INTERVIEW

Great expectations

Jo Green (University of York) talks to Jon Sutton about birth and more

How did you become interested in the psychology of birth?
In 1984 I applied for a job with Martin Richards in Cambridge examining implications of medical staffing structures for maternity staff and for women. At interview I said, 'I'm afraid that my only previous experience of this field is having my own children,' and Martin said, 'Don't denigrate it'. I was amazed that a Cambridge academic was telling me that personal experiences were valid ways of knowing. As I got to know Martin better – we worked together for 12 years – I realised that starting from personal experience was his hallmark. Since 1996 I have worked in the Mother and Infant Research Unit (MIRU) where many of my colleagues have a background in midwifery. I have always worked in multidisciplinary research groups and am a strong believer in psychologists working with other disciplines.

During your time in the unit, has the way women view the care they receive in labour and delivery changed?
Yes, I think that it has. Firstly, it is part of the bigger picture of how people view their relationship with the health service. We have been increasingly encouraged to think of ourselves as 'consumers' and to value 'choice' as desirable for its own sake even if only one (or none) of the options on offer is actually what we want. Secondly, there tends to be a bit of a cycle in how childbearing women view medical intervention. When I had my children in the seventies it was the start of a backlash. Do you remember that moment in Monty Python's *The Meaning of Life* where a woman giving birth, surrounded by machines that go ping, asks what she should do and is told, 'Nothing! You are not qualified.' That is rather the way it was then. However, much has changed and now some parents are wondering what is so bad about medical intervention. A study I published with Helen Baston in 2007 suggested that they may not actively want those interventions but they are more likely to accept them if offered.

I would imagine that perceptions of control are important in the birth experience, as they are in many other situations in life.
The word 'control' is often used to refer to 'external' control, over what is done to you, and it is often equated with involvement in decision making. However there are also 'internal' senses of control – of your body and behaviour. Our work has investigated the extent to which these different senses of control are important to different women.


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Do you find that birth is one situation when many women, and men, are happy to relinquish control to the medically qualified?
The importance of feeling in control was something that emerged from the early work that we did in Cambridge and from many other studies since. I argued in a 1999 paper that 'feeling in control' and 'making decisions' are not the same thing and that an important way of achieving that feeling of control is to relinquish decision making to professionals that you trust.

And what impact does control have on outcome?
With Helen Baston in 2003, I found that internal and external control were predicted by different groups of variables and that all three types of control contributed to psychological outcomes. The key message is that interactions with caregivers are fundamental. The ways in which women are helped to deal with pain affects internal control; the extent to which they feel that they are actually cared about, rather than care being something that is done to them, affects external control. Both contribute to satisfaction and emotional well-being.

One of your papers asks 'Why do women go along with this stuff?' What's the answer?
This was the title of a 2006 set of invited discussion pieces in the journal *Birth*. I argued that women 'go along with this stuff' (a) because they trust their caregivers; (b) because they don't want to experience pain, and in some cases are extremely anxious about this; (c) because they don't necessarily see 'this stuff' as bad; and (d) because both caregivers and women are losing faith in women's bodies to do the job.

My experience of National Childbirth Trust classes was that there was a lot of talk of resisting medical intervention, but that most participants were pretty open to the idea of epidural from the start.
Different NCT teachers will have different ways of putting things across. I would think that the common theme is to make parents aware that they can be active participants in the birth process; unlike the Monty Python scenario, it is not just something that is done to you. Ulla Waldenström in Sweden has called it being a 'subject' rather than an 'object'. Most parents, especially those giving birth for the first time, will be anxious about

pain and their ability to cope with it, and effective birth preparation should be addressing that. High levels of antenatal worry about labour pain predict poor obstetric and psychological outcomes. Women who, antenatally, are in favour of interventions are more likely to get them but their obstetric and psychological outcomes are generally poorer than women who find other ways of coping.

The appeal of an epidural is understandable. What are the disadvantages?

The disadvantages are primarily that if you cannot feel what your body is doing then you cannot work with it effectively. That means that women who have epidurals are much more likely to need help in getting the baby out. That in turn is associated with more morbidity for both mother and baby. There are also psychological sequelae: women who end up having an instrumental birth or unplanned caesarean section feel less in control, are less satisfied. When we run multivariate statistics on these outcomes, having an epidural is always a major factor.

What can psychologists do to offer the support and encouragement to pursue other strategies?

Research by a number of psychologists in the UK, notably Pauline Slade, is adding to the evidence base in this field. There are also psychologists working in and with the health services who work directly with women with extreme fears, anxieties and post-traumatic stress disorders relating to birth. These are more common in some countries than others, notably in Sweden.

You are right to identify 'support and encouragement' as things that women need, but psychologists are not necessarily the people who need to supply them. There is increasing interest in the role of trained lay supporters, known in some places as 'doulas', and we have just started some exciting new research in this field.

What are your views on the role of the father during birth? There can't be many dads left who take the Gordon Ramsey view; he apparently justified his absence from the delivery room by saying, 'Skinned rabbits and conger eels coming at me from everywhere. I didn't want that to be in my memory'.

Mrs Ramsey was probably pleased not to have him there if that was how he felt. It's not what all couples want; they need to decide what's right for them. No father should feel obliged to be there; if he is feeling negative he probably won't be a lot of support to his partner. However, there is surprisingly little direct research evidence about this.

I know your interest doesn't stop at birth. I read an interesting study of yours regarding fathers' views on breastfeeding. You found that some worry about their breastfeeding partners attracting predatory male attention?

Yes, birth itself has only been a part of my interest in the whole reproductive continuum. The paper that you are referring to arose from a serendipitous combining of two different studies which both included focus groups with low-income men. The first, led by Lesley Henderson, focused on media representations of infant feeding. The second, led by Brian McMillan, was on the role of the theory of planned behaviour in understanding women's infant feeding intentions. In the latter our focus groups with pregnant teenage women raised very similar issues about the sexuality of breasts, portraying breastfeeding as a morally suspect activity.

Is there a growing appreciation of culture and class in your work, regarding areas such as breastfeeding and postnatal depression?

No, I think that it has always been there. However, I think that the research community as a whole is now more alert to social inequalities than it was, which makes it easier to air these issues.

How much input do psychologists get into, for example, midwifery training?

That varies from place to place. Most student midwives will get modules covering some basic psychology, but typically not taught by a psychologist. I do have some input to undergraduate midwifery education at York via MIRU, but that is unusual. I suspect that not all midwives realise just how important the interactions between parents and caregivers are. More input from psychologists could be a very good thing.

What areas are still lacking in research?

There is always lots more needed! There are still quite a few gaps in our knowledge. We need more large-scale longitudinal studies so that we can disentangle the way that antecedents to birth relate to what happens at the birth itself and then to sequelae. It is all too easy to focus on one aspect of people's lives and think that that is all that matters without seeing the rest of the picture. For example, a lot of what is called 'postnatal depression' is pre-existing, but if you focus only on the postnatal period you would not know that. We know that antenatal emotional well-being also relates to the sort of birth experience that you have, but few studies have the resources to look at it. Ideally, we should also have comparable studies in different countries so that we can have a better understanding of the role of cultural factors. I have tried doing this with colleagues in Sweden and the Netherlands, but it is incredibly complex. For example we found that, compared to those in England, first-time mothers in Sweden consistently used much more positive words to describe themselves during labour, and yet their overall outcomes were very similar. We really don't know why. I have been working with a cross-national alliance of multidisciplinary maternity researchers across Europe towards the goal of a European Survey of Maternity Expectations and Experiences (ESMEE) which we hope will allow us to eventually answer some of these questions.

Further reading

Baston, H.A., Rijnders, M., Green, J.M. & Buitendijk, S. (2008). Looking back on birth 3 years later. *Journal of Reproductive and Infant Psychology, 26*(4), 323–340

Green, J.M. (1993). Expectations and experiences of pain in labor. *Birth, 20*, 65–72.

Green, J.M. (1998). Postnatal depression or perinatal dysphoria? *Journal of Reproductive & Infant Psychology, 16*, 143–155.

Green, J.M. (1999). Commentary: What is this thing called control? *Birth, 26*, 335–336.

Green, J.M. (2006). Why do women go along with this stuff? *Birth, 33*, 154–155.

Green, J.M. & Baston, H.A. (2003). Feeling in control in labor: Concepts, correlates and consequences. *Birth, 30*, 235–247.

Green, J.M. & Baston, H.A. (2007). Have women become more willing to accept obstetric interventions and does this relate to mode of birth? *Birth, 34*, 6–13.

Green, J.M., Coupland, V.A. & Kitzinger, J.V. (1990). Expectations, experiences and psychological outcomes of childbirth. *Birth, 17*, 15–24.

Green, J.M., Coupland, V.A. & Kitzinger, J.V. (1998). *Great expectations* (2nd edn). Books for Midwives Press

Henderson, L., McMillan, B., Green, J.M. & Renfrew, M.J. (2011). Men and infant feeding. *Birth, 38*, 61–70.

McMillan, B., Conner, M., Woolridge, M. et al. (2008). Predicting breastfeeding in women living in areas of economic hardship. *Psychology & Health, 23*, 767–788.

Schytt, E., Green, J.M., Baston, H.A. & Waldenström, U. (2008). A comparison of Swedish and English primiparae's experiences of birth. *Journal of Reproductive and Infant Psychology, 26*, 277–294.

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