"Have your baby and get out. We need this bed for somebody else." Compassionate intrapartum communication: a discourse analysis of language use during labour in South African public and private maternity settings.

by

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Declaration

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Abstract

The intrapartum care received by a woman in labour critically influences her perceptions of the birth experience. At best, she can perceive the encounter as compassionate, retaining feelings of empowerment; at worst she can perceive the birth as obstetric violence, and be left feeling traumatised. Seeing that a significant portion of intrapartum care is delivered through communication, this study investigates the linguistic contribution that compassionate language makes in healthcare, specifically with regards to the discursive reconstruction of the memories of participants' recollections of their birth experiences, be it as birthing mothers or in their capacity as maternity care-providers. The main theoretical point of departure of this study constitutes a combination of two theoretical paradigms, namely Discourse Analysis (DA) and Interactional Sociolinguistics (IS), positioned within a health communication context. Aspects of Gee's (2014) theory of DA serves as the primary theoretical framework of this study. Gee's (2014) theory is enhanced by appropriate concepts taken from the field of IS, especially the approaches adopted by scholars such as Gumperz (2015) and Goffman (1974, 1981). In addition, the notion of identity formation in both DA and IS is expanded by Bucholtz & Hall's (2015) Sociocultural Linguistic approach to identity; and Pennycook (2005) and Butler's (1999) approaches to identity performativity.

The key findings of this study are that i) through the discursive (re)construction of their birth experiences, participants have indicated that the manner of care which takes place in an intrapartum environment has a critical impact on not only mothers and babies/children, but, importantly, also on the care-providers themselves; ii) through these discursive (re)constructions, participants revealed that the realities of their birth experiences were not in line with their expectations of the communication during the intrapartum period in the instances where the births were perceived as negative or abusive; iii) in addition to describing the styles and strategies of compassionate intrapartum communication, care-provider participants, significantly, provided potential solutions to mitigate the traumas stemming from abusive intrapartum care, thereby benefitting both mothers and care-providers. This study makes a contribution by creating consciousness around obstetric violence, violence against women, and human rights violations in general.

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Opsomming

Die intrapartum sorg wat ’n vrou in kraam ontvang, het ’n kritieke invloed op haar persepsies van die geboortelike ervaring. Ten beste kan sy die gebeurtenis as deernisvol beskou, en gevoelens van bemagtiging behou; ten ergste kan sy die geboorte as obstetriese geweld beskou, en getraumatiseerd wees. Gegewe dat ’n beduidende deel van geboorte-sorg oorgedra word deur kommunikasie, bestudeer hierdie studie die linguistiese bydrae wat deernisvolle taalgebruik maak in gesondheidsorg, spesifiek m.b.t. die diskursiewe herkonstruksie van die herinneringe van deelnemers se herroepings van hulle geboortelike ervarings, hetsy as die moeder wat geboorte skenk of in die kapasiteit as kraamversorgers. Die hoof teoretiese vertrekpunt van hierdie studie beslaan ’n kombinasie van twee teoretiese paradigmas, naamlik Diskoersanalise (DA) en Interaksionele Sosiolinguistiek (IS), geposisioneer binne ’n gesondheidskommunikatiewe konteks. Aspekte van Gee (2014) se teorie van DA dien as die primêre teoretiese raamwerk vir hierdie studie. Gee (2014) se teorie word verryk deur toepaslike konsepte geneem uit die veld van IS, veral die benaderings wat aangeneem is deur academici soos Gumperz (2015) en Goffmann (1974, 1981). Verder word die nosie van identiteitvorming in beide DA en IS uitgebrei deur Bucholtz & Hall (2015) se Sosiokulturele Linguistiese benadering tot identiteit; en Pennycook (2005) en Butler (1999) se benaderings tot identiteitsperformatiwiteit.

Die sleutelbevindinge van hierdie studie is: i) deelnemers het deur die diskursiewe (her)konstruksie van hulle geboortelike ervarings, aangedui dat die wyse waarop sorg plaasvind in ’n intrapartum omgewing, ’n kritiese impak het, nie net op ma’s en babas/kinders nie, maar, belangrik, ook op die versorgers self; ii) deur hierdie diskursiewe (her)konstruksies het deelnemers onthul dat die realiteite van hulle geboortelike ervarings nie ooreengestem het met hul verwagtinge tydens die geboorte-periode nie in die gevalle waar die geboortes beskou is as negatief of geweldadig; iii) versorgers het, bykomend tot hul beskrywing van die style en strategieë van deernisvolle intrapartum kommunikasie, ook potensiële oplossings verskaf om die traumas wat ontstaan weens geweldadige geboortelike sorg te verminder, en daardeur beide ma’s en versorgers te laat baat vind. Hierdie studie maak ’n bydrae deur bewustheid te skep rondom obstetriese geweld, geweld teen vroue, en menseregte-skendings oor die algemeen.

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TABLE OF CONTENTS

Chapter 1: Introduction **1**

1.1 Background and problem statement 1

1.2 Linguistic perspectives on healthcare 3

1.3 Aims and objectives 5

1.4 Research questions 6

1.5 Theoretical framework 6

1.6 Research design 7

1.6.1 Type of study 7

1.6.2 Data analysis 7

1.7 Thesis chapter outline 7

Chapter 2: Perspectives on compassionate intrapartum communication **9**

2.1 An introduction to compassion 9

2.1.1 Definitions of compassion 9

2.1.2 Compassion in healthcare 11

2.2 Obstetric violence and the mistreatment of women during childbirth 13

2.2.1 Obstetric violence internationally 13

2.2.2 Obstetric violence in South Africa 13

2.2.3 Narratives of distress 14

i) Physical abuse and sexual abuse 15

ii) Verbal abuse 15

iii) Stigma and discrimination 16

iv) Failure to meet professional standards of care 16

v) Poor rapport between women and providers 17

vi) Health system constraints 17

2.3 Reasons for obstetric violence and mistreatment 18

2.3.1 How systemic failure affects care-providers 19

2.3.2 A flawed medical model of birth 20

2.3.3 Negative patient attitudes 20

2.3.4 Burnout and Compassion Fatigue 20

Stellenbosch University https://scholar.sun.ac.za

2.3.5 The maternal mortality ratio 22
2.3.6 Violation of human rights 23
2.4 The consequences of traumatic birth 23
2.4.1 Consequences to the mother 23
i) Childbirth related PTSD and depression 24
ii) Negative effect on self-identity 25
iii) Deprived of embodied agency 25
iv) Feeling undeserving of care 25
2.4.2 Consequences to the child 26
2.5 The discourses around childbirth 26
2.5.1 The metaphor of the body as a machine 27
2.5.2 Risk 27
2.6 Compassionate communication in healthcare 29
i) Appropriate introductions 29
ii) Attentiveness 29
iii) Active listening 30
iv) Narrative medicine 30
v) Care-provider vulnerability 30
2.7 The process of compassionate intrapartum care 31
i) Recognising suffering 31
ii) Emotional connection and motivation to act 31
iii) Acting to alleviate suffering 32
2.8 The significant role of compassionate communication during childbirth 33
2.8.1 Effective communication supported by health advocates 33
2.8.2 Nuanced care 34
2.8.3 Respectful Maternity Care 34
2.8.4 Compassion need only be momentary to be effective 35
2.8.5 Doulas 35
2.9 The benefits of compassionate intrapartum communication 36
2.9.1 Physical benefits 36
2.9.2 Emotional benefits 36
2.10 Conclusion 37

Stellenbosch University https://scholar.sun.ac.za

Chapter 3: Theoretical Framework **38**
3.1 Introduction 38
3.2 Situating the study in a health communication context 39
3.2.1 Important contributions of DA to the field of health communication 40
3.2.2 Important contributions of IS to the field of health communication 41
3.3 Discourse Analysis 42
3.3.1 Gee's (2014) theory of Discourse Analysis 43
3.3.2 The importance of context in DA 45
3.3.3 Gee's building tasks of reality 47
3.3.3.1 The Significance Building Task 47
3.3.3.2 The Activities Building Task 48
3.3.3.3 The Identities Building Task 49
3.3.3.4 The Relationships Building Task 51
3.3.3.5 The Politics Building Task 52
3.4 Interactional Sociolinguistics 55
3.4.1 Contextualisation and inferencing 55
3.4.2 Interactive frames and footing 57
3.4.3 Diversity in IS 58
3.4.4 Bucholtz and Hall's (2005) Sociocultural linguistic approach to identity 58
3.5 Conclusion 62

Chapter 4: Analytical Methodology **65**
4.1 Introduction 65
4.2 Research design 65
4.3 Research population and recruitment procedures 66
4.3.1 Mother participants 67
4.3.2 Maternity care-provider participants 68
4.3.3 Ethical considerations 69
4.4 Method of analysis 69
4.4.1 Thematic analysis 70
4.4.2 Discourse Analysis, Interactional Sociolinguistics, and Sociocultural Linguistics 71
4.5 Conclusion 72

Stellenbosch University https://scholar.sun.ac.za

Chapter 5: Discourse Analysis of language use during labour................................. 73

5.1 Introduction.. 73

A. MOTHER PARTICIPANTS... 73

5.2 THEME 1: *Hotfooting myself out of this hell-hole* - The physical birth setting.. 73

5.3 THEME 2: *I felt like I was being raped* - Non-compassionate care................... 78

5.3.1 Risk and coercion.. 78

5.3.2 Absence of consent.. 80

5.3.3 Indifference and disrespect... 82

5.3.4 Privacy.. 83

5.3.5 Violation and physical violence.. 84

5.3.6 Verbal abuse.. 85

5.4 THEME 3: *Slapped in the face with love* - Compassionate care......................... 86

5.4.1 Silence... 86

5.4.2 Reassurance and encouragement... 87

5.4.3 Recommendations... 89

5.4.4 Compassion... 90

5.5 THEME 4: *Absolutely euphoric that we survived* - Traumatisation and empowerment.. 93

5.5.1 Traumatisation.. 93

5.5.2 Empowerment... 95

B. CARE-PROVIDER PARTICIPANTS... 97

5.6 THEME 5: *They put the fear of God into them* - The language of birth............. 98

5.7 THEME 6: *This is government. It's a mess here* - Reasons for abusive care....... 100

5.7.1 Systemic failure... 101

5.7.2 Risk and litigation... 102

5.7.3 Trauma and burnout.. 103

5.8 THEME 7: *They walk out here as changed women* - Compassionate care......... 105

5.8.1 Offering compassionate care.. 105

5.8.2 Doulas... 106

5.8.3 How to be compassionate... 107

5.8.4 The effects of compassionate care.. 108

5.9 Conclusion... 108

Stellenbosch University https://scholar.sun.ac.za

Chapter 6: Discussion and Conclusion **110**

6.1 Introduction **110**

6.2 Aims and objectives of the study 110

6.3 Addressing the research questions 110

6.3.1 Research question 1 111

6.3.1.1 Discourses of traumatisation 111

6.3.1.2 Discourses of empowerment 113

6.3.2 Research question 2 115

6.3.3 Research question 3 116

6.4 Key findings of the study 119

6.5 Limitations of the study 120

6.6 Recommendations for future research 120

6.7 Social impact of the study 121

References **122**

Appendix A: Mother participant informed consent form **132**

Appendix B: Care-provider informed consent form **135**

Appendix C: Mother participant questionnaire **138**

Appendix D: Care-provider questionnaire **145**

Appendix E: Facebook recruitment poster **150**

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CHAPTER ONE

INTRODUCTION

1.1 Background and problem statement

The intrapartum care received by a woman in labour critically influences her perceptions of the birth experience. Intrapartum is that which occurs, or is provided, “during the act of birth” (Merriam-Webster 2018) and refers to the period from the “onset of labour until the delivery of the baby and the placenta” (Dahlen, Kennedy, Anderson, Bell, Clark, Foureur et al. 2013:657). At best, a woman can perceive the encounter as compassionate, retaining feelings of elation and empowerment; at worst she can experience the birth as traumatic or violent, and be left feeling disregarded, devastated or traumatised. The presence of compassionate care, or the lack thereof, can have a profound effect on the mother, as studies have shown that even though a mother or infant could experience intense anguish and physical trauma during a birth, with the presence of compassionate care, the mother does not identify the birth as traumatic (Beck 2004b; Soet, Brack & Dilorio 2003). Inversely, in the absence of compassionate care during a birth, a mother could not experience any anguish or physical trauma, yet still identify a birth as being traumatic (Greenfield, Jomeen & Glover 2016:264).

Traumatic birth is a concept that is in the process of being developed and defined (Greenfield et al. 2016:255), and as the body of research on the topic grows, the effects thereof are being acknowledged. The indelible negative consequences of traumatic birth include “mental health problems, compromised maternal-infant relationships, poorer-quality marital relationships, concomitant depression in partners and challenges to future reproductive decisions” (Greenfield et al. 2016:263). Currently, the literature asserts that “mode of delivery” (vaginal or caesarean) is the main indicator of traumatic birth, yet as more studies are being done, traumatic birth is being understood as an intricate occurrence where the type of care provided can either increase or decrease the trauma experienced (Greenfield et al. 2016:264). This matter is of great importance as the absence of a concrete definition of traumatic birth is prohibitive to the dispensing of services to the women afflicted by such an experience (Greenfield et al. 2016:256).

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Furthermore, researchers have thus far not agreed upon standardised terminology pertaining to the mistreatment of women and girls during labour and childbirth. Typologies range from "disrespect and abuse", "mistreatment during facility-based childbirth", and "obstetric violence" (Savage & Castro 2017:2). These concepts do, however, share several commonalities. Firstly, they emphasise the medicalisation of the "natural processes" of birth and the increased capacity for harm which this brings. Moreover, they highlight the potential for the imperilment of women's rights, the amplification of gender disparities, and "violence against women" (Savage & Castro 2017:1).

It is, accordingly, important that the abusive and violent manner in which some women and girls are treated during childbirth, their most vulnerable state, be acknowledged as a form of gender violence. Gender violence during childbirth echoes the manner in which women and girls are depreciated, and how violence against women is normalised, by society at large (Chadwick 2016:423). This study will utilise the concept of obstetric violence as a blanket term to encompass the aforementioned concepts. Obstetric violence is defined as

> … the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it a loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women" (Chadwick 2016:423).

In South Africa (and globally), the limited number of studies that have focussed on the intrapartum experiences of women reveal a very unfavourable situation (Chadwick, Cooper & Harries 2014). Notwithstanding devastating issues around physical care - such as neglect; inadequate care; the prevention of birth partners during labour; physical and sexual abuse; and assault - the verbal issues are staggering. Reports of non-compassionate, abusive language; women being shouted at and humiliated; and the withholding of information are prevalent. In addition, the World Health Organization (WHO) (2015) reports that women who are unmarried, HIV positive, have low socio-economic status, are migrants, belong to ethnic minorities, or who are adolescents are especially prone to suffer abusive and disrespectful maternal care.

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Furthermore, it has been determined that the aspect of labour which birthing women criticise the most pertains to communication during labour (McIntosh 1988:166). The dissatisfaction sprouts from two spheres: firstly, distress about the content and manner of communication, but, more prevalently, distress about what was not communicated. Interventions, like the application of forceps, the acceleration of labour, and an alarming percentage of episiotomies, are not communicated to birthing women before they are administered (McIntosh 1988:169), thereby usurping women's rights to give consent over what will be imposed upon their bodies. Women proclaim that they *"*were treated as being the property of the hospital" which leads to feelings of alienation towards their own bodies and birth processes (Macintyre cited in McIntosh 1988:166). Inadequate communication in a healthcare milieu can, therefore, engender heightened feelings of stress, anxiety and trauma (McIntosh 1988:167).

1.2 Linguistic perspectives on healthcare

Healthcare has undergone an immense metamorphosis over the past century which has not been seen in any other institution (Thomas 2006:10). From an archaic and primitive system where doctors were to be evaded and hospitals were considered places of dying and death, to the highly respected and influential role it plays in society today, healthcare has shown its ability to adapt. As the esteem and authority of its representatives grew, so also did the financial revenue flowing in its direction. Economic, political and educational structures became affiliated with healthcare, resulting in it being institutionalised and the "medicalization of everyday life" becoming the norm. This resulted in numerous "conditions" (like obesity and childbirth, for instance) being redefined as "medical problems" (Thomas 2006:11). As a result, doctors have become revered as specialists in a wide range of issues, many of them not purely medical, but leaning more towards the social and emotional spheres of life.

Due to its prominence and power, healthcare as an institution plays a dominant and influential role in society with "complete consumer trust" present in "the system in general and in hospitals and physicians in particular" (Thomas 2006:22). For instance, a study by Bluff and Holloway (1994:159-160) on the experiences of women during labour and birth describe the implicit trust that women and their partners have in their maternity care-providers, thereby

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substantiating their positions of power and authority. Clinicians are perceived as specialists who “know best”, are “trained” and “experienced”, and who “do it every day” (Bluff & Holloway 1994:159). Women then, by implication, transfer the innate trust they should have had in the abilities of their own bodies to birth babies, to perceived “expert” care-providers. Clinicians encourage this belief in their authority, resulting in women who renounce control over, and responsibility of, their labours, thereby endorsing clinicians' rights to tell the women what to do (Bluff & Holloway 1994:163). This trust is so ingrained that even when women's own wishes are dismissed, they still continue trusting their care-providers (Bluff & Holloway 1994:160).

Furthermore, it is imperative that health professionals pay attention to the importance of effective communication in the healthcare environment. A global escalation in malpractice suits, misinterpretations, misdiagnoses and patients who don't adhere to medical advice - all consequences of ineffectual health communication - is indicative of the crucial role that efficient communication plays in healthcare (Thomas 2006:v). In South Africa, for instance, there has been a considerable increase in the amount of medical professionals who are being sued (Seggie 2014:433). The amounts claimed for have risen by almost 550% in the past decade, with several claims in excess of R30 million. The fact that most of these claims relate to negligence in obstetrics and gynaecology has resulted in a tremendous increase in the rates which obstetricians have to pay for medical malpractice insurance. In 2011 the Medical Protection Society premium was already in excess of R180 000 annually (Pepper & Slabbert 2011:29). In 2017, this amount had increased to a staggering R850 000 per year (Erasmus 2017). This mirrors the fast growing international trend towards a proliferation of medical malpractice claims.

Ironically, in response to the climate of malpractice claims, doctors are increasingly moving away from practising compassion-based medicine to, instead, practising defensive medicine. An escalation in the amount of tests done, along with a surge in the number of (at times unnecessary) procedures like caesarean sections, indicate that doctors are regarding patients as a “liability risk”, and are frequently implementing services only to “persuade the legal system that the standard of care was met” (Pepper & Slabbert 2011:32). This results in inflated costs of health services, along with care that is not focussed on a particular patient,

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but rather on assumptive legal action (Pepper & Slabbert 2011:34). An improvement in the communication between care-providers and patients could, instead, have a profound effect on the healthcare system – advancing positive outcomes, and boosting the effect of prevention and health promotion campaigns (Thomas 2006:4).

In terms of obstetrics specifically, the advantages of a positive care-provider/patient relationship have been clearly proven. In a study on what constitutes a very positive birth experience, Karlström, Nystedt and Hildingsson (2015:1) found that after trust in their own abilities and strength to birth their babies, women rated a "trustful" and "respected" relationship with their care-providers as the most important contributing factor. Women reported the sense of having been "seen and heard" by supportive care-givers which, in turn, resulted in a feeling of the birth happening according to the mother's specifications. Furthermore, being seen and heard facilitated a feeling of safety for the mothers. The presence of a compassionate care-giver, whether they are actively involved or just quietly present, simultaneously evokes a feeling of calm in the mother, along with enhancing her ability to remain in control of her birthing process (Karlström et al. 2015:5). Therefore, the skills associated with compassionate communication in healthcare can genuinely assist a woman with her birthing process.

1.3 Aims and objectives

Considering that a significant portion of intrapartum care is delivered through communication, this research project aims to understand the role that compassionate language plays in healthcare. It will focus on how maternity care-providers and mothers articulate birth experiences - their own and their patients' experiences if they are care-providers, and their own experiences if they are mothers - and what they expect from, and consider appropriate, communication during labour.

There will be a specific focus on the use of compassionate language, or the lack thereof, during birth, and whether care-providers and mothers differ in their definitions of compassionate language. The research will investigate the type of language used to speak about birth and how memories are reconstructed through language, in other words, there will

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be a particular focus on the discursive reconstruction of participants' recollections of their birth experiences, be it as birthing mothers or in their capacity as maternity care-providers.

1.4 Research questions

The research questions this study attempts to answer are as follows:

1. How do maternity care-providers and mothers articulate the memories of their birth experiences?
2. What do maternity care-providers and mothers expect from their birth experiences in terms of communication, and how do their experiences compare to these expectations?
3. How do maternity care-provider and mothers describe the styles and strategies of compassionate intrapartum communication?

1.5 Theoretical framework

In order to consider the discursive (re)construction of the recollection of participant's intrapartum experiences, the main theoretical departure of this study constitutes a combination of two theoretical paradigms, namely Discourse Analysis and Interactional Sociolinguistics, as positioned within a health communication context. Aspects of Gee's (2014) theory of Discourse Analysis serves as the primary theoretical framework of this study. Gee's (2014) theory is enhanced by appropriate concepts taken from the field of Interactional Sociolinguistics, specifically the approaches adopted by scholars such as Gumperz (2015) and Goffman (1974, 1981). In addition, the notion of identity formation in both Discourse Analysis and Interactional Sociolinguistics is expanded by Bucholtz and Hall's (2015) Sociocultural Linguistic approach to identity; and Pennycook (2005) and Butler's (1999) approaches to identity performativity. The combination of approaches was chosen for the value they add to the study of compassionate intrapartum communication, where Discourse Analysis provides the building tasks of reality which would allow for an analysis of the discursive reconstruction of participants' birth experiences, and Interactional Sociolinguistics and Sociocultural Linguistic provide ancillary information regarding interaction, and ads depth to the examination of identity formation in interactions.

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1.6 Research design

The following section will provide an overview of the methodology of this study.

1.6.1 Type of study

In order to investigate the discursive (re)construction of the language used during intrapartum situations a qualitative multi-method study was conducted. Data were collected through questionnaires and one-on-one semi-structured interviews. The research population consisted of ten mother participants who had each given birth to between two and five children; and six care-provider participants who work across a variety of maternity settings, namely private and public hospitals, and home-birth environments.

1.6.2 Data analysis

The first phase of the analysis consisted of thematic analysis. This was done according to Braun and Clarke's (2006) six-step approach which, through its utilisation, provided this study with a systematised structure within which data was presented and interpreted. Thereafter, data were analysed according to a discourse analytical approach, specifically Gee's (2014) Building Tasks of Reality, which was supplemented by relevant aspects of Interactional Sociolinguistics, and Sociocultural Linguistics.

1.7 Thesis chapter outline

The first chapter of this study outlines the topic under investigation, namely that of compassionate intrapartum communication, by providing the background to the study, as well as examining perspectives on healthcare. This chapter also outlines the aims and objectives of the study, along with the research questions posed.

Chapter 2 provides an overview of the literature pertaining to compassionate intrapartum communication. Firstly, it provides an introduction to the concept of compassion, which is followed by a discussion of obstetric violence; the discourses around childbirth; the

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consequences of traumatic birth; and the reasons for obstetric violence and the mistreatment of women during the intrapartum period. Lastly it discusses the role of compassionate communication during birth; and the process of compassionate intrapartum care, along with the benefits of such care.

Chapter 3 discusses the theoretical framework of this study by first situating the study in health communication context, followed by a discussion of Discourse Analysis as the main theoretical point of departure. This is followed by a discussion of Interactional Sociolinguistic and Sociocultural Linguistics, which augments the understanding of key concepts in Discourse Analysis.

Chapter 4 examines the analytical methodology of the study, and discusses the research design; research population and recruitment procedures; and the method of analysis.

Chapter 5 provides a detailed analysis of the data gathered from both mother and care-provider participants, which was achieved through the tools provided by thematic analysis and Discourse Analysis, as well as by means of applicable aspects of Interactional Sociolinguistics and Sociocultural Linguistics.

Chapter 6 presents a synthesis of the findings and conclusions that have been arrived at through the data analysis, and provides links between these findings and the literature, and the theoretical perspectives on which this study is based. It also presents a review of the limitations of the study, and recommendations for future research, along with a discussion of the potential social impact of this study.

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CHAPTER TWO

PERSPECTIVES ON COMPASSIONATE INTRAPARTUM COMMUNICATION

2.1 An introduction to compassion

This chapter presents an overview of the literature pertaining to compassionate intrapartum communication. Compassion as a concept is defined, and the process of compassion is outlined, followed by a discussion of compassion in healthcare. This is followed by an examination of obstetric violence from both a global and a South African perspective, and the manner in which women are physically and verbally mistreated during the intrapartum process is outlined through the narratives of distress expressed in international and local studies. The reasons for obstetric violence and the mistreatment of women are explored from an individual and institutional perspective, including a discussion of the global drive to promote facility-based birth, how the excessive medicalisation of the birth process is actually serving as a deterrent to women seeking facility-based birth, and how the abusive care prevalent at these facilities is an infringement on human rights. Subsequently, the serious and far-reaching consequences that traumatic birth has on both the mother and the baby are discussed, followed by an exploration of the discourses around childbirth along with how it perpetuates the medical model of childbirth.

The second part of this chapter explores the concept of compassionate communication in healthcare. Furthermore, the methods through which clinicians show compassion to their patients are considered. The process of compassionate care is applied to the intrapartum sphere, followed by an examination of the significant role of compassionate intrapartum communication during childbirth, and the importance of positive relationships with maternity care-providers. Lastly, this chapter examines the physical and emotional benefits of compassionate care.

2.1.1 Definitions of compassion

The nascent field of compassion as a topic of empirical study is burgeoning, and its relevance

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over several disciplines, such as healthcare, law, and education, is being widely recognised. However, despite increased academic interest, the lack of a precise, homogeneous definition, along with a dearth of suitable tools to accurately measure compassion, are impeding scientific advancement, and are motivating researchers to explore, conceptualise and review the field of compassion (Strauss, Taylor, Gu, Kuyken, Baer, Jones & Cavanagh 2016:25). Compassion is often confused with the concepts of sympathy, empathy, kindness and altruism, and although compassion bears aspects of these concepts in its definition, it is, as a whole, a more densely packed construct.

The Oxford English Dictionary (2008) defines sympathy as, “feelings of pity and sorrow for someone else's misfortune”, and empathy as, “the ability to understand and share the feelings of another”. Altruism is described as, “disinterested or selfless concern for the well-being of others”, and kindness as, “the quality of being friendly, generous, and considerate”. Despite compassion encompassing the qualities of sympathy, empathy, kindness and altruism - indicating that one has an awareness, along with an understanding of, and concern for another's suffering - what sets compassion apart is its core element, namely the motivation to act to assuage the other's suffering (Strauss et al. 2016:18).

Goetz, Keltner and Simon-Thomas (2010:351) define compassion as “the feeling that arises in witnessing another's suffering and that motivate a subsequent desire to help”, which establishes compassion as an affective or emotional state of being. Alternatively, concepts such as sympathy, empathy, altruism and pity are best described as “compassion-related states” which have as their focus the mitigation of another's suffering. Lexically these words, along with words like “kindness, tenderness, warmth and caring”, generally form part of the same semantic field and therefore are included in the same “emotion family” (Campos et al. cited in Goetz et al. 2010:352).

In a review of the existing definitions of compassion, Strauss et al. (2016:18-19) consolidate and tabulate the similarities between all the definitions and concludes that compassion is,

> a cognitive, affective, and behavioural process consisting of the following five elements that refer to both self- and other-compassion: 1) Recognizing suffering; 2)

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Understanding the universality of suffering in human experience; 3) Feeling empathy for the person suffering and connecting with the distress (emotional resonance); 4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g. distress, anger, fear) and so remaining open to and accepting of the person suffering; and 5) Motivation to act/acting to alleviate suffering.

2.1.2 Compassion in healthcare

Compassion is frequently classified as an essential element of superior healthcare. A scoping review of healthcare literature was conducted by Sinclair, Norris, McConnell, Chochinov, Jack, Hagen, McClement and Bouchal (2016) in which 25 years of empirical literature on compassion was reviewed. They found that compassion is possibly one of the "most referenced" conventions of quality healthcare, regardless of the lack of empirical studies done on the topic. Their findings show that approximately three quarters of the research on compassion in healthcare has been done since 2010, indicating a distinct upsurge in interest (Sinclair et al. 2016:10). Fuelled by the need to improve the quality of healthcare delivered, along with reports about the substandard provision of compassionate care, governing bodies are requiring that more research be done on the topic, especially from the perspectives of patients (Sinclair et al. 2016:14) and in terms of cross-cultural communication (Sinclair et al. 2016:13). However, regardless of the increased attention compassion is receiving, it is still a nascent area of study in the field of healthcare and Sinclair et al. (2016:14) express a "pressing need for applied research".

Furthermore, Sinclair et al. (2016:2) state that a lack of compassion in healthcare is exacerbated by the fact that as the majority of healthcare students near the end of their studies and their direct contact with patients increase, they simultaneously display less caring behaviour. By the time they are in practice, care-providers omit to notice "70% of clearly identifiable empathetic opportunities" (Sinclair et al. 2016:2). In a systematic review of studies done with medical students and recent graduates, it was found that their empathy deteriorated significantly from their third year of study onwards, and then declined even further once they started clinical practice or residency (Neumann, Edelhäuser, Tauschel, Fischer, Wirtz, Woopen, Haramati & Scheffer, 2011:998).

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One of the main factors contributing to this decline in empathy is distress, which sprouts from various sources. Firstly, an intense workload, and the resultant lack of sufficient time spent with loved ones, indicate a decline in the student's/resident's social support structure (Neumann et al. 2011:1000). Secondly, many students'/residents' enthusiasm and idealism dwindle once they are accosted by the reality of patients' mortality and morbidity. As a self-preservation method, clinicians then shield themselves by "dehumanizing" patients (Neumann et al. 2011:999). Thirdly, "inadequate role models" in the form of superiors who treat patients in a demeaning or unethical manner; society and the media's glorified impression of the medical community; and the notion that they form part of an "elite and privileged group" could result in a "rational distancing" from those in the care of students/residents, along with a further decline in their levels of empathy (Neumann et al. 2011:998, Stratton 2008:282).

Ironically, the very decline in empathy could lead to further feelings of distress in clinicians. West, Huschka, Novotny, Sloan, Kolars, Habermann and Shanafelt (2006:1072) set out to assess "perceived medical errors" made by medical residents, and to evaluate the link between these errors and the residents' "quality of life (QoL), burnout, symptoms of depression, and empathy...". A considerable amount of residents stated that they made errors, and it was revealed that these errors have a profound effect on the residents' frame of mind, and in turn, on patient care. The occurrence of errors goes hand-in-hand with feelings of burnout, which results in a reduction of the amount of compassion and empathy shown towards patients. However, the decline in empathy and compassion results in more medical errors being made, leading to additional distress and yet further deterioration of compassion, effectively trapping physicians in a vicious cycle (West et al. 2006:1075). The study suggests that, for the benefit of physicians and patients alike, programmes be developed that curtail burnout, and espouse empathy and compassion (West et al. 2006:1076). In fact, by practising compassion at the workplace, maternity care-providers could increase their experience of Compassion Satisfaction. Compassion Satisfaction is the awareness of gratification which care-providers experience through their service to "traumatised" individuals and is seen as their contribution "to the workplace or society" (Allen, Watt, Jansen, Coghlan & Nathan 2017:403). It was found that through an intervention which comprised "work-focussed discussion groups" care-providers reported reduced instances of Compassion Fatigue and Burnout, and increased levels of Compassion Satisfaction (Allen et al. 2017:405)

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2.2 Obstetric violence and the mistreatment of women during childbirth

Obstetric violence, as outlined in the introduction, is also defined as “dehumanized care”, or “disrespect and abuse”, and is increasingly falling under the international spotlight, yet continues to be considered an underdeveloped field of research. This is due to the fact that maternal health institutions and policy makers are still developing best practice to quantify disrespectful care (Savage & Castro 2017:2).

2.2.1 Obstetric violence internationally

The term 'obstetric violence' originated in Spain and Latin America in an attempt to “demedicalise” childbirth, and “humanise” and “empower” women during pregnancy and the intrapartum period. It is a contentious term, and was intentionally selected by activists - instead of more impartial phrases - to draw attention to previously concealed and surreptitious negative practices, and to lead to the prosecution of guilty parties. In Latin America, obstetric violence forms part of the prevailing societal practice of gender violence and discrimination in relation to “race, class, age and ethnicity”, and has been declared illegal. Doctors globally, however, have not been very accepting of the phrase out of fear that its implementation would lead to routine procedures being “criminalised” (Chadwick 2016:423).

2.2.2 Obstetric violence in South Africa

In South Africa specifically, the origins of obstetric violence are complex and multifaceted. The abuse originates from both individual and institutional sources, with the latter frequently leading to loss of privacy, the prohibition of birth partners due to ill-designed birthing facilities, and the mismanagement of medical resources (Chadwick 2016:423). On an individual level it includes both emotional and verbal abuse (yelling, rebuking, intimidating, and shaming), physical abuse (coercing women into unwanted procedures, or implementing procedures without permission) with the goal of “asserting authority” and shaming women (Pickles 2016:6), and in some instances also involves sexual abuse (Chadwick 2016:423). This type of abuse does not, however, always stem from intentional malignance. Frequently it is born out of a misguided intention to act in the best interest of the mother and infant.

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Pickles (2016:6) argues that the obstetric violence profile in South Africa matches that of Latin America, due to the fact that the type of behaviour classified as obstetric violence internationally echoes behaviour that takes place in the South African maternity system, and that "criminalising" the intrapartum mistreatment of women in South Africa would be "an appropriate legal response". *Saving Mothers 2008 - 2012*, the fifth official report issued by the Department of Health on the confidential enquiries into maternal deaths in South Africa, concludes that "over 53% of maternal deaths in the public maternity system in South Africa are linked to avoidable factors" (Chadwick, Cooper & Harries 2014:863). The significance of this figure is escalated by the fact that 85% of South Africans make use of the public health system (Chadwick et al. 2014:86). Furthermore, there is a dearth of research on the calibre of care from the perspective of women themselves, as the literature mostly concentrates on "health system factors" and "access to services".

2.2.3 Narratives of distress

Adopting a qualitative, narrative methodology, Chadwick et al. (2014:863) collected the birth narratives of women in order to evaluate their opinions of giving birth in the South African public sector. The study found that the primary approach women took in expressing their intrapartum care encounters in public maternity settings was that of "narratives of distress", indicating substandard intrapartum care, along with its related mistreatment (Chadwick et al. (2014:864). These narratives of distress from South Africa echo reports on the abuse and exploitation of women during facility-based childbirth globally.

With the aim of developing a standardised typology around the occurrences of the mistreatment of women at facilities around the world, Bohren, Vogel, Hunter, Litsiv, Makh, Souza et al. (2015) reviewed studies from 34 countries, and identified seven domains of mistreatment: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between patients and healthcare providers; and health system conditions and constraints. It is clear from the review that the abuse traverses two broad spheres: firstly, women that are mistreated by their care-providers, and secondly, women that are mistreated by health facilities or systems (Bohren et al. 2015:2). Apart from direct physical and sexual abuse (domains one and two), all other domains

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indicate poor communication, or a combination of poor communication and physical abuse.

i) Physical abuse and sexual abuse

Physical and sexual abuse pertains to women being hit or struck, kicked, pinched on their legs, having their mouths gagged during labour, and / or sexually abused or raped by their care-providers (Bohren et al. 2015:9). Pickles (2016:7) outlines, amongst others, avoidable episiotomies (performed as routine procedures or purely for training purposes), stabbing women "with scissors", "tying women's legs to the delivery table", pushing women's legs together while the baby is appearing, and women having to undergo vaginal examinations in front of groups of students for "training purposes", as examples of physical abuse during childbirth.

ii) Verbal abuse

Verbal abuse occurs in all categories of mistreatment, and was reported in every geographical area, across low-, mid-, and high-income levels (Bohren et al. 2015:14). A considerable portion of women's narratives of distress stem from "negative interpersonal relationships with care-givers". Women describe belligerent and punitory treatment which entails being humiliated and shamed, for instance being told that they smell bad (Chadwick et al. 2014:864). They experience their care-providers as "judgmental" or "accusatory", as they threaten them with negative consequences (for instance harm to, or death of, infants) or the refusal of care (Bohren et al. 2015:14). Some women ascribe the mistreatment to the fact that they refrained from being silent during labour, or due to "disobedient" acts like pushing when their bodies require it, instead of when they are granted permission to do so (Bohren et al. 2015:15). Of linguistic interest are the words which women use to describe the verbal abuse, for instance verbs such as "dehumanize", "threaten", "intimidate", "scream", "shout", "yell", "scold", "humiliate", "insult", "belittle", "ridicule", and "mock" (Bohren et al. 2015:16). The punitive nature of these interactions has an exceedingly negative impact on women's birth experiences.

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iii) Stigma and discrimination

Research shows that societal behaviours are mirrored in maternal health facilities, especially in low-income regions like sub-Saharan Africa. Those that are already oppressed are being further mistreated during the intrapartum period. Furthermore, unmarried women, adolescents, sex workers, rural women, immigrants, and women of low socio-economic status are discriminated against in a manner which reflects how they are treated by society in general (Bradley, McCourt, Rayment & Parmar 2016:165). Bohren et al. (2015:15) found that stigma and discrimination at maternity care facilities manifested across the four main areas of "ethnicity, race, and religion", "age", "socioeconomic status", and "medical conditions".

Women state that their cultural traditions are disregarded, and that they are "stereotyped" based on race (Bohren et al. 2015:15). Teenagers encounter derision and scorn due to the fact that they engaged in premarital sex, and have their confidential medical records shared with their legal guardians. Poorer women are discriminated against due to their inability to pay for maternity services or offer bribes, shamed for being illiterate, and classified as "dirty" (Bohren et al. 2015:15). Some are "blamed for acting like savages" and told "not to give birth like a barbarian" (Bradley et al. 2016:165). Lastly, HIV-positive women conclude that their health status results in maternity care-providers being hesitant of, and evading, giving treatment (Bohren et al. 2015:15).

iv) Failure to meet professional standards of care

Throughout these narratives runs the motif of neglect and abandonment, in which women describe being left "largely unattended" during labour and having to yell for support. In some instances the care-providers only arrive after the baby's head is delivered. Women are left feeling "forgotten" and "invisible" which results in a "lack of connection" between them and their care-providers (Chadwick et al. 2014:865). High instances of "neglect", "abandonment" or "long delays" are described, along with the denial of medication for pain (Bohren et al. 2015:11).

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v) Poor rapport between women and providers

Insufficient communication and the withholding of information exacerbate the occurrence of poor rapport between women and their care-providers (Bohren et al. 2015:12-13, Chadwick et al. 2014:865). Women are routinely denied access to information regarding how far their labours have progressed. Some are denied access to information pertaining to complications that have arisen, and are transferred to emergency facilities without knowing why (Chadwick et al. 2014:865). Furthermore, the prohibition of birth partners during labour, which is a common occurrence in the South African public maternity sector, leads women to express a narrative of loneliness and fear, particularly new mothers. Women also report a disregard for the positions in which they prefer to give birth, "objectification", that they feel "stripped of their dignity" in labour, and in some instances "detainment" in health facilities when they have insufficient funds to cover the birth (Bohren et al. 2015:12-13). In addition, women frequently disclose that asking for assistance from a care-giver is construed as an intrusion (Bohren et al. 2015:11).

The review explicitly notes, however, that the actions of abuse and mistreatment are not always deliberate, and could coincide with compassionate behaviour from care-providers. Stressful working conditions like long hours, understaffed clinics, insufficient salaries, and supply shortages could result in care-providers treating women abusively. Yet, women are still experiencing abuse, and despite the motives, there should be no rationalisation of the mistreatment (Bohren et al. 2015:22). Furthermore, substandard levels of care are interpreted as an explicit obstacle in convincing women of the benefits of facilities-based childbirth (Bohren et al. 2015:30).

vi) Health system constraints

A mistrust in the safety or efficacy of facilities is not just engendered by the care-providers themselves. The actual facilities and health systems contribute to the problem too. Labour and delivery areas are described as "dirty", "overcrowded", and "noisy" (Bohren et al. 2015:19). Staff shortages, or untrained and unskilled care-providers, coupled with lack of adequate medical supplies, result in unnecessary complications, along with pessimistic care-providers

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who are placed under (avoidable) pressure. Violation of privacy is a major theme in how the health system is failing birthing women. A shortage of curtains between beds, or on windows, leads to women undergoing vaginal exams, or labouring, in the presence of other patients, their families, or care-providers and, as mentioned above, big groups of observing students. Women describe the lack of privacy, especially whilst feeling defenceless during labour, as "undignified, inhumane, and shameful". Furthermore, women's lack of autonomy over their birth processes is demonstrated through the violation of their privacy. Exacerbating this, women are also frequently subject to "unreasonable requests" from care-providers, in which they are instructed to clean up their own blood or vomit ("mess") directly after, or even during, birth (Bohren et al. 2015:13).

Treatment of this nature is failure on a systemic level. Women "lamented" the "lack of redress" at their disposal and are apprehensive to air their grievances, in case it leads to wrongful treatment or that they are discriminated against. Furthermore, a paucity of adequate channels of complaint leave women defenceless and incapable of seeking reparation and compensation for the way they have been treated. The ramifications of this level of systemic and individual abuse are severe. The "hierarchical authority" of the healthcare system places care-providers in "legitimized" situations of power. It is also responsible for the abusive treatment women are subjected to, and places women, who should be the ones in charge of their birthing processes, at the bottom of the scale. Fear of abuse, along with health facilities' appalling reputations, diminish women's confidence in the system and cause them to avoid facility-based childbirth (Bohren et al. 2015:13).

2.3. Reasons for obstetric violence and mistreatment

The reasons for obstetric violence and the mistreatment of women during the intrapartum period stem from three broad spheres. Firstly, there is failure on a systemic level in which mistreatment has become ritualised. Secondly, the negative attitudes of patients themselves result in their mistreatment, and lastly, due to the nature of their work care-providers may suffer from burnout and compassion fatigue. These reasons are discussed in more detail below.

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2.3.1 How systemic failure affects care-providers

Jewkes, Abrahams and Mvo (1998) studied the reasons why nurses in South Africa's obstetric services abuse patients, and found that the source of much of the disrespect of women's birth instincts, along with the accompanying mistreatment of women, emanates from how maternity care-provider identities have been shaped and reinforced by the institutions which govern them. In nursing, for example, the reluctance of South African nursing authorities to hold nurses accountable for their poor treatment of patients is ascribed to "guilt over working conditions" (Jewkes et al. 1998:12).

Maternity care-providers in South Africa's primary healthcare service are confronted with working long hours for low salaries, whilst facing a shortage of pharmaceuticals, equipment, and trained colleagues, along with oppressive hierarchical practices which are maintained amongst care-provider ranks (Jewkes et al. 1998:13). In addition, some nurses feel themselves abused by patients, as well as having to suffer animosity from their communities, where the narrative of the 'abusive nurse' is perpetuated (Jewkes et al. 1998:5). Maternity nurses and midwives are also faced with unreliable emergency services (for instance ambulances that need to transport patients from low-risk care facilities like Midwife Obstetric Units (MOUs) to hospitals), in a milieu where complications can suddenly arise (Jewkes et al. 1998:8-9), leaving them vulnerable to the failures of the system in which they work.

As a result, a need to exert control over their work environment, and their patients, is developed (Jewkes et al. 1998:9). This is paired with a desire to assert their "middle-class" status, which is achieved through verbally affirming their disassociation from their patients, demonstrating uncompassionate actions, and, in some cases, resorting to verbal and physical assault (Jewkes et al. 1998:13). Behaviour such as this is justified by asserting that they have the best interest of the baby at heart, along with an undertaking to educate women - such education being motivated by an "ideology of patient inferiority" (Jewkes et al. 1998:8). Patients are described as "illiterate" and "ignorant", along with being "dirty", "cheeky", "unmotivated", "lying" and "irresponsible". In return for care-providers delivering healthy babies, women are expected to listen to, and comply with, all commands dictated by maternity staff. Adherence is demanded, and failing to do so, results in care-providers feeling warranted,

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and sometimes compelled, to adopt an assortment of methods in order to gain acquiescence (Jewkes et al. 1998:10).

2.3.2 A flawed medical model of birth

Both women and care-providers state that the mistreatment of women in maternity services is enacted by a few “rotten apples”, but due to the fact that the abuse is accepted and permitted by co-workers, it has been allowed to become ritualised (Jewkes et al. 1998:8,10). Jewkes et al.'s (1998) study was conducted over 20 years ago, however, more recent studies on maternity services in South Africa's primary healthcare sector (Kruger & Schoombie 2010; Spencer, du Preez & Minnie 2018; Hastings-Tolsma, Nolte & Temane 2018) still echo much of the above findings. The principles of a medical model of birth, in which events and processes are orderly, systematised and regulated, are not achieved in full, despite the system aspiring to it. Instead, birth discourses speak of chaotic, unmethodical, flawed, and destructive interactions between women and their care-provider (Kruger & Schoombie 2018:97).

2.3.3 Negative patient attitudes

On the one hand, maternity care-providers concede that a negative mind-set and a pessimistic approach have an adverse impact on the type of care provided. Some patients, on the other hand, are also described as having negative attitudes. Due to a lack of education around labour practices, patients are frequently unrealistic in their expectations of maternity care-providers. The situation is often exacerbated by hampered communication, as women and care-providers do not speak the same languages (including sign language). Patients' unmet expectations culminate in their mistreatment of care-providers, which has a direct impact on the type of care they receive in return (Spencer et al. 2018:6).

2.3.4 Burnout and Compassion Fatigue

Working long hours in a harsh and stressful environment, with little support from superiors or government, frequently results in maternity care-providers suffering from burnout (Spencer et al. 2018:3). Burnout occurs when care-providers are exposed to incessant pressure and tension

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from their work environment, and manifests as fatigue, irritation, outrage and despair. Burnout forms one component of Compassion Fatigue. The other component is Secondary Traumatic Stress, which manifests as angst, insomnia, distressing flashbacks and evasion. It generally occurs after a care-provider has been exposed to a person who has suffered trauma (Allen et al. 2017:403), and usually after the care-provider has cultivated an empathetic connection with a client (Rice & Warland 2013:1057).

A combination of burnout and Secondary Traumatic Stress results in Compassion Fatigue, which is defined as a steady deterioration of a person's desire to care for others (Allen et al. 2017:403), and culminates in a general lack of empathy and compassion. Maternity care-providers (both nurses and doctors) report higher levels of burnout than other clinicians (Allen et al. 2017:404). This can be ascribed to various factors: on the one hand, as illustrated above, there is failure on the part of the healthcare system to adequately support care-providers in terms of working hours, along with extremely stressful and frustrating working conditions; on the other hand, the actual essence of maternity care calls for rapport, and a connection, to be established between the birthing woman and her care-provider. Private midwives, in particular, establish a deeply compassionate connection with their clients, and it is really this empathetic affiliation that escalates their exposure to distress on an emotional level (Rice & Warland 2013:1057).

In order to alleviate the effects of burnout and Compassion Fatigue, it is essential that care-providers equip themselves with the skills to do so. Allen et al. (2017:404) postulate that training medical students and residents in “mindfulness techniques” will prepare them to be able to cope with Compassion Fatigue once they encounter it. In addition, repeated therapist-led group discussions resulted in substantially reduced degrees of burnout, Compassion Fatigue, and Secondary Traumatic Stress, and increased levels of Compassion Satisfaction (Allen et al. 2017:405). Rice and Warland (2013:1062) found that “debriefing” sessions with fellow care-providers, as well as with personal support structures like family members, aided them in working through the effects of being present at a traumatic birth. Care-providers therefore need to actively seek (and have access to) counselling and debriefing resources in order to assuage the manifestations of Compassion Fatigue and Secondary Traumatic Stress.

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2.3.5 The maternal mortality ratio

In recent years there has been a huge drive to increase the amount of women who give birth at maternal care facilities, in order to address the United Nation's Millennium Development (MDG) Goal 5, which aimed to reduce the maternal mortality rate (MMR) by 75% by 2015. Between 1990 and 2015, the MMR was reduced by 43.9%, from 385 deaths per 100,000 live births in 1990 (a total of 532,000 deaths per annum globally) to 216 deaths per 100, 000 (a total of 303,000 deaths per annum globally) in 2015. Sub-Saharan Africa reflected a total of 546 deaths per 100,000 live births, versus as few as 12 deaths per 100,000 for more developed countries (Alkema, Chou, Hogan, Zhang, Moller, Gemmill et al. 2015:467). Although strategies varied between specific countries, results which reduced the MMR were achieved through increasing the "service coverage" of maternity care facilities and expanding the amount of maternity care-providers, specifying "standards of care", outlining when women should be referred to better equipped facilities, and "training programmes for qualified health providers such as midwives" (Alkema et al. 2015:471).

Furthermore, the spotlight is starting to fall on the fact that the excessive medicalisation of intrapartum processes is serving as a deterrent to women seeking facilities-based birth, especially in sub-Saharan Africa (Bradley et al. 2016:157), and is thereby directly affecting the MMR. The recently released WHO recommendations on intrapartum care for a positive childbirth experience concur that the global drive to promote facility-based birth in order to curtail the MMR, may not ensure care of a high calibre, and that the "disrespectful" and "undignified" care provided are acting as a "significant barrier" to women seeking care at these facilities (WHO 2018).

Lastly, it is significant to note that even though there has been an improvement in the MMR, most of the conditions responsible for maternal deaths are typically treatable or avoidable through the provision of efficient care by skilled maternity care-providers (Bohren et al. 2015:30). The current rate of 303,000 deaths globally per year can therefore still be classified as calamitous.

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2.3.6 Violation of human rights

In addition to negatively affecting the MMR, the mistreatment of women during facility-based birth is, as mentioned in Chapter 1, also a gross "violation of women's basic human rights" (White Ribbon Alliance 2011). The WHOs statement on the "prevention and elimination of disrespect and abuse during facility-based childbirth" declares that all women have the right to "dignified, respectful healthcare" for the duration of their pregnancy and during the intrapartum period, along with "the right to be free from violence and discrimination" (WHO 2015). However, global human rights guidelines on obstetric and institutional violence during facility-based birth is still a nascent field. Currently the majority of the attention falls on topics such as "forced sterilization" and inadequate procurement of emergency maternal care (Khosla, Zampas, Vogel, Bohren, Roseman & Erdman 2016:131). In order to ensure the inclusion of all types of obstetric violence into human rights charters, along with methods to address the violations, Khosla et al. (2016:138) advise the constant observation of the mistreatment of women, along with the establishment of appropriate redress for women who suffered intrapartum obstetric and institutional violence.

2.4 The consequences of traumatic birth

Traumatic birth is defined as "the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (Greenfield et al. 2016:265). Women describe their births as traumatic when they perceive themselves to have been "invisible" or "out of control" amid the intrapartum process; and if they experienced the treatment received from care-providers as "inhumane" and "degrading" (Fenech & Thomson 2014:186). Due to the depth of the psychological trauma resulting from a traumatic birth, women describe themselves as being "changed forever", and having retained emotional "scars", even after having had a subsequent positive birth. Furthermore, women who have been so distressed by the traumatic birth that they cannot imagine having another, do not experience the potential benefits of a subsequent healing birth, and some still suffer from nightmares and flashbacks years after the event (Thomson & Downe 2010:108) Lastly, as discussed in Section 2.3.4 above, women who have suffered trauma at birth facilities are

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reluctant to return to these facilities for subsequent births, which has a direct negative impact on the MMR. However, the consequences of a traumatic birth reach far further than that, and carry critical and significant ramifications for women, their partners, and their children.

2.4.1 Consequences to the mother

i) Childbirth-related PTSD and depression

Kitzinger (2012:304) argues that the anguish a woman suffers after childbirth is frequently misdiagnosed as post-natal depression, but in actual fact is Post Traumatic Stress Disorder (PTSD). Furthermore, the American Psychiatric Association has classified childbirth as a proven source of PTSD, and defines PTSD as a "trauma and stressor related disorder" which occurs after being exposed to "actual or threatened death, serious injury or sexual violation to self or others" (Fenech & Thomson 2014:185). Childbirth-related PTSD results from women feeling "disempowered" by the medical model of birth followed in birth facilities, which involves "obstetric management, physical immobilization, lack of emotional support, frequent interventions, rigid timing, and an operative delivery", and culminates in an encounter some women feel is akin to rape. These women feel defenceless, disfigured and violated by the actual system and people who have "given them the baby" (Kitzinger 2012:304). Additional negative consequences of a traumatic birth include other mental ailments such as anxiety and post-natal depression (Greenfield et al. 2016:262), panic attacks and the contemplation of suicide (Elmir, Schmied, Wilkes & Jackson 2010:2149).

PTSD manifests through four main threads: firstly, women experience "persistent re-occurrence" of the event through flashbacks and bad dreams; secondly, they display "pathological avoidance" of anything that would remind them of the birth, like birthdays for instance; thirdly, they suffer "negative cognitions" which involves attributing blame towards others or themselves, or having no recollection of portions of the birth; and lastly, women become hyper-stimulated exhibiting symptoms ranging from heightened irritability to insomnia (Fenech & Thomson 2014:185).

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ii) Negative effect on self-identity

Along with the birth being internalised as an intensely negative experience, it is equally important to consider the research which reveals the abiding adverse effects on "self-identity and relationships" (Fenech & Thomson 2014:185). The extreme negative mental states and reactions women suffer after traumatic birth is described by metaphors such as being "consumed by demons", and that they are "drowning in darkness". This is due to the intense anguish, angst and rage they feel, which is, in severe cases, accompanied by thoughts of killing themselves or their babies. Significantly, women frequently suffer through these intense emotions on their own, due to fear of "reprisal" or that their babies would be taken away from them (Fenech & Thomson 2014:187).

iii) Deprived of embodied agency

The implementation of "medicalised and hierarchical" models of care usurps the innate awareness and understanding women have about their own birth processes (Bradley et al. 2016:167), and robs them of their "embodied agency", which is the capacity to recognise and trust their own physical or bodily signals and sensations. This results in women feeling vulnerable and at the mercy of care-providers who don't truly care for them (Chadwick et al. 2014:864). In addition, they feel particularly resentful and inept when people attempt to console them with presumably one of the most frequently used remarks following traumatic birth, namely, "at least you have a healthy baby" (Cohen Shabot 2016:240). By saying this, the mother's experience of the birth is disregarded, and her opinion of it is presumed insignificant, adding to her feelings of disempowerment.

iv) Feeling undeserving of care

Furthermore, due to the "dismissive" way in which women are admonished, have their opinions about their birth processes ignored, and continuous disturbances, care-providers are described as stumbling blocks and hindrances rather than actual facilitators of birth, and this results in women interpreting that they are undeserving of receiving "care and dignified treatment" (Chadwick et al. 2014:864). Another cause of women feeling undeserving of care

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occurs when women are denied access to information, on, for instance, how far their labours have progressed, and why complications have arisen. It results in them feeling inert and neglected, and it communicates that they are inconsequential and irrelevant.

2.4.2 Consequences to the child

Traumatic birth is not only detrimental to the mother, but also to the child. An infant's brain starts being responsive to the world outside of the womb from the final trimester of pregnancy onward, with "social interaction" forming the essence of their intellectual and emotional expansion (Berg 2016:iii). Suffering from postnatal depression or postnatal PTSD (as a result of traumatic birth, for instance) has the potential to result in women who disengage or retract from their infants (Berg 2016:iv). "Maternal withdrawal" constitutes women who display abnormal behaviour towards their infants: they do not instigate interaction or consoling practices, they create physical distance between themselves and their infants during communication, or they remain quiet during interactions (Lyons-Ruth, Bureau, Easterbrooks, Obsuth, Hennighausen & Vulliez-Coady 2013:577). Due to the mother's fragile mental state, and in order to maintain her equilibrium, she is required to "tune out" the infant's requests for interaction (Ainsworth cited in Lyons-Ruth et al. 2013:564).

Such maternal withdrawal has recently been proven to be the "single strongest" indicator of a range of antisocial behaviours and disorders in late adolescence (Lyons-Ruth et al. 2013:562, 569). If the child's requests to be comforted and consoled are routinely ignored, he/she experiences acute anguish, which, in turn, has the potential to manifest in either repetitive reflection on suicide, or - in an effort to evoke a connection with the mother - repetitive self-harm (Lyons-Ruth et al. 2013:572). In late adolescence it can culminate in "antisocial personality disorder", "eating disorders" or "borderline personality disorder" (Lyons-Ruth et al. 2013:577).

2.5 The discourses around childbirth

The manner in which women are treated during facilities-based childbirth is to a large extent informed by the medical discourses around childbirth. The natural processes of pregnancy and

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childbirth have exceedingly been repositioned as "medical problems" which need supervision and management (Hewison 1993:226). Language is pivotal in how a sense of the world is constructed - not just as a primary form of communication, but also as a depiction of the "wider social reality" (Hewison 1993:225).

2.5.1 The metaphor of the body as a machine

The implementation of scientific language into the intrapartum realm has afforded maternity care-providers the means to reformulate labour and birth by adopting the "metaphor of the body as a machine" (Hewison 1993:226). Within this model, a woman's body has to achieve certain goals within certain time limits, such as that the cervix should dilate at a rate of one centimetre per hour, in order to ensure a successful birth. Labour as a process governed by nature has made way for labour as a process governed by science. It has been redefined as a "technological process" where science is the authority which controls the "uncertainties" of labour and birth (Hewison 1993:227). However, recent publications are advising against such measures, with the WHO (2018) stating that "the cervical dilation rate threshold of 1 cm/hour…is unrealistically fast for some women and is therefore not recommended for identification of normal labour progression".

2.5.2 Risk

Perhaps most detrimental to the perception that labour and birth are natural processes is the introduction of the concept of risk. Risk necessitates intervention, and by renaming birth a risk, it has legitimised care-providers' endeavours to scientifically control the presumed perils of birth. As a result, it ensures "patient passivity", thereby eradicating women's control over the natural processes of their bodies (Hewison 1993:227). Procedures are explained via a lexicon of medical terms, utilising the "authority" of scientific terminology in effectuating desired outcomes (Hewison 1993:229).

Furthermore, the advancement of strategies to control risk is frequently equated with the rise in litigation risk (MacKenzie Bryers & van Teijlingen 2010:488), along with the concomitant rise in medical malpractice insurance costs, as discussed in section 1.2 above. In healthcare,

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risk, and the supervision thereof, has developed into "a central tenet of care", especially in maternity services (MacKenzie Bryers & van Teijlingen 2010:489), and has resulted in the social model of care being usurped. The social model of intrapartum care is situated within the notion that childbirth is a "natural physiological" occurrence, in which a plurality of women succeed in having a safe, successful, normal birth, without the need for medical management or intervention. Within this model not only is the health and safety of the baby deemed essential, but also the mother's intrapartum encounter, along with her embodied agency. Within the medical model of intrapartum care, in contrast, the careful observation and management of a birth is undertaken in order to ensure a safe delivery. Intervention is the hallmark, and the normality of the birth is proven only "in retrospect" (MacKenzie Bryers & van Teijlingen 2010:490).

One of the consequences of the medicalisation of childbirth is that women are losing confidence in the ability of their bodies to naturally birth their babies, and instead, rely on the medical system to provide support and intervention (MacKenzie Bryers & van Teijlingen 2010:491). Women are inherently reinventing themselves as patients who need care (MacKenzie Bryers & van Teijlingen 2010:493), instead of retaining their identities as healthy women following natural birthing processes. The relinquishing of this power can, in part, be ascribed to the type of risk associated with childbirth. Obstetrics is classified a "high risk clinical speciality" due to the acute outcomes when complications do arise, namely death of the mother and/or infant, or severe brain damage of the baby (MacKenzie Bryers & van Teijlingen 2010:492). All pregnancies and births carry risk; however, monitoring all women from that perspective, on the assumption that something will go wrong, reinforces the dominant medical model of care.

Within this discourse of risk (and the inherent fear it creates) women are becoming hesitant about their abilities to birth naturally, and are more inclined to give birth in a hospital, within a medical model of care, where constant surveillance and its associated interventions are available. However, De Vries (cited in MacKenzie Bryers & van Teijlingen 2010:489) postulates that maternity professionals achieve dominance by "creating risk", through accentuating that which is potentially risky, thereby redefining natural occurrences as risky. Furthermore, by treating labours that are progressing normally as high risk, with the

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interventions associated with high risk labour, these normal labours then indeed become high risk (Kitzinger 2012:303).

2.6 Compassionate communication in healthcare

Given that this study was conducted from a linguistic perspective, it is essential to observe that in a medical milieu, compassion is predominantly shown through communication (Sinclair et al. 2016:8). Clinicians who demonstrate compassionate communication in a clinical setting display the skills of being attentive, listening to what their patients are saying whilst trying to understand it, and giving prognoses in a sensitive and clear manner (Sinclair et al. 2016:8). Compassionate communication can be demonstrated through the following means:

i) Appropriate introductions

Compassionate communication starts from the moment a clinician meets a patient, and is expressed by something as basic as the care-provider introducing themselves to the patient. Over the span of their careers it is possible for clinicians to conduct in excess of 150,000 interviews with patients, making it one of the most frequently performed 'procedures' they'll ever have to do. However, the communication skills required to conduct these interviews in a suitable manner, are hardly touched upon during their education as doctors (Institute for Health Communication 2018).

ii) Attentiveness

Van der Cingel (2011:676) identifies attentiveness as the most important aspect of compassion, which she describes as a “process of intuition and communication”. By being attentive a care-provider consciously endeavours to display interest in what the patient is trying to convey. This involves even small gestures like maintaining eye contact and sitting down next to a patient (Van der Cingel 2011:676).

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iii) Active listening

Another essential component of compassion communication in healthcare is illustrated through the act of “active listening”, as it invites a patient to tell their full story to an audience interested in hearing it. Active listening might not be a pleasant experience for the care-provider though, as communication interactions in a clinical milieu typically articulate suffering. Even though a care-provider may find it uncomfortable or unpleasant to acknowledge the suffering, by repeating back to the patient what has been heard, the care-provider “confronts” the reality of that person, again showing courage in the face of discomfort. It is recognizing this suffering, and confronting it, which ignites the spark of compassion, as the care-provider “legitimises” the person's experience (Van der Cingel 2011:677).

iv) Narrative medicine

Narrative medicine, which is “medicine practiced with... narrative skills of recognising, absorbing, interpreting, and being moved by the stories of illness” is achieved through teaching the narrative processes of reading, writing, reflecting, sharing, and responding (Arntfield et al. 2013:283). This results in clinicians developing the skills of listening attentively and mindfully, reflecting on what their patients narrated by writing about it, and thereby increasing their understanding of, and empathy for, their patients (Charon 2012:4). In the end, these narrative procedures contribute to, or sometimes actually are, the treatment, as they respect and give “voice” to those being cared for (Charon 2015:249).

v) Care-provider vulnerability

The concept of vulnerability on the part of the care-provider is also central to establishing a compassionate communication encounter, and could be achieved by clinicians displaying their own vulnerability through “appropriate self-disclosure” (Sinclair et al. 2016:8). By permitting themselves to be influenced emotionally by the suffering of their patients, whilst communicating and interacting with them, care-providers show compassion. Patients who feel that their care-provider listens, shows interest in them, exhibits a “warm and open”

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disposition, along with being conscious and present, increasingly rate their experiences as positive, whilst simultaneously holding their care-providers in higher regard (Sinclair et al. 2016:12).

2.7 The process of compassionate intrapartum care

i) Recognising suffering

One of the primary antecedents to compassion is the notion of suffering. In order for someone to act compassionately towards another, they first notice the other's suffering, which leads to an emotion or reaction towards the suffering. This, in turn, serves as a catalyst for the actions required to alleviate the suffering. However, in the field of midwifery, care-providers try not to construct the process of birth through use of the term "suffering", as their principal objective is to empower women through the use of supportive and positive language (Ménage, Bailey, Lees & Coad 2017:565), and the term "suffering" carries a negative connotation. In addition (as stated by the WHO above), healthy women giving birth are simply experiencing a "normal physiological process" (Ménage et al. 2017:559), and not a medical treatment, and are therefore not sick patients who are suffering from an illness. However, the fact that childbirth is usually accompanied by extreme physical pain, and concomitant emotional strain, allows it to still be able to evoke the antecedents of compassion in care-providers.

ii) Emotional connection and motivation to act

An emotional bond with a care-provider is one of the most deeply valued features of compassionate intrapartum care. Compassion contains a "spontaneity", which therefore makes it "authentic" and credible, and instils a belief in the patient that the care-provider is genuinely "there for them" (Van der Cingel 2011:681). NICE (2017) emphasises the importance of the establishment of rapport between a maternity care-provider and a woman. The Institute advises that a care-provider should pay special consideration to the "tone and demeanour" of their communication, along with the "actual words" adopted. In their communication guidelines, they list words like "encourage", "discuss", "reassure", "involve", "ask", and "explain", as constituents of establishing rapport. Caring for someone in this manner

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constitutes a partnership-environment between a birthing woman and her care-provider, and sets the stage for compassionate intrapartum care to take place (Ménage et al. 2017:567). This emotional connection mitigates the idea of "the difficult patient" in the minds of the care-providers, and results in nurses who indicate a greater acceptance of the behaviour exhibited by patients. By establishing an emotional connection with their care-providers, patients perceive that they are experiencing "genuine attention", and in return are not so demanding of their care-providers (Van der Cingel 2011:683). This could be beneficial in a maternity ward, where patients are regularly incorrectly labelled as difficult due to the behaviour they exhibit during labour.

iii) Acting to alleviate suffering

Due to the fact that women and their care-providers have entered into a partnership, the implementation of compassionate intrapartum care is achieved through care-providers and birthing women "negotiating" approaches through which suffering can be assuaged or avoided by implementing "shared decision making" (Ménage et al. 2017:568). In addition to compassionate physical care, such shared decision making emanates from good communication whereby care-providers describe and advise women of the risks involved, along with the alternatives available to them, throughout the intrapartum process, with the goal of encouraging "knowledge, understanding and respectful compassionate care" (Ménage et al. 2017:567).

Another way in which a care-provider can act to alleviate suffering is through their "calm presence" (Berg, Lundgren, Hermansson & Walhberg 1996:14). The idea of being calmly present comprises three features. Firstly, women require of their attendants to treat them with respect, and appreciate them as individuals. Secondly, having the perception of trust in their care-provider ensures feelings of safety. This is illustrated by a care-provider who is able to notice what a woman requires, and to take care of her, without the woman having to articulate what she needs. A care-provider might not be actively involved, just quietly aware and conscious, resulting in feelings of safety instead of abandonment. The last feature of being calmly present consists of women wanting to feel "supported" and "guided", but according to their own specifications, and not those of a care-provider (Berg et al. 1996:13). Even during

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emergencies, women would like their care-givers to communicate with them, albeit only for an instant.

2.8 The significant role of compassionate communication during childbirth

International maternal advocacy agency, the White Ribbon Alliance (2015), reiterates Greenfield et al.'s (2016:264) sentiments discussed in Section 1.1, that the relationship between a woman and her maternity care-providers, along with the healthcare system in which she gives birth, is extremely significant. On the one hand, there's the potential to console, encourage and empower a woman; on the other, there is the potential to wreak long-term destruction - both physical and mental. Since a significant portion of care is delivered via communication, ranging from abusive to compassionate, it plays a crucial role in a woman's perception of the type of intrapartum care she receives, and directly impacts her relationship with her care-providers.

2.8.1. Effective communication supported by health advocates

The significance of communication as an element of excellent care in maternity services is reiterated by international health advocates like the National Institute for Health and Care Excellence (NICE), a special health authority that advances counselling and quality measures in public care in the United Kingdom's National Health Service; and the WHO, through its 2016 policy framework on "standards for improving quality of maternal and newborn care in health facilities" (WHO 2016). These organisations advise that women who receive "effective communication, support and compassion" from their care-providers during the intrapartum process feel "in control" of their birth processes, and as if their decisions are important and honoured. It also supports the achievement of a "positive birth experience" (Chang, Coxon, Portela, Furuta & Bick 2018:5). The WHO further advises that maternity care-providers "treat all women with kindness, compassion, courtesy, respect, understanding, and honesty, and preserve their dignity" (WHO 2016), and states that giving birth is a "physiological process" which can be attained without "complications" by the majority of healthy women and their babies. It reports that of the almost 140 million births that take place annually across the world, the majority consist of "vaginal births... with no identified risk factors, either for

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themselves or their babies, at the onset of labour" (WHO 2018).

2.8.2 Nuanced care

Should complications emerge, however, the risk of mortality and morbidity could increase exponentially. Yet, it is through the mitigation of this risk (as discussed in Section 2.5.2), and the increased implementation of interventions and medicalisation of birth processes which this brings, that maternity care-providers contribute to the erosion of women's confidence in their capacity to safely birth their babies, which, in turn, adversely affects their birth experiences (WHO 2018:8). Therefore, the type of care provided during childbirth is nuanced; on the one hand care-providers have as their principal objective the safety of the mother and baby, on the other hand their implementation of measures to ensure this safety frequently leads to women being deprived of their autonomy, which results in them feeling disempowered.

2.8.3 Respectful Maternity Care

In addition to the institutions mentioned above, global maternal-health advocacy agencies like Birthrights, and The Maternal Health Task Force, are increasingly calling attention to "evidence-based" care at maternal health establishments - an approach called "respectful maternity care" (RMC), which purports that maternal care should be "humane and dignified", and be delivered in such a manner that it "respects women's fundamental rights" (Miller, Abalos, Chamillard, Ciapponi, Colaci, Comandé et al. 2016:2181). RMC entails inquiring what women anticipate, supplying them with succinct and transparent facts that aid them in making informed decisions, treating them with dignity and courtesy, and including them in choices about their care (Miller et al. 2016:2185) - all indicators of good communication skills. RMC is the first recommendation in the latest WHO report on types of care required for a positive childbirth experience, followed by effective communication delivered in a "simple and culturally acceptable" manner as the second recommendation, all central to compassionate intrapartum care (WHO 2018).

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2.8.4 Compassion need only be momentary to be effective

Communication is integral to compassionate care. Yet, there exists the notion that compassion takes time, and this notion has frequently been used as a rationalisation for inadequate compassionate care (Bramley & Matiti 2014:2795). Significantly, it has been shown that the time spent on compassionate actions need only be momentary for it to be effective. Even if there is no time for the formation of long-term relationships, "smaller gestures", like the manner in which a care-provider looks at a patient, touches them, places a hand on their shoulder, or listens to them, are deemed adequate. In fact, there is general acceptance of the fact that care-providers (especially maternity care-providers) are extremely busy both internationally (Bramley & Matiti 2014:2795) and in South Africa (Hastings-Tolsma et al. 2018:e36), and it is through these seemingly insignificant gestures that care-providers can truly show compassion. By giving even a portion of the little time they have, care-providers demonstrate that they care. In a busy maternity ward, this can serve as a good starting point for the implementation of increased compassionate communication, as it seems easily achievable.

2.8.5 Doulas

Doulas have been proven to be hugely valuable in the support they provide to a birthing woman, especially in the absence of a partner or family member due the prohibition of (male) birth partners in labour wards (Spencer et al. 2018:6). A doula is "a person (usually without formal obstetric training) employed to provide guidance and continuous support during labour or postnatally" (Oxford English Dictionary 2008). Uninterrupted support during the intrapartum period has demonstrated a host of advantages: women feel protected and free of harm, birth results are improved, and the possibility of unnecessary interventions are greatly reduced (Spencer et al. 2018:1). Furthermore, the likelihood of a "spontaneous vaginal birth" is improved, along with an increase in positive birth experiences, a decrease in the duration of labours, and, significantly, a reduction in instances of post-partum depression (Bohren, Hofmeyr, Sakala, Fukuzawa & Cuthbert 2017:2) A doula is also an effective solution to reducing the workload of midwives and obstetricians. In the public sector it will ensure that women are not left to birth alone whilst care-providers are tending to more urgent births,

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whereas in the private sector women have someone to act as a barrier between them and possible medical interventions.

2.9 The benefits of compassionate intrapartum communication

Intrapartum communication forms the foundation of a woman's perception of her birth experiences. To that end, the benefits of compassionate intrapartum communication are far-reaching and significant.

2.9.1 Physical benefits

On a physical level it has the ability to reduce the duration of women's labours, curtail the amount of unnecessary interventions performed, and diminish women's perceptions of pain, thereby improving “maternal satisfaction”. (Madula et al. 2018:8). It also brings about better birth results, an increase in favourable intrapartum encounters, and, significantly, a decline in post-natal depression and PTSD. (Ménage et al. 2017:564). Furthermore, effective communication leads to satisfied women who are exceedingly more inclined to opt for facility-based birth, thereby directly affecting the MMR (Madula et al. 2018:8).

2.9.2 Emotional benefits

On an emotional level it creates a relationship of trust between a woman and her care-provider, along with imbuing women with the perception of control over their intrapartum processes. This, in turn, further increases “maternal satisfaction”, and leads to women who not only feel empowered by their labours and births, but also have less fear about birth (Ménage et al. 2017:564). In a study aimed at illustrating women's experiences of a very positive birth, Kärlstrom et al. (2016:1) found that the emotional aspects of intrapartum care has the most significant effect on women's perceptions of their birth experiences. By receiving personalised emotional care and being given the freedom by their care-providers to partake in choices about their births, women experience an important sense of control, and describe their care-providers as being “supportive” and “considerate” (Kärlstrom et al. 2016:2). Furthermore, having access to information regarding how far labour has progressed and being given reasons

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for complications that have arisen, has the potential to instil a sense of power and confidence during a possibly overpowering situation. (Chadwick et al. 2014:865)

A positive birth experience results in women perceiving their births as “a very special journey” and an “important moment of life”. It fills them with a sense of pride in what they have achieved and they describe birth as an “outstanding experience” that they feel confident in achieving again. In recounting their positive birth experiences women use words such as “fantastic”, “wonderful”, “magic”, “incredible”, and “significant” (Kärlstrom et al. 2015:3), which is in absolute juxtaposition with the lexicon of trauma used to describe negative birth experiences.

2.10 Conclusion

This chapter provided an overview of the literature pertaining to intrapartum compassionate communication. It supplied an examination, and definition of, the concept of compassion, along with a discussion of compassion in healthcare in particular. Furthermore, the concept of obstetric violence was defined. The chapter provided a discussion of how obstetric violence is inflicted on women, as well as the consequences of, and reasons for, the mistreatment of women in the intrapartum period. Lastly, the chapter discussed the importance of compassionate communication during childbirth, ways in which it can be implemented, along with the benefits of compassionate care. The following chapter provides an outline of the theoretical framework of this study. It provides a multi-perspectival approach by discussing theories in the fields of Discourse Analysis, Interactional Sociolinguistics, and Sociocultural Linguistics as applied to the field of health communication.

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CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

In order to consider the discursive (re)construction of intrapartum experiences, the main theoretical point of departure of this study constitutes an amalgamation of two paradigms, namely Discourse Analysis (DA) and Interactional Sociolinguistics (IS), set within the context of health communication. Aspects of Gee's (2014) theory of DA will serve as the principal theoretical framework of this study. Gee's (2014) theory will be augmented by relevant aspects of IS, especially the approaches adopted by prominent scholars in the field such as Gumperz (2015) and Goffman (1974, 1981). Furthermore, the notion of identity in IS is augmented by Bucholtz & Hall's (2015) Sociocultural Linguistic (SL) approach to identity; and Pennycook (2005) and Butler's (1999) approach to identity performativity. This multi-perspectival approach, whereby various analytical perspectives are incorporated, has been selected as it contributes to the acquisition of various types of knowledge of an occurrence, and in so doing, results in increased insights into the phenomenon (Jørgensen & Phillips 2002:4). The combination of approaches was chosen, therefore, because they all add value to the study of compassionate intrapartum communication, where DA provides the building tasks of reality which would allow for an analysis of the discursive reconstruction of participant's birth experience, and IS and SL provide supplementary information with regard to interaction, as well as adding depth to the examination of identity formation in interactions.

Interactants in an intrapartum communication environment constitute people from diverse backgrounds with different identities, coming together in a potentially stressful context where, through the construction of identities and relationships, the possibility for misunderstanding and power imbalances is rife, thereby directly affecting the level of compassionate care present. Through the tools provided by the abovementioned theories, it is possible to gain a greater understanding of the possible pitfalls - along with the capacity for solutions - in the field of compassionate intrapartum communication.

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The chapter starts by situating the study within the broad field of health communication. It discusses key contributions from both the disciplines of DA and IS, and concludes how these disciplines are valuable to the analysis of communication in a healthcare context. The second part of the chapter provides a broad overview of the field of DA which includes a discussion of five of Gee's (2014) seven building tasks of reality. This is followed by an overview of the field of IS, which outlines key concepts related to this study. Furthermore, enhancing the discussion of identity in IS is a section which relates to identity construction in the field of SL.

3.2 Situating the study in a health communication context

The expansive field of health communication is increasingly drawing the attention of discourse analysts to the myriad opportunities for inquiry it offers. Health communication concerns all the elements and approaches to communication that occur during clinical contexts, or generally relates to the matter of health and disease (Jones 2015:841; Harvey & Adolphs 2012:470). Healthcare is a dynamic field which is in a constant state of change, and DA, through its focus on language-in-use, provides the potential to examine the occurrence and trajectories of these changes (Harvey & Adolphs 2012:470). One of the most significant developments in healthcare over the last decade is the focus on the empowerment of patients, and their positioning as central to the care process. This is demonstrated through the conventional term "patient" which is being superseded, in some contexts, by the term "client", and indicates a departure from a "paternalistic" paradigm of healthcare where the care-provider is at the helm of a patient's health, to a consumer-focussed ideology motivated by choice, shared decision-making, and mutual responsibility (Harvey & Adolphs 2012:471).

Sarangi (2004:1) states that communication is a fundamental feature of healthcare as it forms the basis of every interaction between a care-provider and a patient. Central to this is the fact that these interactions have a cause-and-effect sequence, in that the care-provider facilitates the patient embracing, or altering, certain health-related conduct. Another important development which has been observed through the study of discourse in healthcare is the identification of the disadvantages of a "biomedical model" of healthcare. In order to address the disadvantages of this model, patients' descriptions and narratives about healthcare is

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gaining prominence in current research on health communication, particularly in the examination of the discursive (re)constructions of their experiences (Harvey & Adolphs 2012:471). The comprehensive collection of analytical tools supplied by DA greatly facilitates the manner through which meaning is created in healthcare contexts through these discursive processes (Jones 2015:841). Due to the fact that there is a large spectrum of discourse-focussed studies situated over a spectrum of disciplines, scholars have adopted "theoretical eclecticism" in an effort to integrate these various theoretical perspectives, and to gain a clearer picture of healthcare situated discourse (Harvey & Adolphs 2012:472). Combining fields such as DA, IS, Critical Discourse Analysis (CDA) and Conversation Analysis (CA) allows scholars to scrutinize, explain, as well as critically appraise, current health communication developments (Harvey & Adolphs 2012:472).

3.2.1 Important contributions of DA to the field of health communication

With the focus on the perspectives of patients in clinical interactions, scholars such as Fairclough (1992), Fisher (1991), and Mishler (1984) have uncovered the interactional imbalances, or asymmetries, present in the discourses between care-providers and patients. Fairclough's (1992) CDA approach has exposed how physicians demonstrate power and control during an interaction (through linguistic resources like topic shifts and turn-taking) and thereby dominate the interaction. Through such dominance the physician aims their attention at the medical and scientific features of the patient's affliction, whilst simultaneously overlooking, or disregarding, the social and personal aspects of patient realities (Harvey & Adolphs 2012:475).

Fairclough's (1992) research builds on an influential study by Mishler (1984, cited in Fisher 1991:159) and examines the dichotomy between the medical and the social, which is prevalent in doctor-patient interactions. Fairclough (1992) asserts that the world of medicine is separated into two distinct discourses, namely the "Voice of Medicine" (VoM) and the "Voice of Lifeworld" (VoL). The VoM exhibits a scientific logic which evaluates disease by purely considering the patient's bodily symptoms, without taking into account the social context of the patient's complaint. In contrast, the VoL exhibits a "common sense" logic which considers the social context in which the patient's illness is occurring (Fairclough

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1992:144). Doctors, who are mainly focussed on the bioscientific, communicate almost entirely in the VoM, which is the voice which has dominance during medical interactions, whereas patients, who communicate in the VoL, have less power during these interactions, and therefore have little chance of having their VoL included in the interaction. Health communication thus comprises a merger of various voices or discourses, and the meanings attached to them, thereby illustrating the innate "heteroglossic" nature of the field (Harvey & Adolphs 2012:475, Jones 2015:842).

Also using Mishler's (1984) findings as one of the theoretical departures for her comparison between the communication strategies of nurses and doctors, Fisher (1991:158) concurs that within a medical model, which focusses almost entirely on "medical topics" and almost never on the social facets of patients' lives, the issue to be addressed lies purely in the anatomical realm of the patient, and that any failure or breakdown within the body occur in a "mechanistic" manner, in which the manifestation of the social aspects of patients' lives are not welcomed. This perspective is reminiscent of Hewison's (1993:226) metaphor of the body as a machine, as discussed in section 2.5.1 of the previous chapter. A discourse analytical approach is, therefore, able to reveal and examine how the conflict between a medical model and the social aspects of a patient's life is frequently manifested during interactions in a healthcare context (Harvey & Adolphs 2012:475) and what the effect of that is on participants.

3.2.2 Important contributions of IS to the field of health communication

IS has also been central to the examination of interactions in a health communication setting, as it enables theorists to analyse how interactants travers interactions by contextually and socially positioning themselves in relationship to their listeners, and that which they are discussing, and to focus on the verbal and non-verbal cues interactants employ to compose their actions and identities (Jones 2015:845). The key finding of IS studies in health communication is that interactants are frequently required to traverse various concurrent activities, including conflicting interpretations of those involved in the interaction (Jones 2015:845).

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Another important contribution of IS to health communication is the awareness it has engendered in the field of intercultural communication, and that, instead of ascribing misunderstandings to cultural differences (as purported by the field of medical anthropology), it demonstrates that misunderstandings are more frequently the result of conflicting assumptions which interactants exhibit during an interaction (Jones 2015:846). The concept of "interactive volatility" has been brought to the fore by Iedema (2006:1126, cited in Jones 2015:846), and examines how interactants from diverse backgrounds, with contrasting inferencing habits and discursive strategies, need to collaborate in order to arrive at shared meaning.

Harvey and Adolphs (2012:479) conclude that the analysis of discourse in healthcare settings (albeit from a DA or IS perspective), therefore, firstly broadens the perspective on, and awareness of, the merger of social and medical activities, and, secondly, is instrumental in the generation of more compassionate procedures in healthcare. Furthermore, it allows for a detailed examination of the habitual activities of care-providers and is, therefore, capable of turning the spotlight on possible asymmetrical power relations between care-providers and patients during interactions.

3.3 Discourse Analysis

Discourse Analysis (DA) consists of a collection of interdisciplinary approaches which can be employed to examine various social spheres (Jørgensen & Phillips 2002:1). The inception of contemporary DA can be traced back to the mid 1960s when a variety of unrelated scholars pursued the application of linguistic approaches to the examination of texts. It wasn't until the beginning of the 1970s that DA emerged as an autonomous method of research within, and traversing, various fields (Van Dijk 1985:4). Discourse analytical methods are based on the assertion put forward by structuralist and poststructuralist linguistic philosophies that reality is always accessed through language. Language, therefore, does not merely echo a prior reality, but produces portrayals of reality, and assists in the creation of reality. According to these philosophies, reality, therefore, only gains meaning through discourse (Jørgensen & Phillips 2002:9).

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From its roots in linguistics, linguistic philosophy, social anthropology, and theoretical sociology (Coupland & Jaworski 2001:134), DA is now also deployed in domains such as psychology, artificial intelligence, education, and healthcare, to name but a few (Schiffren, Tannen & Hamilton 2015:1). Coupland and Jaworski (2001:134) state that the consolidated observation which DA makes across all these disciplines is that significant facets of our lives as social beings are formulated through the medium of language, albeit through our day-to-day interactions, or through the ideologies and assumptions which underpin our existence (Coupland & Jaworski 2001:135), and it is through DA that one would be able to analyse and hypothesise about these formulations. Phillips & Hardy (2002:3) support Coupland and Jaworski's (2001:135) assertion that DA examines the process through which social reality is created and perpetuated. They describe DA as an epistemological methodology which not only demonstrates how humans obtain knowledge about their social reality, but also provides tools for investigating this knowledge.

Johnstone (2007:2) states that discourse analysts usually define 'discourse' as "actual instances of communicative action in the medium of language", whereas Jørgensen and Phillips (2002:1) expands on this notion by broadly defining discourse as a certain manner in which one speaks about and makes sense of the world, or elements of it. For an analytical approach to be considered discursive it requires the performance of an "interpretive analysis" of a type of text, with the goal of arriving at insights into discourse and its influence in establishing social reality (Phillips & Hardy 2002:10). In contrast to various qualitative research methodologies which aim to comprehend and clarify reality, the significance of DA lies in the fact that it seeks to reveal the manner in which reality is produced through discourse. DA, therefore, maintains that knowledge about the world cannot be generated independently from discourse (Phillips & Hardy 2002:6)

3.3.1 Gee's (2014) theory of Discourse Analysis

Gee (2012:5) defines DA as the study of language-in-use, and states that it examines how "social and cultural perspectives and identities" are (re)constructed through spoken (and written) language (Gee 2011:i). DA involves the systematic study of language in social contexts where it creates meaning, aids in the formation of identity, and allows the

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achievement of specific aims (Gee 2012:5). Gee (2011:16) states that language-in-use is inherently about *saying* (informing), *doing* (activities), and *being* (socially significant identities). Through saying, doing, and being, humans execute particular practices, which then, at the same time, imbue their saying, doing, and being with meaning. The practices enacted are always socially, culturally, or institutionally constructed, and therefore, also permeate these domains. Through language-in-use, interactants are able to "shape, produce, and (re)produce" the world, and at the same time be shaped by the world itself. This action of "mutual shaping" has the potential to influence a person's life at a deep level. The significance of DA, therefore, lies in the fact that discourse itself is significant (Gee 2012:5).

Through this "world building", people are constantly and resolutely employing language to build various areas of reality (Gee 2014:91). One way this is achieved is through the register, or social language, which they adopt (Gee 2014:61). For instance, the use of specialist language, like the language used in the field of medicine, constructs, (re)produces, and perpetuates the field of medicine in the world. However, language can also be used to destroy things in this world, like relationships. For example, there is frequent discord between someone's "life-world" (the space in which people operate as "everyday" people using "everyday knowledge") and more authoritative claims to knowledge (Gee 2014:77), like the specialist field of medicine, which can result in the breakdown of provider-patient relationships. An intrapartum environment is one instance where conflict can arise between a patient's life word and a specialist claim to knowledge. It is a milieu where care-providers frequently adopt the language of science and medicine (VoM), which is often juxtaposed by the everyday language used by mothers (VoL). The contrast is especially prevalent in public maternity settings, where mothers are often not that educated, and the use of specialist language to describe and explain things has the potential to lead to a breakdown in communication, and in turn, a breakdown in care-provider and patient relationships. The analysis of the type of social languages used in an intrapartum environment, and the effect this has, is therefore crucial.

Building the world of activities, identities, and institutions is usually achieved habitually, or routinely. However, if these worlds are not constantly rebuilt through language, they will expire. Furthermore, if they are altered during their construction, they adapt and modify,

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which results in "transformation" (Gee 2014: 91). The transformation of worlds can have a very positive effect. For instance, if there is conflict within these worlds, such as tension, misunderstandings, or power struggles, it is possible that interactant's communication choices could result in the destruction of their relationships. However, through its examination of these problems, DA can aid in people's comprehension of the context in which the interaction takes place and, if not completely rectify it, can attempt to make it "righter" (Gee 2014:43). This, then, can ultimately lead to the transformation of less than ideal communicative practices. To Gee (2011:12), it is crucial that DA not only examines and illustrates the functions of language-in-use, but that it also adds value with regards to awareness and intervention in critical issues that affect us as social beings. The relevance of DA, therefore, to this study is ascribed to the fact that it facilitates the examination of the objectives and structures of language situated within the patterns and associations present in healthcare interactions. This, in turn, could lead to findings which have the potential to contribute to intervention in abusive intrapartum practices.

3.3.2 The importance of context in DA

Consideration of the context in which discourse is produced is essential in DA, and central to comprehending language-in-use. Gee (2011:100) defines context as "the physical setting of communication and everything in it". This comprises aspects such as the "bodies, eye gaze, gestures, and movement" of the interactants, along with everything that had been communicated or accomplished earlier in the interactions, and lastly, any mutual knowledge (including cultural knowledge) the interactants possess. This type of knowledge is usually assumed and implicit. It is up to the listener to take into account that which was said, along with the (frequently unspoken) context, to be able to infer what the speaker intended to convey (Gee 2014:18).

Speakers utilise various tools to construct the context such as, amongst others, the use of deixis, the choice of subjects and predicates, and intonation. Deictics, or "pointing words", are lexical items which require context to determine what they refer to, and are categorised according to person, time, and place (Gee 2014:14). Deictics, therefore, directly connect the context to the utterance. Speakers assume that listeners will be able to deduce deictics'

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reference from context, but if they don't successfully do so, misunderstandings could occur (Gee 2014:15). For example, when a midwife says to a patient, “He's so grumpy”, the care-provider assumes that a previous conversation they had about a nasty anaesthetist is sufficiently salient for the patient to understand who the midwife is talking to. A second tool which speakers use to construct the context is the strategic selection of subjects and predicates in an utterance. It establishes how listeners should structure the information mentally, along with how they should perceive what is being spoken about, and is one of the fundamental grammatical tools in DA (Gee 2014:25).

Another essential tool a speaker uses to create the context is intonation, as it determines the amount of information saliency a word or a phrase has in an utterance (Gee 2014:34). The information saliency, or importance, a word has is usually increased when the information it provides is new, and when the word is unpredictable. The information saliency of a word is indicated through the speaker's intonational contour, in other words, with how much stress the word is uttered (Gee 2014:31). Through the speakers' intonation contour, they are able to manipulate which part of the utterance should be given priority, and which part is of less importance. It also gives the listeners important information about the speaker's mindset and emotions (Gee 2014:34). Speakers are, therefore, not just purely conveying information, but are also endeavouring to construct and negotiate meaning.

Lastly, the notion of “reflexivity” is crucial in understanding context in interactions. Gee calls it a “magical” characteristic of language (Gee 2011:101), and it refers to the fact that language has the ability to concurrently reflect and construct the context in which it is applied. For example, when a nurse is having a conversation with a doctor, facets of the context (the fact that they're in a work relationship) already exists in the world. Yet, facets of the context is also simultaneously (re)produced through the conversation, for instance, the manner in which the nurse speaks (deferential and polite), characterises the relationship as one being formal and respectful. The fact that the doctor and nurse have a work relationship exists even if they are not having a conversation; however, the work relationship could potentially be terminated if the conversation is not one that is respectful. Utterances, therefore, reflect the context, and, in turn, the context reflects or shapes the utterances.

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3.3.3 Gee's Building Tasks of Reality

In this section, five of Gee's building tasks of reality are discussed, namely Significance, Activities, Identities, Relationships, and Politics, as the main theoretical and analytical departure of this study. However, the building tasks of Identities, Relationships and Politics will be supplemented by key studies in the field of IS and Sociocultural Linguistics in order to provide a broader perspective on those tasks.

As mentioned in section 3.2.1 above, people are continually building the worlds of activities, identities, and institutions through language-in-use. Gee (2014:94) states that along with language-in-use, people also use non-verbal devices such as "objects, tools, technologies" and particular ways of "thinking, valuing, feeling, and behaving" to construct their worlds. Through communication people consistently and concurrently construct one of the domains of "reality". Context is central to these building tasks, as world building rests on what is explicitly said, but also on what the speaker indicates about the context and it relevance to the listener's interpretation (Gee 2011:101). Furthermore, there is frequently more than one word or grammatical selection at play in one building task, as well as more than one building task operating at the same time. For clarity, they will, however, be discussed separately.

3.3.3.1 The Significance Building Task

The first of Gee's (2014:95) building tasks of the world is significance, and refers to the fact that people formulate things as important, relevant and meaningful through the way in which they use language. The opposite is also possible, where people minimize the value of something, making it less significant through their language and grammatical choices (Gee 2014:98). Although various grammatical choices can add or detract from significance, the principal device for building significance is the selection of information contained within the main clause of an utterance. This is the information which is "foregrounded". Alternatively, any information contained in a subordinate clause is that which is "backgrounded", or made less significant, and also refers to information which listeners are expected to assume or infer. It is the foregrounded, or significant, information which the speaker expects the listener to react to, by either concurring or contradicting it (Gee 2014:98).

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Another way of building significance is to foreground information that seems irrelevant. This usually pertains to phatic communication, the main purpose being to create social harmony, or to be polite. A comment on the weather, for instance, therefore, does not really in all instances refer to the weather, but rather to an attempt at social pleasantry. Due to the fact that the comment about the weather is unimportant, the fact that it is foregrounded makes it significant, and therefore allows the listener to attach new meaning to it, for instance, that the speaker is attempting to be polite in order to maintain a cordial relationship (Gee 2014:100).

In an intrapartum interaction that which is foregrounded or backgrounded could provide pertinent devices for analysis. Interactants in such an environment could have contrasting views on what is deemed significant. The birth of a child is a momentous event in most people's lives; however, for maternity care-providers, who see many babies born a day, the event might not hold the same significance as it does for the mother. For the care-provider it forms part of routine work where the safety of the mother and baby is their first priority, whereas for the mother it is a life-changing event filled with many and mixed emotions, along with feelings of vulnerability, and the need for kindness and compassion. The care-provider might foreground medical requirements and the language of science, whilst the mother converses within her lifeworld context. Misunderstandings and different expectations, especially in light of the multi-cultural context of many birth settings, could come to the fore, and by investigating how language is used to contribute or reduce significance, some of these misunderstandings might be reduced.

3.3.3.2 The Activities Building Task

Through language-in-use people are able to, in addition to merely saying something, achieve a variety of actions, for example to inform, promise, and console. Actions can be executed via direct and indirect speech acts and are present in every speech utterance (Gee 2014:51), for instance a nurse which encourages a mother to breathe, or a mother who expresses her vulnerability. It refers to that which is being done through language, and the focus is on the here and now (Gee 2014:103). Activities (also called “practices”) are composed of a series of actions, and the focus is on how this series of actions accomplish aims which are meaningful, socially acknowledged and understood, as well as perceived as institutional or cultural

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standards. Actions, therefore, have institutional, cultural, and social relevance, or significance (Gee 2014:103). A midwife in a public maternity setting could, for instance, have a more autocratic way of "caring" for a mother, whereas a home-birth midwife could have a more compassionate and inclusive way of caring, both of which reflect the values of the institutions and social groups which govern them.

In order to achieve an activity, interactants need to, through discourse, construct, execute, and create the activity from scratch every time. Furthermore, for the activity to be socially recognisable, it is required to follow a pattern related to that activity. DA allows for the analysis of the patterns or frameworks related to activities. Should an interactant deviate substantially from the pattern, it is possible to detect a potential transformation of the activity (Gee 2014:104). Furthermore, despite an interactant following the framework of an activity, it is still within their power to accomplish their own "agenda" (Gee 2014:105). Interactants are also regularly engaged in concurrently accomplishing one or more of the other building tasks, for instance to create social relationships whilst performing an activity (Gee 2014:107). For example, the intake procedure at a hospital (activity) is generally rather rigid, routine, and usually completed in the same manner. However, interactants are still able to create a caring relationship through the use of phatic communication imbedded within the structured intake session, or, alternatively, the need for a purely professional relationship through the use of specialist language. Social activities, therefore provide abundant possibilities for people to conduct social work, while simultaneously "hiding" within an activity and its norms (Gee 2014:108).

3.3.3.3 The Identities Building Task

Gee's (2014:112) third tool examines the construction of identity through language-in-use. It is through the means of language that interactants are identified as having adopted a particular role or identity. Each person has a repertoire of identities which they enact in various social contexts, for instance at work a person might portray the identity of a no-nonsense nurse, whereas at home she takes on the identity of a caring mother. Each of the identities an interactant portrays can impact on their other identities. Due to the fact that people are all members of various social groups, cultures and institutions, with distinctive roles within each,

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interactants have to employ language and actions appropriate to each, in order to be identified as portraying the applicable identity.

An important aspect in the study of identity is that of a “lifeworld identity”. It is the principal identity which every person can enact, and refers to their identity as an “everyday person”, and not as that of a professional or expert. Within a person's lifeworld identity they communicate according to the dialect of the culture to which they belong. Because a person's lifeworld identity is closely linked to their culture or social group, there exists a contrast between the identities amongst people from various cultural or social groups (Gee 2014:113). When communicating from the perspective of a lifeworld identity, people adopt various versions of what Gee (2014:113) calls a “vernacular” expression of language. The vernacular also varies across interactions within the lifeworld context, where, for instance, a woman would converse in one way with her child, in another with her partner, and yet in another with her parents.

When people communicate, however, from the perspective of identities outside of their lifeworld identity, for instance from the perspective of their professional identity, they adopt various “social languages” or registers. The language of medicine adopted by care-providers, or the academic language adopted by professors whilst lecturing to their students, are examples of such registers. Social languages, therefore, refer to the array of languages (or even a combination of languages) which are related to a particular social identity, for instance our professional identity. In order to be recognised as portraying a specific social identity, it is important that the typical lexicon and grammar associated with that social language is adopted (Gee 2014:162). It also allows people to be recognised as performing the actions and activities related to that identity (Gee 2014:163). It is important to note that the specialist language of medicine, with its more formal sentence constructions, could be construed as aloofness, thereby dissociating a mother and a care-provider, affecting their interactions negatively.

Another way in which interactants enact their social identities is to compare or contrast their identities to others. Frequently certain social identities are unable to continue without others embracing or enacting associated identities (Gee 2014:115). This is demonstrated in the intrapartum milieu, for instance, where a midwife is unable to be a midwife without the

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presence of birthing mothers. Identities are also enacted by "inviting" listeners to embrace a certain identity themselves. This refers to a speaker "positioning" the other in a particular manner (Gee 2014:116). This could be done in a positive or a negative manner, for instance, to incorrectly position a fearful first-time mother as an uncooperative and difficult patient, or, on the positive side, to invite them to partake in decisions over their labours, and thereby positioning them as a "partner" in the birthing process. The analysis of such positioning is significant in the study of types of intrapartum care, especially now that an ideology of "patient-centred care" is starting to permeate the medical environment, in which patient empowerment and autonomy are seen as central to the process of care (Schrewe, Bates, Pratt, Ruitenberg & McKellin 2017:664). DA is, therefore, useful in facilitating the analysis of how interactants position their own identities as well as those of their listeners within an interaction. Due to the myriad of enacted identities relevant to this study, for instance those of care-givers, midwives, nurses, and mothers, the analysis of identity is particularly valuable in providing insight into the manner in which it is constructed, the meaning which these constructions creates, as well as the consequences of these enactments. DA is, therefore, interested in examining how people articulate their various social identities through language-in-use, and the effect it has on others, along with the meaning it creates.

3.3.3.4 The Relationships Building Task

Related to the construction of identity is Gee's (2014) relationships building task. The identities that interactants construct in any interactional context is frequently informed by how they interpret and define their relationship with, not only other interactants individually or as groups, but also institutions (Gee 2014:120). Although the two tasks are closely associated, they are not, however, identical, as it is the identities of interactants that construct the framework in which relationships are formed. Furthermore, the type of relationship an interactant has with another will be dependent on the type of identity the speaker positions the listener as having (Gee 2014:121). For instance, a compassionate care-provider and a happy mother would be engaged in a reciprocal, respectful, empowering relationship, whereas a dismissive care-prover and overly anxious mother could result in an abusive and neglectful relationship which could cause great physical and mental damage.

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The objectives of identity and relationship formation during an interaction pertains to the manner in which speakers position themselves, regulate both their own and their listeners' face needs (discussed in Section 3.3.3.5 below), and mediate power and "social distance" through interactions (Coupland & Jaworksi 2001:136). Interactants usually have multiple objectives during and interaction such as the accomplishing of actions and activities, and/or identity and relationship building goals, either simultaneously, or with an emphasis on one goal over another (Coupland & Jaworksi 2001:136). For instance, the camaraderie between a group of nurses could at the same time establish their relationship as friendly colleagues, as well as their "in-group" identity as nurses, whilst simultaneously illustrating their divergence from "out-group" members like patients or doctors.

Another good example of the many levels on which relationship formation can take place in healthcare lies in the notion of someone being in a "helping profession" (Gee 2014:121). Care-providers are believed to be duty-bound to help those in their realm of care, and should, therefore, be implicitly compelled to assist them. By defining a care-provider as being in a helping profession it, by implication, also defines the care-provider's relationship with the medical institution they work for, as well the institution itself as a system in which help is to be found. The person seeking care at this institution, at the same time, forms their relationship with the care-provider as that of a person in need of care. Some care-providers don't, however, always assist those in need of care, for instance those that do not have sufficient funds to cover the cost of their treatment. Relationship building is, therefore, fraught with risk, as the relationship an interactant seeks to build might not be reciprocated (Gee 2014:122).

3.3.3.5 The Politics Building Task

Gee (2014:124) refers to "politics" not in the conventional sense of the word, but rather to those situations where the dissemination of "social goods" are at stake. Social goods refer to that which society or (sub)groups within society deem as "a good worth having", for instance like treating others kindly. Some social goods are seen as universal social goods, whereas others are only seen as beneficial to certain subgroups of society. In an intrapartum environment being included in decisions on labour interventions could be seen by mothers as a social good, for example. The dissemination of social goods can also result in disagreement,

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or disputes, if interactants deprive one another of a particular social good, or if they misunderstand the social good the other is trying to give them. For instance, if one interactant prefers a more formal, deferential relationship, and another would like to be treated more congenially, it could result in conflict or disappointment during an interaction (Gee 2014:125).

Language can, therefore, be utilised to distribute or withhold social goods, and can, as a result, affect an interactant's face requirements (Gee 2014:125). Drawing on Goffman's (1967) theory on face and facework, and Brown and Levinson's (1987) politeness theory, Gee (2014:125) states that the concept of "face" is a significant aspect of the notion of social goods. Even though these theories hail from the fields of IS (Goffman 1967) and Pragmatics (Brown & Levinson 1987) they are applicable to DA because an individual's face wants can be equated to the distribution or withholding of social goods, thereby linking it to Gee's (2014) Politic's Building Task. Gee (2014:125) states that face wants centre around the perception of value or dignity every person has of themselves, and which they wish for other social groups or individuals to respect. Roberts and Sarangi 2005:634 described it as a "ritualistic element" which focusses on the "fragility" of human social relationships. Face has the potential to be lost ("losing face"), and preserved or augmented ("saving face") (Goffman 1967:9), the latter which is usually navigated through approaches aimed at politeness, with choices on the level of candidness or indirectness, as well as on how casual or deferential to be. During interactions where there is an unbalanced distribution of power, such as an intrapartum care setting, efforts at confronting the more powerful party are usually assuaged through the use of modal auxiliary verbs like "might" or "could", and utterances like "I think" (Roberts & Sarangi 2005:634).

Expanding on Goffman's (1967) face theory, Brown and Levinson's (1987:13) theory on politeness asserts that interactants always have two primary face wants, namely, "negative face" wants, or "positive face" wants. Negative face wants pertain to an interactant's need for privacy which they do not want others to infringe upon; whereas positive face wants concerns the instances where an interactant want to feel that they are part of something and are participating, rather than being excluded. It is the dichotomy between these types of face needs that imbues an intrapartum interaction with the potential for difficulty. On the one hand

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birthing mothers have an inherent need for privacy, and want to be spoken to in a manner which respects their need for privacy; on the other, they also wish to feel included and as if they are participating in their own birth processes.

Another significant aspect of social goods is the inherent need humans possess to have themselves, the way in which they act, and that which they own, considered as natural, suitable, legitimate, deserving and acceptable. If this does not happen, in other words if such social goods are withheld, it has the potential for significant disagreement and animosity (Gee 2012:126). The distribution, withholding, and mediation of social goods, as constructed through lexical and grammatical choices, can therefore be seen as "political", as it is within the realms of government and politics where such decisions over social goods are usually made.

In a primary healthcare context, especially in the intrapartum sphere, interactants frequently need to negotiate social and cultural "taboos", and the potential loss of face (Ragan et al. 1995:189). Furthermore, face wants acquire additional significance in situations where both interactants construe it as intrusive (Ragan et al. 1995:188). The conducting of pelvic exams, for example, could be perceived as a face threatening action by the mother, as well as being a possibly awkward experience for the care-provider, if not managed discursively in a sensitive manner. Goffman (1955, 1959, cited in Ragan et al. 1995:188), however, proposes that should the physical consequences of saving face be riskier than the loss of face, the face threat may, in fact, be justified. For instance, in an intrapartum scenario, the risk of not performing the pelvic exam, and thereby not gaining crucial information, might be considerably weightier than the possible uneasiness or humiliation of the actual exam.

Notwithstanding the above, there are still various ways in which a care-provider can facilitate face saving strategies during an interaction with a mother. The manner in which advice is imparted, for instance to not frame it as instructions but rather as recommendations, has the ability to promote a woman's participation in decision-making processes, as well as her ability to save face in a potentially face threatening environment and refers to Brown and Levinson's (1987:132) notion of a negative politeness strategy. Adopting an interactional approach which does not involve berating, or admonishment of, the mother lets her feel included, as well as

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establishes her as an active participant in her birth processes (Ragan et al. 1995: 191-193). It is also possible to give advice in a conversational tone, employing aspects of phatic communication, which results in more personalised and compassionate encounter (Ragan et al. 1995:198).

However, many care-providers conclude that it is their "institutional right" to dominate the interaction, stipulate treatment plans, and to establish their control over the encounter (Ragan et al. 1995:191). Such encounters are usually conducted in a patronising or condescending manner, in which "orders" are given, and can result in negative face threats, but also instil patient passivity (Ragan et al. 1995:193). Alternatively, when interactants approach the clinical encounter in the spirit of partnership, both participants display enthusiasm for clearing up any misunderstanding without the loss of face for either of them (Ragan et al. 1995:198).

3.4. Interactional Sociolinguistics

Interactional Sociolinguistics (IS) is a theoretical and methodological approach to discourse analysis which examines the language used by people in one-on-one interactions (Gumperz 2015, Jaspers 2012). It has evolved from a vast range of disciplines, such as dialectology, conversation analysis, ethnomethodology and linguistic anthropology (Jaspers 2011:135), with the goal of establishing approaches to qualitative analysis that explains the ability to interpret that which interactants aim to convey during interactions, as well as to provide perspectives on broader social practices and ideologies (Gumperz 2015:309). IS, therefore, provides a "microscopic and insider" perspective on far-reaching social movements that are inherently reliant on these miniscule instances of interaction (Jaspers 2012:141).

3.4.1 Contextualisation and inferencing

IS operates from the premise that it is not possible for interactants to categorically communicate everything they mean, and have to, therefore, due to this "incompleteness of talk" rely on "extra-communicative" knowledge to construe or hypothesise about how what is said, is applicable to the current situation, and what the speaker aims to communicate (Jaspers 2012:135). The focus of inquiry thus pertains to not just inferring the meaning of an utterance,

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but also to determine how evaluation and interpretation of an utterance pertains to the "linguistic signalling processes" whereby it is negotiated (Gumperz 2015:312). Also called "contextualisation cues", these signalling channels run concurrently with spoken words and can be both vocal, consisting of prosodic elements such as intonation, accent or code-switching; or non-vocal, which refers to posture, gaze, gesture, etc. (Jaspers 2012:136); and usually operate in groups or clusters. Contextualisation can be either explicit, or implicit. It is in the latter (and mainly vocal aspects of these cues) which IS is interested, due to the fact that it has the potential for intricate interpretive value. Prosodic elements do not convey much in terms of meaning in isolation, however, it is when they are examined within a certain context, that meaning transpires (Japers 2012:137). The concepts of contextualisation cues and inferencing in IS is closely related to how Gee (2014) describes context in DA. As discussed in section 3.3.2 above, Gee (2014:18) also refers to the implicit nature of the knowledge which a listener needs to draw on in order to infer the context of an utterance. Furthermore, the tools which interactants use to infer context (namely, deictics, subjects and predicates, intonation, and reflexivity) (Gee 2014), are related to Gumperz's (2015:312) notion of contextualisation cues. The combination of these theories, therefore, provide a more in-depth understanding of context in discourse analysis.

Gumperz (2015:310) argues that all communication is deliberate and set in inferences that rely upon the expectation and acceptance of reciprocal "good faith", that is, that interactants have faith in the fact that the other interactant will appropriately interpret their words. An interactant's sociocultural history plays a critical role in what it is they infer during an interaction. They, therefore, also require of those they interact with to be cognisant of the social world that transcends the boundaries of the current interaction. Misunderstandings or unsuccessful inferences breach the speaker's confidence in the expectation that the hearer shares their view on what contextual knowledge is applicable, which culminates in social repercussions (Jaspers 2012:135). Even if the interaction runs smoothly, if a participant is construed as breaking the boundaries of the expected cues, they could still be penalised, and be considered inarticulate or ill-mannered (Jaspers 2012:137). Furthermore, social repercussions are aggravated in instances where there is anxiety or tension, or when interactants are not of the same social standing, like in many intrapartum interactions.

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3.4.2 Interactive frames and footing

Another aspect central to IS is Goffman's (1974, 1981) theory on the concepts of framing and footing. Goffman (1986:10) defines framing as "definitions of a situation" and describes it as a type of "filtering process" through which widespread beliefs, attitudes and conventions are reconstructed and redirected to become applicable to the present interaction (Gumperz 2015:311, Roberts & Sarangi 2005:634). During an interaction the frames provoke certain inferences through the construction of various "scenarios" (Roberts & Sarangi 2005:634), and is useful for the analysis of how interactants formulate and understand social interactions, including how they construct footings or "alignments" (Gordon 2015:325).

Goffman (1981, cited in Roberts & Sarangi 2005:634) adapted the notion of "putting something on proper footing" to illustrate the manner in which social roles and relationships can be altered amidst an interaction. An adjustment in footing indicates an adjustment in the "alignment", or a re-positioning of interactants to each other, and is signified through the manner in which interactants control the construction, or acceptance, of an utterance (Goffman 1981:128). Furthermore, there is also an alignment between listeners and utterances, which is referred to by Goffman (1981) as "participant frameworks", and pertains to the manner in which speakers align themselves to listeners by the manner in which they regulate their utterances within a certain interaction (Roberts & Sarangi 2005:634).

During an intrapartum interaction, a care-provider could, for instance, set up a frame for a formal medical encounter in order to gain information on where the mother is in her birthing process. The mother could, due to her vulnerability in the moment, not respond accordingly. The care-provider could then change footing and introduce a frame of small talk in order to let the mother feel more at ease, before reverting back to the more academic frame to elicit medical information. An analysis of the frame and footing in an intrapartum encounter could, therefore, provide valuable hypotheses about the potential pitfalls in such encounters. IS, then, aims to illustrate three things: firstly, how relevant contexts are inferred through communication; secondly, how and whether these inferences are perceived by others; and thirdly, how this communication, and its reception affects future interactions (Jaspers 2012:136).

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3.4.3 Diversity in IS

Due to the intrinsic cultural and linguistic diversity present in current social interactions, IS's interpretation of diversity is fundamentally semiotic, as it examines the signalling channels or contextualisation cues that have an influence on interaction, along with the conversational inferences present in an interaction (Gumperz 2015:313), all of which are grounded in the interactants' varying cultural backgrounds. Gumperz's (1982a, 1982b, 1991, cited in Gumperz 2015:320) seminal studies on diversity in "urban workplace settings" focus on nonprofessional interactants who were placed in stressful instances of performance appraisal by professionals. Due to their different communicative cultures and backgrounds (those of professionals versus non-professional), the professionals used contrasting inferencing procedures to those of the nonprofessionals, and therefore had contrasting background expectations. This could also occur in stressful intrapartum situations where highly educated doctors (professionals) could have different inferencing habits to, for instance, uneducated mothers, and therefore difference communicative cultures and backgrounds, One of the main aims of IS, therefore, is to demonstrate how diversity influences inferencing (Gumperz 2015:314), which makes it an appropriate lens through which to examine interactions in potentially stressful multi-cultural, multi-identity intrapartum interactions that aim to ensure the physical well-being of mothers and infants, but also has a significant influence on their emotional states.

3.4.4 Bucholtz and Hall's (2005) Sociocultural linguistic approach to identity

Sociocultural Linguistics (SL) is a wide-ranging interdisciplinary approach which focusses on "the intersection of language, culture, and society" and presents a broad sociocultural linguistic view on identity as created on the interactional level, whilst examining not only the elements of language, but also the mechanisms of society and culture. The benefit of sociocultural linguistics lies in the fact that it is an amalgamation of several social disciplines, such as sociolinguistics, discourse analysis, and social psychology, and thus provides an interdisciplinary perspective which allows one to apply all these disciplines synchronously in the study of identity construction (Bucholtz & Hall 2005:586).

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Bucholtz and Hall (2005:586) devised a framework consisting of principles through which the production of identity may be analysed, focussing specifically on the interactional level. They suggest the analysis of identity as a "relational and sociocultural phenomenon" which arises in, and permeates, the interactional aspects of the immediate discourse framework, rather than the view of identity as a fixed construction situated in an individual's mind, or in rigid social dimensions, as it is in interaction, they assert, where social meaning is created. Furthermore, they assert that identity is an intersubjective construct which concurrently functions in various positions, and defines it as "the social positioning of the self and other". These concepts are closely related to Gee's (2014) notion of identity (discussed in section 3.3.3.3 above). Gee (2014:112) states that each person has a collection of identities which impact not only on each other, but also on the identities of those they are interacting with. Furthermore, Gee (2014:116) supports Bucholtz and Hall's (2005:586) notion of the social positioning of the self and others, by asserting that interactants invite others to embrace a certain identity, along with positioning others' identities in a certain manner. Coupland and Jaworski (2001:135) assert that DA's theoretical point of departure can be classified as "constructivist" due to the fact that it fundamentally declares that the realities we understand as those that construct our social contexts and identities, are mainly constituted socially, thereby echoing Bucholtz and Hall's (2005:586) notion that identity is an intersubjective construct. Due to the fact that identities in an interaction are reciprocative, the identity of one interactant has an influence on the identity of the other. The results of these interactions is that "social meaning" transpires, and that the identities of all interactants can evolve during an interaction (Coupland & Jaworski 2001:135). The notion of identity in DA is, therefore, complimentary to the view of identity in sociocultural linguistics, and results a more in-depth view of the concept.

Bucholtz and Hall's (2005) principles most relevant to this study, namely the emergence and relationality of identity as a concept, will now be discussed further.

i) The emergence principle

The first principle focusses on the ontological status of identity, and stems from the notion of emergence in IS and linguistic anthropology. It confronts a conventional academic perspective which states that identity resides mainly within a person's psyche, and thus only

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echoes their inherent mental condition (Bucholtz & Hall 2005:587). The principle asserts that identity should primarily be considered as emerging from, instead of residing in, linguistic and other sign systems, and is therefore essentially a cultural and social occurrence. Yet, it does not eliminate the likelihood that identity construction might be influenced by systems like ideology, linguistic structure, or a combination of the two (Bucholtz & Hall 2005:588). This premise closely echoes the views of Pennycook (2004) and Butler (1999) in their seminal studies on the concept of identity performativity.

Pennycook (2004:1) purports that the concept of performativity allows for an examination of language and identity which proposes that identities are constructed in the "linguistic performance", and emerges from social interactions and not merely from foundationalist beliefs. This supports Gee's (2014:163) notions that the performance of the social actions and activities related to an identity, allows the recognition of an interactant's identity. In fact, performativity has developed into a fundamental concept in anti-foundationalist ideas around identity, gender, and sexuality (Pennycook 2004:8). Central to this field is Butler's (1999:33) influential work on gender and identity in which she maintains that gender is performative in that it is "constituting the identity it is purported to be". This means that gender is consistently a "doing", however not by a subject who "preexist(s) the deed". According to this, performativity can then be understood as the manner in which interactants perform identity as a continual succession of socially and culturally informed performances, and not as the enactment of a preexisting identity (Pennycook 2005:8). Butler (1999:43) further maintains that it is this continual repetition of gender allocation which accumulates into the production of the person's gender identity, and also the notion of gender as a construct imbued with social meaning. It is important to note that the production of an identity is not a pre-elected preference, but instead transpires within a "highly rigid regulatory frame" which results eventually in "the appearance of substance, of a natural sort of being" (Butler 1999:43). Identity is, therefore, not an expression of an inherent quality, but rather the result of performance during interaction (Bucholtz & Hall 2005:590).

The concept of identity performativity is particularly applicable to the examination of identity formation in a clinical environment. Studying the discourses adopted by medical students during their training at a hospital, and the professional identities performatively constructed

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through these discourses, it was found that these identities are, in fact, through repetition, formed by the discourses inherent to this medical context (Schrewe et al. 2017:658). Furthermore, these professional identities are also inevitably created performatively through their discursive formulation of what it means for the other to be a 'patient' (Schrewe et al. 2017:664). Their professional identities are, therefore, related to the identities they construct for the people in their care. This leads to the next principle of identity construction, namely that of relationality.

ii) The relationality principle

In asserting that identity is a relational occurrence, Bucholtz and Hall (2005:598) intend to achieve two goals: firstly, to emphasise the opinion that identities consistently obtain social significance in relational to other relevant identities and interactants present in an interaction, and, therefore, are not independently produced; and, secondly to challenge the widely held, yet simplistic, belief that the relationality of identities is only ascribed to their “sameness and difference”.

In order to illustrate the fact that they are distancing themselves from the conventional beliefs on relationality, Bucholtz and Hall (2005:599) adopt the terms “adequation and distinction” instead of the traditional concept of “sameness and difference”. Adequation refers to the notion that for interactants to be described as similar, it is not necessary, nor, in fact, possible for them to be alike, and that they only need to be perceived as adequately similar within the relevant interaction. When adequation takes place, everything that is considered extraneous and detrimental to current identity construction will be minimised, and pertinent and complementary correlations will be augmented. The counterpart of adequation is the notion of distinction, which examines that which is distinct, or contrasting, between identities in an interaction. Due to the fact that it is easily detectable and frequently produced through language, it has garnered a lot of interest in the academic study of identity relation. Distinction is reliant on the elimination of correlations that would obstruct the enactment of that which is different in identity relationality (Bucholtz & Hall 2005:600).

The second set of intersubjective identity relations is that of “authentication and

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denaturalisation" which refers to the methods though which interactants assert credibility or "realness", and duplicity or "artifice" in an interaction. On the one hand, authentication examines the manner in which identities are validated through discourse, and is inherently a social process. On the other hand, denaturalisation investigates the manner in which expectations about the continuity of an identity can be fractured (Bucholtz and Hall 2005:601). It observes the manner through which identities are devised, and are ambiguous, or deceptive, especially when an identity disrupts ideological norms (Bucholtz and Hall 2005:602).

The last set of identity relations refers to the concepts of "authorisation and illegitimation", and examines how identities are constructed through institutional elements. Authorisation considers how identity is asserted or dictated through the authority and beliefs of institutional structures, and illegitimation explores how institutional structures reject, suppress, or disregard identities (Bucholtz and Hall 2005:603). Intersubjective identity relations such as these can easily be produced in a medical environment when a care-provider, for instance, establishes themselves as representing the voice of medicine, and in so doing affirms their authority on what is best practice. This principle, therefore, concludes that relationality manifests in various way through language, and that identities only materialise as relational to the identities of others within an interaction (Bucholtz and Hall 2005:605).

DA and IS, are, therefore, useful tools with which to analyse the lexical and grammatical choices of interactants in their construction, cultivation, or transformation of various relationships with other interactants, cultural or social groups, or institutions (Gee 2014:121).

3.5 Conclusion

This chapter discussed the relevance of a discourse analytical approach to health communication along with key contributions from both DA and IS, which illustrate a strong focus on patient empowerment and patient-centred care. This was followed by an overview of the theoretical frameworks upon which this study is based, namely those of DA and IS, along with relevant concepts in the field of Sociocultural Linguistics. The main theoretical departure of this study is grounded in the discourse analytical approach of Gee (2011, 2014), that

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provides the building tasks of reality which will also inform the analytical methodology utilised in the analysis of this study's data. DA provides a comprehensive collection of tools with which to examine the discursive approaches undertaken by interactants during medical, and specifically intrapartum, communication situations. There is a strong focus on the contextual references interactants use to create meaning, as well as how they use language-in-use to establish significance, enact activities and identities, build (or destroy) relationships, and bestow or withhold social goods.

Enhancing the principles of Gee's (2014) theory, this chapter also discussed the field of IS, which investigates the language used by interactants in one-on-one interactions. Through IS's analysis of the detailed components of an interaction, the theory not only sheds light on interactants' ability to interpret interactions, but also contributes to the understanding of far-reaching social practices and ideologies. IS examines the signalling channels during an interaction, how interactants negotiate frame and footing shifts in order to navigate social roles and relationships, along with the impact of diversity on interaction.

Identity formation, and the concomitant relationships this forms, are key elements, not only in the fields of DA and IS, but also in Sociocultural Linguistics. Bucholtz and Hall's (2005) perspectives on identity formation illustrates how identities emerge during an interaction, as well as that they are relational to other identities within an interaction. Pennycook (2004), and Butler' (1999) theories on identity performativity shed light on how identities are constructed through performance during an interaction, and that they do not materialise as a pre-existing inherent quality of the interactant.

Through the uncovering and investigation of interactants' discursive (re)constructions of their birth experiences, the findings which these theories could generate may provide the potential to create consciousness around those practices that are compassionate, but also, those that are less than ideal, and in the process, assist in the start of their transformation into more compassionate methods of communicating. It is therefore a valuable resource for the analysis of medical discursive practices, the meaning created during such interactions, as well as the effect such practices have on the interactants themselves and society in general.

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The next chapter will discuss the analytical methodology which will outline this study's research design, research population, data collection strategy, as well as the analytical tools through which the data will be analysed.

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CHAPTER FOUR

ANALYTICAL METHODOLOGY

4.1 Introduction

This chapter sets out to discuss the analytical methodology and research design selected to gather and analyse the data for this study. The methodology was selected in order to achieve the principle research objective, namely, to consider the discursive reconstruction of the recollections of participants' birth experiences, the linguistic contribution of compassionate language (or the lack thereof) in healthcare, and the effect it has on participants.

4.2 Research design

This study employed a multimethod strategy through which data were gathered. Participants were, at first, presented with questionnaires, followed by one-on-one, semi-structured interviews. The questionnaires collected biographical data; data about the clinical details of mother participants' labours and births; task- and language related data from the care-provider participants; as well as data regarding the language use during labour and birth interactions. Once the questionnaires were received back from the participants, interview questions were composed from the data collected through the answers provided in the questionnaires.

The use of interviews in linguistic and social research has garnered some criticism from scholars, who purport that it is impossible for researchers to stay completely neutral, that they construct the agenda for the interview, and that interviews are, therefore, essentially inadequate, as they result in fabricated and contaminated data (Edley & Litosseliti 2010:155). However, by regarding the interview as a collaboration between researcher and participant, in other words, as an interactional occurrence in which the researcher is an active participant, the conducting of research interviews is construed as being greatly advantageous (Edley & Litosseliti 2010:160).

Following a constructionist approach, Edley and Litosseliti (2010:160) argue that because

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both interviewer and participant are inevitably involved in "meaning making work", meaning is, therefore, interactionally constructed during an interview. By being an active participant, the researcher is able to consider the indexical nature of the participants' discursive reconstruction of identity and relationship, as well as their memories of previous interactions, and in so doing gain greater insight into the reasons participants feel like they do, the manner in which they are affected by others, as well as facilitating rapport between themselves and participant (Edley & Litosseliti 2010:165, 170). From the perspective of the research participant, the act of contributing to the construction of meaning in the research project, in turn, empowers the participant.

In this study, the interview data were greatly enhanced by the data gathered in the questionnaires. Considering the private and delicate nature of some of the data, it served as a significant aid to participants to be allowed to write about their encounters before being requested to verbalise it. It facilitated the circumvention of participants feeling too inhibited to discuss the topic face to face first, thereby successfully setting the stage for the interviews to take place. Furthermore, the establishment of rapport with the participants was crucial, and was accomplished through conducting interviews in an empathetic manner, as well as by disclosing sections of the researcher's own birth narratives. Interviews were conducted at a location of the participant's choice, which was usually at their home, or in a coffee shop. Sessions lasted approximately one hour, and were audio-recorded with the permission of all participants.

Despite the often distressing topics under discussion, all participants, nevertheless, openly and bravely, shared their experiences. Being an "active participant" in the interviews, therefore, greatly aided the researcher in gathering the data required for this study.

4.3 Research population and recruitment procedures

The participants recruited for this study consisted of both mother participants and maternity care-provider participants. The mother participants were, firstly, recruited through social media (Facebook) utilising the personal networks of the researcher, after consulting the social media platform's terms and conditions. In order to ensure anonymity, the invitation requested

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that those interested contact the researcher via direct, private message and not via the researcher's Facebook wall (see Appendix E for the recruitment poster). Requests for posting the recruitment poster to mothering- and childbirth-specific groups on Facebook were denied by the moderators of these groups, as they feared responses to the study would lead to legal action from obstetricians. Nevertheless, a suitable amount of participants were recruited via the researcher's personal platform. Secondly, both mother participants and care-provider participants were recruited through personal networks, specifically through midwives and doulas known to the researcher. In order to ensure anonymity, none of the care-provider participants were recruited via their employers.

4.3.1 Mother participants

The mother participants comprise of 10 women over the age of 18 who had each given birth to between two and five children. Their ages range from 28 to 40 with a mean age of 34.6. In total, the participants completed 24 live births between them, with a total of 434 hours of labour. 16 of these births were vaginal births, and 8 births took place by caesarean section. Of the 16 vaginal births, 11 took place at hospital, and 5 at home. 12 of these vaginal births (hospital n=7; home n=5) constituted natural births, thus with no pain-relief administered, whereas four vaginal births involved the administering of an epidural.

Of the nine caesarean section births, three were elective, four were emergency c-sections, and the remaining two were described as emergencies, that the mothers, in hind sight, felt were not true emergencies, and that they had, in fact, been coerced into having the c-sections performed. Lastly, 16 of the births took place in private hospitals, two in public hospitals, two in midwife-led obstetric units, and the remaining five at the mothers' home. Table 1 summarises the mode and location of the births.

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Table 1: Mode and location of births of mother participants

Location of Birth	Mode of delivery	Amount
Hospital birth	Vaginal - Natural (including water birth)	7
	Vaginal - Epidural	4
	Caesarean Section - Elective	3
	Caesarean Section - Emergency	4
	Caesarean Section - Coerced	2
Home-birth	Vaginal - Natural	5
TOTAL		**24**

4.3.2 Maternity care-provider participants

Six maternity care-provider participants were recruited for this study, and consisted of an obstetrician, an area nursing manager, a registered nurse/midwife, two traditional midwives (one of which also works as a doula), and one doula. Their ages range from 42 to 62, with a mean age of 52.5. In terms of experience, they have spent between 7 and 42 years (a mean of 20.5 years) working in the field. The obstetrician and area nursing manager work only in the public sphere, and the traditional midwife/doula works only in home-birth environments. The remaining four care-providers work across the public, private, and home-birth environments, with the registered nurse working in both public and private hospitals; and the one traditional midwife and the one doula working across all three sectors. This information is summarised in Table 2.

Table 2: Work environments of maternity care-providers

Rank / Title	Public Hospital	Private Hospital	Home Birth Environment
Obstetrician	1		
Area Nursing Manager: Obstetrics and Paediatrics	1		
Traditional Midwife and Doula			1
Registered Nurse	1	1	
Traditional midwife	1	1	1
Doula	1	1	1

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4.3.3 Ethical considerations

Ethical clearance for this study was granted by the Research Ethics Committee: Humanities of Stellenbosch University. Details of the study were explained to participants both verbally, and via the information sheet on the informed consent form, which participants signed before the commencement of data collection. Participants were informed that participation is voluntary and that they may withdraw from the study without any consequence. However, no participants requested to withdraw. In the instances where participants requested certain information to not form part of the study, such information was destroyed and/or removed.

Due to the sensitive nature of the topic it was expected that with some of the mother participants there would be the possibility that one or more of their births, or aspects of a birth, had been unpleasant or even traumatic, and that it would be uncomfortable, difficult, or even upsetting to talk about. With some of the maternity care-providers it was expected that there would be the possibility that some of the births they have attended, or aspects of their job, had been unpleasant or even traumatic, and that it would be similarly uncomfortable, difficult, or upsetting to talk about. To that end, all participants were provided with the details of trauma, anxiety and depression groups which they could contact free of charge. However, regardless of the trauma suffered by some participants during their birth encounters, none of them requested to do so. Lastly, to maintain anonymity, participant identities are only known to the researcher, and participant confidentiality is ensured by only referring to participants through pseudonyms throughout the study.

4.4 Method of analysis

Upon collection of all the interview data, it was transcribed, first, through a free transcription software named Otter.ai, but, due to accuracy limitations, all transcriptions were corrected and updated manually by the researcher. The questionnaires were read several times, and key words and phrases were selected and entered into a spreadsheet. The interview transcriptions were also read several times and relevant sections entered into a spreadsheet. Although the bulk of the data analysis occurred only once all the salient sections had been entered into the spreadsheet, the main hypotheses were already formed during the transcription process.

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Through listening to the interviews and reading the transcriptions, thematic patterns were identified in the data, along with discursive structures and sequences.

In answering the research questions posed in Chapter 1, the majority of the analysis took place within the theoretical frameworks of DA, along with helpful elements from IS, and SL, as discussed in Chapter 3. All these theoretical frameworks were confirmed to provide highly satisfactory tools for examining the relevant discursive instances in the data. However, due to the identification of themes during the transcription process, thematic analysis was employed as the first analytical framework, before the data was analysed within the frameworks of DA, IS, and SL.

4.4.1 Thematic analysis

Thematic analysis is a convenient and adaptable method for the analysis of qualitative data, and allows for the identification, analysis, and description of themes which occur in the data (Braun & Clarke 2006:77). As thematic analysis is not associated with any particular theoretical framework, it is very well suited to be applied in combination with various frameworks, for instance, DA, IS, and SL, as is the case in this study. Braun and Clarke (2006:87) provide a six-phase method for conducting thematic analysis, which, through its utilisation, provided this study with a systematised structure within which data was presented and interpreted.

The six phases of a thematic analysis refer to the following: i) becoming very well acquainted with the data through the acts of listening to recordings of interviews, transcribing the interviews, reading the data several times, and making notes of initial concepts and interpretations; ii) systematically creating basic codes of the complete data set, and arranging the data according to these codes; iii) grouping codes into possible themes, and placing data within these themes; iv) evaluating themes to see if they are suited to the excerpts that have been coded, as well as appropriate to the data set as a whole; v) creating coherent titles and descriptions for every theme; and vi) writing the research findings (Braun & Clarke 2006:87). The last step, however, was conducted only after the data had also been analysed by the DA, IS, and SL frameworks applied to this study.

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There are, however, a few shortcomings to a thematic analytical approach. Firstly, the flexible nature of a thematic analysis can result in a myriad of analytical possibilities, thereby greatly increasing the amount of potential findings. In addition, thematic analysis is restricted in the level of interpretation it can provide, and mainly offers a description of the data. Lastly, it allows no scope for the researcher to make assertions about the applications of language to the data (Braun & Clarke 2006:97). However, it is believed that these limitations have been addressed in a satisfactory manner. Because thematic analysis was combined with a discourse analytical and interactional sociolinguistic approach - which sets out clear frameworks for analysis - along with keeping in mind the specific research questions posed, it allowed for findings to be narrowed down to that which is pertinent to this study. Furthermore, the combination of approaches has also aided in the provision of a clear description of the data, and, lastly, it has, through the DA, IS, and SL tools utilised, allowed for assertions to be made about the use of language in the data.

4.4.2 Discourse Analysis, Interactional Sociolinguistics, and Sociocultural Linguistics

In adopting a discourse analytical approach, supplemented by relevant aspects of IS, it has allowed for the data to be analysed according to Gee's (2011:16) assertion that language-in-use is inherently about *saying, doing*, and *being*. This led the researcher to ask, within each identified theme, what the information was that participants were imparting, which activities they were conducting, as well as how they were socially constructing their identities through their utterances. Augmenting these questions was the reference to Gee's (2011:91) building tasks of reality, through which, he states, people are constantly appropriating language to build various areas of reality. In addition to the questions outlined above, the researcher, therefore, asked how participants were building significance, how they were constructing relationships, and how they awarded or denied social goods. These questions were further enhanced by asking questions relevant to the field of IS.

As discussed in Chapter 3, through a "microscopic and insider" perspective on that which interactants aim to convey during interactions, IS is able to shed light on the effect of these small instances of interaction on far-reaching social practices and ideologies (Gumperz 2015:309, Jaspers 2012:141). For this study, interaction was considered on two levels; firstly,

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the interaction taking place during the actual research interview, with the researcher forming one of the participants and, therefore, actively participating, and secondly, the recollection of participants' interactions during their intrapartum experiences.

Throughout the analysis there was an awareness of the fact that participants were not only discursively (re)constructing their communicative experiences during birth, but that their linguistic performance during the interview was also constructed in such a manner as to create a certain identity within the interview itself. Butler's (1999) theory on identity performativity, therefore, greatly aided the conclusions reached whilst conducting the analysis. Furthermore, the concept of identity formation in DA and IS was further supplemented by relevant aspects of Buscholtz and Hall's (2005) Sociocultural Linguistic approach to identity.

Lastly, the focus on diversity in IS, along with IS's conceptualisation of interactive frames and footing also aided the analysis in terms of how widespread beliefs, attitudes and conventions were reconstructed, and redirected to become applicable to the present interaction. The asking of these questions during the analytical process has thus allowed the researcher to identify and clarify the participant stances in the data. It has also allowed for the analysis of the discursive (re)construction of participants' birth experiences, and has shed light on how these discursive practices augment, or detract from, the delivery of compassionate intrapartum care.

4.5 Conclusion

This chapter has outlined the analytical methodology employed in this study, and has given a description of the research population which form the core of the study. The recruitment and data collection methods were explained, along with the ethical considerations. Lastly, the analytical methodology employed in the study was explained, along with why it is believed suitable to a study of this nature.

The following chapter will present the analysis of the data, outlining the themes identified in the data, along with the meaning making and reality building that became evident in the participants' recollections of their birth experiences.

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CHAPTER FIVE

DISCOURSE ANALYSIS OF LANGUAGE USE DURING LABOUR

5.1 Introduction

This chapter pertains to the analysis of the data through the resources provided by thematic analysis and discourse analysis, as well as by means of applicable aspects of interactional sociolinguistics and sociocultural linguistics. The interview and questionnaire data were first separated into two broad groups, namely that of mother participants, and that of care-provider participants. Once codes were generated for the data, the data were then grouped into seven main themes. Under mother participants, the themes constitute the following; theme 1: the physical birth setting; theme 2: non-compassionate care; theme 3: compassionate care; and theme 4: trauma vs empowerment. The data generated from the care-provider participant interviews and questionnaires were divided into the following themes; theme 5: the language of birth; theme 6: reasons for abusive care; and theme 7: compassionate care. These themes were then further divided into sub-themes, to provide clarity during the analysis. After the data were described under the themes, data were then linguistically analysed through the resources provided by Discourse Analysis (DA), specifically Gee's (2014) Building tasks of reality, Interactional Sociolinguistics (IS), and Sociocultural Linguistics, as discussed in Chapter 3.

A. MOTHER PARTICIPANTS

5.2 Theme 1: *Hotfooting myself out of this hell-hole* - The physical birth setting

The physical context of the birthing environment had a significant effect on how mother participants perceived their births. Private hospital settings were described as a negative experience in 63.16% (n=12) instances, and as a positive experience in 36.84% (n=7) instances. The participants who birthed at public hospitals described it as an overall negative experience in all instances (n=2), whereas the two participants who birthed at midwife-led obstetric units, respectively, had one positive, and one negative experience. Contrastingly,

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90% (n=9) of the home birthing environments were described as positive. The remaining 10% (n=1) refers to a participant who had both a positive and negative experience at home due to the fact that she had an unplanned, unassisted home-birth which happened so fast that she did not have time to close the curtains to create privacy and warmth. The home-birth environment figures include references made by women who birthed their babies in hospital, but who laboured at home before departing for hospital, and are therefore included in the hospital figures too. In all of these instances the participants commented on the stark contrast between the home and hospital birthing environments, with Melissa, in particular, stating, *I laboured at home for so long, and the physical environment IS important, I mean, it changed completely from going in to hospital, like the environment of the hospital just isn't conducive for birthing at all.* With this utterance, Melissa employs Gee's (2014:95) Significance Building Tool through her emphasis on the linking verb, *IS*, to indicate the impact of the birthing environment on her birthing process. Furthermore, through the use of the adverbs *completely* and *just* she indicates the disparity between the two environments, along with how obstructive the hospital environment was to her birth.

i) Negative birth settings

Where mother participants did not perceive the birthing environment as pleasant they described the physical context through adjectives such as *bright, clinical, cold, sterile, noisy, uncomfortable* and *unpleasant*, and said it constituted *disturbing, frightening, intimidating, hostile* places where they felt *lonely* and had *no privacy.*

One of the main aspects of the physical context which disturbed participants during their labours were the bright lights and lack of windows in some of the birthing rooms and theatres. Maya recounts that the space was *super bright and there weren't any windows or anything*, and uses the evaluative adjective *horrible* to describe her perception of the environment. Nina describes the lack of windows at her second birth's environment through the use of a metaphor by saying, *I was stuck like in the dungeon at the bottom* and proclaims, *I was like hotfooting myself out of that hospital within like not even two days. I was like, "I'm getting out of this hellhole"*, thereby foregrounding her negative feelings about the birthing context. Her use of the idiom, *hotfooting,* along with the noun, *hellhole*, builds significance around the

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extent to which she experienced the environment as negative.

Another main aspect of the birthing environment which troubled participants was how clinical and cold the spaces were. Louise says *like, no softness, and no warmth. It was cold, and it was almost like I hit a wall of, of, you know, a Western clinical wall.* Through the use of the metaphor *Western clinical wall,* Louise refers to the medical model of care, and illustrates how impersonal and clinical the context of her first birth was. Some participants were also intimidated by the medical equipment present. Maya comments on the equipment by saying, *it was just, I had my feet in one of those horrible things* (lithotomy stirrups). *It really wasn't pleasant*. By referring to the lithotomy stirrups as *those horrible things* instead of by their scientific name, Maya, firstly builds significance, and therefore foregrounds, how she feels about the equipment, and, secondly, creates a clear delineation between what Gee (2014:113) calls her lifeworld vernacular and the register of the medical context in which she birthed her child.

Megan, who birthed at a large public hospital, and who had to sit in a waiting room for eight hours before being admitted, states, *I don't think sympathetic is a word you can use to describe them. It's literally a case of, "Have your baby, get done, get out, we need this bed for somebody else." For them you are just another patient. No need to be compassionate or sympathetic*. By positioning the care-provider identities as unsympathetic and non-compassionate, along with describing the time-pressures at this hospital, Megan also refers to the lack of resources prevalent in public maternity contexts. This utterance echoes Jewkes et al.'s (1998:13) findings that public maternity care-providers are overworked, short on resources, and that the patients then bear the brunt of these realities. Interestingly, Melissa reiterates this disconnect between mothers and care-providers, even though her birth took place in a private maternity setting. She recounts, *I can't say that any staff member was particularly like, "Look, I'm in your space. Let me be respectful of that". Not at all. I mean, basically, like, they're just doing their job. And they're just getting everything prepped and ready, and I'm just sort of incidental in their, in the thing.* Through her use of the possessive noun phrase *your space*, and the evaluative adjective *respectful,* Melissa indicates her need to have herself and the area in which she is labouring treated with deference. However the fact that the care-providers do not respect it, illustrates that the relationship between herself and

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her care-providers is business-like and cold, instead of the mutually respectful interaction she hoped for.

Lastly, another major feature of the birthing environment which negatively affected mothers was illustrated through references to social goods such as respect. In three instances (once for Maya and twice for Louise) mothers had their natural birthing processes interrupted by instructions from care-providers to complete forms. Maya says, *I was so within myself during the whole birth and what really irritated me was that they constantly came to me with a flippin' form that I had to complete*. Louise says of her second birth, *And then I had to fill out a form, and I remember laughing, but so angry. And it felt very legal, and I saw the word caesarean pop up several times. It was just awful. And then everything seemed to just stop. And I wasn't progressing after that. And I felt a lot of tension coming into my body. I felt very stiff, and uptight.* Louise indicates her dismay at having her birth process interrupted requests to complete forms through the use of the evaluative adjectives *angry* and *awful*.

Through these acts of verbally interrupting the mother's births by requesting them to complete forms, the care-providers were disrespectful of the silence they required. This results in the care-providers denying the mothers the social good of being respected in their birth processes, and to be left to labour undisturbed, thereby indicating a disregard for the type of care these mothers required. The repetitiveness of these actions also illustrates the activity of autocratic care, reflecting the values of these medical institutions, as well as the social language adopted by these institution. There utterances are in keeping with Chadwick et al.'s (2014:864) findings that care-providers are obstructive to the birth processes of mothers, which, in turn, not only physically disrupts their labours, but also contributes to mothers experiencing (aspects of) their births as negative.

ii) Positive birth settings

In the instances where the mothers perceived the birthing environment as positive, they used adjectives to describe it as *calm, warm, dark, cozy, comfortable* and *quiet* places, which felt *familiar, safe, relaxed, pleasant* and *private*. Megan (who had previously birthed at a public hospital) says of her home-birth, *There! Now that's something nice to talk about. So it was all*

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very nice and calm, dark, a lamp was on, we had music on. I laid in the bath in different positions. Jeez, it was completely different. Can't even compare the two. Through this utterance Megan illustrates several things; firstly, by use of the evaluative adjective *calm*, she demonstrates how pleasant she perceived the home-birth environment to be, which was in stark contrast to the environment of her first birth; secondly, that she had autonomy over the birthing environment through the fact that she could control the lighting, as well as change positions at will in the water; and lastly, her use of the Significance Building Tool (Gee 2014:95) through the interjections *There!* and *Jeez*, and the adverb *Now* to emphasise the contrast between her two birthing environments.

In her description of her midwife-led hospital birth, Maya emphasises how she was afforded the social good of respect and support through her doula's interactions with the nurses. She says, *she then took charge of the environment, because they weren't ready for me. So she told the nurses to fill up the bath immediately, and she just sort of bossed everyone around a bit so that I could have my space.* Through this utterance Maya also constructs her relationship with her doula as being mutually respectful and supportive, thereby illustrating the values of Respectful Maternity Care (RMC) as described by Miller et al. 2016:2185. Louise reiterates the value that a doula brings to the birthing environment when she says, *I think we were just sort of all trying to get comfortable with the space. I had some fairy lights.* [The doula] *put those around the bath. And we put a yoga mat down. And we had music.* Here Louise illustrates the partnership-like relationship she has with her doula through her repetitive use of the plural pronoun *we*, again indicating RMC.

The mutually respectful relationship, autonomy, and shared decision making prevalent in RMC was also illustrated through Megan's description of her midwife-led home-birth environment. *I could just do whatever I wanted. My midwife was here but she wasn't in the room. If we needed something done, then she was there. But like she told us before in our appointments, she doesn't interfere at all and I thought that was a bit weird but afterwards I could see why that was important. And it really makes a big difference.* Through her use of the phrase *And it really makes a big difference,* specifically through the intensifier *really,* Megan illustrates the contrast between her home-birth and the lack of autonomy and respect which was present at her public hospital birth. This utterance also illustrates various building

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tasks of reality, in addition to that of relationships, namely, that the midwife's identity is constructed as caring and considerate through the fact that she responded to requests, yet did not infringe upon the mother's need for privacy. This also indicates how the midwife affords the mother the social good of respecting her negative face wants (privacy), as well as respecting her birthing process by not intervening unnecessarily. Lastly, this utterance, and the utterances above which refer to care-providers, indicate that through the actions of these care-providers, they are portraying the socially significant norms and actions central to the 'institution' of midwifery-led care, thereby illustrating the activity or practice of RMC, which can be equated with compassionate intrapartum care.

As illustrated above, the physical birth setting has a profound impact on women's perceptions of their birth experiences, with a clear distinction between the medical model of birth and its concomitant negative repercussions, and a woman-centred model of birth which has a positive impact on how women remember their births.The second theme will now be discussed, namely that of non-compassionate care.

5.3 Theme 2: *I felt like I was being raped* - Non-compassionate care

Non-compassionate care is a broad theme and was, therefore, divided into six sub-themes in order to accurately describe the data. The sub-themes pertain to both verbal non-compassionate care, and non-compassionate language with relation to physical care, and are presented in order of decreasing frequency. The sub-themes that were identified in the data were risk and coercion (n=21); absence of consent (n=21); indifference (n=10); privacy (n=7); violation and physical violence (n=6); and verbal abuse (n=2).

5.3.1 Risk and coercion

The narrative of risk and coercion was present in all instances where births were not attended by private midwives, in other words, all births that occurred within a medical model of care. Care-provider activities such as warnings, coercion, the instilling of fear, manipulation, and the wielding of control communicated the institutional norms and standards present in this model, and resulted in the activity of autocratic care. Accompanying the notion of risk was the

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concept of trust. In all 25 births participants trusted in their care-providers before the birth; however, in retrospect, participants believed that that trust was appropriate in only 48% (n=11) of instances.

Care-providers introduced risk through a variety of discursive means. The most direct way this was achieved was to warn mothers that they, or their babies, could die. Jo-Anne was told through the use of an evaluative noun phrase that it was a *big emergency* when her waters broke at home and that *I needed to get there* (to hospital) *before my contractions start, because, you know, "just now you die"*. The birth ended in a coerced caesarian section. During her second birth, upon attempting to leave the hospital to return home because she was only one centimetre dilated (and planning to return later), Nina recounts that the nurse said to her, "*You're not leaving, are you? You're a VBAC* (Vaginal Birth After Caesarean). *You can't leave". She was like, "We can't have a dead baby on our hands"*. The nurse's use of the personal pronoun *we*, is ambiguous as it could either refer to the nurse and Nina, which would indicate an attempt at getting Nina to join in the decision with her not to leave; or it could refer to the nurse and the hospital which would be indicative of the nurse aligning herself with the institution for which she works, in this case a private hospital. Through this utterance the nurse, firstly, tries to communicate the norms of this institution (that VBAC patients are high risk and should be monitored closely); and, secondly, attempts to exert control over the participant with the warning that her baby might die. Nina, in turn, demonstrated her autonomy, and the trust she had in her body, by still leaving. She returned when she felt it was suitable, and successfully delivered her baby vaginally without pain relief.

The gestational age of the mother was also used by obstetricians to introduce risk. Vivienne was 39 at the time of her third birth and says, *she* (the obstetrician) *started making rumblings. She called me a fucking "geriatric mother". Can we talk about that word? Can you please write a chapter about that fucking word? Honestly. So she made rumblings that it's typically better for a geriatric mother to have a caesar or an induction, that's what she said.* Through the repetitive use of expletives Vivienne communicates her disdain at being called a geriatric mother. "Advanced maternal age", or "geriatric mother", is a term commonly used in the intrapartum environment to describe mothers over the age of 35 (Rydahl, Declercq, Juhl & Maimburg 2019:1). The fact that Vivienne asks the researcher to write a chapter about the

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term is indicative of the active role the researcher (who identified herself to the participant as also being a 'geriatric mother') played in the creation of meaning during the interaction. It is also indicative of the linguistic performance of the participant through which she is aiming to create a specific identity - that of not being geriatric - for herself during the interview, and supports Pennycook's (2004:1) findings that identity emerges during social interactions.

5.3.2 Absence of consent

The sub-theme of absence of consent refers to non-compassionate communication related to physical care, and typically occurred with the performing of interventions and monitoring during labour and birth. The types of interventions performed ranged from epidurals (n=5), the artificial rupturing of membranes (n=5), episiotomies (n=4), inductions (n=3), and in one instance the baby was pushed back into the birth canal.

Lack of consent occurred in the majority of interventions performed, with participants either simply being instructed that they would occur, or, in some instances, took place without informing the participants at all. Furthermore, in all except one instance, all interventions led to a barrage of further inventions, with four of the epidurals leading to episiotomies (and one forceps delivery), and the fifth to a c-section. Significantly, none of the women receiving episiotomies were asked permission, nor told that they would be performed. Where the membranes were artificially ruptured to speed-up labour, two led to c-sections, and two to epidurals. Reminiscent of Hewison's (1993:226) metaphor of the body as a machine, women's bodies were expected to reach certain goals at certain times, and if not, obstetricians tried to control the labour through the use of interventions. For example, Nina's obstetrician said, *"I'm breaking your waters plus giving you the epidural. I expect you to be at least six* [centimetres dilated] *by lunchtime, so that we can carry on*", and the birth ended in a c-section. The use of the noun *lunchtime* is indicative of the fact that the care-provider's timeline was influenced by institutional details, such as when people would get a lunch break. The concept of authorisation (Bucholtz & Hall 2005:603), whereby the obstetrician asserts her identity through the norms of an institution - in this case a controlled, medicalised birth - is demonstrated through the obstetrician's use of the transitive verb *expect*.

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Another example of the metaphor of the body as a machine is illustrated by Melissa's utterance, *so then I said, "Please, can you just give me more time" and she* (the obstetrician) *said, "Okay I'll give you another hour". I just was, that's when I was hysterical.* Through her use of the evaluative adjective *hysterical,* Melissa illustrates the severe emotional distress which the obstetrician's schedule caused her. This birth also ended in a c-section, although the participant firmly believes that she would have been able to birth naturally had she been given the chance. In all of these instances the care-providers are building the activity of a medical model of care, which denies women autonomy over their birth processes, and which had a profoundly negative impact on the mother participants. Furthermore, these examples support Kitzinger's (2012:303) findings that when labour that is advancing normally is managed through the interventions associated with high risk labour, these labours frequently do become high risk.

In terms of lack of consent during monitoring, the procedure which caused participants the most distress was the performance of vaginal examinations during labour. Vivienne describes, *I felt like I was being raped. It felt like someone, against my will, that flippin' obstetrician, I don't know if she shoved something up there, but it was unbearably painful. I screamed because it was so painful.* This internal exam was conducted suddenly, and without warning. Through her use of the evaluative verb *raped* and the phrase *against my will*, Vivienne indicates the lack of consent demonstrated by the doctor's actions. Furthermore, by comparing the action to rape, she indicates how violent she perceived this act to be. The violence of the incident is further foregrounded by her repetition of the evaluative adjective *painful*, along with the intensifier *unbearably*; as well as through the evaluative action *I screamed.* Vivienne's utterance also echoes Kitzinger's (2012:304) findings that the medical model of birth frequently results in experiences which women feel are analogous to rape.

Nina had a similarly harrowing experience and says, *and had the most, I would say abusive now, but the most TRAUMATIC internal I have ever had in my ENTIRE life. I was literally screaming. My husband was BEGGING her to stop and she just carried on doing it. She was like, "No, no I can't find your cervix because it is so posterior". It was HORRIFIC.* Through her use of emphasis, along with the evaluative adjectives *TRAUMATIC* and *HORRIFIC,* and the evaluative verbs *screaming* and *BEGGING*, Nina emphasises the considerable impact the

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event had on both her and her husband. Both of these examples also illustrate the power relations prevalent in medicalised birth, along with the withholding of the social goods of respect, consent, and freedom from abuse. Along with these abusive instances, women also expressed that they found it *demotivating* (Melissa) and *disappointing* (Melanie) when vaginal exams revealed that they hadn't progressed as fast as it was expected during labour, thereby affecting their confidence in the ability to birth their babies.

5.3.3 Indifference and disrespect

The sub-theme of indifference and disrespect occurred across all hospital environments, whether it was a public or private institution, whereas none of the home-birth participants referred to these concepts. Within the data mothers described indifferent care-providers through reoccurring lexical items such as the evaluative adjectives *disrespectful* and *patronising*, and through the negation *not encouraging at all.* In 52% (n=13) of the births, participants were not acknowledged (for example not greeted, not interacted with, or being ignored) by their care-providers during labour and birth, and the majority of participants indicated how disturbing they found this.

Participants were further disturbed by their care-providers having conversations with other care-providers present about topics not related to the births at all. Obstetricians discussed nannies and school holidays (Vivienne), sport (Maya), cycling and renovations (Jo-Anne) whilst these women were in labour. In all cases participants expressed that they were feeling extremely vulnerable during those times, and that the trauma that they were undergoing during their births was not acknowledged at all. Maya's husband filmed the birth and she could listen afterwards to how the obstetricians discussed cricket scores at the exact moment that her son was born. When asked whether the sacredness of the moment was respected she replied *No, not at all, not at all, not at all*, repeating the negation three times to emphasise the lack of respect.

The division between mothers and care-providers was illustrated by how participants constructed their own identities as well as those of their care-providers, along with the relationships sprouting from these identities. Vivienne said of her obstetrician, *to her I was*

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just a big vagina with a baby that couldn't get out. So she did her job. The metaphor used in this utterance foregrounds the disembodiment prevalent in their relationship, and positions her own identity within this interaction as that of a medical problem that needed solving, instead of as a mother undergoing a traumatic birth event. Through this utterance Vivienne invokes Buscholtz and Hall's (2005:603) concept of "illegitimation" whereby the obstetrician, as representative of the institutional structure under which she functions, rejects and disregards the participant's identity as an autonomous human being. Reiterating this disembodiment, Maya also uses a metaphor to describe the nurses as *faceless figures* that were *VERY patronising*, using the Significance Building Tool by emphasising the adverb *VERY.*

5.3.4 Privacy

Lack of privacy occurred in both public and private birth settings, and not in home-birth environments, where all participants expressed that their privacy was respected. Women expressed distress at having their vaginas exposed to groups of medical staff. Vivienne says of her third birth (a c-section), *and there was a period where I was lying with my legs open and we waited, and they were all on that side of the curtain, and I felt like a corpse whose organs are now going to be harvested but I'm actually still alive. So that was horrible. And I started crying and told my husband, "I hate this. This is absolutely horrible", but when they started cutting it felt a bit better because they were focussed on the cutting and not my vagina.* This utterance explicates the loss of face Vivienne experienced during a very vulnerable period. Through the repeated use of the adjective *horrible*, along with the evaluative action *crying*, she builds significance around the negative impact of this humiliating occurrence which caused her to cry during the birth of her child. Furthermore, by equating herself to a corpse whose organs are about to be harvested, Vivienne illustrates her lack of control over a perceived horrifying situation. The disregard for privacy she experienced is also indicative of the norms of a medicalised model of birth where care-providers feel it is their institutional duty to treat mothers as medical objects to be managed, without discursively mitigating their loss of face.

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5.3.5 Violation and physical violence

Apart from the physical violence of, and the feelings of being violated by, the internal exams described in section 5.4.3 above, women also reported feeling violated by other conduct of their care-providers. Susan describes how, when the anaesthetist was sticking ECG pads on her chest before her c-section at a private hospital, he told her she could wear them the next time she goes to *Clifton Fourth* (a Cape Town beach known for topless-tanners). She says, *It was SO invasive. So of course, I was stressed out now after this ARSEHOLE, excuse my language and whatever. It WAS NOT okay. It's DISGUSTING behaviour. It's your BODY. You are so exposed. I felt VIOLATED by the anaesthetist. It felt like sexual, sexual harassment. It REALLY did. It's disgusting.* Through her repeated use of emphasis, Susan communicates how affected she was by the incident. By emphasising the noun *BODY* and stating that she felt *exposed*, she expresses that her privacy and autonomy was violated, thereby affecting her, already limited, control over the situation. Her use of the evaluative verb *VIOLATED* is reminiscent of Vivienne's comment about feeling like she was being raped. Through this utterance she also positions the anaesthetist's identity as negative through us of the expletive *ARSEHOLE,* and her repetition of the evaluative adjective *disgusting*, and constructs their relationship as mismatched in power because he caused her to feel violated through what she perceived was sexual abuse.

The data did not produce many examples of physical violence, apart from the internal exams; however two incidents merit mentioning. The first was when Elsa's baby was pushed back into the birth canal. She recounts that she still does not know why it took place and says, *it was flippin' painful and, ag shame, he* (the baby) *had these marks where they scratched him with the pen.* Through the use of the slang phrase *ag shame,* Elsa expresses her concern for her infant after this violent event. The trauma of the event is exacerbated by the fact that the care-providers did not explain why they were performing the intervention. The second act of violence took place when Megan (after her first birth at a public hospital) was given 16 sutures without any anaesthetic after her perineum tore during the birth. She says, *that's when I screamed, and I swore, and I went mad. I felt every, single stitch and that traumatised me. Wow, it was horrible. There was just one nurse there at the time doing it and I don't know if she was even saying anything.* Through listing the evaluative verbs *screamed*, *swore*, and *I*

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went mad, Megan illustrates the severe emotional and physical anguish she was undergoing during this event. This utterance demonstrates identity construction through the concepts of authorisation and illegitimation (Bucholtz & Hall 2005:603) whereby the nurse, firstly, asserts her identity through the norms of a public maternity institution, and secondly, disregards and rejects the participant's identity through this institutional structure. The fact that the nurse did not administer anaesthetic, nor stopped when the mother started screaming, nor did anything to console her, communicates the disregard which the nurse had for the participant as an autonomous human being, and demonstrates that the nurse perceived the participant as a purely medical object, which, even though she was experiencing intense physical pain, did not warrant the administering of anaesthetic or pain medication. .

5.3.6 Verbal abuse

The data did not reveal many examples of outright verbal abuse; however two instances were significant and had a profound effect on respectively, the identity of the participant (Jo-Anne), and the relationship the participant had with her care-provider (Melissa). Jo-Anne recounts the following interaction after her third birth, between herself and the obstetrician who coerced her into a caesarean section. *And then after the birth I asked him, "Is my womb still fine to have any further babies?" And then he looked at the nurse with him and said, "She's s.t.u.p.i.d. to want to have more babies". He was horrible to me. Horrible. He called me stupid but he spelled it out, as if I'm that stupid that I wouldn't be able to work out what stupid means if he spelled it out. Horrible. It's just his kind of bedside manner. He's very cocky. He's very self-assured and I almost think that he's developed this hot-shot mentality because he knows the people are looking for VBACs.* Through her repetition of the evaluative adjective *horrible* throughout the phrase, Jo-Anne indicates how distressing this encounter was to her. This utterance is in keeping with Pennycook (2204:1) and Bucholtz and Hall's (2005:588) assertion that identity emerges during an interaction, as Jo-Anne illustrates how the obstetrician constructs her identity as someone who does not have the mental means, nor the agency, to determine whether it's safe to have another child. She, in turn, positions the identity of the obstetrician as an arrogant man, through her use of the evaluative adjective *cocky*, whose hubris stems from the fact that there are only a few obstetricians who are willing to facilitate VABCs, and therefore places him in a position of power. This utterances supports

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Schrewe et al.'s (2017:664) notion that professional identities are constructed performatively through the discursive formulation of what it means for the other to be a 'patient'. In this case, the obstetrician believes that he has the right to speak to a patient in this manner, thereby illustrating the position of power he assumes for himself.

The second instance of verbal abuse occurred during Melissa's first birth. She says that when she expressed that she was experiencing pain during labour, the midwife said to her *"You didn't complain when you made it so don't complain now that you need to get it out". And I LOST my shit. I was IN pain and like dozing off and she said that and I was like, WHAT did you just say to me?* This interaction severely impacted the relationship between the mother and the care-provider. The stress and anxiety this created for the participant is illustrated through her emphasis on the adjective phrase, *LOST my shit*, the preposition phrase, *IN pain* and the challenge, *WHAT did you just say to me*. Following this interaction, the participant didn't want the care-provider present at her birth, but because the birth took place at a midwife-led obstetric unit, there was no-one to replace her with. They were forced to navigate the rest of the birth in each other's presence, which resulted in the mother feeling disturbed, instead of supported, during her labour and birth.

This theme illustrated the various examples of non-compassionate verbal and physical intrapartum care. The next theme will now be discussed, namely that of compassionate intrapartum care.

5.4 Theme 3: *Slapped in the face with love* - Compassionate care

Due to the expansiveness of the theme of compassionate care, this theme was divided into four sub-themes to make sense of the data. The sub-themes that were identified in the data were silence, reassurance and encouragement, recommendations, and compassion.

5.4.1 Silence

The first sub-theme of compassionate care is that of stillness or silence. Silence indicated a respect for women's birthing processes and was present in all the home-birth environments, as

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well as during the hospital births that were supported by private midwives, in other words, where RMC was adopted. It was not present in any of the births where a medical model of care was adopted.

In keeping with Karlström et al.'s (2015:5) findings on the benefits of a care-provider being actively, yet quietly, present, the mother participants reported responding very positively to the respectful silence of their care-providers. Melissa states, *I feel silence in the birth is quite important. And* [the doula] *held that space. She was definitely SO present but silent.* The metaphor of holding the space positions the identity of the doula as someone who is present, conscious, and aware of the participant's needs. It is significant to note that the care-provider successfully manages to support the mother even through silence. This is demonstrated through the phrase *She was definitely SO present but silent*, with the emphasis on the adverb *SO*. Even though she was silent, and therefore considerate, she was nevertheless ensuring that the participant felt safe, thereby establishing a respectful relationship between the two of them. Megan echoes Melissa's sentiments by saying, *Ja she* [the midwife] *was quiet and calm. She just sat on the bed quietly and she didn't say anything. I was glad she was there and I was relaxed because I felt that everything would be okay from then.* This utterance demonstrates that the activity of women-centred care, which includes the action of not disturbing the mother, had a very positive effects on the participant.

5.4.2 Reassurance and encouragement

Support and encouragement of the mother during labour occurred across all settings and was present in the majority of births (68%, n=17), albeit not always from their primary care-providers. For instance, two of the participants who had c-sections (Vivienne and Louise), commented on how encouraging the anaesthetists were. Louise says, *and all I remember in terms of a positive experience, was the anaesthetist was really, really wonderful. He stood like, right by my head, whispered, talked right into my ear, reassuring me. He had a wonderful warm tone in his voice. And he was just so kind. He just seemed to have empathy.* Louise constructs the anaesthetist's identity through the predicative adverb *wonderful*, and emphasises this through the repetition of the intensifier *really.* Even though this was the only positive experience she remembers of her labour, the encouragement of the anaesthetist had a

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deeply positive impact on Louise and afforded her the social good of being acknowledged. This utterance also reflects the recommendations made by NICE (2017) regarding how care-providers can establish rapport with a birthing woman, namely by being aware of the tone of their voice, as well as reassuring and encouraging them during birth.

Another important effect that the encouragement from care-providers had on the participants, was to instil the confidence that it was within their power to birth their babies. Melissa recounts, *She* [the midwife] *kept saying, like, "Listen, your uterus is going to birth this baby. So just go with it". She was so amazing.* Through her use of the intensifier *so* and the evaluative adjective *amazing*, Melissa indicates how much this type of support meant to her. Nina also received support from her midwife which is evident from the description of her second birth, when the fetal ejection reflex kicked in, after her midwife allowed her to rest for an hour when she was fully dilated. The fetal ejection reflex ensues when the mother's body spontaneously starts pushing the baby out, and mainly occurs during an undisturbed birth in which a woman feels safe and supported, and where her neocortex isn't stimulated by bright lights and interruptions (Odent 2009:697). Nina says, *and my body was starting to push. Hardly anyone gets to wait till that kicks in because no one, no gynae lets you lie there for an hour. You can only do that if you have a midwife.* She continues, *and it was like, so from a 37 hour labour, I would say 10 minutes, when my body just pushed her out in those three pushes. And it was like if you don't intervene that's what happens.* Nina was left feeling very empowered and confident after her birth. This was facilitated through the encouraging and supportive relationship she had with her midwife, along with the fact that she did not intervene in Nina's birth process, all of which is an example of RMC, and contributed to Nina's sense of identity as that of someone that was able to successfully birth her baby.

The types of words used by care-providers to encourage and reassure participants were, *you're amazing*, *you're doing this*, *trust yourself*, *listen to your body*, *use your voice*, *don't listen to the nurse*, *breathe, labour is hard work so you're doing well* and led to increased feelings of maternal satisfaction. Maya says that her obstetrician kept on saying to her *"You're fine, you're fine, you're fine".* The result of this was that it made her *feel in control, that everything was okay*, and maintained her positive face wants of being supported. Even in the public sector where continuity of care does not frequently take place, reassurance had a

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positive effect on Vivienne. She says, *I'll never forget the last midwife, but to her I was just one of many babies that were born that day. Because I think they do too many births. But the midwife was amazing and she said many encouraging things. I'll never forget her, you know.* By ending this utterance with the phrase *you know,* Vivienne emphasises the positive effect that the encouraging relationship she experienced with this midwife had on her, even though she admits that the midwife probably would not remember her. The benefits of encouragement and reassurance, as illustrated above, supports Ménage et al.'s (2017:564) findings which state that maternal satisfaction can lead to increased feelings of empowerment and decreased feelings of fear around the birth.

5.4.3 Recommendations

The use of recommendations, instead of orders or instructions, had a significant impact on how women perceived their relationships with their care-providers. Vivienne recounts, *It was absolutely empowering. They give you options. The midwives recommend you write a birth plan and I'm sure they laugh a bit about the first-time birth plans because women are like, "When the baby's head comes out, I want this Bruce Springsteen song to play, and four scented candles etc." and first babies generally take a bit longer to come and everything is just more of a mess.* Vivienne's ironic account of how optimistic and naïve first-time mothers are with regards to expectations around their births (herself included), is nevertheless offset by how empowered she felt at the midwives' recommendations of writing a birth plan. This is illustrated through her use of the intensifier *absolutely*, pared with the evaluative adjective *empowering*, Furthermore, her positive face wants of being included in decisions around her birth were met, and resulted in her feeling empowered by the process.

Jo-Anne describes how she worked in partnership with her midwife to facilitate a VBAC3 (vaginal birth after three caesareans). Due to the perceived potential for uterine rupture, VBACs are generally constituted as high-risk births, with very few obstetricians willing to afford women the opportunity to do so, and a VBAC3 even more so. The only way that Jo-Anne could attempt such a birth was with a midwife, and she says the following, *There is risk in everything. And through* [the midwife] *it was an educated risk, a supported risk where I felt that I was equipped with the information that I needed, and even though she wasn't*

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spoon-feeding me she gave me resources to pull on. And she explained the percentages. I felt informed. And she also explained that rupture can happen even if you haven't had a prior caesar. I felt empowered with that information, from the previous birth where I had to go and scratch out that information for myself. [The obstetrician] *wasn't giving me that information and for me to argue from that position with him was like hitting a brick wall. Because he was fighting against me. Whereas* [the midwife] *was fighting for me.* Through her use of the metaphor *fighting for me,* Jo-Anna constructs her relationship with her care-giver as one of mutual trust and support, in which her midwife gives recommendations which allowed Jo-Anne to have two successful home-births after her c-sections. Through her use of the evaluative noun phrase *educated risk*, the evaluative verbs *equipped* and *empowered*, and the verb phrase *she wasn't spoon-feeding me,* Jo-Anne indicates how, through the sharing of information, her midwife led her to make an informed decision about her birth, and that she was granted the social good of being included in the decision-making processes around her birth.

5.4.4 Compassion

When speaking about compassion, participants referred to both the physical and the verbal aspects of it. These two concepts have, therefore, been analysed separately.

i) Compassion related to physical care

Vivienne expressed that eye contact was important, as it *lets you feel seen*, thereby indicating her positive face wants of being accepted as legitimate, deserving and acceptable. Her statement supports Van der Cingel's (2011:676) findings that compassionate care can be demonstrated even through small gestures like eye contact. Face wants become especially significant in instances where participants need to negotiate social or cultural taboos. Because labour and birth is such an intimate and physiological event the muddy waters of 'taboos' frequently need to be traversed during intrapartum encounters, such as during vaginal exams, or when women defecate during the pushing, or second, stage of labour. Yet, if it is spoken about in a respectful manner, it leaves the mothers unashamed of the processes their bodies are going through. Melissa explains, *and the midwives are also as if they don't think*

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something is wrong with you when you're having a baby. They were just like, "It's fine if you poo". Nothing is funny. Everything is so matter of fact.

Being respectful of women's privacy during labour also supported their face needs. Vivienne says, *I remember the midwife covered me, because she saw there were a thousand people coming in, and I appreciated that. Because I was completely naked by that time, and by that time it was balls-to-the-walls emergency stuff. It's weird to think of it now, that you're so naked. It's crazy.* Through Vivienne's hyperbole, *a thousand people,* she builds significance of how naked and vulnerable she felt, and that her privacy was being invaded. She justifies their presence through use of the idiom *balls-to-the-walls* to indicate that it was an emergency and she, therefore, had no choice in the matter. She, nevertheless, expresses her amazement at how culturally strange the situation is (being naked in front of a group of strangers) through use of the adjectives *weird* and *crazy,* and constructs the identity of the midwife as kind through the fact that this care-provider noticed her vulnerability and humiliation during the situation, and covered her body.

ii) Verbal compassion

One of the main ways in which participants perceived care-providers to be compassionate was through the imparting of information, even in situations that participants experienced as less than desirable. Melissa says of her c-section, *being in such a clinical environment, being like the worst possible eventuality of what had happened in my birth, to now feel so okay, was purely because he was communicating everything.* In saying this, Melissa indicates that through awarding her the social good of being included and informed, her care-provider ameliorates the disappointment of her birth having ended in caesarean section. This aligns with Greenfield et al.'s (2016:264) findings that even though a mother could be experiencing trauma during her birth, the birth is not perceived as traumatic when the mother is treated with compassion.

Vivienne defined compassionate communication as the use of words that form part of the register of the mother's lifeworld. She says, *it needs to be mom-based, not medical based. So words that have to do with what YOU now need to do to get this baby out. Even words like*

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episiotomy, I mean, what the fuck is that? Things like that don't make sense when you're there in the moment. Not words like "push". It's so ugly. It makes you feel like a grinding fucking bottle opener. The phrase *mom-based, not medical based* is indicative of Mishler's (1984) assertion that the world of medicine is separated into two distinct discourses, namely the VoL and the VoM, as discussed in section 3.2.1 above. Through her repeated use of expletives, along with the metaphor of a bottle opener, Vivienne builds significance around the dissociation between her "vernacular" (Gee 2014:113) as a normal person, and the register of the medical environment. She also builds significance with her emphasis on the word *YOU,* which indicates her face wants of being considered important in the process, as she is the one that is birthing the baby.

Although most participants described compassionate language as needing to be *encouraging*, *motivating*, *supportive*, *accepting*, *sensitive*, *positive*, *a connection*, *selfless*, and *loving*, Louise also described it as a type of *tough love* when the situation requires it. She explains, *I started to check out and I started to feel faint. And it was then* [the doula] *gave me a very, it was like, you know, tough love, a hard talking to. Which I needed. Because I was checking out and she was basically trying really hard to get me back to fighting for the birth that I wanted. And not to give up. I felt like I'd been sort of slapped in the face with love to like wake up.* Louise's use of the metaphor in the last sentence allows her to draw attention to the fact that compassionate language need not always be soft and gentle, but that care-providers can be firm and supportive when the situation warrants it. Through this metaphor, and through the idiom *tough love*, Louise illustrates the loving relationship she has with her doula and also foregrounds the activity of women-centred care central to compassionate intrapartum encounters. The change in the doula's tone can also be interpreted using Goffman's (1974, 1981) theory on interactive frames and footing, as it illustrates the manner in which social roles and relationships can be altered amidst an interaction. Here, the doula discursively adjusts footing in the type of compassionate care she gives by moving from a frame of gentle communication, to a frame of more forceful communication, albeit still compassionate. The re-positioning of the interactants to each other has a positive effect, as it returns the mother's focus to *fighting for the birth that [she] wanted.*

This theme has illustrated the significantly positive effect that compassionate verbal and

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physical care had on participants. The next theme examines the notions of traumatisation and empowerment.

5.5 Theme 4: *Absolutely euphoric that we survived* - Trauma and empowerment

The experiences which mother participants had during their labours and births resulted in them feeling either traumatised or empowered. Women reported experiencing traumatisation in 56% (n=14) of instances, and empowerment in 44% (n=11) instances. None of the participants reported that they felt neutral about their births.

5.5.1 Traumatisation

The main reason participants gave for feeling traumatised was that they did not feel that they had control over their labours and births, echoing Fenech and Thomson's (2014:186) findings that lack of control is one of the causes of traumatisation. Not only were participants themselves traumatised by their experiences, but also their husbands and, in Nina's case, her baby. She states, *he was super traumatised by the birth. He just cried, and cried, and cried, and cried. And I'm convinced it's because he started in trauma.* By using the intensifying adverb *super*, and four times repeating the verb *cried*, Nina constructs significance about the extent of her baby's trauma. Vivienne states that, *we were also absolutely euphoric that we survived and told everyone that it was amazing, but we quietly thought that we wouldn't do it again*. Through the intensifying adverb *absolutely,* Vivienne expresses how relieved they were to still be alive after the birth. However, she also indicates that they were so traumatised by the birth that they did not want to have any further children, a fact that they were hiding from others, and which she expresses through the verb phrase *quietly thought.* Vivienne's reaction is aligned with the findings of Thomson and Downe (2010:108), who state that women can become so distraught at the idea of having another birth that they do not experience the advantages of another, potentially healing, birth. In Vivienne's case, however, her second birth was a healing experience, and redeemed the experience of her first birth.

The concealment of Vivienne's trauma ties in with the customary response people have when a mother has had a traumatic birth, namely to say that at least the mother has a healthy, happy

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baby. Nina criticises this practice by stating, *That should be the absolute non-negotiable. Obviously my baby must be healthy. But other things matter too. Like, my experience, or trauma. You can't just negate everything else, like the only thing that matters is that your baby is alive.* Nina's use of the intensifier *absolute* with the adjective *non-negotiable*, and her use of the adverb of certainty *Obviously*, expresses how important the well-being of her baby is. Yet, through the conjunction *But* and the phrase *just negate*, she indicates that her well-being is just as important as that of her baby. Nina's utterance supports Cohen and Shabot's (2016:240) findings that this type of remark leaves women feeling particularly resentful and incompetent.

Participants reported that they felt traumatised due to the fact that they were *cheated out of a natural birth* (Elsa), and they mourned the fact that they were made to feel as if their bodies were not capable of birthing their babies. Melissa states, a*fter the first birth I was left with a feeling of failure as a woman, like I just failed as a woman, because this is what my body was born to do, and I didn't manage, but yet sort of feeling like it was stolen from me.* Nina says, *and I think that's like the most criminal thing of all, that women think their body has failed and that they can't do it.* These participants' references to *cheated*, *stolen*, and *criminal* speak of irregularity and violation, and communicates that they feel deceived and victimised. Furthermore, repetition of *failure*, and *failed,* demonstrates how these participants construct their identities as that of powerless, inadequate women who are incapable of naturally birthing their babies. These utterances echo the findings by MacKenzie Bryers and van Teijlingen (2010:493), who state that this lack of confidence is one of the consequences of the medicalisation of childbirth. Other effects of traumatic birth led to women feeling *diminished* and *naïve* (Maya), *numbed* (Melissa), unable to look at or touch their c-section scars (Louise) and a long period of postnatal depression (Nadine).

Vivienne describes the trauma she suffered through the use of similes, emphasis, and an expletive to create significance. Of her first birth she says, *I felt traumatised because I was lying on the table like a slab of meat and I had no idea what was going on. Lack of information. Lack of consent. And I didn't know why there was so much blood.* Of her third birth she says, *I expected the caesar to be disappointing but easy, but it was traumatic and horrible. It felt like a post mortem but I was still alive. It was ABSOLUTELY fucking horrific.*

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Her references to *slab of meat, blood,* and *post mortem* equates to her feeling butchered during the births, and that she was denied the social good of autonomy over her birth processes. The latter is further emphasised through her repetition of the abstract noun *lack*, and through her use of the evaluative adjective phrase *ABSOLUTELY fucking horrific* to emphasise the extent to which she was traumatised by her c-section.

These utterances have demonstrated that traumatic birth had a significant influence on the participants, and constructed the extent of their trauma, along with the effect it had on the participants and their partners. The notion of empowerment will now be discussed.

5.5.2 Empowerment

The experience of having a positive birth resulted in all of the participants (n=11) declaring that they felt empowered by their births. Maya states, *Ah, it was the most EMPOWERING experience of my LIFE. It REALLY was. I felt SO empowered. I just wish I could tell EVERYONE how AMAZING it is to be able to give birth when our bodies were made to do it and you CAN do it. I'll never forget, HOW empowering it was to me. I think you take something away from it for the rest of your life.* Through her repetitive use of emphasis throughout the utterance, along with her repetition of the verb *empower*, Maya communicates how deeply affected she was by her second birth. Vivienne describes her positive birth experience through the use of a simile, and says, *relief, relief, relief, it was amazing. Like if you've heard you've regained the use of your arm or something. It was an incredible feeling.* Furthermore, her repetition of the abstract noun *relief* indicates the tension she experienced of having to give birth after a traumatic first birth, but that her first birth was redeemed through the second.

The notion of redemptive birth permeated these narratives of empowerment. Vivienne states, *It absolutely redeemed the trauma of the first birth. Totally. It really did. I could also now understand how a natural birth really is.* She expresses degrees of certainty through her use of the intensifiers *absolutely*, *totally*, and *really.* This utterance also indicates that Vivienne's confidence in her ability to birth her baby had been restored. Nina called her birth *restorative* and Louise called it an opportunity for *rebirth*. Significantly, these feelings resulted in

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participants feeling that they could immediately have more children, with Maya stating, *It was so lovely that I just immediately wanted to do it again*, and Vivienne saying, *I immediately wanted another baby.* The fact that both participants used the adverb *immediately* illustrates the instant positive effect which a redemptive birth can have on women. These utterances are in contrast to the effects of a traumatic birth, as described above, where women are traumatised to the extent that they do not feel able to go through the experience of birth again, and echo Kärlstrom et al.'s (2015:3) findings that a positive or redemptive birth has the ability to instil mothers with the confidence of achieving such a birth again.

Participants also reported feeling proud at having achieved a positive birth. Louise states, *It was like the MOST, the most wonderful feeling of pride. Like really, really proud. Like oh, my God, I AM doing it. And I just remember I was like, HYSTERICAL, like, happy hysterical. And then I just kept saying we DID it. We did it! And then* [the doula] *was like, YOU did it. And then* [the doula] *said, you are DRAMATIC* [laughs]. By recounting this interaction, Louise illustrates several things. Firstly, she builds significance about the degree of pride she felt through her use of emphasis throughout the utterance. Secondly, she illustrates Pennycook's (2004:1) notion that identity emerges through performativity during an interaction by describing how she and her doula spoke to each other. The doula's identity is positioned as supportive through the way in which she validates Louise's role during the birth by saying, "*YOU did it*". This, and the doula's humorous statement that Louise is "*dramatic*", also illustrates the rapport between the interactants, and that there existed a sense of camaraderie during the birth. Lastly, the utterance demonstrates that Louise was granted the social good of respect and recognition by her doula, which is indicative of RMC, as well as of compassionate care.

Another observation participants made was to describe the feeling of having been seen and heard by supportive care-givers, which culminated in the notion that the birth had happened on the mother's terms. Louise states, *I felt like I'd been seen, you know, like, DEEPLY. Seen like, for who I am. In that moment. It was completely healing.* Through this utterance she illustrates how her positive face want of needing to be communicated to in a manner that would make her feel acknowledged was facilitated by her care-provider. This also resulted in

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her opinion that the birth was a healing event. She continues, *I feel really emotional now, because it's the first time I've had the opportunity to talk about what happened and celebrate it.* This utterance is another example of the active role which the researcher played during the interaction, due to the fact that the actual process of the interview resulted in emotions being evoked in the participant, and afforded her the opportunity to pay homage to her positive birth experience.

Lastly, participants reported that a positive birth was not only an empowering experience for themselves, but also for their husband and the care-providers. Nina states, *and everyone burst into tears.* [The doula] *was bawling.* [The midwife] *was bawling, me and my husband were bawling. It was like, it was special for ALL of us. Because I think every time a midwife does a VBAC they're more empowered.* By repeating the intransitive verb *bawling* as a form of evaluative action, Nina indicates the level of shared emotion displayed at the birth of her child. This utterance aligns with Van der Cingel's (2011:681) findings that an emotional bond with a care-provider is one of the most greatly valued aspects of compassionate intrapartum care. The utterance is also indicative of how relationships are constructed discursively. By saying "*it was special for ALL of us*" Nina indicates that everyone present, including the care-providers, had a vested interest in the birth, and therefore a positive emotional response to it, which is indicative of a compassionate intrapartum relationship. This is further emphasised by Nina's opinion that the birth was empowering to the care-providers, because by successfully facilitating a perceived high-risk birth, these midwives are contradicting the medical model of care, and affirming the benefits of RMC.

This section has illustrated the greatly beneficial impact that a positive birth experience has on not only a mother, but also on her partner and care-providers. This concludes the analysis of the data pertaining to mother participants. An analysis of the data retrieved from care-provider participants will now be provided.

B. CARE-PROVIDER PARTICIPANTS

As discussed in section 5.1 above, the data pertaining to mother participants and care-provider participants were analysed separately. The themes generated for the six care-provider

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participants are; theme 5: the language of birth; theme 6: reasons for abusive care; and theme 7: compassionate care. These themes were also divided into sub-themes in order the make sense of the data.

5.6 Theme 5: *They put the fear of God into them* - The language of birth

This theme pertains to the type of language used in intrapartum care settings as reported by the six care-provider participants, and was split into three sub-themes. The first two sub-themes pertain to negative language use, whereas the third sub-theme pertains to positive language use. As discussed in Chapter 4, the care-providers work across a range of maternity setting, namely public and private hospitals, MOUs, and home-birth environments. What is interesting to note is that participants reported only positive language used in the home-birth settings, whereas they reported both positive and negative language use in the hospital and MOU settings.

i) Dishonesty

The most frequently occurring example of negative language use was reported by four of the six care-providers, namely, that doctors frequently lie to their patients. This was reported as taking place primarily in private hospital settings and pertained to doctors coercing patients into undergoing caesarean sections. Grace states that, *It's not an emergency caesar. That's bullshit when they tell you it's an emergency. I think I've seen probably two, three, that's in over 400 births, three real ones.* Celeste concurs, *I have seen, I think, one or two real emergency caesareans when I was at the hospital. In seven years. And it's, "I love my doctor. He will never lie to me". Please!* Through these utterances the care-providers emphasise the small number of cases that are legitimate emergency caesareans. Through her use of the expletive *bullshit*, and the evaluative adjective *real*, Grace emphasises the extent to which she disagrees with this practice of conducting unnecessary caesareans. By her use of the exclamation *Please!*, Celeste indicates her derision at the doctor's lies and that patients are naïve by believing that the doctors won't lie to them.

Judith states, *These doctors REALLY lie to their patients. They bullshit the patients, and say*

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"Oh, we're going to do a caesar because the cord's in front of the head". The cord will move out of the way with a few contractions. They put the FEAR of God into them. By using the intensifier *REALLY*, the expletive *bullshit*, and the idiom *put the FEAR of God into them*, Judith highlights the extent to which the doctors lie to their patients. Judith continues, *and I'm not going to, it's the doctor's patient, I'm not going to, he's not* [pause] *killing the patient, or doing the wrong thing* [pause], *not THAT wrong* [quietly]. With this utterance, Judith justifies her hesitance by emphasising the phrase *not THAT wrong.* Through this utterance Judith also implies that the doctors are the ones in control, and that even if she doesn't agree with their actions, she will nevertheless respect their authority.

ii) Abusive language

Abusive language was reported as taking place between midwives and patients in public maternity settings. Celeste, a private midwife, says, *They* [the public midwives] *are not loving. There's no, I want to say intimacy. I want to say rapport. It's just, "Kom. Kom. Kom"* ("Come. Come. Come"). By repeating the intransitive verb, *Kom*, Celeste indicates how public care-providers are telling patients to hurry up, which is indicative of how rushed and pressured the public maternity environment is. Another example of abusive language use by care-providers in the public sector is illustrated by Judith, a private midwife, who says, *At* [public maternity hospital] *they're horrible to them. They say to the patients, "It went in like a banana and it's gonna come out like a pineapple". They're cruel. Terrible.* The statement of the nurses compares a banana to a penis which is smooth and small enough to enter a woman's vagina, whereas a pineapple is bigger, spiky, painful to touch, and also does not resemble either a penis or a baby. This statement echoes the experience of mother participant, Melissa (discussed in section 5.3.6 above), who was told that she wasn't complaining when the child was conceived so she should not complain now that she is giving birth to the baby. These examples of negative language use by care-providers are indicative of the power imbalances prevalent in a public maternity setting, as well as the disrespectful relationship these care-providers have with their patients, and supports Jewkes et al.'s (1998:8) findings that public maternity settings are imbued with an "ideology of patient inferiority".

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iii) Positive language

The importance of positive language use in a maternity setting was affirmed by all six the care-providers, across all settings; however the doulas and private midwives placed the most emphasis on it. To them, the main aim was to use language which empowered their clients. Celeste says, *I'm empowering them because they're running a race. They are running a Comrades marathon. And you run along, and say, "You can do this. Wow, you're doing so well. I'm so proud of you"*. By equating labour and birth, not only to a marathon, but to one of the biggest marathons in South Africa Celeste draws attention to the fact that labour is a strenuous event and that mothers require encouragement to help them through it. Through the metaphor *you run along,* she indicates that her relationship with her clients is supportive, thereby indicating the ideology of compassionate care.

Liza feels that by empowering her clients during birth, she is also empowering them for life in general. She says, *And a lot of what we teach our young girls is being polite in society. And birth is such a great opportunity to actually start shifting away from pleasing others.* So instead of making decisions on behalf of her client, Liza says, *"So, okay, you know, why do you think that this information has made you feel this way". Always giving it back to her so that she can mull it over. Because you've got to be selfish to be able to get through such an intense time in your life.* By asking her client to make her own decisions, Liza is giving her the social good of being included in decision-making processes, which enhances her autonomy over her birth processes. Furthermore, by doing this action repetitively (indicated by the adverb *always)* Liza is indicating that she ascribes to the activity of woman-centred care. Lastly, through the use of the phrase *Always giving it back to her so that she can mull it over,* Liza illustrates the mutually respectful relationship she has with her client.

5.7 Theme 6: *This is government. It's a mess here* - Reasons for abusive care

Theme 6 pertains to the reasons why abusive care practices occur in both private and public maternity settings. The data yielded no instances of abusive care in home-birth settings. Three main sub-themes were identified as reasons for abusive care, namely, systemic failure; risk and litigation, and trauma and burnout. Each of these sub-themes will be discussed separately.

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5.7.1 Systemic failure

The mistreatment of women due to systemic failure was mainly linked to public maternity care facilities. Only one instance was related to a private hospital where Judith referred to young and inexperienced midwives who did not have empathy for women in labour. The public care-providers (Judith and Sam) spoke about having to cope with abusive drug addicts in withdrawal during labour, terrified 14-year olds giving birth, and traumatised rape victims, all whilst working long hours with little or no support from the structures within which they operate. Judith summed it up by saying, *It's government. It's a mess here.* The doulas who work with clients in the public sector see the strain that the care-providers are put under, but also the repercussions it has for the mothers. Liza ascribes the mistreatment to care-providers who feel, *"I'm disempowered, so the mother must also be disempowered"*. Through the repetition of the evaluative verb *disempowered,* Liza builds significance around the effect of the immense pressure under which public care-providers find themselves. Furthermore, the utterance draws attention to the fact that due to this pressure care-providers are suffering from compassion fatigue, and are therefore not able to empower mothers. Lastly, the utterance illustrates how care-providers are denying mothers the social good of empowerment due to the fact that they themselves are denied this social good by the institutions for which they work.

Apart from lamenting the lack of privacy in delivery rooms, which upset the care-providers because it upset the mothers (Sam, Liza, Grace), the main cause for distress on the part of the care-providers were described by participants as *management doesn't understand* (Esther); *poor management or lack of money* (Sam); *Because you get a doctor coming along as an intern, and now they've got more authority than a senior midwife which is just not true* (Sam); *You need the support staff around the doctors (*Sam); and *The healthcare sector is SO overloaded* (Liza). Through the use of negation (*doesn't understand)*, evaluative adjectives *(poor)*, intensifiers *(just* and *SO)*, and evaluative verbs (*overloaded*), these care-providers build significance around the extent of the challenges present in the public sector. Furthermore, these challenges lead to severe distress on the part of the care-providers. Celeste, a private midwife whose clients sometimes need to go to public institutions for emergency procedures, notes the abuse suffered by the care-providers (no meal breaks,

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working double and more shifts) and says, *The thing is nobody's actually respecting the staff. They're not feeling honoured, They are not feeling loved. And they don't have enough of their own emotional resources to give then. You can't give what you don't have.* Through the use of the preposition *respecting,* and the evaluative verbs *honoured* and *loved*, Celeste indicates that these care-providers are being denied the social goods of respect, honour, and love, which are all aspects of compassion, and which results in the fact that they, in turn, can therefore not show compassionate care to mothers.

Sam substantiates this by saying, *They abuse you. They don't listen to you. They don't support you. But you're the one standing there with the bleeding patient. You can't find a frickin' drip. So you're the one who's ultimately got to deal with the patient and say, "Sorry, your baby's dead". So that's what I mean by government inefficiencies, and the list is endless.* Through her use of the evaluative verb *abuse*, Sam builds significance about how badly care-providers are treated by public healthcare institutions. By using the deictic word *they*, Sam constructs the context within which she works, indicating a clear delineation between *they* (the government and the management of the hospital) and the care-providers who need to cope with the lack of resources. Furthermore, she builds significance by repeating the pronoun *They* three times followed by examples of how care-providers are unsupported by these structures, along with the slang intensifier *frickin'*. Through this Sam emphasises the mistreatment care-providers are experiencing, and her distress at having to deal with the mothers of deceased babies due to lack of resources.

5.7.2 Risk and litigation

Whereas systemic failure spoke more to the reasons for mistreatment in public maternity facilities, risk and litigation as causes for mistreatment were more prevalent when care-providers spoke of private maternity settings. Liza says the following of private hospitals, *You know, when it's a private entity, it is a business. And this particular business is heavily influenced by its liability and turnover.* Affirming this notion, the care-provider participants describe doctors as being *afraid* (Celeste), *in high alert* (Grace), and *on tenterhooks the whole time* (Judith). Judith also states that, *A lot of our time is spent recording everything for litigation*, and that *the private doctors pay such a high insurance.*

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The results of perceived risk management (an increase in interventions and caesarean sections) have, however, had a very detrimental effect on the well-being of mothers. Celeste says, *I think it's a gross human rights violation that women are sent to the caesarean chambers unnecessarily. And 99% of caesareans are unnecessary, Look, if the baby's in trouble, or the mom's in trouble, by all means, you know, I think that we're really, really blessed to have caesars. But I think they are grossly abused. I think that having a baby is a rite of passage for women. But they're disempowered because their way of proving their strength has been robbed of them. So I think it's evil. And I think it's unethical.* By using the intensifier *grossly*; and the metaphors *strength has been robbed of them*, and *sent to the caesarean chambers* (thereby invoking the notion of gas chambers), Celeste emphasises the helplessness of women when confronted by a caesarean section when their births are deemed high risk. Furthermore, through her use of the evaluative verbs *abused* and *robbed*, and the evaluative adjectives *evil* and *unethical* she discursively attributes negative characteristics to care-providers who misuse caesarean sections, something which she asserts is *unnecessary 99%* of the time. Celeste indicates that she perceives giving natural birth as an empowering event for a woman, which she describes with the idiom *rite of passage,* but through her use of the evaluative verb *disempower* she illustrates the effect of unnecessary caesareans on women, and that it's a human rights violation.

5.7.3 Trauma and burnout

All six care-providers reported feeling stressed, traumatised, and having suffered from burnout. Apart from the stressful situations mentioned in section 5.7.1 and 5.7.2 above, their traumatisation was caused mainly by witnessing the abuse inflicted on mothers and babies. Liza says, *And I see the doulas, how traumatised they are. And one of the things that keeps getting brought up is that they're witnessing this abuse, and then they are asked to be complicit in it and participate in it. And that is not okay on any level.* Through the phrase, *keeps getting brought up,* Liza indicates that the repetitive action of mistreatment is resulting in the activity of abusive intrapartum care. Furthermore, through her use of the noun *abuse* and the adjective *complicit* Liza indicates that the actions of the care-providers are unethical firstly, because they are inflicting abuse, and secondly because they are requesting the doulas to join in the abuse. Her use of the negation *not okay* along with the intensifier *any* builds

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significance around the fact that she strongly disagrees with these practices.

Celeste describes how a nurse was abusing a new-born baby when it wasn't responding well after birth, *I mean, you can flick the feet a little bit if the baby's not breathing. But there are a whole lot of things that I've been taught as a midwife you do before you started abusing the baby, you know. But she hit the baby's feet and she was shaking the baby. "Ek laat nie met my mors nie. Ek laat nie met my mors nie"* ["I don't let anyone mess with me"]. *We were so traumatised. We didn't go back to the hospital for a year.* Through this utterance the nurse positions the identity of the baby as someone that is challenging her authority, an authority which she claims by saying, "I don't let anyone mess with me". This phrase, accompanied by the violence of her actions, speaks of habitual mistreatment, and reflects Jewkes et al.'s (1998:10) findings that abuse has become ritualised in public maternity settings. Furthermore, by positioning her identity as authoritative, the nurse also demonstrates Bucholtz and Hall's (2005:603) principle of "authorisation and illegitimation", where one's identity is asserted through authority and belief in institutional structures, along with how others' identities are rejected and suppressed. In this case, the nurse aligns her identity with that of a medical institution in which the care-provider is the one in power, and the baby a medical problem that needs solving, and, therefore, not a sentient being. Celeste, in turn, discursively positions the nurse's identity as negative through the use of the evaluative adjective *abusing* to describe the nurse's actions.

Another cause for traumatisation of care-providers is the death of a mother or a baby. Judith says, *There's nothing worse than maternal death. I was ABSOLUTELY horrified.* Sam says, *Like today, that baby was dead already and the mother's dying and you're like* [gives a deep sigh]. *So for me, I go, yes, I saved her life. The baby's dead but at least she's alive. And tomorrow, I'll be over it. But 20 years ago, not.* Through building significance by emphasising the intensifier *ABSOLUTELY* and using the evaluative adjective *horrified* (Judith); and through paralinguistic respiration (Sam), these care-providers express the anguish they feel at the death of a mother or baby. However, by stating that she'll get *over it*, Sam illustrates that she has had to learn to distance herself emotionally in order to cope with decades of anguish over the deaths of patients. However, despite attempting to distance themselves emotionally many care-providers still described feeling traumatised and suffering from burnout.

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Care-providers reported feeling *emotionally exhausted* (Grace), *burnt out* (Liza), *suffering* from *physical palpitations* (Judith), and running on *empty batteries* (Esther). Sam states, *I'm EXTREMELY emotionally distressed. That's why I'm on anti-depressants. That's why I'm a hard-assed bitch on the outside.* By positioning her identity as a *hard-assed bitch*, Sam acknowledges the impact that long-term and acute emotional anguish has had on her. Through the phrase *on the outside,* and through mentioning that she's taking anti-depressants, she indicates that she nevertheless still feels the effect of the trauma. Sam's utterance reflects Allen et al.'s (2017:403) findings that burnout and secondary traumatic stress (which occurs after a care-provider has been exposed to a person who has suffered trauma) results in Compassion Fatigue. In turn, the consequences of Compassion Fatigue on a mother are severe, as it results in them not getting the emotional support they require in labour, which leads to their own feelings of traumatisation.

5.8 Theme 7: *They walk out here as changed women* - Compassionate care

The analysis of the data pertaining to compassionate care resulted in the identification of four sub-themes, namely, offering compassionate care; doulas; how to be compassionate after trauma; and the effects of compassionate care.

5.8.1 Offering compassionate care

Care-providers described compassionate care as *sincere love accompanied by respect* (Esther); the *asking of permission* (Celeste); giving *suggestions* instead of instructions (Liza); *empowering* mothers *with knowledge* and the *sharing of decisions* (Grace); *encouraging words such as, "You're doing so well. You're safe. Everything is going to be alright*" (Grace); and also protecting mothers from *this barrage of abuse* (Liza). Compassionate care could also be given non-verbally by looking *into their eyes* and through *subtle touch* (Grace). Celeste states, *I don't believe that a different language is a barrier because I can still show you kindness without words. I can make you feel relaxed, or peaceful, or encouraged, or supported without saying a word. It doesn't matter that you don't understand what I'm saying. If I'm murmuring kind words to you, you're going to get the idea.* This utterance is significant, as the idea of language barriers has often been cited as a reason for the mistreatment of

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women (Spencer et al. 2018:6), and by saying *murmuring kind words to you*, Celeste illustrates that it is possible to give compassionate care even though the mother doesn't understand what the care-provider is saying.

Interestingly, one care-provider also gave an example of compassionate *tough love* as described by Louise in section 5.4.4 above. Grace says, *So I looked at her and I said, "Pull yourself together. And let's do this. Like, show up now, absolutely show up". And she looked at me and she said to me, "Okay". And we got in there. And we did it.* Through the use of the personal pronouns *us* (*let's*) and *we*, Grace discursively constructs her relationship with her client as being supportive and empowering. Furthermore, she performatively constructs her identity as firm, yet kind, by the instructions she gives to her client.

5.8.2 Doulas

The significant contribution that doulas make to compassionate intrapartum care was emphasised by five of the six care-providers. As discussed in section 2.8.5 above, a doula is a person without formal obstetric training who provides continuous *psychological and emotional support* (Grace) during labour. Participants spoke about the value of doulas particularly in the public sector, as they will not only provide emotional support to the mothers, but also remove pressure from other care-providers. Esther states, *The midwives are telling me that I'm freeing their hands to do other stuff when there are doulas here. It will help in the MOUs. Everywhere. The MOUs have too many people. They can't. They can't. They can't. But government doesn't want to pay.* Through Esther's use of the metaphor *freeing their hands* she indicates the manner in which doulas will be beneficial to public midwives. She also builds significance by repeating the negation *They can't* three times, to illustrate the extent to which MOUs are overloaded. The fact that *government doesn't want to pay* is echoed by Grace who says, *I feel that instead of women sitting jobless, that the government, we, train doulas in the community. But then government must pay those women, you know. What a lovely way to encourage and to empower those women.* Grace explains that most doulas working in the public sector are there as volunteers, which, she believes, is not a sustainable model. Should the government employ doulas, many problems pertaining to the mistreatment of women will be eradicated. Through her use of the necessity modality *must*

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pay, Grace builds significance around how crucial it is that government supports this initiative by compensating doulas for the important contribution they can make. Through her use of the evaluative adjective *lovely*, along with the evaluative verbs *encourage* and *empower*, Grace indicates the positive effect it could have on unemployed women from the community.

5.8.3 How to be compassionate

As illustrated above in section 5.6, care-providers find it hard to show compassion due to the fact that they themselves are so traumatised by various aspects of the systems within which they operate. However, care-provider participants still believed that there are ways to circumvent this traumatisation and still show compassion. Firstly, many of the care-providers drew their inspiration and strength from seeing their work in obstetrics as a *calling* and a *privilege*. Esther says, *A midwife without a suit of armour can't be a midwife. It's not a job, it's a calling. You need to love people.* Through her use of the metaphor *suit of armour* Esther builds significance around the self-preservations methods needed to be able to function as a midwife. This is supported by the evaluative noun phrase *it's a calling* which positions midwives' identities as women don't see midwifery as just a job, but rather as women who feel it is their duty to support others. Grace suggests, *to make sure that you're being compassionate with yourself if you're working in the field of compassion. Or that you've got others who are compassionate with you, and you can receive compassion.* Through her repetition of the noun *compassion* and the adjective *compassionate* Grace builds significance around the reciprocal properties of compassion, namely that in order to be able to act compassionately, care-providers also need to be treated compassionately. Liza recommends that care-providers *fake it till you make it, you know. So when I go to a birth I've gotta play a role. I can't bring that into the birth. And I think it's just an adult skill that you need. Nobody cares what's going on in your personal life. You have to show up for this person now.* Through the necessity modal verb *have to* Liza indicates the dedication and perseverance maternity care-providers need to display if they were to continue providing compassionate care. This statement is supported by the aphorism *fake it till you make it*, the phrase *adult skill*, and the phrasal verb *show up* which is indicative of the self-control and commitment required to practice compassionate care.

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5.8.4 The effects of compassionate care

Care-provider participants reported that compassionate care had a profound effect on mothers. Firstly, it assists with pain reduction in labour. Celeste states, *if you're well supported you're not going to have fear. And if you don't have fear your labour is less painful*. Secondly, she believes that compassionate care results in women feeling like they have *autonomy* and *rights*, and imbues women with a sense of confidence. A third positive effect of compassionate care is that it provides women with skills which they can apply in their role as women and as parents. Celeste describes how she achieves this as *I want to nurture her into motherhood.* Through her use of this metaphor, along with the evaluative verb *nurture*, she builds significance around how her compassionate actions can lead to the empowerment of a woman as a mother. Esther concurs by saying, *Feeling in control turns her into a proud mother and she loves that baby from the start. They walk out here as changed women.* Through her use of the evaluative adjectives *proud* and *changed*, Esther illustrates how significant the effect of compassionate care is to a woman, Lastly, and significantly, Liza states that through being treated compassionately women are *able to open up and step into their own compassion.* Liza's use of the metaphor *step into their own compassion,* echoes Grace's illustration in section 5.8.3 above, of the reciprocal nature of compassion and illustrates that once mothers receive compassionate care, they, in turn, can act compassionately towards other. It is clear from these examples that, through these actions, care-providers are portraying the activity of women-centred or compassionate care, and that the provision of such care has a huge impact on women's identities, relationships, and sense of self-worth.

5.9 Conclusion

This chapter provided an analysis and a report of the discursive (re)constructions of participants' recollections of their birth experiences, whether as mothers or as maternity care-providers. Mother participant and care-provider data were analysed under two separate section, with each section divided into themes and sub-themes. Utilising the tools provided by thematic analysis, DA, IS and SL, the manner through which participants created meaning and built reality were analysed. Chapter 6 will provide a discussion of the data. It will also answer the research questions posed the Chapter 1, discuss the social impact of the study and

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its limitations, as well as make suggestions for future research.

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CHAPTER SIX

DISCUSSION AND CONCLUSION

6.1 Introduction

This chapter present a synthesis of the findings and conclusions that have been arrived at through the data analysis, and provides links between these findings and the literature discussed in Chapter 2, and the theoretical perspectives on which this study is based, as discussed in Chapter 3. The first section of this chapter revisits the research aims and objectives of the study, and addresses the research questions as outlined in Chapter 1. Whilst answering the research questions there is also an examination of the linguistic strategies participants used to discursively (re)construct the memories of their birth experiences. This is followed by a discussion of the key findings of the study. Lastly, this chapter presents a review of the limitations of the study, recommendations for future research, along with a discussion of the potential social impact of this study.

6.2 Aims and objectives of the study

The aim of this study was to investigate the discursive (re)construction of participants' recollections of their birth experiences, whether as birthing mothers, or in their capacity as maternity care-providers. By employing a multi-perspectival approach which incorporates the analytical tools provided by the disciplines of DA, IS, and SL, the study has investigated how participants have articulated their birth experiences, and what they expected from, and considered appropriate communication during labour. Furthermore, there was a specific focus on the use of compassionate language, or the lack thereof, during birth, and what the effect of that was.

6.3 Addressing the research questions

The following section will address each research question separately.

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6.3.1 Research question one: How do maternity care-providers and mothers articulate the memories of their birth experiences?

The manner in which participants articulated the memories of their birth experiences can be arranged into two main motifs, namely that of discourses of traumatisation, and discourses of empowerment, both of which was achieved through a variety of linguistic strategies.

6.3.1.1 Discourses of traumatisation

i) Causes for traumatisation of mother participants

The analysis of the data revealed that out of the 25 births mother participants had, 56% of these births were reported as being traumatic. All of the six care-provider participants described feeling traumatised through encounters or experiences they had in their line of work. Mother participants reported that the major cause of traumatisation stemmed from not being in control of their labours and births, and was primarily illustrated through their descriptions of absence of consent over interventions like episiotomies, and monitoring through violent and painful vaginal exams. This is in keeping with the findings of McIntosh (1988:169) who state that interventions (especially an alarming percentage of episiotomies) are not communicated to women before they are conducted, thereby denying women the right to give consent over what will be inflicted on their bodies. Mother participants used evaluative verbs (*raped*; *screaming*), evaluative adjectives (*painful; traumatic; horrific*), evaluative actions (*screamed*), intensifiers (*unbearably*), and emphasis to construct significance around experiences they equated to sexual abuse and rape. This supports Kitzinger's (2012:304) findings that a medical model of care frequently results in experiences analogous to rape, which, in turn, culminates in childbirth-related PTSD, and women who feel violated by the medical system.

Both mother and care-provider participants repeatedly described how women's identities were positioned as medical problems to be resolved. Under the theme of indifference and disrespect, a participant used a metaphor to describe that her care-provider just saw her as a *big vagina with a baby that couldn't get out*. Furthermore, under the theme pertaining to lack

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of privacy, participants used similes (*like a corpse whose organs are now going to be harvested*), evaluative adjectives (*horrible*) and evaluative actions (*crying*) to describe how they felt about having their vaginas exposed to big groups of care-providers. This again positioned their identities as medical problems, illustrating the norms of the medical model of care, and echoes Hewison's (1993:226) findings that pregnancy and childbirth have increasingly been repositioned as "medical problems" which need supervision and management (Hewison 1993:226).

ii) Causes for traumatisation of care-provider participants

The main cause for the traumatisation of care-providers stemmed from them witnessing the abuse inflicted on mothers and babies. Through phrases such as *Ek laat nie met my mors nie* ["I don't let anyone mess with me"], care-provider participants also illustrated Bucholtz and Hall's (2005:603) emergence principle of authorisation and illegitimation to construct the identities of abusive care-providers as shaped by the medical institutions which employ them, as well as indicating the activity of obstetric violence these actions created. This is in keeping with Jewkes et al.'s (1998:10) findings that abuse has become ritualised and habitual in some maternity settings. Another main cause of the traumatisation of care-providers was ascribed to feeling unsupported by the public institutions for which they worked. Through the use of intensifiers (*just; SO*), negation (*doesn't understand*), evaluative verbs (*abuse*; *overloaded*), and repetition, participants described the severe pressure under which they worked, the mismanagement of resources, and the lack of respect they experienced, which supports Jewkes et al.'s (1998) finding that the mistreatment of women in public maternity settings emanates from how care-provider identities have been shaped by the institutions which govern them.

iii) The effects of traumatisation on mother participants

The effects of traumatisation on the part of the mother participants was described through the use of repetition (*failed; failure*), intensifiers (*super; absolutely)*, and evaluative adjective phrases (*ABSOLUTELY fucking horrific*) to build significance about how severely they were impacted by obstetric violence during their births. Participants reported feeling cheated out of

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natural births which resulted in them constructing their identities as women who are incapable of birthing naturally, let them feel like failures as women, and left them feeling averse to having more children. They also reported feeling *diminished*, *naïve*, *numbed*, and as suffering from *post natal depression*. This supports the findings of Thomson and Downe (2010:108) who state that due to the depth of the psychological trauma they suffered, women describe that they feel their identities have been "changed forever", and that they are so distraught by the traumatic birth that they cannot imagine having another.

iv) The effects of traumatisation on care-provider participants

The effects of traumatisation on the care-provider participants resulted in them suffering from burnout and Compassion Fatigue, and was described through the discursive resources of emphasis (*ABSOLUTELY*), and evaluative adjectives (*horrified)* to build significance around their anguish. Furthermore, by describing the repetitiveness of the abusive actions they witnessed and suffered (*one of the things that keeps getting brought up is that they're witnessing this abuse*), they constructed the activity of abusive intrapartum care or obstetric violence. Participants also constructed their identities through the use of evaluative adjectives and expletives (*hard-assed bitch*) to describe how immobilised they have become through the trauma, which is in keeping with Allen et al.'s (2017:403) findings that traumatisation in care-providers can lead to a lack in compassion.

6.3.1.2 Discourses of empowerment

Significantly, the data indicated that positive birth experiences led to all mother participants feeling empowered. Through the use of intensifiers (*so; how*), repetition (*empower; empowering*), and evaluative adjectives (*amazing; wonderful*), participants built significance around the extent to which a positive birth had an empowering effect on them. The notion of redemptive birth as a source of empowerment was a key theme discussed by participants. By expressing degrees of certainty through the use of intensifiers (*absolutely; totally; really*), participants expressed how a redemptive birth restored their confidence in their bodies' ability to successfully birth their babies. Notably, participants also expressed that a positive birth led to them immediately wanting to have another baby, thereby supporting Kärlstrom et al.'s

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(2015:3) findings that a positive or redemptive birth has the ability to instil in mothers the confidence of achieving such a birth again. Through their description of how a positive birth was facilitated, participants described how their positive face requirements of respect, autonomy, and share-decision making were met (*I felt like I'd been seen, you know, like, DEEPLY*), which is illustrative of woman-centred, or compassionate care. Participants also illustrated Pennycook's (2004:1) principle of identity performatively (*And then I just kept saying we DID it. We did it! And then* [the doula] *was like, YOU did it*) in their description of how the caring and supportive identities of their care-providers emerged during their interactions. Importantly, participants indicated that a positive birth also had an empowering effect on not only their partners, but also on the care-providers themselves, thereby indicating the prevalence of a compassionate intrapartum relationship. Furthermore, by successfully facilitating perceived high-risk births, these care-providers also contradicted the medical model of care, empowered themselves in the process, and affirmed the benefits of compassionate intrapartum care.

In terms of the empowering effect the birth setting has on participants, the data revealed that a home-birth setting, or a hospital setting where the birth was assisted by a private midwife and/or doula, had a major positive influence on women's perceptions of their experiences. In contrast to the starkness of institutionalised settings, these birth environments were described as *calm, warm, dark, cozy, comfortable* and *quiet* places, which felt *familiar, safe, relaxed, pleasant* and *private.* The type of care prevalent in these settings was described through how mothers were granted the social goods of respect and support, how their negative face wants of privacy were respected, through the partnership-like relationships women had with care-providers, and significantly, through the lack of interventions present in these environments. Lastly by describing the actions of these care-providers (*she doesn't interfere at all and I thought that was a bit weird but afterwards I could see why that was important. And it really makes a big difference)*, participants portrayed the socially significant norms and actions central to the 'institution' of midwifery-led care, thereby illustrating the activity or practice of compassionate intrapartum care. This also support Karlström et al.'s (2015:1) findings that after trust in their own abilities and strength to birth their babies, women rated a “trustful” and “respected” relationship with their care-providers as the most important contributing factor to a positive birth experience.

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These discursive (re)constructions of participants birth experiences support Greenfield et al.'s (2016:264) findings that the type of intrapartum care a woman receives not only has a profound effect on how she perceives the birth, but also how traumatised or empowered she feels in the aftermath.

6.3.2 Research question two: What do maternity care-providers and mothers expect from their birth experiences in terms of communication, and how do their experiences compare to these expectations?

The analysis of the data revealed that all mother participants expected that they could trust what their care-providers communicated to them; however, significantly, 52% of participants indicated that, in retrospect, the trust was not justified. This supports Bluff and Holloway's (1994:159-160) findings that women implicitly trust in the expertise, and therefore the instructions, of their care-providers, as these care-providers are perceived as specialists who are trained and experienced, "do it every day" and, therefore, "know best". Participants describe that the main way their trust was broken was through the manner in which care-providers introduced risk in order to facilitate the medical management of their birth experiences. The discursive strategies care-providers used to introduce risk was through warnings (*just now you die*), coercion (*You're a VBAC. You can't leave)*, the instilling of fear (*We can't have a dead baby on our hands*), and the wielding of control (*I expect you to be at least six* [centimetres dilated] *by lunchtime, so that we can carry on*), all of which communicated the norms of the institutions for which they work, and are indicative of an autocratic model of care. This supports the findings of Bohren et al. (2015:13), namely that the "hierarchical authority" of the healthcare system places care-providers in "legitimized" situations of power, and due to the abusive treatment which this facilitates, places women, who should be the ones in charge of their birthing processes, at the bottom of the ladder. The majority of participants expected to achieve a natural, unmedicated birth, but felt they were coerced into either directly having a caesarean section, or into interventions which ultimately led to caesarean sections, resulting in severe feelings of distress. This, firstly, supports Kitzinger's (2012:303) findings that low-risk births which are managed as if they are high risk then, indeed, do become high risk, and secondly, supports Hewison's (1993:227) findings that risk requires intervention, and by renaming birth a risk, it has legitimised care-providers'

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attempts to scientifically control the presumed dangers of birth. This results in the eradication of women's control over their birth processes (*I was lying on the table like a slab of meat and I had no idea what was going on*), which, in turn, was described by participants as one of the main causes for traumatisation.

The instances where care-provider participant's expectations of the communication around birth was not met were mainly reported by those care-providers who follow a woman-centred, or midwifery model of care, namely private/traditional midwives and doulas, when they had to support their clients in environments which followed a medical model of care. All other care-providers were well acquainted with the norms of the institutions for which they worked, and did not expect anything different in terms of communication. Within the medical model of care, mothers and babies were seen as medical problems to be solved and not as sentient beings, and were communicated to as such. Not having their expectations of woman-centred care met, for instance when they witnessed that mothers and babies were treated abusively, or when they were asked to be complicit in the abuse, led to the traumatisation of care-providers. This supports the findings of Rice and Warland (2013:1057) that private midwives, in particular, establish a deeply compassionate connection with their clients, and it is this connection which increases their exposure to emotional distress.

6.3.3 Research question three: How do maternity care-provider and mothers describe the styles and strategies of compassionate intrapartum communication?

The data revealed that there were many similarities in the ways that mother and care-provider participants described the styles and strategies of compassionate intrapartum communication. All participants placed great value on the imparting of information as it led to mothers being able to make informed decisions during their birth processes and resulted in them stating that it awarded them the social good of being included in their births. This supports Greenfield et al.'s (2016:264) findings that the imparting of information results in women who feel empowered. The second strategy of compassionate communication which participants agreed upon was that of reassurance and encouragement. This was achieved through phrases such as *You're doing so well*, *You're safe*, *Everything is going to be alright*, *You're amazing*, *Trust yourself*, *You're doing this*, and *Listen to your body*. Through the use of evaluative adverbs,

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evaluative adjectives and intensifiers, women built significance around the positive effect such encouragement had on them. It is important to note that the use of reassurance and encouragement had a positive effect on women who birthed in public settings too, especially since conditions in these setting are less than ideal. It resulted in woman feeling that their positive face requirements of being supported was met, and supports Ménage et al.'s (2017:564) finding that feeling supported can lead to increased feelings of empowerment and decreased feelings of fear around the birth. The third similarity in participants' reports on the styles and strategies of compassionate intrapartum communication refers to the giving of recommendations instead of instructions. Through the use of intensifiers and evaluative adjectives, women constructed the relationships with their care-providers as based in mutual trust and support and indicated that they were awarded the social good of being included in decision-making.

Apart from the verbal ways to communicate compassion, participants also indicated the non-verbal ways through which it could be shown – first of all through small gestures like eye contact and subtle physical touch, care-providers communicated that mothers were deserving of such care, thereby meeting their positive face requirements of being viewed as legitimate and acceptable. This supports Van der Cingel's (2011:676) findings that compassionate care can be demonstrated even through small gestures like eye contact, and still have a profound effect. A second non-verbal way that compassion can be communicated through is silence, and the action of being quiet, yet present and attentive in the birth. This simultaneously does not interrupt the mother's birth process, yet still allows her to feel supported, and supports Karlström et al.'s (2015:5) findings that mothers respond very positively to the respectful silence of their care-providers. A significant finding derived from the data is the notion that a "language barrier" is not a barrier. Language barriers (patient and medical care-providers not sharing a language or lingua franca) are frequently cited (Spencer et al. 2018:6) as reasons for the mistreatment of women; however by showing compassionate care through the tone of one's voice, and *murmuring kind words*, it is possible to communicate compassionate care even though the mother doesn't understand the words that the care-provider is saying.

The data revealed that the implementation of compassionate intrapartum communication has a profound effect on mothers. It leads to a reduction in their perception of pain, instils in them

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self-confidence, grants them autonomy over their birth processes, and lets them feel that they have rights, and therefore has a significant impact on how mothers construct their identities as not only autonomous human beings, but also as confident mothers. Significantly, it was also reported that by receiving compassionate care a mother can *step into* her own compassion and can pass it on to others, thereby creating a cycle of compassion. This supports the findings by Kärlstrom et al. 2015:3 that a positive birth experience results in women perceiving their births as *a very special journey* and an *important moment of life* which fills them with a sense of pride in what they have achieved. Furthermore, it supports the suggestions of organisations like NICE (2017) and WHO (2016) which state that women who receive "effective communication, support and compassion" from their care-providers during the intrapartum process feel "in control" of their birth processes, and as if their decisions are important and honoured.

As discussed in Section 6.3.1.1 above, it is often difficult for care-providers to show compassion due to the traumatisation, burnout, and Compassion Fatigue which they suffer from. However, significantly, the data has revealed ways in which care-providers can mitigate this trauma and still show compassionate care. Firstly, by *seeing it as a calling*, and *fak[ing] it till you make it*, care-providers indicated the dedication and perseverance maternity care-providers need to display, along with the self-control and commitment required if they were to continue providing compassionate care. Furthermore, through the use of metaphors (*A midwife without a suit of armour can't be a midwife*), and necessity modalities (*You have to show up*), care-providers indicated that it is crucial that they implement self-preservation strategies to protect themselves emotionally from the trauma. This reflects the findings of Rice and Warland (2013:1062) and Allen et al. (2017:405) that care-providers can mitigate the effects of traumatisation, burnout and Compassion Fatigue through personal support structures, debriefing sessions with other care-providers, and therapy. Lastly, the value of employing of doulas in the public sector was emphasised by most care-providers. Through the use of metaphors (*freeing their hands*) and repetition (*They can't. They can't. They can't.*), care-providers indicated how much strain is put on already overloaded care-providers. Through the use of evaluative adjectives (*lovely)*, along with evaluative verbs (*encourage; empower)* care-providers describe how beneficial doulas would be on alleviating this strain, and in providing much needed emotional support to women who don't always have birth

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partners with them. The benefits of doulas were asserted by Bohren et al. (2017:2) , who state that, though doulas, the likelihood of a "spontaneous vaginal birth" is improved, along with an increase in positive birth experiences, a decrease in the duration of labours, and, significantly, a reduction in instances of post-partum depression.

6.4 Key findings of the study

The analysis of the data confirmed that there is a clear distinction between a medical model of care and a woman-centred, or compassionate, model of care. Considering that a significant portion of intrapartum care is delivered through communication, it is important to note that birthing mothers frequently equate intrapartum communication with intrapartum care. Within a medical model of care, the institutional norms and values are realised through the practices of autocratic, abusive, and unsupportive care, frequently resulting in obstetric violence, and is achieved linguistically through the introduction of risk, the instilling of fear, manipulation, and control. Women and babies' identities are repositioned as medical problems that need solving, and this results in women feeling cheated, diminished, numbed, deprived of their embodied agency, and suffering from post-natal depression and/or traumatisation. Contrastingly, within a woman-centred model of care the norms and values of compassionate intrapartum care are followed. Woman feel empowered, respected, and supported and are possible to experience the benefits of redemptive births, and have the confidence in their bodies restored. Furthermore, woman are included in the decision-making processes of their births and develop a partnership-like, and mutually trusting relationship with their care-providers.

Three main findings have been identified through the analysis of the data. The first is that through the discursive (re)construction of their birth experiences, participants have indicated that the manner of care which takes place in an intrapartum environment - whether it is abusive or compassionate - along with the physical setting of the birth, has a critical impact on not only mothers and babies/children, but, importantly, also on the care-providers themselves.

The second main finding is that through these discursive (re)constructions, participants revealed that the realities of participants' birth experiences were not in line with their

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expectations of the communication during the intrapartum period in the instances where the births were perceived as negative or abusive.

The third, and most significant, finding of this study is that, in addition to describing the styles and strategies of compassionate intrapartum communication, care-provider participants provided potential solutions to mitigate the traumas stemming from abusive intrapartum care, which could lead to benefits for both mothers and care-providers.

6.5 Limitations of the study

Due to the fact that participants were sourced via the personal networks of the researcher, the data derived from the mother participants were not entirely representative of the birthing population of South Africa as a whole, as only a small amount of participants birthed in the public sector. The study is, therefore, skewed towards participants who birthed in private and home-birth settings. However, the lack of data from mother participants on public maternity institutions was supplemented by the data gathered from the care-provider participants, who worked across the spectrum of maternity settings in South Africa, and therefore provided a more in-depth perspective. Another limitation of this study is that, due to constraints around time and resources, it was able to only focus on a small data sample, and results can, therefore, not be generalised. However, the findings nevertheless support those of the limited number of published studies done on the topic, as well as providing some new perspectives on the topic.

6.6 Recommendations for future research

As mentioned in Chapter 2, compassionate intrapartum communication is a nascent field of research, with scholars in the field repeatedly calling for further research on the topic (Sinclair et al. 2016:14). Studies consisting of larger data samples will be able to provide more generalised findings, along with raising the consciousness around the topic. Furthermore, more in-depth studies on the mitigation of trauma arising from childbirth could result in reducing instances of obstetric violence, and increasing instances of compassionate intrapartum care, thereby improving the experiences of women, babies, and maternity care-

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providers in global intrapartum settings.

6.7 Social impact of this study

The influence which the experiences around birth has on women, their partners, and their children, along with the effect it has on maternity care-providers, has a significant knock-on effect for society in general. The effects of traumatisation or empowerment during birth is carried forward into not only how women treat their children, and how these children are then shaped as human beings, but also redefines women's role in society as traumatised individuals, or as powerful, autonomous human beings. A study of this nature, and future research that sprouts from it, has the potential to not only create consciousness around, and address, obstetric violence, but can also contribute to a reduction in violence against women, and human rights violations in general.

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References

Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, A., Gemmill, A. et al. 2015. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet* 387, 462-474.

Allen, R., Watt, F., Jansen, B., Coghlan, E. & Nathan, E. 2017. Minimising compassion fatigue in obstetric/gynaecology doctors: exploring an intervention for an occupational hazard. *Australasian Psychiatry* 25(4), 403-406.

Arntfield, L., Slesar, K., Dickson, J. & Charon, R. 2013. Narrative medicine as a means of training medical students towards residency competencies. *Patient Education and Counselling* 92, 280-286.

Beck, C (2004b). Birth trauma: in the eye of the beholder. *Nursing Research* 53(1), 28-35.

Berg, A. 2016. The importance of the first 1000 days of life. *Journal of Child & Adolescent Mental Health* 28(2), iii-vi.

Berg, M., Lundgren, I., Hermansson, E. & Walhberg, V. 1996. Women's experience of the encounter with the midwife during childbirth. *Midwifery* 12, 11-15.

Bluff, R. & Holloway, I. 1994. 'They know best': women's perceptions of midwifery care

Bohren, M., Vogel, J., Hunter, E., Lutsiv, O., Makh, S., Souza, J. 2015. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *Plos Medicine* 12(6), 1-32.

Bradley, S., McCourt, C., Rayment, J. & Parmar, D. 2016. Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences. *Social Science &*

Stellenbosch University https://scholar.sun.ac.za

Medicine 169, 157-170.

Bramley & Matiti. 2014. How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing* 23, 2790-2799.

Braun, V., and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(1), 77-101.

Brown, P. and Levinson, S. 1987. *Politeness. Some universals in language usage.* Cambridge: Cambridge University Press.

Bucholtz, M. and Hall, K. 2005. Identity and interaction: a sociocultural linguistic approach. *Discourse Studies* 7(4-5), 585-614.

Butler, J. 1999. *Gender Trouble. Feminism and the Subversion of Identity*. New York and London: Routledge.

Chadwick, R., Cooper, D. and Harries, J. 2014. Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery* 30, 862-868.

Chadwick, R. 2016. Obstetric violence in South Africa. *South African Medical Journal* 106(5), 423-424.

Chang, Y., Coxon, K., Portela, A., Furuta, M. and Bick, D. 2018. Interventions to support effective communication between maternity care staff and women in labour: A mixed-methods systematic review. *Midwifery* 59, 4-16.

Charon, R. 2012. Narrative medicine in the international education of physicians. *Presse Med* 42, 3-5.

Charon, R. 2015. 'Why read and write in the clinic? The contributions of narrative medicine

Stellenbosch University https://scholar.sun.ac.za

to health care' in H. Hamilton & W. Chou (eds.), *The Routledge handbook of language and health communication*, pp. 245-258, Routledge, New York.

Charon, R., DasGupta, S., Hermann, N., Irvine, C., Marcus, E., Colón, E., Spencer, D., and Spiegel, M. 2017. *The principles and practice of narrative medicine.* New York: Oxford University Press.

Cohen Shabot, S. 2016. Making loud bodies "feminine": a feminist-phenomenological analysis of obstetric violence. *Human Studies* 39(2). 231-247.

Coupland, N. and Jaworksi, A. 2001. Discourse. In Cobley, P. (ed.). *The Routledge Companion to Semiotics and Linguistics*. London and New York: Routledge. 134-148.

Dahlen, H., Kennedy, H., Anderson, C., Bell, A., Clark, A., Foureur, M. et al. 2013. The EPIIC hypothesis: Intrapartum effects on the neonatal epigenome and consequent

Edley, N. and Litosseliti, L. 2010. Contemplating Interviews and Focus Groups. In Litosseliti, L (ed.). *Research Methods in Linguistics*. London and New York: Continuum International Publishing Group. 155-179.

Elmir, R., Schmied, V., Wilkes, L. and Jackson, D. 2010. Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing* 66(10), 2142-2153).

Erasmus, S. 2017. 'R1 mill bill: No one left to deliver our babies?' Fin24, viewed 14 August 2018, from https://www.fin24.com/Economy/r1m-bill-no-one-left-to-deliver-our-babies-20170406.

Fairclough, N. 1992. *Discourse and social change*. Cambridge: Polity Press.

Fenech, G. and Thomson, G. 2014. Tormented by ghosts from their past: A meta-synthesis to explore the psychosocial implication of a traumatic birth on maternal well-being.

Stellenbosch University https://scholar.sun.ac.za

Elsevier Midwifery 29, 185-193.

Fisher, S. 1991. A discourse of the social: medical talk/power talk/oppositional talk? *Discourse and Society* 2(2), 157-182.

Gee, J. 2011. *An Introduction to Discourse Analysis. Theory and Method*. London and New York: Routledge.

Gee, J. 2014. *How to do Discourse Analysis. A Toolkit*. Oxon and New York: Routledge.

Gee, J. and Handford, M. (eds.). 2012. *The Routledge Handbook of Discourse Analysis.* New York: Routledge. 1-6.

Goetz, J., Keltner. D., and Simon-Thomas, E. 2010. Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin* 136(3), 351-374.

Goffman, E. 1967. *Interaction Ritual. Essays on face-to-face behavior.* New York: Anchor Books.

Goffman, E. 1981. *Forms of Talk.* Oxford: Blackwell.

Goffman, E. 1986. *Frame Analysis. An Essay on the Organization of Experience.* Boston: Northeastern University Press.

Gordon, S. 2015. Framing and positioning. In Tannen, D., Hamilton, H., and Schiffrin, D. (eds.). *The Handbook of Discourse Analysis. Second Edition.*West Sussex: John Wiley & Sons. 324-345.

Greenfield, M., Jomeen, J. and Glover, L. 2016. What is traumatic birth? A Concept analysis and literature review. *British Journal of Midwifery* 24 (4), 254-267.

Gumperz, J. 2015. Interactional Sociolinguistics. A Personal Perspective. In Tannen, D.,

Stellenbosch University https://scholar.sun.ac.za

Hamilton, H., and Schiffrin, D. (eds.). *The Handbook of Discourse Analysis. Second Edition.* West Sussex: John Wiley & Sons. 309-323.

Hastings-Tolsma, M., Nolte, A. & Temane, A. 2018. Birth stories from South Africa: voices unheard. *Women and Birth* 31. e42-e50.

Harvey, K. and Adolphs, S. 2012. Discourse and health care. In Gee, J. and Handford, M. (eds.). 2012. *The Routledge Handbook of Discourse Analysis.* New York: Routledge. 470-481.

Hewison, A. 1993. The language of labour: an examination of the discourses of childbirth. *Midwifery* 9, 225-234.

Institute for Health Communication. 2018. *Impact of communication in* healthcare. Viewed 20 April 2018 from http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/.

Jaspers, J. 2012. Interactional sociolinguistics and discourse analysis. In Gee, J. and Handford, M. (eds.). 2012. *The Routledge Handbook of Discourse Analysis.* New York: Routledge. 162-173.

Jewkes, R., Abrahams, N., Mvo, Z. 1998. Why do nurses abuse patients? Reflections from South African obstetric services. *Social science & medicine* 47(11), 1781-1795.

Johnstone, B. 2008. *Discourse Analysis*. Oxford: Blackwell Publishing.

Jones, R. 2015. Discourse and Health Communication. In Tannen, D., Hamilton, H., and Schiffrin, D. (eds.). *The Handbook of Discourse Analysis. Second Edition.*West Sussex: John Wiley & Sons. 841-857.

Jørgensen, M. and Phillips, L. 2002 *Discourse Analysis as Theory and Method*. London: SAGE Publications Ltd.

Stellenbosch University https://scholar.sun.ac.za

Karlström, A., Nystedt, A., & Hildingsson, I. 2015. The meaning of a very positive birth experience: focus group discussions with women. *BioMedCentral Pregnancy and Childbirth* 15(1), 1-8.

Khosla, R., Zampas, C., Vogel, J., Bohren, M., Roseman, M. & Erdman, J. 2016. International human rights and the mistreatment of women during childbirth. *Health and Human Rights Journal*18(2), 131-143.

Kitzinger, S. 2012. Rediscovering the social model of childbirth. *Birth* 39(4), 301-304.

Kruger, L. & Schoombie, C. 2010. The other side of caring: abuse in a South African maternity ward. *Journal of Productive and Infant Psychology* 28(1), 84-101.

Lyons-Ruth, K., Bureau, J., Easterbrooks, M., Obsuth, I., Hennighausen, K. & Vulliez-Coady, L. 2013. Parsing the construct of maternal insensitivity: distinct longitudinal pathways associated with early maternal withdrawal. *Attachment & Human Development* 15(5-6), 562-582.

MacKenzie Bryers, H. & van Teijlingen, E. 2010. Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care. *Midwifery* 26, 488-496.

Madula, P., Kalembo, F., Yu, H. & Kaminga, A. 2018 Healthcare provider-patient communication: a qualitative study of women's perceptions during childbirth. *Reproductive Health* 15(1), 1-10.

McIntosh, J. 1988. Women's views of communication during labour and delivery. *Midwifery* 4, 166-170.

Ménage, D., Bailey, E., Lees, S. & Coad, J. 2017. A concept analysis of compassionate midwifery. *Journal of Advanced Nursing* 73(3), 558-573.

Stellenbosch University https://scholar.sun.ac.za

Merriam-Webster. 2018. *Intrapartum.* Viewed 1 September 2018 from https://www.merriam-webster.com/medical/intrapartum.

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D. et al. 2016. Beyond too little, too late and too much, too soon: a pathway towards evidenced-based, respectful maternity care worldwide. *The Lancet* 388, 2176-2192.

National Institute for Health and Care Excellence (NICE). 2017. *Intrapartum care for healthy women and babies.* Accessed on 28 September 2018 from https://www.nice.org.uk/guidance/cg190

Neumann, M., Edelhäuser, F., Tauschel, D., Fischer, M., Wirtz, M., Woopen, C., Haramati, A., and Scheffer, C. 2011. Empathy decline and its reasons: A systematic review of studies with medical students and residents. *Academic Medicine* 86(8), 996-1009.

Odent, M. 2009. "The instincts of motherhood: Bringing joy back into newborn care". *Early Human Development* 85, 697-700.

Oxford English Dictionary. 2008. Oxford: Oxford University Press.

Pennycook, A. 2004. Performativity and language studies. *Critical Inquiry In Language Studies: An International Journal* 1(1), 1-19.

Pepper, M., & Slabbert, M. 2011. Is South Africa on the verge of a medical malpractice litigation storm? *South African Journal of Bioethics and Law* 4(1), 29-35.

Phillips, N. and Hardy, C. 2002. *Discourse Analysis. Investigating Processes of Social Construction.* London and New Delhi: Sage Publications, Inc.

Pickles, C. 2015. Eliminating abusive care. A criminal law response to obstetric violence in South Africa. *South African Crime Quarterly* 54, 5-16.

Stellenbosch University https://scholar.sun.ac.za

ProQOL. 2019. *Professional Quality of Life Measure: ProQOL.org.* Viewed 14 June 2019 from https://proqol.org/

Ragan, S., Beck, C. & White, M. 1995. Educating the Patient: Interactive learning in an OB-GYN Context. In Morris, G. & Chenail, R. (eds.) *The Talk of the Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse.* New York: Routledge. 185-207.

Rice, H. & Warland, J. 2013. Bearing witness: midwives experiences of witnessing traumatic birth. *Midwifery* 29, 1056-1063.

Roberts & Sarangi. 2005. Theme-oriented discourse analysis of medical encounters. *Medical Education* 39, 632-640.

Rydahl, E., Declercq, E., Juhl, M., and Maimburg R. 2019. Cesarean section on the rise – Does advanced maternal age explain the increase? A population register-base study. *PloS ONE* 14(1), 1-17.

Sarangi, S. 2004. Towards a communicative mentality in medical and healthcare practice. *Communication and Medicine* 1(1), 1-11.

Savage, V. and Castro, A. 2017. Measuring mistreatment of women during childbirth: a review of terminology and methodological approaches. *Reproductive Health* (14), 1-27.

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A., Daniels J. et al. 2014. Global causes of maternal death: a WHO systematic analysis. *Lancet Global Health* 2, e323-2333.

Seggie, J. 2013. The 'boom' in medical malpractice claims - patients could be the losers. *South African Medical Journal* 103(7), 433.

Stellenbosch University https://scholar.sun.ac.za

Schiffrin, D., Tannen, D., Hamilton, H. (eds.) 2015. *The Handbook of Discourse Analysis. Second Edition.* West Sussex: John Wiley & Sons. 1-7.

Schrewe, B., Bates, J., Pratt, D., Ruitenberg, C. & McKellin, W. 2017. The Big (D)eal: professional identity through discursive constructions of 'patient'. *Medical Education* 51, 656-668.

Sinclair, S., Norris, J., McConnell, S., Chochinov, H., Hack, T., Hagen, N., McClement, S., Bouchal, S. 2016. Compassion: a scoping review of the healthcare literature. *BMC Palliative Care* 15, 6.

Soet, J., Brack, D. & Dilorio, C. 2003. Prevalence and predictors of women's experience of trauma during childbirth. *Birth issues in perinatal care* 30(1), 36-46.

Spencer, N., du Preez, A. & Minnie, C. 2018. Challenges in implementing continuous support during childbirth in selected public hospitals in North West Province of South Africa. *Health SA Gesondheid* 23, 1-8.

Strauss, C., Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F., Cavanagh, K. 2016. What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review* 47, 15-27.

Thomas, R. 2006. *Health Communication*. New York: Springer.

Thomson, G., & Downe, S. 2010. Changing the future to change the past: women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology* 28(1), 102-112.

Van der Cingel, M. 2011. Compassion in care: A qualitative study of older people with chronic disease and nurses. *Nursing Ethics* 18(5), 672-685.

Stellenbosch University https://scholar.sun.ac.za

Van Dijk, T. (ed.) 1985. *The handbook of Discourse Analysis. Volume 1*. London: Academic Press. 1-10.

West, C., Huschka, M., Novotny, P., Sloan, J., Kolars, J., Habermann, T. and Shanafelt, T. (2006) Association of perceived medical errors with resident distress and empathy. A prospective longitudinal study. *Journal of American Medical Association*, 296(9), 1071-1078.

White Ribbon Alliance. 2011. *Respectful maternity care: The universal rights of childbearing women*. Viewed 16 September 2018 from https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf

World Health Organization. 2015. *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Viewed 3 February 2018 from http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/

World Health Organization. 2016 *Standards for improving quality of maternal and newborn care in health facilities*. Viewed 18 July from https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/

World Health Organization. 2018. *WHO recommendations: intrapartum care for a positive childbirth experience*. Viewed 26 June 2019 from https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

World Population Review. 2019. *Continent and region populations 2019*. Viewed 30 June 2019 from http://worldpopulationreview.com/continents/

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APPENDIX A: MOTHER PARTICIPANT CONSENT FORM

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Sulette Minnaar, from the Department of General Linguistics at Stellenbosch University. You were approached as a possible participant because you have had two or more births, one in which you were treated compassionately by your care-providers.

1. PURPOSE OF THE STUDY

Firstly, the study aims to investigate the use of compassionate language during labour and childbirth by looking at how women feel or react when their care-providers use compassionate language versus when their care-providers use neutral or non-compassionate language.

Secondly, the study will look at compassionate language during labour and childbirth from the perspective of the care-providers and whether care-providers experience any difficulties in using compassionate language or not.

Lastly, the study will look at whether mothers and care-providers differ in their opinions on compassionate care during labour and childbirth and what the implications of this would be.

2. WHAT WILL BE ASKED OF ME?

You will first be asked to complete a questionnaire which the investigator will email or deliver to you and which needs to be returned (by email to, or collection by, the investigator). The investigator will then conduct a one-on-one interview at a convenient and quiet location of your choice (for instance your home, or a nearby coffee shop). The interview will last no longer than an hour. The interview will be recorded with a recording device. All relevant audio data will be transcribed.

3. POSSIBLE RISKS AND DISCOMFORTS

There is the possibility that one or more of your births, or aspects of a birth, were unpleasant or even traumatic, and that it would be uncomfortable, difficult or even upsetting to talk about. Should you feel the need to discuss these events with someone like a therapist or trauma counsellor, the investigator suggests contacting the following professionals at:

1. The Trauma Centre, Cowley House, 126 Chapel Street, Woodstock (if you experienced aspects of a birth as a physically or emotionally violent act)

   Tel: 021 465 7373
   Contact: Yeukai Chideya
   Email: info@trauma.org.za
   Web: www.traumacentre.org.za
2. The South African Depression and Anxiety Group (for depression/post natal depression and anxiety following a birth)

   Counselling line 8am to 8pm, 7 days a week on 011 234 4837 or toll-free on 0800 21 22 23.

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Or join one of the following Depression and Anxiety support groups:

Claremont. Lizelle: 073 209 8890
Fish Hoek. Lisa: 073 467 1265
Kenilworth. Mary: 083 703 3113
Kuilsriver. Karin: 082 463 0221
Khayelitsha. Nodomiso: 076 871 4197

Web: www.sadag.org

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

Although there is no direct benefit to you for participating in this study, you will be contributing to one of the fastest growing healthcare contexts, namely that of compassion in healthcare. Furthermore, awareness around the topic of compassion during labour and childbirth has the potential to lead to the creation of training programmes that deal specifically with compassionate care, thereby increasing the instances of compassionate care during labour and childbirth.

5. PAYMENT FOR PARTICIPATION

There will be no payment for participating in this study.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with the investigator during this study and that could possibly identify you as a participant will be protected. This will be done by the following:

Throughout the questionnaire and interview processes the investigator will refer to you using a pseudonym of your choice, and not your real name. All data (recordings, transcriptions, questionnaires etc.) will therefore be anonymised. Furthermore, all data will be stored as password protected files on a hard drive to which only the investigator will have access. Should you wish to withdraw from the study, all data pertaining to you will be destroyed.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don’t want to answer and still remain in the study.

8. RESEARCHERS’ CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Sulette Minnaar at 082 698 8641 or suletteminnaar@gmail.com and/or the supervisor Dr. Lauren Mongie at 021 808 2321 or laurenm@sun.ac.za.

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

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- **I have read the above information and it is written in a language that I am comfortable with.**
- **I have had a chance to ask questions and all my questions have been answered.**
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I ________________________________ *(name of participant)* agree to take part in this research study, as conducted by Sulette Minnaar.

____ ______________________

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

_____________________________________ ____________________

Signature of Principal Investigator **Date**

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APPENDIX B: CARE-PROVIDER PARTICIPANT CONSENT FORM

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Sulette Minnaar, from the Department of General Linguistics at Stellenbosch University. You were approached as a possible participant because you are a maternity care-provider.

1. PURPOSE OF THE STUDY

Firstly, the study aims to investigate the use of compassionate language during labour and childbirth by looking at how women feel or react when their care-providers use compassionate language versus when their care-providers use neutral or non-compassionate language.

Secondly, the study will look at compassionate language during labour and childbirth from the perspective of the care-providers and whether care-providers experience any difficulties in using compassionate language or not.

Lastly, the study will look at whether mothers and care-providers differ in their opinions on compassionate care during labour and childbirth and what the implications of this would be.

2. WHAT WILL BE ASKED OF ME?

You will first be asked to complete a questionnaire which the investigator will email or deliver to you and which needs to be returned (by email to, or collection by, the investigator). The investigator will then conduct a one-on-one interview at a convenient and quiet location of your choice (for instance your home, or a nearby coffee shop). The interview will last no longer than an hour. The interview will be recorded with a recording device. All relevant audio data will be transcribed.

In addition, you will be invited to a focus-group discussion at a time and place convenient to all participants. The focus-group discussion will last no longer than two hours. The discussion will be recorded and the relevant data will be transcribed.

3. POSSIBLE RISKS AND DISCOMFORTS

As a maternity care-provider there is the possibility that some of the births you have attended, or aspects of you job has been unpleasant or even traumatic, and that it would be uncomfortable, difficult or even upsetting to talk about. Should you feel the need to discuss these events with someone like a therapist or trauma counsellor, the investigator suggests contacting the following professionals at:

1. The Trauma Centre, Cowley House, 126 Chapel Street, Woodstock (if you experienced aspects of your job as a physically or emotionally violent act)

   Tel: 021 465 7373
   Contact: Yeukai Chideya
   Email: info@trauma.org.za
   Web: www.traumacentre.org.za

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2. The South African Depression and Anxiety Group (for depression and anxiety)

   Counselling line 8am to 8pm, 7 days a week on 011 234 4837 or toll-free on 0800 21 22 23 or.

   Or join one of the following Depression and Anxiety support groups:

   Claremont. Lizelle: 073 209 8890
   Fish Hoek. Lisa: 073 467 1265
   Kenilworth. Mary: 083 703 3113
   Kuilsriver. Karin: 082 463 0221
   Khayelitsha. Nodomiso: 076 871 4197
   Web: www.sadag.org

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

Although there is no direct benefit to you for participating in this study, you will be contributing to one of the fastest growing healthcare contexts, namely that of compassion in healthcare. Furthermore, awareness around the topic of compassion during labour and childbirth has the potential to lead to the creation of training programmes that deal specifically with compassionate care, thereby increasing the instances of compassionate care during labour and childbirth.

5. PAYMENT FOR PARTICIPATION

There will be no payment for participating in this study.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with the investigator during this study and that could possibly identify you as a participant will be protected. This will be done by the following:

Throughout the questionnaire and interview processes the investigator will refer to you using a pseudonym of your choice, and not your real name. All data (recordings, transcriptions, questionnaires etc.) will therefore be anonymised. Furthermore, all data will be stored as password protected files on a hard drive to which only the investigator will have access. Should you wish to withdraw from the study, all data pertaining to you will be destroyed.

During the focus group discussion confidentiality can obviously not be guaranteed and you should preferably not share personal information in the group. Opportunity to share personal information or experiences will be provided in the one-to-one interview process.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Sulette Minnaar at 082 698 8641 or suletteminnaar@gmail.com and/or the supervisor Dr. Lauren Mongie at 021 808 2321 or laurenm@sun.ac.za.

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You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- **I have read the above information and it is written in a language that I am comfortable with.**
- **I have had a chance to ask questions and all my questions have been answered.**
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I ________________________________ *(name of participant)* agree to take part in this research study, as conducted by Sulette Minnaar.

____________________________________ ____________________

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

____________________________________ ____________________

Signature of Principal Investigator **Date**

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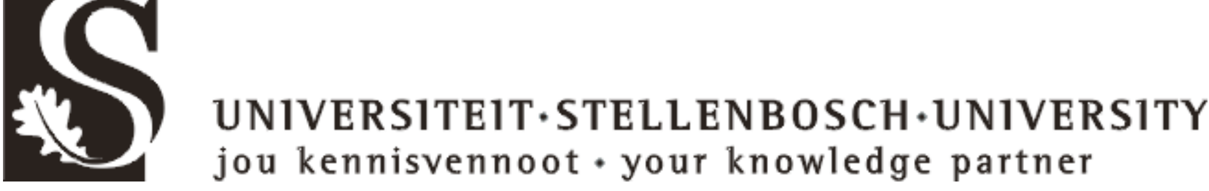
APPENDIX C: MOTHER PARTICIPANT QUESTIONNAIRE



Intrapartum Compassionate Communication

QUESTIONNAIRE

Investigator: Sulette Minnaar
082 698 8641

Supervisor: Dr Lauren Mongie
021 808 2321

April 2018

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BACKGROUND INFORMATION

Pseudonym	
Age	
Nationality	
Mother tongue	
Other languages Spoken	
Relationship status	
Number of children (incl. ages)	

BIRTH AND LABOUR INFORMATION

Number of pregnancies	
At how many weeks gestation were babies born?	
Mother's age when babies were born?	

First birth

Date of birth	
Duration of labour	
Location of labour	
Type of birth (natural, C-section, water, home etc.)	
Who was present during labour?	
Who was present during birth?	
Was a birth partner allowed in the room?	
Which words would you	

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use to describe the birthing environment (i.e. safe, warm, clinical, bright lights, dark etc.)?	
Did caregivers remain silent during contractions and if not what type of words were used?	
Which words were used between contractions?	
Were there any complications?	
Were any interventions performed (i.e. Pitocin, forceps, suction, episiotomies etc.)?	
Were the interventions properly communicated to you? Which words were used?	
Were you happy with the way the interventions were communicated, and why?	
Were you expected to perform certain tasks at certain times, (i.e. the speed at which your cervix dilated?)	
Were you allowed to eat / drink during labour?	
Which words were used to communicate this to you?	
Were you allowed to labour in the position which felt most comfortable to you?	
If not, which words were used to communicate this to you?	
Were you vocal during labour and if so, how was this received by the caregivers?	

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Were you monitored during labour, (internal exams, foetal heart rate monitor etc.) and was it on your terms?	
How was the fact that monitoring would take place communicated to you? Which words were used?	
Were you instructed to push, and if so did you feel ready to do so?	
Which words were used during pushing?	
Which position did you push in and were you comfortable there?	
Was this a position of your choice? If not, which words were used to communicate a change in position to you?	
Who was the first person to touch the baby?	
Where was the baby immediately after birth?	
If not with you, was it communicated to you where the baby was? Which words were used?	
When was the cord cut? Were you in agreement with this?	
Which words, if any, were used to communicate the cord cutting to you?	
Overall, what was the tone of the communication during labour and birth?	
Which type of words were used?	

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Second birth

Date of birth	
Duration of labour	
Location of labour	
Type of birth (natural, C-section, water, home etc.)	
Who was present during labour?	
Who was present during birth?	
Was a birth partner allowed in the room?	
Which words would you use to describe the birthing environment (i.e. safe, warm, clinical, bright lights, dark etc.)?	
Did caregivers remain silent during contractions and if not what type of words were used?	
Which words were used between contractions?	
Were there any complications?	
Were any interventions performed (i.e. Pitocin, forceps, suction, episiotomies, etc.)?	
Were the interventions properly communicated to you? Which words were used?	
Were you happy with the way the interventions were communicated, and why?	
Were you expected to perform certain tasks at certain times, (i.e. the speed at which your cervix dilated?)	

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Were you allowed to eat / drink during labour?	
Which words were used to communicate this to you?	
Were you allowed to labour in the position which felt most comfortable to you?	
If not, which words were used to communicate this to you?	
Were you vocal during labour and if so, how was this received by the caregivers?	
Were you monitored during labour, (internal exams, foetal heart rate monitor etc.) and was it on your terms?	
How was the fact that monitoring would take place communicated to you? Which words were used?	
Were you instructed to push, and if so did you feel ready to do so?	
Which words were used during pushing?	
Which position did you push in and were you comfortable there?	
Was this a position of your choice? If not, which words were used to communicate a change in position to you?	
Who was the first person to touch the baby?	
Where was the baby immediately after birth?	

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If not with you, was it communicated to you where the baby was? Which words were used?	
When was the cord cut? Were you in agreement with this?	
Which words, if any, were used to communicate the cord cutting to you?	
Overall, what was the tone of the communication during labour and birth?	
Which type of words were used?	

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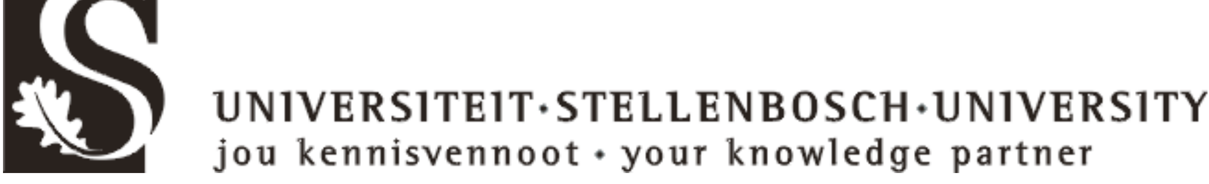
APPENDIX D: CARE-PROVIDER PARTICIPANT QUESTIONNAIRE



Intrapartum Compassionate Communication

QUESTIONNAIRE

Investigator: Sulette Minnaar
082 698 8641

Supervisor: Dr Lauren Mongie
021 808 2321

April 2018

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BACKGROUND INFORMATION

Pseudonym	
Age	
Nationality	
Mother tongue	
Other languages Spoken	
Rank / Title	
Area of specialisation	
Type of institution where employed	
Number of years in field	
Level of education	
Professional development courses completed	
Relationship status	
Number of children (incl. ages) (if applicable)	
Types of births experienced (if applicable)	

BIRTH AND LABOUR INFORMATION

Please describe a typical work day.	
Please describe what is challenging or negative in a typical working day and why.	
Please describe what is encouraging and positive in a typical working day and why.	

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What causes stress at work?	
What reduces stress at work?	
Do you have any coping mechanisms you use to help with stress?	
Do you encounters many 'difficult' patients?	
How would you describe them?	
Do you encounter many 'easy' patients?	
How would you describe them?	
What is your definition of the term 'compassion'?	
How would you show verbal compassionate care?	
Is it easy or difficult to show verbal compassionate care and why?	
Is compassionate care something to be earned, or a right of a patient? Why?	
How is compassion shown through physical care?	
Is it easy or difficult to show physical compassionate care and why?	
Please describe non-compassionate verbal care.	
Please describe non-compassionate physical care.	
What is the type of care typically given at the institution where you work and why?	
Which words would you	

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use to describe the birthing environment at your place of work (i.e. safe, warm, clinical, bright lights, dark etc.)?	
Do you and other caregivers remain silent during patient's contractions and if not what type of words are used?	
Which words are used between contractions when communicating to patients?	
During labour, what would constitute 'failure to progress?'	
Should the need for interventions arise how is this communicated to patients?	
What are you opinions on vaginal birth vs caesarean section?	
What are the norms regarding monitoring (internal exams, foetal heart rate monitor etc.)at your place of work and do you agree with this?	
How is monitoring communicated to patients, if at all?	
What are the norms regarding labour positions at your place of work and do you agree with this?	
Are patients mostly happy with labour positions? Why?/Why not?	
What are the norms regarding pushing	

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(positions etc) at your place of work and do you agree with this?	
Are patients mostly happy with how and in which position they can push? Why?/Why not?	
What is the norm regarding cord clamping at your place of work? Do you agree with this?	
Overall, what is the tone of the communication during labour and birth?	

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APPENDIX E: FACEBOOK RECRUITMENT POSTER

Participants Required for a

Masters Degree Research Project on Compassionate Communication during Birth

Stellenbosch University
Dept of General Linguistics

Eligibility

- Are you older than 18 years of age?
- Have you had at least two births?
- Did you feel that you were treated with compassion by your care-givers during at least one of your births?
- Was your other birth a neutral or even negative experience?
- Would you like to contribute to one of the fastest growing healthcare contexts?

If you are interested please
DIRECT MESSAGE Sulette Minnaar
(To ensure anonymity, please do not reply on any public Facebook spaces)

What would be required of you

- Complete a questionnaire on your birth experiences.
- Be interviewed by a researcher on these experiences at a quiet location of your choice.
- Interviews will last no longer than an hour.
- Anonymity will be maintained throughout.

Participating mothers will be thanked for their time with a small gift