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The uses and abuses of research on support

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Who decides what is 'support' in pregnancy and labour? Midwife Rosemary Mander argues that support is traditionally the territory of the midwife. Yet, regimes for supportive care, like so much else in maternity care, are more often than not devised by medical personnel with little or no knowledge of women's true needs.

Support is one of those indescribable phenomena. You feel you lack the words to describe it, but you know it when you encounter it. To some people, support means belonging to a club or a religious group. To others, it means being married or having a 'best friend'. Still others may regard a gift or possession of material goods as supportive. Clearly, support takes a variety of forms, with definitions that are vague to the point of uselessness: "[Support] suggests an underlying common element in seemingly diverse phenomena and it captures something that all of us have experienced."[1]

Marginally more useful is the definition that relies on positive interpersonal transactions[2]. These interpersonal phenomena involve one or more of the following four aspects: 'Emotional support' tends to be used to differentiate those forms of help that are neither practical nor instrumental. In an early study[3], Gottlieb found that such support, being 'emotionally sustaining', is the most highly valued. Emotional support involves listening and showing concern as well as some intimacy. It may be further defined in terms of its duration and reciprocal nature.

Instrumental support is more practical, tangible or material than the emotional form. It operates by lightening the burden or allowing time for rest and recuperation. Although oneway transmission of instrumental support has been shown to engender resentment[4], this is likely to be overcome through a culture or ambience of instrumental support.

Informational support may not be simply the passage of neutral material. As Kahn and Antonucci indicate[2], the transmission of information carries with it the affirmation that enhances the recipient's self- esteem. Thus, not only is information transmitted, but emotional support as well, leading to a blurring of the boundaries between the different forms of support. The timing of informational support is of greater significance than other forms. This point was established by Langford and colleagues[5], who found that information-giving becomes supportive only if it is provided at a time of stress to facilitate problem-solving.

Esteem support is integral to the psychosocial support already mentioned. Wheatley suggests that a person may use support to enhance her own self- esteem[6]. Such enhancement, though, requires some

degree of self-criticism if the need is to be recognised, creating an uncomfortable - even dangerous - vulnerability. For this reason, for esteem support to be effective, a longstanding and/or close relationship is necessary.

Research on support and childbearing

Given this brief description of some of the facets or support, its complexity becomes apparent. Moreover, the close interrelationship between the different aspects of psychosocial support mean that differentiating them is not only difficult, but may also be futile. Knowledge of the various components that make up support, and their interdependence, is crucial to the effective care of the childbearing woman.

Although research on the effectiveness of support has been undertaken throughout childbearing[7], its beneficial effects have been demonstrated most clearly during labour through a series of seven randomised controlled trials (RCTs). Undertaken in various countries, these RCTs have sought to examine the benefits of psychosocial support during labour provided by a range of personnel. The control groups comprised women receiving standard care.

The nature of the support offered in the course of these RCTs varied widely and, in some cases, is not well described. Although the RCTs claimed to focus on continuous support for the woman, the meaning of 'continuous' is not actually spelt out. That the companion was a human being, complete with stomach and bladder, means that she must have needed to be absent, at least momentarily, for 'calls of nature'. The Johannesburg study came nearest to recognising this when, because of civil unrest, the companion was obliged to leave the woman in labour and return home before dark[8].

The expertise of the companion in providing support was varied, as seen in the Mexico City study by Campero and colleagues[9]. Although the researchers claimed to have recruited and trained lay women, the 11 companions included seven retired nurses. Another example of the difficulty in comparing expertise is found in the Toronto study by Hodnett and Osborn[10]. The companions were eight lay midwives at a time when midwifery was still 'alegal' and receiving a 'bad press' in Canada. The RCT in which the expertise of the companion is most certain is the Botswana study by Madi et al.[11], which involved a female relative of the woman in labour.

These two aspects of the RCTs - the nature of support and companion's expertise - are clearly worthy of serious criticism. More generally, though, the relevance of these RCTs' total environments begs to be questioned. The first of the two Guatemala City RCTs by Sosa et al. found, quite serendipitously, beneficial effects on the woman's experience of the attendant's continuous presence[12].

The second Guatemala City study by Klaus and colleagues replicated and endorsed the first study's findings[13]. The conditions in which the Guatemalan women laboured and gave birth were not congenial. The maternity unit was large enough for almost 30,000 births annually. For various reasons, no family member or continuous caretaker was permitted in the labour room. The routine care of the

labouring woman involved only infrequent vaginal examinations (VEs), fetal heart auscultation and help at the birth.

Seeking research evidence from a source comparable with the developed world, Kennell and coworkers undertook a further study in Houston, Texas[14]. A public hospital with a low-income population of blacks, whites and women of Hispanic origin was the chosen site. The labour and delivery area was a 12-bed ward. Thus, there was insufficient privacy to allow visitors, and companions were not routinely present during the labour and birth. Only brief visits by family were permitted if the labour area was "not too busy".

The low standard of care was demonstrated by the woman being bedfast after admission to allow for electronic fetal monitoring, and by the fact that intravenous infusion and amniotomy were routine. A further impression of the labour environment is gained from the finding that the staff interacted with each woman for only 21 per cent of the time that the woman was in labour. The conditions in which these Houston women laboured and gave birth had more in common with the 'developing', rather than 'developed', world.

It is uncertain, however, whether Hodnett's own RCTs with Osborn[9,15] are any more relevant to the UK situation. The research site, Canada, has been subjected to a series of work- sampling studies, which may reflect the standard of care in labour. Gagnon and Waghorn16 found that supportive care was being provided by the labour area nurse for only 6.1 per cent of her time. In a labour area where staffing permitted one-to-one care, the nurse spent only 9.2 per cent of her time with the first- time mother. In comparison, the indirect care provided in the room made up 47.6 per cent of the nurse's time, of which 16 per cent involved giving or receiving reports. Twelve per cent of the nurse's time was used in preparing medication and an equal proportion in documentation. The time which the nurse spent with the unit was found to occupy 27.3 per cent of her working time.

Discussion

On the basis of these research settings, it is necessary to question the relevance of these RCTs to UK maternity care. This is in view of the possibility that the supportive intervention may have served only to render marginally less hostile the subhuman environment of labour.

Despite this caution, the findings of these RCTs have been welcomed and widely accepted[17] Under these circumstances, support has come to be associated with easily measurable outcomes, including less use of pharmacological pain control, less frequent assisted vaginal birth (forceps/ventouse), less frequent use of the caesarean and fewer Apgar scores below 7 at five minutes.

The benefits of support during labour have led to recommendations for its introduction that ignore the fact that providing support is the traditional role of the midwife. Sadly, this role has been taken from the midwife in the process of the medicalisation of childbearing. Whether this component of her role will be returned remains to be seen.

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