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Different parents, different needs

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Alex Smith looks at meeting diverse needs in an antenatal class

Within every antenatal class there is a glorious complexity of contradictory needs. This article begins to question whether group instruction may undermine individual autonomy.

If we think of our work as an educational intervention, one solution to the problem of different needs is to apply a routine package of care to everybody – a little bit of everything – a sort of mass, multi-target immunisation programme. As reflective practitioners, there are two important questions to ask as we plan and evaluate. Is this approach effective? And does it 'do no harm'?

Evaluation is how we measure whether or not we are reaching our aim – the optimal wellbeing of the new family. Most women we meet would prefer a straightforward birth experience and, under the right conditions, we know this is usually attainable, invariably enriching and has a life-long positive effect on the woman and her baby, and, therefore, on the whole family. Another factor that has a long-term positive effect is the degree to which the woman felt in control, that she was the heroine of her own journey. Despite our very best intentions, and reflecting our own observation, there is little evidence that our one-size-fits-all intervention increases the incidence of either of these things. Yet, somehow, we have a very good sense that we are meeting our learning outcomes. This may mean one of three things:.

- Our aims are unrealistic
- Our learning outcomes are not those required to meet our aims
- Our learning outcomes have a positive effect for some, which is cancelled out by a negative effect on others – that they may occasionally do harm.

The first of these is unthinkable. We know that women, individually and collectively, hold the power they need to enjoy the best possible journey into motherhood. Our aim is realistic.

The second requires a Socratic ability to question our own assumptions. Like any other routine intervention – ultrasound scanning, induction, electronic fetal monitoring, hospital birth – the good intention and apparent logic upon which it is based does not necessarily make it right.

The third explanation is supported by anecdotal accounts of parents being disturbed and even frightened by their NCT classes. Newton's third law of motion states that, 'for every action there is an equal and opposite reaction'. If our intervention moves one person toward their goal, then it may move someone else away – a sort of Karmic counterbalance for our force of will. 'If our 'medicine' is powerful enough to

have a good effect on one person, then it may also have a bad effect on another, or at least cause uncomfortable side-effects that make that person reluctant to 'swallow' everything they hear. In philosophy and ethics, this dilemma is understood as the Doctrine of Double Effect. Teachers who sense this tension may seek to resolve it by watering down the medicine to the point where it does little harm, but also little good.

Reframing the problem of different needs in terms of the routine use of intervention enables a dialectic resolution to our dilemma – for the physicists among you, a string theory unification of apparently incompatible forces that will open up new dimensions for us as antenatal teachers. One new dimension is to embrace the concept of monitors and blunters. Anticipating a perceived threat, monitors cope by seeking information, and blunters cope by avoiding it. Monitors want to know the risks and benefits of medical forms of pain; blunters would rather focus on breathing skills, positive affirmation and visualisation. Monitors tend to be more anxious and less able to manage pain; blunters are not in denial, they simply have another way of managing uncertainty.

Although the concept is controversial, people immediately identify with the idea. Studies show that monitors and blunters benefit from receiving information tailored to their coping style. Monitors who receive too little information will use Google; blunters who receive too much information cannot remove unwanted ideas and pictures from their head and have a poorer experience as a result. After the course, it is easier for the monitors to feedback that more information on caesareans would have been good, than it is for the blunters to admit that the caesarean role play was frightening, and this may mislead us when it comes to evaluation.

Returning to the immunisation analogy, we know that the most important factors in protecting a person's health are not the injections of medicine, but good nutrition and improved living conditions, in the widest holistic sense. Similarly, in our classes, there are many gentle non-graphic ways of promoting wellbeing that will be useful for monitors and blunters alike, no matter how each journey unfolds. Exploring philosophies and strategies for the concept of 'living with uncertainty', for example, enables learning that can be interpreted and applied by each individual according to individual need. Each person's journey into parenthood is unique, it is not a package cruise. By removing that long list of 'what ifs' from the agenda, we can offer individually tailored information – different flavoured doses of Mary Poppins medicine – using our intervention more elegantly, and even more effectively.

If you would like to tell us how your antenatal education, or lack of it, affected your birth, please email editor@AIMS.org.uk.