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Continuous support for mothers and children with a variety of needs

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Abstract

This qualitative descriptive study was performed to examine continuous support for mother and child before and after childbirth, and the role of the maternal and child health coordinator. Here, we report findings in a woman with various difficulties related to childcare and life, and continuing to receive support led by a midwife. The mother with difficulties was interviewed, focusing on her feelings regarding support, and we extracted recognition of/motive for continuing to receive support. The results indicated that she had a feeling of “trust” in the main caregiver (midwife) . The mother experienced various difficulties, such as mental diseases and family-related difficulties before pregnancy. She did not expect her own family members to provide “modeling” as a mother and “support” “consultation” as a first-time mother. However, this was a very important point to improve motherhood in the early postpartum period. She had an opportunity to experience such factors as “maternal modeling,” “advocate,” “listening closely,” and “receptive behavior” from the maternal health staff. She had feelings of “trust” and “anchor-behavior” in the staff, such that she began to accept support from others. In conclusion, it is necessary to build a relationship between caregivers and mothers with fundamental maternity care and to establish methods to develop continuous support in the early postpartum period.

KEY WORDS

maternal and child health coordinator, mother in difficulty, continuous care/ support

Introduction

Maternal and child health in Japan has historically developed to protect and promote the healthy development of both mothers and children. However, due to the recent social phenomenon of low birthrates and an aging society, the number of children is on a downward trend. In Japan, there is concern about this phenomenon, and various efforts to respond continue, but this social phenomenon continues to progress¹⁾. From the beginning of the Angel Plan (1994) to the present, systems to support pregnant/postpartum women and children have been widely established and, in broad fields such as maternal and child health, education, and social welfare, have been planned and implemented²⁾. However, while the issues related to low birthrate have to be resolved, the difficulty of solving this problem is highlighted year

after year. There is no way of achieving our goal to end the phenomenon of low birthrate and an aging society¹⁾. As a recent trend, efforts have focused on the importance of supporting parents' balance of work and child-raising as well as caring for children in order to alleviate anxiety associated with child-raising³⁾. The items to incorporate these efforts started being included in the maternal and child health activities. As part of these efforts, a plan was brought up in 2014 to install a “pregnancy/childbirth comprehensive support center one-stop destination” in each local government⁴⁾. This was proposed by Takahashi et al. with the aim of “establishing a continuous support system” with reference to Finland’s “neuvola” (where advice is provided) . Takahashi et al. stated that, in order to implement the “establishment of a continuous support system,” it is important to allocate a coordinator

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role, which coordinates support services in each field where specialists can provide individual support⁵⁾. Maternal and child health should assume the role as a coordinator to solve these many problems, in addition to incorporating multiple areas, including promotion of health education, support, and services in the health/medicine/welfare aspects from a preventive medicine perspective, in which factors weakening the maternal and child health ought to be removed in the maternal and child insurance activities government services and research areas⁶⁾. A “maternal and child health coordinator” was implemented as a coordinating role in 2014 in order to “keep receiving continuous support” for maternal and child health. However, activities and roles have not been specified, and the activities are not widely acknowledged nationally.

In this study, we aimed to reveal what continuous support means for mothers and children before and after childbirth and to examine the coordinator roles for maternal and child health. We report that we could elucidate the awareness and motives of a mother who has experienced “continuous support” and obtained suggestions for implementing continuous support.

Method

1. Study design

The present study utilized a qualitative-descriptive study design. The study participant, from whom we were able to obtain the consent for study participation, had one childbirth experience. She was in her thirties, had difficulties due to her child-raising and life after delivery, and continuously received support from mainly midwives of the clinic where she delivered the child. Data were collected from the outpatient records of the study participant and transcriptions of the audio recording of semi-structured interviews. We extracted women’s feelings about and motives for receiving support and continuing to receive support by focusing on the woman’s feelings towards a midwife’s support in different scenarios in which she faced difficulties in child-raising and events in her life and asked for support. We repeatedly read the prepared transcription and outpatient record for analysis, focused on the scenarios in which the study participant shared her feelings about when she wanted to continue to receive support and when not, and interpreted the context and chronological change.

In order to enhance the reliability of data analysis, we

received supervision during analysis from psychology researchers, clinical psychology experts, clinical midwives, and midwifery researchers who were familiar with psychology. The survey period was June of 2016, and the number of interviews was one.

2. Ethical Considerations

We explained the objectives and methods of this study to the study participant orally and in written form. We also told her it was possible to stop any time, at any point, and made every effort to guarantee no disadvantage would be caused or imposed on her because of withdrawal. Because there was a relationship of care provider and care receiver between the interviewer and the study participant, there was a concern that the study participant might become anxious about disadvantages being imposed on her or responses being inductive; thus, we used an interviewer who had no conflict of interest with the study participant. We also reinforced the reflection work to examine whether there was any portion that was disadvantageous for the study participant by reading the transcription together with the interviewer and researcher later and receiving supervision from a psychological researcher. We used one room in the facility that Ms. A often visited as an interview location and respected her will so that she could freely express herself without being nervous and with her privacy protected. Regarding the use of final collected data, we confirmed consent with the participant once again, and transcription started once the consent was obtained. We gave an explanation of the study to the facility director and staff of the medical facility that the study participant attended and requested participation from the study participant after obtaining understanding and consent.

Data such as records, transcriptions, and other record documents were handled so that anonymity was maintained, and the storage was locked. This study was conducted with approval from the ethical review committee at Kanazawa University (approval No: 634-1).

Results

Quotation marks (“ ”) indicate what the study participant said, italics are used for the context and words that the researchers used, single quotation marks (‘ ’) are used for the words summarizing the feelings of the study participant and her family. Brackets ([]) are used for words supplementing what the study participant wanted

to communicate, and < > indicate the theme of the study participant's point of view.

1. Participant Overview

Participant A (pseudonym) was a woman in her thirties and had various difficulties, such as a history of mental illness and trouble with family relationships before pregnancy (Fig. 1) . The researcher met Ms. A on her first day postpartum.

It was Ms. A's second year since moving from her parents' home to a distant prefecture where her husband was assigned for work, and she was staying at her parents' home for childbirth. Her primary physician expressed, "Other than being quiet during her prenatal visits, I was treating her without sensing any problems in particular." Therefore, once the nurses confirmed there was a problem, based on an explosion of anxiety and complaints of insomnia, people who were in charge of Ms.

A were determined to a certain extent, and Midwife B became a contact.

Ms. A's family relationships were not very favorable, and all family members were inclined to be sick. Thus, it was difficult for Ms. A to receive support in life and see a role model for motherhood that she desired (Fig. 2) . It was decided that continued support was necessary since Ms. A was in need of support after discharge from the clinic. We began planning for midwife care in collaboration with relevant organizations from the early post-delivery stage by focusing on Ms. A's personal needs.

Ms. A did not disclose her history of mental illness at her prenatal visits during pregnancy, but she started to feel scared about reoccurrence of depression due to the strong anxiety and insomnia on her second day after delivery. When the primary midwife checked her history of medical conditions, Ms. A mentioned, "I went to see

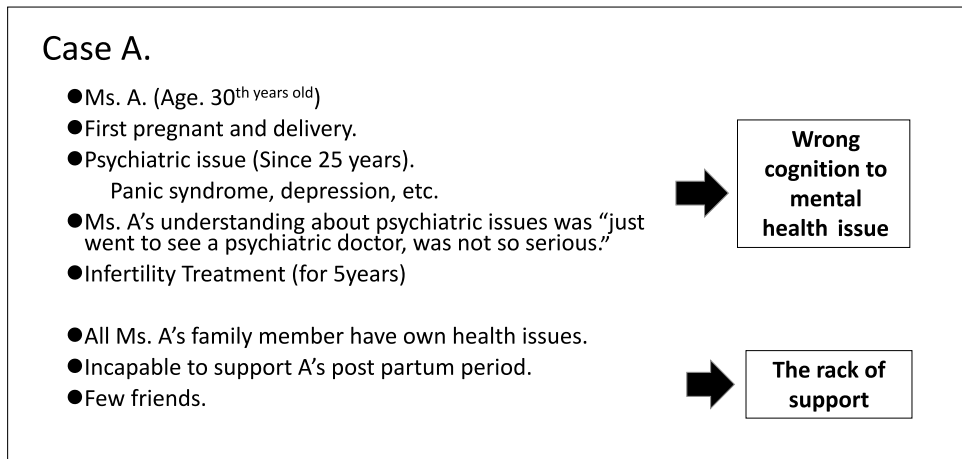


Figure1 The Overview about case A.

Point of problems for care

Relationship between A and her mother was not good. The mother was not supportive.

= **no mother role model** ▪
no support person in her family

Her husband demeaned her as 'naïve', 'less commonsense', 'depend', 'low-earning', 'immature' and said that 'using a support system means you are dependent and incompetent.'

= **Low self-esteem**
Distrust of husband
Non-receptive to support

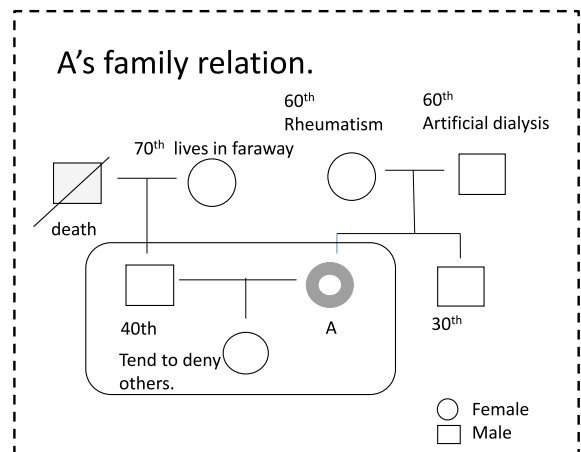


Figure2 Relation of A's family.

the doctor once because I had a symptom like depression. When I received the last examination about 10 years ago, the condition seemed to be improved, so I stopped going to the doctor.” However, the symptoms seemed to remain, and she was not fully recovered (Fig. 1) .

Ms. A was scheduled to stay with her parents for about two months. She had to master child-raising skills and knowledge, establish child-raising support at home, support her husband’s participation in child-raising, and make arrangements for family relations. Moreover, we attempted to provide hands-on support without making her hurry to achieve each goal and established a support system with the public health nurses both in her parents’ hometown and in the local area where she lived with the intention of collaborating widely beyond prefectures (Fig. 3) .

2. Difficulty in Receiving Care and Support and Conversion of this Idea

There is a common consideration that consulting with all family members, including husbands, and receiving support makes the mother become ‘dependent’ or feel ‘an existence of burden,’ and Ms. A strongly shared a similar feeling. Therefore, although breastfeeding did not go well, and she had difficulty raising her child, she did not accept the offer of necessary care. Although Ms. A understood the necessity of first-time breastfeeding, it was difficult to understand it emotionally, and it became an extremely difficult experience (Fig. 3) . However,

she had the experience of receiving “modeling” through a midwife’s child-raising activity and also appropriate “knowledge provision” regarding breastfeeding nutrition and children’s growth when she thought it necessary. She had to be discharged in this condition, but her child-raising skills were insufficient. Thus, she did not refuse to visit outpatient care to receive support from a midwife when it was offered; instead, she decided to try receiving care and support, which led her to an initial outpatient visit with the midwife on the fifth day after discharge.

3. Establishment of Trust Relationship

〈Creating a system to monitor Ms. A and her child’s safety in collaboration〉

Ms. A had a strong psychological disturbance when her child cried, and she felt she did not have enough child-raising knowledge. Especially when she was alone, she was extremely irritated, and it was presumed that prevention of abuse was necessary. Because Ms. A also requested this, we started preventative abuse care during her hospital stay. Midwife B organized the support system by collaborating with the local public health nurses in her parents’ hometown and where she lived and made efforts to build up support relationships with the related destinations so that Ms. A could use their support (Fig. 3) .

Fig. 3 compiles the image Ms. A had concerning the type of support she received before and after childbirth and the interrelations between the support based on the

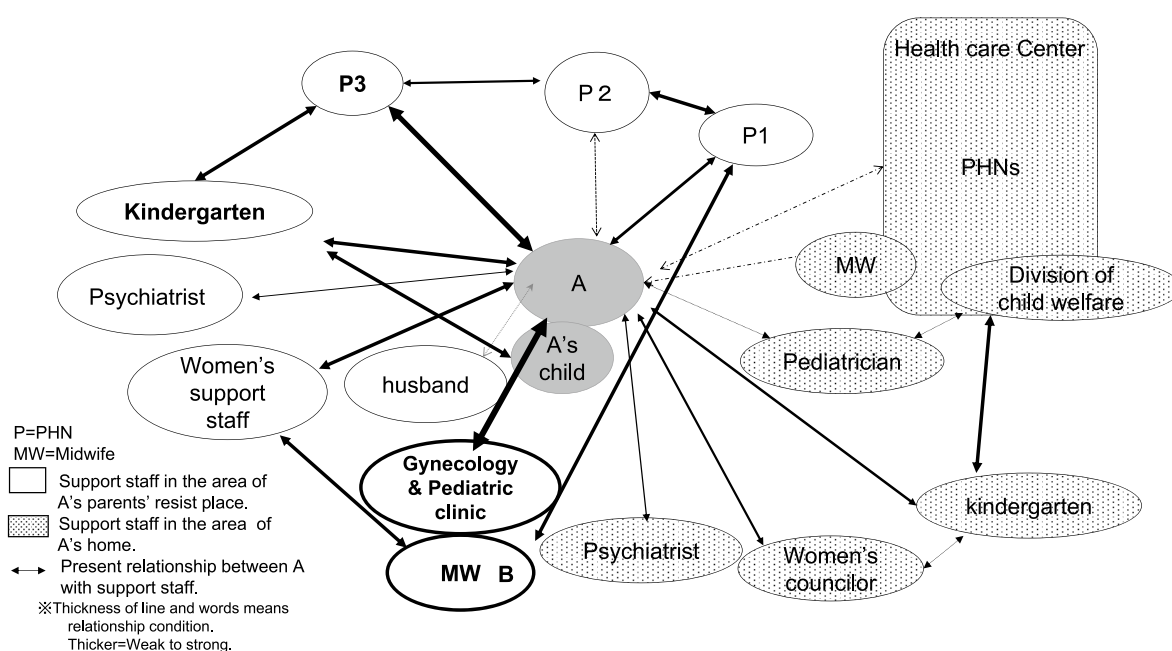


Figure3 A's image of the support during child raising term,

outpatient records and interview results. A clear difference in image was observed regarding relationship between where her parents' home was and where her home was. As shown in the figure, Ms. A went to different places based on the advice and encouragement of Midwife B and public health nurses, and her husband and child received support from the system provided in their area. However, while Ms. A felt she was on good terms with people in the area where her parents' house was and where Midwife B, who continued to stay with Ms. A and provided care after her delivery, was able to coordinate to provide support for Ms. A., she often felt she could not establish a good relationship in the area where her home was located. This suggests that considerable effort from the mother who receives support is required.

〈Making choices to receive support based on security and trust with which the patients can 'make sure' about things without feeling 'denied' by the supporters〉

A: "I came here because I lost confidence in whether my ideas and attitudes are appropriate," "I [thought about coming here] because I started to feel scared...and worried."

(From the outpatient record)

Ms. A's psychological instability became a main reason why she was not confident in child-raising, as seen in the outpatient record: "For Ms. A, she was wondering if she might be hard on her child." Once we confirmed Ms. A's inclination to think of the possibility of becoming a perpetrator for child abuse, we examined support details. We gave several instructions on "how to control anger"⁷⁾ and discussed in detail in the outpatient visit with Ms. A whether she did that well, whether she lost confidence, whether she was able to control anger, and whether her anxiety was stable. At the same time, we instructed her to view her own actions objectively and to try different methods when one method did not work to control irritation and anger. When things did not work out, she received support from multiple angles, such as calling the nursery school teacher in the local nursery Ms. A used for a temporary nursery system. Thus, she became able to control her feelings; she noted in the outpatient record by the time her child became one and a half years old, "Until recently, I had a hard time many times [because I could not control myself when my child cried] , but these days, I rarely get irritated and understand how to handle the situation. I think I am okay." The continuous intervention

from the early stage was successful and has prevented the potential abuse for now.

During this time, Midwife B prioritized accepting and affirming Ms. A's feelings in her care plan and committed to maintaining a trusting relationship (according to the outpatient record) . Ms. A understood her intentions clearly, and it appears she often went to the outpatient for that purpose (Fig. 3) .

Ms. A experienced anxieties constantly raising and breastfeeding her child: "It is important to breastfeed my baby, but I am not breastfeeding properly. I am not doing this appropriately," "I have to do my best more, but I am not," and "What should I do if my breast milk stops coming out?" At the same time, various related negative feelings overwhelmed her and continuously scared her as if her mental diseases were worsening and she might lose her child. She mentioned "the time I don't know what to do myself." She was concerned, saying, "I may be hard on my child. I may hit her or yell at her... What should I do if that should become abusive?" She attempted to control herself by telling herself, "I should control this feeling as soon as possible" and "I will be in trouble if something has already happened." When self-control did not work, she again became intensely frustrated. As she did not receive support from family members when she was tired or worried, she "did not know what to do. My husband asked me to let him concentrate on his work." She did not consult well with a midwife for breastfeeding support who she was introduced to in the local area where she lived. She was instructed but felt it was "something that I could not manage, and I became at a loss for what to do" (according to the outpatient record) .

Based on this situation, Midwife B encouraged her to seek support in order to circumvent isolation. The support included consulting a local public health nurse Ms. A told she was encouraged by Midwife B to meet after the phone consultation. Despite the consultation, the support system was not established because Midwife B felt Ms. A was not comfortable with the local nurse before the nurse could provide a sufficient support relationship. When requesting support, it is necessary for the mother to state the importance of it and make efforts to obtain understanding and have the support system created for her. Ms. A sought support through consultation with Midwife B on her own while carrying anxious feelings and not having people with whom she could establish a secure

relationship. She was practicing self-care by receiving advice, avoiding isolation, striving to raise her child, and overcoming difficulties. We conclude that Ms. A, who is poor at expressing her troubled feelings to others, was able to receive continuous support by showing “SOS” as a method of handling the time of anxiety and trouble and by avoiding crises because she was ‘not denied’ but ‘affirmed’ by the supporter she felt safe with and trusted.

3. Motives for Receiving Support Continuously

〈Receiving support from people who make the mother feel ‘confident that she is understood,’ that ‘the supporter is a reassuring existence,’ that ‘the supporter is an expert,’ and that ‘she can be an advocate.’〉

A: It is difficult even though I am just listened to. When I was in pain, I went to Midwife B with no questions; she understood all [the situations I wanted to communicate] . When I said, “I feel uncomfortable; I don’t know what makes me in pain, but I feel in pain,” she organized my thoughts, and I started to see the conclusions in myself. Also, she had a special knowledge; she proposed how to solve them after I consulted her on what I didn’t know, [but it was me who made the decision] . I believe such a knowledgeable person should become the one.

〈Image that is desired for the supporter before and after childbirth, “maternal and child health coordinator”〉

A: She can just stay with me. She is with me. The same person is determined and watches me all the time, not taking turns. This is the person I think would be best. [omitted] . If this person were a stereotype, I would give up.

In fact, the public health nurses used a system in which the same nurse takes care of the same mother in the prefecture where Ms. A’s house was, but, unfortunately, Ms. A did not identify this system from her experience of using the system (Fig. 3) .

〈Always felt [the call to Midwife B] was a ‘lifeline.’〉

A : [A telephone call to Midwife B] was a lifeline. Although there was distance, I felt like we were always connected. The response was not that quick, as far as I remember, but I always felt I could be in contact with her without a doubt. It was assured that my feelings were communicated without fail. [The problem] wasn’t solved, but I felt like, “yes, I have someone who listens to all my painful feelings without being denied.” I have someone who empathizes with me.

Ms. A expressed the consultation in times of trouble

as a ‘lifeline.’ Through the ‘lifeline,’ she felt the supporter ‘stayed by her side’ and ‘watches her’ and expected the consequences; she ‘will be connected’ ‘absolutely’ and ‘not at all denied’ but with ‘empathy’ with the ‘confidence that she will be understood.’ That feeling strongly influenced her decision-making when she chose to receive support over being isolated.

〈The ‘special treatment’ will change to ‘continuous involvement’ and ‘confidence in being connected with trust’ by ‘the ability to overcome anxiety.’〉

A: I think mine was a very special case, unquestionably, yes. Midwife B was always involved with me. I was encouraged to talk to many people like public health nurses. I was offered a place where I was listened to after delivering my child. At that time, it was really hard, and I wondered what would happen after I returned home... Then, I was told, “If you want to talk, I will respond by phone.” I was half in doubt at the beginning, wondering how she could do such things, but she really did. After that, I became lost and wondered what to do [after I moved to a faraway place] , so I called her. She was not able to answer the phone to take care of the situation at that time, but Midwife B still said, “We will definitely talk [if something occurs] over the phone.” I called her thinking something would work out if I could be connected on the call, so I was able to tell myself, “I should hang in there a little more.”

As described above, we planned and implemented care by focusing on Ms. A’s needs as a mother with her child. This did not mean we treated a particular individual in a special way as a unique case but, rather, we responded with the basic attitude in nursing, in which we considered Ms. A and her child as whole human beings and respected individuals. On the contrary, Ms. A felt that she received “special treatment.” We interpreted this as Ms. A understanding the care she received such that “support was provided according to my needs,” and the care we kept providing was evaluated positively.

We can presume that this case shows that implementing care based on the basic midwife diagnosis made her become open to receiving support, and establishing a continuous relationship enabled her to ask for support without hesitation when she needed it.

Discussion

What kind of condition does “continuous support before

and after childbirth” refer to? Ms. A had many difficulties such as a medical history, unharmonious family, and bringing up her child in an unfamiliar place. This case is unique but not so special in a recent society. Therefore, we were interested in how Ms. A maintained relationships with supporters and became able to receive various types of support in order to search of the coping pattern for a mother with difficulties. We believed the key to “continuous support” was present in that experience, and, therefore, we conducted this study using the qualitative method. By reading data, we were able to see numerous experiences Ms. A had in her spoken words. By comprehending these while checking them against the recorded documents from her admission to discharge from the hospital, her experience embedded in the words was revealed, and we felt the interpretation of data became more profound as if clearly remembering what happened at that time.

Below are the factors for why Ms. A kept receiving “continuous support” based on the extracted data, including discussion.

1. To Conduct Specialty Care Appropriately

Ms. A experienced the effectiveness of receiving consultation and support. She also felt ‘advocated’ for when the supporter ‘stayed beside her’ in the midst of the anxiety and uncertainty that arose afterwards while she faced a loss in confidence. She further perceived ‘being listened to’ and ‘being accepted’ from the early stage of her delivery. These experiences reassured her ‘trust’ towards specialists and the effect of receiving support. The results indicate that these were the factors for why she made the choice to receive continuous support from Midwife B as a core person. In other words, having Midwife B as the main person prevented Ms. A, who was not good at communicating with others, from no-support situations or isolation until the support relationship was established with other specialties. Furthermore, she was able to search for possible support establishments and exchange information with collaborating organizations during that time.

The early postpartum stage is the period when there are countless cases when mothers cannot express their needs and concerns^{8),9)}. It was elucidated from this case that by simply providing coordinating functions to make arrangements, coping with and solving the issues will be postponed until the relationship between support providers and recipients is established. Therefore, it is

important to provide necessary support simultaneously when coordinating support is offered according to the mothers’ circumstances.

Knowing the needs of the mother and child before and after childbirth and implementing care at the appropriate time is what is called specialty care provided by experts. In this study, “trust in the midwife’s specialty” was indicated as a big motive for receiving continuous support in the long term. Ms. A shows one of the preferred results that support coordination and care for self-recovery provided when she felt advocated for through the consultation of support arrangements.

2. Establishment of a Trust Relationship in the Early Postpartum Stage: Approach making breastfeeding support the key to success in fulfilling “the successful experience of receiving support” in the early stage

When the mother needs support for breastfeeding, the special knowledge and skills of experts for support are even more necessary. Therefore, midwives are usually requested to play the role of supporters¹⁰⁾. In the case of this study, building up a relationship to provide breastfeeding support at the early postpartum stage for families that are not good at receiving support significantly contributed to the development of continuing the support moving forward. Based on these findings, in order to support mothers and children in the long term, it is believed to be an important factor for realizing “continuous support” that appropriate care should be provided at as early a postpartum stage as possible, when support is a must, and to have the mother experience “the successful experience of receiving support.”

3. Suggestions for Clinical Nursing

It is widely recognized that the trust relationship between prenatal and postpartum women and midwives is relative to satisfaction with care¹¹⁾. Faithfully conducting daily basic care to enhance satisfaction with care that “seems to be customized” makes “continuous support” possible. Based on this belief, it was suggested that it is important to respect each daily activity in the clinical sites as well as establishing a special system.

Study Limitations and Future Issues

This case is unique, but not special, as mentioned. The result, especially the talk of the Ms. A, could present real voice by ‘mothers nowadays’. Special part of Ms. A is that made it possible to take continuously support even

there were many possibilities that wanted to give up the support. As the part of the result, she has come to take various difficulties coping behavior. Ms. A cooperate to talk about her long term experience and her thought about each happening, that was sometimes emotionally, sometimes in calm. It was not too easy to conduct to organize conditions of this research. This study, however, succeeded in data of the raw voice and the real intention of the woman with a variety of needs.

This study used only one participant's dialogue, so there is a limitation to generalizing the results. It is possible that the experiences of other participants could change the content, so it is important to keep pursuing how continuous support for maternal and child health should exist and to systemize the support.

Conclusion

Factors influencing mothers' choice to receive continuous support after delivery for the long term are provided as specialty care: (1) specialty skills to understand and assist with needs that are difficult to recognize and express in the early postpartum stage,

(2) attitudes toward staying beside the mother as an advocate and accepting her, (3) specialty skills including breastfeeding support provided by midwives, and (4) attitudes as a supporter who is like an anchor. The mothers also must have a successful experience receiving care and support in the early stages after delivery for the necessary preconditions to want continuous support afterwards.

In order to realize continuous support for maternal and child health, it was suggested that a trusting relationship can be established by making the necessary support chosen and available when needed by specialists being involved in the early postpartum stage and continuing to provide specialty care.

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多様なニーズを抱える母子への切れ目ない支援

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要 旨

産前産後の母子にとって切れ目ない支援とは何かを明らかにすることを目的に、多様な困難を抱えながら切れ目ない支援を受け続けることを可能とするケースについて検討した。質的記述的研究デザイン。研究参加者は、研究参加同意が得られた出産1回経験者で、産後の育児や生活による様々な困難感から出産した医院の助産師を中心とした支援を継続して受け続けている30歳台女性。インタビューを行い、育児の困難感や生活上での出来事とその時に支援を求めた場面ごとに、助産師支援に対する女性の気持ちに焦点を当てて、支援を受けることそれを継続して受けることの認識や動機などを抽出した。対象者は、妊娠前から精神疾患既往歴や家族関係の難しさなど様々な困難を抱えていたが、助産師による育児の行動の「モデリング」、母乳栄養や子どもの成長を「相談」することと「支援」を受けることへの効果や、「寄り添い」を受け「アドボケート」されたと感じたこと、「傾聴」、「受容的態度」などを経験したことで、専門職への「信頼」を感じたことが、支援を継続的に受け続けることを選択の契機となっていた。早期産褥期のかかわりによる関係性の持ち方、アンカー的な態度による支援の方法が切れ目ない支援を展開するために必要であることが明らかになった。