

Flemish midwives' perspectives on supporting women during the transition to motherhood – A Q-methodology study

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Abstract

Objective: In this study we aimed to reveal midwives' distinct perspectives about midwifery support of women in their transition process during the continuum from pregnancy to one-year postpartum.

Design: A Q-methodology study, a mixed quantitative-qualitative approach, was conducted. Participants (P-set) rank-ordered 36 statements (Q-set) about how midwives provide support during the woman's transition to motherhood, followed by interviews to motivate their ranking. To extract the perspectives/factors on support during this transition process, centroid by-person factor analysis and varimax rotation was used. The transcripts of the interviews were interpreted per factor.

Setting: Independent (self-employed) and employed, community and hospital-based practising midwives in Flanders, Belgium.

Participants: 83 practicing midwives participated, selected on: variation in practice setting, years of experience, views on the woman's domestic role in family life, and motherhood status.

Findings: Two distinct perspectives (factors) on supporting women in transition to motherhood emerged. The *job-focused midwife* acts according to evidence, knowledge and guidelines and adheres to the scope and tasks within the professional profile (Factor 1). The *woman-focused midwife* acts within a relationship of trust emphasizing the one-on-one connection while supporting transition to motherhood and the woman's needs (Factor 2). Both factors showed an explained total variance of 59% of the Q-set.

Key conclusions: Both the *job-focused midwife* and the *woman-focused midwife* represent distinct perspectives about the midwife's execution of supporting transition to motherhood, including salutogenic elements. This provides an understanding of midwives' thoughts and experiences about why and how support is given.

Implications for practice: More awareness about the subjective distinct ways of thinking about supporting transition to motherhood should be integrated in practice, midwifery education and professional development.

Keywords:

Midwife, Transition, Motherhood, Support, Q-method

Abbreviations

No keyword abbreviations are available

Introduction

Becoming and being a mother is recognised as a major life event in a woman's life constituting paramount personal change in life and is regarded as a developmental and lifespan transition process (Meleis et al., 2000; Mercer, 2004; Prinds et al., 2014). Bridges (1988) defined transition as “*the inner psychological process that people go through as they internalize and come to terms with the new situation that the change brings about*”. During this process, people experience a variety of emotional states (Adams et al., 1976). Rubin (1967) and Mercer (2004), the founders of transition models to motherhood, explained that becoming a mother involves attaining the maternal identity and role. To achieve this, a woman goes through the stages of commitment, attachment and preparation requiring practical and emotional processes (Mercer, 2004). During the process of transition to motherhood, the woman's existing equilibrium changes as well as a shift in her norms, values and thoughts about the meaning of life and of motherhood occurs (Prinds et al., 2014). Acquiring the (re)newed role as a mother varies from the early stages of pregnancy up to four to 12 months postpartum (Delmore-Ko et al., 2000; George, 2011; Mercer, 2004).

Although many mothers sail smoothly through the transition process, others report feelings of insecurity, stress, anxiety, fear and worries (Meleis, 2010). The emotional wellbeing of women, experiences, satisfaction, and the level of coping with transition to motherhood can impact her overall life balance. Feeling good or being emotionally balanced is important to function in daily life, but also to adapt to changes and challenges in life such as becoming and being a mother (Fontein-Kuipers, 2016a). Reduced emotional wellbeing during transition to motherhood is mainly expressed in depression and anxiety, but also atypical/subclinical symptoms have an impact on birth and health problems in the short and long term, for both mother and child (Fontein-Kuipers, 2016a; Huizink et al., 2004; Schuurmans and Kurrasch, 2013). A maternal imbalance has a subsequent impact on her child(ren), family, daily life functioning including work, relationships and societal functioning, and contributes to reduced physical and emotional wellbeing and impaired mothering (Emmanuel et al., 2011; Fontein-Kuipers, 2016b; Nelson, 2003; Perez-Botella et al., 2015; Van de Velde et al., 2011). A balanced transition to motherhood contributes to the emotional wellbeing of a mother and her partner and their family, a satisfying couple relationship, and positive parenting experiences (Milgrom et al., 2011; Paley et al., 2005; Simpson et al., 2003) – showing the importance of adequate support.

Overall, women experience limited healthcare support addressing their needs in transition to motherhood (Deave et al., 2008). Pregnant women expressed the need for informative support to positively progress through the transition to motherhood; what it means to take care of a child and the impact and meaning of being responsible for a **dependent** human being (Gilmer et al., 2016; Halford et al., 2010; Milgrom et al., 2011; Seefat-van Teeffelen et al., 2011). Midwives are appointed by women as experts to provide this care, having the necessary knowledge and skills in supporting them in the transition to motherhood, at the right moment in time (Ahlén et al., 2012; Borelli, 2014). Maternity services, including midwives, however, do not primarily focus on the transcendent changes during transition to motherhood, while it is known that transition to motherhood is a powerful, challenging and a vulnerable period and experience – requiring professional support (Mercer, 2004). Midwives feel the need to support the woman during early motherhood and to prepare her, and her partner, for parenthood. However, evidence suggest that midwives' support during the antenatal trimesters and the early and late postnatal period, seems to be depending on

individual discretion or preference (Fontein-Kuipers et al., 2018c; Heinonen, 2021; Seefat-van Teeffelen et al., 2011; Tichelman et al., 2019; Wilkins, 2006).

In Flanders (Dutch-speaking part of Belgium), midwives are one of the most consulted healthcare professionals by mothers (Gillis et al., 2013) and are therefore a designated healthcare professional to provide support during the woman's transition to motherhood – that is, the first 12 months. The role of the midwife includes family and community health counselling and preparation for motherhood, as well as supporting the woman during the postpartum period in her (new) parenting role and assessing her mood and feelings about motherhood (FRV, 2016; ICM, 2018; KCE, 2014). Midwifery care and support in Belgium can legally be provided up to one-year postpartum, and thus midwives are involved throughout the period of transition to motherhood for a substantial period.

We are aware that supporting women in transition to motherhood shows benefits for women and their families (Emmanuel et al., 2011; Milgrom et al., 2011; Nelson, 2003; Paley et al., 2005; Simpson et al., 2003). Additionally, women identify midwives as the designated care provider for support in transition to motherhood. This combined with the prominent role of the midwife up to one-year postpartum, offers a window of opportunity for Flemish midwives in supporting women in their transition to motherhood. Earlier studies reported on care behaviour of midwives related to transition to motherhood and provide evidence on practice behaviour (Fontein-Kuipers et al., 2018c; Heinonen, 2021; Tichelman et al., 2019). However, the informal and unarticulated aspects of care behaviour are still unexplored (Tiitinen et al., 2014). Behaviour is subjected to attitude, feelings, opinions, thought, values, and viewpoints – known as subjectivity – and might differ **amongst** midwives. We hypothesized that by studying individual subjectivity and diverse discourses in a systematic way, we would be able to unearth the foundational way of midwives' thinking that causes actions within midwifery management of supporting transition to motherhood (Lutfallah and Buchanan, 2019). We also wanted to systematically facilitate participation of midwives on a complex issue such as supporting transition to motherhood. In this study we aimed to reveal midwives' distinct perspectives about midwifery support of women in their transition process during the continuum from pregnancy to one-year postpartum. To our knowledge, this has never been systematically studied. We aim to answer the following research question “What are the perspectives of Flemish midwives towards their role in supporting women in transition to motherhood during pregnancy up to one-year postpartum?”. Juxtaposing and discussing potential different perspectives enables midwives to extend their horizons and develop support strategies, or approaches to care, aimed at supporting the transition to motherhood.

Methods

To reveal midwives' different perspectives, we used the Q-methodology, a mixed-methods approach objectifying subjective opinions of midwives about supporting transition to motherhood. Q-methodology allows us to analyse the differences and similarities in their subjective perspectives (Watts and Stenner, 2012). Q-methodology study utilises different methodological steps: (1) Developing and constructing a set of statements (Q-set); (2) establishing the participant group (P-set); (3) sorting distribution; (4) post-sorting interviews.

Q-set: Set of statements

First, a set of statements was developed by exploring the topic and collecting all possible opinions and thoughts (*concourse*) about transition to motherhood and the midwife's role and tasks during this period. To better understand the phenomenon, we accumulated a wide scope of evidence and opinions through a literature review, and manually searching three volumes (2016–2019) of the bi-monthly published professional midwifery journal of the Flemish Professional Organization of Midwives (VBOV). We searched the grey literature, including books that are popular **amongst** Flemish women for self-help during transition to motherhood, based on book ratings. Additionally, we created a poll on the VBOV Facebook group to provoke reactions on the question: “As a midwife, what are your thoughts about what women need during their transition to motherhood, in pregnancy and in the postpartum period?” We also asked this question during informal conversations with midwives. All answers were recorded in a table. We collected a total of 105 core phrases from personal conversations, the poll, and citations from the literature. The phrases came verbatim from the sources and citations were directly extracted from the literature, with no influence of the reference frame of the researchers. A team of midwives, lecturers and researchers generated a set of 38 thoughts and opinions, after grouping phrases and citations for relevance, similarities in content and meaning. Three researchers formulated the quotes and phrases into statements, ensuring that the statements were balanced in formulation, i.e., that respondents had an equal opportunity to react positively and negatively to statements. The 38 statements were

subsequently pre-tested on comprehensibility, clarity, and duplicates [amongst](#) 13 midwives. Finally, 36 statements were included in the Q-set.

P-set: Sample


Congruent with the Q-methodology, our aim was to include a heterogeneous sample of midwives with various backgrounds and equal representation of practice setting, years of work experience, domestic role in family life and motherhood status (Watts and Stenner, 2012), knowing these factors to influence subjectivity towards supporting transition to motherhood (Allen, 1991; Fontein-Kuipers et al., 2018c; Kantola, 2010; Wilkins, 2006). We used practice setting as our sampling frame (categories: 'being employed', or 'independent practitioner', or 'a combination of both') and fixed sampling fraction for the strata: years of work experience (categories: '>10 years', or '<10 years'); personal view about the domestic role in family life (categories: 'only the mother takes care of the child without the involvement of a partner or another person', or 'the entire family is involved in upbringing', or 'caring for the child is equally divided between mother and partner'), and motherhood status (categories: 'having children', or 'not having children'). Additionally, we collected socio-demographic details. Based on the sampling frame, assuring a heterogeneous sample, we needed 36 different participant profiles – that is, a midwife representing certain sampling categories (e.g.: employed midwife, >10 years of work experience, caring for the child is equally divided between mother and partner, and no children) (Watts and Stenner, 2012).

We purposively recruited midwives in different ways. First, we contacted members of the Flemish Organisation of Midwives (VBOV). The VBOV has a member list that is publicly available on the VBOV website for women seeking a midwife. The members voluntarily provided their personal and contact details, consenting to be freely available and accessible. These members were contacted by e-mail with an invitation to participate. Second, a recruiting post including information about the study and the researchers' contact details was distributed on social media. Additionally, informative flyers were distributed to independent midwifery practices and maternity services in hospitals to invite midwives to participate in the study. Midwives were invited to contact the researchers when they were interested to participate. When midwives showed interest, they received an e-mail with additional information and instructions about the study and the link to the online 'statement-ranking' (Schmolck, 2002). During data collection, the researchers listed the participant profiles of the midwives, to purposively approach midwives with other participant profiles to assure our sample equally represented the factors that influence subjectivity towards supporting transition to motherhood.

During the process of sampling and data collection, it became apparent that midwives only identified themselves with the two domestic roles in family life categories: 'the entire family is involved in upbringing', or 'caring for the child is equally divided between mother and partner'. Moreover, it was very difficult to recruit midwives who had more than 10 years' work experience without children. It was probably an unrealistic and not very emancipated thought to assume that current women do not combine (the thought of) motherhood with a job/career, because only 14,90% of the Flemish mothers has no job (Statbel, 2018). Another aspect is that midwives, with more years of work experience are older and are more likely to have children (Fontein-Kuipers et al., 2014). After the inclusion of 55 respondents, we adjusted our sampling's domestic role in family life strata. Calculation showed that by deleting the stratum category 'only the mother takes care of the child without the involvement of a partner or another person', a minimum of 24 participants were needed in the P-set.

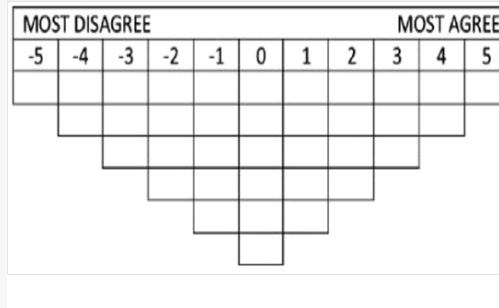
Sorting distribution and post-sorting interviews: data collection

The Q-set was digitally distributed using Q-Software (V.2.35©) (Schmolck, 2002), which included the 36 statements and a score sheet (Q-grid) (Fig. 1). In total 83 midwives sorted the statements. First, the participants were asked to read and sort the 36 statements in three categories: disagree, neutral or agree. Then, the participants rank-ordered the different stockpiles of statements with a forced-choice frequency distribution, according to their level of agreement with each individual statement in the respective categories. The statements were placed on a continuum from 'most disagree' (-5) to 'most agree' (+5) (Fig. 1). After the Q-sorting process was finished, the participants were asked if they were willing to be interviewed about their Q-sort ranking. Thirty-nine participants (47%) left a phone number or email address to be contacted to be interviewed. Dates and times were scheduled, and the interviews were performed over the telephone by one of two researchers (LVdB, NVdC). To verify the participants' Q-sort ranking, participants were asked, during the post-sorting interviews, to further comment on the statements placed at both extreme ends (-5 or +5) of the Q-grid, allowing understanding the participant's rationale for placing the statement (Gallagher and Porock, 2010;

 Images are optimised for fast web viewing. Click on the image to view the original version.

alt-text: Fig. 1

Figure Fig. 1



Q-grid

Q-analysis and interpretation

We used the PQ-method© to analyse the data. Data of each participant was entered into the program. To extract the factors, centroid by-person factor analysis and varimax rotation was conducted for factors with an eigenvalue ≥ 1 (Kaiser-Guttman criterion), a factor loading of ≥ 0.43 ($p < 0.01$) and when the cross-product of the factor's two highest loadings exceeded twice the standard error (Humphrey's rule) (Watts and Stenner, 2012). After extracting the factors, factor arrays were calculated. A factor array is a single Q sort configured to represent the viewpoint of a particular factor. Per factor, the sorts were categorised.

There was a time gap between the Q-sorting and the interviews and, as a form of respondent validation, we asked participants if they remembered their Q-sorting. There were 15 participants who had no clear recollection of their ranking. We did not transcribe these interviews, leaving 24 (29%) transcripts for analysis. Two researchers (LVdB, NVdC) independently read each transcript line by line and assigned codes to paragraphs or segments of texts relevant to the statements that were mentioned in the interviews. The text fragments were extracted and organised per statement, resulting in a matrix representing the codes. The descriptive codes aided the interpretation of the factors (Gallagher and Porock, 2010). Statement numbers are presented between square brackets. Quotes illustrate the factor scores, followed by a participant number (e.g., P4). Three researchers (LVdB, NVdC, YK) used constant comparison to reflect and evaluate the extracted fragments, and coding as a form of triangulation to enhance internal validity and trustworthiness (Creswell and Creswell, 2018).

Ethical considerations

The Ethical Committee on Social and Human Sciences of the University of Antwerp reviewed and approved the study protocol (SHW_19_25). All participants gave informed consent before sorting the statements via box ticking and gave oral consent prior to the post-sorting interview. After the interviews, the names and contact details of the participants were deleted from the data set. Participants could withdraw from the study at any moment.

Findings

Participants

In total 83 midwives rank-ordered the statements. The midwives had a mean age of 33 years (SD 9.65). One male midwife participated. The midwives had an average of 9.6 years' work experience (SD 8.97). Most of the participating midwives had a bachelor's degree (81.9%), although Factor 1 midwives more often had an additional master's degree

(21.7%) compared with Factor 2 midwives (6.3%). Factor 2 midwives had more years of work experience (mean 10.59 years; SD 6.85) than Factor 1 midwives (mean 7.72 years; SD 7.65). [Table 1](#) shows the characteristics of the midwives.

alt-text: Table 1

Table 1

i The table layout displayed in this section is not how it will appear in the final version. The representation below is solely purposed for providing corrections to the table. To preview the actual presentation of the table, please view the Proof.

Characteristics participants

	Total (n = 83)	Factor 1 (n = 23)	Factor 2 (n = 16)
Age mean (SD; range)	33.22 (9.65; 22-61)	31.70 (7.96; 22-53)	32.19 (7.11; 22-49)
Female % (n)	98.80 (82)	95.70 (22)	100 (16)
<p>[Instruction: Table 1 - layout is not correct In attachment you can find the correct table. 'Practice setting' has 3 answer options: independent practitioner, employer, combination of both (the numbers need to be on the same line of the answers). 'Domestic role in family life': the numbers need to be on the same line as the answer option. This is the same for 'highest education level'.][Instruction: MC: Please check comments section.]</p> <p>Practice setting Independent practitioner: % (n) Employer: % (n) × Combination of both: % (n)</p>	38.60 (32) 47.00 (39) 14.50 (12)	39.10 (9) 52.20 (12) 8.70 (2)	50.00 (8) 50.00 (8) 0.00 (0)
Domestic role in family life			
× The entire family is involved in upbringing: % (n)	47.00 (39)	52.20 (12)	43.80 (7)
× Caring for the child is equally divided between mother and partner: % (n)	53.00 (44)	47.80 (11)	56.30 (9)
Being a parent	55.40 (46)	52.20 (12)	56.30 (9)
Years of work experience mean (SD; range)	9.61 (8.97; 0-41)	7.72 (7.65; 0-32)	10.59 (6.85; 1-26)
Highest education level			
Bachelor: % (n)	81.90 (68)	78.30 (18)	93.80 (15)
Master: % (n)	18.10 (15)	21.70 (5)	6.30 (1)

Midwives' perspectives on providing support to women during transition to motherhood


The analysis revealed two distinct viewpoints, which accounted for 59% of the variance.

In total 39 Q-sorts defined the two viewpoints, while 41 confounded Q-sorts (significant loading on F1 and F2) and three non-significant Q-sorts were excluded from the analysis (Watts and Stenner, 2012). F1 was defined by 23 midwives and F2 by 16 midwives (see [Table 2](#)). With aid of the post-sorting interview transcripts, the two factors were interpreted and labelled as (F1) *job-focused midwife* and (F2) *women-focused midwife*. Overall, there was consensus on eight statements [11, 12, 15, 18, 24, 26, 30, 33]. All midwives strongly disagreed (-4) that support during transition to motherhood is only focused on the mother and that the rest of the family does not need to be involved during the transition process [18]. Midwives of both factors also strongly disagreed (-3) with the statement that only women with similar values and norms as themselves can be supported during transition to motherhood [24]. The midwives did not

agree (-2) that a midwife provides only practical solutions to support the transition to parenthood [15]. All midwives disagreed (-1) that support during transition to motherhood consists of drawing up a birth plan [33] and all disagreed (-1) that they are responsible for successful transition to motherhood [26]. The midwives agreed (+1) that antenatal midwife-led care is mandatory for adequate support during transition to motherhood [12]. They agreed (+2) that support during the transition process consists of talking about emotions on being and becoming a mother [30]. Midwives also agreed (+2) that providing support during transition to motherhood is a skill that midwives can learn [11]. Table 3 presents an overview of the Q-set statements and the factor array.

alt-text: Table 2

Table 2

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Q-sorts defining the two factors


Factor	Q-sorts loading on the factor ^a	Total number of Q-sorts loading per factor	Eigen values	Explained variance (%)
1	1, 6, 16, 20, 27, 28, 33, 35, 39, 43, 48, 49, 53, 57, 65, 66, 67, 70, 76, 77, 79, 80, 82	23	45.3966	55
2	3, 7, 9, 10, 18, 24, 36, 37, 38, 52, 55, 60, 61, 68, 69, 81	16	2.9310	4
Confounded	2, 4, 5, 8, 11, 12, 13, 14, 15, 17, 19, 21, 22, 23, 25, 26, 29, 30, 32, 34, 40, 41, 42, 44, 45, 50, 51, 54, 56, 58, 59, 62, 63, 64, 71, 72, 73, 74, 75, 78, 83	41		
Non-significant	31, 46, 47	3		

Table Footnotes

^a Each Q-sort number represents an individual participant.

alt-text: Table 3

Table 3

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Q-set statements and factor array

Statement	Factor array	
	1	2
1 Healthcare funding plays a role in the midwife's supportive task during transition to motherhood	3 ^a , *	0
2 The midwife's support of transition to motherhood has a health promoting effect on the entire family	5 ^a , **	4
3 The midwife acts as a friend in supporting the woman in her transition to motherhood	-4 ^b , *	-1
4 Supporting the transition to motherhood is an exclusive part of the midwife's scope of practice	-2 ^a	-3
5 Only problematic and difficult transition to motherhood should be supported by the midwife	-5 ^b	-4

6	Only primipara must be supported in transition to motherhood	-2 ^a *	-5
7	The woman herself is exclusively responsible for successful transition process to motherhood	1 ^a	0
8	Motherhood is driven by instinct and requires no further support of the midwife	-3 ^b	-2
9	The midwife has a key role in facilitating social contacts between mothers	1 ^a	0
10	The midwife is sufficiently educated to support the transition to motherhood	-1 ^b *	0
11	Supporting transition to motherhood can be learned by midwives	2	2
12	Midwife-led antenatal care is mandatory for adequate support of transition to motherhood	1	1
13	The key role of the midwife in supporting the transition to motherhood is confined to the first 6 weeks postpartum	-2 ^b *	2
14	The midwife does not have time in her remit to support the woman in the transition process to motherhood	0 ^a *	-2
15	The midwife only provides practical solutions to support transition to motherhood	-2	-2
16	Support of the same midwife benefits the transition process to motherhood	0 ^b *	5
17	Recognizing postnatal depression of partners is part of the midwife's remit	1 ^b	2
18	Support of the transition process is restricted to mother and child; the other family members do not have to be involved	-4	-4
19	The midwife has predominantly a coaching role during transition to motherhood	2 ^b	4
20	The midwife who is a mother herself is the only one who can adequately support transition to motherhood	-3 ^b	-2
21	The midwife and the woman travel together on the journey to motherhood	1 ^b *	3
22	Supporting transition to motherhood is not part of the medical model	-1 ^a *	-3
23	The midwife is the expert in the physiological transitional process to motherhood	0 ^b *	3
24	I can only support women in the transition to motherhood with the same norms and values as myself	-3	-3
25	The midwife contributes to social healthcare through supporting transition to motherhood	4 ^a	3
26	The midwife is responsible for successful transition to motherhood	-1	-1
27	The midwife's personal interest in the transition process to motherhood is conditional for support	0 ^b *	-1
28	As a midwife I have sufficient knowledge about transition to motherhood	-1 ^b *	1
29	Standard guidelines should be necessary to support transition to motherhood	0 ^a	-1
30	Supporting transition to motherhood includes talking about the emotions towards becoming and being a mother	2	2
31	In supporting transition to motherhood, the midwife has an exemplary role in the practical care of the newborn baby	0 ^b	1
32	Supporting transition to motherhood consists of preparing the woman for a new identity as a mother	3 ^a *	0
33	Supporting transition to motherhood consists of drawing up a birth plan	-1	-1
34	Supporting transition to motherhood consists of preparing the woman for adjusting to her new role (as a mother)	4 ^a *	0
35	Supporting transition to motherhood consists of teaching the woman how to bond with her (unborn) child	2 ^a	1

36	Supporting transition to motherhood consists of preparing the woman for the fact that motherhood does not always agree with her personal expectations	3 ^a *	1
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Table Footnotes

^a Ranked higher than the other factor.

^b Ranked lower than the other factor.

* $p \leq 0.01$.

** $p \leq 0.05$.

The description of the two factors includes the perspectives of the significant factor scores and some of the distinct higher and lower ranking between the factors. In describing the factors, speak of midwives as we are representing the perspectives of 'prototype' midwives (Rhoades and Williams-Brown, 2019).

Factor 1: Job-focused midwife

The term 'job-focused midwife' was chosen because this midwife's way of supporting transition to motherhood is evidence based and task-focused. This midwife substantiates her way of working by theoretical frameworks and guidelines like "family centred parenting" (P28). She does not regard herself as an expert or having the necessary knowledge about transition to motherhood. She thinks that midwives are not sufficiently educated to give this support [10, 23, 28]. "I think that we need more training to know why this is important, information about the outcomes when support is not given properly (P1)". For this midwife support consists of giving standardized care and information [21, 34, 32]. In this perspective giving practical information and tips contributes to social health care and has a health promoting effect on the entire family [25, 2]. "I think a midwife has only positive effects on the health of the entire family. To the woman, but also to the partner and to other children (P1). "(...). Important during the support of this transition process is to prepare women for the fact that motherhood does not always meet personal expectations [36]. "Women have an image and that doesn't always match with the reality, and this can make a woman feeling very down (...). I see this very often and this results in many emotional problems (P77)". Although this midwife disagrees that only primipara must be supported, she assumes that probably first-time mothers need more information [6]. "Giving a lot of explanation is important, especially with firstborn children" (P1). The job-focused midwife is keen to adhere to the scope of her professional profile, providing support up to one-year postpartum [13]: "(...) our postnatal care timeframe has been extended to one-year postpartum, so supports should be given during this period" (P28). With a focus on tasks and responsibilities, the midwife will not act as a friend in supporting women in their transition to motherhood [3]. "A midwife can be friendly (...), but you still have to keep a certain professional distance" (P35). The midwife regards supporting women during transition to motherhood to fit the (bio)medical model [22]; "I think this is part of the medical model, because we are a medical profession" (77). This midwife states that detecting problems, such as postpartum depression, is the midwife's task but further support is out with her scope of practice [17]; "As a midwife you are not supposed to act like a psychologist" (P28). This midwife voices that finances play a big role in if and how the midwife is supporting the transition process [16, 14, 1, 27]. "The problem is money, (...) 'I am not getting paid for this', so I think more money would help" (P77). "It is about money" (P1).

Factor 2: Woman-focused midwife

The term woman-focused midwife was chosen because of the individualized way of supporting transition to motherhood. This midwife is convinced that transition to motherhood improves when there is continuity of care by the same midwife [16]. Transition to motherhood care is based on the one-on-one connection with a mother and consists of demand-oriented care, focused on a mother's needs. This midwife sees her role as a coach and almost as a friend [19, 3]. "The relationship of trust is important. If you only have that professional side and there is a certain distance, women are less likely to open up then when you are more informal" (P55). She describes it like being on a journey with a woman, and that journey is based on a relationship of mutual trust [21]. "The transition to motherhood is not something to be taken lightly. There is a lot involved, both emotional and practical. I have the feeling that when women are supported by the same midwife, the bond of trust materializes faster and is stronger and you can support women more individualized, because they are much more responsive. (...) They are just more open, so you know what is going on, what their fears are (P55)". For this midwife finances or time will not affect if and how she supports this transition process [1, 14]. "You have to make time (...) If I am going on a home visit, I will sit down, drink some tea together and let her tell her story. (...) And when you take time, more sensitive aspects will come up and you create

space to talk about this. People will feel it is okay to talk about their feelings” (P18). The woman-focused midwife utilises a biopsychosocial approach, focussing on more than only the medical aspects [22]. “If you only focus on the medical factors, you will miss a lot of important information” (P55). According to the woman-focused midwife not only primipara need support during this transition process [6]. “Not only primipara need support, but also women who already have children start a new episode in life” (P9). The woman-focused midwife has no strict ideas about the exact content or procedure of supporting women during transition to motherhood [32, 34, 36] and dismisses the implementation of standards or guidelines to support this process [29]. “It is all about women's needs” (P18). This midwife is focused on the woman's personal environment and involves family members in the process, convinced her support to have a health promoting effect on the entire family [2]. “Everyone has to find a new balance when there is a new baby, also the partner or other children. (...) When the mother feels good, respected, and supported in the choices she makes, this will have a positive influence on the family as a whole” (P18). To support women during transition, this midwife predominantly focuses on the first six weeks after giving birth [13]. The woman-focused midwife regards herself as knowledgeable about giving support during transition to motherhood, showing an intrinsic interest in the topic [27] and being an expert of physiology, regarding transition to motherhood as a physiological process [28, 23]. “I think we just need to support the physiology, what is normal, by letting it all happen. (...) Making emotions something to discuss openly (...) and just being there to listen” (P18). The midwife thinks that expertise positively contributes to supporting transition to motherhood [10].

Discussion

Using the Q-methodology we extracted two factors to aid in explaining different discourses on supporting women during transition to motherhood **amongst** our participants. The statements in our study conveyed various feelings, opinions, thought, values, and viewpoints about supporting transition to motherhood and the midwife's role and tasks during this period. Our analysis revealed two principle thoughts about supporting women in transition to motherhood, including different interpretations of the tasks involved and what is required to perform these tasks. The difference in perceptions predominantly showed in how the respective midwives approached their role: being a professional in a medical versus a biopsychosocial model, and utilisation of care: tasks versus relation focused. When midwives' core ideas about their role differ, simultaneously their individual practice differs (Fontein-Kuipers et al., 2019; Eri et al., 2020). Despite the two factors, all midwives emphasized that support during transition to motherhood not only focuses on mothers but should involve the family's needs – representing a positive and strong belief in the value of not only supporting women but conveying an inclusive family approach (Bradfield et al., 2018). Also, all midwives emphasized that supporting transition to motherhood enables family health promotion effectiveness. These perceptions are in line with the suggestions resulting from the study of Heinonen (2021) that a more conscious salutogenic approach in midwifery care would positively support parents and their family in their wellbeing in their new role as a parent. When applying the salutogenic approach to supporting women during transition to motherhood - life as a mother is meaningful, manageable, and comprehensible – it is important to understand how the midwives in our study promote and enhance positive states of maternal health and wellbeing during their support of transition (Perez-Botella et al., 2015). The midwife within a medical model of care, being task and guideline focused, and having a salutogenic and inclusive approach to care, addresses meaningfulness (theoretical knowledge), comprehensibility (standardized information) and manageability (time and finances) whilst supporting women during transition to motherhood. The midwife within a biopsychological model of care, being woman-focused, and having a salutogenic and inclusive approach to care, emphasizes the manageability (relationship) and the meaningfulness (mothers finding an emotional balance) and comprehensibility (fears and feelings) when supporting women during transition to motherhood (Thomson and Dykes, 2011; Perez-Botella et al., 2015). Although the distinct perspectives, both midwives incorporate the salutogenic elements, albeit in a different way. Using the salutogenic elements in reflecting on care of women during transition to motherhood, might help to understand what generates and what helps mothers during this transition process (Perez-Botella et al., 2015). The mentioned approaches and models of care regarding the midwife's support of women in transition to motherhood contain epistemological differences and congruences (Fontein-Kuipers et al., 2019; Eri et al., 2020). The congruence as well as the differences in midwives' epistemological foundation increase the awareness of the effect of these foundations for supporting women during transition to motherhood - functioning as theoretical guiding tools for midwifery practice and education (Eri et al., 2020). Additionally, it can be advised to explore how women make sense of their midwife's support during the transition process to illuminate their needs in terms of manageability, meaningfulness and comprehensibility (Thomson and Dykes, 2011).

Traditionally, the midwife provides care up to six weeks postpartum (World Health Organization, United Nations Children's Fund, World Bank Group, 2018). When postpartum care is provided up to one year postpartum, the midwife needs to know what the focus and content of her care should be. While women merely focus on instrumental support to recover physically and emotionally and start to establish networks during the first six weeks postpartum, after this period women tend to focus on their changes in life, relations and lifestyle (Barkin et al., 2014; Negron et al., 2013). This implies that women have different needs during the early and later stages of the first year postpartum in terms of transition support, requiring the midwife to adjust her care and focus accordingly (Choi et al., 2005).

The midwives' different perspectives about knowledge may have implications for midwifery education. Fonteinkuipers et al. (2018c) describe that student midwives think transition to motherhood is under addressed during pre-registration education and they experience minimal guidance in how to support transition to motherhood in practice. More attention for this topic in the education program of midwifery and professional development is necessary to make midwives (feel) competent to give support to woman during their transition to motherhood. As all participating midwives agreed that providing support during transition to motherhood is something you can learn as a midwife, it is important to address and implement transition to motherhood into education programs for the (student)midwife to create an environment where women can grow during motherhood (Fonteinkuipers et al., 2018c; VBOV, 2019). It is of merit to explain to students and midwives that the topic of supporting transition to motherhood can be approached according to two distinct views. Given the number of confounders between Factor 1 and Factor 2, it is likely that (student)midwives will recognise both perspectives, providing food for thought with which factor they feel most comfortable and why, aiding critical reflection on practice. It is known that more years of midwifery experience, predict the utilisation of certain professional behaviour with regard to psychological issues (Fonteinkuipers et al., 2014). In this study we observed that the woman-focused midwife, who regards herself as an expert of supporting transition to motherhood, has more years of work experience in comparison with the job-focused midwife, who does not regard herself as an expert. The women-focussed midwives were more likely to be independent practitioners, allowing more freedom and autonomy and a self-ruling and self-determining sphere of practice (Clemons et al., 2020; Mestdagh et al., 2019a, Pollard, 2003). Moreover, we observed a difference in education level between the two midwives. The job-focused midwife more often has a master's degree compared to the woman-focused midwife. These comparisons are, however, just observations. Because of the design of the study and the small sample size meaningful statistical inferences cannot be made. Therefore, caution is warranted to draw conclusions on whether years of work experience and education level are factors that contribute to midwives' perceptions of supporting transition to motherhood.

This study has some limitations. The participants used the online program for ranking the statements and weeks or even months later the interviews were performed. During the interviews it became clear some midwives had forgotten their Q-sorting. We learned it is best to do the interviews immediately after the Q-sorting. However, organising interviews through telephone was a very practical and easy way to collect the qualitative data (Janghorban et al., 2014). Because of the self-selective way participants were recruited, there is a chance of selection bias. Maybe only midwives who were interested in the topic participated in our study. Around half of the Q-sorts could not be classified in one of the two factors and were excluded from our analysis. A follow-up study could use our results as the basis for a stakeholder analysis (i.e., midwives), to find out the prominence of the different perspectives but also for analysing the underlying structure of the confounding between perspectives. Our results can be considered as a hypothesis generating method that can serve as a steppingstone for further research to explore underlying reasons of these perspectives in a wider population of midwives. We included less than half of the participants in our quantitative analysis and a third in the qualitative analysis, which can be regarded as a major flaw, albeit the numbers for both parts of the analysis were sufficient for this study. Q-methodology, however, is not focused on estimating the frequency and distribution of perspectives within a population, but rather on mapping the plurality of these perspectives. Additionally, this type of study tends to use samples that are small (Watts and Stenner, 2012). As this is first Q-methodology study about transition to motherhood had an exploratory focus and these perspectives can be subsequently tested in larger populations (Valenta and Wigger, 1997). Q-methodology studies are not intended to generalize a finding or determine the proportion of individuals holding a particular opinion (Watts and Stenner, 2012). We are therefore aware that our results are not generalizable to the broader population of midwives and an additional qualitative study exploring midwives' perspectives in more depth would be of merit. Lastly, it is important to stress that our results do not argue for or against a specific type of midwife or typology of supporting women in transition to motherhood.

Conclusion

In this study we identified two perspectives of Flemish midwives toward supporting women in transition to motherhood, including epistemological foundation with subsequent theoretical and practical implications. The job-focused midwife has a more medical approach to care and acts according to evidence, knowledge and guidelines and is keen to adhere to the scope and tasks of her professional profile. The woman-focused midwife has a more biopsychosocial approach to care and acts according to the needs of the women and sees a relationship of trust and the one-to-one connection as key factors in supporting transition to motherhood. Both perspectives however include elements of a salutogenic approach of supporting women during transition to motherhood. More attention to the topic transition to motherhood is necessary in the education program of midwifery. Considering the results and the limitations of this study, further research providing additional insights how supporting transition to motherhood fits the midwife's scope and role as well as women's needs, is necessary.

Ethical approval

The study was approved by the Ethical Committee on Social and Human Sciences of the University of Antwerp (SHW_19_25).

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Bart Van Rompaey: Methodology, Validation, Writing-Reviewing & Editing, Supervision, Funding

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Q2 All authors have approved the final article

Uncited references

~~Fontein-Kuipers et al., 2018a, Aernouts, 2019, Fontein-Kuipers et al., 2018b, Mestdagh et al., 2019, Barimani and Vikström, 2015, VBOV 2020, VLHORA 2007.~~

CRedit authorship contribution statement

Laura Van den Branden: Methodology, Investigation, Formal analysis, Validation, Writing – original draft. **Natacha Van de Craen:** Investigation, Formal analysis, Validation, Writing – review & editing. **Luka Van Leughenage:** Investigation, Validation, Writing – review & editing. **Eveline Mestdagh:** Project administration, Writing – review & editing, Funding acquisition. **Olaf Timmermans:** Methodology, Validation, Writing – review & editing, Supervision, Funding acquisition. **Bart Van Rompaey:** Methodology, Validation, Writing – review & editing, Supervision, Funding acquisition. **Yvonne J Kuipers:** Conceptualization, Methodology, Validation, Formal analysis, Writing – review & editing, Supervision, Funding acquisition.


Declaration of competing interest

The authors report no conflict of interest.

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Queries and Answers

Q1

Query: Please confirm that given names and surnames have been identified correctly.

Answer: Yes

Q2

Query: This section comprises references that occur in the reference list but not in the body of the text. Please position each reference in the text or, alternatively, delete it.

Answer: We deleted the references that occurred in the list but not in the body of the text.