

Effective Communication

Tandy Deane-Gray

Introduction

The purpose of this chapter is to relate and understand how the development of communication from infancy can influence and inform your skills as adults in order to enhance your work-based experience to meet needs of the clients in your care. The chapter encourages you to draw from the lessons of optimal parent–infant relationships, including sensitive responsiveness, which underpins effective communication, as well as providing an outline of communication issues for practice. This is a condensed chapter on communication skills for midwives, and is designed to stimulate the reader to seek the original sources for expansion of the concepts.

Midwives are in a unique position to observe how humans learn to communicate. When time is taken to observe infants it is apparent that babies are ‘pre-programmed’ to interact with adults (Stern 1985). This is due to their preference for the sound, sight and movement of adults rather than other comparable stimuli. They are especially attracted to their mother. This is probably a biological instinct, as humans depend on their mother and other adults to care for them to ensure survival.

MacFarlane (1977) highlighted the ability of babies and dispelled many myths about infants, such as the belief that they cannot see. Not only can they see – and focus well at about 30 cm – but they like to look at the contrast and contours found in the human face. They turn to sound, particularly their mother’s voice; and will turn to the

smell of their mother's breast pad in preference to another woman's. So they develop recognition of their mother very quickly through their senses, and communicate their needs through behaviours (RCM 1999).

Babies also mimic the behaviours of adults, most noticeably by facial expression. If you smile, open your mouth wide or stick out your tongue, the baby will watch carefully and then copy. This is quite remarkable – how do they know that they even have a mouth? This can be observed in the first hour after birth and it is this response to adults that makes the baby a social and communicative being, as they will demonstrate taking turns in their non-verbal responses and vocalisations (Murray and Andrews 2000), provided the adult is sensitive to them.

It is not surprising that adults are attracted to baby features. We find certain attributes of the human infant 'cuddly': a relatively large head with big eyes, a receding chin and large forehead, round body outline and relatively short limbs, small size and high-pitch vocalisation (Eibl-Eibesfeldt 1996). These features normally stimulate care-taking responses and are perceived as loveable.

Care-taking and our sensitivity to infants is normally based on how we were cared for as infants. If we formed a good enough attachment to our parents and they were in tune with our needs, if they were 'baby-centred', then we become secure adults (Steele 2002). Every time babies are changed in a loving way or sympathetically responded to when lonely, tired, hungry or frightened, they take in the experience of being loved in the quality of care received. For a baby, physical discomfort is the same as mental discomfort, and vice versa (Stern 1985).

How do mothers respond sensitively to the specific emotional needs of their infant? Sadly not all of them do. 'Insensitive mothers' base their responses on their own needs and wishes, or general ideas about infants' needs. What is sensitive from an adult's point of view may not be perceived as such by the infant.

As the WAVE (Worldwide Alternatives to Violence) report (Wave Trust 2005, section 3) summarises, it is the parental attunement to the needs of infants, which midwives have a role in fostering, that leads to loved individuals who do not become anti-social. Sinclair (2007) suggests that through our early relationships and communication from conception to 3 years of age, we develop our emotional brain and our capacity for forming relationships occurs. Fundamentally, human beings at any age respond and feel understood when an attuned sensitive other interacts with them. As a professional, if you respond to the client in your care as a sensitive parent would, your communication with her can be improved.

Sensitive responsiveness is one of the key constructs of attachment theory (Bowlby 1973). The early infant–mother relationship has far-reaching consequences for the developing child’s later social and mental health. It is the underpinning theory in national agendas and frameworks interventions (e.g. DH 2004; Wave Trust 2005; DfES 2006; Sinclair 2007), and recommended for effective practice in the promotion of family health and parenting skills, which are now a priority politically and professionally.

The concept of sensitive responsiveness includes the ability of parents to perceive and respond to infants’ signals accurately, because they are able to see things from the baby’s point of view (Paavola 2006). This has been refined by many researchers.

Mothers who are sensitively responsive demonstrate the following (the key concept is in *italics*):

- They are observers who *listen* and see their strengths and help them with their difficulties
- They have warm and responsive interactions with caretakers. The mother’s task is to respond *empathically* – to mind read. Babies have no control or bad intent, but they learn they can self-regulate through maternal containment. They then learn to self-soothe, for example, by sucking
- They offer structure and routine, which is flexible and age-appropriate, and set *boundaries*. They provide psychological and physical holding. Holding also relieves anxiety – they feel held together
- They maintain interest by providing things to look at and do through play and touch, but *in tune*, e.g. they recognise a yawn means ‘leave me to sleep’
- Vocalisation is reinforced by response-dialogue. Hearing and *being heard* – respond to parent’s voice, familiarity gives sense of security; and babies need to hear talking to develop speech

(Paavola 2006, drawn from DH 2004; Wave Trust 2005; DfES 2006; Ponsford 2006).

Sensitive responsiveness can be facilitated, and when mothers’ sensitivity and responsiveness are enhanced, this results in a dramatic increase in secure attachments with fussy infants (Steele 2002).

Our infant–parent attachment patterns are largely acquired, rather than determined by genetic or biological make-up (Steele 2002), so with support we can improve our ability to relate to others. For midwives this means relating to clients and colleagues, but also facilitating parent–infant relationships. This can be done by praising the sensitivity you observe in parents and helping them see and

Table 1.1 Helping parents know their baby

Ask them to tell you about their baby:

- What does he/she like?
- What does he/she like to hear, look at, feel and smell in particular?
- How does he/she get your attention?
- How does he/she tell you they are content?
- What does he/she like when going to sleep? What do you notice about their sleep or their crying?

understand their baby. Using the questions in Table 1.1 might enable parents to realise that they can understand their baby.

The basic method of improving our relationships are those that mothers ideally use with their infants. This is primarily non-verbal, which is not surprising as over 65 per cent of our communication is non-verbal (Pease 1987). Observe bodily and facial cues, and be in touch with what that person might be feeling. This is truly listening and being with another person, and because we are listening and empathising, we provide a safe environment. This is something midwives demonstrate by holding women physically, which seems to help contain the labouring women in their pain, and at birth by encouraging skin-to-skin contact giving the baby a safe framework after being contained in the womb. But we also provide holding psychologically, by being with women and trying to understand what the experience is like for them. This is demonstrating empathy. When we reflect back what the client says and feels by our actions, whether by touch or words, the client feels held and heard.

Humans become socialised and learn that they should not do certain things: they should not upset others; they should stop arguing. We learn to hide our feelings and disguise what we really mean, which in turn leads to a lack of communication.

Dissatisfaction with midwifery care and in family life is often due to lack of communication. Our early skills in relation to communication become set in patterns, and the stamped foot of a toddler's temper tantrum can still be apparent in the adult. Nichols (1995) summarises the four early stages of development of self described by Stern (1985), which helps inform us of how we adopt patterns of acting and reacting which become unconscious responses in adult life. Interesting as these stages are between the ages of 0 and 18 months, this partly explains why, when we are anxious, we become inarticulate because we have reverted to a pre-verbal developmental stage.

Effective communication can be hard to achieve. Sometimes it seems that no matter how carefully we phrase what we say, the

listener either does not understand or misunderstands us. In verbal communication we often add emphasis through body language or intonation. We may adopt a defensive or threatening posture to reinforce our message and, of course, we may raise or lower our voice. These techniques are used spontaneously, having developed through our socialisation in childhood.

Some common problems in communication

Bolton (1979) suggests there are six peculiarities or common problems in human communication. These are mainly to do with understanding and listening:

1. Lack of clarity as words can have different meanings
2. Failure to understand because a message is 'coded'
3. Failure to receive the message as another agenda is clouding the issue
4. Being distracted and not hearing the message
5. Not understanding because the message is distorted by perception or other filters
6. Not handling emotions during a conversation

The first problem is poor understanding, often due to an unclear message or ambiguous words, because words may have different meanings for different people. As Ralston (1998) points out, terms such as incompetent cervix or inadequate pelvis are open to a very different interpretation to the non-professional listener. But even straightforward terms such as mayonnaise, when it is not differentiated into 'home-made' (using raw eggs, which should be avoided in pregnancy) and a commercial product, can lead to women misunderstanding the information they are given (Stapleton et al. 2002).

When the message is 'coded' the real meaning is masked; for example, when the client asks you to put her flowers in water, it could be a message to keep her company. It can also often be observed that clients present with one agenda, but really have a different problem – for example, they present with backache, but are really concerned that the pregnancy is normal. Midwives also miss conversational codes for more information from clients (Kirkham et al. 2002a). 'I don't know' and 'What would you do?' are both tactics women use to elicit more information, tactics which unfortunately are not very successful.

The way a message is spoken can also conceal a message within the message. Most speech has both an obvious and a hidden meaning

(Kagan et al. 1989). For example 'What did you say?' has the obvious meaning 'Please say that again', but the hidden meaning could be, 'You're so boring, I wasn't really listening'. However, if we say what we really mean we can hurt another's feelings. So we try to look and act professionally and this creates barriers to communication, because our message is not clear. Indeed, as professionals there are times when we are acutely aware of appropriate interactions and the need to adopt a professional face. For example, it is inappropriate to look cheerful or go into a long explanation of care during a life-threatening emergency (Mapp and Hudson 2005).

Clients also do not hear, or take in, what we say when they are distracted by the environment or physical symptoms. The disruption of a child needing attention during a conversation is an example. A client who is in pain or focused on their child, for example, may miss the information you are giving. However, midwives often miss non-verbal cues and carry on their own conversations neglecting the woman. The woman may interpret this as an 'I've started so I'll finish' attitude, while the midwife thinks 'I know I have given her the information', even if the client 'could not hear'. It is interesting to observe that mothers will say 'Look at me when I am talking to you' when addressing their children, thus ensuring the non-verbal feedback needed, which tells us we are being heard (Yearwood-Grazette 1978). Midwives should ensure that they respond to non-verbal cues with their clients, particularly eye contact.

Midwives and clients can filter information, because of perceptions, emotions or simply hearing what they wish to hear. For example, if you say 'You can go home after the paediatrician has discharged the baby', the client may hear only 'You can go home' and so phones her partner to collect her. Midwives too filter information by avoiding discussion. They emphasise physical tasks and this sends the message that discussion, particularly about how the woman feels, is less important. Indeed, discussions are often avoided by filling time asking for urine samples, ignoring possible anxiety even when the last pregnancy was a stillbirth, for example (Kirkham et al. 2002a). In essence, filters become blocks to communication.

Another block to communication is 'don't worry', a term that is used to reassure (Stapleton et al. 2002). However, paradoxically it causes anxiety as the client is denied the opportunity to express how she is really feeling (Stapleton et al. 2002). The words 'don't worry' should be avoided (Mapp and Hudson 2005). A smile or touch is more helpful and reassuring (Mapp and Hudson 2005).

It is not just what we say and do, it is also how we listen. It is rare for midwives to explore topics such as what foods a client eats to invite discussion (Stapleton et al. 2002), yet this would enable the

client to say what she knows. However, the midwife would then need to listen for any relevant missing information. This is hard, so instead there is a tendency to tell clients what to do – things they often already know, such as the advantages and disadvantages of breastfeeding – but not what the client wants to know, e.g. ‘what does breastfeeding feel like?’ (Stapleton et al. 2002). Kirkham (1993) suggests:

‘Good care must involve sensitive communication. Good communication is concerned with the exchange of information, ideas or feelings so that both parties understand more and have appropriate expectations. Just to impart our instructions cannot be called good care.’

Finally, people who have difficulty with emotional issues may deny their emotions or become blinded by them (Bolton 1979) because anxiety and fear or any high levels of emotional arousal lock the brain into one-dimensional thinking (Griffin and Tyrrell 2004). Our emotions affect our physiology and hijack the brain’s capacity for rational thought. This inhibits our ability to rationalise or entertain different perspectives, because traumatic and distressing experiences – whether big or small – cause imbalances in the nervous system which create a block or incomplete information-processing. This is why it is difficult to take in medical or other information or advice when we are upset, frightened, angry or in pain. This dysfunctional information is then stored in its unprocessed state in both the mind (neural networks) and the body (cellular memory) (Pert 1997). During emergencies poor communication can compound stress, so careful, sensitive communication that is congruent (i.e. the non-verbal matches the verbal) is what is required (Mapp and Hudson 2005).

Non-emergency situations can also involve high emotional arousal. Emotional arousal as a consequence of a power struggle will evoke a defensive response. As the thinking part of the brain becomes inhibited when the client feels conflict or stress, learning and taking in information cannot be effective (Griffin and Tyrrell 2004). When a midwife says, ‘I want to tell you about breastfeeding’, the emotional arousal from the client may come from the unspoken – ‘Who are you to tell me how to bring up my family!’ It would be more useful to reduce the emotional arousal and reframe or present the information another way, for example, ‘It’s good you have decided on your method of feeding. I would like to hear more about how you are going to feed your baby.’ As Nichols (1995) points out, ‘It isn’t exuberance or any other emotion that conveys loving appreciation; it’s being noticed, understood and taken seriously.’

Midwives may find that employing open questions is time-consuming. However, when information becomes blocked, misunderstanding is increased and this eventually leads to spending more time sorting out the problem later. Midwives also limit their emotional effort and may stereotype in order to increase control over work situations (Kirkham et al. 2002b), although if they were to increase their sensitive responsiveness, clients would be able to get the information they need, understand and feel understood.

Midwives need to give their clients emotional care, particularly those in labour, but this is draining. Many midwives realise they do not have time for their own emotional feelings so they 'pull down the shutters' in order to appear calm. It is this that can give the impression of aloofness, whereas others are perceived as naturally friendly (John and Parsons 2006). As John and Parsons (2006) suggest, support mechanisms need to be developed and implemented in order to reduce stress in practice. According to Nichols (1995):

'If you see a parent with blunted emotions ignoring a bright-eyed baby, you're witnessing the beginning of a long, sad process by which unresponsive parents wither the enthusiasm of their children like unwatered flowers.'

Thus far the problems and the ways midwives have been seen to communicate have been discussed. To be more effective in communication our sensitive responsiveness needs to be developed. The scope of this chapter can only scratch the surface in this respect as communication skills need to be developed experientially as our patterns of communicating are often learnt from childhood. Having said that there are areas individuals can develop, which will also improve their professional practice. This particularly includes listening and empathy. Some pointers will be outlined here, but learning these skills needs to be gained through experience in order for long-term change in practice to take place.

Listening

Listening skills are essential. Listening is an active process requiring the individual's full attention as you need to listen and fully hear what is actually being communicated, not just what is being said. Listening involves the mind, senses and emotions to pick up what is not said. Also required is the development of self-awareness, the awareness of when we fail to listen and attend, which, if addressed, is likely to have a positive effect on future communication. Good

communication minimises misunderstanding; poor communication can lead to complaints (Sidgewick 2006).

Part of the process of communication is receiving messages. Obviously, verbal messages are heard, but the receiver needs to be actively listening. Passive listening includes encouraging fillers such as 'umm', 'uh huh', as well as non-verbal nods and eye contact (Balzer-Riley 1996). Passive listening implies understanding, but active listening removes the guesswork as it ensures messages are received properly (Balzer-Riley 1996).

Listening skills vary depending on what we are doing. Sometimes passive attentive listening is sufficient. However, if we require more information, or if our clients are giving an emotional account, then a more active approach is helpful (Kagan et al. 1989). Attending is listening to what is really being said. This may also require the skill of appropriate questioning (questioning skills are addressed later). If we focus on our questions, then we go back and forth between what is being said and our reply, and we may not really hear what is being said (Rowan 1993). It cannot be emphasised enough that listening is one of the most important communication skills.

Guidelines for Listening

- Listen without interruption as far as possible; minimise questions
- Remember what is being said, as if you are going to be tested on it. Listen to what is not being said, particularly feelings
- Observe the client's body language as well as your own – is she giving you any clues?
- Have an empathic stance – what would it be like if you were in the client's situation?
- Try not to rush in with explanations and answers. The client generally has the answer
- Look like you have time, or make it clear how much time you have, and give your full attention

(Adapted from Jacobs 2000.)

Unfortunately, because much of midwifery requires information from the client we focus on questions rather than listening. Questions are so much part of conversation they seem almost to have replaced the ability to listen or respond in any other way, because we are already forming the next question. In order to enable clients to talk and midwives to listen and talk less, it is generally useful to begin with open questions. Open questions usually begin with words such as would, could, tell me, seem to be, I think, I feel, or I wonder. Questions that begin how, what, where and particularly

why can leave the client feeling they are under interrogation, whereas an open question allows them to describe their experience.

Activity

One of our tasks is to ask personal questions. Some of us find these easier to ask than others. However, you still have to ask them. So think about the following – could they be rephrased into more open questions?

- When was the first day of your last menstrual period?
- Have you had your bowels open?
- When did you last have sex?
- Can I see your sanitary towel?
- How are your breasts?

The following are part of the activities for daily living which may be used on admission forms. How would you phrase the questioning order to gain the information you need? How could you broach the question on issues such as:

- Expressing sexuality
- Death
- Safer sex
- Termination of pregnancy
- Alcohol consumption
- Domestic violence
- Mental health

When trying to establish legal responsibility for a child, how will you ask this when the child's surname is different from the mother's and the 'next of kin' – who is the 'father'?

Listening to what is not being said

In ordinary listening we are often interested in the content or subject. We generally try to relate this to our own experience (this is sympathy), thinking of interesting replies to carry the conversation on. In contrast, in a therapeutic relationship we are listening not only to the content, but also to the message within the message. This may be about the client's emotions, so if our own thoughts, experiences and emotions arise, we should put them aside because it is the client's experience that is the focus (Rowan 1993).

Jacobs (2000) recommends that we listen to the 'bass line' of a conversation, as if it were a piece of music. This invites us to listen

to what is not being openly said, but possibly being felt by the client.

Activity

Tom, a young father-to-be, is talking about his dissatisfaction with his partner's maternity care. Whether or not he is justified, what can Tom's bass line tell you? Imagine how you might feel in his position.

What is Tom's bass line saying? He is young, so possibly has little experience of the world, and the transition to parenthood is not without stress, partly due to the unknown. He may be unsure of himself, so any threat might elicit a defensive/hostile response. Tom may be feeling helpless and powerless as he feels he can do little for his new family. He may be concerned for his partner or their baby. These are all possibilities, so what are the feelings he could be expressing – anxiety, anger, frustration?

Activity

Tom is talking about his dissatisfaction with his partner's maternity care.

Tom: Excuse me, you said you would give my wife some more of those tablets to get her started in labour, we have been waiting for hours.

Think how you would answer. The labour ward has been busy and you were told not to induce Tom's partner. You also have been frantically trying to discharge clients in order to give beds to the women waiting to clear the delivery ward. The paediatrician has not discharged the babies and the consultant wants to do a round with you.

Midwife: I am sorry, we are busy and have not had time.

Tom: You seem to be making time for everyone else who has babies already.

Midwife: Well the delivery ward does not have space for you anyway.

Tom: Then why were we dragged in here at 7 am?

Midwife: Well, it's one of those things. We do not know what the workload will be like.

Now think how you could answer differently.

The midwife has been polite, but she is defensive, and her answers sound like excuses to Tom. The midwife feels stressed and is having

trouble coping with her workload. Her factual response does not demonstrate any understanding or concern for Tom and his partner. Concern and understanding will be demonstrated by letting Tom know you have heard him. Giving full attention is difficult in this case. I am sure you have heard a conversation like this while the midwife is on the phone and writing up some notes. Pushing the mute button on the phone, putting the pen down and giving good eye contact may have been the midwife's first reaction and would go a long way to contributing to Tom's perception that she really was listening. Furthermore, reflecting back or summarising what was said might ensure the midwife understands and Tom would feel heard.

Case Notes

Tom: Excuse me, you said you would give my wife some more of those tablets to get her started in labour, we have been waiting for hours.

Here are some possible replies that are more likely to help Tom feel heard and understood.

- Yes I did. You have been waiting a long time.
- Yes I did. I am sorry you have been waiting so long, it must be very frustrating for you.
- You have been waiting a long time, and it's disappointing when you expected the induction to have begun by now.

Not only are some of Tom's words being used to help him feel heard, but also the midwife has listened to the 'bass line' and is tentatively reflecting possible feelings. The midwife may be stressed and she might have started the conversation by using factual replies as that is an old habit, but she could recover or repair the communication by demonstrating empathy.

Tom: Excuse me, you said you would give my wife some more of those tablets to get her started in labour, we have been waiting for hours.

Midwife: I am sorry, we are busy and have not had time.

Tom: You seem to be making time for everyone else who has babies already.

Midwife: You seem concerned that there is no time for you and your wife. You feel anxious because it seems like the induction is never going to happen.

Empathy

Jacobs (2000) suggests that if you listen to yourself and how you might feel in a given situation, this will be a way of understanding – the first step towards empathy. Empathy involves the capacity to recognise the bodily feelings of another and is related to our imitative capacities. We associate the bodily movements and facial expressions we see in another with the feelings and corresponding movements or expressions in ourself.

Mothers help babies regulate their emotions in this way. You may have observed a distressed baby being cuddled gently by its mother whose facial expression is as pained as the infant's. Her tone of voice and touch mirror the infant's state – 'Oh dear! There there' gradually soothing into a calmer state with soft voice and holding: 'I know. Mummy is here, you can cope' (Gerhardt 2004). Humans also seem to make the same immediate connection between tone of voice and other vocal expressions and inner emotion. Thus, empathy is a synonym for communicated understanding (Balzer-Riley 1996). It is mentally putting yourself in the shoes of another so that you can understand how they are feeling in an accepting way without judgement or evaluation (Balzer-Riley 1996).

A midwife needs to be empathic and also has to understand the woman and provide the care and support needed while watching the process of labour and any deviation that might cause concerns (Ralston 1998). The midwife who gets this right is truly 'with woman'. By being empathic she is unlikely to have a different perception from the patient's.

Midwives also convey compassion, understanding and empathy through touch. Not being touched is related to emotional deprivation, yet midwives have been observed to touch the fetal heart monitor and not the woman in labour, thus distancing themselves from the intimacy of the relationship (Yearwood-Grazette 1978). Sensitive touch can help relax a person in pain, but the midwife needs to recognise when this becomes intrusive (Ralston 1998), just as a mother does who is sensitive and does not ignore or over-stimulate her baby (RCM 1999).

To be empathic requires you to listen and identify the emotion. As in the mother–infant relationship we tune in non-verbally, noting behaviours. Sometimes we pick up the feeling in our own body – our stomach may be in knots. If these factors are taken into account along with what we imagine it must be like, then we can identify the emotion. However, we also need to communicate this to our client.

Jacobs (2000) cautions that we should choose our words carefully when describing others' emotions. Clients may not feel that you

understand them if you suggest they are furious when they are just feeling mildly irritated, and vice versa. However, if you truly are sincere and congruent (your words match your behaviours and emotions), then you will find that people will simply correct you when they respond. Nevertheless, it is important to recognise accurately the shades of emotion which might be present in a particular interaction.

Empathy can be expressed as a phrase, a word or even sensitive touch. But first the emotion needs to be identified (Tschudin 1985). For example, a friend tells you they are happy to be pregnant. You already have the information that she is pleased to be pregnant, hence the one emotion you could respond with empathetically is 'happy'. A phrase that might reflect a similar feeling is: 'You look like you're on cloud nine.' Often we congratulate people on their achievements, so you could say, 'You must be delighted with your achievement'. Or you can simply state 'You feel happy because you are pregnant'. These responses may not feel right to you, but remember it is how you say them that shows you are trying to understand. In responding empathetically the client is aware that you have heard and are trying to understand.

Developing empathetic understanding is about staying with the client's experience and not being judgemental or giving advice. One of the difficulties is that it is easy to be sympathetic and the midwife may identify with her own feelings which the client's message evokes. This transfers the focus from the client to the professional and consequently the listening becomes conversational rather than therapeutic.

Here are some unhelpful classic examples:

- You think that's bad!
- I'll do that for you
- Don't worry
- I remember when I had just the same

All of these impose the midwife's experience on the client. Being sympathetic brings out the meaning for the midwife rather than for the woman.

The difficulty can be putting empathy into practice. Tschudin (1985) suggests a formula for an empathetic approach. First, identify the emotion in the statement made by the client. Then respond to the words spoken and acknowledge them by reflecting back that feeling with a rationale for the feeling if possible. For example, in 'I don't know what to do' the feeling or emotion is confusion or possibly anxiety. The rationale for this is uncertainty about the future. An empathetic reply might be 'You feel confused, because you are

not sure what to do'. In summary, Tschudin's (1985) 'formula' for empathy is: you feel ... because ...

Activity

Read the examples below and write down your usual response.

- Is my blood pressure OK? (a woman at 32 weeks' gestation)
- I'm dying (a woman in labour)
- I can't cope (a mother on postnatal ward)

Now try to identify what the client is really saying.

As you formulated your answers did you notice that these statements are often voiced by clients to midwives? The first client may, of course, simply be enquiring about her blood pressure. However, if there is an underlying emotion you will probably hear it in the tone of their voice. The client may be anxious about their blood pressure or the growth of their baby. 'I'm dying', sometimes heard in childbirth, is probably an expression of primitive fear. 'I can't cope' is a direct request for help, but there may be an underlying sense of desperation. Appropriate empathetic responses might be:

- You feel anxious about your blood pressure
- You feel terrified because the pain is so bad
- You feel desperate because of the responsibility

You now have a tool for practising empathy when you interact with clients, colleagues and families. The key is to practise, even if you begin by listening to conversations on the bus, in the canteen or on television, and rephrasing the responses in an empathic way. For those of us that do not find it natural to be empathic there is a steep learning curve. Learning to be more empathic can also be unsettling for the midwife, because their experiences of expressing emotions were not received sensitively, so the fear of hurting another's feelings can be overwhelming. Sadly, when they do not know what to say, they either say nothing or deny the client's emotions in their response. There is nothing wrong with saying, 'I don't know what to say'. The fear of getting it wrong, voicing the wrong emotion or opening a can of worms is why this needs to be practised. Additionally, the midwife needs to move the conversation to a close sensitively and refer on if needed.

The following activities and comments invite you to exercise the skills described thus far, and illustrate how responses carry on a conversation through sensitive listening and an empathic stance.

They also demonstrate how the responses might draw the conversation to a close.

Activity

Analyse this conversation using the skills discussed so far – listening, questioning and empathy. Then look at what each student might be feeling at the end of the conversation and how you might continue the communication.

Two students have just received their exam results.

Student A: What did you get?

Student B: (sadly) It's a pass.

Student A: What did you get?

Student B: 'C'.

Student A: A 'C'?

Student B: (sounding devastated) Yeah.

Student A: Yeah.

Note the style of the questions; they are not open. Student A uses an echo statement and repeats student B's statement, which can be quite useful when you are not sure what to say. I expect student A also wants to burst out with the news that she has an 'A' grade, but is sensitive enough not to. However, student A has not listened to the sadness and has not been empathic.

Student A may also be feeling bad that she cannot make it better for student B, but also fears she has opened a can of worms for student B. She could try to make it better by saying it's not such a bad grade. But this denies student B's emotion and is unhelpful and is not listening. It is like putting a bandage over a 'wound' to mask the problem.

Examine the next part of conversation in the following activity.

Activity

Analyse this conversation using the skills discussed so far: listening, questioning and empathy.

Student A: You sound disappointed.

Student B: Yeah, well I worked really hard on that assignment.

Student A: It's disappointing only to get a 'C' grade when you've worked so hard.

Student B: (angry) It's just so unfair!

Student A: Do you feel angry because others do not seem to work as hard as you and yet they get a better grade?

Here we observe active listening, open questions and empathic responses. Student B has had her emotion heard and is beginning to feel understood. Notice how the empathic response helps clarify how student B is feeling. She can now think more clearly as she releases some of the emotion.

Now analyse the next part of the conversation.

Activity

Analyse this conversation using the skills discussed so far: listening, questioning and empathy. How do you imagine you might feel if you were student A?

Student B: Oh, maybe they do work hard, it's just that I am a single parent, so I have to find time, whereas others don't have this responsibility.

(Student A wants to bring this to a close, so moves on the interaction)

Student A: You do sound stressed. I wonder if you could get more help from someone.

Student B: Umm, well I cannot afford any more childcare.

Student A: That is difficult; I guess you must have to be very organised. Could you ask for more academic help?

Student B: Well, I always seem to just scrape through. I am concerned I will never finish this course.

Student A: Have you talked to the tutor?

Student A may be feeling anxious that she has opened up herself to being the answer to the problem. Remember, it is not your problem to solve; the other person holds the key. Student A follows with a sensitive answer that demonstrates all the conversation has been heard, and offers some praise for the difficult place student B holds. We can imagine that student B, having been heard, is likely to ask student A about her result.

Moving towards more effective communication would improve midwifery care (Kirkham 1993). Observing mothers and babies communicating and facilitating sensitive care is likely to have an impact not only on midwifery, but also on society, as responding and communicating effectively with 'small babies make a big difference' (Sinclair 2007), which impacts on their sociability and thus society as a whole. It is interesting to note that common errors in communication are also those found in midwifery. As highlighted in official inquiries such as Daksha Emerson (Joyce et al. 2003) and Victoria

Climbié (Laming 2003), the consequences of poor communication can have devastating outcomes. The Nursing and Midwifery Council (2004) standards of proficiency state that communication is a key skill that enables the effective delivery of care and support for women in the pre-conception, antenatal, intrapartum and postnatal periods. Indeed the standard implies adopting the 'bass line' of listening and empathic skills as suggested by Jacobs (2000). It seems clear that much of the issues for midwifery care discussed here would be minimised or prevented if this standard were fully embraced. It follows that midwives would also facilitate parents effectively communicating with their infants as they would be able to demonstrate these skill in their care. Effective communication is the cornerstone of good practice and essential to the provision of good maternity care. This is achieved with intimate and sensitive communication between midwives and their clients.

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