Women's Experience of Trust Within the Midwife–Mother Relationship

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This article summarizes the main findings from my PhD study exploring individual women's experiences of trust within the midwife–mother relationship.

Evidence suggests that trust is an important element of care provision (Department of Health, 2010; Nursing and Midwifery Council, 2015), yet it is poorly defined as a concept.

AIM: The aim of the study was to explore the concept of trust within the midwife–mother relationship increasing understanding of individual women's experience of trust and its meaning to them within the caring relationship. No specific research questions were identified at the outset as congruent with the hybrid methodological approach used.

METHODOLOGY: A hybrid model approach was used, underpinned by a Heideggerian phenomenological approach. The hybrid model provides a theoretical framework for incorporating the literature and theory in the developing concept analysis with empirical data as a continuous concurrent process (Schwartz-Barcott & Kim, 1993). Longitudinal semi-structured interviews were carried out at three time points: in early pregnancy, at 37 weeks of pregnancy, and 8 weeks postnatal with a purposive sample of nine women experiencing straightforward pregnancy. Phenomenology allowed the concept to be explored within the lived experience of the participants in the natural setting.

ANALYSIS: Thematic analysis was conducted, supported by Nvivo 9. The text was analyzed as a whole, by sections of text and by line-by-line coding examining the participant's words for meaning. Extracts were coded, clustered, and synthesized into overarching themes. Comparison of the themes at each stage assisted in the understanding of the development and changes within the concept being studied over time. Themes were taken back to participants to guide subsequent interviews clarifying their meaning, authenticity, and ensuring that the data gathered reflected their personal insight.

FINDINGS: The experience of trust was described as an evolving concept that developed over time as a series of building blocks. The participants described an initial trust associated with an expectation of assumed competence in the midwife, but this was then influenced by the developing relationship between midwife and mother. The concept of trust was interwoven with women's agency; women expressed a desire to develop a two-way trust that included the midwife trusting the woman. This article reports on the overall findings, concentrating on the development of trust and key themes relevant to clinical midwifery practice: need, expectation, the midwife–mother relationship, and impact of continuity of carer and the importance of women's agency.

IMPLICATIONS: Understanding the concept of trust from the woman's perspective is important for developing maternity services that meet the needs of women.

KEYWORDS: partnership; empathy; reciprocity; women's agency; decision making; safe birth

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INTRODUCTION

Literature suggests that trust is an essential component of the midwife–mother relationship and that models of care should be developed that support women to develop trusting relationships with a known midwife (DOH, 2010; Sandall, Soltani, Gates, Shennan, & Devane, 2013). Despite trust being a focal point of many strategic documents, trust as a concept is not well defined. Government reports spanning over three decades have attempted to focus on the principles of woman-centered care, embracing women as full and equal partners in the midwifery care relationship (DOH, 1993, 2010; Welsh Assembly Government, 2008, 2011). Hunter, Berg, Lundgren, Olafsdottir, and Kirkham (2008) suggested that good quality relationships were the key to developing effective maternity services; without strong consideration for relationship issues, initiatives to promote normal physiological childbirth would be ineffective. Many initiatives have been implemented to change maternity care provision and allow women to develop better relationships with midwives that are based on a notion of trust. Moreover, the revised NMC code (2015) emphasizes the importance of promoting professionalism and trust as one of its key themes. It is necessary for women and their families to place trust in maternity services; understanding the basis of that trust is essential if midwives are to develop maternity services in a way that upholds the woman's trust. Yet there is little evidence in the literature of any substantial studies looking at what trust means to women within the midwife–mother relationship or how trust develops and what influence it has on the decisions made by women. Hence, maternity services need to know more about the concept of trust to develop effective services.

Considering trust in health care more generally, the need for trust is frequently identified within a wide range of literature, yet the concept is not well defined or its importance to decision making quantified. The existing literature suggests that trust is multidimensional (Thiede, 2005). It is not purely a value, emotion, or belief, or is it confidence, satisfaction, or reliance but rather a broad concept which encompasses all. A distinction is made between initial trust which may, on face value, be more focused on nonrational "gut feelings" (Sellman, 2006) or belief and interpersonal trust based more on a rational calculation. Evidence suggests that trust changes over time in response to social interactions and experience (Gulati & Sytch, 2008; Harrison, Innes, & van Zwanenberg, 2003). What is not clear from the literature is how this applies to midwifery care or what value individual women place on each type of trust. Thus, little is known about the particular aspects of trust that are important to women or at what stage trust is crucial to aiding the care process. There is also little evidence about how women use interactions with midwives to assess their trustworthiness, or if this differs at different care stages. For example, is the trust placed in midwives providing routine antenatal care the same as the trust placed in a midwife to safely help birth the baby? It may be possible to explore these issues by looking at the development of trust as the relationship moves through different stages of the childbearing process, and it was this intention that provided the rationale for this study.

The broad aim of the research study was therefore to explore the concept of trust from the individual woman's perspective with a view to developing a better understanding of trust within the midwife–mother relationship. No specific research questions were identified as congruent with the hybrid methodological approach used. This article reports on the overall findings, concentrating on the development of trust and key themes relevant to clinical midwifery practice: need, expectation, the midwife–mother relationship, and impact of continuity of carer and the importance of women's agency.

METHOD

Research Approach

The qualitative study was set within a naturalistic paradigm to explore the lived experience of the individual woman's concept of trust.

Theoretical Framework

The study design used the hybrid model described by Schwartz-Barcott and Kim (1993).

The hybrid model (Schwartz-Barcott & Kim, 1993) combines an initial concept analysis with empirical data collected, enabling refinement of the concept within its given context. The benefit of concept analysis is its ability to explore meaning rather than simply describe a concept (Baldwin, 2008).

In this study, the hybrid model provided a framework to assist the researcher in developing the concept analysis while ensuring that the women's voices remained the central focus.

My choice of the hybrid model was influenced by a study conducted by Davis (2010) to understand

and develop the concept of normalcy in childbirth. She described the purpose of concept development to clarify the use of a concept in real life and to form the foundation for a further inquiry. Davis used the hybrid model together with hermeneutic phenomenology to incorporate the literature on normalcy with a fieldwork component. It seemed appropriate to consider the hybrid model to assist me as a novice researcher in structuring the integration of the theoretical concept with the experiences of the women for my study. The hybrid model used with a phenomenological methodology for the empirical data collection as described by Davis (2010) offers a framework to ensure that the lived experience is used to develop understanding of the concept as experienced by the individual.

The hybrid model consists of three stages that allow the researcher to develop a deeper understanding of the concept by working backwards and forwards in a hermeneutic cycle between Stage 1, the theory; Stage 2, the lived experience; and Stage 3, a constant comparative technique that also acknowledges the prior knowledge and experience of the researcher and draws the central essences from the individual journey of the participants.

Hybrid Model Stage 1: Concept Analysis

Stage 1 of the hybrid model was important to develop theoretical understanding of trust as a colloquial concept including the language used to describe it (Rodgers, 1989). This understanding subsequently informed the next stage of the model: data collection. A theoretical concept analysis of trust was undertaken using a broad literature review and concept analysis process described by Rodgers (1989). This allowed an exploration of theory and literature related to all uses of the word *trust*. This included the language used to describe trust, the other words within the literature that are interchanged with the word trust such as *faith*, *belief*, *reliance*, *satisfaction*, and the theoretical meaning of trust within the context of the midwife–mother relationship. John's (1996) concept analysis of trust within nursing was identified as key literature and was the closest research study that I could find related to midwifery. I did not find any midwifery studies directly evaluating the concept of trust within midwifery, although some studies do identify the significance of trust (Dahlberg & Aune, 2013; McCourt & Stevens, 2009; Sandall et al., 2013).

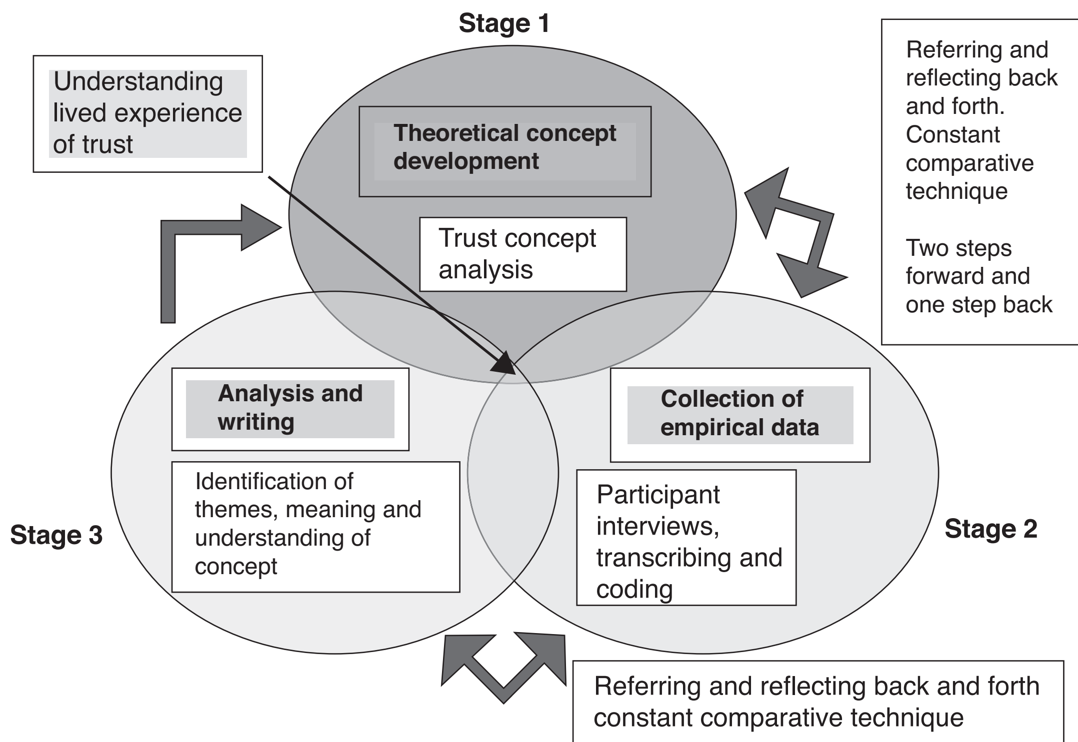

FIGURE 1 Hybrid model framework. Figure 1 shows how the "hybrid model" was used as the theoretical framework. The existing literature in the form of a concept analysis was integrated with new empirical findings to develop a central understanding of the individual woman's experience of trust within the midwife–mother relationship.

The concept analysis was divided into sections: trust within midwifery, trust in health care, and trust as a generic concept.

Hybrid Model Stage 2: Empirical Study

Stage 2 of the hybrid model involved the collection of empirical data underpinned by a phenomenological approach to ensure that the woman's "real world" experience was central to the concept analysis.

Recruitment

Following NHS ethical approval, a purposive sample of participants was recruited from one Health Board in Wales that offered women an opportunity to get to know their midwife throughout pregnancy as part of a caseload continuity type midwifery model. As the study aimed to explore the concept of trust longitudinally, it was important that participants were cared for in this way as they were able to get to know the midwife. This enabled me to explore the concept of trust within this relationship context. Women who were identified as low risk at the beginning of their pregnancy (therefore suitable to receive midwifery led care) were invited to take part in the study.

Sample

All participants were cared for predominantly by their named midwife within the community setting and planned to give birth within the local birth center or at home. Of the nine participants who completed the study providing 27 interviews, five were experiencing their first pregnancy and four were pregnant with their second, third, or fourth child. Five participants developed complications during their pregnancy necessitating a change from planned midwifery care to the hospital consultant unit; one participant required to be transferred to the consultant unit in labor. Another participant decided because of social reasons to go to the hospital for the birth of her baby, leaving two of the participants who achieved their planned home births.

Data Collection

Data were collected over the time frame of the pregnancy to enable me to capture the experience of trust as an unfolding process and to explore the concept over a given time. Face-to-face interviews were conducted with each of the participants. Three interviews were conducted with each participant; the first one was conducted at 8–10 weeks into the pregnancy—just after the initial booking appointment with the midwife. The purpose of this interview was to collect views relating to initial trust which formed a "baseline" understanding for the concept prior to any relationship being established. The second interview was conducted at around 37 weeks of pregnancy following the appointment with the midwife to discuss the birth plan. The purpose at this stage was to collect data relating to trust within the relationship that had been formed. The third interview took place at around 6–8 weeks after the baby was born; the purpose of this interview was to verify the previous data collected, to establish the consequences of trust at the end of the woman's journey, and to give women an opportunity to disclose any information that they perhaps were reluctant to share while still under the care of the midwife. The longitudinal design which is relatively rare in midwifery research also allowed the researcher to develop a rapport with the participants, which was important for encouraging in depth discussion and a more personal insight into their experience. All the interviews were transcribed verbatim and the data stored and managed through Nvivo 9 software.

Hybrid Model Stage 3

Stage 3 of the hybrid model uses data from the individual journeys of the participants, the reflections of the researcher, and the theoretical background built in Stage 1 concept analysis to identify the central essences and deeper understanding of the concept within the given context.

Data Analysis

The hybrid model used within a hermeneutic cycle (see Figure 1) inspired the approach to data analysis. Using Nvivo 9 software, the interview data were coded into descriptive and interpretive codes and grouped into themes using explanatory codes (Burns & Grove, 2005); the themes were developed iteratively with the available literature to form an initial understanding of the individual woman's lived experience. Data and literature were worked back and forth between Stage 1 and Stage 2 until initial understanding gained. This initial understanding then informed the subsequent interviews, for example,

questions and points for further discussion. Stages 1 and 2 work forwards and backwards with the researcher developing the understanding gained from each interview with the available literature and using this to return to the participants for further discussion and opportunity to gain a deeper understanding of each theme (reality checking). The researcher and participants work together in constructing the concept as described in the Heideggerian phenomenological approach as a hermeneutic cycle (Davis, 2010; Heidegger, 1962). Emerging themes were taken back to participants in subsequent interviews for clarification and further discussion before being refined with the literature and researcher reflections to construct a mutually defined meaning. Themes and meanings were subjected to scrutiny from my two academic supervisors prior to completion of Stage 3 of the hybrid model. Stage 3, combining the theory and the empirical data in this cyclical model, allows the researcher to move away from purely describing the experience to a deeper analytic understanding of the concept.

Findings

Stage 1 of the hybrid model resulted in a theoretical concept analysis that enabled the researcher to use the available literature to form a background working definition of trust to inform the collection of data in Stage 2. As a result of undertaking the theoretical concept analysis, trust was described in three parts: the antecedents—that which come before, the attributes—that which form the core, and the consequences—that which come after (Table 1). In each part, several key elements were identified.

Stage 2 of the hybrid model generated a substantial amount of qualitative data that enabled me to gain a better understanding of the concept of trust from the woman's perspective. The data indicated that trust as a concept was not static but was fluid, an evolving concept that developed over time. The data gathered focused on the experience of how trust developed. This was conceptualized as a series of building blocks, a term used by one of the participants.

> *Like building blocks, I guess you start off with a certain level of trust because you know they are a professional in that, a professional in that field. But as you move on, I imagine you would need to stay with that midwife to build a relationship because at the end of the day, she is going to be there at the birth.* (Fiona Interview 1)

The women described the importance of these blocks to their experience of trust at each stage and how this experience was interwoven with a second important concept—woman's agency (i.e., the ability to remain in control and make own decisions—self-determination).

The women's journey through the building blocks of trust demonstrated how women risk assessed, communicated, and made decisions that influenced the evolvement of trust from that initially placed to a trust based more on interpersonal relationships that would enable them to reach their goal—a safe and satisfying birth (Figure 2).

TABLE 1 The Theoretical Analysis–Trust in Three Parts

ANTECEDENTS	ATTRIBUTES	CONSEQUENCES
Need	Relationships	Realization of expectations
Past experience	Expectation	Increase in trust
Risk	Value	Decrease in trust
	Emotion	
	Goodwill	

Antecedents

Two building blocks were identified related to the antecedents of trust. The first of these is *need*—the need to feel safe. The second building block is *expectation*—initial trust appeared to be founded on the expectation that the midwife was a competent professional. Interestingly, there were some subtle differences noted in the responses from women who were experiencing their first pregnancy to those who had a baby previously. For women experiencing their first pregnancy, the need to feel safe was highlighted as a need for information to overcome the vulnerability resulting from experiencing a journey into the unknown, in which participants described themselves as "blind." Their expectation of the midwife was based on what they had heard socially or from the media. This resulted in an assumed competence that the midwife would provide them with the information and knowledge to increase their own understanding of pregnancy and birth, thus enabling the women to make their own decisions.

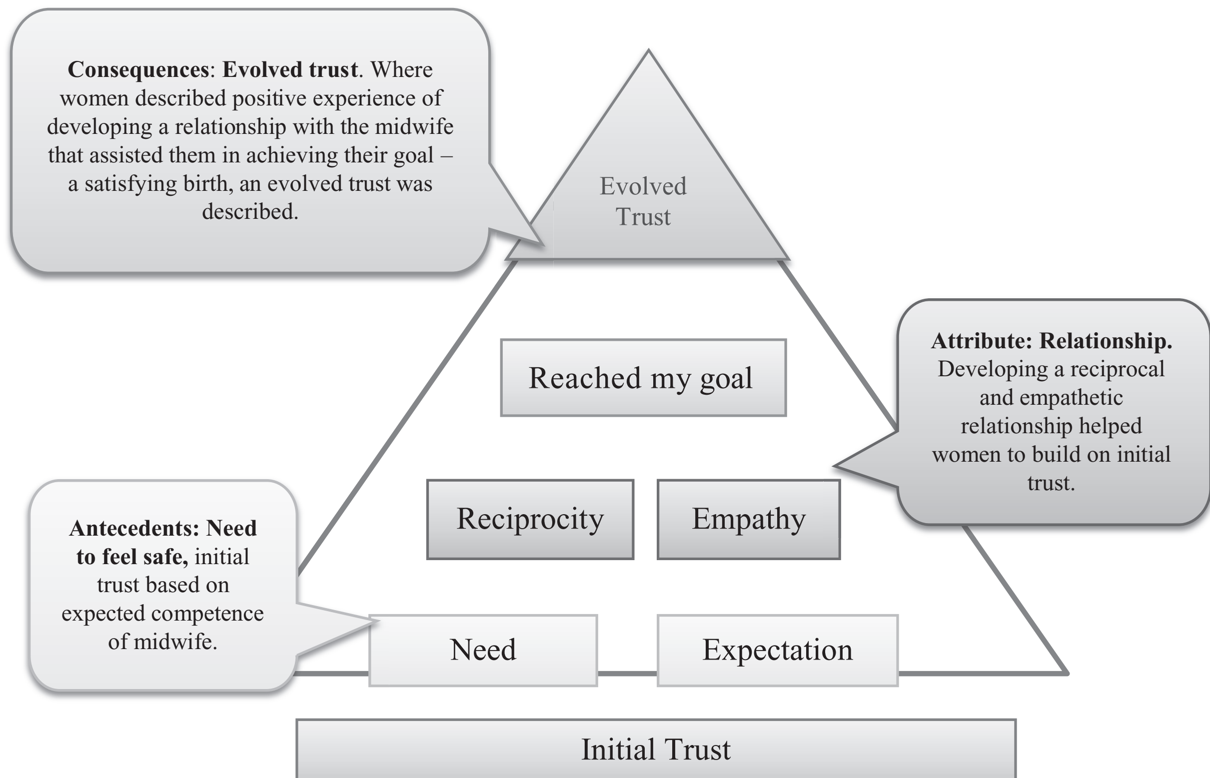

FIGURE 2 Building blocks of trust.

> *Being my first baby, I don't know what to expect. I was going there completely blind. I asked a lot of questions that day. I had been in limbo with all these questions building up.* (Jane Interview 1)

> *She (midwife) has got all the equipment because she does all the medical things as well.* (Sally Interview 1)

The participants' need to feel safe appeared to be focused on a need for information and the opportunity to improve knowledge, and the midwife appeared to be a trusted source for achieving this.

The women who had experienced pregnancy and birth previously described their need and expectation differently. Their need to feel safe focused on a fear of childbirth that originated in their prior experience and a desire for emotional safety. The women described needing to develop a relationship with the midwife to establish emotional support to manage their fear. For the participants, the fear was not related to the birth process, pain, or adverse outcome but was a fear that the midwife would not be caring in her approach toward them. This was described as a direct reflection of the poor care they had experienced previously.

> *For me, I need to feel safe that someone is right by me and is saying, "You are ok," giving me attention and I would feel I am OK now actually.* (Jo Interview 1)

During interviews, the women reflected on their previous birth experience and how this affected their expectations of the midwife for this pregnancy. The women with direct experience used their own knowledge to make decisions and plan for birth; they sought verification from the midwife that she would support them to maintain their agency.

The antecedents of the concept included an initial trust, based on the *expectation* that the midwife had technical skills, placed in response to the woman's *need* for maternity care. However, this initial trust was not considered to be an absolute. The women described the need to test and gain additional confidence in the

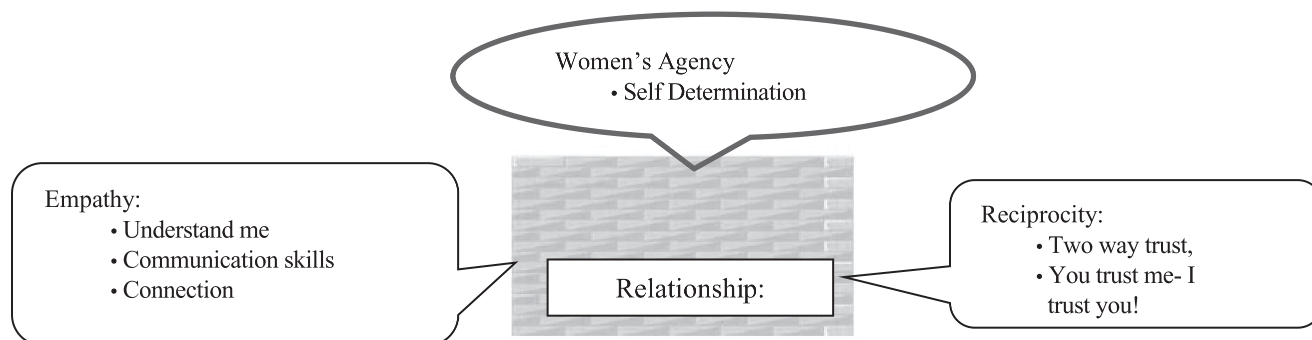

FIGURE 3 Attribute of the concept sub-themes.

midwives ability to provide emotional support and willingness to support the woman's own agency. Both first time mothers and those having subsequent pregnancies recognized pregnancy as an important and potentially "risky" process. Engagement with the midwife to build a trusting relationship appeared to be an investment by the women to assist them in achieving their desired outcome—a safe birth as the ultimate goal. Safe birth described in the study was not so much a lack of physical harm but more of a birth that women felt in control of and one that achieved their individual needs. The relationship between midwife and mother was identified as the core attribute to the concept of trust.

Attribute

The women described the attributes (Figure 3) of trust as a two-way relationship involving the midwife demonstrating a trust for the woman and her ability to make her own decision as well as the trust placed by the woman in the midwives' skills. The midwife and the mother can get to know each other and develop an understanding of each other leading to a reciprocal, empathetic relationship. The women described the feeling that the midwife and mother "get along" with each other as very important in the building of trust.

> *I think you need to feel confident that you trust her, but I guess in reality that she should trust you. So it's not just a one-way thing is it? It's a two-way thing. It is about her trusting you and you trusting them.* (Sally Interview 2)

The women also described the importance of "getting to know each other" as a tool for evolvement of trust. This was not related so much as a mechanism for engendering social friendship but as a way of developing professional friendship, whereby women felt that the midwife could develop an understanding both of what the woman wanted and needed to maintain her agency and enabled the midwife to respect the decision making of the woman. This was particularly the case for those women who had prior experience of childbirth, where the lack of respect for their own decisions in a previous pregnancy had left them feeling unsafe. The time available to women during the development of the relationship allowed women to evaluate the quality of the information provided by the midwife and to test how the midwife's attitude and views fitted with their own values and priorities. In addition, it provided an avenue to verify the midwife's knowledge and willingness to trust the woman. Hence, women could establish who they would trust and in what situations.

There was evidence in the participants' accounts that women considered the midwife to be in a position of power and control. This resulted in women attempting to equalize the power balance through the pursuit of information in preparation for what they described as "the fight" for recognition of the woman's own authoritative knowledge and need to self-determine.

> *I do my homework—I had an answer for everything this time.* (Alice Interview 1)

> *They are not accepting of you as being the person in control, you know what is best. They are assuming that they know what is best, but I have to make a decision and tell you.* (Jo Interview 3)

Lucy recognized the midwife's potential to influence and coerce, describing midwives as in "a position of authority." Although she recognized this as a risk, she clearly articulated that she remained aware of the choices and options open to her.

> *Because when it is a choice. Because they are in a position of authority and it is very easy for them to persuade people and convince them that that is the absolute thing that they have to do, when, in fact, actually it is a choice and there are a lot of different options.* (Lucy Interview 1)

Lucy highlighted her self-determination and strategies, such as "my own birth plan" that she had employed to ensure she remained in control of decisions.

> *Getting into your head what is really going to happen [. . .] I hadn't have read those two books, I think might still feel quite nervous [. . .] If I hadn't have prepared for it [. . .] It has really helped [. . .] I have a pile of books by the bed this big [. . .] I mean they range from the Haynes manual to babies to like an old what's it called you know unassisted birth [. . .] I flicked through them and thought.* (Lucy Interview 2)

> *I probably didn't listen to them [. . .] I wasn't going to let her do what she wants to do [. . .] I said no, actually I have got my own [. . .] I had my own birth plan here and then we did go through it. But if I hadn't have done that, I could have been left here having never spoken about those thoughts that I had.* (Lucy Interview 3)

The existence of the initial professional trust could be the foundations that supported women to gain experience and knowledge for becoming more self-determining. The women described the initial trust as something "we will build on it later." The women placed importance on the midwife getting to know them personally and being able to demonstrate understanding or empathy. They described a more evolved trust where empathy was demonstrated within a reciprocal relationship, and this appeared to be an investment for the future from the women in having confidence that empathy would be present during the birth. They appeared to describe the building of trust as easier with a midwife whom they could relate to. Some of the women focused on trust in relation to midwives who could demonstrate that they had shared a similar life experience, that is, they had experienced childbirth.

> *I think to be a good midwife, you should have to have your own children; you need to experience it to understand women's thoughts because until you have been through labor, you really don't know.* (Molly Interview 3)

> *It would show that they understand where I am coming from and that they understand how I am feeling which goes that bit towards building a trusting relationship for further on in the pregnancy.* (Jo Interview 1)

What is important to note is that some of the women who described their midwife and the empathy they perceived to relate to midwives who had experienced childbirth actually received care from a midwife who had never been pregnant. Hence, what would seem important is not necessarily the shared experience of giving birth but the midwives' ability to communicate empathy to the woman. The midwives' communication skills were highlighted as the window that allows women to see the potential for developing trust with the midwife within a reciprocal relationship. Developing this deeper level of understanding and trust appeared to be an investment on the woman's part for the ultimate goal—a safe birth. Hence, the consequence of reaching their goal was a more evolved form of trust.

Consequences

Through the repeated contacts with the midwife during the pregnancy, the women were able to build on the initial trust that was described as "Just there." Initial trust was based on the woman's need for maternity care and the expectation that the midwife could provide skill. Through repeated interactions with the midwife, initial trust was tested during the development of a reciprocal, empathetic relationship with the midwife that in turn resulted in a more evolved trust. Essential to the evolution of trust was the ability for the midwife and mother to "get to know" each other. The woman desired a relationship where they were acknowledged by the

midwife as an individual with their own thoughts, motivations, and desires, and in turn, the woman acknowledged that the midwife herself was an individual with similar motivations and desires. This mutual acceptance and respect seemed important for the establishment and evolution of trust and resulted in both individuals "fitting" together to form a professional friendship. From the accounts, it seems that the motivation for developing the relationship in this way and evolved trust was to achieve the birth that the woman desired.

> *That midwife is the person delivering your baby. So that trust relationship is really important.* (Jo Interview 1)

> *When you are the mum, you need her. They can't go off; they can't just leave you. They are there for you. I got what I want.* (Molly Interview 3)

It seems clear from the data that trust for the women in the study had a clear purpose. Investing in developing a trusting relationship with the midwife seemed to be an indication of women's agency (maintaining control and self-determination); investing in preparing and planning so that they felt safe enough to let themselves concentrate on the intimate birth process. Trust within the context of the midwife–mother relationship assisted the woman to achieve what she wanted to support her agency.

DISCUSSION

In Stage 3 of the hybrid model, the researcher synthesizes the theoretical data obtained in Stage 1 with the empirical data from Stage 2. This results in a deeper contextual understanding of the concept and how it applies to practice. Analysis of the empirical suggested that the concept of trust in midwife–mother relationships was made up of a series of building blocks which began with an initial trust placed in response to a need for something and an expectation that the midwife would meet that need. During pregnancy, women risk-assessed, communicated, and made decisions leading to the development of a reciprocal, empathic relationship. Where this experience was positive and supported the woman to maintain her agency, a more evolved trust was described. The building blocks were then further refined by combining empirical and theoretical data. These synthesized findings are considered in the next section:

Building Blocks of Trust

Initial Trust—Need and Expectation

The article highlighted that for all of the participants, an initial trust was present at the beginning of pregnancy, and participants described how important this trust was to them. Hupcey, Penrod, Morse, and Mitcham (2001) proposed that trust is important when a person has a specific need for something that can only be met by engaging in a relationship with another. All participants described an initial need to gather information and develop individual knowledge as a priority for overcoming uncertainty and fear. Childbirth is a complex natural phenomenon that for some women can be the cause of intense fear and vulnerability (Kirkham, 2011). This in turn may lead them to seek assistance from midwives and maternity services, placing trust in them to meet their needs. Carty (2011) suggested that fear is a common emotion experienced by women leading up to birth. In an opinion piece, Kirkham (2011) suggested that one of the most important elements of trust for women is their self-trust and trust in their ability to birth and nurture a child. She proposed that good midwife–mother relationships can help alleviate fear, promote confidence, and foster a woman's self-trust.

Similarly, the study participants described an expectation that the midwife would be a trusted source for obtaining the required information and knowledge to build self-trust. As trust assumes the reliability of another, professionals have a duty to uphold this by being trustworthy (Rhodes, 2001; Thiede, 2005; Trojan & Yonge, 1993). Although they do not give a specific definition of trust, the UK Nursing and Midwifery Council highlights it in *The Code*, promoting professionalism and trust as one of four key themes. Within this, they include:

- Act with honesty and integrity at all times, treating people fairly and without discrimination.
- Treat people in a way that does not take advantage of their vulnerability or cause them upset or distress. (NMC, 2015)

Women's experience of placing trust in the midwife was influenced by the midwife's ability to display trustworthy characteristics, similar to those described

by Dinç and Gastmans (2012): generosity, compassion, honesty, and reliability. The participants described the midwives' ability to "give them time," be "nice" and nonjudgmental. They also described situations where initial trust did not evolve, primarily based on their first impressions of the midwife or from their own past negative experiences. Negative past experiences could lead to reduced confidence and trust in the midwife and midwives in general. The literature suggests that women may be frightened by the inflexibility of the systems in place and feel unable to conform to them and therefore may make the decision to birth without midwifery assistance (Beech, 2008; Edwards & Kirkham, 2013; Nolan, 2008). This is important for maternity services and the need to understand women's perspectives on the concept of trust as intended by my study. The empirical data identified that the key ingredients for trust to be present and evolve were respect for a woman's agency, reciprocity, and empathy.

Evolved Trust—Two-Way Relationship

The findings of the study indicate that trust is contextual and is experienced as an evolving concept that changes over time in response to social interactions. This appears to reflect an earlier concept analysis of trust within general health care by Harrison et al. (2003) who described four stages highlighting the progressive nature of trust which develops alongside the interpersonal relationship and "getting to know" an individual. Authors such as Gulati and Sytch (2008) and Calnan and Rowe (2006) also described trust as a multidimensional phenomenon. They likened it to a state of mind rather than a trait, which would vary in different conditions and contexts.

The participants described the evolvement of trust as "something more" than the initial need and expectation. The process of developing interpersonal trust was dependent on the ability to get to know the midwife and to develop a reciprocal relationship. The participants described this relationship as a professional friendship or partnership.

Participants highlighted that continuity of carer was essential to this concept as it allowed the mother and midwife to build a relationship over time, getting to know and understand each other. Huber and Sandall (2006) discussed the value of continuity of carer for the development of trust and supporting women with breastfeeding. They described how continuity of carer facilitated building trust within the relationship by the bridging of life worlds, space to develop self-confidence, development of supportive relationships, and joint expectations leading to greater technical expertise and confidence. In McCourt and Stevens (2009) study exploring how case holding midwifery affected the emotional work of midwives and women, the benefits of women getting to know midwives as "real people" was highlighted by midwives who described feeling valued as an individual person and not just a "cog in the wheel." The midwives also described the benefits of getting to know women through continuity of care schemes which meant they did not have to consistently start over and could develop an understanding of the woman. Reciprocity was described by many of the participants as core within the relationship. Repeated interaction and communication enabled the woman and the midwife to get to know and trust each other. The benefits of continuity of carer are well documented within the midwifery literature and include the ability to develop relationships, enhance levels of satisfaction, personal closeness, and trust (Dahlberg & Aune, 2013; Sandall et al., 2013; Williams, Lago, Lainchbury, & Eagar, 2010).

Connectedness

Within the building blocks of empathy and reciprocity, the study highlighted the importance of continuity and building a relationship with the midwife primarily based on the idea that they would be able to "connect" with each other. Empathy was considered more likely where the midwife and mother felt "connected." Phillips-Salimi, Haase, and Kooken (2012) used the hybrid model to understand the concept of connectedness describing it as a close intimate relationship, characterized by empathy, caring, and trust. They associated better connectedness within health care relationships as influential to patient's ability to participate in decision making, as was the motivation for the participants in this study. The participants described this connection as womanhood or motherhood, highlighting the importance of a shared experience. When the data was analyzed further, it was not the actual shared experience that seemed important but more the midwives' ability to demonstrate empathy and understanding of the women's needs within a more social context.

Women's Agency

One of the main differences between Stage 1—the theoretical concept and the empirical data was the importance of women's agency. Within the original literature review on trust, agency was described more in relation

to the vulnerability for the person placing trust and professionals being in a position of power (Crawford, 2011; Petersen, Nilsson, Everett, & Emmelin, 2009). However, the participants within my study demonstrated a strong sense of agency and highlighted the importance of this to the evolvement of a two-way trust.

Support for a woman's agency appeared more important to the participants for feeling safe than organizational safety measures such as guidelines, audit, and risk management.

The link between self-determination and safety can be found in the wider midwifery literature; for example, participants in Magee and Askham's (2007) study rarely mentioned hospital policies in relation to their perceptions of safety. Instead, they described how rigid policies and processes restricted the amount of control felt by the individual which resulted in them feeling less safe. Emotional safety and the need to be self-determining are also cited within the literature for women who choose to "freebirth." Women who choose freebirth often feel that it is safer to birth without midwifery support than risk engaging with a midwife who is bound by strict hospital procedures that will not allow them to determine what is best for themselves and their baby (Edwards & Kirkham, 2013).

A Two-Way Concept

The participants in my study described trust as a two-way concept, placing high value on the importance of feeling that the midwife trusted them as much as they trusted the midwife. The importance of receiving trust, as well as placing trust, has been shown in research studies (Huber & Sandall, 2006; McCourt & Stevens, 2009; Oudtshoorn, 2005; Tanassi, 2004) to give benefits to women such as increased satisfaction with care, dispelling fear, feeling in control, and self-efficacy.

Trustworthiness and Limitations of the Study

The researcher, as an experienced midwife working within the study specialty, gave a certain level of credibility and engagement in encounters with the participants who were given pseudonyms to maintain anonymity. However, my own experience as an insider also had the potential to weaken the study through my own preconceived ideas. To ensure the trustworthiness of the study, a researcher diary was kept—a little like a ships log detailing what was happening in the study, the decisions being made, and my own individual thoughts and feelings at every stage. This provided transparency and an audit trail of decisions made as well as detailed reflection providing a counter balance for any potential influence. The researcher also engaged with two experienced academic supervisors (second author [AJ] and third author [BH]) who assisted with some independent coding and reflective discussion of the themes identified ensuring objectivity by advising and reviewing at each stage of the study.

The study was given ethical approval by Dyfed Powys NHS Ethics Committee and Research and Development approval was gained from Powys Teaching Health Board.

One of the main limitations of this study is the purposive sampling and unique setting chosen for its specific model of midwifery care. The findings are in-depth but specific to the individual journey of the participant, making the findings difficult to generalize as the sample may not represent the wider more diverse population; therefore, it can not be assumed that the findings represent all women. However, the final concept analysis does contain many central themes that could be transferred to another setting. The central themes could be used to inform a future study and influence thinking across other areas of health care.

CONCLUSION

The aim of the study was to explore the concept of trust from the individual woman's perspective with a view to developing a better understanding of trust within the midwife–mother relationship. This was achieved through a qualitative study using the hybrid model as described by Schwartz-Barcott and Kim (1993) which provided a concept analysis framework to assist the researcher in developing understanding of the concept, while ensuring that the women's voices remained the central focus. This article provides an overview of the study and summarizes the key findings which included an understanding of trust as a general concept with insight into the woman's experience of how this evolves and develops within the midwife–mother relationship.

The study has thrown new light on the importance of developing a reciprocal, empathetic relationship with the woman in order for trust to develop. It is critical for midwives to understand how trust develops as a direct response to their interaction with women to maintain and optimize the initial trust placed in them. The study highlights the importance of supporting a woman's

agency and trust in the woman to make her own decision as a two-way process. Although the need for trust is frequently cited within health care policy and professional standards, it is not well defined or its importance to decision making quantified.

To assist midwives in optimizing trust within the midwife–mother relationship, demonstrating trust in women to make decisions, maternity services first need to demonstrate trust in midwives to work as autonomous practitioners. Models of care need to center on a shared philosophy and on commitment to partnership working and facilitation of the midwife–mother relationship. Pregnant women have a need to place trust in maternity services; understanding how women experience the evolvement of trust is essential if maternity services are going to be developed in a way that upholds the woman's initial trust. The central themes identified within this study are transferrable to other settings and could be used to inform further research in this area.

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