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Genuine Caring in Caring for the Genuine

*Childbearing and high risk as experienced by women and
midwives*

BY

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ACTA UNIVERSITATIS UPSALIENSIS
UPPSALA 2002

Dissertation for the Degree of Doctor of Philosophy (Faculty of Medicine) in Obstetrics and Gynaecology presented at Uppsala University in 2002.

ABSTRACT

Berg M. (2002). Genuine caring in caring for the genuine. Childbearing and high risk as experienced by women and midwives. Acta Universitatis Uppsaliensis, *Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 1146, 71 pages. Uppsala. ISBN 91-554-5299-X.

The experience of pregnancy and childbirth is a central life event with special implications for women at high risk. This thesis describes the meaning of pregnancy, childbirth and midwifery care in four qualitative interview studies based on the lifeworld theory. Women were interviewed during pregnancy and within one week after childbirth. Midwives were interviewed concerning midwifery care for women at high risk. In an intervention study, childbirth experience as reported through a post partum questionnaire was compared between women receiving standard care and women who had formulated a birth plan preceded by a questionnaire on their expectations and feelings about childbirth.

The findings emphasise that childbearing women at high risk live in an extremely vulnerable situation. The vulnerability is obvious in the use of an individual birth plan, where negative feelings become more frequent in women at high risk than in those with normal pregnancy and childbirth. During pregnancy the women feel a moral commitment towards the child, including feelings of objectification and of exaggerated responsibility. During an obstetrically complicated childbirth the essential meaning is the women's desire to be recognised and affirmed as individual persons. Like women with normal pregnancy and childbirth, they need an emotionally present midwife who sees, give trust and supports.

Good midwifery care of childbearing women at high risk is synthesised as *genuine caring in caring for the genuine*. The ethos of caring constitutes the basis of caring. Women's transition during pregnancy and childbirth is described as a genuinely natural process. Midwives have a special responsibility to encourage and preserve this process within women at high risk. The caring relationship is the core and the most essential tool in the care. Distinctive features in the midwifery care are embodied knowledge, physical as well as emotional presence, sensitivity, a mutual dialogue including shared control between midwife and woman, and confirmation and support of the genuine in each woman. The midwifery care is a struggle and a balance between natural and medical perspectives.

Key words: High risk, childbearing, pregnancy, childbirth experience, midwifery, lifeworld research, phenomenology, hermeneutics, motherhood, birth plan, caring relationship.

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ISSN 0282-7476

ISBN 91-554-6299-X

Printed in Sweden by Akademitryck AB, Edsbruk 2002

Dedicated
to my Family
to all Childbearing Women
and to all Carers of Childbearing Women

ORIGINAL PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

- I Berg M, Lundgren I, Hermansson E, Wahlberg V. (1996). Women's encounter with the midwife during childbirth. *Midwifery* 12:11-5.
- II Berg M, Dahlberg K. (1998). A phenomenological study of women's experiences of complicated childbirth. *Midwifery* 14:23-9.
- III Berg M, Honkasalo M-L. (2000). Pregnancy and diabetes – a hermeneutic phenomenological study of women's experiences. *J Psychosom Obstet Gynaecol* 21:39-48.
- IV Berg M, Dahlberg K. (2001). Swedish midwives' care of women who are at high obstetric risk or who have obstetric complications. *Midwifery* 17:259-66.
- V Berg M, Lundgren I, Lindmark G. (2002). Childbirth experience in women at high risk - Is it improved by use of a birth plan? *Manuscript*.

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ABBREVIATIONS

ACU	Antenatal Care Unit
IDDM	Insulin dependent diabetes mellitus

PREFACE AND ACKNOWLEDGEMENTS

Often I have noticed the similarity between my work with the thesis and childbirth. The research has been a prolonged labour, including both positive and negative senses. The metaphor is limping if the thesis is compared with the child. Whereas the little child is developed with all its organs well differentiated at the end of the first trimester, the wholeness of this research remained diffuse until the end of second stage. Somewhere I had to bring it to an end, and now it has “been born”. The result may speak for itself.

Many people have contributed to the preparation of this research. First of all the participants, the women and the midwives, constitute the basis. You have taught me so much by generously sharing your experiences through interviews. To all participating midwives at Sahlgrenska University hospital and at the seven antenatal care units, thanks for patience with performance of questionnaires and birth plans.

Professor Gunilla Lindmark, my main supervisor, you guided me with a steady hand. Your assistance and clarity of vision has been invaluable, not at least in the last study and in the composing of the frame. Professor Karin Dahlberg, you have been my supervisor for a long time. Your brilliant competence in qualitative research and lifeworld research has been invaluable. Professor Vivian Wahlberg, you taught me the basics in research, including how to write an article. Thanks for guiding me, in spite of curved roads, to the graduate in medicine licentiate. Professor Marja-Liisa Honkasalo, thanks for a fruitful collaboration, which unfortunately had to end when you moved back to Finland. Ingela Lundgren, you and I have been strenuous co-researchers, dealing with both joy and sorrow in our complex lives as researchers, midwives, mothers and wives. The first and the last study we carried out together, alpha and omega. Thanks for enduring with me. During the performance of the last study, Karin Nyberg was our enthusiastic supervisor. Now, she has passed away but her achievements in research will live forever.

Thanks to George Lappas for statistical guidance and to Krister Johannesson for assistance in the search for literature. Karin Törnblom, thanks for excellent secretarial assistance, and thanks to Inga Andersson for brilliant administrative support. Shirley Reverly PhD, thanks for linguistic guidance and friendship overseas. Nigel Rollison, thanks for proofreading at the last minute.

Margareta Wennergren, Head of maternity care at Sahlgrenska University Hospital in Göteborg, thanks for your positive attitude towards my research. Leif Persson, Head of Antenatal care unit, thanks for believing in me when others doubted. Lena Mårtensson,

Dean of the Department of Health Science, University of Skövde, thanks for offering time for research within my post. All my colleagues at maternity care Sahlgrenska University hospital, and at University of Skövde, thanks for support. Monika Höfvner, thanks for a wonderful interpretation of the research on the cover page. All my relatives and friends, thanks for encouragement. I also want to thank Sahlgrensringen, Inger Hultmans fond, and University of Uppsala, for financial support.

My dear family, what would I do without you?! Enduring a mother and wife so occupied with research for such a long time! Tobias, thanks for assistance in the forest of SPSS. Lina, thanks for all the times you reminded me that I am suitable as a mother. Elias and Jonathan, thanks for still ensuring me that the pleasure of every day life with cooking, homework and other duties did not get forgotten. Urban, You are not only a faithful mate but my best friend. You have been a sounding board and have given assistance with proof-reading. I love you all!

My God,
thanks for Your perpetual presence
immanent
and transcendent!

INTRODUCTION

This research concerns experiences, inside stories, in relation to childbearing. First of all it describes Swedish women's experiences when their situation is characterised as high risk, i.e. with presence of obstetric risk factors or manifested complications. Midwives' experiences and midwifery care of these women is also focused. Childbearing is a term used here to label the life process in women from conception through pregnancy and childbirth (cf. Stedman Medical Dictionary 1995). Childbearing women are fragile, especially when at high risk (Mercer 1990, Stainton, McNeil & Harvey 1992). Their overall well-being and identity as mothers is directly linked to the health of themselves, their families and their unborn child.

Small nuclear families, the lack of extended network and cohesive communities are characteristics of modern society. Caregivers often act as substitute kinsfolk of mother and baby. The goal of maternity care is thus far more than having a live mother and baby leave the hospital on discharge. Health and well-being of woman, child and the family should be enhanced (WHO 1997, Clement 1998). Healthy children should be born by healthy and well-prepared parents with the least possible intervention. The care should be adjusted to parent's needs and women's experiences should be positive (SFS 1981:4, Socialstyrelsen 2001). Experiences in connection with pregnancy and childbirth follow women throughout life (Lagerkrantz 1979, Brudahl 1985, Beaton 1990, Berg-Brodén 1997, Simkin 1991). The overall aim of this research is to increase knowledge regarding how to promote positive childbearing experiences for women at high risk.

The research is based on general ontology and epistemology of human science. Five empirical studies have been carried out. Four of them are based on lifeworld theory in which epistemology and central concepts are described. The ethos of caring, fundamental for all provided care, is portrayed. The central concepts of normality, complication and risk are described. A picture of Swedish maternity care, including history, organisation, development, and midwifery is presented. The transition to motherhood, including experiences during pregnancy and childbirth, is described.

NORMALITY, RISK AND COMPLICATION

Attitudes towards childbearing reflect the ideas and fundamental values of society (Davis-Floyd 1992). The terminology of science and medicine has an impact on the attitudes to childbearing (Giles & Coupland 1991, Hewison 1993). In modern western cultures fear of nature and bonds of traditions have been replaced by belief in progress

and technology (Giddens 1991). This is obvious in maternity care, where scientific advances and new technology during the last half of the 20th century have led to a new approach. Two opposite perspectives of childbearing exist today (Nylund Skog 1998). One is the biomedical, which focuses on the biological, hormonal and physiological changes. An interventionistic approach is employed with the aim to control nature. In its extension the human body is seen as a machine and birth is treated as an illness. With the “worst scenario image” every possible medico-technical investigation and treatment is performed (Scheper-Hughes & Lock 1987, cf. Coyle et al. 2001). In a more moderate biomedical view the aim is to do the most essential and to intervene in the laws of nature as little as possible. In the opposite perspective childbearing is seen as a natural biological and social-psychological process comprising an experiential dimension. A non-interventionist approach is employed (cf. Coule et al. 2001). In the extreme point of a “natural” view the process is taking its own course and no intervention at all is allowed. As this implies high level of both morbidity and mortality for mother and child, it is relatively uncommon. Several mixes of these two perspectives exist.

Normality, complication and risk are three central concepts in modern maternity care. However, the boundary between normality and complication is not fixed. Rather it is socially and culturally defined, changing over time (Downe 1996). The normal is defined by statistical measures, where individual deviations from the norm justify standards of conformity (Adelswärd & Sachs 1996). A consensus of normal birth exists. It is defined as a spontaneous vertex delivery of one single healthy child at term (gestational week 37+0 to 41+6) after a normal progress of pregnancy (including a low risk for medical risk factors). The progress should be normal without any instrumental assistance, with blood loss less than 1000 ml, and without main tears (perineal tears degree 3 or 4), or other medical complication. Mother and child should be in good health (Socialstyrelsen 2001, WHO 1996).

A pregnancy is defined as complicated if any abnormality in the maternal or fetal condition exists. It includes a diversity of pathology such as preeclampsia, thrombosis, bleedings, premature contractions, intrauterine death and gestational diabetes. A complicated childbirth includes as various conditions or interventions as vaginal breech delivery, duplex, forceps, vacuum extraction, urgent caesarean section, manual removal of placenta, perineal tear degree III-IV, blood loss > 1000 ml and neonatal asphyxia.

With the goal of reaching optimal security for mother and child, the concept of risk has come into focus in modern maternity care. Originally introduced in the seventeenth century in the context of gambling, risk meant the probability of an event occurring

combined with the magnitude of losses or gains this might entail. Thus, the concept itself was neutral. Today, however, the word *risk* has a negative implication as it tends to be associated with negative outcomes (Douglas 1990). The risk culture has followed in the wake of modernity (Giddens 1991). Security is based on constantly changing risk calculus. A growing number of abnormalities in the human body are detected, and more and more people are defined as being at risk of various diseases (Sachs 1996, Adelswärd & Sachs 1996, Blåka Sandvik 1998) or of childbearing complications. The risk approach became popular in maternity care during the 1960s. Since then various scoring systems have been used to identify pregnant women at high risk for complications. Factors from the past obstetric medical history and current pregnancy, as well as psychological and socio-economic factors are included (Dragonas & Christodoulou 1998). Women are defined as being at low or high risk for complications during their childbearing period. High risk is when there is significant possibility of fetal demise, abnormality or life-threatening illness in the newborn infant, or serious health risks for the expectant mother (Penticuff 1982). Women at high risk are today subjected to increased attention and care, both when there is a presence of risk factors and of complications. Only half the number pregnant women have an uneventful pregnancy and delivery (Berglund & Lindmark 2000), and thus the women assessed as at high risk are numerous.

Women with insulin dependent diabetes mellitus (IDDM) may stand as a model for women at high risk. They constitute 0.39% of all women giving birth (Socialstyrelsen¹ Feb. 19, 2002, personal communication Milla Pakkanen). Through increased glycaemic control and proper care initiated before conception, obstetrical and neonatal risks have decreased remarkably during last decades. Good glycaemic control is obtained through frequent monitoring of blood glucose, intensified insulin therapy, regular and strict dietary habits and life style. However, the frequency of complications is still elevated. Congenital malformations, perinatal mortality and morbidity, pregnancy complications such as preeclampsia and intrauterine growth restriction, and technical interventions during childbirth are more frequent (Hansson 1985, Miranda et al. 1994, Wennergren et al. 1994, Casson et al. 1997, von Kries et al. 1997).

The lay view

A difference exists between the professional assessment of risk and the public's perception and understanding of the concepts of normality and risk (O'Brien 1986). Ordinary people do not assess the probability of outcome only on known statistical odds, but on the entire web of beliefs (Kahnemann & Tversky 1982). When women

¹ Socialstyrelsen = The National Board of Health and Welfare

make an assessment of normality and risk they are influenced by a broad variety of factors, not only those focused on medical science.

Among childbearing women a great number only trust expert knowledge and medico-technical achievements. Medical care for them means security and protection from risk. Others focus on confidence in oneself and one's own body, and search for internal power and contact with their own body (cf. Fjell 1998, Marander-Eklund 1998). The reliance on one's own strength is said to increase dignity, liberty and choices (Berger 1998, Nylund Skog 1998). Feminists argue that the enhancement of natural womanhood may maintain the unequal power balance between the sexes. They have also raised criticism against the medico-technical view (Hörnfeldt 1998, Nylund Skog 1998).

MATERNITY CARE

Short history

Care in relation to childbearing has been a natural need from ancient times. Midwives/traditional birth attendants and other significant women have offered care to women during pregnancy and childbirth in all cultures. Since the art of medicine was developed and depending on supply, also doctors have been engaged in the care (Exodus 1984, Raphael-Leff 1991, Höjeberg 1991). During the 15th century, the church and the government in several western countries made great efforts to control the care of childbearing women. Traditional birth attendants, considered as subversive and obstinate by the prevailing hierarchy and thought to have a connection with witchcraft, were persecuted and executed (Oakley 1989, Höjeberg 1991). The principal control and supervision over maternity care was successively given to the medical domain.

In Sweden a group of university-trained doctors established the Collegium Medicum (CM) in 1663. A new form of maternity care with rules and regulations was introduced with the purpose of improving the health care offered. Midwifery was placed under the supervision of CM. Formally educated midwives, having possessed examinations, were seen as an important resource in society as they could save life and promote health of both mothers and their children (Höjeberg 1991, Åberg & Lindmark 1992, Romlid 1998). CM tried to show that high mortality and morbidity was caused by uneducated midwives, but this could never be proved. Many factors contributed to the great change of maternity care. During the eighteenth century, natural science acquired a firm position, both as power base and power resource, which strengthened the authority and legitimacy of medicine science. The decrease in population size also played an important role (Romlid 1998).

Two categories of historical descriptions about the change in maternity care exist, “the traditional” and “the critical” (Romlid 1998). The traditional history points to the need of medical care, including the involvement of physicians (Romell 1998, p. 24). The critical historiographies (Höjeberg 1991 & 1995, Öberg 1996) describe the change as a result of a masculine assumption of power. The need for control over female reproduction both by government, church and male physicians, is seen as a determining motive. A description of how the intentions of licensed midwife Helena Malhiem to publicise an obstetric manual for midwifery students in 1758 were suppressed by the CM, supports this idea (Höjeberg 1995). Romlid (1998, p. 34), describes the changes in maternity care as a “creation of power”, not a “taking over of power”. The certified doctors struggled for power, control and authority over the whole health care system. This endeavour partly served their own interests but was also done to improve public health and medical care. According to Milton (2001), it is important to distinguish between medicalisation and pathologisation of maternity care. Medicalisation in the sense that childbirth became a part of the domain of medicine took place in Sweden but it did not mean that it was treated as an illness, at least not until the 1950s.

20th century: institutionalisation and antenatal care

The approach to childbearing gradually changed from that of folk medicine to a medical, scientific perspective. During the 20th century maternity care underwent massive change in Sweden. The hospitalisation of women in childbirth began at the end of the 19th century when the great majority of the Swedish population still lived in rural areas (Höjeberg 1991, Öberg 1996, Romlid 1998). In 1935, the proportions of home- and hospital deliveries were equal (Lindmark 1992) and in the early 1950s the institutionalisation was almost complete (Milton 2001). Today, the number of planned childbirths at home in Sweden is 1-2 promille (Socialstyrelsen 2001). Childbirth has gradually been separated from women's everyday life. It has been moved from being secret and hidden to being public (Höjeberg 2000).

Later, maternity care was divided into antenatal care on community level, intrapartum care in hospital delivery wards, and postpartum care in hospital postpartum wards. The antenatal care was introduced in the late 1920s on the pattern of British practices. Initially, the goal was somatic health, but with increased knowledge it included also a psychosocial approach. Today the care is based on a national consensus supported by National Board of Health and Welfare (SFS 1981:4, Socialstyrelsen 1996). Almost all pregnant women today attend antenatal care (Lindmark 1992). It is part of the community health care system, which offers care during both pregnancy and twelve

weeks postpartum including childbirth education. When further evaluation is needed, women are referred to the hospital.

In recent decades the organisation of Swedish maternity care has changed as a result of political decisions based on both an altered view on childbearing, medical considerations and health economy (Socialstyrelsen 1996). The length of the postpartum stay has steadily decreased from 4.3 days 1990 to 3.0 days 2000 (Socialstyrelsen Feb. 8, 2002, personal communication Milla Pakkanen). A few hospitals have supplemented the early postpartum discharge with domiciliary visits to support mother and child.

At the same time, the division between “normality” and high risk has become more obvious. Two levels of care exist; 1) care of women with normal pregnancy and childbirth (WHO 1996, Socialstyrelsen 2001), and 2) care of women at high risk, i.e. with obstetric risk factors or complications. Each woman is cared for by increased numbers of specialised carers. Simultaneously, the frequency of interventions has increased in Sweden. Inductions of labour increased from 3.3% 1990 to 10.1% 2000, caesarean section from 10.6% to 14.7%, vacuum extraction from 5.3% to 7.2% and forceps from 0.4% to 0.6% during the same period (Socialstyrelsen Feb 8, 2002, personal communication Milla Pakkanen).

Alternatives to institutionalised care

The organisational changes of maternity care in Sweden have not been without opposition, with conflicts both in- and outside the medical discourse (Romlid 1998). The alternative birth movement, which started at the 1970-80s in United States, has also reached Sweden. The aim is to emphasise the normalcy of pregnancy and childbirth and to let the women/parents maintain control. It includes non-pharmacological methods (Mathews & Zadak 1991, Oakley 1993). Midwifery-led care, continuity of caregivers, and a homelike setting are other significant factors. Many different models of care have been developed, of which ABC-units (Alternative Birth Care) are best known (Raphael-Leff 1991, Waldenström 1993). In Sweden, two ABC-units have existed, one in Stockholm and one in Göteborg. A few modified forms of maternity care units for women at low risk exist.

Midwifery

Practical midwifery has developed within the cultural praxis of women. Knowledge has been based on experiences built up through generations of presence at other women's childbirth. The most important tool of midwives has been themselves (Blåka Sandvik 1997). From the beginning of the eighteenth century, the training for Swedish midwives

was organized and formalized. The licensed midwives became, as the first female occupational group, part of the official Swedish medical system (Romlid 1998). In 1908 the municipalities became obliged to employ licensed midwives (Romlid 1998). During a long period, mainly during the 18th century, the licensed midwives struggled against the traditional birth attendants who, in the opinion of the midwives, used quackery (Höjeberg 1995, Milton 2001). In this respect, they were supporters of the medicalisation of maternity care (Milton 2001).

Swedish midwives have created a professional identity that has carried weight and respect over the years. Various factors have contributed to their professional development. With the realm of agrarian history they have been signified as persons with both physical and mental strength. Patience has been an outstanding feature. A long history as an established professional group, a great shortage of doctors, societal factors such as low economy, low population rate, and the establishment of the welfare state have been conducive. In addition, the organisation of Swedish health care has not precluded the possibility for women to secure assistance from physicians through the privatisation of maternity care. Over the years midwives have had a closer collaboration with doctors/obstetricians, than with nurses. Swedish obstetricians, in turn, have in contrast to their colleagues in, for example, the United States, been influenced by the midwives' art of patience including waiting and standing by. Childbirth has been seen as an art and a craft whose skills are demonstrated in the artful use of the hands rather than instruments (Milton 2001).

Over time, Swedish midwives have expanded their working domain with a wide field of activities. The vocational education for licensure as a midwife includes completion of a 3-year nursing degree and one and a half years in the midwifery educational program. The midwifery domain, obstetric and gynaecologic care, comprises both preventive care of women's reproductive health in a lifecycle perspective, maternity care, and gynaecological care (SFS 1981, SOSFS 1995, Socialstyrelsen 1996).

Optimal care of mother and child requires a distinct division of responsibility as well as good collaboration between the parties concerned (Socialstyrelsen 2001, 4). Since the first midwifery regulation in 1711, it has been more or less clear that midwives are responsible for women with normal childbearing, and doctors for women at high risk (cf. Milton 2001, Lundqvist 1940). However, history demonstrates that there have been restrictions for midwives' professional practice. Since CM was established they have carried on their trade at the direction of doctors, whereas there has been no formal hindrance to prevent doctors handling normal childbearing (cf. Milton 2001). In the care of women at high obstetric risk midwives work under supervision of obstetricians.

Nevertheless, they work very independently. Numerous midwives specialised in different fields are given delegated responsibility. In spite of this, the “narrow” definition of normality in childbearing and the increased focus towards risk and complications has indirectly limited their professional role and domain of responsibility. One key question is whether midwives have a defined responsibility of their own in high risk obstetric care, or whether they only have the role of being assistants to the obstetricians, thus becoming marginalized in this context?

MOTHERHOOD

A transition

Childbearing and motherhood in modern western countries are dominated by the rational and a belief and dependency on experts and advanced technology (cf. Giddens 1991). Rites de passage, traditional stories, taboos and other connected norms are largely negotiated. Instead, medico-technical equipment seems ritualised (cf. Höjeberg 2000).

Motherhood is a transitional process, an endless embodied experience with many meanings (Bergum 1997). A mother is a woman “with a child on her mind” (Bergum 1997, p. 14). A distinct *maternal thinking* including responsibility for the child’s life, develops successively based on the capacity of attention and the virtue of love (Ruddick 1989). The developed motherhood is a prerequisite for the woman to be able to identify herself with the child and to meet its needs (Winnicott 1990/1965). *Mothering* consists both of doing, which deals with caring and nourishing, and of being. Culturally specific norms, roles and expectations influence its expressions (Holm 1993) as well as the woman’s history and life situation (Stainton et al. 1992). Three phases of development corresponding to the three trimesters of pregnancy are identified. The focus shifts from pregnancy, to fetus, to child (Raphael-Leff 1991 & 1993). The development process during pregnancy and childbirth includes seeking safe passage for oneself and the child, ensuring acceptance by significant others, binding-in to the child, and learning to give of oneself (Rubin 1976, 1977).

Presumption for a mother’s distinct identity and self-esteem is a positive childbearing experience (Kemp & Page 1987). During pregnancy, mother and child are one indissoluble whole, but at the same time two bodily identities (Kristeva 1991, Raphael-Leff 1991, Bergum 1992 & 1997). Through her pregnant body the woman comes to know herself as mother. However, she may experience a split subjectivity being neither

a woman nor a mother (Young 1984). She puts herself and her identity in question, the self-esteem is affected and her control of life is lost. She is faced with overwhelming tasks and fear (Bardwick 1971, Levesque-Lopman 1983, Raphael-Leff 1991, Bergum 1997).

Psychosocial support, both from partner, family, other relatives, friends, professionals and society, influences the transition to motherhood in a positive direction (Oakley, Rajan & Grant 1990, Imle 1990, Raphael-Leff 1991, Schumacher & Meleis 1994). Mothers-to-be seek out positive support, which offers emotional or practical help, or acts as role models (Smith 1999).

High risk and motherhood

Women at high risk do not follow the usual transitional process. Their situation is accompanied by loss of “normal” pregnancy experiences (Snyder 1979, Stainton et al. 1992). They live in a threatening situation and perceive their overall risk as significantly higher than women with uncomplicated pregnancies (Gupton, Heaman & Cheung 2001). They are more anxious, worried, and ambivalent about their pregnancies (Mercer et al. 1987, Mercer 1990, Gupton et al. 1996, Hatmaker & Kemp 1998) and have significantly lower self-esteem compared with other women (Kemp & Page 1987, Stainton et al. 1992). Feelings of failure may be central (Jones 1986). The unpredictability of the experience leads to uncertainty (Stainton et al. 1992, Stainton, Harvey & McNeil, 1995, Gupton, Heaman, & Ashcroft 1997). Relating Rubin’s development tasks (Rubin 1976 & 1977) to their situation, emphasis on the words *safe*, *others* and *giving*. The giving of oneself for the child is intensified. Safety is gained through a reliance on medical and technological information as a means of maintaining control and ensuring safe passage. Instead of relying on embodied knowledge, the women try to regulate the level of anxiety by turning their bodies and their experience over to the external technological world. The need of support from others is increased, acceptance from the involved healthcare professionals is important (Stainton et al. 1992). Social support seems associated with less emotional conflict (Corbin 1987). Perceived support, i.e. the belief that help or empathy is readily available if needed, is a great buffer in stressful situations (Cohen et al. 1985, Mercer 1990).

Most literature indicates that a high risk situation does not negatively influence the binding-in to the child (Kemp & Page 1987; Mercer et al. 1988, Muller 1992) although the opposite is described (Stainton, 1992). Women with a previous perinatal loss protect themselves from binding-in to avoid the pain of loss (Stainton et al. 1992). Mothers of premature children have less strong bonds with their child. The development of

maternal identity appears to be delayed compared with “full term” mothers (Cranley 1981, Reid 2000). Most women compensate for this deficiency, although it depends on their social situation (Thomson & Westreich 1989).

Lack of control is also part of the high risk experience (Waldron & Asayama 1985, Loos & Julius 1989, Stainton et al. 1992). The risk-status may result in variable degrees of stress depending on the nature of the risk and women’s perception of the threat to the pregnancy (Kemp & Page 1986). Increased stress during pregnancy is described as associated with poor reproductive outcome (Smilkstein et al. 1984, Istvan 1986), increased anxiety and depression (Mercer & Ferketich 1988), and less positive maternal attitudes and behaviour (Crnic et al. 1984). Women’s interpersonal resources contribute to their ability to cope with stresses (Imle 1990, Raphael-Leff 1991, Schumacher & Meleis 1994).

Bed-rest and hospitalisation affect interpersonal and family relationships. Common feelings are helplessness, mood swings, boredom, loneliness, uncertainty and concerns regarding the well-being of the fetus (Waldron & Asayama 1985, Mercer & Ferketich 1988, Loos & Julius 1989, Heaman 1992, McCain & Deatruck 1994, Gupton et al. 1997). Physical side effects are common (Gupton et al. 2001).

Women’s own actions play significant roles in the management of the high risk situation. Physical stability in the high risk condition as well as stabilisation of the home environment contribute to this ability. Women with a chronic disease, which may negatively influence the outcome, are shown to use a strategy to increase their chances. It is labelled “protective governing” and consists of three different parts; assessing the risk level, balancing potential benefits and risks, and controlling (Corbin 1987).

Childbirth – experience and outcome

Within the transition to motherhood, the childbirth experience probably is the most outstanding experience. It is a multidimensional, transcendent, personal, intimate, intense and complex experience coloured by elements such as time, cultural beliefs, traditions, and expectations (Marut & Mercer 1979, Simkin 1992 & 1992, Halldórsdóttir 1996, Callister, Vehvilainen-Julkunen & Lauri 1997 & 2001). It is not a question of a positive or negative childbirth experience (Slade et al. 1993, Waldenström et al. 1996a), rather it is a bittersweet paradox including many opposite senses, both “good” and “bad” (Callister et al. 2001). The childbirth experience influences women’s performance of the maternal role (Deutscher 1970, Mercer 1986), including relationships with the newborn child and the partner. Research indicates that women

with a positive childbirth experience seem to bind-in easier to the child (Brudal 1985, Winnicott 1990) while a childbirth experience filled with anxiety may lead to emotional blocks towards the child (Lagercrantz 1979, Raphael-Leff 1991).

The literature stresses that the childbirth experience consists of two parts, the perception of the received care and the birth experience as such (Séguin et al. 1989). Women are less satisfied with the childbirth itself than with the care provided (Seguin et al. 1989, Waldenström & Nilsson 1993a, Waldenström & Nilsson 1994). The standpoint in this research is that childbirth experience forms a whole consisting of multiple dimensions. A description of different factors influencing the women's experiences and the childbirth outcome is given below.

A sense of participation during childbirth has a great impact on the experience (Seguin et al. 1989, Green, Coupland & Kitzinger 1990, Slade et al. 1993, Bramadat et al. 1993, Mackey 1995, Waldenström et al. 1996a, Lavender, Walkinshaw & Walton 1999). Participation means being central, and being treated as a subject and not as a passive object. It includes being informed about what is happening and having the possibility to influence decisions. The nature of the caring relationship influences a woman's sense of participation (Brown 1998). Communication increases a woman's mastery of childbirth (Oakley 1989). Women who have got the right amount of information and who have experienced good communication with midwife/carer, describe their baby more positively, are more satisfied and have a higher level of emotional well-being after childbirth compared with women who experience lack of information (Kirke 1980, McIntosh 1988, Flint, Poulengeris & Grant 1989, Green et al. 1990, Waldenström et al. 1996, Rowley et al. 1995, Turnbull et al. 1996).

A sense of control, closely related to sense of participation, is also a key factor in a woman's experience of childbirth (Humenick 1981, Simkin 1991, Lavender et al. 1999). It has to do with whether a person perceives what happens to her as being within her own control or in the hands of external forces (Rotter 1966), but also with the possibility to flow with the body during delivery (Green et al. 1990, Green, Kitzinger & Coupland 1986). There is a positive correlation between perceived control and childbirth satisfaction (Knapp 1996). Crucial for the experience is the presence of a professional caregiver (Hodnett & Osborn 1989) who is sensitive, and who performs individualized care (Flint et al. 1989, Waldenström 1993a, Rowley et al. 1995, Turnbull et al. 1996). Women with lack of control are less satisfied, feel less fulfilled, and have low postnatal emotional well-being. Another closely related element is *self-confidence*. It is influenced by the childbirth experience, but also in turn influencing women's perception of and management of childbirth (Mercer, Hackley & Bostrom 1983, Simkin

1991 & 1992, Callister et al 2001). *Satisfaction with self* in labour is strongly associated with the ability to control panic and other aspects of personal control (Slade et al. 1993). There are indications that women evaluate their childbirth experience according to how well they have managed the process (Mackey 1997).

Support from a health care professional or other trained or un-trained person has been shown to improve the childbirth experience. Such support has reduced the likelihood of use of medication for pain relief, operative vaginal delivery, caesarean delivery, and a 5-minute Apgar less than 7. A slight reduction in the length of labour has also been noticed (Hodnett 2001). Perceived support and perceived control are related to each other. Women in midwifery-led units experience a balance if they feel informed, have options and choices, have someone to trust and a supportive environment (Walker et al. 1995).

Experience of *pain* during childbirth has also an impact on women's experiences. Pain is connected with a negative experience (Seguin et al. 1989, Slade et al. 1993, Mackey 1995, Norr, Block, Charles et al. 1977, Doering et al. 1980, Waldenström et al. 1996b, Lavender et al. 1999). However, it is a complex phenomenon, ambiguous and contradictory, and influenced by other experiences and confidence in oneself and in carers (Lundgren & Dahlberg 1998). Use of pain-relief is not found to be correlated with a positive childbirth experience (Waldenström 1999).

Childbirth education affects the anticipated level of control during childbirth (Hart & Foster 1996). *Demographic variables* such as age, education, and social background seem to have less importance for the total experience (Socialstyrelsen 2001). The more fear of childbirth, the more negative is the experience (Areskog, Uddenberg & Kjessler 1983, Areskog, Uddenberg & Kjessler 1984, Crowe 1989). Severe and non-treated childbirth fear is connected with at least twice double the risk of caesarean section. The fear often persists after an elective section while a vaginal delivery often is curing (Ryding 1998). *First-time mothers* have more fear (Alehagen, Wijma & Wijma 2001) and a worse childbirth experience than multiparous women (Green et al. 1990, Waldenström & Nilsson 1994). For first-time mothers, a positive childbirth experience is furthered by positive characteristics and professional skills of the attending midwife, by the positive attitude of the spouse/child's father and by a short duration of childbirth (Tarkka, Paunonen & Laippala 2000). A homelike *environment* is associated with a positive childbirth experience (Waldenström 1993, Enkin et al. 1995, Hodnett 1998). The *model of care* is shown to influence. Higher levels of satisfaction are found in a birth-centre group than in a standard group of women (Waldenström & Nilsson 1994). The satisfaction is probably more related to the setting and to the carer's attitude and

philosophy, rather than to personal relationship with a particular midwife (Waldenström 1998).

Women's *expectations* of the childbirth experience seem to influence their perceptions, although there is inconsistency in results between different studies. Expectations may or may not be realistic and there may be a discrepancy between expectations of self and those of others (Schumacher & Meleis 1994). Detailed expectations are concerned with pain, analgesia, interventions, control, involvement in decision-making and assistance from staff and companion (Green et al. 1990, Bluff & Holloway 1994, Waldenström et al. 1996a). Women with higher expectations have higher levels of satisfaction and those with lowest expectations have the poorest experiential outcome (Green et al. 1990, Slade et al. 1993, Hallgren et al. 1995). Expectations of being in control, both self-control and control of what was done to one, are positively associated both with achieving that aim and with higher satisfaction (Lowe 1989, Green et al. 1990).

High risk and childbirth

There is not much information in the literature on experiences related to complicated childbirth. Nevertheless, more negative childbirth perceptions (Mercer et al. 1983, Green et al. 1990) as well as negative perceptions of the newborn child are described (Cranley, Hedahl & Pegg 1983). There are indications that *instrumental delivery* (Seguin et al. 1989, Waldenström et al. 1996a, Mercer et al. 1983, Salmon & Drew 1992, Fawcett, Pollio & Tully 1992, Fisher, Astbury & Smith 1997) and *prolonged childbirth* (Seguin et al. 1989, Mackey 1995, Waldenström et al. 1996a) influence the experience negatively. Elective *caesarean section* is not found to be positively correlated to childbirth satisfaction (Waldenström 1999), rather it is associated with worse experience compared with vaginal childbirth. It also leads to lower frequency of breast-feeding and delayed and decreased mother-child interaction (Mercer et al. 1983, Cranley et al. 1983, Fawcett et al. 1992, Di Matteo et al. 1996). Acute caesarean section is experienced negatively if the woman has shown fear of childbirth. One in four mothers blame themselves to some extent for the event. A severe childbirth experience may be accompanied by traumatic stress, whilst planned caesarean section rarely gives such symptoms (Ryding 1998). Pregnant nulliparous women at high risk are shown to have significantly fewer positive *expectations* than those at low risk. They expect more medical interventions and more difficulty in coping with pain during their labour and birth compared with low-risk women (Heaman et al. 1992).

To sum up, the high risk situation influences a woman's perceptions and in some way even her identity as a mother. More research has been performed on the experiences during pregnancy than during childbirth.

THE ETHOS OF CARING

The motif for health care is that there are patients in need of care. The utmost goal for caring is to preserve and safeguard life and health, and to alleviate suffering (Eriksson 2001b). *Patient* denotes the person who receives care from the organized health care system. In this research, the patients are pregnant women and those giving childbirth. As the words *woman* and *mother* are more often used than *patient* these words are used synonymously. Common interpretations of the word *care* as implied in the English *care*, the Latin's *cura* and the Greeks *therapeia*, include both meanings of curing and caring (Sarvimäki & Stenbock-Hult 1991).² Health care is provided by a wide range of professionals. In maternity care they are mostly midwives and obstetricians but a wide range of other categories of professionals are engaged. No matter which health professional offers the care there is something common and essential in caring. Therefore, the term *carer* is used here for all health professionals. At the same time each health profession has something unique to contribute in caring, i.e. "specific care" (Halldórsdóttir 1996).

Caring research comprises studies about caring and about human beings in different life situations from birth to death in connection with health and suffering (cf. Eriksson 2001a & b). This research focuses upon midwifery care. It is practiced at the intersection of several sciences but its innermost core is caring. Thus caring science is the essential basis (cf. Eriksson 1997, p. 9)³. The task of caring science, as a part of human science, is to investigate the basic motives and meanings in the context of caring. It comprises studies about caring and about human beings in different life situations from birth to death in connection with health and suffering (cf. Eriksson 2001a & b). There is a caring world in the care of childbearing women that has to be studied in order to promote good care.

² The Swedish word "care" and its former words from old Swedish, point to properties such as attention, protection and guarding. A "carer" is a guardian, spirit and phantom (Hellqvist 1980).

³ Eriksson writes about nursing but I apply it to Midwifery.

Clinical caring implies an ontological basis, including fundamental ethical presumptions about the human being, the patient, health, suffering, caring and values that form the basis of care (Eriksson 1997). Natural caring was originally fundamental in all cultures. The intention was the same, to assist the individual human to live a life in dignity (Eriksson 1996). The human being has a value just in existing (Norberg, Engström & Nilsson 1994). To affirm the dignity of human beings and to have personal ethics gives joy to the carer's daily work (Eriksson 1996). The most spontaneous and natural form of caring is expressed in the idea of motherhood, which means giving spontaneous love, to nurture, and to clean. Caring is thus akin to "mothering", the concept defined by Holm (1993) as an intersubjective activity in which one is formed as a human.⁴

Human beings, and thus patients, are described as parts of a whole in the world. They live and realize themselves in relation to both nature and objects, to the spiritual world, to other human beings and to themselves. They are equipped with a free choice, conscious of, and responsible to, their own actions (Sarvimäki & Stenbock-Hult 1991, Norberg et al. 1994). In holistic caring, wholeness is more than the sum of the parts (Eriksson 1987). Health has to deal with experience of wholeness and implies a movement of becoming, being and doing towards unity and wholeness. It entails an effort to experience well-being, a form of balance or harmony of inner being. Health is also consistent with suffering on condition that it is manageable and endurable (Eriksson 1990 2001a & b). In holistic care of childbearing women at high risk, they are seen as a whole including all their relations.

According to Swedish National Board of Health and Welfare, good care is provided within a holistic perspective wherein the person is seen as a whole, and where human dignity is preserved. It is based on respect for the patient's self-determination and integrity, and the possibility for the patient to participate in decisions about and carrying through care (SOSFS 1993, SFS 1982, SOSFS 1997). The national policy programme of the Swedish Midwifery Association (1995), states that the midwife should work in a humanitarian and respectful way with regard to the woman, the baby, and the family. Woman's right to self-determination and self-esteem should be affirmed, her integrity should be maintained by regarding her needs, and by demonstrating loyalty.

⁴ The Swedish word for midwife ("barnmorska"), relates to the word mothering (Holm 1993). Midwife's caring is thus a sort of "mothering" of childbearing women who later will mother their own newborn child. As women in the transition to motherhood are searching for identity, the midwives' "mothering" caring of the women may stand as a model in their transition to motherhood.

The caring relationship

Relationship includes everything that happens in an encounter. In order to become aware of wholeness and unity of the other, one has to move from the distance position and enter into the relation, to participate and not observe. In a true dialogue the whole person is present so the limit between the two persons disappear. Through acceptance of otherness, human life and humanity come into being. The other, “Thou”, is affirmed as unique, peculiar and different than “I”. It is not a question of sympathy, to give up the own unique “I”, or to accept properties similar to own personality (Buber 1957, 1990, 1993, 1994).

The dialogue constitutes the basis from which the work of caring and healing starts (cf. Dahlberg 1996). The essence of caring, the caring relationship between patient and carer, has a feature of communion that reaches beyond mere understanding to truly sharing (Eriksson 1997, p. 11). The basis for a sense of community is that the carers promise patients care and they receive it. It is a prerequisite for the carer’s mothering of the patient (Kasén 1996). Two individual persons, patient and carer, meeting for a certain purpose, characterize the authentic caring relationship. Both of them decide how open they want to be (Paterson and Zderad 1988). The purpose of the caring relationship is to nurture, so that well-being and more-being may be released. Openness paves the way to a real I-Thou relationship where something “between” is liberated (Paterson & Zderad 1988). Somewhat similar to “the between” has been described in research by Halldórsdóttir (1996). Through professional nursing consisting of competence, caring and connection, a “bridge” is built between the nurse and the patient. Lack of professional caring, on the other hand, leads to a wall being constructed between the patient and carer. It involves perceived incompetence, indifference, and disconnection. This points to the fact that the nature of the caring relationship, involving both a mode of being and doing of something (Paterson & Zderad 1988), to a great extent depends on the carer’s mode of being.

Midwives believe that the relationship is the vehicle for any change in the childbearing woman’s state. It is the basis for a therapeutic relationship where helping and healing exist (McCrea & Crute 1991). The meaning of the English word for *midwife*, which means to be *with woman*, stresses this.

The caring relationship is always a relationship of dependency. The carer is dependent on the patient’s will to be cared for, and the patient is dependent on the carer’s knowledge and possibility to give care. The carer, however, always has the advantage and thus has the responsibility for the relationship to develop into a constructive dependency (Sarvimäki & Stenbock-Hult 1991). Through such a relationship the patient

obtains power and the possibility to find meaning (Gadow 1992). Own choice and history, both patient's and carer's, also influence the interaction. The caring is taking place in a web of connections with other persons. The carer is involved in the care of other patients and has relationships with other carers and superiors. The childbearing woman has other important relationships with family, friends, workmates, other carers and patients. Everything is in its place in the caring organisation and in society (cf. Sarvimäki & Stenbock-Hult 1991).

Sharing women's life stories

One main element of the caring relationship is the patient's story. The story grows out of touch, which shapes the human being (Kasén 1996). Through story and dialogue in the care of the childbearing woman the carer begins to hear the context, the life as lived by her. This knowledge helps the carer to understand the meaning of the woman's lived experience (Bergum 1992, p. 15). Symptoms, for example, of complications of different kinds, may mean different things to different women. Care of the childbearing woman includes openness to her unique story, the actual situation as well as her life story.

When life stories are shared it becomes obvious that they are impossible to reduce to biology, psyche or spirit. As human beings we have access to lifeworlds as "subjective bodies". We are to the world as body, and the body is constantly perceived. It connects us to the world as "our anchorage" and it is our means of communication with the world (Merleau-Ponty 1995/1945, p. 144). The body is subjective. We do not *have* a body but we *are* the body. The idea of subjective body replaces the old dichotomy and problem of body and/or soul (ibid, p. 84). In caring, childbearing women have to be understood as living and whole entities, as subjective bodies. The carers are sharing women's life stories as subjective bodies. The caring relationship is thus an intersubjective encounter between two subjective bodies where the patient's story/lifeworld is shared.

There is expectancy in a woman's encounter with the midwife and other professionals in maternity care. They are seen as mediators between herself and her child, as having the key to the unknown, to happenings in her body, to the child's condition, its growth and even its estimated day of birth. They may give advice about a way of living in order to get a healthy child. These expectations place ethical demands on carers. Each woman is, in her transition to motherhood, more vulnerable but also more receptive to advice and help. Caring routines and the carer's behaviour have an impact on the woman's experience of the child and of motherhood. Un-caring treatment may lead to alienation from feelings about the child, while an open and tender-hearted atmosphere provides

the possibility of emancipation, of inborn power, of growth and maturity in parenthood (Lagerkrantz 1979, Brudahl 1985, Berg-Brodén 1997, Raphael-Leff 1991).

This chapter presents numerous reasons why the ethos of caring constitutes the basis of caring, and why ultimately it is the interaction between the two encountering persons that determines what the unique relationship, and thus the care, will be. To study the meaning of caring and the caring relationship between midwives and childbearing women places an ethical demand on researchers. Ontological questions relevant in this research are: What sort of care does the childbearing woman at high risk need? What is the innermost core of midwifery caring in this context? Other central questions are: What are the main components in the caring relationship between midwife and woman? Is it possible to create a caring relationship that promotes women's transition to motherhood? What are the components of such a relationship? A main issue is to find out how good care of childbearing women at high risk is practised?

AIMS

The overall aim of this research is to describe the meaning of pregnancy, childbirth and midwifery care when risk factors and obstetric complications exist, as these phenomena present themselves in the experience of the women and the midwives. Specific objectives are to study women's experiences during "normal" childbirth and to compare experiences of different groups of women with complicated or with "normal" courses.

The principle issues are:

- What are the women's experiences of the encounter with the midwife during "normal" childbirth? (Paper I)
- What is the meaning of a complicated delivery to the women giving birth? (Paper II)
- What is the meaning of women's experiences of a pregnancy characterized as high risk, such as women suffering from IDDM? (Paper III)
- How do midwives experience their care of women at obstetric high risk during pregnancy, childbirth and early parenthood? (Paper IV)
- What are the experiences of childbirth for women at obstetric high risk compared with women with "normal" pregnancy and childbirth, and how does a birth plan influence the experience? (Paper V)

METHODS

The general basis of this research is a human science research approach. It is based on a worldview, a paradigm, which describes basic assumptions about the way the world is comprised (Törnebohm 1985) and answers to philosophical standpoints about reality and knowledge. Ontological questions as “what is a world” and epistemological questions as “what is knowledge” are central. Ontological and epistemological presuppositions have consequences for the choice of research method and constitute the basis for a critical analysis of the research procedure (Bengtsson 1999). In human science research the goal is to understand the expressions of life (Palmer 1969). Human beings and their experiences are considered as the source of knowledge. They are unitary wholes in continuous interrelationship with their dynamic and cultural worlds (Dilthey 1992/1883). The whole influences the parts, and the parts the whole (Dahlberg et al. 2001). Human life is viewed as a process of continuous becoming which manifests itself in the dynamic unity of experiences (Mitchell & Cody 1992).

Lifeworld research

The present research is mainly based upon the epistemology of phenomenology. Phenomenology as a research approach has two basic components. The first is to go to “the things” themselves, which means doing justice to the everyday experience, to the lived experience. Secondly, there is a demand for sensitivity to “the things”. Phenomenology turns to the world as it is experienced. The term *experience* denotes the relationship we, as humans, have with the world in which we are engaged. The phenomenon, that which is apparent, is apparent for somebody, for a subject (Husserl 1970b/1900, Bengtsson 1999). Consequently, the phenomenological epistemology is the foundation of lifeworld research.

Husserl laid the foundation of a science grounded in real lifeworld. He envisioned science as part of the world and stated that reality should be understood as a unity of life and world. Every lifeworld is subjective-relative, a world always experienced as something in relation to a subject, from a specific perspective and with a specific meaning (Husserl 1970a). In lifeworld research neither the specific personal perspective, nor the depersonalised “objective” perspective is desired (Kohák 1978). It comprises thus of a reciprocal dependency between object and subject, the phenomenon is present to the subject (Bengtsson 1999).

Lifeworld phenomenology and hermeneutics

Husserl's lifeworld theory became lifeworld phenomenology in the philosophy of Merleau Ponty (1995/1945). He emphasized that fundamental to this epistemological approach is the belief that the lifeworld precedes all knowledge and thus constitutes the starting point and basis of all scientific knowledge about the lives of humans and the world.

By turning to the ontological question of existence, the philosopher Heidegger (1998/1927) developed what we today call modern hermeneutics. "Being" and "being-in-the-world" was central for him and subsequent philosophers such as Gadamer (1995/1960) and Ricoeur (1981). They stress that "the things" always are mediated by the subject's anchorage in history, in a social environment, and in a special language (Palmer 1969, Bengtsson 1999). Pre-understanding, historicity and interpretation are viewed as necessary conditions for an understanding of Being and of the phenomena in the world (Heidegger 1998/1927, Palmer 1969, Nicholson 1997). Consequently this movement could be called "lifeworld hermeneutics" (Dahlberg et al. 2001).

Lifeworld research focuses on experiences in everyday life, as experienced before theoretizing. Lifeworld is studied in a non-reductionistic way, as it is shown in all its variation and complexity (Giorgi 1989). The research is similar to "a creative attempt to somehow capture a certain phenomenon of life in a linguistic description" (van Manen 1992, p. 39).

Openness

In lifeworld phenomenology and lifeworld hermeneutics openness is crucial. Openness is counteracted by *intentionality* and *pre-understanding*. As humans in the world we are "condemned to meaning" (Merleau-Ponty 1995/1945, p. xix). This fact is the starting point for lifeworld research. Meaning is directly related to the understanding of phenomenon, and always contextual as it emerges in relation to lifeworld (cf. Merleau-Ponty 1995/1945, Gadamer 1995/1960). As humans we have "a natural attitude", an intentional consciousness where the lifeworld is perceived as "taken for granted". We just are and we just do. Intentionality refers to the relationship between a person and the object of her/his experience (Husserl 1970b/1900, cf. Bengtsson 1999, cf. Dahlberg et al. 2001). Consciousness always is consciousness of something (Merleau-Ponty 1995/1945). We experience everything in the world, as something, i.e. it has meaning.

In lifeworld research the common presupposition is that the researcher is part of the data and has an impact on it. A criteria of objectivity means to be as open as possible to the studied phenomenon (Palmer 1969). Even if the researcher's nearness to a subject is

more an asset than a problem, it is necessary to be aware of it (Kvale 1996). The researcher is influenced by his/her intentional consciousness. Thus, openness includes keeping in touch with one's own intentionality in order to restrain it (Drew 2001, 22). Self-awareness, reflection and a self-critical stance over one's own pre-understanding including theoretical standpoints, are crucial in order to restrain previous habits of thought and to acquire a new way of looking at the phenomenon (Dahlberg et al. 2001, Drew 2001).

When studying the meaning of experiences of patients and carers, lifeworld theory, including the theory of intentionality, is an essential theoretical basis. The patient is the most important and central person in caring. If we are to understand caring we first of all have to understand the lifeworlds of patients. Secondly, the carer's perspective could be focused upon (Dahlberg et al. 2001, pp. 20-21). Human beings can, according to the phenomenological philosophy, never be understood without being considered as whole living entities, i.e. as subjective bodies (Merleau-Ponty 1995/1945). Thus, childbearing women at high risk are understood as lived bodies, including a history, a social environment and a special language. The lived body, as I understand Merleau-Ponty, consists of everything that a human is, physicalities as well as more abstract qualities such as thoughts, feelings, desires, will and spirit.⁵

Research design

With human science as the philosophical basis, five empirical studies were conducted. Four of them were interview studies based on the lifeworld theory, three with a phenomenological approach (I, II, IV), and one hermeneutic (III). The fifth study (V) was an intervention study based on results of qualitative studies (I, II, III, Lundgren & Dahlberg 1998, Lundgren & Wahlberg 1999). Here, the lifeworld theory is surrendered. Figure 1 and Table 1 present an overview of the research design.

⁵ In the original French writing of Merleau-Ponty (1995) the words used for "body and mind" are "le corp et l' esprit". "L' esprit" may also be translated as "the spirit". The spirit or spirituality is, transferring Eckhart's (1981) description, understood as the core of the lived body. Spirituality is both immanent (inherent) and transcendent (beyond) to the lived body. The lived body consciously or unconsciously, through its spirituality, seeks identification and community with the transcendent spirituality (in Christian traditions called God) (cf. Bischofsberger 1994, cf. Eckhart 1981).

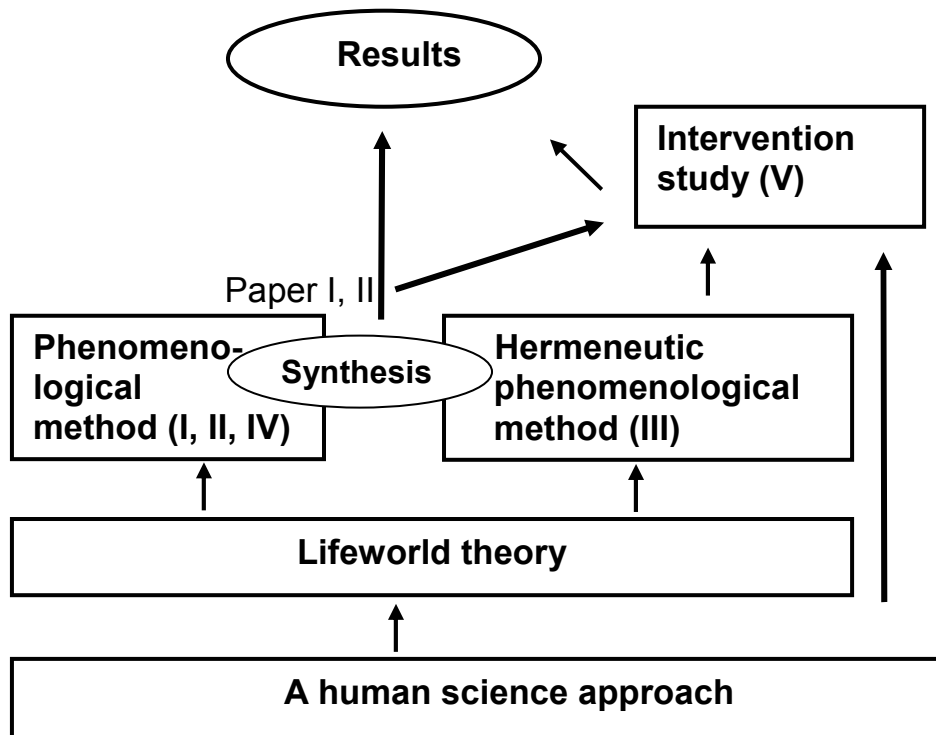


Figure 1. Overview of the empirical studies

Table 1. Schematic description of the research studies

Paper	Data collection	Analysis	Study phenomenon
I	Interviews	Phenomenological	Women's encounter with the midwife during childbirth
II	Interviews	Phenomenological	Women's experience of an obstetrically complicated childbirth
III	Interviews	Hermeneutics	IDDM and pregnancy – women's experiences
IV	Interviews	Phenomenological	Midwifery in care of women at high risk
V	Questionnaires Birth plan	Statistic analysis Intervention study	Childbirth experience - comparison of women at high risk with women with "normal" conditions

Setting

The study was carried out in Göteborg area in the western region of Sweden (I, II, III, V) and in four Swedish hospitals (IV). During the study period (1997), a big reorganisation took place. Three different hospitals in the area of Göteborg were merged into one, Sahlgrenska University Hospital. The maternity care was differentiated into two levels, care for women with normal pregnancy and childbirth, and care for women at high risk. New delivery and post partum wards for women at high risk were opened. The ABC-unit was closed.

Participants and proceedings

Ethical approval and permission to undertake the research was obtained from the Research Ethical Committee, Göteborg University. The participating women gave birth at Sahlgrenska University Hospital (I, II, III, V), both before (I, II) and after (III, V) the reorganisation. Participating midwives (IV) worked at four hospitals in Sweden with differentiated care (normality/high risk). All the participants were required to have good knowledge of the Swedish language (Table 2).

Table 2. Overview of participants and interviews for the different studies

Study	Participants	No.	Age (range)	Parity	Interviews No.
I	Women with normal childbirth	18	23-28	P*: 6 M*: 12	18
II	Women with complicated childbirth	10	18-32	P: 8 M: 2	10
III	Pregnant women with IDDM	14	25-38	P: 8 M: 6	44
IV	Midwives	10	41-52	-	10
V	Women before and after childbirth	SG**: 271 IG**: 271	SG: 18-46 (mean: 31.9) IG: 17-44 (mean: 30.44)	SG: P: 131 M: 140 IG: P: 131 M: 140	-

* P = primiparae; M = multiparae

** SG = Women with standard care; IG = Women with intervention

The participants in *study I* gave birth at the ABC-unit, Sahlgrenska University Hospital in 1994. Participating women in *study II* had undergone a complicated childbirth between November and December 1995. Interviews in studies I and II were performed two to five days after delivery. *Study III* was performed in 1997-1998. Seven of the participating women had an IDDM of a duration of 10-20 years and seven a duration of more than 20 years, of whom three had vascular complications. Interviews were performed three times during pregnancy (gestational weeks 11-15, 22-27 and 32-39). Participating midwives in *study IV* had between 9 and 29 years midwifery experience of which five to eight years in any sort of differentiated care for women at high risk.

Interviews and analysis, papers I - IV

A description of methodological principals for studies I – IV, interviews and analysis, is given, followed by a further description of application under each paper.

As a midwife in clinical work for more than 20 years, engaged in the care of women at high risk for more than 10 years, I was really an “insider” when I entered the research field. I am also a mother with my own experience of four childbirths. Altogether I had a lot of pre-understanding to be aware of and to restrain in order to be as open-minded as possible for the different phenomena at hand. This was not an all at once work but had to be a conscious activity in all phases of the research from planning to interviewing, through analysis, and the final conclusion of the results.

Openness to the research question means carrying out the research in such a way that the basic question about the phenomenon can be fully answered. In the interviews the participants shared their lifeworlds with me as a researching interviewer⁶. Participants' confidence in me as interviewer was crucial. Consent to conduct and record the interviews was obtained from each respondent, who was assured that all information would be treated confidentially. There is always an imbalance in every interview situation (cf. Dahlberg et al. 2001). In order to maintain open, the interview approach was characterised by a perceptive, sensitive and reflective stance including a true willingness to listen, see and understand (Dahlberg & Drew 1997). It involved respect, sensibility and flexibility, even for the unpredicted and unexpected (Palmer 1969). In each of the four studies there was only one single initial question after which the participants were asked to describe the experience as closely and deeply as possible, using narratives to express their possible feelings and thoughts of the studied phenomenon. Statements of the participants could be explored in depth by clarifying and exemplifying as much as possible. Thus, the researcher posed questions such as:

⁶ In study I we were two interviewers

What do you mean?, Can you give an example?, Can you explain it more? How did you feel? What did you think? The interviews were tape-recorded and transcribed word by word.

The analysis in the four first studies followed some general principles. It had a tripartite structure with a movement between whole, parts and whole. The goal was to understand each part in terms of the whole and the whole in terms of its parts (Dahlberg et al. 2001). Further it aimed at identifying meaning, to make explicit the implicit, to discover, articulate, illuminate and to describe the tacit knowledge (van Manen 1992, Giorgi 1997, Dahlberg et al. 2001). Openness during the analysis meant being present to what was given, an awareness of how the phenomenon revealed or concealed itself (Giorgi 1989, 1997, Drew 2001). By repeatedly returning to the data, the deeper meaning could be grasped. Validity was obtained in the analysis through joint work between the involved researchers. The goal was to ensure agreement, to restrain pre-understanding and thus cover more true meanings.

In *papers I, II and IV* a phenomenological analysis was practised. Besides some minor differences the analysis of these three studies followed the same structure as described by Giorgi (1997). First, the analysis is based on detailed concrete descriptions of a specific experience. The claim for description also means that the researcher, and thus the analysis, should not be interpretive. Secondly, phenomenological research operates through what Giorgi calls “phenomenological reduction”, which means that the researcher must withhold past knowledge about the studied phenomenon in order to be fully attentive to the concrete instance of the phenomenon as experienced and presented by the informants (p. 244). This means recognizing and restraining the pre-understanding as careful as possible (Dahlberg et al. 2001, p. 118). Consequently there is a need for openness on behalf of the researcher so that implicitly understood experience can be articulated (Dahlberg & Drew 1997). Thirdly, there is a search for what Giorgi (1997, p. 244) defines as a “scientific essence”, that is, a general structure of the phenomenon. The analysis began with reading the transcribed interviews in order to gain a general sense of the whole statement. The text was then reread with the aim of organising and expressing the data from the disciplinary perspective, meaning units were marked. The transformed meaning units were synthesised and clustered and an essence of the phenomenon was formulated and expressed with its variations through different constituents (themes). Finally the findings were translated into English.

In *paper III* a hermeneutic phenomenological method (van Manen 1992), i.e. a lifeworld hermeneutic approach, was used. Broadly the analysis corresponds to the description above. However the pre-understanding is not as strongly restrained. It may,

more correctly, be called a holding of the pre-understanding in order not to let it affect the analysis in an uncontrolled way. The researchers' personal experience and understanding of midwifery was used in order to gain rich interpretations.

Paper V

The overall aim of study V was to determine if an intervention, including a questionnaire at the end of pregnancy followed by a birth plan, could improve women's experience of childbirth. The aim of paper V, which is an account of this prospective study, was to study if essential feelings, as described by women at high risk and with obstetric complications (II, III) are more common than in women with normal outcomes during both pregnancy and childbirth. A second objective was to study if the childbirth experiences of women at high risk during pregnancy and childbirth, could be positively influenced by an individual birth plan.

There are 19 ACUs in the area of Göteborg. Women are free to choose where to give birth but are transferred if the delivery ward is crowded. The participants were chosen from seven ACUs; five public, one private, and one for women at high risk. Three ACU are located in suburbs, two in the City Centre, and one in a mixed area. The ACU for women at high risk is situated at the Sahlgrenska University Hospital. Between April and August 2000, women (n=271) giving birth at SU/Östra, normal delivery ward and special delivery ward, who had received care during pregnancy at the seven ACUs, were consecutively recruited to the study as a control group and given a questionnaire within one week post partum that assessed their childbirth experience. Between November 2000 and July 2001, pregnant women from the same seven ACUs were recruited for the intervention. All women were invited to participate, except women whose childbirth was planned with elective caesarean section and women who did not speak or write Swedish well. All the women intended to give birth at the same regional hospital SU/Östra. Of the eligible women, 41 were never included because the midwife did not have time, and 45 women did not want to participate in the study. Lost to follow-up were 49 women who were transferred to another hospital and two women who had a stillborn child. In total, 271 women participated.

In five qualitative studies of women's experiences during both pregnancy and childbirth (I, II, III, Lundgren & Dahlberg 1998, Lundgren & Wahlberg 1999), five categories were found to be essential; relationship with midwife, physician and partner/other relative, fear of childbirth, pain during childbirth, sense of control and concerns for the child. These categories were used as a basis for the construction of two questionnaires and a birth plan.

The intervention consisted of a *questionnaire* at the end of pregnancy (after 33 gestational weeks), followed by an individual *birth plan* written by the ACU midwife and woman together. The childbirth experience was evaluated in a *questionnaire* within one week after childbirth. The group of women who got standard care were given only the post partum questionnaire to answer, which thus was the instrument for evaluation of the intervention.

The questionnaire before childbirth included 28 statements. Twenty-six of the statements focused on specific concerns related to the five categories, one statement was related to general experiences of pregnancy, and one statement was related to previous childbirth experiences. In addition, there were three open questions about the pregnancy, fear of childbirth and the experience of childbirth. The questionnaire post partum consisted of 61 statements on the five categories mentioned and on the total experience (Appendix 1). There were two open questions concerning fear of childbirth and the experience of childbirth. In addition two statements and one open question concerned an evaluation of the birth plan. The statements measured degree of satisfaction on a six-graded scale from “totally disagree” to “totally agree”. For each statement, the women scored the degree of agreement from 1 to 6.

The *birth plan* had six headlines; the five mentioned categories and one labelled other wishes and needs. With this as a basis, midwife and woman together identified woman’s needs and desires (Appendix 2). The woman gave the birth plan to the midwife at delivery ward when she was admitted for childbirth. Midwives at delivery ward had been instructed to use the birth plan as a guide for the care. The study design is described in Figure 2.

In the analysis for this paper (V), based on the findings in papers II and III, 23 statements in the questionnaire post partum were chosen (Appendix 2). The statements touched three central areas; *relationship*, *control*, *demands and worry*, and *the total experience* of the childbirth (Table 3). The category *relationships* included experience of midwives, physician and husband/partner. If the woman had been cared for by more than one midwife she was asked to judge the first (midwife 1) and one of the others (midwife 2). Examples of statements were: *The midwife listened and paid attention to my needs and desires*; *I had confidence in my own capacity*; *during childbirth I was constantly afraid that complications would affect the child*.

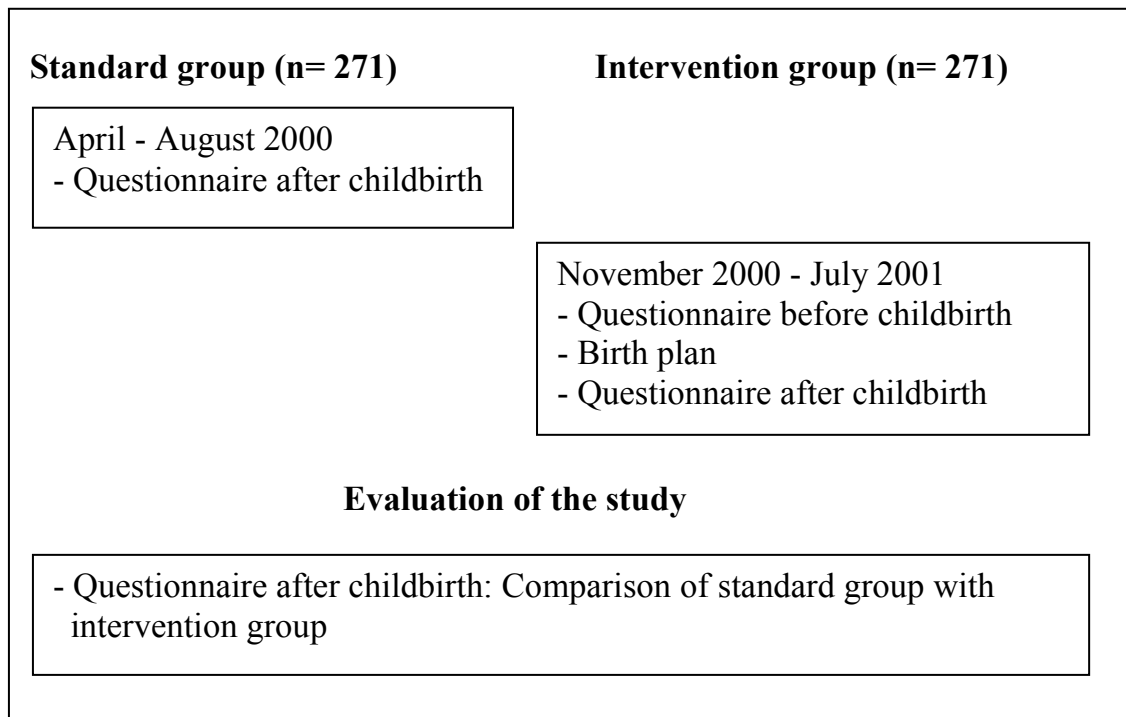


Figure 2. Study design (V)

Table 3. Questions in study V – evaluation of childbirth experience

Category	Questions /statements
<i>Relationship</i>	Listening and paying attention to needs and desires;
Midwives 1, 2 and physician	trust (3x2 statements)
Husband/partner	Support (1 statement)
<i>Control</i>	I had control during labour; I had control during second stage; on the whole, I had control; no need of control if the staff had control; check-ups basis for security; no participation in decision/objectification; difficult to interpret body signals during labour; difficult to interpret body signals during second stage; on the whole difficult to interpret body signals (9 statements)
<i>Demands and worry</i>	Confidence in own capacity; too severe demands; feeling of failure; hard birth for the child; constant fear of complications to affect the child, suffer pain for the child's sake (6 statements)
<i>The total experience</i>	The childbirth experience on the whole (1 statement)

For the analysis, women in the standard and intervention groups were divided into four subgroups with respect to risk factors and complications during pregnancy and delivery; 1) Normal Pregnancy and Normal Childbirth (NPNC), 2) Complicated Pregnancy and Normal Childbirth (CPNC), 3) Normal Pregnancy and Complicated Childbirth (NPCC), and 4) Complicated Pregnancy and Complicated Childbirth (CPCC). *Complicated pregnancy* was defined as either presence of risk factors for obstetric complications, or a complication manifested during pregnancy. *Complicated childbirth* included forceps / vacuum extraction, urgent Caesarean section, blood loss > 1000 ml, manual removal of placenta, perineal tear degree III-IV, duplex, neonatal asphyxia (Apgar score < 7 at five minutes), or vaginal breech delivery. Each “complicated” subgroup (CPNC, NPCC, CPCC) was compared with the “normals” (NPNC). The comparative analysis was between subgroups 1) in the standard group, 2) in the intervention group and 3) between subgroups in standard group and intervention group.

Data were analysed using SPSS (Statistical Package for Social Sciences) version 10.0. The cross-tabulation program was used for the statistical calculations of differences (Person chi-square) and a p-value of less than 0.05 was considered significant. Significance test (Chi-square) was done for each of the three comparisons, one by one. All scores (1-6) were used in the calculation of Chi-Square.

RESULTS

Women’s encounter with the midwife during childbirth

The essence of women’s experience of the encounter with the midwife during childbirth (I) was defined as *presence* including three themes: *to be seen as an individual*, *to have a trusting relationship* and *to be supported and guided on one’s own terms*. If any of the mentioned features are lacking the midwife is *absently present*, which increases the risk of a negative birthing experience (Table 4).

An obstetrically complicated childbirth

During an obstetrically complicated childbirth (II) the essential meaning was the woman’s desire to be recognised and affirmed as a genuine subject. If this happens the woman feels accepted as a childbearing woman and as a mother-to-be, even if obstetric interventions are necessary and high technology is used. The essence is defined as *confirmation* and includes five dimensions: *to be seen*, *trust*, *a dialogue*, *control* and *mothering*. When women feel affirmed they can still keep control although it is

necessary to let the professionals take over. If any of the mentioned features are lacking the women experience *dis-confirmation* with negative feelings such as stress, insecurity, sense of guilt, disappointment, worse pain management, and poor motherhood (Table 4).

Pregnancy and diabetes

The essential meaning of women's experiences of being pregnant and having IDDM (III) was entitled *being controlled by blood glucose levels for the child's sake. The child*, experienced as an entirely separate person from the very beginning of pregnancy, *makes demands*, with consequences that are expressed in two main themes. *Objectification*, including loss of control and awareness of having an unwell risky body; and *exaggerated responsibility* including constant worry, a constant pressure and constant self-blame. The own body is put aside. All of the women improved the level of glycated hemoglobin concentration (HbA_{1C}), indicating a better blood glucose level control. The mean value at the beginning of pregnancy was 7.1% compared with 5.4% as the last noted value before childbirth (Table 4).

Midwifery care of women at high risk

The essence of midwifery in the care of women at obstetric high risk, i.e. with risk factors or manifested complication (IV), was defined as *a struggle for the natural process*. Women's transition, physically as well as emotionally, during pregnancy, childbirth and early parenthood, is understood as a genuinely natural process. Midwives' struggle consists of encouraging and preserving this process within each woman. It includes a *balancing* between the medical and the natural perspectives. It is based on *embodied knowledge*, which consists of theoretical and practical knowledge, and sensitive knowledge, i.e., a developed ability to use one's senses. In this way, midwives can successively raise the limit as to what they consider to be normal, without losing awareness of emergencies. Insufficient medical knowledge as well as limited practical experience increases the risk of pathologisation. Prerequisites, and therefore part of the struggle for the natural process, are *sensitivity to the spontaneous, mutual interaction with the woman* and an *enduring presence* (Table 4).

Table 4. Overview of results, papers I – IV

Paper/phenomenon	Essence	Constituents /themes
I Women's encounter with the midwife during childbirth	Presence / Absently presence	To be seen To have a trusting relationship To be supported and guided on one's own terms
II Women's experiences of a complicated childbirth	Confirmation / Dis-confirmation	To be seen Trust A dialogue Control Mothering
III Pregnancy as experienced by women with insulin depended diabetes	The child makes demands	Objectification: An unwell body – a risk Loss of control Exaggerated responsibility: Constant worry Constantly under pressure Constant self-blame
IV Midwifery in the care of women at obstetric high risk	A struggle for the natural process	Sensitivity to the spontaneous Mutuality Enduring presence Balancing Embodied knowledge

Synthesis of the qualitative studies

From the four qualitative studies (I, II, III, IV) a synthesis of good midwifery care of women at high risk is evolved. It is summarised *genuine caring in caring for the genuine*. The *genuine* stands for the authentic, true, natural, valid, ingenuous and not false. *Genuine caring* expresses the nature of the midwife-woman relationship. Caring is a mutual, interactive process between midwife and woman. Both are open to each other, the midwife affirms the woman in her authenticity and the woman affirms the midwife, including her personality and professional competence. Trust and respect are keywords in the mutual relationship. Genuine caring is a way of being in the caring situation, no matter what action is performed. It is learnt when the midwife is open and authentic to herself and to the woman. Through this, she dares to live out herself and her embodied knowledge in the care. In genuine caring the midwife is present. Presence means both to be there physically and to be with the woman emotionally. Enduring presence is shaped through the midwifery community.

In *caring for the genuine* the midwife is open and sensitive for the genuine in each woman, for what she presents, senses and behaviour. The midwife respects the woman

and supports her on her own terms. By this the woman feels affirmed, during pregnancy, childbirth and as a mother. She may also have a sense of control in the situation and even dares to share the control with the midwife and other carers, if obstetric interventions are needed. The midwife performs a mindful, active search for the inborn and spontaneous physical as well as emotional transition within the childbearing woman, so easily repressed by assessments and interventions of different kinds. A balancing between the natural and medical perspective is performed, and if the medical perspective is too dominant the midwife struggles for the genuine process to persist (Figure 3).

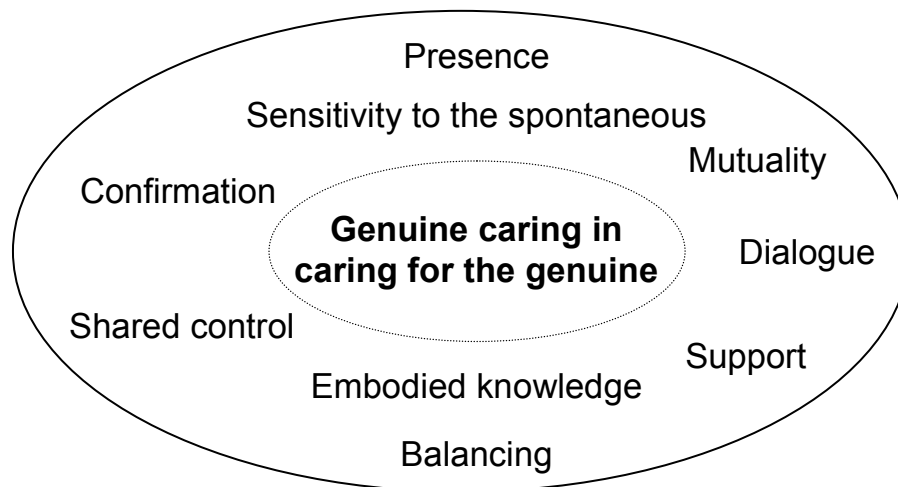


Figure 3. Good midwifery care of women at high risk during childbearing

However, caring is not always understood as *genuine caring for the genuine* (I, II, III). In such a situation, the care is characterised by dis-confirmation, including no seeing, no dialogue, and an absently present midwife/carer. The woman may have senses of distrust, fear, objectification, of bad motherhood and loss of control including no confidence in her own body and an increased dependency on external check-ups and assessments of health professionals.

Childbirth experience in women at high risk and use of a birth plan

The respondent rate was 91.4% in the group receiving standard care (SG) and 98.0% in the group given a questionnaire and formulating a birth plan in late pregnancy (IG). There were 48.3% primiparous and 51.7% multiparous women. The mean age was

31.9% in SG versus 30.4% in the IG. 30.6% (n=83) of women in SG, and 28.0% (n=76) in IG were at high risk, i.e. had either presence of obstetric risk factors or complications (Table 5). The birth plan did not seem to improve the overall childbirth experience. The results in the whole groups are described by Lundgren, Berg and Lindmark (2002, unpublished).

Table 5. Characteristics of study participants

Characteristics	Standard group	Intervention group
<i>Subgroups</i>	<i>No. (%)</i>	<i>No. (%)</i>
NPNC	126 (46.5)	134 (49.5)
CPNC	60 (22.1)	57 (21.0)
NPCC	62 (22.9)	61 (22.5)
CPCC	23 (8.5)	19 (7.0)
<i>Maternal age</i>	<i>Mean</i>	<i>Mean</i>
NPNC	29.92	29.67
CPNC	30.88	29.96
NPCC	36.23	31.33
CPCC	33.74	34.42
<i>Primiparae</i>	<i>No. (%)</i>	<i>No. (%)</i>
NPNC	61 (48.4)	58 (43.3)
CPNC	30 (50.0)	26 (45.6)
NPCC	33 (53.2)	40 (65.6)
CPCC	7 (30.4)	7 (36.8)

CP= Complicated Pregnancy; NC= Normal Childbirth;

NP= Normal Pregnancy; CC= Complicated Childbirth

Within the standard and intervention group, each “complicated group” was compared with the group of women with normal pregnancy and childbirth, the “normals”. The results are presented together in summarised form under the headings below. In the result, the extreme answers, i.e. 1+2 (disagree) and 5+6 (agree), are presented. An overview of the significant differences in any of the complicated groups compared with the “normals”, is presented in Table 6, 7 and 8, following the three categories *relationships, control, demands and worry* and *overall satisfaction*.

The results indicate that women at high risk during childbirth have more “negative feelings” than women with normal conditions. The intervention with use of questionnaire and birth plan did not improve the childbirth experience in any subgroup but appears to intensify the negative feelings in the women at high risk.

Relationship

The women generally had very high positive scores for the relationship to the midwife ($\geq 68.4\%$), the physician ($\geq 56.0\%$) and the partner/other relative ($\geq 92.0\%$). Between 68.4% and 95.4% in all subgroups rated that they felt trust in the midwife and that she listened and paid attention to needs. The corresponding frequency for physicians was between 56.0% and 84.7%. The analysis revealed some statistical differences when comparing the “normals” with the other subgroups with complications both in the standard group and in the group with birth plan (Table 6).

Table 6. *Relationship*

Overview of differences between “complicated” and “normal” subgroups (score 5+6)

Standard group	CPNC	NPCC	CPCC
Midwife 1: listening and paying attention to needs and desires	ns	↓	ns
Midwife 1: Confidence	ns	↓	ns
Intervention group: questionnaire + birth plan	CPNC	NPCC	CPCC
Midwife 2: listening and paying attention to needs and desires	↓	ns	ns

↑ = higher than the “normals”; ↓ = lower than the “normals”; ns= non significant

Sense of control

The ratings about aspects of sense of control varied considerably within all subgroups, but without major differences between the groups. A vast majority in all groups (63.1-81.6%) had low ratings (1+2), indicating that they did not agree with the statement that *there was no need of control if the staff had control*. Only 12-14% agreed totally that *they could leave the control to the staff*. The majority of women in all subgroups felt that some *capacity to interpret body signals* was maintained. In the intervention group, women with normal pregnancy and complicated childbirth (NPCC) felt *difficulty in interpreting body signals during the second stage* to a higher degree than “normals” (5+6: 25.0% vs. 12.7%; $p=0.006$). Women with complicated pregnancy and normal childbirth (CPNC), in the intervention group, had also to a greater extent *difficulty in interpreting body signals on the whole* compared with the “normals” (5+6: 18.1% vs. 5.9%; $p=0.019$). A majority of women in all groups disagreed with the statement of *no participation in decisions (objectification)*, although women with a complicated pregnancy and normal childbirth (CPNC) did it to a lesser degree, indicating less feeling of participation (1+2: 72.7% vs. 91.3%; $p=0.020$) compared with the “normals” in the standard group. A similar difference in CPNC was seen in the intervention group

(1+2: 77.2% vs. 87.9%; $p=0.04$). The *dependency on check-ups as a basis for feeling of security* was scored similarly in the different groups, except in the group with complicated pregnancy and normal childbirth (CPNC) using a birth plan. These women needed the check-ups as a basis for security to a significantly greater extent (5+6: 46.3% vs. 23.5%; $p=0.021$) (Table 7).

Table 7. *Sense of control*

Overview of differences between “complicated” subgroup and “normals” (Score 5+6)

Standard group	CPNC	NPCC	CPCC
I had control during labour	ns	ns	↑
I had control during second stage	ns	↓	ns
No need of control if the staff had control	ns	↑	ns
No participation in decisions/objectification	↑	ns	ns
Intervention group: questionnaire + birth plan	CPNC	NPCC	CPCC
Check-ups basis for security	↑	ns	ns
No participation in decisions/objectification	↑	ns	ns
Difficult to interpret body during second stage	ns	↑	ns
On the whole, difficult to interpret body signals	↑	ns	ns

↑ = higher than the “normals”; ↓ = lower than the “normals”; ns= non significant

Feelings of demands and worry and the overall experience of childbirth

All groups had quite high ratings concerning *confidence in one's own capacity* (5+6: $\geq 50.0\%$) although women with both complicated pregnancy and childbirth expressed less confidence (5+6: 57.7% vs. 65.4%). *Too severe demands* was rated quite low in all groups, but a significantly higher affirmation to this statement was seen in the group of women with a complicated pregnancy and normal childbirth (CPNC) with birth plan compared with the “normals” (5+6: 14.3 vs. 4.5%; $p=0.1$). *Feeling of failure* was not common, few women totally agreed. Nevertheless, the feeling was more frequent among the subgroups with either complicated pregnancy or childbirth (CPNC and NPCC) using a birth plan. The highest ratings affirming that *their child had got a difficult birth* were seen in the subgroup of women with normal pregnancy but complicated childbirth (NPCC). This difference was even larger after use of the birth plan (SG: 5+6: 23.4% vs. 10.4%; $p=0.017$. IG: 5+6: 31.2% vs. 9.8%; $p=0.001$). Scores concerning fear for complications to affect the child was generally higher in the subgroups with complications compared with the “normals”, but the only significant difference was found for the comparison between the CPNC-group with a birth plan and the “normals” (5+6: 41.1% vs. 14.9%; $p=0.001$). The majority in all subgroups had

a high degree of acceptance to *suffer pain for the child's sake*, except women with complicated pregnancy and normal childbirth in the standard group, whose ratings were significantly lower than the “normals” (5+6: 40.3% vs. 60.6%; $p=0.029$) (Table 8).

Most women ($\geq 51.8\%$) expressed agreement with the statement that *childbirth as a whole was positive*, but among women with a birth plan, significantly lower scores were seen in groups with either complicated pregnancy or childbirth (CPNC and NPCC) (Table 8).

Table 8. *Demands and worry and overall satisfaction*

Overview of differences between “complicated” subgroup and “normals” (score 5+6)

Standard group	CPNC	NPCC	CPCC
My child had a hard birth	ns	↑	ns
Suffer pain for the child's sake	↓	ns	ns
Intervention group: questionnaire + birth plan	CPNC	NPCC	CPCC
Confidence in own capacity	ns	ns	↓
Feeling of failure	↑	↑	ns
My child had a hard birth	ns	↑	ns
Constant fear of complications to affect the child	↑	ns	ns
On the whole, a positive childbirth	↓	↓	ns

↑ = higher than the “normals”; ↓ = lower than the “normals”; ns= non significant.

Comparative analysis of women who received standard care versus women who used a birth plan, according to subgroup

A comparison of women who received a birth plan versus women who got standard care, was carried out subgroup by subgroup. When comparing the two groups of women with normal pregnancy and childbirth (NPNC), the two groups of women with normal pregnancy and complicated childbirth (NPCC) and those with complicated pregnancy and childbirth (CPCC), no significant differences were found in any of the statements. In contrast, a difference was observed when comparing the two groups of women with complicated pregnancy and normal childbirth (CPNC). Women who were prepared with a questionnaire and an individual birth plan scored much higher than women without such an intervention, when the statement of *constant fear of complications to affect the child* was presented (5+6: 41.1% vs. 14.9%; $p=0.007$). They also more often expressed that they could *suffer pain for the child's sake* (5+6: 71.8% vs. 40.3%; $p=0.025$).

DISCUSSION

The findings emphasise that childbearing women at high risk live in an extremely vulnerable situation. The vulnerability is obvious in the use of an individual birth plan, where negative feelings seem to be more frequent compared with women with normal pregnancy and childbirth. During pregnancy the women at high risk feel a moral commitment towards the child, including feelings of objectification and of exaggerated responsibility. During an obstetrically complicated childbirth the women have a desire to be recognised and affirmed as individual persons. Like women with normal pregnancy and childbirth they need an emotionally present midwife who sees, gives trust and supports. Good midwifery care of childbearing women at high risk is synthesised *genuine caring in caring for the genuine*.

Methodological aspects

The lifeworld approach was found to be very useful in the qualitative studies. Although I tried to keep a critical stance it became clear that pre-understanding could not be totally restrained (cf. Dahlberg et al. 2001). When interviewing, instead of remaining with what was about to be described and dig deeper into every descriptive moment, I sometimes moved on. Interviewing is indeed both an art and a technique (cf. van Manen 1992). During the analysis we were at least two researchers. The other researcher's perspective, by not knowing the study field in detail, contributed to maintaining objectivity.

In the study about midwifery in care for women at high risk (IV), the interviews did not sufficiently grasp the phenomenon in depth. Probably the very nature of midwifery is not recognised by midwives themselves. They just live it. To deepen the knowledge of how the natural process is promoted, a methodological multiplicity including video observations or reenactment (cf. Dahlberg et al. 2001) could serve as a basis for the questions in the interview.

Some limitations in the intervention study (V) are obvious. The questionnaire was not previously validated, although the studied areas were found to be essential in qualitative studies carried out earlier. Further, randomisation was not considered feasible, but the study controls were very close in time and similar in all respects to the women in the intervention group. As the data collection in the control group was done before the intervention, it would not influence these women and their midwives. Finally, there were many statistical comparisons in the analysis, and thus the risk of mass significance

can not be ignored. However, there is a pattern in the results that is in rather good accordance with the essential findings in the two qualitative studies (II, III).

Reflection on the results: Genuine caring in caring for the genuine

The synthesis of the qualitative studies expresses midwifery care, but the women sometimes did not distinguish the different health professionals from each other (II, III). Therefore the results may to some extent be applicable in caring situations when the carer is from another profession. Even in the fifth study there are elements that have connection with the synthesis. A reflection on the results will therefore be presented based on the synthesis of the four qualitative studies within which the results from the fifth study are interwoven. The constituents overlap and interact with each other but will be discussed one by one.

The results offer a basis for an understanding of the meaning of childbearing and midwifery in the context of high risk. It is highlighted that the core of midwifery care of women at high risk is caring, and the innermost core of caring is the caring relationship. This is in accordance with other literature (Eriksson 1997). Relationship is always of supreme importance. It is power, no matter if it is a relationship of human to human, of carer to patient, or of mother to child (cf. Bergum 1992). The synthesised *good midwifery care*, with its constituents, is largely in concordance with a model of exemplary midwifery care developed by Kennedy (2000). Essential elements in that model are belief in normalcy of birth, respect, empowerment, non-judgement, exceptional clinical skills and knowledge of self.

Demands and responsibility

It was impossible to distinguish different developmental phases of motherhood during pregnancy as other researchers have done (Brudal 1985, Raphael-Leff 1991), although the interviews were carried out during the three trimesters of pregnancy (III). The transition to motherhood is more of a continuous process (cf. Bergum 1997). From the very beginning of pregnancy the child, experientially speaking, is very present, and in a demanding way. Every time the blood glucose level is monitored, the women are reminded that the child is in need of the very best conditions for a “healthy” start. The women’s developing readiness for mothering is obvious (cf. Winnicott 1990/1965). Motherhood is a responsibility, and the developing relationship between mother and child is the natural ground for the morality of responsibility, there is a move from “me” to “us” (Bergum 1997). An ethical relationship arises when “the other”, i.e. the child, elicits a response (cf. Levinas 1992). However, in the women at high risk the responsibility is exaggerated. There is a sort of pain (cf. Marck, Field & Bergum 1994),

a demand expressed through feelings of constant worry, insufficiency, self-blame and pressure. The behaviour of putting one's own body aside supports other indications that childbearing women today perceive the overall risk for their child as much higher than the overall risk for themselves. It is suggested that the reason for this is that the real risk and the perceptions of, or fear of, death for the mother have largely disappeared with medical advances (Queniart 1992, Enkin 1994, Gupton et al. 2001).

A feeling of too severe demands, fear that complications should affect the child, and feelings of failure were more frequent when the women were stimulated to think further about their situation. They also estimated the overall childbirth experience as less positive (V). This emphasises the increased vulnerability in women at high risk. The concern for the child's health is a legitimate source of anxiety, and uncertainty is more dominant in women with high risk pregnancies than in those with low risk pregnancies (Rubin 1976, Stainton et al. 1992, Clauson 1996). This has to be taken seriously by health professionals as it is shown that if a mother feels that she is not fulfilling her perceived role, guilt, depression and despair can set in (Elliot 1990, McKay 1997). Feelings of "poor motherhood" as described by women with complicated childbirth (II) should not be so dominating if the care is labelled "good".

Risk and objectification

There is a real, increased risk of complications for women and their children at high risk, compared with other women. The dilemma is that whereas epidemiologists speak of risk as an estimated characteristic of a group of people, for the unique woman at risk it becomes an experience of her everyday life. Scientific risk is quantified and objectified. Experienced risk is qualitative and subjective and is hanging over the women throughout pregnancy. Caring routines, such as special antenatal care programmes, including numerous investigations and visits to the clinic, confirm the risk (III). Increased risk awareness not only changes the way people think about health, disease and death. More profoundly and more seriously, it ultimately changes human values, self-identity and perspective of life (Förde 1998).

The attitude towards the human body differs depending on the situation to which it is exposed. When healthy, we have a natural taken-for-granted attitude to our subjective body, whereas illness objectifies itself and hinders the natural access we have to ourselves (Gadamer 1996). When objectified, the lived body feels encumbered by itself. The objectification here refers to the experienced otherness of the self (cf. Gadow 1980). Both illness (Toombs 1992) and pregnancy (Young 1984) can be understood as bodily dissonance. For women at high risk there is thus a double reason for feeling objectified (II, III, V). It is as if they live in a double transition; the transition to

motherhood and the renewed transition to live with a chronic disease and/or in a risk situation.

Suffering inflicted by care

The findings emphasise that people in modern society, where scientific rationality dominates, are increasingly burdened by their own sense of responsibility (cf. Förde 1998) and when their situation is defined as *at risk* they are more vulnerable. Anticipatory thought processes that precede a stressful event play a major role in determining how an individual will cope during the actual event and in the period after the event (Janis 1958). This may be applicable in our study (V) as the women at high risk through the intervention, i.e. the questionnaire followed by a birth plan, were stimulated to think further about their situation. It is remarkable that in women with normal conditions there was no such negative effect.

A dis-confirming way of caring also contributes to negative feelings. It is evident that elements in the care may influence vulnerable women who are at high risk in a negative way. The results show that women's suffering also may be related to caring routines (II). Other examples of suffering inflicted by care are described in the literature (Halldórsdóttir 1996, Eriksson 1997). It is not only related to illness, pain, worry, waiting and uncertainty. It may also be due to the carer's manner of acting, related to deprivation of dignity, of not being understood, not being taken seriously, and of being reduced to a physical body (Eriksson 1997). Awareness of this suffering is significant for good caring (Eriksson 1997). Midwives, and other carers, have to reflect over how, and if, they contribute to such suffering.

Presence

As the participants in the first study were women with normal childbirth conditions, and those in the second experienced a complicated childbirth, there seem to be some common needs of presence among women in childbirth, no matter whether normality or high risk. Presence is found to be a central concept in the caring relationship (Paterson & Zderad 1988, Parse 1981, Rogers 1981, Watson 1985, Gilje 1992, Swanson 1991). Presence is being here and not elsewhere. It is being with, which means closeness in a physical, psychological, emotional and spiritual sense. It is nearness in time, space, amount or resemblance (Vaillot 1962, Paterson & Zderad 1988). Fives modes of being with the patient in caring is described; being open to and perceptive of others, being genuinely concerned for the patient, being morally responsible, being truly present and finally being dedicated and having the courage to be appropriately involved (Halldórsdóttir 1996). To be present, i.e. to serve and be accessible, means to value the patient's dignity (Eriksson 1996, Ericsson, Nordman & Myllymäki 1999). Presence is

essential in midwifery. It is eminently subjective and cannot be taught. It is learnt by the midwife as she is present to herself. From this awareness of oneself the presence of others can be discovered (cf. Donna, Haggerty & Chase 1997).

Mutuality and dialogue

Caring is a giving and receiving for both patient and carer. In order to receive, one must give of oneself (Eriksson 1996), climb over the limit of self into the no-mans-land where nobody has the control (Lindström 1987). Mutuality, or reciprocity, is crucial in a confirming, caring relationship'. It bestows the patient a place "to be" (Dahlberg 1996) and is built on confidence. Women need to feel confidence in the midwife, her personality as well as in her professional competence (I, II, IV). This is an important aspect of the caring relationship (McCrea and Crute 1991, cf. Halldorsdottir 1996).

Mutuality is also confirmation. In a mutual, confirming relationship, where both the midwife and the woman collaborate, two living "I" are affirming each other (Bergum 1992). Mutuality means openness to each other but also openness to oneself (IV). Carer's openness and knowledge of self is of great importance for a true and meaningful confirmatory dialogue to occur (Dahlberg 1996). The midwife is open to the woman and her lifeworld. She is also open to herself and dares to "be herself" (IV). In such a relationship the midwife is utilised as a resource by the woman (Coyle et al. 2001).

"Skilled companionship" is identified as "being with", rather than "doing for" (Campbell 1984). The core of midwifery practice is defined as a "being with" relationship between midwife and woman (Fleming 1998). Mutual intentionality is the basis and the core of support for low-income African-American women during high risk pregnancy and early parenthood. "Being there" is included. It includes availability and willingness to provide help when needed. Caring, respecting, sharing information, knowing, believing in, and doing for the other are also included (Coffman & Ray 1999). Thus presence and mutuality is closely connected.

A dialogue is ethical as it demands that the self must answer when addressed by the other (Lögstrup 1956). It implies going with the other through an emotionally engaged presence (Blåka Sandvik 1997, Lögstrup 1956). Midwives' mutuality and enduring presence seem to be part of this (IV). In a functioning dialogue continuous information is essential so that women feel a part of their own process, both for women with normal and complicated childbearing (I, II, V). All women giving birth need to participate in the childbirth process and a sense of participation has a great impact on the childbirth experience (Seguin et al. 1989, Green et al. 1990, Slade et al. 1993, Bramadat et al.

1993, Mackey 1995, Waldenström et al. 1996a, Lavender 1999), especially when interventions are necessary (McIntosh 1988). A genuine caring dialogue is found to nurture the well-being and more-being (Paterson & Zderad 1988).

Support and control

Women giving birth at an ABC-unit want to be supported, encouraged and guided on their own terms (I). These women are found to be far more interested in decision-making than women who receive standard care (Waldenström 1993). To control the situation is essential even for women with a complicated childbirth. They do not want to relinquish control totally to the staff (II, V) but want to keep a sense of control. Women who do not feel in control either of themselves or of their environment are less satisfied and have low postnatal emotional wellbeing (Green et al. 1990). Sense of control and sense of participation here seem to be similar (cf. Rotter 1966, Green et al. 1990).

Sometimes during complicated childbearing the control is obtained through “shared control”, or “entrusted control” which means that the women have sufficient trust and confidence in the health team to delegate to them the responsibility for performing the necessary action (Corbin 1987). Women who feel affirmed express a form of “entrusted control”, they can still keep the control although it is necessary to let the professionals take over (II). This is a type of collaborative relationship between the woman and her carer. It includes a listening and supportive caring where the woman is given a sense of control over the experience. A provider-dominated, relationship on the contrary, designates the woman as a passivated participant with a lack of involvement in decisions (cf. Coyle et al. 2001).

The more control women have of their lives, the more positively they view their pregnancy (Gara & Tilden 1984). Control over one’s own body and health influences overall satisfaction, whereas loss of control functions as a stressor in high risk pregnancy. It leads to feelings of helplessness or powerlessness and to a high level of dependency on expertise (Loos & Julius 1989, Stainton et al. 1992, Waldron & Asayama 1985). This is expressed by the women with IDDM (III).

The actual nature of pregnancy and childbirth is uncontrolled, but humans are increasingly trying to control it (Colen 1986). The need for control has successively evolved in society. One reason is the focus on risk in western countries (Beck 1992). Any danger, any misfortune, and ultimately the future itself, is portrayed as a risk (Lughmann 1993). Our results illustrate how childbearing women at high risk are

influenced by the need of control, although control has a different meaning for different women (I, II, III, V).

Young (1987) argues that the medical healthcare discourse has transformed pregnancy into an objective observable process. A more moderate opinion is expressed by Bergum (1997) who declares that dependency on examinations outside woman's own body may devalue her body knowledge. Women with high risk pregnancy seem more easily to lose touch with their own body and to accept objective knowledge as more correct and valuable (III). Today, medicine science and caring routines give more value to the objective knowledge. The ultrasound vision of the child, the printout of analyses, or fetal monitoring during labour, reinforces a woman's need of external control and weakens her belief in her own bodily signals.

Confirmation and sensitivity to the spontaneous

Confirmation contains several of the aforementioned constituents. Mothering is part of confirmation. Complicated childbirth often includes separation of mother and child, which may make it more difficult for the woman to feel like a good mother (II). The ultimate purpose of caring, and the basis for health, is to support the human being to develop into what she is meant to be (Eriksson 2001b, Lindström 1990). The woman has to be recognised as a good mother. The basis for this is a confirmative relationship (IV). There is a potential for confirmation, and dis-confirmation, in the caring relationship (Drew 1986, Gustafsson & Pörn 1994). Dis-confirmation includes suffering (Lindström 1990) whilst genuine caring is confirmative. Confirmative caring releases feelings of hope, comfort, relaxation and positive self-evaluation (Drew 1986, Lindström 1990), i.e. fulfilment (Gustafsson 1992). Just as the mother responds to the child's needs, the carer is confirming the patient's needs. This response is one form of confirmation (Lindström 1990).

“Faith in women's bodies gives power, not power over but power to go with, to move within the forces of body knowledge” (Bergum 1997, p. 58). Faith in women includes sensitivity to their spontaneous natural childbearing process (IV). The focus on risk may obstruct the natural transition to motherhood. However, there is an enormous power embedded in motherhood as shown in women with IDDM who all developed a strong, unconditional motivation during pregnancy with decreased HbA_{1C} as an objective sign (III).

Embodied knowledge

We live as subjects in and through bodies. All understanding, memory, perception, emotional and cognitive relations to the world are embodied (Husserl 1970a & b,

Merleau-Ponty 1995, Heidegger 1998). All knowledge that we develop is embodied knowledge (Merleau-Ponty 1995/1945). Midwife knowledge becomes embodied and lived out in daily work, when it becomes integrated within the midwife. It develops over time with increasing work experience. Knowledge of complicated conditions and diseases gives midwives a feeling of security and safety in their professional role so they can successively raise the limit as to what they consider to be normal, and more easily guide women through the natural course of events (IV). This kind of knowledge is described as important in an applied discipline (Benner, Kyriakidis & Stannard 1999). Practical knowledge is “know-how”-knowledge, theoretical knowledge is “know-that” knowledge. The sensitive knowledge (IV) seems to be the same as Benner’s “perceptual knowledge”. The more integrated knowledge described by the midwives as intuition is similar to what Benner (1984, p. 295) defines as the “intuitive grasp” the expert nurses. It relies on perceptual capacity and is defined as a “direct apprehension of a situation based upon a background of similar and dissimilar situations and embodied intelligence or skill” (p. 295). The intuitive grasp is a useful tool and “may lead to early identification of problems and the search for confirming evidence” (Benner 1984, p. xix). Embodiment also means to respond to another with authenticity. It includes both vulnerability and risk (Bergum 1992). Both midwives and women are vulnerable and at risk in the genuine caring relationship, but in different ways.

Balancing

The balancing of midwives implies finding a level where both the natural and the medical perspectives may exist side by side. To focus upon the natural process does not mean removing the reason for the special treatment. Even if medicalisation is not the same as pathologization (Milton 2001), the risk for equivalence in this aspect seems impending. Otherwise there would be no need for struggle (IV). Midwives are more likely to view childbearing as a normal process while obstetricians tend to view childbearing as a risk state, the risk approach increasing with clinical experience (Schuman & Marteau 1993, Rooks 1999).

Collaboration and conflict between doctors and midwives in Swedish maternity care has been a historically recurrent theme throughout history (Milton 2001). Without doubt midwives and doctors represent different perspectives. It is obvious that two different discourses exist in modern maternity care, “the medical science of birth” which emphasises that all births have a potential of pathology, and “the traditionally-based knowledge” that includes a natural view on childbearing (Blåka Sandvik 1997). Midwifery is practised at the point of intersection between these two discourses.

Although it is shown that midwives are striving for normalising the unusual (IV, Bredmar 1999), other research lends support to the view that there is a risk for the medical perspective to dominate midwives' mode of working. In antenatal care, for example, their way of relating to parents consists of either an obstetric or a parental perspective, the former focusing on the physical process and the latter on the psychosocial. The motherhood transition could be understood as either a feminine risk project or a trustworthy physical, emotional, existential and social process (Olsson, Sandman & Jansson 1996, Olsson 2000). A mix of the obstetric/medical and parent-oriented perspectives includes a confirming mode of working and is seen as preferable (Hallgren, Kihlgren & Norberg 1994).

Midwives' mode of working and philosophy is influenced by the health care organisation (Coyle et al 2001, McCourt & Page 1996). Midwives working with normal childbearing in birth centres are experienced by women as treating childbearing as something natural, and encourage women to listen to their own body and trust in their own ability. Midwives in hospital settings on the other hand, are experienced by women as having an intervenistic approach, treating pregnancy and birth as a condition with many potential dangers (Coyle et al. 2001).

It is proposed that midwives must be allowed to give care based on their own standpoint taking into account both discourses when creating a new self-image in modern maternity care (Blåka Sandvik 1997). Models of care developed by midwives for women at low obstetric risk have significantly lower rates of interventions without compromising safety compared with mainstream care (Linder-Pelz et al. 1990, Harvey et al. 1996, Waldenström et al. 1997). If midwives manage to support the natural process in high risk women, would there be an effect on outcomes in the same way as in midwifery care of low risk women? Further research is required before this question can be answered. However, it is doubtful if it will succeed as long as midwives have to struggle for the natural process. Midwives themselves suggest that balanced care could be reached through a close, equal collaboration between midwives and the obstetricians. The basis should be mutual respect and confidence, both professions striving for the same goal, to help the mother to get through pregnancy and childbirth with as little sickness, complication and intervention as possible (IV). The future of childbearing will depend largely on what happens to, and within, maternity care. It is crucial that midwifery and medicine can exist on equal terms for the women's sake and for the view of childbearing to be balanced. Modern midwives who see advantages with advanced technology, creating security for both themselves and woman/child, may also have difficulty in finding a balance in the care as they, at the same time want to preserve the good in traditional practices. This is characteristic of the post modernity (cf. Giddens

1991). It is suggested that the post modern midwife will live with doubt and uncertainty as to what is the best care for the woman giving birth (Blåka Sandvik 1997).

FINAL REFLECTIONS AND GENERAL CONCLUSIONS

Modern Swedish maternity care has a risk focus. The proportion of women defined as at high risk is constantly increasing, mainly due to three reasons. First, conditions that previously did not enable women to go through pregnancy and childbirth with a healthy outcome are today manageable owing to medical developments. Secondly, new obstetric risk factors are constantly identified and, finally, interventions, especially of technical nature, are continuously increasing.

This research has illuminated childbearing women at high risk. The findings emphasize that they live in an extremely vulnerable situation, with an increased risk of being out of balance. During pregnancy there is a moral commitment towards the child, the woman's own health is put in second place, and feelings of objectification and of being a risk are frequent. They feel a loss of control and develop an increased dependency on check-ups, on health professionals and on significant others. They are also filled with exaggerated responsibility to the child, including constant worry, pressure and self-blame.

During an obstetrically complicated childbirth it is essential for the women to be recognised and affirmed as genuine subjects. Like women with normal pregnancy and childbirth they need an emotionally present midwife who sees, supports and inspires self-confidence. Feelings of dis-confirmation include lack of affirmation, loss of control, lack of dialogue, distrust and self-blame for giving the child a brutal birth.

The women's vulnerability is demonstrated in their response to the introduction of a birth plan intended to formulate their expectations and needs for the coming birth. It stimulates further reflections and during the following childbirth more negative feelings are present in women at high risk, whereas women with "normal" conditions do not react in the same way. Midwives and obstetricians have to be cautious in the care of women at high risk, not exposing them to unnecessary interventions without preceding evaluation. Carers must reflect upon caring routines and on the nature of the caring relationship so that it does not inflict more suffering in women at high risk.

Of course, the midwives' role and functions have changed over time following all organisational and societal changes. The move of childbirth from home to hospital, the centralisation, specialisation and technicalisation, have all influenced the exercise of the profession. Midwifery of today is practiced at the point of intersection between the medical science of birth and "traditionally-based knowledge" (Blåka Sandvik 1997). Specific midwifery care exists (cf. Halldórsdóttir 1996). Good midwifery care of childbearing women at high risk is summarised as *genuine caring in caring for the genuine*. Midwives have a special responsibility in promoting the natural process within these women. The caring relationship is the most essential tool in the care. Distinctive features of this are physical as well as emotional presence and a mutual dialogue including shared control between midwife and woman. Confirmation and support of the genuine in each woman through a developed sensitivity is essential. The care is carried out through embodied knowledge, practical as well as theoretical. Finally the care is provided with a balance between the natural and medical perspective.

To maintain health and to regard childbearing as a natural condition, are main tasks for Swedish midwives (cf. Svenska barnmorskeförbundets policyprogram 1995) and, according to our research, a special responsibility when high risk is present. The results highlight that there is a source of power in midwives' ethos. They struggle for childbearing women and for a meaningful care (cf. Eriksson 2001a, p. 63). Balanced care is of utmost importance, on one hand satisfying all women's medical needs and on the other, promoting their right to be mothers and to give birth in a natural manner. To reach a balance it is important to encounter each woman in her unique lifeworld. Optimal maternity care for women at high risk has to be in balance, wherein the midwives' and obstetricians' perspective exists on equal terms. The basis for this is mutual respect and confidence, both professions striving for the same goal, to help the mother to get through pregnancy and childbirth with a minimum of sickness, complications and intervention.

The literature suggests that the risk dimension in health science causes the practice of midwifery to be ever more narrowly circumscribed (Downe 1996). The present results show that this is not true in Sweden although the promotion of natural processes in the care of high risk women is a greater challenge and often a struggle. The question has been posed (Oakley 1989, p. 217): "If technology is the obstetrician's weapon, what is a midwife's anyway?" The present study offers one answer: The midwives' weapon is *genuine caring in caring for the genuine*. This is probably not limited solely to the Swedish context but is a main, universal element in exemplary midwifery practice.

REFERENCES

- Adelswärd V, Sachs L. (1996) The meaning of 6,8: Numeracy and normality in health information talks. *Soc Sci Med* 43:1179-87.
- Alehagen S, Wijma K, Wijma B. (2001) Fear during labor. *Acta Obstet Gynecol Scand* 80:315-20.
- Areskog B, Uddenberg N, Kjessler B. (1983) Experience of delivery in women with and without antenatal fear of childbirth. *Gynecol Obstet Invest* 16:1-12.
- Areskog B, Uddenberg N, Kjessler B. (1984) Post natal emotional balance in women with and without antenatal fear of childbirth. *J Psychosom Res* 28:213-20.
- Bardwick J M. (1971) *Psychology of women: A study of bio-cultural conflicts*. New York: Harper & Row.
- Beck U. (1992) *Risk Society: Towards a New Modernity*. London: Sage.
- Bengtsson J. (1999) (ed.) *Med livsvärlden som grund* (The lifeworld approach). Lund: Studentlitteratur.
- Benner P. (1984) *From novis to expert*. Menlo Park, CA: Addison-Wesley.
- Benner P, Kyriakidis PH, Stannard D. (1999) *Clinical wisdom and interventions in critical care*. Philadelphia: W.B. Saunders Company.
- Berg M, Lundgren I, Hermansson E et al. (1996) Women's encounter with the midwife during childbirth. *Midwifery* 12:11-5.
- Berg M, Dahlberg K. (1998) A phenomenological study of women's experiences of complicated childbirth. *Midwifery* 14:23-9.
- Berg M, Honkasalo M-L. (2000) Pregnancy and diabetes – a hermeneutic phenomenological study of women's experiences. *J Psychosom Obstet Gynaecol* 21:39-48.
- Berg M, Dahlberg K. (2001) Swedish midwives' care of women who are at high obstetric risk or who have obstetric complications. *Midwifery* 17:259-66.
- Berg-Brodén M. (1997) *Mor och barn i ingenmans land* (Mother and child in no-man's land). Solna: Almqvist & Wiksell.
- Berger I. (1998) Det naturlige valg. In: Fjell IT, Hagström C, Marander-Eklund L, Nylund Skog S. pp. 19-39. *Naturlighetens positioner* (Positions of naturality). Åbo: Åbo Akademi.
- Berglund A, Lindmark G. (2000) Risk assessment at the end of pregnancy is a poor predictor for complications at delivery. *Acta Obstet Gynecol Scand* 79:853-60.
- Bergum V. (1989) *Woman to mother. A transformation*. Massachusetts: Bergin & Garvey Publishers.
- Bergum V. (1992) *The dialectical approach to clinical judgement in nursing. Paper presented at Third International Invitational Pedagogy Conference, University of Victoria May 31-June 3*. Victoria, Canada.

- Bergum V. (1997) *A Child on Her Mind. The Experience of Becoming a Mother*. London: Bergin & Garvey.
- Bischofsberger E. (1994) *Mäster Eckharts andliga undervisning* (Spiritual teaching by Meister Eckhart). Uppsala: Katolska förlaget.
- Bluff R, Holloway I. (1994) They know best: women's perspective of midwifery care during labour and childbirth. *Midwifery* 10:157-64.
- Blåka Sandvik G. (1997) *Moderskap och födselarbeid* (Motherhood and labour). Bergen-Sandviken: Fagbokforlaget.
- Bramadat I, Drieger M. (1993) Satisfaction with childbirth. Theories and methods of measurement. *Birth* 20(1):22-9.
- Bredmar M. (1999) *Att göra det ovanliga normalt* (Making the unusual normal). Linköping: Studies in Art and Science 195, University of Linköping.
- Brown CE. (1998) Women and their care providers. An exploration of knowledge, confidence and relationship in the context of childbearing, and childbirth. *Birth* 17:95-100.
- Brudal L. (1985) *Födandets psykologi* (The Psychology of Birth). Vällingby: Natur och Kultur.
- Buber M. (1957) Distance and relation. (originally published in Hibbert Journal (1951) 49:105-13. (Transl. Smith RG) *Psychiatry* 20:97-104 .
- Buber M. (1990) *Det mellanmänskliga* (Between man and man). Ludvika: Dualis.
- Buber M. (1993) *Dialogens väsen* (The dialogue). Ludvika: Dualis.
- Buber M. (1996) *I and thou*. (orig. Ich und Du 1923) Edinburgh: T&T Clark.
- Callister LC, Vehvilainen-Julkunen K, Lauri S. (1996) Cultural perceptions of childbirth: A cross-cultural comparison of childbearing women. *J Holist Nurs* 14:66-78.
- Callister LC, Vehvilainen-Julkunen K, Lauri S. (2001) Giving Birth. Perceptions of Finnish Childbearing Women. *MCN* 26(1):28-32.
- Campbell A. (1984) *Moderated love: a theology of professional care*. London: SPCK.
- Cartwright A. (1979) *The dignity of labour?* Cambridge: Travistock Publications.
- Casson IF, Clarke CA, Howard CV et al. (1997) Outcomes of pregnancy in insulin dependent diabetes women: results of a five years population cohort study. *BMJ* 315:275-8.
- Clauson M. (1996) Uncertainty and Stress in Women Hospitalised With High risk Pregnancy. *Clin Nurs Res* 5:309-25.
- Clement S. (1998) *Psychological Perspectives on Pregnancy & Childbirth*. Edinburgh: Churchill Livingstone.
- Coffman S, Ray MA. (1999) Mutual Intentionality: A Theory of Support Processes in Pregnant African American Women. *Qual Health Res* 9: 479-92.

- Cohen S, Mermelstein R, Kamarck T et al. (1985) Measuring the functional components of social support. In: Sarason IG, Sarason BR. (Eds) *Social support: Theory, Research and Applications*, pp. 73-94. Boston: Martinus Nijhoff.
- Colen BD. (1986) *Hard choices: Mixed blessings of modern medical technology*. New York: G.P. Putman.
- Corbin JM. (1987) Women's perceptions and management of a pregnancy complicated by chronic illness. *Health Care Women Int* 8:317-37.
- Coyle K, Hauck Y, Percival P et al. (2001) Normality and collaboration: mother's perceptions of birth centre versus hospital care. *Midwifery* 17:182-93.
- Cranley MS. (1981) Roots of Attachment: The Relationship of Parents with their Unborn. *Birth Defects Orig Artic* 17:59-83.
- Cranley MS, Hedahl KJ, Pegg SH. (1983) Women's perceptions of vaginal and caesarean deliveries. *Nurs Res* 32:10-5.
- Crnic, KA, Greenberg, MT, Ragoian, AS et al. (1983). Effects of stress and social support on mothers and premature and full-term infants. *Child Dev* 54:209-17.
- Crowe K, von Bayer C. (1989) Predictors of a positive childbirth experience. *Birth* 16:59-63.
- Dahlberg K. (1996) Intersubjective Meeting In Holistic Caring: A Swedish Perspective. *Nurs Sci Q* 9:147-51.
- Dahlberg K, Drew N. (1997) A lifeworld paradigm for nursing research. *J Holist Nurs* 15:303-17.
- Dahlberg K, Drew N, Nyström M. (2001) *Reflective lifeworld research*. Lund: Studentlitteratur.
- Davis-Floyd RE. (1992) *Birth as an American Rite of Passage*. Berkeley & Los Angeles: University of California Press.
- Deutscher M. (1970) Brief family therapy in the course of first pregnancy: A clinical note. *Contemp Psychoanal* 7:21-35.
- Di Matteo MR, Morton SC, Lepper HS et al. (1996) Caesarean childbirth and psychosocial outcomes: a meta-analysis. *Health Psychol* 15:303-14.
- Donna ME, Haggerty LA, Chase, SK. (1997) Nursing Presence: An Existential Exploration of the Concept. *Sch Inq Nurs Pract* 11:3-16.
- Douglas M. (1990) Risk as a forensic resource. *Daedalus* 119:1-16.
- Downe S. (1996) Concepts of normality in maternity services: Applications and consequences. In: Frith L. (ed) *Ethics and Midwifery*. Oxford: Butterworth-Heinemann.
- Dragonas T, Christodoulou, GN. (1998) Prenatal care. *Clin Psychol Rev.* 18:127-42.
- Drew N. (1986) Exclusion and Confirmation: a phenomenology of patients' experiences with caregivers. *J Nurs Scholarsh* 18:39-43.

- Drew N. (2001) Meaningfulness as an Epistemologic Concept for Explicating the Researcher's Constitutive Part in Phenomenologic Research. *Adv Nurs Sci* 23:16-31.
- Eckhart M. (1981) Meister Eckhart. The Essential Sermons, Commentaries, *Treatises, and Defenses*. (Transl. and introd.: Colledge E, McGinn B.). New York: Paulist Press.
- Elliot SA.. (1990) Commentary on "Childbirth as a Life Event". *J Reprod Infant Psychol* 8:147-59.
- Enkin MW. (1994) Risk in pregnancy; The reality, the perception, and the concept. *Birth* 21:131-34.
- Eriksson K. (1987) *Vårdandets idé*. (The idea of caring). Stockholm: Norstedts Förlag.
- Eriksson K. (1990) *Den mångdimensionella hälsan: verklighet och visioner* (The multidimensional health). Projektrapport, institutionen för vårdvetenskap, Åbo: Åbo Akademi.
- Eriksson K. (1996) Att vårda eller inte vårda. *Omsorg* 4:9-12.
- Eriksson K. (1997) Understanding the World of the Patient, the Suffering Human Being: The New Clinical Paradigm from Nursing to Caring. *Adv Prac Nurs Q* 3:8-13.
- Eriksson K, Nordman T, Myllymäki I. (1999) *Den trojanska hästen* (The Trojan horse). Institutionen för vårdvetenskap, rapport 1. Åbo: Åbo akademi.
- Eriksson K. (2001a) Humanvetenskapens angreppspunkt. (The point of attack of Human science). In: *Workshop "Teoriutveckling inom sykepleievitenskap/Omvårdnadsvetenskap/Vårdvetenskap i Norden. Nordic workshop 12 November 1999*. Vårdalstiftelsens rapportserie Nr 2.
- Eriksson K. (2001b) *Vårdvetenskap som akademisk disciplin* (Caring science as an academic discipline). Åbo: Åbo akademi.
- Exodus 2:17. (1984) In: *The Holy Bible*, New King James. Nashville: Thomas Nelson Publishers.
- Fawcett J, Pollio N, Tully A.. (1992) Women's perception of caesarian and vaginal delivery: Another look. *Res Nurs Health* 15:439-46.
- Fisher J, Astbury J, Smith A.. (1997) Adverse psychological impact of operative obstetric interventions: a prospective longitudinal study. *Aust N Z J Psychiatry* 31:728-38.
- Fjell TI. (1998) Introduction. In: Fjell IT, Hagström C, Marander-Eklund L, Nylund Skog S.(eds.) *Naturlighetens positioner* (natural positions), pp. 19-39. Åbo: Åbo Akademi.
- Fleming VEM. (1998) Women-with-midwives-with-women: a model of interdependence. *Midwifery* 14:137-43.
- Flint C, Poulengeris P, Grant A. (1989) The Know Your Midwife's scheme- a randomised trial of continuity of care by a team of midwives. *Midwifery* 5:11-6.

- Förde, OH. (1998) Is imposing risk awareness cultural imperialism? *Soc Sci Med* 47 (9): 1155-59.
- Gadamer H-G. (1995/1960) (orig 1960). *Truth and method*. Second revised edition (J. Weinsheimr & D. Marshall, Trans.). New York: The Continuum Publishing Company.
- Gadamer H-G. (1996) *The enigma of health*. Stanford: Stanford University Press.
- Gadow S. (1980) Body and Self: A Dialectic. *J Med Philos* 5:172-85.
- Gadow SA. (1992) Existential ecology: the human/natural world. *Soc Sci Med* 35:597-602.
- Gara EO, Tilden VP. (1984) Adjusted control: An explanation for women's positive perceptions of their pregnancies. *Health Care Women Int* 5:427-36.
- Giddens A. (1991) *Modernity and Self-identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press.
- Giles H, Coupland H. (1991) *Language: Contexts and Consequences*. Milton Keynes: Open University Press.
- Gilje F. (1992) Being There: An Analysis of the Concept of Presence. In: Gant DA. (Ed.) *The presence of caring in nursing*, pp. 53-67. New York: National League for nursing.
- Giorgi A. (1989) One type of analysis of descriptive data: procedures involved in following a scientific phenomenological method. *Methods* 1:39-61.
- Green JM, Kitzinger JV, Coupland VA. (1986) *The division of labour: implications of medical staffing structures for doctors and midwives on the labour ward*. Child Care and Development Group, Cambridge: University of Cambridge.
- Green J, Coupland V, Kitzinger J. (1990) Expectations, Experiences and Psychological Outcomes of Childbirth. A Prospective Study of 825 women. *Birth* 17:15-24.
- Gupton A, Heaman M, Ashcroft T. (1997) Bed rest From the Pregnant Woman. *J Obstet Gynecol Neonatal Nurs* 26:423-30.
- Gupton A, Heaman M, Cheung LW-K. (2001) Complicated and Uncomplicated Pregnancies: Women's Perception of Risk. *J Obstet Gynecol Neonatal Nurs* 30:192-201.
- Gustafsson B, Pörn I. (1994) A motivational approach to confirmation: An interpretation of dysphagic patients' experiences. *Theor Med* 15:409-30.
- Hall MH. (1990). Identification of high risk and low risk. *Baillieres Clin Obstet Gynaecol* 4:65-76.
- Halldórsdóttir S. (1996) *Caring and Uncaring Encounters in Nursing and Health Care - Developing a Theory*. Medical Dissertations No. 493, Linköping: Linköping University.
- Hallgren A, Kihlgren M, Norberg A. (1994) A descriptive study of childbirth education provided by midwives in Sweden. *Midwifery* 10:215-24.

- Hallgren A, Kihlgren M, Norberg A et al. (1995) Women's perceptions of childbirth and childbirth education before and after education and birth. *Midwifery* 11:130-7.
- Hansson U. (1985) *Diabetes and Pregnancy*. Medical dissertation. Stockholm: Department of Obstetrics and Gynecology, University of Stockholm.
- Hart MA, Foster SN. (1997) Couples' Attitudes toward Childbirth Participation: Relationship to Evaluation of Labor and Delivery. *J Perinat Neonat Nurs* 1:10-20.
- Harvey S, Jarell J, Brant R et al. (1996). A randomised controlled trial of nurse-midwifery care. *Birth* 23:128-35.
- Hatmaker DD, Kemp VH. (1998) Perception of Threat and Subjective well-being in Low-risk and High risk Pregnant Women. *J Perinat Neonat Nurs* 12:1-10.
- Heaman M. (1992) Stressful life events, social support, and mood disturbance in hospitalised and non-hospitalised women with pregnancy-induced hypertension. *Can J Nurs Res* 24:23-47.
- Heaman M, Beaton J, Gupton A et al. (1992) A Comparison of Childbirth Expectations in High risk and Low-Risk Pregnant Women. *Clin Nurs Res* 1(3):252-65.
- Heidegger M. (1998/1927) *Being and Time* (Trans. Macquarrie J, Robinson E.). Oxford: Blackwells.
- Hellqvist E. (1980) *Svensk etymologisk ordbok*. (Swedish etymological dictionary) Lund: Liber läromedel.
- Hewison A. (1993) The language of labour: an examination of the discourses of childbirth. *Midwifery* 9: 225-34.
- Hodnett ED. (2001) Caregiver support for women during childbirth (Cochrane Review). In: *The Cochrane library*, Issue 4. Oxford: Update Software.
- Holm UM. (1993) *Mordrande och praxis En feministfilosofisk undersökning* (Mothering and praxis). Uddevalla: Daidalos.
- Humenick S. (1981) Mastery: The key to childbirth satisfaction? *Birth and the Family Journal* 8:79-83.
- Husserl E. (1970a/1936) *The crisis of European sciences and transcendental phenomenology. An introduction to phenomenological philosophy*. (orig. 1936: "Die Krisis der europäischen Wissenschaften und die transzendente Phänomenologie", *Philosophia* (Bryssel) 1 (2) pp. 203-225). Evanston: North Western University Press.
- Husserl E. (1970b/1900) *Logical investigations: Vol 1. Prolegomena to pure logic*. (Trans. Findlay J. Orig: *Logische Untersuchungen*). London: Routledge Kegan Paul.
- Höjberg P. (1991) *Jordemor. Barnmorskor och barnaföderskor i Sverige* (Midwives and childbearing women in Sweden). Stockholm: Carlssons.
- Höjberg P. (1995) *Helena Malhiems barnmorskelära år 1756* (Helena Malhiem's manual for midwives). Stockholm: Hälsopedagogik.

- Höjeberg P. (2000) *Tröskelkvinnor* (Women on the threshold). Oskarshamn: Carlsson.
- Hörnfeldt H. (1998) Det naturliga födandets politik. In: Fjell IT, Hagström C, Marander-Eklund L, et al. (eds.). *Naturlighetens positioner*, pp. 19-39. Åbo: Åbo Akademi.
- Imle MA. (1990) Third trimester concerns of expectant parents in transitions to parenthood. *Holist Nurs Pract* 4:25-36.
- Istvan J. (1986) Stress, anxiety, and birth outcomes: A critical review of the evidence. *Psychological Bulletin* 100:331-48.
- Janis T. (1958) *Psychological stress: Psychoanalytic and behavioural studies of surgical patients*. New York: Wiley.
- Jones MB. (1986) The high risk pregnancy. In: Johnson S H. (Ed.) *Nursing assessment and strategies for the family at risk* (2nd ed.), pp. 11-128. Philadelphia: Lippincott.
- Kahneman D, Tversky A. (1982) On the study of statistical intuitions. *Cognition* 11:123-41.
- Kasén A. (1996). Vårdrelationen som berättelse och förbindelse – en begreppsanalytisk upptäckt (The concept caring relationship). *Hoitotiede* 8:175-82.
- Kemp V, Page C. (1986) The psychosocial impact of a high risk pregnancy on the family. *J Obstet Gynecol Neonatal Nurs* 15:232-36.
- Kemp VH, Page C. (1987) Maternal self-esteem and prenatal attachment in high risk pregnancy. *Matern Child Nurs J* 16:195-206.
- Kennedy HP. (2000) A model of exemplary midwifery practice: results of a delphi study. *J Midwifery Women Health* 45:4-19.
- Kirke PN. (1980) Mothers' views of obstetric care. *Brit Obstet Gynaecol* 87:1029-33.
- Kristeva J. (1991) *Strangers to ourselves: European perspectives*. New York: Colombia University Press.
- Kohák E. (1978) *Idea & Experience: Edmund Husserl's Project of Phenomenology in Ideas I*. Chicago: University of Chicago Press.
- Knapp L. (1996) Childbirth Satisfaction: The Effects of Internality and Perceived control. *J Perinat Educ* 5:7-16.
- Lagerkrantz E. (1979) *Förstföderskan och hennes barn* (The first-time mother and her child). Stockholm: Wahlström & Widstrand.
- Lavender T, Walkinshaw SA, Walton I. (1999) A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery* 15:40-6.
- Levesque-Lopman L. (1983) Decision and experience: A phenomenological analysis of pregnancy and childbirth. *Hum Stud* 6:247-77.
- Levinas E. (1992) *Tiden och den andre*. (orig.: Le temps et l'autre). Stockholm: Brutus Östlings Bokförlag.
- Lindmark G. (1992) Assessing the scientific basis of antenatal care. The case of Sweden. *Int J Technol Assess Health Care* 8 (suppl 1):2-7.

- Linder-Pelz S, Webster MA, Martins J et al. (1990) Obstetric risks and outcomes: birth centre compared with conventional labour ward. *Community Health Stud XIV* (Australia) (1):39-46.
- Lindström UÅ. (1987) *Psykiatrisk vårdlära* (Psychiatric caring). Stockholm: Almqvist & Wiksell.
- Lindström UÅ. (1990) Bekräftelse -grunden för hälsa. (Confirmation- the basis for health). *Vår framtid och nutid i mentalhygieniskt perspektiv, studiedagar 16-17 mars 1990*. Sjuksköterskeföreningen i Finland. pp. 6-10.
- Loos C, Julius L. (1989) The client's view of hospitalisation during pregnancy. *J Obstet Gynecol Neonatal Nurs* 18:52-6.
- Lowe N. (1989) Explaining the pain of active labor: the importance of maternal confidence. *Res Nurs Health* 2:237-45.
- Lughmann N. (1993) *Risk: A Sociological Theory*. Berlin: Walter de Gruyter and Co.
- Lundgren I, Dahlberg K. (1998) Women's experience of pain during childbirth. *Midwifery* 14:105-10.
- Lundgren I, Wahlberg V. (1999) The Experience of Pregnancy: A Hermeneutic/phenomenological Study. *J Perinat Educ* 8:12-20.
- Lundqvist B. (1940) Svenska barnmorskeväsendets historia. In: Lundqvist B. (ed.) *Svenska barnmorskor* (Swedish midwives) pp. T41-45. Stockholm: Svenska yrkesförbundet.
- Lögstrup KE. (1956) *Den etiske fordring* (The ethical demand). Copenhagen: Gyldendalske Boghandel Nordisk Forlag.
- Macintyre S. (1982) Communication between pregnant women and their medical and midwifery attendant. *Midwives Chron* 95:387-94.
- Mackey M. (1995) Women's evaluation of their childbirth performance. *Matern Child Nurs J* 23:57-72.
- Mackey M. (1997) Women's Evaluation of the Labor and Delivery Experience. *Nursingconnections* 11:19-32.
- Marck, PB, Field AP, Bergum V. (1994). A Search for understanding. In: Field PA, Marck PB. (eds.) *Uncertain motherhood*. Thousand Oaks: Sage Publications.
- Marut JS, Mercer RT. (1979) Comparison of primiparas' perceptions of vaginal and caesarean birth. *Nurs Res* 28:260-66.
- Mathews JJ, Zadak K. (1991) The Alternative Birth Movement in the United States: History and Current Status. *Women Health* 17:39-57.
- McCain GC, Deatrick JA. (1994) The Experience of High risk Pregnancy. *J Obstet Gynecol Neonatal Nurs* 23:421-27.
- McCrea H, Crute V. (1991) Midwife/client relationship: Midwives' perspectives. *Midwifery* 7:183-92.

- McIntosh J. (1988) Women's views of communication during labour and delivery. *Midwifery* 4:166-70.
- McKay S. (1997) Communication and Motherhood. *Midwives* 110:122-4.
- Mercer RT, Hackley K, Bostrom A. (1983) Relationship of psychosocial and perinatal variables to perception of childbirth. *Nurs Res* 32:202-7.
- Mercer RT, Ferketich SL, May KA et al. (1987) *Antepartum Stress: Effect on Family Health and Functioning*. Final Project Report, Center for Nursing Research, National Institutes of Health. San Francisco: University of California.
- Mercer RT, Ferketich S. (1988) Stress and social support as predictors of anxiety and depression during pregnancy. *Adv Nurs Sci* 10:26-39.
- Mercer RT, Ferketich SL, DeJoseph J et al. (1988) Effects of stress on family functioning during pregnancy. *Nurs Res* 37:268-75.
- Mercer RT. (1990) *Parents at risk*. New York: Springer Publishing Company.
- Mercer RT, Ferketich SL. (1994) Predictors of maternal role competence by risk status. *Nurs Res* 43:38-43.
- Merleau-Ponty M. (1995/1945). (orig. 1945). *Phenomenology of Perception* (trans: Smith C.). London: Routledge.
- Milton L. (2001) *Folkhemmet's barnmorskor. Den svenska barnmorskekårens professionalisering under mellan- och efterkrigsåren* (Midwives in the Folkhem. Professionalisation of Swedish midwifery during the interwar and postwar period). *Studia Historica Upsaliensia* 196. Uppsala: Uppsala Universitet.
- Miranda JA, Mozas J, Rojas R, et al. (1994). Strict glycemic control in women with pregestational insulin-dependent diabetes mellitus. *Int J Gynaecol Obstet* 47:223-7.
- Mitchell GJ, Cody WK. (1992) Nursing knowledge and human science: Ontological and epistemological considerations. *Nurs Sci Q* 5:54-61.
- Muller ME. (1992) A critical review of prenatal attachment research. *Sch Inq for Nurs Pract* 1:5-22. *Nationalencyklopedins ordbok* (1996) Höganäs: Bra böcker AB.
- Nicholson H. (1997) Hermeneutical phenomenology. In: Embree L, Behnke EA, Carr D et al. (eds) *Encyclopedia of Phenomenology*. Dordrecht: Kluwer Academic Publishers.
- Norberg A, Engström B, Nilsson L. (1994) *God omvårdnad. Grundvärderingar* (The art of nursing. Basic values). Falköping: Bonnier Utbildning AB.
- Norr K, Block C, Charles A. et al. (1977) Explaining pain and enjoyment in childbirth. *J Health Soc Behav* 18:260-75.
- Nylund Skog S. (1998) Den ideala förlossningsupplevelsen. In: Fjell LT, Hagström C, Marander-Eklund L, Nylund Skog S. (eds) *Naturlighetens positioner*, pp. 19-39. Åbo: Åbo Akademi.

- O'Brien B. (1986) *What are my Chances Doctor? - A Review of Clinical Risk Office of health economics*. London: Office of Health Economics.
- Oakley A. (1989) Who cares for women? Science versus love in midwifery today. *Midwives Chron* 102(1218):214-21.
- Oakley A, Rajan L, Grant A. (1990) Social support and pregnancy outcome. *Br J Obstet Gynaecol* 97:155-62.
- Oakley A. (1993) *Essays on women & health*. Edinburgh: Edinburgh university press.
- Olsson P, Sandman P-O, Jansson L. (1996) Antenatal "booking" interviews at midwifery clinics in Sweden: A qualitative analysis of five video recorded interviews. *Midwifery* 12:62-72.
- Olsson P. (2000) *Antenatal midwifery consultations. A qualitative study*. Medical dissertation, New Series No 643. Umeå: Umeå University.
- Palmer RE. (1969) *Hermeneutics. Interpretation theory in Schleiermacher, Dilthey, Heidegger and Gadamer*. Evanston, IL: North Western University Press.
- Parse RR. (1981) *Man-living-health: A theory of nursing*. New York: Wiley.
- Paterson J, Zderad L. (1988) (orig. 1976). *Humanistic Nursing*. New York: National League for Nursing.
- Penticuff JH. (1982) Psychological implications in high risk pregnancy. *Nurs Clin North Am* 17:69-83.
- Queniat A. (1992) Risky business: Medical definitions of pregnancy. In: Currie DH, Raoul V. (Eds.) *Anatomy of gender: Women's struggle for the body*, pp. 161-74. Ottawa, Canada: Carleton University Press.
- Raphael-Leff J. (1991) *Psychological processes of childbearing*. London: Chapman & Hall.
- Raphael-Leff J. (1993) *Pregnancy. The inside story*. London: Heldon Press.
- Reid T. (2000) Maternal identity in preterm birth. *J Child Health Care* 4:23-9.
- Ricoeur P. (1981) *Hermeneutics and The Human Sciences*. (Edit and transl. Thompson J.) Cambridge: Cambridge University Press.
- Rogers D. (1981) Science of unitary man. In: Lasker G. (Ed.). *A paradigm for nursing*, pp. 1719-22. New York: Pergamon Press.
- Rooks JP. (1999) The midwifery model of care. *J Nurse-Midwifery* 44:370-74.
- Romlid C. (1998) *Makt, motstånd och förändring*. Forskning och utveckling Vårdförbundet. Stockholm: Bromma-Tryck.
- Rotter JB. (1966) Generalized expectancies for internal versus external control of reinforcement. *Psychol Monogr* 80:1-28.
- Rowley MJ, Hensley MJ, Brinsmed MW et al. (1995) Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Med J Aust* 163:317-27.
- Rubin R. (1976) Maternal tasks in pregnancy. *J Adv Nurs* 1:367-76.

- Rubin R. (1977) Binding - in the maternal role. Part II: Models and referents. *Nurs Res* 16:324-46.
- Ruddick S. (1989) *Maternal thinking: Toward a politics of peace*. Boston: Beacon Press.
- Ryding EL. (1998) *Psychological aspects of emergency caesarean section*. Medical dissertations, 576. Linköping: Linköping University.
- Sachs L. (1996) *Att leva med risk. Fem kvinnor, gentester och kunskapens frukter*. Stockholm: Gedins förlag.
- Salmon P, Drew N. (1992) Multidimensional assessment of women's experience of childbirth: Relationship to obstetric procedure, antenatal preparation and obstetric history. *J Psychosom Res* 36:317-27.
- Sarvimäki A., Stenbock-Hult B. (1991) *Vård ett uttryck för omsorg*. (Expressions of care). Kristianstad: Almqvist & Wiksell.
- Scheper-Hughes N, Lock MM. (1987) The Mindful Body: A Prolegomen to Future Work in Medical Anthropology. *Med Anthropol Q* 1:6-41.
- Schumacher KL, Meleis AI. (1994) Transitions: A Central Concept in Nursing *Image: J Nurs Sch* 26:117-25.
- Schuman AN, Marteau TM. (1993) Obstetricians' and midwives' contrasting perceptions of pregnancy. *J Reprod Infant Psycho* 11:115-18.
- Seguin L, Therrien R, Champagne F et al. (1989) The components of women's satisfaction with maternity care. *Birth* 16:109-13.
- SFS (1982) *Hälso och sjukvårdslagen*. (Health and welfare law) SFS 1982:763. Stockholm: Socialstyrelsen.
- SFS 1981:4 (1981) *Hälsovård för mödrar och barn inom primärvården*. (Health care for expectant mothers and children within the primary care) Stockholm: Socialstyrelsen.
- Simkin P. (1991) Just another day in a woman's life? Women's long-term perceptions of their first birth experience part 1. *Birth* 18:203-10.
- Simkin P. (1992) Just another day in a woman's life? Part II: Nature and consistency of women's long-term memories of their first birth experience. *Birth* 19:64-81.
- Slade P, MacPherson SA, Hume A, Maresh M. (1993) Expectations, experiences and satisfaction with labour. *Br J Clin Psychol* 32:469-83.
- Smilkstein G, Helsper-Lucas A, Ashworth C et al. (1984) Prediction of pregnancy complications: An application of the biopsychological model. *Soc Sci Med* 18:315-21.
- Smith JA. (1999) Identity development during the transition to motherhood: an interpretative phenomenological analysis. *J Reprod Infant Psychol* 17:281-99.
- Snyder DJ. (1979) The High risk Mother Viewed in relation to a Holistic Model of the Childbearing Experience. *J Obstet Gynecol Neonatal Nurs* 3:164-70.

- Socialstyrelsen (The National Board of Health and Welfare) (1996) *Hälsovård före, under och efter graviditet* (Health care before, during and after pregnancy). SOS-rapport 1996:7. Stockholm: Socialstyrelsen.
- Socialstyrelsen (The National Board of Health and Welfare) (1996) *Kompetensbeskrivning för sjuksköterskor och barnmorskor* (Guidelines for nurses and midwives). Stockholm: Socialstyrelsen.
- Socialstyrelsen (The National Board of Health and Welfare) (2001) *Handläggning av normal förlossning*. (Normal birth - state of the art). Stockholm: Socialstyrelsen.
- SOSFS (1993) *Omvårdnad inom hälso- och sjukvården* (Nursing in health care). SFS 1993:17. Stockholm: Socialstyrelsen.
- SOSFS (1995) *Kompetenskrav för tjänstgöring som sjuksköterska och barnmorska* (Guidelines for nurses and midwives). 1995:15. Stockholm: Socialstyrelsen.
- SOSFS (1997) Lag om ändring i hälso- och sjukvårdslagen (law on changes in Health and welfare). SOSFS 1997:142. Stockholm: Socialstyrelsen.
- Stainton MC, McNeil D, Harvey S. (1992) Maternal tasks of Uncertain Motherhood. *Matern Child Nurs J* 3:113-23.
- Stainton MC, Harvey S, McNeil D. (1995) *Understanding uncertain motherhood. A phenomenological study of women in high risk situations*. Calgary: Faculty of Nursing, University of Calgary. *Stedman's Medical Dictionary* (1995) Baltimore: Williams & Wilkins.
- Svenska barnmorskeförbundets policyprogram (1995) *I livets tjänst* (Serving life). Svenska barnmorskeförbundet (The Swedish Midwifery Association) och Vårdförbundet, Stockholm: Realtryck.
- Swanson KM. (1991) Empirical Development of a Middle Range Theory of Caring. *Nurs Res* 40:161-66.
- Tarkka M-T, Paunonen M, Laippala P. (2000) Importance of the Midwife in the First-time Mother's Experience of Childbirth. *Scand J Caring Sci* 14:184-90.
- Thomson A. (1980). Planned or unplanned? Are midwives ready for the 1980s. *Midwives Chron* 93:68-71.
- Thomson M, Westreich R. (1989) Restriction of mother-infant contact in the immediate postnatal period. In: Chalmers I, Enkin M, Keirse MJNC. (eds). *Effective Care in Pregnancy and Childbirth*, pp 1322-30. Oxford: Oxford University Press:
- Toombs SK. (1992) *The meaning of illness. A Phenomenological Account of the Different Perspectives of Physician and Patient*. Philosophy and medicine 42. Dordrecht: Kluwer Academic.
- Turnbull D, Holmes A, Schields N et al. (1996) Randomised, controlled trial of efficacy of midwife-managed care. *Lancet* 348:213-18.
- Törnebohm H. (1985) *Vad betyder vetenskapsteori* (What is philosophy of science?). Institutionen för vetenskapsteori, rapport nr 145. Göteborg: Göteborgs universitet.

- Vailliot C. (1962) Existentialism: A philosophy of commitment. *Am J Nurs* 66:500-5.
- van Manen M. (1992) *Researching lived experience: human science for an action sensitive pedagogy*. Ontario: The Althouse Press.
- von Kries R, Kimmerle R, Schimdt JE et al. (1997). Pregnancy outcomes in mothers with pregestational diabetes: a population-based study in North Rhine (Germany) from 1988 to 1993. *Eur J Pediatr* 156:983-7.
- Waldenström U, Nilsson CA. (1993) Women's satisfaction with birth center care: a randomized, controlled study. *Birth* 20:3-13.
- Waldenström U, Nilsson CA. (1994) Experience of childbirth in birth center care. A randomised controlled study. *Acta Obstet Gynecol Scand* 73:547-54.
- Waldenström U, Borg IM, Olsson B et al. (1996a) The childbirth experience: A study of 295 new mothers. *Birth* 23:144-53.
- Waldenström U, Bergman V, Vasell G. (1996b) The complexity of labour pain: experiences of 278 women. *J Psychosom Obstet Gynecol* 17:215-28.
- Waldenström U, Nilsson C, Winbladh B. (1997) The Stockholm birth centre trial: maternal and infant outcomes. *Br J Obstet Gynaecol* 104:410-18.
- Waldenström U. (1998) Continuity of carer and satisfaction. *Midwifery* 4:207-13.
- Waldenström U. (1999) Kejsarsnitt ger inte bättre förlossningsupplevelse (Caesarean section does not improve the childbirth experience). *Läkartidningen* 96: 4545-47.
- Waldron J, Asayama V. (1985) Stress, adaptation and coping in a maternal-fetal intensive care unit. *Soc Work Health Care* 10:75-89.
- Walker JM, Hall S, Thomas M. (1995) The experience of labour: a perspective from those receiving care in a midwife-led unit. *Midwifery* 11:120-29.
- Walkinshaw SA. (2002). *Very tight v s tight control of diabetes in pregnancy* (Cochrane review) In: The Cochrane Library, Issue 1, 2002. Oxford: Update Software.
- Watson J. (1985) *Nursing: Human science and human care*. New York: National League for Nursing.
- Wennergren M, Sultan B, Stigsson L et al. (1994) *Fetal distress correlated to fetal size to birth and White group in diabetic mothers*. Presented at the 14th European Congress of Perinatal Medicine, Helsinki 1994; abstr. 257.
- WHO (1996) *Care in normal birth. Report of the Technical Working Group Meeting on Normal Birth 25-29 March*. Geneva: World Health Organisation.
- WHO (1997) *Regional committee for Europe. Forty-seventh session Istanbul 15-19 September. Health for all for the twenty-first century. The health policy for Europe*. Copenhagen: World Health Organisation, Regional Office for Europe.
- Winnicott DW. (1990) *Maturation processes and the facilitating environment*. (Orig. 1965). London: Hogarth Press.
- York R, Brown LP, Armstrong Persily C, et al. (1996) Affect in diabetic women during pregnancy and postpartum. *Nurs Res* 45:54-6.

-
- Young IM. (1984) Pregnant embodiment: subjectivity and alienation. *J Med Philos* 9:45-60.
- Young D. (1987) Crisis in obstetrics: The management of labour. *Int J Childbirth Educ* 2:13-15.
- Åberg A, Lindmark G. (1992) Competence and compliance in antenatal care: Experience from Sweden. *Int J Technol Assess Health Care* 8:20-4.
- Öberg L. (1996) *Barnmorskan och läkaren. Kompetens och konflikt i svensk förlossningsvård 1870-1920*. (The midwife and physician 1870-1920). Stockholm: Ordfronts förlag.

Questionnaire after childbirth

Category	Statements
<i>Relationship with midwives (1 and 2)</i>	Listening and paying attention to needs and desires*; support; time; competence; guiding; trust*; respect; support to cope with pain
<i>Relationship with physician (1 and 2)</i>	Listening and paying attention to needs and desires*; competence; guiding; trust*; respect
<i>Relationship partner/other</i>	Support*
<i>Fear of childbirth</i>	Confidence in one's body during labour; confidence in one's body during the second stage; on the whole, confidence in one's body; difficult to interpret body signals during labour*; difficult to interpret body signals during second stage*; on the whole, difficult to interpret body signals*; fear of giving birth; awareness of reason for fear of childbirth (yes/no)
<i>Pain during childbirth</i>	Fear of labour pain; fear of pain during second stage; pain during labour was positive; pain during second stage was positive; on the whole, pain was positive
<i>Sense of control</i>	Exciting to encounter the unknown; being in the process; no need of control if the staff had control*; no participation in decision/objectification*; need of control during labour; need of control during second stage; on the whole, need of control; check-ups basis for security during labour; check-ups basis for security during second stage; on the whole, check-ups basis for security*; I had control during labour*; positive/negative experience of control; I had control during second stage*; positive/negative experience of control, on the whole, I had control*; positive/negative experience of control
<i>Concerns for the child</i>	Hard childbirth for the child*; constant fear of complications to affect the child*; suffer pain for the child's sake*
<i>Total experience</i>	Confidence in own capacity*; feeling of strength; too severe demands*; feeling of failure*; the childbirth experience on the whole*.

* statements chosen for paper V

INDIVIDUAL BIRTH PLAN (an example)**Name****Civil Registration Number****Estimated date of delivery****Relationship to midwife, physician, partner/other relative**

I would like my husband to be present during the childbirth. Not too many people in the delivery room. I would like support from the midwife.

Fear of childbirth

I am afraid that something unexpected happens and that a state of emergency may occur that might influence my capacity to manage, mentally and emotionally. I am also afraid that a perineal rupture may occur.

Pain during childbirth

I have a fear of pain during the second stage. I also fear that something will happen to the child. I am afraid that I will not be able to cope with the pain. However I want the childbirth to be as natural possible. To achieve this I need great support.

Sense of control

I would like to be informed about what is happening. I certainly don't want to be disregarded.

Concerns for the child

I want it to be calm and peaceful and that the child should have as soft and pleasant birth as possible, for example, softened light, an avoidance of scalp electrode.

Other needs and desires

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