1

Effective Communication

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Aim

This chapter aims to relate and understand how the development of communication from infancy can influence and inform our skills as adults in order to enhance your work-based experience to meet the needs of clients in your care.

Learning outcomes

By the end of this chapter you will be able to:

1. appreciate that development of interpersonal skills is co-dependent on key concepts from parent–infant interaction
2. analyse the needs of infants which parallel the needs of adults to enhance the care of mothers and babies
3. enhance communication skills to overcome common barriers to communication and building relationships in practice
4. develop strategies in practice that meet essential skills clusters for pre-registration midwifery education.

Introduction

This chapter will highlight the unique abilities of babies to communicate from birth, and how their optimal development relies on contingent responses, which are part of the parent–infant attachment process. These qualities in interpersonal skills are fundamental to building relationships, and the lessons from

The Student's Guide to Becoming a Midwife, Second Edition. Edited by Ian Peate and Cathy Hamilton.

infancy influence our adult ability to communicate. Thus, by enhancing early relationships between parents and babies, midwives can reapply these principles in everyday communication. The common errors that inhibit midwifery communication will be outlined and skills of listening and empathy will be analysed.

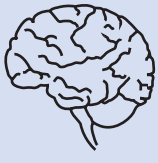
Midwives are in a unique position to observe how humans learn to communicate. When time is taken to observe infants, it can be noticed that babies are 'pre-programmed' to interact with adults (Stern 1998). This is due to their preference for the sound, sight and movement of adults to other comparable stimuli and they are especially attracted to their mother. This interaction is probably a biological instinct, as humans depend on mother and other adults to care for them to ensure survival.

The work of MacFarlane (1977) clearly highlighted the ability of babies, and dispelled many myths around infants, such as the idea that babies cannot see. Not only can they see (and focus well at about 30 cm) but they like to look at contrast and contours found in the human face. They turn to sound, particularly the mother's voice; they will turn to the smell of their own mother's breast pad in preference to another. So they develop recognition of their mother very quickly through their senses, and communicate their needs through behaviours (RCM 1999). As adults, we also communicate through voice and behaviours.

The behaviours of a human baby are social and communicative; they mimic adults, most noticeably by facial changes. So if you smile, open your mouth wide or stick out your tongue, the baby will watch carefully and then copy (Murray & Andrews 2010), which is quite remarkable when you consider how they know that they even have a mouth. Indeed, this mimicking can be observed in the first hour after birth. This response to adults demonstrates babies turn taking in their non-verbal responses and vocalisations, provided the adult is sensitive to them (Brazelton et al. 1974).

Being sensitive to interaction in this dance of communication requires that the other is responding to that baby (or indeed an adult) and does not ignore or overwhelm with intrusive responses. The critical aspects of building relationships is engagement but its absence gives the message of indifference, which indicates lack of importance, and possibly feeling unwanted by the other or even a feeling of non-existence (McFarlane 2012). This indifference can readily be recognised when a mother is suffering with postnatal depression (RCM 2012). 'Insensitive mothers' may be overintrusive in communicating with their baby, and base their responses on their own needs and wishes, or general ideas about infants' needs. The same dynamic is easily replicated by midwives when they have an agenda which differs from the client's needs, for example during a booking history.

Midwifery wisdom



You cannot feel indifferent towards clients in your care. If you find yourself feeling this way, then think 'how can I love this person?'. And 'who can help me feel cared for?'.

Care taking and our sensitivity to infants are 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) and naturally become 'woman centred' in midwifery care. Sensitivity also comes from our attitudes and behaviours. Thus, 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 1998).

The key aspects of early parenting and building a sensitive relationship are described clearly in the RCM's *Maternal Emotional Wellbeing and Infant Development* (RCM 2012). It is the parental attunement

to the needs of the infant (which midwives have a role in fostering) that leads to loved individuals who do not become antisocial adults. Through our early relationships and communication from conception to 3 years of life, Sinclair (2007) suggests that we develop our emotional brain and our capacity for forming relationships. Fundamentally, human beings at any age respond and feel understood when an attuned warm, positive and sensitive other interacts with them. As a professional responding as a sensitive mother would, you too can communicate in this way with clients in your care, which can enhance how you build relationships and improve communication.

Sensitive responsiveness is one of the key constructs of attachment theory (Bowlby 1980, RCM 2012). 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. DfES 2006, DH 2004, 2009, RCM 2012, Sinclair 2007), 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 to accurately perceive and respond to infant signals, with contingent responses because the person is able to see things from the baby's point of view. These key concepts (in italics below), that mothers who are sensitively responsive seem to demonstrate, are fundamental to all our interactive relationships.

- An observer who *listens* and sees their strengths and helps them with their difficulties.
- Warm and responsive interactions with caretakers. The mother's task is to respond *empathically* – to mind read. The baby has no control or bad intent; they learn that they can self-regulate through maternal containment. They then learn to self-soothe, for example, by sucking.
- Structure and routine, flexible,and age appropriate, that give *boundaries*. Providing psychological and physical holding; holding also relieves anxiety the baby feels 'held together'.
- Maintains interest by providing things to look at and do through play and touch, but *in tune*, e.g. recognises that a yawn means 'leave me to sleep'.
- Vocalisation reinforced by response-dialogue. Hearing and *being heard* – responds to familiar parent voice, giving a sense of security. Babies need to hear talking in order to develop speech (DfES 2006, DH 2004, Paavola 2006, Ponsford 2006, RCM 2012).

Sensitive responsiveness can be facilitated, and when mothers' sensitivity and responsiveness are enhanced, this results in dramatic increases 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 all 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 the parents, and helping them see and understand their baby. Using the questions in Box 1.1 with parents might enable them to realise that they can understand their baby. The RCM's *Maternal Emotional Wellbeing and Infant Development* (RCM 2012) also has many suggestions to develop your skills in this area.

Box 1.1 Helping parents to 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 he/she is content?
- What does he/she like when going to sleep? What do you notice about sleep? Or crying?

The basic methods of improving relationships are those that mothers ideally use with their infants. This is primarily non-verbal so it is not surprising that over 65% of our communication is non-verbal (Pease & Pease 2006), observing bodily and facial cues, and being in touch with what the 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. Sometimes midwives demonstrate this by holding women physically, which seems to help contain the labouring women in their pain, and at birth by encouraging skin-to-skin contact, thus giving the baby safe framework after having been 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, sometimes by touch or words, then the client feels held and heard.

Humans become socialised, and learn that they should not say this or that or that they should not upset another person or that they should not argue. We often learn to hide our feelings and not say clearly what we mean, which in turn leads to a lack of communication. Dissatisfaction in midwifery care and family life is often due to lack of communication. It is recognised that communication is one of the key elements for a compassionate workforce.

> *Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.*
>
> (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser 2012)

Our early skills in relation to communication become fixed into patterns, and the stamped foot of a temper tantrum in a toddler can still be apparent in the adult. Nichols (2009) summarises the four early stages of the development of self, described by Stern (1998), which helps inform us of how we adopt patterns of acting and reacting that become unconscious responses in adult life. This partly explains why, when we are in an anxious state, we cannot find the words to describe it because we have returned to a developmental stage which was preverbal.

Effective communication can be hard to achieve. Sometimes it seems that no matter how carefully we try to phrase the things we say, the listener either doesn't understand us or they misunderstand us. In verbal communication, we often add emphasis through body language or the intonation of our voice. We may adopt defensive or intimidating postures to reinforce the intended messages and, of course, we may raise or lower our voices. These techniques are used subconsciously, having developed through our socialisation from childhood.

Some common problems in communication

Bolton (1997) suggests that there are six common problems of human communication. These are mainly to do with understanding and listening:

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

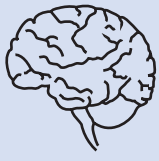
The first problem is poor understanding, which is often due to an unclear message or unclear words, because words can have different meanings for different people. As Ralston (1998) points out, terms such as 'incompetent cervix' or 'inadequate pelvis' are open to very different interpretation for the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

When the message is 'coded', the real meaning is masked; for example, the client asks you to put her flowers in water but she could really be asking you 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 they 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, which unfortunately are generally not very successful.

The way a sentence is spoken can also indicate an underlying message. Most speech has an obvious and a hidden meaning (Kagan et al. 1989). For example, 'What did you say?' has the obvious meaning of 'please say that again' but the hidden meaning could be 'you are so boring, I was not listening'. But if we said what was meant, we may hurt someone's feelings so we try to act in a professional way, thus creating barriers to communication, because we are not clear in our message. Indeed, as professionals there are times when we are acutely aware of appropriate interactions and needing to maintain a professional face. For example, it is inappropriate to look cheerful or go into a long explanation of care during life-threatening emergencies (Mapp and Hudson 2005).

Clients also do not hear or take in what we say because they are distracted, by the environment or physical symptoms. The disruption of a child needing attention during a conversation is an example of distraction, or a client may be in pain and can consequently miss the information given. However, what is tragic is that midwives often miss the non-verbal cues and often carry on with their own conversation, neglecting the woman. This could end up with the midwife thinking 'I know I have given 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 that tells us we are being heard (Yearwood-Grazette 1978). Midwives need to ensure that they respond to non-verbal cues with their clients, particularly eye contact.

Midwifery wisdom



Reflect on your interactions with clients. If you are doing most of the talking, then you are not listening, and the client probably has switched off too!

Midwives and clients often filter information because of perception, emotions or simply hearing what they wish to hear. A midwife may say 'you can go home after the paediatrician has discharged the baby' but the client hears only the 'go home' part and so phones her partner to collect her immediately. Midwives filter information by avoiding discussion. They may emphasise physical tasks, giving the message that discussion, particularly on how women feel, is less important. Indeed, discussion if often avoided, for example by filling the time with asking for urine samples and ignoring possible anxiety,

even when the last pregnancy was a stillbirth (Kirkham et al. 2002a). In essence, filters become blocks to communication.

Another block to communication is the phrase 'don't worry', used frequently to reassure (Stapleton et al. 2002). However, it has the effect of causing anxiety. The client is denied expression of how they really feel, and as such the words 'don't worry' should be avoided (Mapp and Hudson 2005) as this blocks the client from disclosing further concerns or feelings (Stapleton et al. 2002). A smile and touch are more helpful in allowing the client to feel human and reassured (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). This would enable the client to say what they know, but the midwife then needs to listen for the relevant missing information. This is harder work, 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 is seeking, for example how it feels to breastfeed (Stapleton et al. 2002).

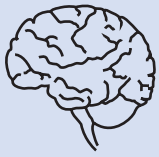
Finally, people who have difficulty with emotional issues may deny their emotions or become blinded by them (Bolton 1997). Blinded because anxiety and fear or any high levels of emotional arousal lock the brain into one-dimensional thinking (Griffin & Tyrrell 2004). Our emotions are then affecting our physiology, hijacking the brain's capacity for rational thinking. This inhibits our ability to rationalise or entertain different perspectives, because these traumatic and distressing experiences, big and small, cause imbalance in the nervous system, thus creating a block or incomplete information processing. This is why it is difficult to take in medical or other information or advice when upset, frightened, angry or in pain. This dysfunctional information is then stored in its unprocessed state both in the mind (neural networks) and in the body (cellular memory) (Pert 1999). Certainly, during emergencies poor communication can compound the stress. Careful sensitive communication that is congruent, i.e. the non-verbal matches the verbal communication, is what is required (Mapp and Hudson 2005).

Non-emergency situations can also involve high emotional states. Emotional arousal, for example, as a consequence of a power struggle, will evoke a defensive response. The thinking part of the brain becomes inhibited in emotional arousal, so it follows that learning and taking in information cannot be effective when the client feels conflict or stress (Griffin & Tyrrell 2004). When a midwife says 'I want to tell you about breastfeeding', the emotional arousal in the client may come from the unsaid 'who are you to tell me how to bring up my family?'. It would be more useful to first reduce the emotional arousal, and reframe or present the information another way: 'It's good you have decided on your method of feeding and I would like to hear more about how you are going to feed your baby'. Nichols (2009) points out that 'It isn't exuberance or any other emotion that conveys loving appreciation; it's being noticed, understood and taken seriously'.

However, midwives may perceive that the use of open questions in this way will take up too much time. When information becomes blocked, then misunderstanding is increased which leads to spending more time correcting the problem at a later date. Midwives also limit their emotional effort, and they may stereotype in order to increase control over work situations (Kirkham et al. 2002b), although if they were able to increase their sensitive responsiveness, clients would be able to find out the information they need, understand and feel understood.

Midwives need to give emotional care to their clients, particularly those in labour, and this is draining for them. Many midwives realise they do not have time for their own emotional feelings so they pull down the shutters to look calm. It is this that can give the impression of 'aloofness', whereas others are perceived as naturally friendly (John & Parsons 2005). As John and Parsons (2005) suggest, support mechanisms need to be developed and implemented in order to reduce stress in practice. According to Nichols (2009): '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'.

Midwifery wisdom



Blunted emotions can be seen in overstressed midwives. These midwives need support, and a discussion with their supervisor could be helpful here. Some units have staff counsellors in highly stressful areas.

Thus far, the problems and the way midwives communicate have been discussed. To be more effective in communication, our sensitive responsiveness, as defined earlier, needs to be developed. 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 ingrained from childhood. Having said that, there are things individuals can practise every day which will improve professional practice, particularly listening and empathy. Some pointers will be outlined here but learning these skills needs to take place through experience in order for long-term change in practice to occur.

Listening

Listening skills are essential for a midwife; listening is an active process requiring the full attention of an individual as one needs to listen and fully hear what is actually being communicated, not just what is said. Listening involves the mind, senses and emotions, to pick up what is not said. This is bound up with 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 does need to be actively listening. Passive listening includes encouraging phrases such as 'umm', 'uh huh' as well as non-verbal nodding of the head and eye contact (Balzer-Riley 2012). Passive listening implies understanding but active listening removes the guesswork as it ensures messages are received properly (Balzer-Riley 2012).

Listening skills will differ depending on what we are doing. On some occasions, passive attentive listening will be sufficient. However, if we require more information from clients, or perhaps they 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 by the speaker, which 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, so we may not really hear what is being said (Rowan 1998). 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, and minimise questions.
- Remember what is being said, as if you might be tested on it. Listen to what is not being said, particularly feelings.
- Observe the client's body language as well as your own; are there any clues being given?
- Have an empathic stance; what would it be like if you were in the client's situation?

- Try not to immediately 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 and not listening. Questions are so much part of conversation that they seem to have almost replaced the ability to listen or respond in any other way, because we are 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 at the Spanish Inquisition, whereas an open question allows them to explain their experience.

Activity 1.1

One of our jobs is to ask questions which are of a personal nature. Some of us find these easier to ask than others. However, you still need to ask them. So think about asking 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 some 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?
- use of alcohol?
- domestic violence?
- mental health?

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

Further reading: England C, Morgan R (2012) *Communication Skills for Midwives: challenges in everyday practice*. Buckingham: Open University Press.

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 to the content but also the message under

the message. This may be about the client's emotions and if our own thoughts, experiences and emotions arise, we try to put them aside because it is the client's experience that is the focus (Rowan 1998).

Jacobs (2000) suggests we listen to the 'bass line' in conversations, as if it were a piece of music. Under a melody there is a bass line. This invites us to listen to what is not being openly said but possibly being felt by the client.

Case study 1.1

Tom's Story

'My partner Amy and I arrived early this morning to get things started. Our baby was due last week. It's been awful having people phone constantly asking what is happening. So we really want this induction thing. Amy is scared and disappointed as she wanted a 'natural birth', but I think it's for the best and it's great to know we will have a baby today.

Well, we were kept waiting for an hour before we were seen, then the midwife checked us in, examined Amy, while I had a coffee. But I returned to be told the labour ward is busy and the birth could not be started!

We were sent for breakfast, then lunch. I feel confused and worried as Amy is getting more anxious and nothing is being done. They said the induction was because it's dangerous to go overdue. If that is so then why are we not a priority? The staff all seem rushed and say they will be with us later.'

Tom and his frustrations will be examined below and the interactions with the midwife analysed.

Activity 1.2

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

What is the bass line saying? He is young, so possibly has less experience of the world, and the transition to parenthood is not without stress, partly due to the unknown. So possibly he is unsure of himself, so any threat might elicit a defensive/attacking response from him. He 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 baby. These are all possibilities, so what are the feelings he could be expressing – anxiety, anger, frustration?

Activity 1.3

A young father-to-be, Tom, is talking about his discontent with his partner's maternity care.

Tom: 'Excuse me, you said you would give my wife some 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 her. 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 again about how you could answer differently.

In Activity 1.3, the midwife is polite but defensive, and it sounds like excuses to Tom. The midwife is stressed and is having trouble coping with the workload; her factual response is not demonstrating any understanding or concern for Tom and his wife. Concern and understanding are demonstrated by letting Tom know you have heard him. Giving full attention is difficult in this case; I am sure you have seen this type of conversation occurring while the midwife is on the phone and writing up some notes. Pushing the silent 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 the midwife was listening. Furthermore, reflecting back or summarising what was said might also ensure the midwife understands and Tom would feel heard.

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

Tom: 'Excuse me, you said you would give my wife some of those tablets to get her started in labour, we have been waiting for hours.'
Midwife: 'Yes I did, you have been waiting a long time' (reflecting back what he said so he knows you heard him).
Midwife: 'Yes I did, I am sorry you have been waiting so long, it must be very frustrating for you' (empathy).
Midwife: 'You have been waiting a long time, and it's disappointing when you expected the induction to have begun by now' (empathy).

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 tentatively is 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.

Activity 1.4

Tom: 'Excuse me, you said you would give my wife some 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 think how you might feel in a given situation, this might be 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 ourselves (Balzer-Riley 2012).

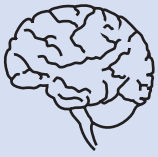
Mothers help babies to regulate their emotions in this way. You may have observed the distressed baby who is cuddled gently by a mother whose facial expression is as pained as that of her infant, her tone of voice and touch mirroring the infant's state, 'Oh dear! There there', gradually soothing into 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 the tone of voice and other vocal expressions and inner emotion. Thus, empathy is a synonym for communicated understanding. It is mentally putting yourself into the shoes of another, so that you can understand how they are feeling without judgement or evaluation, just acceptance (Figure 1.1).

A midwife needs to be empathic and has to understand the woman and provide the care and support needed while watching the process of labour and any deviations from it that might cause concern (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 parents. Midwives also convey compassion, understanding and empathy through touch. Not being touched is related to emotional deprivation; 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 also needs to recognise when this becomes intrusive (Ralston 1998), like a mother who is sensitive and does not ignore or overstimulate her baby (RCM 1999).

To be empathic first requires you to listen and identify the emotion. Like the mother–infant relationship, we tune in non-verbally, noticing behaviours. Sometimes we pick up the feeling in our own body, e.g. the stomach is knotted. 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.

Figure 1.1 Example of empathy.

Midwifery wisdom



If you find yourself feeling, for example, anxious, maybe because you have a knot in your stomach, consider whether this is your anxiety or the client's? Humans can transfer their feelings and they are picked up by others. If the feeling does not seem to be yours, then say something like 'I notice I am feeling anxious, and I wonder if that is how you are feeling'.

Jacobs (2000) suggests we choose our words carefully when describing other people's emotions; clients may feel you do not understand them if you suggest that they are furious when they are only feeling cross. However, if you truly are sincere and congruent (your words match your own 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 (Tschudin1989). For example, a friend tells you she is happy to be pregnant. You already have the information that she is pleased to be pregnant so one emotion you could respond with empathically 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 feel delighted with your achievement'. Or you can simply state 'You feel happy because you are pregnant'. Some of these possible responses may not feel right for you but remember, it is how you say them with congruence that shows you are trying to understand. When you respond empathically, the client is aware that you have heard and are trying to understand.

Developing empathic understanding is about staying with the client's experience and not being judgemental or giving advice. One difficulty is that it is easy to be sympathetic and the midwife may identify with her own feelings which arise from the client's message. This transfers the focus from the client to the professional and consequently the listening becomes conversational rather than therapeutic. Here are some classic unhelpful examples which illustrate this:

- '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 put the midwife's experience onto the client. Being sympathetic brings out the meaning for the midwife rather than the woman. The difficulty can be putting empathy into practice (Figure 1.2). Tschudin (1989) suggests a formula for an empathic approach. First, it is necessary to 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, 'I don't know what to do' (a mother with twins); the feeling or emotion is confusion or possibly anxiety. The rationale for this feeling is uncertainty about the future. An empathic reply might be 'You feel confused, because you are not sure what to do'. In summary, Tschudin's (1989) 'formula' for empathy is: 'you feel …because…'.

Sympathy = I know how you feel, I had just the same. (Let me cry with you)

Empathy = I understand you feel awful, let me help you.

Figure 1.2 Empathy and sympathy.

Activity 1.5

Read the examples below and write down your usual response.

- 'Is my blood pressure OK?' (A woman at 32 weeks of pregnancy.)
- 'I'm dying.' (A woman in labour.)
- 'I can't cope.' (A new mother on the postnatal ward.)

Now try to identify what the client is really saying.

As you formulated yours answers, did you notice that the statements used are commonly made by clients to midwives? The client may simply be enquiring about her blood pressure, of course. However, if there is an underlying emotion you will probably hear it in the intonation of the voice. The client may be anxious about her blood pressure, or the growth of her 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 feeling of desperation. Appropriate empathic responses might be:

- 'You feel anxious about your blood pressure, because you are worried about your baby?'
- '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 in your own mind. For those of us who do not find it natural to be empathic, there is a steep learning curve. Learning to be more empathic can also be scary for the midwife, because their experiences of expressing emotions were not received sensitively, so the fear of hurting another's feelings can overwhelm them. 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 is why this needs to be practised experientially. Additionally, the midwife needs to move the conversation to a close sensitively and refer on if needed.

Activity 1.6

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

Two students have just received their results.
Student A: 'What did you get?'
Student B (sadly): 'It's a pass.'
Student A: 'What percentage did you get?'
Student B: '60%.'
Student A: 'Oh, 60%?'
Student B (sounding devastated): 'Yeah.'
Student A: 'Yeah.'

The following activities and comments invite you to exercise the skills described thus far, and illustrate how responses can encourage a conversation through sensitive listening and an empathic stance. They also demonstrate how the responses might draw the conversation to a close.

Note the style of the questions, which are not open. Student A uses an echo statement, repeating Student B's statements, 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 of a '90%' grade, but is sensitive enough not to. Student A did not say she heard 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 and make it better, by saying 'that's not a bad grade'. But this denies Student B's emotion and is unhelpful and is not listening. It is like putting a bandage over the 'wound' to cover up the problem. Examine the next part of the conversation in Activity 1.7.

Activity 1.7

Analyse this conversation using the skills discussed so far, i.e. 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 to only get a 60% grade when you worked so hard?'
Student B (angrily): 'It's just so unfair!'
Student A: 'You feel angry because others do not seem to work so hard but get a better grade?'

Here we observe active listening, open question and empathic responses. Student B has had her emotion heard and is beginning to feel understood. Notice how the empathic response helps clarify the feeling for student B. She can now think more clearly as she can let some of the emotion go. Now analyse the next part of the conversation.

Activity 1.8

Again analyse this conversation using the skills discussed so far, i.e. 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 too, so I have to find time, whereas others don't have responsibility.'
(Student A wants to bring this to a close, so moves the interaction on.)
Student A: 'You do sound stressed. I wonder if you could get more help from someone.'
Student B: 'Um, 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. But I am concerned I will never finish this course.'
Student A: 'Have you talked to the tutor?'

Student A may be feeling anxious initially that she has opened herself up 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 some praise for the difficult place Student B holds. We can imagine that Student B, now having been heard, is likely to ask Student A about her result.

Moving toward more effect communication would improve midwifery care (Kirkham 1993). Observing mothers and babies communicating and facilitating sensitive care are 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), affecting their sociability and thus society as a whole.

It is interesting to note that common errors in general communication are also those found in midwifery. As highlighted in inquiries such as those on Daksha Emerson (Joyce et al. 2003) and Victoria Climbié (Laming 2003), the consequences of poor communication can have devastating effects. The NMC (2009) includes detailed competencies for communication in the skills clusters. These standards of proficiency, that enable the effective delivery of care and support for women in the preconception, antenatal, intrapartum and postnatal periods, embrace the principles outlined in this chapter. Improving listening and empathic skills and the use of open questions in midwifery care as discussed in this chapter would go some way to embracing these standards in practice. It follows that midwives would also help parents to communicate effectively with their infants as they would be modelling these skills in their care.

Conclusion

Effective communication is the cornerstone of good practice and paramount in the provision of good maternity care. This is achieved by intimate and sensitive interaction between midwives and their clients.

This chapter has invited readers to embrace the principles of sensitive responsiveness to enhance their communication skills, and facilitate parent–infant relationships. Midwives need to analyse their own communication and develop more active listening to minimise misunderstanding. Additionally, by developing a more empathic stance, they will be more able to address emotional issues and enhance their care of clients.

Quiz

1. Which is the most empathic response?

   (Sigh) 'I am so tired with this pregnancy.' (35 weeks gestation with a 2 year old)
   a. 'Yes I found my second pregnancy difficult too.'
   b. 'It must be difficult for you coping with pregnancy, work and a little one.'
   c. 'It's normal to feel tired at this stage of pregnancy.'
   d. 'You will feel better soon.'
   e. 'I am sorry to hear that.'

2. Which are the responses of a good listener?

   When I believe I know what someone means but I'm not really sure …
   a. I let my mind wander until it's my turn to talk.
   b. I give little verbal or non-verbal feedback to the other person.
   c. I ask for clarification or repeat what I believe they have said before I speak.
   d. If I consider the subject boring, I stop paying attention.
   e. I summarise what I believe I heard.

3. Which is the response of an active listener?

   When someone is telling me a story or making a point about something, as soon as I realise what he is thinking, I respond as follows:
   a. 'That's nothing, let me tell you what happened to me.'
   b. I try to give him appropriate advice.
   c. I wait and reflect back his point.
   d. I tell him he is rambling and ask him to get to the point.
   e. If I disagree with the point, I stop listening and begin formulating in my head what I want to say to refute what he has said.

4. Which statements are more likely to leave a client even more angry because she has not been heard?

   A term pregnancy has just been diagnosed as a breech, and the client has been told she must have a caesarean. She says angrily 'I don't want a caesarean!'.
   a. 'I know how you feel.'
   b. 'Try to cheer up. These things happen.'
   c. 'Try to pull yourself together.'
   d. 'You are angry because as your pregnancy is a breech, a caesarean is advised.'
   e. 'I expect you are very disappointed because you wanted a natural birth.'
   f. 'It looks like you'll just have to tough it out.'
   g. 'I'm sorry you feel that way.'

5. A client has been diagnosed with a Down's fetus. Still in shock, the parents look to you for reassurance. Which responses are most helpful?
   a. 'Perhaps this is God's will.'
   b. 'This could have happened to anyone.'
   c. 'It's not your fault, you have looked after yourself and done all the right things.'
   d. 'You will just have to decide if you can cope with a Down's child.'
   e. 'You're a tough person – I'm sure you've been through worse.'

f. 'This must be a difficult time, and I will be working to help you through this.'
g. 'I am saddened to hear of your situation, and want to express my condolences.'
h. 'Remember when we talked about some of the risks that can't be anticipated or prevented? Well, this is one of those instances. But there are several actions that we're going to take to help you, and we'll answer your questions so that you and your family are aware of what we're doing.'

6. On a postnatal visit to a woman who had a caesarean birth, she says she is still traumatised about her birth experience. Which of the following will allow the client to say as much as she needs to share about this experience?
   a. 'Just be happy you have a healthy baby.'
   b. 'Traumatised?'
   c. 'Be grateful; a hundred years ago you both would have died.'
   d. 'You feel traumatised because it was a caesarean birth?'
   e. 'Could you say more about the experience for you?'

References

Balzer-Riley J (2012) *Communications in Nursing*, 7th edn. St Louis, MO: Elsevier Mosby.

Bolton R (1997) *People Skills: how to assert yourself, listen to others and resolve conflicts*. New York: Touchstone.

Bowlby J (1980) *Attachment and Loss. Vol. II: Separation*. London: Random House.

Brazelton TB, Kolski B, Main M (1974) The origins of reciprocity: the early mother–infant interaction. In: Lewis M, Rosenblum L (eds) *The Effect of the Infant on Its Caregiver*. London: John Wiley & Sons.

Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser (2012) *Compassion in Practice. Nursing, midwifery and care staff, our vision and strategy*. London: Department of Health. Available at: www.dh.gov.uk/health/2012/12/nursing-vision/ (accessed December 2012).

Department for Education and Skills (DfES) (2006) *Every Child Matters. Change for children, parenting support, guidance for local authorities in England*. London: Department for Education and Skills.

Department of Health (DH) (2004) *The National Service Framework for Children, Young People and Maternity Services*. London: Department of Health.

Department of Health (DH) (2009) *Healthy Child Programme: pregnancy and the first five years of life*. London: Department of Health.

Gerhardt S (2004) *Why Love Matters*. London: Routledge.

Griffin J, Tyrrell I (2004) *Human Givens*. East Sussex, Human Givens Publishing.

Jacobs M (2000) *Swift to Hear. Facilitation skills in listening and responding*. London: SPCK.

John V, Parsons E (2005) Shadow work in midwifery: unseen and unrecognised emotional labour. *British Journal of Midwifery* **14**(5): 266–271.

Joyce L, Hale R, Jones A, Moodley P (2003) *Report of an Independent Inquiry into the Care and Treatment of Daksha Emerson MBBS, MRCPsych, MSc and her Daughter Freya*. London: North East London Strategic Health Authority.

Kagan C, Evans J, Kay B (1989) *A Manual of Interpersonal Skills for Nurses. An experiential approach*. London: Harper and Row.

Kirkham M (1993) Communication in midwifery. In: Roche S, Alexander J (eds) *Midwifery Practice: a research based approach*. London: Macmillan.

Kirkham M, Stapleton H, Thomas G, Curtis P (2002a) Checking not listening: how midwives cope. *British Journal of Midwifery* **10**(7): 447–450.

Kirkham M, Stapleton H, Thomas G, Curtis P (2002b) Stereotyping as a professional defence mechanism. *British Journal of Midwifery* **10**(9): 549–552.

Laming WH (2003) *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming*. London: Stationery Office.

Mapp T, Hudson K (2005) Feelings and fears during obstetric emergencies – 1. *British Journal of Midwifery* **13**(1): 30–35.

MacFarlane A (1977) Mother–infant interaction. *Developmental Medicine and Child Neurology* **19**(1): 1–2.
McFarlane K (2012) Love: taking a stance. *Psychotherapist* **52**, 24–25.
Murray L, Andrews L (2010) *The Social Baby*. Surrey. CP Publishing.
Nichols P (2009) *The Lost Art of Listening*. New York: Guilford Press.
Nursing and Midwifery Council (NMC) (2009) *Standards for Pre-Registration Midwifery Education*. London: Nursing and Midwifery Council.
Paavola L (2006) Maternal sensitive responsiveness characteristics and relations to child early communicative and linguistic development. PhD dissertation. Oulu, Finland: Oulu University Press.
Pease A, Pease B (2006) *The Definitive Book of Body Language: how to read others' attitudes by their gestures*. London: Orion.
Pert C (1999) *Molecules of Emotion*. London: Pocket Books.
Ponsford C (2006) The emotional needs of the under 3s and good practice in their care. What About The Children? Annual Conference. Kent: WATch.
Ralston R (1998) Communication: create barriers or develop therapeutic relationships. *British Journal of Midwifery* **6**(1), 8–11.
Rowan J (1998) *The Reality Game: a guide to humanistic counselling and therapy*. London: Routledge.
Royal College of Midwives (RCM) (1999) *Transition to Parenthood*. London: Royal College of Midwives.
Royal College of Midwives (RCM) (2012) *Maternal Emotional Wellbeing and Infant Development: a good practice guide*. London: Royal College of Midwives Trust.
Sidgewick C (2006) Everybody's business: managing midwifery complaints. *British Journal of Midwifery* **14**(2): 70–71.
Sinclair A (2007) *0-5: How Small Children Make a Big Difference*. London: Work Foundation.
Stapleton H, Kirkham M, Thomas G, Curtis P (2002) Language use in antenatal consultations. *British Journal of Midwifery* **10**(5): 273–277.
Steele H (2002) Attachment. *Psychologist* **15**(10): 518–523.
Stern D (1998) *The Interpersonal World of the Infant*. London: Karnac Books.
Tschudin V (1989) *Beginning with Empathy*. London: Elsevier Health Science.
Yearwood-Grazette H (1978) An anatomy of communication. *Nursing Times* **October** 12: 1672–1679.