

# 1

## Birth

*Lydia Ottavio*

### Chapter Overview

This chapter aims to develop your understanding of aspects of birth as a transition. Practitioners working with young children draw on their professional experience and training and also from their own experiences as a sibling to understand the experience of birth as a transition. They know that the birth of a new member of the family can create not only delight but also insecurity and troubled behaviour in siblings, particularly those who are close in age to the new-born family member. New parents may experience a change in identity, lifestyle and family relationships. In this chapter a health visitor argues that birth is a transition experienced by the whole family. This can compound its impact on young children, and when we view it in this way we are better able to support children and families as an interprofessional team. Birth may be a ubiquitous experience in life and a common occurrence in society, but there is no doubt it feels like a unique experience for the individuals in the family. As a health visitor, it is a privilege to be involved in this major life transition from pregnancy, to birth and after. However, the best support for a family relies on leadership skills that reach across agencies to link up with other professionals so that the most responsive and sensitive services are mobilised.



## Introduction to the case study

The antenatal period is a very important and undervalued transition. Transition to parenthood affects the unborn baby as well as the whole family, and pregnancy and the first years of life are crucial to development; the seeds are planted for future health and well-being. If this period is disrupted, if parents fail to bond with their child, emotional problems could result and babies become at risk of disadvantage and impaired development.

The chapter presents a case study of a birth in a family. It is presented from the perspective of the baby before and after birth. First, there is an example of some problems met by a family in which a new baby is soon to be born. Then, things improve largely because of good 'interventions' by the health visitor. Next, the health visitor reflects on the case study explaining what was happening in order to illuminate understanding of the transition process. Finally, the health visitor discusses aspects of her own role and leadership skills while working with other professionals and agencies to support the child and family through this major life transition. The chapter closes with some thoughts from the health visitor on what she has learned from the case and how she and her team will seek to change their approach.



### Soon to be born ... baby Luca

I'm waiting to be born and be part of the outside world. My parents are Anglo-Italian; living with us are aunties, grandparents, cousins; and it's noisy. Mummy is quiet; she helps look after my poorly Nan while Auntie makes pesto and pasta. Daddy works hard in a city; I hear his voice at weekends. Auntie worries about Mummy, not caring for herself – bad eating, late rising, no energy and missing her midwife appointments. Despite this I'm doing well. It helps Mummy doesn't smoke or drink alcohol.

Oh – some movement – Auntie seems to be taking Mummy somewhere in her pyjamas. Is it to hospital or the surgery? They are both annoyed with the midwife, will they go again?

Back at home, more problems for Auntie. My cousin can't go back to nursery as he's not potty trained. He is very lively around the house. Cross voices.

A new midwife visits, with a health visitor. Mummy likes this one. There's lots of tears and Mummy says there is no-one to help. The midwife promises

to help Mummy. A phone rings and she is called away. Maybe she is too busy?

Oh dear. Nan's doctor is here. Everyone's sad. Mummy is quiet, not eating Auntie's pasta. Where are the midwife and the health visitor? Who cares about Mummy and me?

I'm born! There's shouting about which creams to put on my rash. Nan scolds Mummy – she's crying but she won't have help from anyone. When I cry she doesn't hear me. When she holds me she stares into space. Here's the doctor to visit Nan. Will he notice how Mummy is?

My cousin tries to climb in my cot to be a baby with me. He is in trouble again. Mummy shouts at Auntie to keep him away ...

## Things improve for baby Luca

I'm home and 12 days old. It's cosy with Mummy and Daddy, aunts, nanny and granddad, especially my cheeky cousin. Everyone's helping and Mummy's happier; I hear her voice more now. The health visitor and midwife give her ideas for baby groups to join; I'm looking forward to that.

At the group Mummy finds tips – childhood ailments, illnesses, safety and development. We learn about children's centres and baby-friendly places to go, and the librarian tells us about 'rhyme time' and 'story time' at the library.

My cousin is allowed to cuddle me – with help and supervision. Wow, he is lively and exciting! He can do so much – I love him. He makes Mummy laugh too. Mummy reads him a story about new babies and shows him how to play with me gently.

Mummy is talking, reading and singing to me more and more each day; great for my development and helps with bonding, social, emotional skills, and speech. I meet up with other babies, play on my tummy and enjoy the music Mummy plays for me. Life is good!

Mummy sees the doctor now who is very helpful, caring and interested in us. The midwife comes back. She is very kind. I feel safe, secure and happy now. All these professionals are aware of our family. There is so much help available for us.

This week I will be four months old! I have just come back from a special cinema with Mummy and Daddy, and lots of other families. They can change and feed me there and don't have to worry if I cry or make noises.

Great!

## Dilemmas for the health visitor

There are four transition dilemmas highlighted in this case study. The first is how best to provide early support for the family, a shift of focus from postnatal support to more help in pregnancy (Sinclair, 2007). The second relates to how to develop better communication and information sharing whilst recognising that, as Leadbetter (2006) writes, new ways of working can cause difficult tensions in professional teams and across multi-professional services. The third is lack of team cohesion; having separate roles, responsibilities, working independently in our own spaces (Rushmer and Pallis, 2002). Finally, the fourth is how to give culturally sensitive information and advice, without making assumptions about another's beliefs. One person's mother-infant reactions can be very different from another's (Lynch and Hanson, 1992). This is particularly challenging when there are cultural and language differences between members of the family and the health visitor.

### Early support for the family

The health visitor in the case study was part of an 'Early Support' project, a new venture for local midwives, GPs, health visitors and a wider team of professionals. They meet weekly at a children's centre to discuss referrals face to face (Regan and Ireland, 2009). Quarterly 'formal' meetings include the wider team and managers. Letters to GPs explain the project, posters and flyers are distributed, and they obtain consent from clients to work using this different approach. However, they are worried that transition and relationship issues that they came across are being referred too late to support vulnerable families. Naturally the top priority is to save the lives of babies or mothers. Lower down the agenda are family and social relationships. The challenge remains to energise their team to think broadly and creatively about when early support may benefit families (Davies and Brighouse, 2010) and prevent difficulties developing.

A positive antenatal period is vital for baby's brain development. If the potential for a special relationship between professionals and the family can be developed, much can be achieved. There can be positive outcomes for bonding, breast feeding, child health and development (Larson, 1980). Postnatal depression and accidents can be reduced if supportive networks are enhanced (DOH, 2009a).

## Communication and information sharing

Communication, confidentiality and information sharing among professionals are crucial to effective support for the family – which needs to be seen as a holistic unit as well as composed of individuals. Historically, lack of ‘sharing’ information by health visitors and midwives has meant a gap in service provision. When we share skills, we learn so much more (Ancona et al., 2007). Joint working offers opportunities for discussion, openness and fluid information and skill-sharing that can lead to more responsive services. However, trust takes time to develop between professionals. One way to build interprofessional trust is to work and train together including ‘shadowing’ each other to appreciate our roles (Mintzberg, 1998).

CAF (Common Assessment Framework) training across professional boundaries develops understanding, encourages responsible risk-taking and learning from new experiences, and builds strong associations with colleagues (Leadbetter, 2006). Holding joint meetings in neutral venues such as the children’s centre means we can all ‘own’ the space and develop mutual understanding of responsibilities (HM Government, 2010). Interprofessional team-working helps sense-making, relating, visioning and inventing but it also provides live links that create a safety net for children and their families.

It is really helpful when professionals ensure that there are opportunities to update each other on new developments; for instance a health visitor can organise her team to receive updates from midwives on issues like breast feeding. Actions like this improve professional relationships and understanding and can be surprisingly well received. Crucially, provision of timely and relevant information to families can ‘head off’ difficulties. As the auntie in this case study said: ‘The health visitor has been a tower of strength, giving us information on a number of our concerns.’

## Team cohesion

In this case study the family did not receive connected care from the midwife, health visitor, doctor and other professionals from the start (Regan and Ireland, 2009). Perhaps lack of team cohesion – having separate roles and responsibilities, working independently in their own centres (Rushmer and Pallis, 2002) – limited the responsiveness of care services to the needs of the child and the family. A co-ordinated

team approach, in partnership with parents, can address a host of difficulties such as depression, accident prevention, nutrition and dental care (Hall and Elliman, 2003). Meeting in the family home can help to identify a broad range of medical and family needs. In this case the GP knew of the grandmother's illness, but not the client's pregnancy and opportunities were lost to consider the impact of one aspect of the family's circumstances on another.

Hosking and Walsh (2005) emphasise that if there is sensitive care and good attachment to key people such as parents in the early years, children will grow up appreciating others' feelings, being able to empathise and be secure and resilient. However, the road to parenting is difficult, isolating and frightening (Cowan and Cowan, 2000). Marriage/relationship difficulties may affect parenting which, in turn, is likely to affect the child's overall development. The challenging outcomes to work for are children who are less violent, better behaved and with fewer mental health problems as they grow up.

Early referrals and interventions may prevent difficulties, and ease relationship building (Field, 2010). An example of positive joined-up working is when a CAF assessment of a pregnant teenage pupil sets up a meeting at her school, so professionals from health, education and the children's centre can adopt a team approach that creates seamless support for her and around her. The focus must be working 'with' the client, keeping their needs as the central concern (DoH, 2000).

### **Cultural sensitivity**

Awareness that the person working with a child and their family is giving 'culturally sensitive' information and support is important. With the best will in the world the intervention intended to support the child and family may be unfamiliar or families may be vulnerable during a difficult transition. In addition, professional 'help' can be overpowering (Lynch and Hanson, 1992). Illich (2000: 17) states this point clearly: 'they not only recommend what is good, but actually ordain what is right'. Families may feel pressured to do what 'professionals want' instead of being empowered to do what they desire once given the facts and advice. Professionals are good at 'giving' advice, instead of finding out what people want. Illich (2000) challenges us about 'knowing best'. Being culturally aware requires flexibility, an open heart, and a willingness to accept different perspectives

using a sensitive and respectful approach and taking unobtrusive actions (Mintzberg, 1998).

In the case study the health visitor suggested baby groups, baby massage and seeing a mental health worker, but any one of these hold the potential to upset the family's beliefs (Lynch and Hanson, 1992). The advice on 'research-based' creams was not well received. The family agreed out of politeness and continued their own practice after the health visitor left. She talked about 'potty training' as an intentional practice, assuming the family understood. However, it was not in the family's vocabulary. For this family, the child gains control of her bowels through a natural progression from birth which follows the baby's cues and mother's reactions (Lynch and Hanson, 1992). When reflecting in her professional log, this health visitor recollected that, when she was in Africa with the Masai, breastfeeding mothers knew when their babies were going to 'perform' and never used nappies.

Keeping a professional log like this highlights the benefits of writing experiences down, thinking about what happened, and forming fresh views after 'chewing it over' (Bolton, 2001). The health visitor was mindful of 'border crossing' (Moss, 2008) or collaborating with others to become aware of alternatives, learn from colleagues' expertise and experience, and be open to and curious about other ways of living and disciplines. So she talked things through with some colleagues. In this case study the health visitor's discussions with colleagues, such as the community psychiatric nurse, helped to identify solutions to some of the difficulties faced by the mum. She agreed with Ancona et al. (2007: 94) in her professional log: 'I appreciate a good leader is incomplete; having strengths, weaknesses but able to draw on others for skills they don't have'. Laming (2009) argues for organised, regular, reflective supervision and peer support to ensure sufficient effective support is available to the professionals who are supporting families.

Services should provide culturally sensitive, relevant information. Developing relationships with parents, social support and using effective leaflets are essential for health promotion (McKellar et al., 2009). It is the time spent listening to people's stories and the processes used to engage with families that make an important difference to the quality of care and support they receive. Tritschler and Yarwood (2007) recommends knowing ourselves as helpful to gaining insight into a family's needs, arguing that we can relate to the family using personal experience and knowledge. This is an ongoing process. We always have more learning to do.

## A health visitor's perspective

Pregnancy and the first years of life are vital to development; seeds are planted for future health and well-being. As a health visitor (and previously a midwife), I believe this is a crucial and undervalued transition. Gerhardt discusses the 'toxicity of stress' on a vulnerable, developing baby. The baby's brain development is rapid during the months before birth and up to the age of five and if this process is disrupted babies may become disadvantaged with emotional and development problems (Gerhardt, 2004). As Sinclair (2007: 18) says: 'The most important six years in a person's life are up to the age of five.' Early intervention can improve the attachment process (Heywood, 2009). By identifying needs, giving support, we improve family outcomes, the child's well-being, and social and emotional development (Hosking and Walsh, 2005; DoH, 2009b).

Transition to parenthood is one of the most challenging periods of anyone's life (Cowan and Cowan, 2000; Berlin et al., 2005). With policy changes, lack of funding and modifications to the health visitor's role, families may only receive one home postnatal visit. This is a huge contrast to Scandinavia where the early postnatal period is considered precious (Sinclair, 2007) and much greater resources are devoted to supporting it.

In the case study, antenatal tension was seen. It is best that the health visitor endeavours to give positive, reassuring comments during visits at this time because occasionally families may be experiencing unhappiness and isolation rather than the joyful anticipation they expected. Later in the case study the newly qualified midwife engaged well with the family, was interested and they felt supported (Molyneux, 2001). Professional input through home visiting can improve parents' attitude and quality of the home environment (Kendrick et al., 2000). It can also help the health visitor to form an early picture of the family and establish a sound relationship.

The health visitor wrote in her professional log: 'In some ways we had failed this family. I met them very late on in the pregnancy, and it made it more difficult to form a trusting relationship.' Only one antenatal visit occurred, so opportunities to build confidence and trust were missed. Fortunately, relationships improved during the postnatal visits and the family fed back they were extremely grateful for her visits. The health visitor noted in her professional log that she was surprised how worried the mum was. The mum had said,



'The thought of meeting you [the health visitor] was quite scary'. The comment gave the health visitor pause for thought and caused her to consider ways to make the first meeting less threatening.

Many professionals were involved with this family which was surprising and confusing for all. Initially each health professional worked 'blindly'. However, sharing information is essential to ensure families get the support they require and may request. It entails honesty, openness and following up on plans, while keeping the child as the central focus. Pooling information while respecting confidentiality and gaining consent from clients enables liaison with a wider team which provides a holistic picture of the family that helps to improve and progress care (HM Government, 2010). The midwife knew the mother's dilemma; the GP had significant information about the grandparents' health needs; and the nursery nurse and health visitor saw multiple needs impacting on the unborn baby, parents, siblings and grandparents but the information was not shared effectively. Professionals undoubtedly felt they were giving the 'best' care. However, if they had taken a team approach, it would have helped to understand the family dynamics and may have improved support for everyone, even the health visitor herself. The health visitor wrote in her professional log: 'I felt a huge burden lay with me.' This is typical as ultimate responsibility often rests on the health visitor (Morrow et al., 2005).

In fact this family had many significant strong features. The mother and child had exceptionally good household support, rarely seen in British families as relatives often live hundreds of miles away (Lynch and Hanson, 1992). This family's situation improved after their needs were recognised and professionals were invited to work together (Foley and Rixon, 2008; Laming, 2009). The midwife saw that the mum appeared depressed in the antenatal period. She feared bonding between mother and baby would be affected (Cleaver et al., 2010). The mum consented to see her doctor in the postnatal period and gradually matters improved and strong bonds developed between mum and her baby. There was facial contact, cuddles and cooing and the mum became attuned to her baby.

## Reflections

Because the health visitor's team was thoughtful, reflective and dedicated to doing their best for clients at all times, they drew up an

action plan with recommendations to improve their leadership and support for the transitions of children and families. The health visitor recommended some changes in the way the team worked with families based on her learning and observations from this case study. This led to four priorities for action.

First, having observed that relationships between the health visitor and parents are affected by the timing and context of the initial encounter, the team agreed to be flexible about the time and place of the first meeting and to take note of the family's preferences. They brought forward the target date for meeting the parents-to-be and devised a 'criteria for referral' pack to formalise the record of early referrals as well as to act as an aide-mémoire.

Second, the team discussed how to improve information sharing and provide a seamless service for clients. They decided that to provide care without knowing what professionals from other services are doing is not a connected service. Their view was that joint working builds trust and develops understanding, making our expertise explicit, instead of tacit, for all professionals. Strong team cohesion gives families continuous seamless support that reaps rewards when things for the family are not going well. Early identification and consistent provision are crucial to protect our children (Leadbetter, 2006). One action was to take the time to give some positive feedback to other professionals when they had done a good job and a positive outcome for the family was achieved. This appeared to energise the wider team.

Third, in order to build team cohesion some joint training was arranged. The health visitor arranged for 'Bookstart' to give a training session in order to give colleagues from a range of professional backgrounds an insight into why books affect both bonding and socialisation. She wrote in her professional log: 'I think the leadership model "*asilo per uccelli*" (Italian for a "nest for birds") is a metaphor for nurturing and developing our teams so we can nurture and develop our children and families.'

Fourth, the health visitor realised that she and the team would benefit by being more culturally sensitive and self-aware, to avoid making assumptions regarding language and customs. For instance, one simple initiative was to find out more about what is available to families whose oral English is still developing. In the case study the interpreting services were brought in for important meetings to make sure that all members of the family could be included.

### Stop Press! Update on the case study

All is well with the family. Mum and baby have an attuned, responsive relationship that bodes well for the future social integration, well-being and language development of the baby. Because of the successful outcome of this case the health visitor and her team felt encouraged and re-energised in their roles. They knew that early antenatal input would be paramount in improving this transition for families like this as well as giving babies the best start and outcomes in their lives and those around them (Olds et al., 2010). Our county has now commissioned the Family Nurse Partnership which offers the intensive early support for young first-time mothers. Family nurses (some may have health visiting, and/or midwifery experience) have begun this valuable, cost-effective work supporting families from early pregnancy; improving life chances of babies and future generations.



### Further Reading

Gerhardt, S. (2011) *Why Love Matters: How Affection Shapes a Baby's Brain*. New York: Brunner-Routledge.

This book argues that early relationships are vital to create optimal well-being for future generations. It challenges some established views of what babies need, drawing on brain science to justify its arguments.

Murray, L. and Andrews, L. (2005) *The Social Baby*. Richmond: CP Publishing.

This book helps adults understand the communication of babies and how they can provide sensitive care. It includes photos of babies that give clues needed to begin to read and understand baby cues right from birth.

Rosengren, D. (2009) *Building Motivational Interviewing Skills*. London: Guilford Press.

This book is a great tool to use for positive behaviour change with clients and professionals, encouraging use of alternative wording to elicit behaviour changes in clients and in transition workers' professional and personal lives.