and our own research with co-mothers identifies feeling further excluded by such initiatives (Howat 2021); it seems plausible too that trans men may not feel a sense of belonging here.

Some small-scale studies have indicated that prevalence of perinatal mental health difficulties may be higher in LGBTQ+ parents (Greenfield and Darwin 2021; Flanders et al. 2017). The aforementioned research by Greenfield et al. (Greenfield et al. 2021) that revealed higher rates of LGBTQ+ women seriously considering

freebirth also showed differences in postnatal mental health, whereby postnatal anxiety was significantly higher in LGBTQ+ birth mothers than in cishet birth mothers. Birthing trans men and non-binary people did answer the survey; however, the small sample size precluded statistical testing. Whilst continued invisibility in research and practice means that we lack accurate estimates on the prevalence in LGBTQ+ parents, qualitative research identifies vulnerability and protective factors that could be amplified or distinct to these groups. For example, vulnerability in any LGBTQ+ parent may be increased due to heteronormative systems and homophobic/transphobic discrimination; there may also be stressors that are distinct to non-gestational non-male parents and to non-female gestational parents (e.g. lack of recognition as a parent, lack of role model); there may also be different barriers to seeking and accepting help, linked to discrimination in health systems and fears that parenting may be judged more harshly, adding further stigma to that relating to perinatal mental health (Abelsohn et al. 2013; Alang and Fomotar 2015; Maccio and Pangburn 2012; Ross 2005; Ross et al. 2007; Wojnar and Katzenmeyer 2014). Potential protective factors suggested in the context of lesbian women and postnatal depression include the possibility of greater partner support, relationship satisfaction, division of childcare and preparation for parenthood (Ross 2005). Research is needed to explore this further with a range of sexual and gender minority groups and across the breadth of perinatal mental health.

6 Conclusion

We summarise here evidence relating to different aspects of midwifery and perinatal services. We must acknowledge the limitations of this evidence base (i.e. predominantly the Global North, usually with small sample sizes and a lack of intersectionality) and need for further research and service improvement initiatives. Nonetheless, there are key messages that offer clear areas for action in our individual midwifery practice and as organisations.

We need to stay curious and open about what family formations can look like, understanding both that the gender of at least one of the parents may differ from societal expectations and that people may be LGBTQ+ even where a midwife is caring for what appears to be a cishet couple or a lone parent. Additionally, there may be more than two parents, and more than one person may be (or have pursued being) a gestational parent, which may impact the experience of all parents in this pregnancy. Midwifery language such as ‘primiparous’ may be physically accurate, but psychologically inappropriate, including with reference to mental health.

To improve the experiences of LGBTQ+ people interacting with midwives, visibility is needed. This means ensuring that LGBTQ+ people are represented in the language we use to talk about families and parents, in the paperwork you use to record details, in the imagery that exists in information you provide to parents and in public spaces such as waiting areas. Efforts to become more father inclusive and family focused are important but need to ensure that marginalised groups are not marginalised further; additive language can help here (see Appendix 1). Some of

these changes can be made by individual midwives; other changes will require midwives to create organisational change.

LGBTQ+ families report that simultaneously too little is asked about their experiences, and too much irrelevant information is requested of them. As part of the changes to paperwork, midwives should consider *why* information is requested; focusing on the reason for the request will help to differentiate whether the request should be made. It is important to record who is using our services—including sexual orientation and gender as part of monitoring—to inform inequalities and service improvement. Some information is relevant for care; it is for example useful to request details of biological parenthood to screen for certain conditions and to ask about fertility history as a family to open conversations, including those about perinatal mental health.

However, asking questions as part of one's own fascination is different to enabling conversation that follows the (expectant) parents' lead, supporting wider transition to parenthood. The midwifery relationship can create dynamics of power and dependence, and people may not feel able to refuse providing information that has been sought simply through curiosity or in seeking to develop own education. Midwives also need to be aware that people they are caring for may bring experiences of heteronormative care—including their own direct experience and experience in their community—which may lead them to anticipate discriminatory care and feel vulnerable. Providing good midwifery care to LGBTQ+ families not only can result in a good experience of pregnancy and birth, but also helps to change their overall experiences of healthcare systems.

Appendix 1: Glossary

Language help	
Additive language	The process of adding to language to ensure that everyone is included, not replacing terms—for example 'fathers AND lesbian non-gestational mothers' or 'pregnant women AND other pregnant people'
Assigned gender at birth	The gender that is assigned to an infant at the time of their birth. Some literature may use terms such as AFAB (assigned female at birth) and AMAB (assigned male at birth) to describe trans or non-binary people
Bisexual	Someone who is sexually or romantically attracted to more than one gender
Chestfeeding	A term for infant feeding preferred by some trans men and non-binary people
Cis or cisgender	Someone whose gender is the same as that which they were assigned at birth
Cishet	People who are cisgender and heterosexual, i.e. experiencing romantic and sexual attraction to people of the opposite sex
Cis man	A man who was assigned male at birth
Cis woman	A woman who was assigned as female at birth

Language help	
Co-mother	A term used to denote either or both parents in a lesbian relationship or to denote the non-gestational mother
Co-parent or co-parenting	The term co-parent can have different meanings. It can be used to describe any parent (for example a father, co-mother or any other co-parent). It can be used to describe the relationship between parents in parenting their child. It can also be used to describe arrangements where two or more people choose to conceive and raise a child together without necessarily being in a romantic or sexual relationship with each other, for example where a lesbian couple and a man may pursue parenthood together
Donor	In this chapter, used to refer to a sperm donor. They may be known to the gestational parent or may be sourced through a fertility clinic with varying levels of anonymity
Gay	A man or man-aligned person who is sexually or romantically attracted to other men or men-aligned people; in some usage, this need not exclude being attracted to people of other genders
Gender dysphoria	When a person experiences discomfort or distress because there is a mismatch between their gender and their assigned gender at birth. Not all trans people experience gender dysphoria
Gender transition	The process of changing gender presentation or sex characteristics to be consistent with gender identity. Transition can be social (using a new name and pronouns, and changing gender presentation (i.e. clothes, hairstyle). Transition can also be medical and may include taking hormonal medication and/or various surgeries. This process may take many years and for some people may be lifelong
Gestational parent (also referred to as carrying parent or birthing parent)	Someone who is pregnant, who will also be the parent of the baby once it is born. Sometimes, this is a preferred term for pregnant trans men or non-binary people. It may also be used within lesbian couples to denote which mother-to-be is pregnant
Heteronormative	The assumption that binary gender identity and heterosexual orientation are the norm
Intersectionality	How different aspects of social identity or characteristics (e.g. race, ethnicity, gender, sexuality, class) combine to create different experiences of discrimination and inequalities
Intersex	People with variation in sex characteristics (e.g. sex chromosomes, internal genitalia, external genitalia) which do not fit the typical definitions of male and female; people who are intersex may or may not identity with being part of the wider LGBTQ+ community
Lesbian	A woman or woman-aligned person who is sexually or romantically attracted to other women or women-aligned people; in some usage, this need not exclude being attracted to people of other genders
Non-binary	An umbrella term for people whose gender is something other than man or woman. Many different non-binary identities exist
Pansexual	Someone for whom sexual or romantic attraction is not connected to the person's sex or gender identity
Polyamory	When a person has more than one sexual or romantic partner, with the knowledge and consent of all involved
Same-gender couple	Describing a couple who share the same gender identity; they may or may not have the same biological sex
Same-sex couple	Describing a couple of the same biological sex

Language help	
Third-party reproduction (also referred to as donor-assisted reproduction)	Where reproduction involves a third party, for example a donor that provides donor gametes or a surrogate that provides gestation, carrying the pregnancy
Trans or transgender	Someone whose gender is not the same as that which they were assigned at birth; this includes binary trans people (trans men and trans women) as well as non-binary people
Trans man	A man who was assigned as female at birth; he may have reproductive anatomy to become pregnant, to birth and to lactate
Trans woman	A woman who was assigned as male at birth; she may retain the ability to impregnate a partner
Transmasculine	A term that encompasses both trans men and non-binary people who have moved or are moving towards a masculine gender or gender presentation
Queer	An umbrella term for anyone who is not cishet. Individuals may vary with the extent to which they use this term (and indeed any of the terms listed here) with queer having been used pejoratively
Women-aligned/ man-aligned	People who are not cisgender, but who are affected by the issues connected to being perceived as a man or woman, and have either a political alignment with that gender or an internal sense of connection to that gender

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Spirituality and Spiritual Care in the Transition to Motherhood

Josephine Attard

1 Introduction

The transition to motherhood is a deeply personal experience that can influence women's psychological, social and spiritual sense of self (Young et al. 2021). Research on women's lived experiences of their transition to motherhood and the role that spirituality plays in the process of transformation reports how the experiences of motherhood and spirituality mutually influence and intertwine each other toward the development of an integrated identity as mother (Martin and Gall 2021; Laney et al. 2015). Some mothers may struggle through this transformation, and therefore it highlights the need for midwives to attend to the potential positive and negative roles of spirituality in women's transition to motherhood.

Spirituality as a concept in healthcare is being recognised as central to our humanness, an attribute of our being that provides access to self-fulfilment, peace and the ability to meet life's challenges as physical, mental, social and fundamentally spiritual beings (Crowther and Hall 2015). Women describe motherhood as a dramatic life-changing event that involves not only the experience of giving birth but also the creation and transformation of personal relationships, a shift in self-identity and world view, an expansion and intensification of an emotional experience and an enhanced awareness of existential and spiritual issues (Prinds et al. 2014).

The research on the role of spirituality in women's transition to motherhood remains limited. Although studies have focused on women's experiences of either pregnancy or motherhood, they do not fully capture how spirituality emerges within the transition from pregnancy to motherhood. Studies have not addressed how motherhood may influence spirituality as well as how spirituality may have an

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impact on the transition to motherhood. Furthermore, research on motherhood has not fully addressed the potential effects of negative aspects of spirituality or spiritual struggles that may impede adjustment at times of transition (Exline 2013).

Moreover, the spiritual dimension of spirituality and spiritual care over the course of several decades has been a source of contention and viewed with a degree of scepticism. Part of the reason for this may stem from the subjectivity of the concept and the misconceptions associated with the meaning and interpretation of this word (Lepherd 2014). However, in recent times, there has been a growing realisation of the importance and significance of this dimension for the health and wellbeing of individuals (European Commission 2020), especially those facing key life events such as birth, motherhood, illness and/or death (National Health Service (NHS) England 2015).

A significant milestone in the provision of spirituality and spiritual care in midwifery and other professions such as nursing evolves around the development of spiritual care competencies. The whole area of competency development in nursing and midwifery practice has been the subject of much debate with several of the leading scholars in this area through the EPICC (Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care Through Innovative Education and Compassionate Care) project 2016–2019 (http://blogs.staffs.ac.uk/epicc/).

The EPICC project has laid the foundations to help reduce the gap and disconnect between professional regulatory bodies' statements and aspirations for high-quality spiritual care and actual practice. This recommendation affirms that the concept of spirituality is important at all key life events such as birth and motherhood while emphasising the fundamental role this dimension plays in clinical midwifery practice.

The success of the EPICC project which developed the European core competency standard in spiritual care for nurses and midwives hinged on the fact that the project was not starting with a 'blank canvas' as it built on existing work. One of the foundational works was a PhD study (Attard et al. 2019) which developed the first spiritual care competency framework for preregistration nurses/midwives. The research involved an in-depth review of the international literature, stakeholder focus groups and modified Delphi method.

The outcome of this body of work was the construction of an educational framework that comprised of 54 items arranged in 7 domains: knowledge in spiritual care; self-awareness and the use of self; communication and interpersonal skills; ethical and legal issues; quality assurance in spiritual care; assessment and implementation of spiritual care; and informatics in spiritual care (Attard et al. 2019). This pioneering and unique framework was used as the starting point in the development of the EPICC Spiritual Care Education Core Competency Standard for nursing and midwifery.

The 'EPICC Standard' (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf) details a table of four key spiritual care competencies, which are flexible and applicable to various nursing and midwifery care settings. The aim of these core competency standards is to equip undergraduate/preregistration nursing and midwifery students with knowledge (cognitive),

skills (functional) and attitudes (behavioural) in spiritual care at the point of registration and to adopt them in the provision of spiritual care in clinical practice.

For every competence, the learning outcomes are described in aspects of knowledge (cognitive), skills (functional) and attitudes (behavioural). The underpinning philosophy is that these competencies are practised within a compassionate relationship and founded in a person-centred and reflective attitude of openness, presence and trust, which is fundamental in clinical practice. The four competencies in spiritual care will be discussed to highlight their use in clinical midwifery practice, more specific to assist midwives to attend to and intervene at any indication of spiritual struggle in women's adjustment to motherhood.

2 Competence 1: Intrapersonal Spirituality

Prior to childbirth, women hold idealised thoughts of how motherhood would unfold and often find that they are not fully prepared for the realities of motherhood (Young et al. 2021). They may experience paradoxical overwhelming of concurrent feelings of joy and frustration as well as thoughts of clarity of purpose and doubt (Young et al. 2021; Martin and Gall 2021). For some women, motherhood entails a spiritual awakening, and they describe the process of pregnancy, childbirth and mothering as a miracle in which they participate with the divine as co-creators of life. Motherhood captures a transcendent reality as women move outward from their self toward meeting the needs of their child now and in the future (Prinds et al. 2014).

These experiences are addressed in the first competence identified in the EPICC competency standard as intrapersonal spirituality (Table 1). In essence, this competence helps the midwife to journey with women in their thoughts and feelings in their transition to becoming a mother. This competence relates to the impact of one's own spirituality, values and beliefs in providing spiritual care. It entails the

Table 1 Competence 1: Intrapersonal spirituality (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf)

Competence	Knowledge (cognitive)	Skills (functional)	Attitude (behavioural)
1. Intrapersonal spirituality Is aware of the importance of spirituality on health and well-being	– Understands the concept of spirituality – Can explain the impact of spirituality on a person's health and well-being across the lifespan for oneself and others – Understands the impact of one's own values and beliefs in providing spiritual care	– Reflects meaningfully upon one's own values and beliefs and recognises that these may be different from other persons – Takes care of oneself	– Willing to explore one's own and individuals' personal, religious and spiritual beliefs – Is open and respectful to persons' diverse expressions of spirituality

midwife in being present, attentive and available in a trustful relationship with the woman.

From the perspective of midwives, intrapersonal spirituality entails that midwife should show willingness to explore one's own and their clients' personal, religious and spiritual beliefs. The intrapersonal competence asks for meaningful reflection upon one's own values and beliefs and the recognition that these can differ from other people.

The context of intrapersonal spirituality lies in paying attention to one's own spirituality by relying on the holistic view of the woman, which is fundamental to good practice and has significant benefits for the midwife–woman relationship. It enables midwives to be open-minded about diverse situations of mothers avoiding prejudices or preconceptions that may affect their attention to or acceptance of the woman's spiritual needs. Paying attention to own's spirituality enables the midwife to empathise and welcome new experiences, viewing the pregnant woman as a person with a unique life story and unique views of her life. The interplay between the woman's intrapersonal spirituality also impacts midwife's own values and beliefs and her relationship with the woman (Crowther and Hall 2015).

To achieve this competence entails attentive listening to the woman's feelings, taking them seriously as well as respecting and affirming the woman for who she is which often mediates the interaction/experience of a meaningful contact, self-transcendence and meaning in life (Crowther and Hall 2015). Both meaning and self-transcendence have shown a significant impact on anxiety and depression, as well as on physical, emotional, social, functional and spiritual well-being (Haugan 2014).

Intrapersonal spirituality also refers to intrapersonal values, like what is most important for each person, such as relations to oneself, family, friends, work, things' nature, art and culture, ethics and morals, and life itself (Nolan et al. 2011). These values embrace spirituality as the very core enabling the provision of genuine spiritual care. Spirituality has been defined as being dynamic in nature, which means that the intrapersonal values of spiritual care are a force that changes during the time care is provided but stays with the woman in seeking meaning, purpose and transcendence from her experience.

3 Competence 2: Interpersonal Spirituality

This competence (Table 2) refers to spirituality that acknowledges the unique spiritual and cultural world views, beliefs and practices influencing healthcare. It involves the education and development of interpersonal relationships and communication skills of midwives by exploring the impact of the spiritual and cultural world views, beliefs and practices in the provision of care, and additionally, the importance of effective, reciprocal verbal and non-verbal interaction between persons and carers through the development of trustful relationships.

In relation to this competence, the transition to motherhood embodies a process of intimate and deep connections with child, family, other mothers, midwife and the

Table 2 Interpersonal spirituality (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf)

Competence	Knowledge (cognitive)	Skills (functional)	Attitude (behavioural)
2. Interpersonal spirituality Engages with persons' spirituality, acknowledging their unique spiritual and cultural world views, beliefs and practices	– Understands the ways that persons express their spirituality – Is aware of the different world/ religious views and how these may impact persons' responses to key life events	– Recognises the uniqueness of persons' spirituality – Interacts with and responds sensitively to the person's spirituality	– Is trustworthy, approachable and respectful of persons' expressions of spirituality and different world/ religious views

divine. Women reorient their values, behaviour and outlook on life toward greater connectedness (Martin and Gall 2021).

In their connection with the midwife, women felt comforted, reassured and supported (Crowther and Hall 2015). Furthermore, adopting a communicative approach promotes self-empowerment in women and allows them to be involved in the decision-making about their choices in birth and after birth (Crowther and Hall 2015). Midwife's relationship with the mother is often a spiritual catalyst, emotional growth and transformation for the mother (Callister and Khalaf 2010). These relationships are considered to evoke feelings of companionship, compassionate care and spiritual care attitudes, such as sharing, caring, empathy, listening, touch and presence.

Connectedness with women in an open and trustful relationship makes space for compassion, which has been identified as a core element of midwifery practice and the heart of midwifery care (compassionate care). Specifically, it is impossible to practise spiritual care without compassion. Compassion is an 'active feeling', which means that there is an obligation to act in order to make a change in the woman's situation particularly when the woman is struggling to make sense of events that challenge her world view.

Younas and Maddigan (Younas and Maddigan 2019) identified three direct indicators of compassionate care applicable to the events that challenge a woman's world view during her transition to motherhood, i.e. recognising, accepting and alleviating suffering. Compassion is expressed when midwives authentically work to understand the woman's challenges and become sensitive to their experiences. They also proposed four foundational elements of practising compassion:

1. Authentic presence (Aune et al. 2014) (connecting meaningfully with women being present and building genuine relationship with them, doing and sharing with one another and being in solidarity with them)
2. Empathy and understanding (Crowther and Hall 2015) (being aware of being sensitive to and vicariously experiencing the feelings, thoughts and experience of another of either the past or the present, see things from their point of view)

3. Respect (Thachuk 2007) (respecting women's values, choices, autonomy and dignity to make them comfortable to share their happiness and suffering, involving the women in decision-making processes, being kind and communicating with them in a kind manner and spending time with them).
4. Openness to women's needs (trying to understand, respect and carefully meet needs, recognising their concerns and emotions)

Being aware of the attributes of compassion facilitates an increased knowledge about how to practise compassionate care, and how education should be delivered to make compassionate care real in clinical settings (Younas and Maddigan 2019). Compassionate care influences the quality of midwifery care, which impacts the childbirth outcome and motherhood.

Effective student reflection on their personal spirituality and the spirituality of others can be an appropriate teaching and learning strategy to promote knowledge and application of compassionate care. This can take a variety of methods, for example class discussion, role-plays and use of stories (based on real experiences) reflecting on personal and other people's experience of being a mother or a parent (Giske and Cone 2012).

Interpersonal spirituality also acknowledges the unique spiritual and cultural world views, beliefs and practices influencing care. Research shows that there is a spiritual shift: particularly once the child was born, faith and spirituality took on a more central and significant role in the mothers' lives (Pargament 2007). Viewed as an innately spiritual event, motherhood triggered a renewed spiritual awareness on the part of these women. It is not uncommon that significant life transitions such as childbirth are seen to be sacred events as they 'reveal the underlying transcendent dimension of existence' (Pargament 2007, p. 48). Within increasingly diverse societies, brought about by migration and asylum seeking, spiritual, religious and cultural beliefs and practices can be unfamiliar and confusing, thus presenting challenges for both the midwives and women under their care.

It is recognised that having a faith structure has a positive effect on psychological well-being and general health (Pargament 2007). It is being shown that women's religious belief is also known to be relevant to care; however, there is very little research in this area. Instead, the evidence is based on women from a variety of cultural and religious backgrounds from several countries (Crowther and Hall 2015). Spirituality and religious belief appear to provide support or impact decision-making during the pregnancy continuum. Religious women have a spiritual awareness of their unborn and may alter their health behaviours as a result (Heidari et al. 2014). Religious belief and spirituality have also been identified to have an impact on the levels of anxiety in pregnancy (Mann et al. 2008) as giving birth may bring religious women closer to the Higher Being they believe in and demonstrate better coping (Baumiller 2002; Heidari et al. 2014).

4 Competence 3: Assessment and Planning Spiritual Care

As previously stated, midwives need to attend to the potential positive and negative roles of spirituality in women's transition to motherhood and intervene early to address any indications of emotional or spiritual struggle in women's adjustment (Young et al. 2021; Martin and Gall 2021).

There is a great deal of transition to parenthood research which describes difficulty and struggle during this transition, which is followed by the implementation of a variety of coping skills and strategies (Darvill et al. 2010; Nystrom and Ohrling 2004). Although many parents adapt well to the demands of parenthood, the transition to parenthood is associated with adverse spiritual distress, which may lead to parental mental health issues such as depression and anxiety (Mann et al. 2008).

The expectation that midwives should assist and provide spiritual care suggests that the dimension of assessment and planning for spiritual care (Table 3) is fundamental to the delivery of high-quality midwifery care. This competence informs the reader to different approaches to spiritual assessment that may be used in midwifery practice. It distinguishes between what is considered formal and informal methods of spiritual care assessment. This entails that midwife must understand what is meant by spiritual care and possess the necessary skills to be able to support women with their spiritual demands that are observable, tangible and indeed considered fundamental.

4.1 Why Do Spiritual Assessment and Planning Matter?

Spiritual assessment is central to the planning and delivery of spiritual care by identifying the requisite knowledge (cognitive), skills (functional) and attitudes (behavioural) necessary to do this confidently and competently. As already claimed,

Table 3 Assessment and planning spiritual care (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf)

Competence	Knowledge (cognitive)	Skills (functional)	Attitude (behavioural)
3. Spiritual care: assessment and planning Assesses spiritual needs and resources using appropriate formal or informal approaches, and plans spiritual care, maintaining confidentiality and obtaining informed consent	– Understands the concept of spiritual care – Is aware of different approaches to spiritual assessment – Understands other professionals' roles in providing spiritual care	– Conducts and documents a spiritual assessment to identify spiritual needs and resources – Collaborates with other professionals – Be able to appropriately contain and deal with emotions	– Is open, approachable, and non-judgemental – Has a willingness to deal with emotions

spirituality is unique to each human being. It is at the core of our identity, shaping how we make sense of and draw meaning from our lives. Spirituality is central to our relationships and guides us in how we face challenges. Birth and transition to motherhood are major life events for the woman and her family providing many challenges. It is therefore important for midwives to be able to identify their inner core feelings and thoughts that highlight their spiritual need and well-being needs.

A definition of spiritual assessment is that it is an attempt to enquire positively and unobtrusively with the woman and the midwife into areas of life that are associated with their life health and well-being. It is more than just an enquiry into her physical health, her pregnancy, labour and post-partum period. Spiritual assessment is all about listening to the woman and her partner, devoting time to draw on what will bring them hope and courage during times of uncertainty in adapting to their new role as parents. Therefore, spiritual assessment is not defined by a set of checkboxes or structured plan; it is a conversation with the midwife looking to truly find the person in the mother and family (Nursing and Midwifery Council 2018).

Approaches to spiritual assessment are described as being formal (active) and informal (passive). Formal (active) assessment involves the use of a spiritual assessment tool. There are several assessment tools that are applicable to assess spiritual challenges during transition to motherhood, for example the FICA tool (Faith and belief, Importance, Community and Address in care) (Puchalski and Romer 2000). This tool is widely used in a variety of clinical settings in the USA and Canada. These tools allow the clinician the opportunity to diagnose spiritual distress or identify spiritual resources of strength and then integrate that information into the care plan.

Informal (passive) assessment involves listening to the woman's stories using a combination of skills, observation and interaction integrated within total care. It is continuous in nature and involves the midwife and all healthcare professionals. Listening to the woman's stories assists the midwife in assessing the innermost needs which when satisfied will improve the birth and transition to motherhood experience. Listening to the woman's life stories can also provide insights in developing the woman's awareness of her own spirituality through reflection, coping and acceptance (Young et al. 2021).

As human beings, to feel valued and have your needs acknowledged are heartwarming. To know that there are others looking out for you and who personally care about you is reassuring. Spiritual assessment enhances the bond between the midwife, the woman and the family, motivates the woman and the partner identify resources that can help them in tough times and inspires strenghth and courage which is crucial in the spiritual assessment process (Young et al. 2021; Martin and Gall 2021).

5 Competence 4: Intervention and Evaluation Spiritual Care

There is a great deal of transition to parenthood research, which describes difficulty and struggle followed by the implementation of a variety of interventions such as coping skills and strategies (Darvill et al. 2010). Enhancing factors which appeared

in these studies include meaning making, optimism, social support, family relationships and social connectedness. Parents framed developing greater capacity for acceptance, being in the present, empathy and compassion as important coping skills over the transition to parenthood (Young et al. 2021). These factors are reflected and provided in the context of EPICC intervention and evaluation spiritual care competence (Table 4).

The primary requirement within this competence framework is to respond to the woman's spiritual needs, tap on resources within a caring and compassionate relationship and evaluate whether needs have been met. Thus, relationship building with mothers and their families to delve into their innermost concerns is a key competence for all midwives in providing spiritual interventions (Young et al. 2021; Laney et al. 2015; Crowther and Hall 2015). Communication is the foundation of the relation between them. The power of effective attendance is reinforced and improved by good communication. As midwives possess a specific position in the journey of women through the transition to motherhood, they spend much time in speaking with mothers and listening to their concerns, feelings and needs.

Beyond this, the midwife must understand the concepts of compassion and presence because having these skills facilitates the provision of spiritual care and these are in themselves interventions. The midwife must also know how to respond appropriately to the woman's identified spiritual needs, which may include a need for meaning and purpose in her life, the need to love and feel loved, the need to feel a sense of belonging and the need to feel hope, peace and gratitude.

The interventions to meet spiritual needs include respect for privacy, dignity, helping women and partner to connect, listening to their concerns, comforting and reassuring, observation of religious beliefs and practices and sometimes referral to other members of the multidisciplinary team and chaplaincy.

Some of these conversations between the mother, partner and family may be difficult for midwives and may be accompanied by serious feelings such as

Table 4 Intervention and evaluation spiritual care (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf)

Competence	Knowledge (cognitive)	Skills (functional)	Attitude (behavioural)
4. Spiritual care: intervention and evaluation Responds to spiritual needs and resources within a caring, compassionate relationship	– Understands the concept of compassion and presence and its importance in spiritual care – Knows how to respond appropriately to identified spiritual needs and resources – Knows how to evaluate whether spiritual needs have been met	– Recognises personal limitations in spiritual care giving and refers to others as appropriate – Evaluates and documents personal, professional and organisational aspects of spiritual care giving, and reassess appropriately	– Shows compassion and presence – Shows willingness to collaborate with and refer to others (professional/ non-professional) – Is welcoming and accepting and shows empathy, openness, professional humility and trustworthiness in seeking additional spiritual support

nervousness, sadness and spiritual pain emerging from family struggles, situations such as those caused by loss of pregnancy, and birth or situations which threaten the woman's and baby's life (Thachuk 2007). Besides tapping for resources, to support the mother and her family, resources to support the midwife with these tasks must also be in place. It is essential for the midwife to learn, understand and be aware of her personal and professional boundaries.

Evaluation of spiritual care entails the midwife to understand and assess whether spiritual needs have been met and whether resources for support have been utilised (Aune et al. 2014). This is achieved by using reflection, observation through the woman–midwife now restorative relationship, journeying with the woman and the family in restoring integrity and acceptance to the reality of the situation and building resilience in recognising a process or condition without attempting to change it or protest it (Young et al. 2021; Laney et al. 2015).

6 Conclusion

The transition to motherhood can be understood as the reality of motherhood and spirituality, intertwined and mutually influencing each other in the process of identity formation (as a mother) and of spiritual renewal and growth. Becoming a mother is a spiritually transformative journey revealed as a time of creation, intimacy and ultimate connection with another human being and the divine. The transition to motherhood ignites midwives to adequately assist mothers during this important phase in their lives. This may present midwives with challenges, personally and professionally. Working with and providing spiritual care through the four EPICC core spiritual care competencies (https://blogs.staffs.ac.uk/epicc/files/2019/06/EPICC-Spiritual-Care-Education-Standard.pdf) may bring a reorganisation and reprioritisation of life values and purpose, more active incorporation of spiritual beliefs and practices that support a sense of connection and ultimate meaning in life. Realising these factors may ease the transition to motherhood by building resilience and acceptance in the mother and her family.

Competence and confidence in spiritual care can be acquired at many levels and through many activities. As midwives, we must constantly strive for excellence in caring for women spirituality, and this can only be achieved through having sound underpinning knowledge in conjunction with the correct attitudes, behaviours and skills. These however must be balanced with an understanding that any expectations around the comprehensiveness of these are realistic and attainable. It is not so much about being an expert but about demonstrating sensitivity rather than ignorance. It is about being informed, knowing one's own limitations and seeking, actively engaging the support of other multidisciplinary team professionals when necessary.

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Breastfeeding: Women's Experiences in the Transition to Motherhood

Rhona J McInnes and Roslyn Donnellan-Fernandez

1 Introduction

The post-partum period presents a significant transition period for the new mother, where she faces physical, emotional, social and psychological changes while assuming the role and tasks of motherhood. It also involves changes in partner-to-partner and parent-to-child relationships. Additionally, the woman is embarking on a new skill: that of breastfeeding and caring for the newborn, 24 hours a day. Breastfeeding is an integral aspect of the post-partum period, where its presence or absence conveys physical, psychological and sociocultural implications for mothers. This chapter explores the social complexities of midwifery, breastfeeding and maternal well-being in the post-partum period. Baby feeding beliefs and choices are established during the parents' own childhood and adulthood through exposure to family norms and values and those of the wider society. Baby feeding is rarely a simple choice of one type of feeding over another but comprises a series of decisions that are strongly influenced by interactions between various individual, societal and organisational factors, including structures and processes within health or maternity care services. In many cultural contexts, breastfeeding has come to symbolise the 'good' mother, and therefore feeding choices, decisions and outcomes can impact women at a very deep emotional level (Marshall 2011; Pangastuti 2018). Again, it is not simply that breastfeeding is the 'good' or 'morally right' choice because a decision to breastfeed contrary to family norms may feel morally and emotionally challenging if the choice is perceived as judging of other family members, including

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the woman's own mother (Darwent 2014). This chapter explores how various factors influence women's breastfeeding experiences and decisions at different stages of the feeding journey.

2 Birth: Opportunities to Optimise Feeding

The immediate post-birth phase is a sensitive period that potentially programmes future behaviours and physiology, including breastfeeding (Moore et al. 2016). This first hour following birth has been coined 'the Golden Hour' because of its importance for establishing breastfeeding (Neczypor and Holley 2017).

2.1 Skin-to-Skin

At birth, the natural habitat for the baby is skin-to-skin (StS) with the mother. StS refers to placing the infant immediately, without separation, on or next to the mother's bare abdomen or chest and then covering both with a blanket to keep warm (Moore et al. 2016; Brimdyr et al. 2015, 2020; UNICEF UK n.d.). Facilitating undisturbed StS between mother and baby from birth for at least an hour, or longer if possible, is recognised best practice and meets the needs of many mothers who experience a very strong desire to remain close to their baby during this time (Neczypor and Holley 2017; Niela-Vilen et al. 2020).

StS facilitates maternal-infant attachment, instinctual behaviours of both the mother and the infant (Olza et al. 2020) and breastfeeding (Cohen et al. 2018). It has a calming effect on the mother's and infant's physiology, helping to regulate heart rate, breathing and temperature as the infant adjusts to the extra-uterine environment. Babies who experience StS are less likely to develop hypoglycaemia, a condition that contributes to mother-infant separation and can disrupt breastfeeding (Moore et al. 2016). Importantly, StS enables colonisation of the infant with the mother's own skin commensals, thus developing newborn immunity and the neonatal microbiome (Houghteling and Walker 2015; Widström et al. 2019).

The importance of StS has been increasingly recognised and is underpinned by mammalian studies, whereby separation of mother and infant results in dysregulation and distress cries (Moore et al. 2016). Likewise, human infants placed in a cot separate from their mother exhibit more signs of distress through increased crying compared to those remaining StS (Moore et al. 2016).

StS during the Golden Hour is an important first step in the initiation of breastfeeding and positively affects breastfeeding duration and exclusivity (Moore et al. 2016). At this time, the infant moves through nine pre-feeding behavioural phases that ultimately enables latching onto the breast and effective feeding. These phases are *birth cry*; *relaxation*; *awakening* where the baby becomes increasingly alert; *active* where baby moves limbs and head and demonstrates rooting; *crawling*; *resting* where infant also shows some sucking activity; *familiarisation* with licking of the areola; *suckling* where the infant latches and sucks; and finally *sleeping*

(Widström et al. 2011, 2019). During the Golden Hour, the infant has a heightened response to odour, and will locate the areola by smell (Moore et al. 2016). It is therefore important to consider both optimisation of undisturbed physiological birth practices and the disruptive impact of common facility-based practices such as washing or wearing strong-scented body products. Interruptions at this time, such as weighing the infant or carrying out other institutionalised requirements, further disrupt this natural process and can prevent the infant from latching and feeding effectively.

Oxytocin

The hormone oxytocin has a key role in breastfeeding and is critical for mother-infant bonding (Widström et al. 2019). Oxytocin promotes the milk ejection reflex through the contraction of the myoepithelial cells around the mammary gland alveoli and the relaxation of milk duct sphincters and facilitates prolactin release and thereby milk production (Uvnäs Moberg et al. 2020). Oxytocin may also reduce stress, plasma cortisol and pain, and enhance well-being (Uvnäs Moberg et al. 2015, 2020). Oxytocin is released in response to StS, breast stimulation (e.g. expressing or breast massage) and breastfeeding (Uvnäs Moberg et al. 2020). Salivary and plasma oxytocin levels are found to be higher among breastfeeding compared to formula-feeding mothers (Grewen et al. 2010), but release of oxytocin can be delayed or reduced by birth interventions, e.g. caesarean-section (CS) birth (especially pre-labour CS) and maternal anxiety, depression and alcohol use (Uvnäs Moberg et al. 2020). A long-term follow-up study identified significantly fewer depressive symptoms and lower salivary cortisol levels in the first weeks and months after birth, greater mother-infant dyad social engagement and reciprocity in conversation at 9 years, and longer duration of breastfeeding among those who had experienced StS at birth (Bigelow and Power 2020). Oxytocin was hypothesised as the underlying driver of these outcomes (Bigelow and Power 2020).

Factors Affecting Skin-to-Skin

Current best practice recommends that babies remain StS with their mother for the first hour after birth (the Golden Hour). However, a number of factors relating to birthplace cultures, care provider practices or mother/parent characteristics can disrupt this period and negatively affect breastfeeding outcomes. The initiation of StS may be delayed, disrupted or stopped early due to birthplace rules (Niela-Vilen et al. 2020), time constraints (e.g. busy birth rooms that result in a rushed approach to StS) and unsupportive birthplace policies (Neczypor and Holley 2017). The quality of StS can be affected by specific practices, including mode of birth, requirement for emergency treatment and maternal well-being. For example, birth analgesia such as pethidine and fentanyl can dampen the newborn's instinctual behaviours, including feeding. Forced or rushed attachment of the baby to the breast and some approaches for management of the third stage of labour and care of the perineum will affect StS (Niela-Vilen et al. 2020; Widström et al. 2019). These factors do not have to be complete barriers to StS, and some midwives adapt their practice to optimise StS opportunities, for instance preparing the mother's clothing for ease of StS,

arranging surgical screens at CS, drying the infant or conducting routine neonatal assessments on the mother's abdomen, and delaying non-urgent tasks (Neczypor and Holley 2017). Where StS is disrupted, the infant should be returned to this niche at the earliest opportunity.

A positive influence on StS is preparation of the birth space and anticipatory guidance (Neczypor and Holley 2017). This includes actions to optimise high-quality StS, adapting the layout of the birth space, changing protocols and providing staff and family education (Neczypor and Holley 2017). Equipping parents with appropriate information that places the focus on the neonate (Neczypor and Holley 2017; Widström et al. 2019) enables them to advocate for high-quality StS, as required (Anderzén-Carlsson et al. 2014).

Skin-to-Skin in Challenging Circumstances

Specific circumstances around birth and the immediate post-birth period might mean that mother-infant StS is not possible or needs a different approach. CS birth does not preclude StS. With thoughtful planning, the infant can be placed immediately on the mother's abdomen and kept StS with the mother during the rest of the surgery and transfer. Enabling StS post-CS is important because CS birth can negatively impact the initiation and continuation of breastfeeding. Where continuing StS immediately after birth is not possible (e.g. maternal emergency treatment), the infant will benefit from StS with the mother's partner or birth companion. Mothers and infants separated at birth (e.g. admission to the neonatal unit) also benefit from StS. Studies with stable preterm infants show increased oxytocin levels in the infant and the parents following StS (Vittner et al. 2018), promoting neonatal and maternal well-being, maternal-infant attachment and protection of future breastfeeding opportunities.

Significant global events such as natural disasters, war and pandemics have the potential to disrupt birth, attachment/bonding and breastfeeding. The safest place for the newborn infant is most likely to be StS with the mother. Efforts should focus on keeping the infant StS for the purposes of thermoregulation, to support the physiological transition to the external world and to enable breastfeeding. This latter is particularly important where access to other means of infant feeding may be unsafe and insecure (Gribble et al. 2019; Gribble and Berry 2011). A recent example is the COVID-19 pandemic, which resulted in some infants being removed from their mother at birth (Kuehn 2021). This practice does not align with current knowledge and evidence about neonatal immunity nor the protective effect of StS, where the exposure to the mother's known microbiome is superior to the foreign microbiome of other caregivers. Separation affects the success of breastfeeding, which is crucial for infection prevention and normal development of neonatal immunity and microbiome.

3 Initiating and Sustaining Breastfeeding

The term *initiating breastfeeding* refers to the period of time from birth until breastfeeding is established (Edwards et al. 2018). Initiation is not a single event but is a continuous process from birth, whereby the mother and infant learn this new skill. It is variously considered to last from birth to 48 hours (Edwards et al. 2018), the period of hospitalisation or the first week of life (Cohen et al. 2018). During this time, the mother transitions from secreting small volumes of colostrum (Lactogenesis I) to copious amounts of milk, normally around 2–4 days post-birth (Lactogenesis II). Care at this time should protect and support this delicately balanced process, avoid practices known to undermine breastfeeding and preserve future breastfeeding opportunities. In societies where breastfeeding is less visible, new mothers need confidence and belief in their ability to nourish their infant and good support from healthcare providers (HCPs) and their social network. Skilled support requires an understanding of breastfeeding physiology, neonatal metabolism and normal newborn behaviour, and influential sociocultural beliefs and practices (Gavine et al. 2016; Perez-Escamilla et al. 2016; Smith et al. 2018).

For example, learning a new skill such as breastfeeding requires personal confidence/self-efficacy, belief in the skill (i.e. it will benefit you or someone else) and belief in the ability to carry it out. In the case of breastfeeding, there is substantial evidence that mothers who have higher levels of confidence and breastfeeding self-efficacy are more likely to breastfeed successfully (James et al. 2020; Lau et al. 2018).

3.1 Breastfeeding and Context

Context refers to the physical place, people (i.e. mother's family and social network, HCPs and other potentially unknown people) and their sociocultural attitudes,

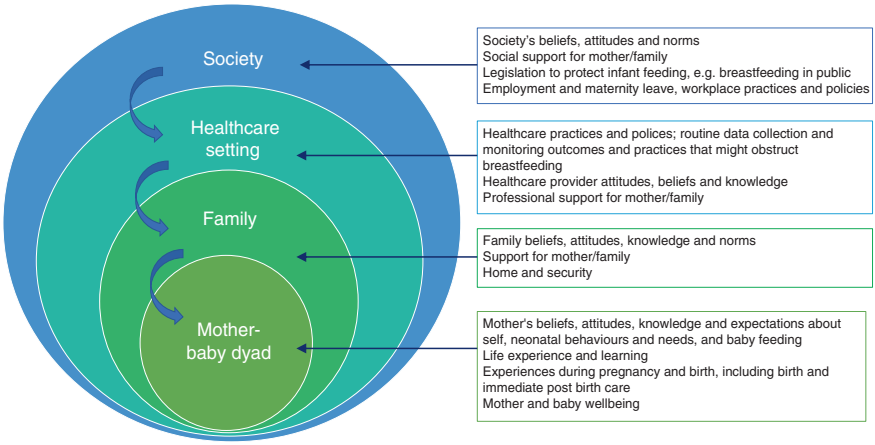

Fig. 1 Contextual factors that interact to influence breastfeeding

Table 1 Maternal characteristics and socio-demographic factors influencing breastfeeding initiation and continuation: evidence from systematic reviews and/or meta-analyses

Non-modifiable factors
Maternal socio-demographics: e.g. age, education, marital status, parity, household income, ethnicity, birth country and immigration status (Cohen et al. 2018; Dhami et al. 2021; Dennis et al. 2019; Garrison and Maisano 2019; Mangrio et al. 2018; Monge-Montero et al. 2020)
Family factors (e.g. income), family feeding norms; effect varies; e.g. it may be the mother's mother, mother-in-law or partner who has the greatest influence depending on ethnicity and culture; intergenerational effects (Negin et al. 2016; Di Manno et al. 2015; Sharma and Byrne 2016)
Adverse childhood events (Channell Doig et al. 2020)
Maternal employment and maternity leave (Habtewold et al. 2019; Navarro-Rosenblatt et al. 2018)
Previous feeding experience (Garrison and Maisano 2019; Huang et al. 2019a)
Breast implants (Cheng et al. 2018)
Modifiable or potentially modifiable factors
Maternal beliefs, attitudes and knowledge about colostrum, breastfeeding, neonatal behaviour and views on motherhood (Cohen et al. 2018; Lau et al. 2018; Sharma and Byrne 2016; Lyons et al. 2018)
Maternal BF confidence or self-efficacy; feeding intentions and perceptions of social support (Lau et al. 2018; Lyons et al. 2018; Rocha et al. 2018)
Maternal mental health: depressive symptoms associated with lower BF rates (Butler et al. 2021; Dias and Figueiredo 2015; Hoff et al. 2019)
Intimate partner violence (Mezzavilla et al. 2018)
Maternal smoking (Cohen et al. 2018) or exposure to second-hand smoke in pregnancy (Suzuki et al. 2019)
Maternal pre-pregnancy BMI and/or inadequate or excessive weight gain during pregnancy and body image (Flores et al. 2018; Garcia et al. 2016; Huang et al. 2019b)

beliefs and norms about parenting and baby feeding. It also includes societal and healthcare system influences and processes that directly or indirectly impact breastfeeding (Fig. 1). A number of international studies identify the impact of a range of these contextual factors on feeding outcomes and maternal-infant well-being (Cohen et al. 2018) (Tables 1 and 2). However, the direction and magnitude of influence vary by socio-economic and cultural context, including infant feeding norms; for example, in many high-income countries, breastfeeding is less prevalent among low-income, less educated populations, whereas in some low-middle-income countries, breastfeeding rates might be lower among more affluent families (Dhami et al. 2021). The identification of factors influencing feeding outcomes in particular population groups provides an opportunity to identify women most in need of additional individualised support.

The context in which breastfeeding initiation takes place is crucial to its success or otherwise, highlighting the critical importance of evidence-based practices and individualised support. Rates of breastfeeding around the world tend to drop off

Table 2 Clinical factors that might influence breastfeeding outcomes (NB: the potential influence of clinical factors will vary by contextual factors such as maternal characteristics and situational norms as well as care provision; an awareness of these influences can help to design individualised support and could be part of any conversation during clinical decision-making)

Clinical factors	Evidence from systematic reviews (SR) and meta-analyses (MA)
Access to AN education or classes or AN care	Positive effect on BF initiation and duration associated with BF education (Cohen et al. 2018), BF counselling (Habtewold et al. 2019) and access to AN care (Dhami et al. 2021; Habtewold et al. 2019)
Gestational diabetes (GDM)	GDM associated with less exclusive BF and shorter BF duration (Manerkar et al. 2020; Nguyen et al. 2019)
Birth location	Affect varies around the world. For example, in Nepal, India and Ethiopia, higher BF initiation rates recorded among women birthing in health facilities (Dhami et al. 2021; Habtewold et al. 2019; Alebel et al. 2017)
Induction of labour (IOL): has a range of potential mechanisms, e.g. reason for IOL, gestation, labour duration, drugs such as oxytocin or other interventions	Effect of IOL on BF is unclear. The most recent Cochrane review (Middleton et al. 2020), which included two trials with BF at hospital discharge as an outcome, showed no effect. However, a large multicentre retrospective study identified IOL in low-risk women as a risk factor for not implementing skin-to-skin and for not initiating BF (Espada-Trespalacios et al. 2021); one small cohort study identified lower BF initiation in relation to IOL (Bryanton et al. 2020)
Gestation: early-term birth (37–38^{+6} weeks)	Consistently poorer feeding outcomes are found in early-term infants (37–38^{+6} weeks) compared to term or post-term infants (Fan et al. 2019). Feeding challenges related to immaturity and more disorganised or uncoordinated motor/feeding skills
Mode of birth	Caesarean-section birth is consistently associated with poorer feeding outcomes, when compared to vaginal birth (Cohen et al. 2018; Dhami et al. 2021; Garrison and Maisano 2019; Habtewold et al. 2019; Prior et al. 2012)
Synthetic oxytocin: commonly used for a range of purposes, at different stages of labour and different dosages (e.g. labour induction or augmentation, routine management of the third stage of labour, management of post-partum haemorrhage or a combination of these)	Some evidence for a negative effect of peripartum oxytocin. One SR identified an association between oxytocin and unsuccessful BF (Monks and Palanisamy 2021) and an integrative literature of studies published between 1978 and 2015 identified a possible negative association (Erickson and Emeis 2017). Cohort study evidence is unclear (Bryanton et al. 2020; Fernández-Cañadas Morillo et al. 2019, 2017; Gomes et al. 2018) Assessing impact on feeding is confounded by additional interventions, and variations in dose, timing or duration of exposure

(continued)

Table 2 (continued)

Clinical factors	Evidence from systematic reviews (SR) and meta-analyses (MA)
Labour analgesia and anaesthesia	Any potential effect varies by drug, dose and route and by a range of clinical and socio-demographic confounding variables. A useful resource is an overview by the American Academy of Breastfeeding Medicine (Martin et al. 2018). One SR of labour epidural was inconclusive (French et al. 2016). A systematic evaluation found no effect of low-dose fentanyl (Zhu and Xia Ho 2018)
Skin-to-skin after birth	Skin-to-skin has a positive effect on first BF (Karimi et al. 2019), exclusive BF (Karimi et al. 2020) and initiation and continuation (Cohen et al. 2018)
Separation of mother and baby after birth	Effect is unclear: the most recent Cochrane review (Jaafar et al. 2016a), which included only one trial, was inconclusive. A SR of RCTs and non-randomised prospective controlled studies identified no clear effect of rooming-in (Ng et al. 2019), but a meta-analysis which included 17 studies demonstrated lower BF initiation and duration associated with dyad separation (Cohen et al. 2018)
Pacifier use	Effect is unclear: the most recent Cochrane review of 2 trials identified no effect (Jaafar et al. 2016b), but a SR and meta-analysis that included 44 observational studies found a consistent association between pacifier use and risk of BF interruption (Buccini et al. 2017)

Abbreviations: *AN* antenatal, *BF* breastfeeding, *BFHI* Baby Friendly Hospital Initiative, *GDM* gestational diabetes, *MA* meta-analysis, *RCT* randomised controlled trial, *SR* systematic review

steeply in the first 1–2 weeks after birth, which is when women are learning a new skill while simultaneously recovering from the birth and adjusting to their new role (Hoddinott et al. 2012; McInnes et al. 2013). It is also when some women, especially those in high-income/well-resourced countries, have access to intensive professional support. However, for many new mothers particularly first-time mothers, the reality of breastfeeding often comes as a shock. Unrealistic expectations may stem from idealistic representation of breastfeeding in the media and biased or incomplete information (Fallon et al. 2019; O'Brien et al. 2017). For example, antenatal classes or educational resources often provide a sanitised version of breastfeeding for fear of putting women off. However, this is harmful because if women believe breastfeeding to be easy, then difficulties can be perceived as personal failure (Jackson et al. 2022) and may result in negative emotions of guilt, shame and regret (Russell et al. 2022). During pregnancy, women want to hear realistic stories about breastfeeding preferably from mothers who have managed challenges or 'broken the rules' in how they fed their baby. A frequent comment from women reflecting on the early post-birth days is 'why did no one tell me how difficult it would be'.

Feeding Location

Location can compound the challenges of learning to breastfeed—often in the busy, and public, hospital environment where effective support is not always forthcoming (Buck et al. 2020; James et al. 2017; McInnes and Chambers 2008). Several global and national initiatives aim to address poor or inconsistent breastfeeding support in healthcare facilities. These include UNICEF's Baby Friendly Hospital Initiative (BFHI), which, recognising the crucial role of health services, assesses the standards of care in maternity facilities against evidence-based steps to promote, protect and support breastfeeding (World Health Organization 2017), and the World Breastfeeding Trends initiative (WBTi), which assesses the implementation of policies and programmes from the World Health Organization's Global Strategy for Infant and Young Child Feeding (World Health Organisation 2003) in 98 participating countries (World Breastfeeding Trends Initiative 2021).

Internationally, breastfeeding in public spaces is contentious (Russell et al. 2022) with frequent media stories of breastfeeding women confronted in shops, cafes and other spaces. Being able to breastfeed in public has a crucial influence on breastfeeding (LoCascio and Cho 2017; Meng et al. 2013; Roche et al. 2015; Scott et al. 2015). For many women, the healthcare facility, postnatal ward or their own home is also a public place where she risks being viewed and judged by others (Hauck et al. 2020; Sheehan et al. 2019). Adolescent women in particular describe public and hospital spaces as challenging (Hunter and Magill-Cuerden 2014; SmithBattle et al. 2020). Inhabiting a shared space with other mothers, their visitors and a range of HCPs can feel undermining for the exhausted mother. Mothers in shared ward areas may fear disturbing other mothers and may reach for a bottle in an attempt to sooth their crying baby. During the COVID-19 pandemic, many hospitals severely restricted visitors to postnatal ward areas. While some women found this difficult, others enjoyed the time with their infant and opportunity to focus on breastfeeding (Stulz et al. 2022).

Model of Care

Consistent evidence from a range of international settings demonstrates higher breastfeeding rates in relationship-based models of care such as midwifery continuity of care (Burns et al. 2020; Homer et al. 2017; Sandall et al. 2016). Potential explanatory factors include increased opportunities to share information, provide breastfeeding education and anticipate women's concerns through an ongoing relationship built up during pregnancy. This trusting relationship can have an important influence on women's confidence and sense of well-being as she transitions to motherhood. Midwifery continuity models often provide community-based care near or in the mother's home, enabling involvement of the mother's support network during antenatal preparation for breastfeeding and empowering them to provide post-birth support.

3.2 Supporting Women to Breastfeed

Healthcare facility clinical practices that support and protect breastfeeding are enshrined in the UNICEF BFHI (World Health Organization 2017). Supportive practices comprise StS; avoiding pre-lacteal feeds (e.g. glucose or formula milk prior to breastfeeding) or formula milk supplementation; avoiding the use of pacifiers (dummies), bottles or teats; keeping mother and baby together (rooming-in); encouraging responsive or baby-led feeding rather than restricting feeds by the clock; and preserving the mother's breastmilk supply and future opportunities to breastfeed if the mother and infant are separated or feeding is not possible for any reason (Gharib et al. 2018). Hospitals adhering to the BFHI package have improved breastfeeding outcomes (Perez-Escamilla et al. 2016; Fallon et al. 2019).

Women want effective practical support, reassurance and confidence building and care that is family-centred rather than guideline-based (Hoddinott et al. 2012; Fallon et al. 2019; Cook et al. 2021). Women have identified seven key supporting factors, namely trust and security, consistent advice, proactive breastfeeding support, breastfeeding education, comfortable environment, positive attitudes and emotional support, and individualised care (James et al. 2017). High-quality evidence demonstrates the effectiveness of different forms of breastfeeding support, including scheduled individualised support by trained professional or lay/peer supporters (James et al. 2020; McFadden et al. 2017) and internet-based electronic technology interventions (Almohanna et al. 2020).

Women's experiences of establishing breastfeeding critically affect continuation. Key factors are self-efficacy, support and beliefs around sustainability. Self-efficacy influences readiness and motivation to return home and ability to overcome breastfeeding challenges. 'Sustainability' is what women value in relation to continuation of their breastfeeding journey, for example accessible, people-based breastfeeding services in the community or holistic and individualised breastfeeding assessment and care plans (James et al. 2020).

Healthcare Provider (HCP) Influence

HCP influence spans pregnancy, birth and postnatal period. Their attitudes, knowledge and approach can have a significant impact on women's feeding experience (Cramer et al. 2021). Women want HCPs who are kind, genuinely care and demonstrate that they have the time to provide help (McInnes and Chambers 2008; Cramer et al. 2021; Blixt et al. 2019). The essential skills of the HCP include technical and knowledge, advanced communication and good interpersonal skills. However, negative experiences are frequently reported comprising poor communication, perceptions of judgement and criticism (Fallon et al. 2019; Cramer et al. 2021). Conflicting or inconsistent advice is common and can leave women feeling confused and demoralised (Fallon et al. 2019; McInnes and Chambers 2008). Poor-quality support can derail the best attempts to breastfeed and does not empower women to learn how to breastfeed. The perception that HCPs are busy often prevents mothers from asking for help. Mothers identify that having a trusting relationship with their HCP is beneficial by reducing conflicting advice and the need to frequently repeat their

story. A trusted carer knows the mother's goals and values and will work with her to help her to achieve them (Dykes and Flacking 2010).

3.3 Women's Feeding Decisions and Choices

Feeding Rules

The history of infant feeding is littered with rules about what women can or cannot do when feeding their infant. Women find rules-based approaches patronising, unrealistic and unsupportive (Fallon et al. 2019). In the 1980s, women often received advice to feed every four hours and to restrict feeding to 1 minute per side (breast), building up to 3 and then 5 minutes. This advice, which lacked evidence, had a destructive effect on feeding outcomes and women's confidence, and highlights the importance of woman-centred evidence-based practice. To avoid unintentionally causing harm, careful consideration of women's needs, desires and context and a full understanding of the physiology of feeding and evidence-based practice are required. Ultimately, exactly how a mother feeds her infant is her choice and is enabled by the provision of woman-centred unbiased information, support and guidance.

Drivers for Breastfeeding Decisions

Breastfeeding promotion and preparation largely focus on health outcomes with the assumption that women will weigh up the risks and benefits to make a logical choice about what is best for their baby. However, intimate partners and other family members are also highly influential at critical time points (Negin et al. 2016; Schafer et al. 2016). During the early postnatal period, breastfeeding is one of many competing activities and decisions are often precipitated by post-birth experiences such as pain, anxiety and lack of sleep, in a context of heightened emotions (McInnes et al. 2013). At this time, decisions are often reactive to restore a sense of well-being during moments of distress (Hoddinott et al. 2012).

A powerful driver of feeding decisions is a perception of inadequate milk supply, frequently affected by infant factors. For example, a fussy or unsettled baby or 'slow' weight gain might lead to a belief of poor milk supply and the need for formula milk supplements, which negatively impacts feeding outcomes. Conversely, confidence in ability and motivation are drivers for successful outcomes (Cook et al. 2021).

Maternity leave, returning to work and employment factors can influence initial feeding choices and ongoing feeding decisions (Lubold 2017). Returning to work in the first year is associated with shorter and less exclusive breastfeeding, highlighting the importance of providing good workplace support and access to onsite facilities to breastfeed or express and store breastmilk (Smith et al. 2018). Women value workplace support; it helps them to continue breastfeeding, but access can be difficult due to workplace gender inequalities (Chang et al. 2021).

Protecting Breastfeeding

As discussed, good professional and social support can have a powerful protective effect on breastfeeding. Mothers who feel confident about their ability to breastfeed and who experience positive feedback such as a settled baby, good growth and enjoyment of feeding will feel more able to continue to breastfeed. Creating new social networks that are congruent with the women's own feeding choices is also important if this support is not forthcoming in pre-existing networks (McInnes and Chambers 2008). This might become even more important when the mother and child continue to breastfeed beyond the prevailing social norm.

3.4 Breastfeeding, Emotions, Morals and Guilt

Infant feeding is strongly influenced by social and moral norms (Russell et al. 2022), but the breastfeeding discourse has often come to symbolise 'the good mother' (Darwent 2014; Russell et al. 2022; Marshall et al. 2007), where women feel a moral obligation and social pressure to breastfeed (Russell et al. 2022). The moral discourse and perceived judgement can result in feelings of shame or guilt, when feeding does not go according to plan, and embarrassment about breastfeeding in front of others (Fallon et al. 2019; Russell et al. 2022). Family, social and moral pressure to breastfeed can contrast with societal (including health service) norms that appear to favour bottle feeding, undermining women's feeding experiences and choices. Positive emotions (e.g. satisfaction and bonding) can be experienced when mothers focus on their own desires and beliefs, rather than these pressures and obligations, and are associated with breastfeeding initiation and longer duration (Russell et al. 2022). Breastfeeding successfully can enhance maternal well-being and sense of achievement and control (Fallon et al. 2019). Navigating the moral maze is challenging and may result in inner conflict. Mothers who stop breastfeeding earlier than planned may require 'moral work' to preserve or repair their sense of self, for example, justifying or rationalising their actions and reframing events from uncomfortable to a comfortable or acceptable position, or as outside of her control, e.g. blaming others or external events (Ryan et al. 2010). For these reasons, sensitive individualised breastfeeding support is critical to optimise maternal confidence and autonomy, as well as the transition to parenthood (Blixt et al. 2019; Dykes and Flacking 2010).

3.5 Bonding and Attachment

The mother-infant bond is the mother's emotional involvement with her infant and can be seen in how she cares for her infant, seeks closeness and responds to her infant's cues (Roth et al. 2021). Bonding is not a single event, but increases positively across the first 6 months after birth and is negatively impacted by breastfeeding difficulty, e.g. pain (Russell et al. 2022; Roth et al. 2021). Breastfeeding is promoted as a way to bond with the infant, and knowing this can influence women's feeding choices and

may also be an outcome of breastfeeding (Russell et al. 2022). However, when considered in the family context, this might lead to formula-milk supplementation to enable other family members to bond through feeding (Hoddinott et al. 2012).

3.6 Further Reading: Breastfeeding in More Unusual Circumstances

There are many specific unusual and unique circumstances that can affect breastfeeding mothers and babies (Gribble et al. 2019; Gribble and Berry 2011). These include national or global emergencies or natural disasters; a baby with additional needs including congenital anomaly, prematurity or poor health; and a mother with complex healthcare or treatment needs such as substance addiction, chronic mental health conditions, some medical requirements, intimate partner violence, incarceration or child protection oversight. In almost all situations, breastfeeding continues to be recommended. In some instances, the mother may choose to express and bank her own breastmilk if possible, or donor breastmilk may be a preferred parental option or recommendation. The key considerations are non-judgemental support of women's choices; protecting breastfeeding from harmful practices; keeping mother and babies together; providing access to skilled, knowledgeable people for feeding support; and, where breastfeeding is not possible, supporting women to express and store their milk to provide breastmilk for the infant, maintain their supply and protect the option to breastfeed at a future time.

3.7 Conclusion

Breastfeeding is a complex social behaviour strongly influenced by a range of biopsychosocial factors including the healthcare context. How women experience breastfeeding has short- and long-term implications for their continuing parenting role and their relationship with their infant. This highlights the need for realistic antenatal preparation, informed decision-making and ongoing individualised skilled support.

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Perspectives on Midwifery and Parenthood

Julie Jomeen

1 Introduction

Transition to parenthood (TtoP) is a frequently used term within the maternity, child and family literature (Cowan and Cowan 2000), most usually referring to the period of time following the birth of the first baby (Doss and Rhoades 2017) and the early weeks. However, as discussed in the introduction chapter, it is suggested that the TtoP starts with the decision about planning a pregnancy and extends to as far as the second year after birth (Deave et al. 2008; Deave and Johnson 2008; Polomeno 2000, 2006); it is about becoming a mother, a father and a parent and the formation of a family (Gameiro et al. 2011). The TtoP is a significant period of change of an individual's lifespan and is both momentous and critical. Transitions, such as the TtoP, influence future well-being of parents and families (Meleis 2010) and the developmental trajectories of children. A successful TtoP is a tenet of early positive parenting (Salmela-Aro 2011). TtoP comprises and is shaped by both context and variables at the individual, couple, family and societal levels. What can be and has been conceptualised as a period of positive growth and fulfilment can also be challenging in terms of parental resilience.

2 Perspectives on Midwifery and Parenthood

The chapters in this book take the reader through the contexts and circumstances that have the potential to hinder a positive TtoP. It clearly highlights the perinatal period as a spectrum illustrating explicitly how what happens in the antenatal period

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(chapters "Midwifery and the Transition to Parenthood, Preparation for Parenthood, The Parental-Fetal Tie During Pregnancy, Wellbeing and Early Motherhood, Midwifery and Perinatal Mental Health, Infertility, Repeated Loss, and Surrogacy, and Supporting Early Parenting Following Preterm Birth") inevitably influences the postnatal experience and TtoP. It explores in chapters "Adolescent Pregnancy and Early Parenting, Drug and Alcohol Use in Pregnancy and Early Parenthood, Violence, Abuse and Coercive Control in Pregnancy and Early Parenting, and Migrants, Midwives, and the Transition to Parenthood" and chapter "Diversity of Family Formation: LGBTQ+ Parents" some of the social contexts that women find themselves in and the environments they create that can also substantively influence how TtoP is experienced. Further, the value and importance of the support structures that surround new parents and which can characterise their experiences positively and/or negatively during this significant life journey experience are discussed and considered.

Chapter "Midwifery and the Transition to Parenthood" sets the context for this book, describing the construct that is TtoP and its significance. Despite the fact that the decision to become parents is often an active choice, many feel ill-equipped to face the challenges of parenthood, with particularly confronting issues caused by the social and cultural context of contemporary society, which has evolved rapidly over the last 50 years to recalibrate the nature of parenting but with a legacy of traditional gender roles. Transition involves how couples can adjust individually but also relate to each other and negotiate many variables not least of which is expectation versus the reality of TtoP. Chapter "Preparation for Parenthood" picks up this theme by stating that despite evidence that being adequately prepared for parenthood results in enhanced outcomes for parents and their children, many parents still report feeling unprepared for the realities new parenthood brings. This chapter reveals recent evidence of the value of preconceptual preparation, much of which is psychological preparation in terms of life goals but can also include employment and financial contexts as well as consideration of factors such as maternal age; these are aspects of consideration that continue into pregnancy. Relationship preparation is a key element that features; despite this, current approaches to preparation for pregnancy still leave parents feeling largely unprepared for the realities of new parenthood.

Antenatal and birth experiences that influence postnatal TtoP are explored in chapters "The Parental-Fetal Tie During Pregnancy, Infertility, Repeated Loss, and Surrogacy, and Supporting Early Parenting Following Preterm Birth" through issues such as the parental-foetal tie (PFT), challenges of infertility and preterm birth.

The PFT is a relatively newly described phenomenon, which describes a process of relationship building with the unborn child. That the PFT is a dynamic process that both parents undergo is of substantive interest, as well as its relationship to 'bonding' as we would normally understand and interpret it. The different populations described in this book may experience PFT differently culture and context play an important role in the PFT, is a focus for future research as well as the need to undertake longitudinal research, which is able to examine the relationship between the PFT and TtoP, including parental relationships with the baby. This has

a significant overlap with the issues of infertility discussed in chapter "Infertility, Repeated Loss, and Surrogacy"; it is of value to consider how the PFT may differ in the context of pregnancy after infertility, often considered a precious pregnancy (Minkoff and Berkowitz 2005), with its own transition and emotional context. The issue of surrogacy and donor pregnancy has clear implications for psychological sequelae, in part because of the challenges of adequate or effective support for both donor and receiver. The issues in this chapter intimately link to those explored in chapter "Diversity of Family Formation: LGBTQ+ Parents" regarding the experiences of some LGBTQ+ parents, who take this route to parenthood.

If the PFT has implications for the parental relationship with the baby post-birth, then understanding its value as a mediator or moderator when the TtoP is disrupted, such as in the case of preterm birth and admission to the neonatal intensive care unit, could also be of significant interest for future research. It is widely accepted that preterm birth is associated with stress-related outcomes. Chapter "Supporting Early Parenting Following Preterm Birth" illustrates the sources, from which these arise, including infant health, physical and cultural environment of the neonatal unit, challenges to pre-existing identity and assumptions and how they are supported and prepared for parenthood transitions. Most parents in this circumstance report a sense of alienation. This experience means that parents have to reorganise the process of transition, which if done poorly can adversely affect parenting identity and relationship to the infant. How parents react to and cope with these stresses is moderated by a number of factors, but integration into the neonatal unit and infant care activities are key aspects of support that facilitate a more positive TtoP.

TtoP is significantly affected by societal discourse regarding aspects such as lifestyle choices, non-traditional families, displaced families and migrants and breastfeeding, all of which are addressed in this book.

Chapter "Adolescent Pregnancy and Early Parenting" explores the impact of adolescent pregnancy, which may or may not be a lifestyle choice but has, though not inevitably, an impact on outcomes for individual parents, parenting and child as well as societal outcomes. Adolescent pregnancy creates a point at which two transitional life stages collide. Hence, the intensity of the physical, emotional, relational and social change is magnified, creating an additional vulnerability for poorer physical and mental health outcomes. Chapter "Diversity of Family Formation: LGBTQ+ Parents" discusses the impact of diverse family formation on the TtoP, specifically LGBTQ+ parenting. Despite a somewhat increasing visibility of sexual minority and gender minority people as parents, due to policy and social changes in some countries, there remains a dearth of perinatal research in this field. Outcomes are difficult to monitor due to a failure to record gender or sexual orientation in maternity records in spite of seemingly increasing numbers of lesbian and trans men becoming parents. Assisted conception and being deemed high risk as a consequence and the tenuous legal status of partners in many countries add to the risk of poorer mental health outcomes. Of particular interest in this chapter is that there is also evidence of increased numbers of adolescent unwanted pregnancies in LGBTQ+ individuals. When coupled with the discussions about adolescent pregnancy and throughout chapter "Adolescent Pregnancy and Early Parenting", it is easy to see

how a profile of vulnerability, particularly for negative psychological consequences, can be sketched out by practitioners caring for LGBTQ+ individuals in a maternity context. This group of parents are clearly faced with a unique set of issues, which derive from physical experiences but are defined within prevalent societal discourses that may not allow for their recognition and hence their acceptance, with significant implications for the role of perinatal care providers.

The vulnerabilities associated with being a migrant woman are addressed in chapter "Migrants, Midwives, and the Transition to Parenthood". The significant role that the social determinants of a migrant woman's health can play in terms of the outcomes of their pregnancy is presented and discussed. A key message and call from this chapter are the need for a universally acceptable definition of the term 'migrant' and the interchangeable use of the term 'refugee'. This, as with LGBTQ+ parents, underpins a failure to generate an evidence base from which to base care and maternity service delivery decisions. The health risks of being a migrant are well articulated in the chapter, which are compounded by a pregnancy in which circumstances are often not economically, socially or culturally stable. The importance of relationship and financial stability as well as support are articulated across the different chapters of this book, as significant in the TtoP, yet migrant women are likely to be the most affected by a lack of those aspects which support the quality of the postnatal environment, their own mental health and the future well-being of the child.

Chapter "Drug and Alcohol Use in Pregnancy and Early Parenthood" discusses that health inequalities are also inextricably linked to drug and/or alcohol use during pregnancy, both as antecedents and as consequences. Often pregnancies in this group of women are unplanned due to a common misconception that they are unable to get pregnant. The scope of this book enables us to make clear links between the differing contexts that might coalesce for women as they TtoP. Chapter "Violence, Abuse and Coercive Control in Pregnancy and Early Parenting" focuses on intimate partner violence (IPV), abuse and coercive control. The risk of experiencing IPV is significant in pregnancy; it is often a point of inception as well as escalation of existing IPV. Violence does remain a gendered issue, though not exclusively; IPV is experienced disproportionately by women and perpetrated predominantly by men. Women in already vulnerable contexts such as migration, substance misuse and adolescent pregnancy bring together a range of risk factors that increases their risk for IPV and coercive control. Physical and psychological consequences of IPV and coercive control are inevitable and may have an interactional relationship with alcohol or drug use. The significant psychological consequences, outlined in the chapter, as well as the detrimental environment that women may be returning to are significant in terms of women's own health outcomes but also those of their infants. Chapter "Drug and Alcohol Use in Pregnancy and Early Parenthood" highlights the stigma associated with substance use during pregnancy and assumes an inability to parent, resulting in inherent barriers to care that women then experience as a consequence. The same issues of stigma and shame can apply to women who experience IPV and limit disclosure. Yet pregnancy can work as a facilitator to seek support with related individual and societal benefit, making

accessible and non-judgemental care a critical factor in supporting these women to make a successful TtoP.

The concept of 'good mothering' infuses several of the chapters in this book including chapter "Drug and Alcohol Use in Pregnancy and Early Parenthood", as above. Women are often societally judged for the choices they make, even more so when pregnant. Chapter "Breastfeeding: Women's Experiences in the Transition to Motherhood" addresses the, sometimes contentious, area of breastfeeding. The chapter usefully deconstructs and highlights the potential complexity for women of a choice to breastfeed: that it is much more than just a choice of one feeding type over another but is rather *'a series of decisions that are strongly influenced by interactions between individual, societal and organisational factors, including structures and processes within health or maternity care services' (McInnes and Donnellen-Fernandaz 2022)*. The moral discourse around feeding can imbue feelings of shame or guilt when perceived to have made the wrong feeding choice or feeding does not go according to plan; often women are faced with contrasting pressures from family, society and health services. Situations such as feeding and lifestyle choices which are framed by a 'good mothering' narrative often involve significant moral work from women, which can have emotional consequences. A woman's experience of breastfeeding, successful or not, inevitably has implications for TtoP and relationship with their infant.

A theme which runs throughout this book is the psychological aspects of the TtoP. This is also a potentially bidirectional relationship. Evidence on the impact of deleterious mental health on adaptation to parenthood and negative outcomes for mothers, fathers and their infants is now unequivocal. While there are clear antecedents to perinatal mental health problems that can affect TtoP, the latter itself is a potential antecedent to developing a perinatal mental health problem. Chapter "Midwifery and Perinatal Mental Health" presents some of the current debates and issues related to perinatal mental health, highlighting that awareness of what makes a woman psychologically vulnerable enables midwives to identify women and their partners who require further support. Causes of mental health problems are multifactorial, as lucidly evidenced in this book; many are not specific to the perinatal period. Enduring evidence now links perinatal mental health problems to low socioeconomic status, poverty, physical health and pregnancy complications, interpersonal violence, substance and alcohol use and other forms of disadvantage, poor relationships and lack of support (Howard et al. 2014). As already indicated in chapter "Diversity of Family Formation: LGBTQ+ Parents" and above, while published literature is lacking, limited evidence suggests that there may be a higher incidence of perinatal depression in lesbian women. Birth-related events are also risk factors for poorer emotional health in the TtoP. It is always noteworthy that partners of women suffering from perinatal mental health problems are more likely to experience mental health issues themselves with a concomitant impact on the quality of the family environment (Nazareth 2011).

Chapter "Wellbeing and Early Motherhood", however, presents a different paradigm for consideration, where supporting well-being and promoting self-care can support women to effectively manage the TtoP, which involves the

often-overwhelming nature of new motherhood, responsibility for the baby, competing demands on mothers' time which undermine time for oneself, and profound changes to women's sense of identity and purpose. The emerging evidence presented in this chapter suggests that enabling self-care is a core element of women's efforts to experience or foster a sense of well-being. To support women to have permission to undertake self-care is a broader social issue; not only does it compete with the socially dominant notion of parents as self-sacrificing for the good of their children, but it also undoubtedly presents a challenge to both health services and individual practitioners who often work within a risk-based paradigm. Yet, this approach which aims to facilitate women to use their own personal resources to support well-being during the TtoP seems worthy of further investigation.

The dominant focus of the TtoP literature is focused on women with fatherhood remaining a relatively neglected subject, despite acknowledgement that parental roles within contemporary society create expectations for fathers, yet conversely do not give new fatherhood the same importance as new motherhood. Fathers have a core role in enhancing maternal well-being and improving the quality of their children's physical, emotional and social development, with wider societal benefits. Chapter "Midwives and the Transition to Fatherhood" highlights issues that overlap with those identified in chapter "Preparation for Parenthood" around preparation for parenthood, including preconceptual preparation, which while inherently has connection and some similarity with women experiences also has distinct differences. Yet the development toward fatherhood is less explicit; again, it may be useful to connect to the PFT discussions in chapter "The Parental-Fetal Tie During Pregnancy" and the role that visual mediums such as scans play. Men, in the same way as women, are influenced by social discourses, around good fatherhood, which create particular pressures and potential stresses, with evidence of paternal perinatal mental health now consolidating in the literature. Of interest in this chapter is the influence of the relational aspect to the mother and the nature of that in terms of how that facilitates or inhibits fatherhood experiences and the TtoP. A key discussion here is how midwives and maternity services can ensure an inclusive approach for fathers. More research is critical in this space; chapter "Adolescent Pregnancy and Early Parenting" also highlights the dearth of literature in the adolescent father field.

Throughout this book, authors have focused on the role that midwives can play in positively impacting the lives of individuals, couples, infants and families. Chapter "Spirituality and Spiritual Care in the Transition to Motherhood" presents the value of spirituality to the experiences of women as they TtoP; '*motherhood and spirituality mutually influence and intertwine each other toward the development of an integrated identity as mother*', though it is feasible to suggest that this is equally as relevant to fathers. The chapter highlights how midwives can play a role in attending to the positive and negative roles of spirituality in women's transition. Research in this domain remains limited, but the chapter presents a framework to guide both the education and practice of midwives in spiritual care.

Chapter "Midwifery and the Transition to Parenthood" identifies the International Confederation of Midwives' (ICM) definition of the midwife, and the State of the

World Midwifery report, as positioning the midwife as a practitioner, educator and counsellor of the woman and her family during the TtoP.

The core message that infuses this book is that in all circumstances, midwives are ideally placed to provide respectful, compassionate and holistic care. Such care should attend to all the domains that characterise pregnancy, physical, psychological, spiritual, cultural and social to optimise the well-being of the woman, her partner, the unborn child and neonate, across the perinatal spectrum.

Midwives care for women in many diverse situations and contexts during the TtoP; they are part of a wider team in all circumstances. Several chapters highlight the need for strong interconnectivity between services, which requires effective service design to facilitate care pathways that promote seamless care and good communication to benefit women, couples and families.

3 Conclusion

This book has presented a set of contemporary issues pertinent to the work of midwifery and maternity care. It lucidly illustrates the diverse needs of parents and the impact that effective care can have on outcomes not only for them but also for their children in an enduring sense on physical, psychosocial, emotional, cultural, economic and spiritual well-being. Within that context, several chapters indicate that this needs us as practitioners to examine our own views, potential prejudices and biases, which are influenced by the same social discourses that parents are exposed to. Maternity professionals have unique and privileged relationships with parents during the TtoP. This book has offered perspectives across a range of differing situations, presenting new knowledge, offering solutions to how differing scenarios should be approached and bridging a gap in literature, to support midwives and other maternity professionals to enhance the health and well-being of mothers, fathers and families in the TtoP.

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