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Releasing and relieving encounters

Experiences of pregnancy and childbirth

BY

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Abstract

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The experience of childbirth is an important life event for women, which may follow them throughout life. The overall aim of this thesis has been to describe and analyse these experiences from the women's perspective as well as the encounter between the woman and the midwife, and the possibility that a birth plan might improve women's experience of childbirth. The setting has been the ABC-centre (Alternative Birth Care), antenatal clinics and Sahlgrenska University hospital in Göteborg, and Karolinska hospital in Stockholm, Sweden. The studies have used both qualitative (phenomenological and hermeneutic) and quantitative approaches. The essential structure of the experiences of pregnancy and childbirth may be conceptualised under the heading 'releasing and relieving encounters', which for the woman constitutes an encounter with herself as well as with the midwife, and includes stillness as well as change. Stillness is expressed as being in the moment; exemplified as presence and being one's body. Change is expressed as transition; to the unknown and to motherhood. In the releasing and relieving encounter, for the midwife stillness and change equals being both anchored and a companion. To be a companion is to be an available person that listens to and follows the woman through the process of childbirth. To be anchored is to be the person that in the transition process respects the limits of the woman's ability as well as her own professional limits. The 'releasing and relieving encounter' is not improved for women by a birth plan. Instead, in some aspects, the relationship between the woman and her midwife during childbirth is reported as less satisfactory if preceded by a birth plan although some experiences of fear, pain and concerns for the child might be improved.

Keywords: pregnancy, childbirth, women's experiences, encounter, pain, birth plan, hermeneutic, phenomenological, intervention study.

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To the woman giving birth and her care-giver

Original papers

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Contents

Introduction

While reflecting upon my experiences as a midwife, two issues have always been at the fore. First, in many conversations with women after childbirth I have been astonished over how differently the experiences of childbirth are expressed. Some women radiated harmony and happiness and told me that the experience has had a great positive influence on them. Only by looking at them I could notice that giving birth had been empowering and strengthening. However, I have also encountered women who told me that giving birth was their worst experience in life; a terrifying experience with fear of death, which they hope they will never experience again. These divergent experiences has engendered the following question; is the experience of childbirth to be understood as essentially private, thus as totally relative to the individual woman, or can it be related to external factors, such as societal norms and expectations or, e.g., the design of maternity care? Secondly, the issue of the societal views on childbirth has been of immense interest to me. In the 1980s, when I was educated as a midwife, prevalent media renderings of childbirth were dominated by ideals of natural childbirth and a strong critique of impersonal and authoritarian maternity care. Today, a prevalent theme in discussions on giving birth and experiencing pain during childbirth is that pain should be avoided by a planned and controlled caesarean section. Why endure or struggle with pain of giving birth if it can be avoided? Is questioning women's wishes for a planned caesarean section not patriarchal in character? In a way, this line of thinking is a reminder from the 1970s, when women's demands for painless childbirth gave Sweden a law stating that medical pain relief during childbirth is a prerogative.

The main aim of this thesis is to describe and analyse experiences of pregnancy and childbirth. To be able to understand these experiences the context of the birthing women must be described, e.g., the period, the culture, the ideas and the society surrounding the woman giving birth.[1] Therefore, a brief historical review will follow below, focusing popular ideas about childbirth during different periods. Little is known about pregnancy and childbirth

[1] According to Kitzinger (1989) childbirth is to be understood as a cultural artefact. Birth is a rite of passage which is not only important to the woman who becomes a mother, but usually also has special meaning for the father, the extended family of each, and the wider society within which birth takes place. In looking at the way people are born and how they die we have an opportunity to discover details about the social construction of reality and also about the dynamics in relationships between human beings in that culture (Kitzinger 1989). The societal variations in attitudes towards childbirth as either a natural event, a supernatural or sexual one, or an illness in need of treatment, largely determines whether the birth is a private or a social event, whether it is attended by a midwife, by the woman's mother, by in-laws or religious elders, and, finally, whether men, including the husband, may attend the delivery (Raphael-Leff 1991).

before the new medical paradigm was introduced in the seventeenth century. The cut-off point for the review will therefore be this period. The focus will be on how ideas about childbirth influenced the organisation of maternity care, views about pain during childbirth and understanding of normal birth and of complications during childbirth. Finally, after the historical part the above questions will be compared with present ideas of pregnancy and childbirth.

Historical ideas on pregnancy and childbirth

Before the new medical paradigm

In historical times, childbirth was mostly considered a matter for women and took place in, metaphorically, a closed holy room (Höjeberg 1981, 2000). However, some historical marks are known from, e.g., China and Ancient Greece. In Tao Te Ching, a book originally for the wise men of China, a woman giving birth is described (Heider 1986).

> *Imagine that you are a midwife; you are assisting*
> *at someone else's birth. Do good without show*
> *or fuss. Facilitate what is happening rather than*
> *what you think ought to be happening. If you*
> *must take the lead, lead so that the mother is*
> *helped, yet still free and in charge.*
> *When the baby is born, the mother will rightly say:*
> *'We did it ourselves!'*
>
> (Lao Tzus *Tao Te Ching,* 2500 BC,
> Interpreted by Heider 1986, p. 33)

Midwives are mentioned in philosophical texts from Ancient Greece. Midwives were respected, and besides assisting in childbirth they did some medical work, and were also, at times, matchmakers (Höjeberg 1981). During this period the term 'gynaecology' comprised all diseases affecting women, and childbirth was understood as an event having a beneficial effect on the whole female body. The midwife could be a female practitioner who assisted in childbirth but, because of the general understanding of the womb, menses and the whole female body, could also be of value in other female bodily disorders (King 1998). The Greek word for midwife is 'maia', which originates from Hermes, 'the Messenger of God', whose mother was called Maia. Hypocrites´, the father of medicine (ca. 460-370 BC.) and Socrates´ (ca 470-399 BC.) mothers were midwives. In the dialogue Theaetetus, Plato (428-345 BC.)

characterises Socrates dialogues as 'midwifery art' (Plato, interpreted by Warrington 1961, p. 77-78).

> *Apply to me as to a midwife's son who practices his mother's art. The art of midwifery as I practice it is very much like her. I have this in common with a midwife, that I cannot give birth to wisdom…the many grand truths, which they bring into the world, have been discovered by themselves and from within.*

These thoughts influenced the New Greek era, and, especially, the philosophy of Socrates was named Maietik – the birth of thoughts (Höjeberg 1981). Socrates used to say that he could not give his partners in conversation new thoughts, but only help them to give birth to their own thoughts (Herzberg 1990).

There are some historical notations that traditional midwives[1] called in special persons if problems during childbirth occurred. These persons could be Hippocratic healers (King 1998) or shamans (Larsson 2000, Höjeberg 2000). Central to shamanism is the belief that some individuals have the ability to direct contact with spirits, can make their souls leave their bodies to travel to the spirit world and to allow spirits to enter their bodies (Townsend 1997). During this period, leading astray the woman's spirit of life was thought to be the cause of complicated childbirth (Höjeberg 2000). The healing process, the co-ordination of the disintegrated female body is shown in 951 pictures from the Cunaindians in Panama (The Ethnographic Museum in Göteborg, Höjeberg 2000). In Christian societies it was believed that sins were the causes of complications during the delivery. This is exemplified in the novel called Kristin Lavransdatter (Undset 1995, p. 339). To assist in Kristin´s difficult delivery of the child she had conceived in secret her husband is called in.

> *If a women could not otherwise be delivered of a child she had conceived in secret, 'twas said it might help if she were set on the father's knee.*

[1] Traditional midwives or traditional birth attendants (TBA) is defined as 'a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants' (WHO 1992). As mentioned by Anderson & Staugård (1986) many TBAs are also providing prenatal and postnatal care, treating maternal and child illness. Therefore, the term 'traditional midwife' more accurately reflects the broader role played by traditional midwives. In this thesis the different terms, 'traditional midwives' and 'traditional birth attendants (TBA)' will be used interchangeably, depending on the use of the reported authors.

Thereafter the priest, as a special healer, is called in to assist in Kristin's difficult childbirth.

> *Even while the priest was speaking, it came to pass. Through the mother's weary, bewildered head there flitted, half remembered, the wisdom of a bud she had once seen in the covent garden- something from out of which broke red crinkled silken petals-and spread themselves out into a flower.* (Undset 1995, p. 343)

This model of traditional midwives for normal labour, and male healers only when something went wrong, is deeply ingrained in our reading of the past (King 1998). However, according to King (1998), the midwife's response to a difficult birth was often to call in another midwife. Also, Hippocratic healers were often women, and also male practitioners handled normal births. Thus, the debates arising from early modern times and re-enacted in the nineteenth century, are still in force today. Should a male practitioner be involved in normal childbirth and in what situations should an obstetrician be called? Who decides at what point the progress of labour is 'abnormal' (King 1998)?

How did women experience pain during childbirth during this period? Maybe pain was considered a smaller problem than it is today, due to generally harder living conditions? The struggle for survival in life and during childbirth was probably considered more momentous problems than the pain. According to Gélis (1991) it is difficult to find any documentation on childbirth pain until the end of the eighteenth century. Aristotle (384-322 f. Kr) suggested that pain is the suffering of the soul, '*pain and lust as well as all feelings of the senses has its source in the heart*' (Fridh 1988, p. 7). According to the Holy Bible (1978), pain is an unavoidable necessity during childbirth: '*I will greatly increase your pains in childbearing; with pain you will give birth to children.*' This quotation is a contributory cause to Western attitudes toward pain as the most central to childbirth (Heiberg Endresen & Bjornstad 1994). However, a translation from Hebrew of this quotation would rather lead to replace the word pain with the word effort, which would lead to a different meaning (Heiberg Endresen & Bjornstad 1994).

During the Middle Ages, disease and pain were often perceived as punishments for wickedness and sin (Simkin 1989). Midwives drew heavily on their practical knowledge of plants, foods, drugs, poultices, rituals and good luck charms, as well as on their wisdom and experience to help women during childbirth (Wertz & Wertz, 1977). Entangled in all these roles the traditional midwife had an exposed position, held dangerous knowledge. 'Churel',

the childbirth demon and the sorceress that midwives were assigned to protect and warn against, became the demon midwives were compared with and tied to (Højeberg 2000). Such departures from religious doctrine did not go unheeded and at times midwives were condemned as witches (Simkin 1989).

The new medical paradigm

With the Renaissance new attitudes prevailed; thinkers and scholars in the Age of Reason questioned accepted dogma, and mastery over Nature became an explicit goal during the Enlightenment (Simkin 1989). Pain and suffering as the result of sin were no longer passively accepted; they were now perceived as natural phenomena which could be studied, controlled, altered, or wiped out (Caton 1985). This understanding was also coherent with new medical science and the development of obstetrical knowledge. The period was influenced by Descartes' (1596-1650) thoughts, with his dualism between body and soul, and between physical and mental substance, which has had an enormous impact on western thinking (Bengtsson 1988).

With the new medical paradigm and the ascent of natural science at the end of the seventeenth century, male doctors began to enter the childbirth room (Öberg 1996). A transformation from a closed, holy room to an open public room began to take place (Højeberg 2000). In Sweden this process started with the formation of 'Collegium Medicum in 1663' (Öberg 1996). A Swedish doctor, Johan von Hoorn, had learned 'the art of childbirth' by experienced midwives and barber-surgeons in Paris (Faxelid et al 1993). At the French and German courts, Louyse Bourgois (1564-1636) and Justine Siegemundin (1670-1750) practised as midwives. They also wrote two of the first midwifery books (Öberg 1996). Von Hoorn wrote the first midwifery books in Sweden[1], and he also started midwifery education in Sweden and the first midwives were educated in 1712 (Højeberg 1981). Thus, the licensed midwives became, as the first female occupational group, part of the official Swedish medical system (Romlid 1998). The need of the state for a large and healthy population, and the desideratum to strengthen the position of medical science, created a situation in which it was necessary to allow licensed midwives to fill a major role within maternity care and the public health sector. For instance in 1829 they were given the unique, by international comparison, right to use obstetrical instruments (including sharp tools) (Romlid 1998).

[1] Den svenska wäl-öfwade jord-gumman (1697), and Siphra och Pua (1719)

Although one of the most important objectives of the new medical paradigm was to save mothers and children's lives there were problems with the establishment of licensed midwives in the country (Romlid 1998). First, all education took place in Stockholm and educated midwives and doctors were few in numbers. In addition, the new paradigm was also met with popular resistance, direct protests such as letters and complaints to the Crown and indirectly, as in resistance against engaging licensed midwives (Romlid 1998). The system of traditional midwives was deeply rooted in society. The usual explanation given for not hiring a midwife was that it was too expensive and also unnecessary, since traditional midwives were considered just as good (Romlid 1999).

Both licensed midwives and doctors were carriers of the new medical paradigm and had to fight traditional understanding of and customs of childbirth (Romlid 1998). The new medical paradigm was associated with progress, modernity, rationality, reason and enlightenment (Romlid 1998), all of which was contrasted with excluded medical practitioners, such as traditional midwives, who were associated with ignorance, irrationality, superstition, prejudice, and, generally, with obsolete traditions. Helena Malheim, a midwife working in the eighteenth century exemplifies this: '*The midwife does not allow superstition a room*'[1] (Höjeberg 1995, p. 20). Malheim wrote a book on midwifery in 1756 and sent the manuscript for publication to 'Collegium Medicum' in 1758, but it was turned down (Höjeberg 1995). Two hundred years later Höjeberg and two historians found the book and it could be published. Von Hoorn (1697) also wrote about problems with traditional birth attendants.

> *...now degenerated into the hands of drunken women without conscience, who serve, and maltreat their fellow human beings to get a piece of bread. Instead of helping a woman who is tormented by fear of death, they wish to be near food and drink*[2]

In Malheim´s midwifery book from 1756 we see an attempt at defining normal birth (Höjeberg 1995). In writing her book Malheim was influenced by von Hoorn. The German midwife Siegemundin, in turn, had inspired von Hoorn´s book on midwifery. In that way,

[1] My translation. The original Swedish text is: Barnemorskan låter icke widskippelser, som annars hoss gemene man äro nog rotade, få något rum.
[2] My translation. The original Swedish text is: Nu förfallit uti många Samvetslösa Fyllkiäringars händer, som mer betiena, ja misshandla theras Nästa för et stycke Bröd skul, och at the må allstädes få wara med Fingren uti Fatet och med Näsan uti Kannan än at hielpa en uti Döds-Ångest swäfwande Hustru uti des swåra Barn-Fänge"

Malheim's book is characteristic of the period, a transition period from traditional midwifery to the scientific, medical period (Höjeberg 1995, p. 57).

How can you distinguish a natural childbirth from an unnatural?
If the mother is sick
And has problems with her physical constitution
And a weak foetus
And the position of the foetus is askew
Or both at once
Leading to prolonged labour
Then it is an unnatural childbirth.
As for example
When the mother is losing a lot of blood
Or has a stroke
When the baby has a foot presentation with the umbilical cord
Or wrong presentation of the head
And with the umbilical cord around.[1]

The medical paradigm was strengthened at the beginning of the nineteenth century, when an act restricting medical quackery was established in 1809. However, it was not until 1908 that municipalities became obliged to employ licensed midwives. Also, the government did not introduce subsidised wages until 1920 (Romlid 1998). At the beginning of the twentieth century, 20% of the women in northern Sweden and 10% in southern area were still assisted by traditional birth attendants.

Hospitalisation of maternity care is considered a key factor in establishing the new medical paradigm (Öberg 1996, Romlid 1998). Stockholm was the first city in the world to set the transformation from home birth to hospital births in motion, and Sweden the first country with a majority of hospital births (Öberg 1996). Allmänna BB in Stockholm was established

[1] My translation. The original Swedish text is:
Huru kan man åtskilga en naturlig förlosning ifrån en onaturlig?
När antingen af moderns Siuklighet
och swåra krops Constitution
eller fosterets swaghet
och galna stälning eller beges tilika
förwållande något swårt oordenteligit
och födseln hindrande sig til drager,
är det en onaturlig förlosning
Som til exempel
när modren får blodgång
anstöter af slag
när barnet kommer först fram med
en fot gumpen nafwelstrengen
med garlit wänt huvud
och genom nafelstrengen beswär(a)d kropp.

in 1775 and Sahlgrenska Hospital in Göteborg had two beds for childbirth in 1782. At the beginning, only poor women who wished to be anonymous were giving birth at hospitals (Höjeberg 1981). At the end of nineteenth century, 90% of the childbirths took place at home in Sweden. In 1940 there were 35% home births and in 1960 only 5% (Öberg 1996). In Sweden, community midwives, who were assigned to assist women who wanted a home birth, were replaced in the 1960s, with antenatal midwives, who were not involved in deliveries. With this change of maternity care, home birth disappeared as an option in public health care in Sweden.

The hospitalisation of childbirth led to great changes in attitudes towards birth. In the hospitals there were no place for old birth traditions, and the terminology seemed strange for the women (Faxelid et al 1993). Male doctors took control over childbirth and female midwives. Empirically based knowledge about childbirth and baby care became less valued and superseded by new highly esteemed scientific knowledge. The new science was a matter solely for male doctors, because women had no entrance to science (Öberg 1996). According to Öberg (1996), this process led to a firmly established nation wide gender hierarchy in maternity care.

The hospitalisation of childbirth was not only a matter of concern for the health care sector. According to Johannisson (1991), it was coincident with the establishment of the concept public health as a political goal in Sweden. This process took place in agreement between doctors, politicians, and civil servants (Johannisson 1991), over the establishment of a novel project, the modern rational maternity care.

Normal deliveries remained the professional domain of midwives, whereas complications became a growing area of competence for doctors and for obstetrical science (Öberg 1996). Therefore, there is an absence of historical documents-especially written by women - covering ordinary (everyday) births among rural women. The documents, from the seventeenth century and onwards, were mostly written by male doctors and surgeons describing extraordinary births, that they as doctors were called to, or births among urban elite, or in institutions (Holmqvist 2000). As a consequence, normal deliveries, or ‘ordinary births’, seldom figured in scientific texts and often were invisible in scientifically informed contexts. Accordingly, the stock of knowledge about normal births that midwives had and transmitted to others became ‘tacit knowing’. In Polanyi´s (1983) characterisation of tacit, practical

knowing, the individual relies on and is aware of that her/his knowledge is founded in previous practical experience. Tacit knowing is seldom written down and often transferred from generation to generation of practitioners.

Ideas on pregnancy and childbirth today

In contemporary Western societies, the prevailing views on childbirth are strongly influenced by increased hospitalisation and by the focus on complications that started in the seventeenth century, and by the still dominant mind-body dualism (Bengtsson 1988). The predominant view is that childbirth is a medical crisis (Kitzinger 1989). Furthermore, the body is seen as merely a kind of machine, mechanism governed by laws of physics, while the human soul is seen as different and separated from the body (Bullington 1999). These views, when summarised, form what may be labelled 'the worst scenario', leading to an organisation of maternity care focusing on the worst that can happen during childbirth (Kjölsrud 1992).

The main advantage of the medical perspective on maternity care is its ability to handle complications, shown in evaluation based on morbidity and mortality rates (Bergum 1997, Kloosterman 1991). Very low infant and mother mortality rates are indices of a very safe maternity care in contemporary Western countries. In an international perspective, the maternal mortality rates of the poorest countries of the world are over 200 times higher than in the richest countries. In Sweden we have to go back as far as to the middle of the eighteenth century to find similar mortality rates (Höjeberg 1981, UNICEF 1998). However, maternal mortality rates must also be related to the huge discrepancies in general living conditions.

However, some consequences of the prevailing medical perspective have been more and more questioned and problematzied. The narrow focus on the medical aspects or on the outcome of childbirth has led to that less attention is paid to the experience (Davis-Floyd 1997, Kitzinger 1989, Bergum 1997, Holmqvist 2000), and to the majority, to women with normal childbirth (Kjölsrud 1992, WHO 1996, Oakley 1984). Repeated warnings that there is a risk that we conflate care during normal childbirth to care during complicated childbirth are raised (WHO 1996). Such a conflation has several dire repercussions: it carries the potential of transforming

a normal physiological event into a medical procedure, it interferes with women's freedom to experience the birth of their children in their own ways, at a site of their own choice; it leads to unnecessary interventions, and, due to demands for economies of scale, its application requires a concentration of large numbers of labouring women in technically well-equipped hospitals, with concomitant increases in costs (WHO 1996).

An additional problem with the medical perspective is increased technology. This has engendered greater demands on midwifery staff to oversee equipment, leaving them less time to offer support or even to be with the woman in labour continuously (Chalmers & Wolman 1993). There is also a risk that pain during childbirth is treated as equivalent to pain caused by disease, since childbirth is now primarily a medical event, occurring in an atmosphere associated with disease and death (Bergum 1997). But may pain during childbirth, a normal event in life, in fact be compared to pain caused by cancer or by other diseases? (Bergum 1997) Chloroform was introduced at childbirth in the mid-nineteenth century, and given a huge boost in acceptance when Queen Victoria used and enjoyed it for the birth of her eighth child in 1853 (Wertz and Wertz 1977). Twilight sleep (a mixture of scopolamine and meperidine) was used widely in Europe before and after World War I. The demand for a painless childbirth in the early 1900s originated and was kept alive by childbearing women who equated pain with danger and freedom from pain with safety (Simkin 1996). Most American physicians were at first opposed to the new drug. Women often perceived physicians who opposed the use of twilight sleep and general anaesthetics as old-fashioned, sadistic, and anti-woman (Sandelowski 1984). The introduction of anaesthesia and pain medication in childbirth has always been accompanied by protests from professional and lay people of varying persuasions; common claims have been that medication is too complex and unsafe, that it could rob a woman of the pain considered necessary to ensure that she will love her baby, that it is defying of God's will, and that the emotional state is the underlying factor which leads to painful perceptions of labour (Simkin 1989). Today a common attitude to pain is that it should be denied, by replacing the word pain with the word contractions and by the promotion of positive attitudes (Bergum 1997). However, while a birthing woman's positive attitude may be of great value, denial of pain may create expectations not borne out in reality. What, more exactly is being denied in the denial of birthing pain? (Bergum 1997) Another common assumption today is that pain must, without exception, be relieved with drugs, which may result in loss of touch not only with our painful sensation but also with ourselves. (Bergum 1997). Today, pain is described either in physiological term, as a response to outer

sensations and physiological stimuli, as the body's way to signal a hazard, or in existential terms (Mahon 1994). These theories and explanations contribute to our understanding of pain, but they also fragment the sense of wholeness in the pain experience (Bergum 1997).

Consequently, an analysis of the concept normal birth is material for midwifery practice, as the medicalisation of childbirth increases (Socialstyrelsen 2001, Gould 2000). An analysis of the concept is also of importance for the co-operation and the division of responsibility between midwives and doctors (Socialstyrelsen 2001). If normal birth were to be defined as a spontaneous childbirth without interventions (such as medical pain relief and augmentation of labour) less than 10% of all childbirths in Sweden today would be classified as normal births (Socialstyrelsen 2001).

Due to the problems in defining a normal birth, WHO (1996) as well as The Swedish National Board of Health and Welfare (2001), have summarised the state of knowledge, and issued practical recommendations for maternity care. The definition of normal birth according to WHO (1996, p. 6) is.

> *We define normal birth as: spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition.*

All Western countries have the same way of thinking about childbirth as a medical crisis, except the Netherlands in which pregnancy and childbirth are considered normal physiological processes (Hingstman 1994). Almost 31% of all deliveries are home confinements under supervision of a midwife or a general practitioner, and maternity care assistants give 84% of all postnatal care at home. According to Hingstman (1994), the structure of Dutch obstetric care is characterised by; a special, protected position of the midwife, a generally accepted screening system for high-risk pregnancies, and a well-organised maternity home care system.

In many contemporary traditional societies the prevailing views on childbirth can be recognised from historical times. Psychological aspects of the experience and the quality of relationships between those involved are believed to affect the progress of labour. Someone else's anger or envy, unresolved conflict between the father or mother and other members of

the community, or parents sexual misdemeanours can, it is believed, delay dilatation (Kitzinger 1989). Traditional birth attendants (WHO 1998) today deliver approximately 50% of the women of the world. The role of the traditional midwife is complex, routed in the culture and the society. She is a representative of the society, and her role is to mark out boundaries (Höjeberg 2000), functions as a shepherdess between being and non-being, as a spiritual adviser, and as a mediator between worlds of life and death and, finally, as an orchestrate of female mysteries (Kitzinger 1989). During childbirth, the traditional birth attendants' most important role is as a masseur (Höjeberg 2000, Hedstrom & Newton 1986, Anderson & Staugård 1986). According to WHO (1992) traditional birth attendants (TBA) have a role in supporting women during labour, but are not generally trained to deal with complications. Most maternal deaths could be prevented if women had access to basic medical care during pregnancy, childbirth and the postpartum period (WHO 1998). Where the use of TBAs is strongly rooted in local customs, it is highly beneficial to train TBAs to recognise danger signals and to become accustomed in referring complicated cases to higher-level care, to establish linkages between TBAs and the general health care system, and to ensure that health centres and hospitals will accept referrals from TBAs (WHO 1998). Many women turn to TBAs because doctors and licensed midwives are not available or cost too much, or because TBAs are neighbours or friends who know local customs and respect women's needs (Davis-Floyd 2000, Fortney 1997, Anderson & Staugård 1986). A study from Yemen found that a large number of rural women found that the contact with modern health care was dissatisfactory. Major points of concern were the quality of client-care provider interaction, freedom of choice with regard to delivery position, availability of psycho-emotional and practical support and a sensitive approach to the bonding process between mother and child (Kempe 1996).

There have been protests against the medical perspective on childbirth, especially during the 1970s and 1980s. Back-to-nature and do-it-yourself movements grow a more general interest in natural childbirth and personal autonomy. Home birth, midwifery care and breastfeeding made a comeback among the trend-setting, well-educated middle class (Simkin 1996). Communication difficulties (Cartwright 1979, Kirke 1980, Macintyre 1982, MacIntosh 1988) and negative childbirth experiences (Lagerkrantz 1979) were the main causes of complaints among women during this period. As a result of voiced demands among women, the Swedish parliament gave all women the prerogative to pharmacological pain relief during childbirth (Socialstyrelsen 1978). However, in the 1980s, requests for a more natural maternity care with

fewer interventions, such as pharmacological pain medication arose (Faxelid et al 1993). Alternative Birth Care (ABC) centres were developed as a response to these requests to move away from institutionalised maternity care. The characteristics of ABC centres are that they provide midwifery-led care, continuity of care, restriction of medical technology, and finally, seek to promote parental responsibility and self-care (Waldenström 1993a). Lack of continuity in the care form pregnancy to childbirth is recognised as a problem for Swedish maternity care, since midwives in hospitals and within the primary health care have different employers (Socialstyrelsen 1996). In addition to ABC-centres, birth plans were introduced in the 1980s in order to help women to be more in control of occurrences during childbirth (Kitzinger 1983). A birth plan allowing options to be considered in advance and choices to be made about some of the contingencies that might happen during childbirth (Kitzinger 1988, Kitzinger 1983). It may take a variety of formats: a list of things which might occur during labour which the woman ticks as acceptable, a list with 'yes' or 'no' options, or a more open format with headings as prompts (Whitford & Hillan 1998). Although birth plans have been introduced to help woman to an improved experience of childbirth, the numbers of studies that evaluate the effect of birth plans are limited. Whitford and Hillan (1998) found that even if the use of a birth plan did not affect the degree of control felt by women, most women found that the process of completion of a birth plan valuable. However, according to Too (1996a) some women prefer midwives to exercise control and decision making, and a birth plan may offer meaningless choices for the woman.

During the 1990s a new attitude to childbirth emerged, in which the ultimate 'guarantee' of safety is believed to be a caesarean section (Simkin 1996). One explanation proposed in the North American context was the pressure from the legal profession (Simkin 1996). The public, in Western countries, and especially in the USA, has been accustomed to look for someone to blame and punish when untoward events occur. Obstetricians have become prime candidates to punish if something goes wrong, and thereby insurance companies have influenced obstetric care (Simkin 1996).

> *Today, both parents are likely to be working long hours and have little time to learn and less interest in learning about pregnancy and birth. The woman may seek personal fulfilment from her career or other avenues rather than from giving birth. Childbirth is a means to the end of parenthood, and how it is done does not seem all that important to most pregnant woman today. Birth is seen as a lot of pain and effort, and anything that can ease the process for the mother is desirable, as long as the infant can be brought safely through the birth* (Simkin 1996, p. 250)

Women's experiences of pregnancy and childbirth – a literature review

Even though past research has been more focused on the outcome than on the experience of childbirth, there are a few recent studies focusing on women's experiences. These studies have, however, been more centred on childbirth than on pregnancy. Hitherto, psychological and psychoanalytical approaches (Reid & Garcia 1989, Bondas 2000), describing pregnancy as a crisis (Raphael-Leff 1991), have dominated the research. Ergo, there is a lack of knowledge about women's experiences of normal pregnancies (Imle 1990), and of descriptions of the perinatal period that take their point of departure in the birthing woman's life-world (Bondas 2000). Yet, pregnancy may also be described as a transition (Imle 1990). According to Shumacher and Meleis (1994) transition implies process, direction and change of fundamental life patterns. Factors that affect positive transitions are subjective well being, role-mastery, and the well being of relationships. Transition during pregnancy may be described as 'being with child', a paradox of joy and suffering (Bondas 2000). This process is characterised as an altered mode of being when women's bodies change; variations in moods and worries related to their own health, as well as to the baby's and the family's health, the delivery and the future (Bondas 2000). According to Bergum (1997), the presence of the baby is an essential part in the transformation to motherhood. Mothers experience the baby as a person at varying times during pregnancy and birth, and some do not see their babies as genuine persons until after the birth (Bergum 1997). Olsson´s research (2000) reveals that there is a reductive tendency in antenatal care to understand the transition to parenthood as mainly a female bodily risk. Women's bodily capacities, and the complexities of the emotionally, socially, and existentially unique transitional experiences of the childbearing families are but seldom considered.

The research related to childbirth indicates that the experience of childbirth is an important life experience for women, which may follow them throughout life (Simkin 1992). The quality of this experience has an impact on the future wellbeing of the woman, and the child, and on the relationship between mother and child (Lagerkrantz 1979, Oakley 1983, Green et al 1990, Morris-Thompson 1992), and the relationship between the woman and her partner (Brudal 1985). Features, such as pregnancy-related factors, complications, expectations, pain, the organisational form of care, and support, all influence women's experiences of childbirth.

Pregnancy-related factors, which bear a negative influence on the experience of childbirth, are unplanned pregnancies, previously terminated pregnancies (Salmon & Drew 1992), and fear of childbirth in late pregnancy (Areskog et al 1983). Fear of childbirth is correlated to complications during childbirth (Sjögren & Thomassen 1997), and to difficulties in the attachment to the child in the immediate postnatal period (Areskog et al 1983).

Complications during childbirth affect the overall experience of childbirth (DiMatteo et al 1996, Salmon & Drew 1992, Ranta et al 1995, Séguin et al 1989, Waldenström, 1999). Caesarean section is understood as a less difficult, yet also as a less fulfilling and more distressing experience (Salmon & Drew 1992) than vaginal birth, often signifying a negative experience of birth (Waldenström 1999, Séguin et al 1989). Caesarean mothers, compared with mothers who delivered vaginally, express less immediate and long-term satisfaction with the birth, are less likely ever to breast-feed, take much longer time to the first interaction with their infants, express less positive reactions to their new-borns after birth, and finally interact less with them at home (DiMatteo et al 1996). Instrumental deliveries (caesarean section and forceps) (Ranta et al 1995), and instrumental vaginal delivery (Waldenström 1999) are associated with a negative birth experience. On the other hand Salmon and Drew (1992) found that forceps and unassisted deliveries are experienced in similar fashions.

There are but few studies that evaluate women's **expectations** and experiences of childbirth (Green et al 1990, Gibbins & Thomson 2001). Results indicate that high-risk pregnant women have significantly less positive expectations for their childbirth experience than low-risk pregnant women (Heaman et al 1992). Low expectations are related to a negative experience, but high expectations are not, per se, to be understood as detrimental to women (Green et al 1990). Attendance at one specific type of antenatal class could be seen as correlated to more fulfilling birth experiences (Salmon & Drew 1992). Primipara who had received prenatal

childbirth training had lower pain scores than those who had received no such training, although the effects registered were relatively small (Melzack et al 1981).

Pain during childbirth affects the total birth experience (Séguin et al 1989, Mackey 1998, Waldenström et al 1996, Reading & Cox 1985, Waldenström 1999). Pain is associated with a negative experience (Séguin et al 1989, Waldenström 1999, Mackey 1998), and post-partum mood (Reading & Cox 1985). On the other hand, Salmon et al (1990) found that the degree of pain could not alone define or exhaust the experience of childbirth. The complexities of pain during labour have been described by Waldenström et al (1996) Even if pain during childbirth is characterised as a very severe pain (Melzack 1993, Niven & Gijsbers 1984) it is not described as an entirely negative experience (Waldenström et al 1996). Additionally, pharmacological pain relief need not always be connected with a positive experience of childbirth. According to Waldenström and Nilsson (1994), women giving birth at Birth Centre Care units, who were supported in avoiding pharmacological pain relief, had slightly more positive birth experiences than women giving birth at traditional maternity wards. A study comparing experiences of childbirth in Norway in 1969 and in 1986 displayed no differences even though maternity care and use of pharmacological pain relief had undergone considerable changes during the period (Lind & Hoel 1989).

Control, information, choices and taking part in decisions may all be linked to positive experiences of childbirth (Green et al 1990, Kaufman 1993, Fleissing 1990, Waldenström & Nilsson 1993b, Seguin et al 1989, Walker et al 1995, Hodnett 1996). Control is often understood as being able to control what is being done to one during childbirth (Green et al 1990), but can also mean to be able to flow with the body (Green et al 1986). Through team midwifery, an **organisational form** that emphases continuity, women are cared for by a midwife they know beforehand, women are supported in gaining more control during labour (Flint 1991, Enkin et al 1995, NCT 1995, Walker et al 1995, McCourt 1998). Team midwifery can be related to more positive childbirth experiences for women (Flint 1991, Rowley et al 1995, Hodnett 1997, Waldenström et al 2000). Birth centres that provide care by the same caregivers during pregnancy, childbirth and postpartum is another example of continuity. Waldenström and Nilsson (1993b) found that birth centre women expressed greater satisfaction with antenatal, intrapartum, and postpartum care especially the psychological aspects of care. Another study by Waldenström (1998), however, shows that the levels of satisfaction of women having birth centre care were probably more affected by

the attitudes of the carers, the prevailing philosophy of care, and the generally nice and calm environment than by the fact that the birthing women were fairly well aquatinted with a specific midwife.

One of the most significant aspects of the global birth experience is **support** (Hodnett 1999, Waldenström 1999, Lavender et a1 1999, Socialstyrelsen 2001). Support is a factor that increases breastfeeding rates, has a positive impact on mother-child bonding, and produces fewer interventions (Hemmiki et al 1990, Hofmeyr et al 1991, Zhang et al 1996). Support during childbirth also reduces the duration of labour (Klaus et al 1986, Zhang et al 1996). The support offered should include, 'continuous presence, the provision of hands-on comfort, and encouragement' (Hodnett 1999, 10, p 1). Support during childbirth can be provided by fathers, families, friends, trained supporters, untrained lay supporters, obstetricians and midwives (Chalmers & Wolman 1993). In comparing doulas and fathers, doulas were found to spend significantly more time talking to mothers in both early and late stages of labour. Doulas also spent more time than fathers rubbing, stroking, clutching and holding mothers during early and late labour (Bertsch et al 1990). The effectiveness of father's support remains unclear (Chalmers & Wolman 1993). Support given by trained or lay untrained female supporters, who were not previously known to the labouring woman, yields the most extensive, methodologically reliable, and consistently positive effects, as concerns obstetric and psychosocial outcomes (Chalmers & Wolman 1993). Support received from midwives has been focused in some studies by describing the relationship between the woman and the midwife from women's perspectives. The midwife can be described as 'caring/empowering' vs. 'uncaring/discouraging', as a 'cold professional' vs. 'warm professional', and as a friend (Halldorsdottir & Karsldottir 1996a, McCrea et al 1998, Walsh 1999). The relationship between the woman and the midwife also has an impact on the birthing woman's experience of pain. A good relationship between the midwife and the woman during childbirth will generally speaking be conducive to alleviation of pain (Niven 1994, Bergum 1997). Despite the evidence indicating the relationship between the midwife and the woman as a determinant for the quality of the childbirth experience, there is a notable lack of research regarding midwives´ experiences of participating in this relationship, and even less regarding the emotional issues involved (Hunter 2001).

Research area and aims of the study

To sum up, since childbirth became a matter for science in the seventeenth century the main focus has been the outcome of pregnancy measured in infant and maternal mortality rates. Thereby women's experiences have been less in focus. Even if there are some later research about women experiences, few of them is focusing solely on pregnancy and very few are directed at women's perspective on the phenomenon. However, there are several studies that evaluate women's overall experiences of childbirth. These studies indicate that childbirth is a momentous life experience following women throughout life. The character of this experience has implications for the future wellbeing of the woman, the child, the relationship between mother and child, and the relationship between the woman and her partner. The structuring and management of maternity care are factors that affect women's experiences of childbirth. Different forms of continuity from pregnancy to childbirth are proven to be beneficial for women. One example of continuity is birth plans, allowing options to be considered in advance, and choices to be made about some of the things that might happen during childbirth. However, studies that evaluate if birth plans are improving women's experiences of childbirth are few in numbers. All in all, the most pivotal factor for a positive childbirth experience for the birthing woman is support, which can be provided by professionals as well as by families. Support received from midwives affects women's experiences of childbirth not only in modern western contexts of birth, but also in contemporary traditional societies. Support received from midwives has been described in some studies through the relationship between the woman and the midwife from the woman's perspectives. However, there is a lack of research regarding midwives´ experiences of participating in this relationship.

Therefore the aim of the research within this thesis has been to describe experiences of pregnancy from women's perspective. Additionally, the aim has been to describe experiences of childbirth by focusing on support received from midwives. A final aim of the study has been to determine if a birth plan could improve women's experience of childbirth.

Methods

To be able to enter deeply into the experience of pregnancy and childbirth a qualitative approach is called for, and consequently a life-world approach grounded in phenomenology and hermeneutics was chosen. To determine if a birth plan could be proven to improve women's experiences of childbirth a quantitative method is suitable. The study design is exemplified in Figure 1.

Study	Participants	Setting	Method	Data-gathering
III: Women's experiences of pregnancy	12 women: 8 primiparae 4 multiparae	Sahlgrenska University Hospital, ABC, Göteborg 1996-1997	Hermeneutic/ Phenomenological	Anonymous diaries
I: Women's experience of the encounter with the midwife during childbirth	18 women: 6 primiparae 12 multiparae	Sahlgrenska University Hospital, ABC, Göteborg, 1994	Phenomenological	Interviews
II: Women's experience of pain during childbirth	9 women: 4 primiparae 5 multiparae	Sahlgrenska University Hospital, ABC, Göteborg, 1995	Phenomenological	Interviews
IV: Midwives experience of the encounter with women and their pain during childbirth	9 midwives	Sahlgrenska University Hospital, Göteborg, and Karolinska Hospital, Stockholm, 2000	Phenomenological	Interviews
V: Is childbirth experience improved by a birth plan?	542 women	Sahlgrenska University Hospital, and 7 antenatal care units, Göteborg, 2000-2001	Intervention	Questionnaire

Figure 1. Study design

Phenomenology

The word 'phenomenon' is derived from the Greek word 'phainomenon', which means 'that which appears or presents itself to consciousness'. With phenomenology Husserl challenged philosophers to 'go back to the things themselves' (1965, p. 102), and study the everyday world as it appears, varied and complex, by adopting what he called a life-world approach. Husserl was critical of scientific reductionism, as presented in the view that natural science offers the superior methods to truth. This monolithic understanding of science distances it from the common everyday world and engenders crisis of confidence, according to Husserl. Instead, he wanted science to do full justice to mundane prescientific experiences, to lived human experience (Dahlberg, Drew & Nyström 2001). The things of which Husserl spoke are not to be understood as existing solely in themselves, but as things of perceptual experience. Phenomenologically expressed, 'going to the things themselves', means that, as researchers, we must seek to position ourselves so that these things may appear to or present themselves to us. Thus, 'the thing' is understood as a phenomenon. Husserl envisioned science to be part of the world, instead of holding a remote and elite position. This means that science must acknowledge its origins in the life-world, the world as experienced by humans (Dahlberg et al 2001).

The life-world approach was further developed by Merleau-Ponty, a French philosopher (1908-1961). The lifeworld is characterised by Merleau-Ponty (1995, IX) in the following way:

> *To return to the things themselves is to return to the world, which proceeds knowledge, of which knowledge always speaks, and in relation to which every scientific schematization is an abstract and derivative sign-language as is geography in relation to the countryside in which we have learned beforehand what a forest, a prairie or a river is.*

In order to be able to turn to, and being sensitive to 'the things themselves', research based on a life-world approach needs openness. Openness means that as researchers we make ourselves available to the world, to the phenomenon of interest, as it presents itself (Dahlberg et al 2001). This means a true willingness to listen, see, and understand. It involves respect, and certain humility toward the phenomenon, as well as sensitivity and flexibility. An open approach also needs an awareness of the intersubjective influence on the research situation. This means that the researcher shall hold her/his own experience of the phenomenon back as

much as possible in favour of the experience of the informant, so that the unequal relationship is formed in favour of the informant (Dahlberg et al 2001).

The phenomenological method is guided by some basic principles. According to Giorgi (1997), a phenomenological method entails pure description. First, the analysis is based on the subjects' descriptions, concrete and experiential descriptions of the investigated phenomenon. Second, this method also implies a solely and purely descriptive analysis of the data. In other words, no interpretation is recommended. On the contrary, Giorgi emphasises that the overall aim is to stay close to the phenomena, precisely as they are presented. Giorgi (1997) further advises researchers within phenomenology to adhere to what is called 'the phenomenological reduction'. This means that the researcher holds in abeyance theoretical and experiential knowledge, all preconceived notions or expectations, that, if unheeded, would interfere with an open-minded and pure description of the phenomenon. During analysis, the researcher moves from an understanding of data, e.g. an interview text, as a whole, through understanding the single meaning units of the text, to a new whole where the essential meaning of the phenomenon is illuminated (Dahlberg et al 2001).

Hermeneutics

Hermeneutics and phenomenology are broad and rich philosophical and empirical traditions, each with a distinct line of development, but with a common ground (Dahlberg et al 2001). The word hermeneutics is derived from Hermes, the Greek deity who was known as 'The Messenger' of the gods and who interpreted theses often obscure godly messages to humans (Sjöström, 1994). Principles of hermeneutic biblical interpretations date from the seventeenth century (Dahlberg et al 2001). The German philosopher Schleiermacher (1768-1834) introduced hermeneutics as a systematic method for interpretation, as well as a theory of understanding the act of understanding itself (Dahlberg et al 2001). One of the hallmarks of hermeneutic research is 'the hermeneutic circle' introduced by Ast (1778-1841), a forerunner too Schleiermacher. This means that an understanding of the relationships between the whole and the parts can be done only in relation to the whole. The purpose for hermeneutic interpretation is to search for the deeper, underlying, and at times hidden meanings inherent in data and to transform the unknown into something that can be understood by others. Finally, a new whole, a main interpretation is offered as a form of structure at a higher level of abstraction than the earlier interpretations during the process of analysis (Dahlberg et al 2001).

The qualitative studies

Methods for data gathering in research based on a life-world approach could be interviews and narratives. The research interview is characterised by openness, by a genuine willingness to listen to, see, and openly understand a phenomenon (Dahlberg et al 2001). However, the research interview differs from everyday dialogues and conversations, since the researcher maintains the initiative and controls the interview, i.e. it is not mutual and accidental in the same way as everyday dialogues. The opening questions aim at directing the interviewee's thought toward a certain area of interest. An example could be: 'Can you tell me about your experience of pain during childbirth?' After the initial question the initiative is handed over to the interviewee, who the researcher must follow in an open-minded way. The questions now presented are aimed at clarifications such as 'What do your mean, can you give me an example?' To follow or to be attentive towards the interviewee may also mean to be silent and patiently wait for the answer.

The main reason for collecting data in the form of written narratives are to obtain data that are optimally undisturbed by the researchers (Dahlberg et al 2001). As soon as the researcher and informant have come to an agreement, the informant who, is asked to produce a narrative, is left by the researcher, who is absent when data are being developed.

The participants and settings of the studies are presented in Figure 1. Interviews were used in three studies (study I, II, and IV) for describing experiences of the encounter between the woman and the midwife. The women/midwives were interviewed on one occasion by one interviewer. The interviews were conducted in a private setting in the hospitals and lasted between 45-75 minutes. The initial question was: 'Can you tell me about the experience of the encounter/pain during childbirth?' The women/midwives were encouraged to describe their feelings about and experiences of the event.

Anonymous diaries were used in one study, focusing on women's experience of pregnancy (study III). During the first visit to antenatal care unit in early pregnancy; both primiparous and multiparous women were invited to participate. The diary was divided into three parts: the first trimester (0-13th week), the second trimester (14th-26th week), and the third trimester (27th-40th week). The women were asked to express their reflections and experiences during the different phases of pregnancy (first trimester, second trimester, and third trimester).

Women's experience of the encounter with the midwife (Study I), pain during childbirth (Study II), and midwives experience of the encounter with women and pain during childbirth (Study IV) were analysed following a phenomenological approach. Besides some differences in use of references the analysis of these three studies was following the descriptions of Dahlberg et al (2001) and Giorgi (1997). The interviews were transcribed and, primarily, analysed by the interviewer. Each interview was first read to bring out a sense of the whole, and after that meaning units were marked. The meaning of the text was organised into different clusters by 'unpacking' the meaning of the text and relating the meaning units to each other. In the final operation, the essence of the investigated phenomenon, a description of what has been revealed was formulated. Through a transformation from the subjects' naïve descriptions to a language designed to be meaningful for midwifery, a new understanding of the phenomenon was developed.

The diaries describing women's experiences of pregnancy were interpreted hermeneutically (Barbosa da Silva 1996). A phenomenological approach was used for structuring the data (Girogi 1997). Each diary was first read to bring out a sense of the whole, and after that meaning units were marked. To first read to bring out a sense of the whole, and after that, go to the parts is a way of data structure relevant for all qualitative research (Giorgi 1997). Next, the different diaries were analysed together, moving from the part to the whole (the hermeneutic circle) and an interpretation was developed (Barbosa da Silva 1996).

The quantitative study

The results from the qualitative studies describing women's experiences (Study I, II, and III), and two studies focusing women's experiences of a complicated pregnancy and childbirth (Berg & Dahlberg 1998, Berg & Honkasalo 2000), constituted the basis for the study determining if a birth plan could be proven to improve women's experiences of childbirth. The results from the above mentioned qualitative studies revealed five essential categories;

- relationship to midwife, physician and partner/other relative
- fear of childbirth
- pain during childbirth
- sense of control
- concerns for the child

These five categories constituted the basis for construction of the intervention expressing woman's needs and desires concerning the coming childbirth. The intervention consisted of a questionnaire at the end of pregnancy, followed by a birth plan. The childbirth experience was evaluated in a questionnaire after childbirth, using the same categories. The group of women who got standard care only answered the questionnaire after childbirth, which thus was the instrument for evaluation of the intervention. The statements measured degree of satisfaction on a six-graded scale from `totally disagree´ to `totally agree´. The study design is exemplified in Figure 2.

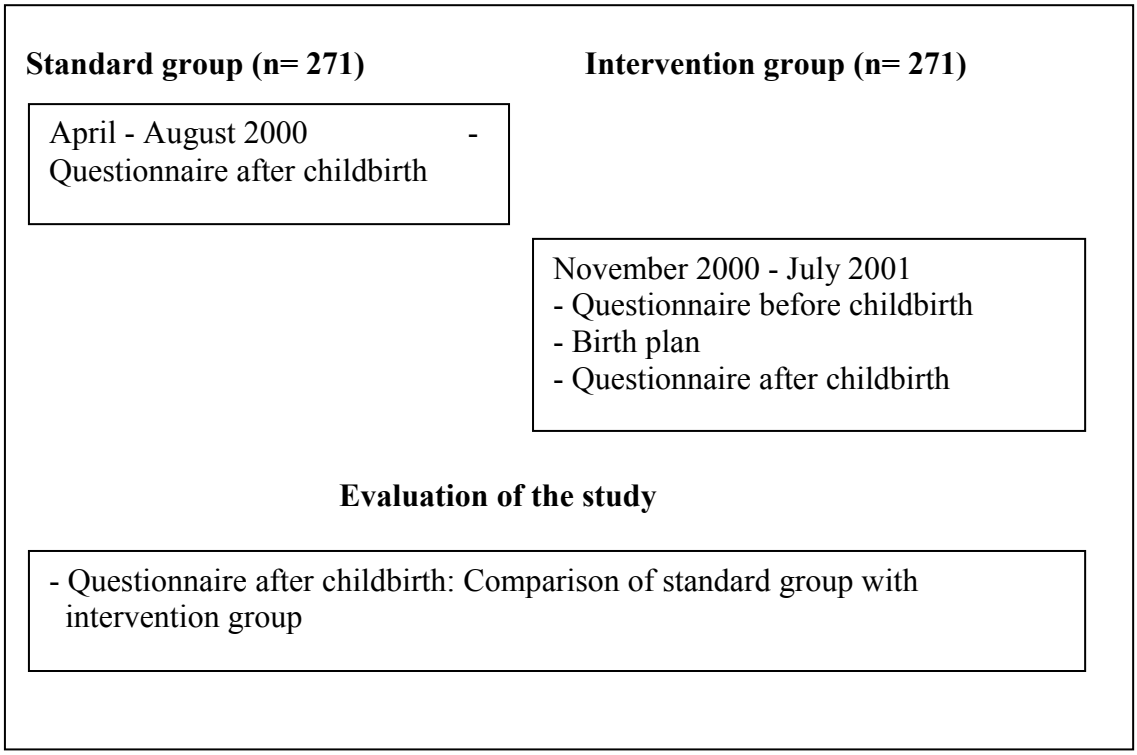

Figure 2. Study design; the quantitative study

The birth plan consisted of six headlines; the five mentioned categories and one labelled 'other wishes and needs', where the woman could express needs and desires in her own words. With this as a guide, the midwife and the woman together formulated her needs and desires. The women then at admission for childbirth brought their birth plans to the delivery wards and gave the birth plan to the midwife, who was instructed to use the plan as a basis for care. A birth plan from one woman is exemplified in Appendix 1.

The midwives present at the delivery ward were asked to evaluate each respective birth plan; one question assessed their attitudes to the birth plan as helpful or not for them, and one question their assessment of the woman's general experience of childbirth.

The questionnaire before childbirth included 28 statements (on the five categories mentioned, and on the total experience). In addition, there were three open questions about the pregnancy, fear of childbirth and the experience of childbirth. Twenty-six of the statements focused on specific concerns related to the five categories, one statement was related to general experiences of pregnancy, and, finally, one statement was related to previous childbirth experiences. The women answered the questionnaire at the end of pregnancy (after 33 gestational weeks).

The questionnaire after childbirth (within the first week postpartum) included 61 statements on the five different categories, and on one category for the total experience. In addition, there were two open questions concerning fear of childbirth and the experience of childbirth. Two statements and one open question concerned an evaluation of the birth plan. The questions on the relationship to the midwife and the physician were divided into midwife 1/physician 1 (the first midwife/physician the women encountered during childbirth) and midwife 2/physician 2 (the second midwife/physician the women encountered). Examples of statements were; the midwife listened and paid attention to my needs and desires, I was afraid of giving birth during the delivery, I experienced pain during labour as positive. The statements are listed in Appendix 2.

In Göteborg, Sweden, there is only one large unit for maternity care, Sahlgrenska University (SU) Hospital. It consists of four delivery wards, situated in two different areas of Göteborg. The study was performed at SU/Östra, Göteborg, Sweden, which has two delivery wards, one for women with normal pregnancy, and one `special delivery ward´ for women who are at high obstetric risk or have obstetric complications. The women may choose between different delivery wards, but those with risk factors or with complications are referred to SU/Östra and the special delivery ward.

In the Göteborg area there are 17 public antenatal care units (ACU) and one private. The private ACU is managed and owned by midwives but funded from the health care insurance. A clinic for women who are at high obstetric risk or have obstetric complications is situated at

the hospital, SU/Östra. The participants in this study were chosen from seven ACUs; five public, one private, and one for women either at high-risk or with obstetric complications. Three ACU are located in suburbs, one in the City Centre, and one in a mixed area. The private ACU is located in the City Centre. A summarised description of the pregnancy is given by the midwife in the medical file at the end of pregnancy. This summary, at times, also includes a listing of the woman's specific needs and desires concerning the childbirth. A letter from the woman may also be added to the journal. In some hospitals in Sweden birth plans have been introduced. These birth plans are mostly focusing on specific needs and desires voiced by the women, concerning, e.g., pain relief methods or other specific procedures.

The sample size (@ = 0.05, two sided B=0.20) required to indicate an improvement of 10% in satisfaction after the intervention was 271 women in each group. Between April and August 2000, women (n=271) giving birth at SU/Östra, normal delivery ward and special delivery ward, who had received standard care during pregnancy at one of the seven ACUs, were consecutively recruited to the study as a control group. Their pregnancies and childbirths were categorised as normal, complicated or 'at high risk' for complications. Between November 2000 and July 2001, pregnant women from the same seven ACUs were recruited for the intervention. All women from each ACU were invited to participate. Women who were planned to undergo elective caesarean section and women who did not speak and/or write Swedish well were excluded. All women intended to give birth at the regional hospital SU/Östra. Out of the eligible women, 41 women were never invited due to midwife's lack of time for information, and 45 women declined participation. Lost in the follow up of the study were 49 women who were transferred to another hospital, and two women who had stillborn children. In total, 271 women in each group completed the study.

The sample was divided into two subgroups defined on Swedish socio-economic classification (Statistiska centralbyrån, 1984). Women classified as salaried employees at high and middle level were categorised as having high socio-economic status, and women classified as salaried employees at lower level, on sickness pension, unemployed, on parental leave, student and unknown were categorised as having low socio-economic status.

The questionnaire after childbirth from the standard group and the intervention group were used for evaluation. 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 (chi-squared) and a p-value of less than 0.05 was considered significant. In the result the extreme answers, i.e. 1+2 (almost or totally disagree) and 5+6 (almost or totally agree) are presented. All scores (1-6) were used in the calculation of Chi-Square.

Ethical approval and permission to undertake the study was obtained from the Ethical Committee at the hospitals. Permission to conduct and tape-record the interviews was obtained from each woman/midwife and each was assured that all information would be treated confidentially. Access to the clinics and their staff and clients were obtained from the physician in charge at the hospital and the antenatal care.

Finally, the findings from both the qualitative and quantitative studies will be presented in a general structure of the meaning of pregnancy and childbirth.

Results

Women's experience of pregnancy (study III)

The essential structure and interpretation of women's experience of pregnancy can be captured under the heading 'transition to the unknown,' which includes three themes: 1) meeting one's life situation, 2) meeting something inevitable, and 3) preparing for the unknown. The 'transition to the unknown' includes travelling from the past, through the present, towards the unknown and the future. In the first trimester, women's feelings about their life situations and about their relations to people around them were primary. Descriptions about the past outnumbered those of the future. In the second trimester, feelings of encountering a situation outside their personal control dominated. The women also described this period as a time of fewer physical problems and of living in the present without reflections on the past or the future. In the third trimester, reflection about the future arises and the women are preparing for childbirth; they are getting ready to meet the unknown. Reflections about the baby are frequent during the whole pregnancy, but increase as the pregnancy proceeds. The ultrasound examination after 16 weeks constituted a confirmation of the presence of the baby. The women differed in the ways they describe their feelings about meeting the unknown. Both a desire of meeting the unknown in early pregnancy and a hesitation and fear of meeting the unknown in late pregnancy are represented.

Women's experience of the encounter with the midwife during childbirth (Study I)

The essential structure of women's experience of the encounter with the midwife can be expressed as *presence*, and includes three themes: 1) to be seen as an individual, 2) to have a trusting relationship, and 3) to be supported and guided on one's on terms. To be seen as an individual is expressed as being met with respect and seen for oneself. To have a trusting relationship describes the midwife's character, professional knowledge and proficiency as well as the women's feeling of security. Keywords here are friendliness, openness, safety, interpersonal congruity, intuition and availability. To be supported and guided on one's own terms expresses the women's need for control, to listen to their innermost feelings and to be given time. But most of all the presence of the midwife is recognised as a main theme. The essential structure therefore can be summarised as presence. If any of the mentioned features is lacking, the woman feels that the midwife is 'absently present'.

Women's experience of pain during childbirth (Study II)

Four themes were identified in the meaning of the experience: 1) pain is hard to describe and is contradictory, 2) trust in oneself and one's body, 3) trust in the midwife and husband, and 4) transition to motherhood. The essence of women's experience of pain during childbirth can be expressed as *being one's body,* which includes a non-objectified view of one's body, a presence in the delivery process, and a meaning connected to the transition to motherhood. A non-objectified view of one's body is understanding the body as a subject, which means that women look upon pain as a natural part of the delivery process, and that the strength and power to cope with it come from within their own subjective bodies. The context of the birthing woman must support this. Then the woman can be present, be in the process and interpret the signals from her body during the delivery. The people around her should only interfere if the natural process is disturbed, e.g. by complications. By *being one's body* the woman go through the experience of pain in a way that is also meaningful for her new life situation with her new baby.

Midwives´ experience of the encounter with women and their pain during childbirth (Study IV)

The midwives´ approach to the woman and pain during childbirth is described as a striving to become an *anchored companion. To be a companion* is to be available for the woman, to listen to and see her situation mirrored in her body, and to share the responsibility of her childbirth. To be available is to be open, to establish a trustful meeting, and to follow the

woman through the process of childbirth. To listen to the woman is being sensitive to the wishes and the needs of the woman. If verbal communication is hindered, the midwives can see the condition of the woman through the expression of the woman's body. The expression of the eyes, the face, and the whole body are important signals to the midwife. The non-verbal communications through the woman's body increases as the process of childbirth proceed. If this process is disturbed and the limit of the woman's ability is exceeded, the midwife can notice this through the expression of the woman's body. To share the responsibility of the childbirth mean that focus should be towards the woman's needs and desires. It also means that the woman has a responsibility to express herself to the midwife, and a will to go through the childbirth and meet the pain during childbirth. According to the midwives, there is a risk of being burnt out if the midwife takes all the responsibility for the childbirth. To be *anchored is* to show respect for the limits of the woman's ability as well as the midwife's professional limits. To show respect for the limit of the woman meant that the midwife has a responsibility to ensure that the woman does not exceed the limit of her ability and that the pain do not become too much for her. When the woman is in this state, the midwife can try to interrupt this development by for example a more distinct communication and by establishing eye contact. To respect the professional limits mean to support the woman's capacity to see the normal process of childbirth but also to see the boundaries to the complicated childbirth. Its five constituents can further describe the essential structure: 1) listening to the woman, 2) giving the woman an opportunity to participate and to be responsible, 3) a trusting relationship, 4) the body expresses the woman's situation, and 5) to follow the woman through the process of childbirth.

Is childbirth experience improved by a birth plan? (Study V)

A new routine with a questionnaire at the end of pregnancy to define important aspects for a birth plan did not improve women's experience of childbirth. Instead, some aspects of the relationship to the first midwife the woman encountered during childbirth; listening and paying attention to needs and desires, support, guiding and respect, were experienced as less satisfactory after the intervention. However, some aspects of fear, pain, and concerns for the child were improved for some groups of women. Multiparae in the intervention group had experienced less fear of giving birth and less fear of labour pain than in the standard group. Primiparae and women with low socio-economic status who had used the birth plan had a more positive experience of pain during labour. Women with high socio-economic status in the intervention group expressed less concern about the delivery as difficult for the child.

A general structure of the meaning of pregnancy and childbirth

A general structure of experiences of pregnancy (study III) and childbirth (study I, II, and IV), may be conceptualised under the heading *releasing and relieving encounters.*[1] For the woman a *releasing and relieving encounter* constitutes an encounter with herself as well as with the midwife. A *releasing and relieving encounter* also implies stillness as well as change. Stillness is expressed as being in the moment; exemplified as presence and being one's body. Change is expressed as transition; to the unknown and to motherhood. In the *releasing and relieving encounter,* for the midwife stillness and change equals being both anchored and a companion. To be a companion is to be an available person that listens to and follows the woman through the process of childbirth. To be anchored is to be the person that in the transition process respects the limits of the woman's ability as well as her own professional limits.

Being in the moment during pregnancy equals the ability to encounter the inevitable, and a situation out of total personal control. During childbirth being in the moment is an encounter between woman and midwife characterised by presence. Presence includes to be seen as an individual, and to be met with respect. For the midwife equals to be a companion to meet the woman's desire to be seen as an individual by listening to her and by following her through the process of childbirth. The presence by the midwife should also include a trusting relationship, the characteristics of which are friendliness, openness, safety, interpersonal congruity, intuition and availability. A trusting relationship built on a sense of security may strengthen the birthing woman's self-confidence, especially if the midwife communicates belief in the woman's capacity to give birth. In this process the midwife's support for the woman includes helping the woman to face the unknown without fear, to be attentive to the birthing process, to feel trust in her own body, and to trust her own ability. Such openness for the signals from their bodies and presence in the process of delivery is for women expressed as being one's body. Being one's body also includes a non-objectified view of one's body, e.g., looking upon pain as a natural part of the delivery process, and feeling that the strength and power to cope with it comes from within the own subjective body. To be a companion is for the midwives to see the condition of the woman through the expression of the woman's body. The non-verbal communication through the woman's body increases as the process of

[1] In Swedish: 'förlösande möten' förlösande: lösa, befria någon eller något, göra någon eller något fri eller fritt från ngt som binder, fängslar,. trycker eller tänkes binda, fängsla eller trycka.

labour proceeds. If this process is disturbed and the limit of the woman's ability is exceeded, the midwife can notice this through following the expressions of the woman's body. Presence during childbirth is also to support and guide each woman on her terms. In this process, control, time, and an ability to listen to her innermost feelings are crucial for the woman. To be a companion is for the midwife to meet each woman's need for support and guidance on individual terms by a sharing of responsibility and participation. This implies that the woman must do her share, express her wishes to the midwife, and have a will to go through the childbirth and to encounter the pain. There is a risk for the midwife to be burnt out if all responsibility for the childbirth is taken by her.

The *releasing and relieving encounter* also implies transitions. Pregnancy may be described as a transition to the unknown. This includes travelling from the past through the present towards the unknown and the future. In the first trimester the relationship to the people around the woman is primary. You may find a desire of meeting the unknown in early pregnancy as well as a hesitation and fear of meeting the unknown in late pregnancy. During childbirth, the experience of pain, together with the experience of strength gives meaning to the transition to motherhood. When a midwife follows a birthing woman through the process of labour she strives to become anchored. To be anchored means, for a midwife, to show respect for the limits of the woman's ability as well as for her own professional limits. To show respect for the limit of the woman means that the midwife has a responsibility to ensure that the woman does not exceed the limit of her ability and that the pain does not become too much for her. Once a birthing woman is entering such a state, the midwife may try to interrupt the process by, for example, a more distinct communication and by establishing eye contact. Also, to respect professional limits means to support the woman's capacity to identify and acknowledge normal process of childbirth, but also to clearly identify the boundaries to a complicated childbirth.

The *releasing and relieving encounter* is not improved for women by a birth plan (study V). Instead, in some aspects, the relationship between the woman and her first midwife during childbirth is less satisfactory if preceded by a birth plan. However, some aspects concerning fear, pain and concerns for the child were improved for some groups of women by a birth plan.

Discussion

The experiences of pregnancy and childbirth can be summarised as *releasing and relieving encounters*. From China in historical times and from Ancient Greece there are similar narratives in which midwives are described as helpers for something to be born. The New Greek era, which was the foundation of modern European philosophy, was dominated by respect for the intellect. The philosophy of Socrates was named maietik, a metaphor using midwifery to describe the birth of thoughts (Herzberg 1990). However, Socrates did not, like his mother and other midwives, help women nor bodies, but instead assisted the mind to bring forth thoughts in labour. *'First, my patients are men, not women; and secondly I am concerned not with bodies but with souls in labour.'* (Plato, interpreted by Warrington 1961, p. 77). On the contrary, according to the result from the studies reported in this thesis, the body, exemplified as *being one's body,* is central in a *releasing and relieving encounter*. The attitudes towards the body have changed over time. The woman's body during pregnancy and childbirth, once respected and feared in Western rural societies (du Boulay 1986), was made more invisible by the influence of the new European philosophy, which focused on mind and on thoughts (Höjeberg 2000), and saw the body as a physical object, all in accordance with the mind-body dualism so prevalent in seventeenth century thought (Bengtsson 1988). By introducing the concept subjective body, Merleau-Ponty (1995) sought to surpass the problem of the old dichotomy body/soul. According to Merleau-Ponty (1995) one's own living body is not to be understood as a thing, but instead it is the subject and performer of all actions. This means that a human being does not 'have' a body, but instead 'is' her/his body. We cannot step outside the body, instead we experience it from the inside as well as from the outside simultaneously (Dahlberg et al 2001). The body is both a quasi-object (something we can observe as if it were a thing), yet at the same time it is *me*, it is the very medium through which there can be other objects for me at all. The body is, therefore, a special kind of 'thing', which I cannot really 'objectively observe', although something about the body (its corporeality) may make us think that we can observe it like any other thing in the world. The science of medicine, focusing upon one side of the duality between body and mind has during the course of the last few centuries achieved to sediment a notion of the body that most Westerners, unproblematic ally and without further ado, seem to subscribe to. This notion states that the body is first and foremost a conglomerate of physiological processes, bones, tissues, fluids and cells. This body may be prodded and examined, both inside and out. But

this so-called objective body does not equal the body, which is the vehicle for each individual's existence, the lived body (Bullington 1999). As a consequence of this attitude, the body is thought to be a kind of machine, mechanised and obedient to the rules of physics, while the human soul is something different from the body (Bullington, 1999). In the context of childbirth this attitude has resulted in one-sided focusing upon the medical aspects or the outcome of childbirth, with much less attention paid to the experience (Davis-Floyd & Sargent 1997, Kitzinger 1989, Bergum 1997, Holmqvist 2000). However, with the concept 'subjective body' both the outcome and the experience of childbirth can be focused. This is important since the experience of childbirth has an impact on the future well-being of the woman, the child, the relationship between mother and child (Lagerkrantz 1979, Oakley 1983, Green et al 1990, Morris-Thompson 1992), and the relationship between the woman and her partner (Brudal 1985). The concept 'subjective body' does not, however, in any sense ignore the physical processes of the body that has been the main focus of science. This is also in agreement with modern attitudes towards childbirth. Certainly, if forced to choose every woman would prefer a safe outcome of childbirth even if it is experienced as unpleasant before a nice but dangerous.

Apparently, traditional birth attendants in different contemporary societies have, by their role as masseurs, continued to focus on the woman's body during childbirth (Höjeberg 2000, Hedstrom & Newton 1986, Anderson & Staugård 1986). These birth attendants are not, however, trained to deal with complications (WHO 1992). Thereby, they are focusing on the experience but have no knowledge on how to influence the outcome of childbirth. It is noteworthy that some rural women say they prefer a traditional midwife, even if she can not handle complications (Kempe 1996). The main ground for this is the quality of the care received (Kempe 1996). It is also noteworthy that present hospital care in developing countries is very poor at meeting women's needs (Kempe 1996, Davis-Floyd 2000). In Western societies communication difficulties (Cartwright 1979, Kirke 1980, Macintyre 1982, McIntosh 1988), and negative childbirth experiences (Lagerkrantz 1979) have been reported in research since the 1970s and 1980s. However, according to the results from this research communication between women and midwives during childbirth has improved. On the whole, the women evaluated the different aspects of the relationship to the midwives in positive terms, over 90% scored high (5 or 6 on a 6-item scale) concerning all aspects of the relationship to the midwife they encountered during childbirth, except time. One question now arises: Must the introduction of modern maternity care in developing countries go

through a similar process from bad to better treatment of the women? Yet another worrisome fact reported by Davis-Floyd (2000), is that professional midwives in the developing world are themselves often maltreated by the healthcare system in which they work.

The prevalent negative objectification of the body does not make the process of learning to listen to one's body easier. Young girls and women are constantly bombarded by the media with the idea that their bodies must be changed and remodelled to cope with demands coming from outside. A question now follows: how will women learn to be able to trust their bodies during childbirth? One suggestion is given by the interviewed women, who said that childbirth education should involve intensive training of the body, including relaxation, breathing exercises and discussion about different ways to prepare the body for childbirth. In Sweden today only 10-15% of the antenatal education consists in preparing the body (Socialstyrelsen 1996). Only recently has physical support become available to Western women during childbirth (Kennel et al 1991). According to Field et al (1997), massage during labour decrease anxiety and pain leading to shorter labours shorter hospital stays and less post partum depression. Additionally, massage during pregnancy has an impact on anxiety, sleep and pain (Field et al 1999). In our study in Göteborg about 25% of the women were afraid of giving birth (scoring 5 or 6). Therefore, it would be valuable to introduce and evaluate different forms of physical support in maternity care. Such interventions might also highlight the most important role for the traditional midwives that of masseur for women in pain (Höjeberg 2000, Hedstrom & Newton 1986, Anderson & Staugård 1986).

The body, for both midwives and women has a central role. For women *being one's body* includes a presence in the delivery process, as exemplified in openness for the signals from their bodies during the delivery. The midwives in this study, who could get information about the women's situation from their bodily expressions, verify this. The most important signals come from the eyes. But also the face, the breathing, and expressions of the whole body are important. This bodily communication is verified by Merleau-Ponty.

> *I cannot know what you are thinking, but I can suppose it, guess at it from facial expressions, your gestures, and your words - in short from a series of bodily appearances of which I am only the witness* (Merleau-Ponty 1964, p. 114).

The opportunity of *being one's body* can help women to cope with pain during childbirth. Pain is hard to describe and contradictory. This is verified by Waldenström et al (1996), describing pain as not an entirely negative experience. With her theory of suffering, caring theorist Eriksson (1993) offers a deeper understanding of pain. According to Eriksson (1993), suffering has both a positive and a negative pole. To suffer means to fight, to have pain, to be in agony, to endure, to bear, to sustain, and to be submitted, but it also means to become reconciled. Furthermore, Eriksson (1993, p. 19) says.

> *The key to the riddle of suffering and lust lies precisely in the movement between suffering and lust, or, in other words, in every person's ability to love passionately and accept life in all its glory, while at the same time, being able to unconditionally integrate painful and inevitable suffering. By a union of extremes possibilities are created, that is, suffering may gain a meaning.* [1]

The above mentioned integration of meaning is verified by our studies. By being their bodies the women went through the experience of pain in a way that gave meaning to the transition to motherhood.

Besides being one's body, presence was found to be central in a releasing and relieving encounter. Presence is a central concept in caring theorising and has been applied in different contexts of nursing. Presence is described as a special way of 'being there' or 'being with' another (Nelms 1996). According to Paterson and Zderad (1976), presence is the cardinal concept for encounters. '*For genuine dialogue to occur there must be a certain openness, a receptivity, readiness or availability. The open or available person reveals himself as present*' (Paterson & Zderad 1976, p. 28). Parse (1995, p. 81-82) emphasises true presence as '*the artful living of the human becoming theory. It is a special way of being with the other that recognises the other's value priorities as paramount.'* According to Burkhardt and Nagai-Jacobson (1994), being with another, to be present at the particular moment and experience, involves a knowing that is of the intellect, heart, body, and spirit. Genuine presence may, at times, demand activities, and, at other times, demand stillness and honouring of silence. Osterman and Schwartz-Baccott (1996) claim that health care professionals in the encounters with patients can be present in different ways; from being physically present, but emotionally

[1] My translation. The original Swedish text is: …man kan fråga sig om nyckeln till lidandets gåta finns just i rörelsen mellan lidande och lust eller mao. människans förmåga att passionerat älska och bejaka livet i all dess härlighet samtidigt som hon förutsättningslöst integrerar det smärtsamma och oundvikliga lidandet. Genom en förening av ytterligheter skapas möjligheterna, dvs. lidandet kan få en mening.

nonpresent, to unconditional global – physical, intellectual, emotional – presence, complete immersion in the encounter with the patient. By being *present* the midwife can help the woman to recognise and develop her own abilities, to interpret the signals from her body, and to cope with pain, i.e. *being one's body*. This idea is verified by Marcel (1956, pp. 39-40).

> *There are some people who reveal themselves as present…when we are in pain or in need…the person who is at my disposal is the one who is capable of being with me with the whole of himself…*

The midwives further exemplify presence in the context of midwifery by their role as companions. The midwives role as a *companion* is fundamental for midwifery. The word midwife is derived from the old English 'with woman' (Kaufman 1993). To be a companion is to see the woman as an individual, to listen to her and to follow her through the process of childbirth, but also to share the responsibility for the childbirth. Are women allowed and expected to take personal responsibility during childbirth in modern maternity care? According to Giddens (1990), the prevalent organisation of maternity care, characterised by a high degree of expert-dependence for women during childbirth, often results in a decreased participation and personal responsibility. Is this really an unavoidable consequence of our demands on safe care during childbirth? As pointed out by Biesele (1997), some women in the world are still at the other end of the spectrum, going from technologically managed birth to an ideally unassisted birth. These women, when interviewed by Biesele, said that they see birth as a transformation to motherhood. This transformation may include a strength-giving experience, but also an experience of impending death. Finally, the transformation is understood as entailing a responsibility for women. E.g., the birthing woman's fear is, at times, seen as itself causing complications (Biesele 1997). In contrast, in modern maternity care the understanding of women's experiences of their own performance during childbirth is still poor (Mackey 1998). According to Mackey (1998), women who managed well also thought that their own performance and the nature of labour and delivery (physical aspects) went well; women who had difficulties thought labour and delivery and the performance of others went well, but women who managed poorly had problems identifying anything that went well. This indicates the important role of own performance and responsibility to achieve a positive experience. According to the midwives in our studies a sharing of responsibility is important to prevent burnout. However, the women did not talk in terms of own responsibility. They reported that they themselves had an important role during childbirth, they had trusted themselves and their own bodies. The women also reported that the

midwives´ guiding and support must be individually fashioned. When it was so, this helped them to have control, to listen to their innermost feelings, and to not feel rushed. The findings show that approximately 60% of the women trusted their own capacity during childbirth and approximately 10% did not trust their own capacity. Additionally, 10% of the women thought that there were too many demands during childbirth and approximately 70% of the women did not think that there were too many demands. The sharing of responsibility between midwives and women during childbirth needs further investigation. This sharing of responsibility may be understood as a unique feature, which differs from presence and companionship in other caring encounters. Women giving birth are not sick. Nevertheless, birthing care is often modelled on care of the sick, due to the fact that childbirth is now primarily a medical event, occurring in an atmosphere associated with sickness and death (Bergum 1997). From China in historical times and Ancient Greece another image is mediating; representing childbirth as a shared responsibility between midwives and women. Here the midwife is described as a person who helps the birthing woman to experience childbirth as something that she herself has accomplished (Heider 1986) and discovered from within herself, a Platonic idea (Plato, interpreted by Warrington 1961).

The midwife's role as a companion should be combined with being *anchored*. To *be anchored* first implies respect for professional limits. The concept of 'normal birth' is not well defined, and it furthermore varies over time and in different cultures (WHO 1996). It is noteworthy that the midwives in this research had no problems with defining their professional limits, even though normal birth is not well defined. However, one may think it plausible that experienced midwives have a clear understanding of this concept, embedded in practice and long tradition. Additionally, to be *anchored* implies respect for each individual woman's limits. Each woman should be individually helped in her transition to motherhood. The challenge for midwives as described in this research, is to encourage the woman to be 'fully there' in this transition and special state of mind, but not to pass the limits of her capacity. A term borrowed from the philosopher Jaspers is 'boundary situation'. A boundary situation is defined as a situation that in some way expresses the contradictions of being. Hereby, forces that are included in the lust of being, meaning and growing, are developed (Jaspers 1963). That there is a development of forces in a boundary situation is, in these findings, verified by the midwives here cf. midwives´ statements that the experience of childbirth can strengthen a woman. Maybe a passing of the limits of one's capacity in a boundary situation is leading to an experience of giving birth as the worst experience of life; a

terrifying experience with feeling of fear for death. According to the midwives, they have a responsibility to ensure that the woman does not exceed the limit of her ability and that the pain does not become too much for the woman.

Control and the unknown are important aspects for women during pregnancy and childbirth. Pregnancy can be described as a transition to the unknown, including meeting one's life situation, something inevitable, and unknown. The women differed in the ways they described their feelings about meeting the unknown. A desire of meeting the unknown in early pregnancy as well as hesitation and fear of meeting the unknown in late pregnancy were represented. Preparing for the unknown during pregnancy was also essential for the women in this study. The questionnaire before childbirth verifies these findings, with high scores by 34% of the women concerning fear of the encounter with the unknown. To give birth involves something unknown, concomitantly with pain, emotional stress, augmented vulnerability, risk of physical injury and even death, role change and responsibility for the baby to come (Simkin 1992). The ability to maintain a sense of autonomy and personal control during this, in some respect, uncontrollable process is associated with a positive experience of childbirth (Green et al 1990, Simkin 1991, Bluff & Holloway 1994, Niven 1994, Hall & Hollaway 1998, Halldorsdottir & Karlsdottir 1996b). My studies verify the importance of control for a positive experience; a sense of being in control during childbirth was experienced in more positive terms than not being in control. Approximately 93% of the women that felt in control vs. approximately 31% of the women that did not feel in control were describing this positive. However, control may mean varying things for women. It can mean control over the labour process (Niven 1994), what is being done to one during childbirth (Green et al 1990), but it can also mean flowing with the body (Green et al 1986). However, according to Green et al (1990), involvement in decision making may confuse the women and increase her anxiety level. Therefore it is pivotal that the midwife gets to know the woman in order to be able to understand her individual understanding of control.

The women in this study expressed relationships as an essential part of transition to the unknown during pregnancy. Bergum (1997), who claims that the vulnerability a woman begins to feel in pregnancy is not to be understood as a sign of weakness, verifies this. Instead, vulnerability can be read as a sign of her increasing need for relationships with others. Examples of central relationships for pregnant women are with their mothers (Martell, 1990), their mothers and grandmothers (Wiktorell & Saveman 1996), and their partners

(Raphael-Leff 1991). However, according to the findings, the most significant relationship for the women was their relationship to the child's father. The pivotal point here was his reaction to the pregnancy. The women's responses highlight the important role for the partner not only during pregnancy but also during childbirth. Trust in the partner is of cardinal importance for women's coping with pain during childbirth. According to Chalmers and Wolman (1993) studies of fathers' support during childbirth have yielded contradictory findings, although, in most studies, women appear to value partners presence. Fathers report feelings of anxiety, helplessness and concern for their partners and especially for the pain experienced by their partner (Nichols 1993, Vehviläinen-Julkunen & Liukkonen 1998, Hallgren et al 1999). Women are rating support from their partners very highly, and in most cases, higher than support received by professionals (Keirse et al. 1989), also in our study. Approximately 97% of the women scored very high (5 or 6) for support received from the partner/other relative. However, some authors argue that since fathers are so personally and intimately involved they may harbour and transmit anxieties, demands, and expectations, which may have negative effects on the course of labour and birth. Also, fathers may themselves need support during childbirth (Kennel et al 1987, Keirse et al 1989, Odent 1984). This is verified by the midwives in this research, describing the woman's partner as a resource, but also, at times, as an obstacle to a good relationship between the woman and the midwife. For instance, aggressiveness from the men was, understandably, described as a problem. The midwives´ strategy for these problems was to give support to the woman as well as the partner. These findings indicate the need of further investigation. It would, e.g., be of value to ask partners about their experiences of childbirth. And how does the lack of hospital resources, resulting in less time for the individual woman, affect and alter the role of the partner? And how about women without a partner or other relative during childbirth?

The structuring and management of maternity care are factors that affect women's experiences of childbirth. Different forms of continuity from pregnancy to childbirth are proven to be beneficial for women. Because of that, maternity care in United Kingdom has changed (Department of Health 1993) allowing the midwife to 'get to know the woman' before childbirth (Flint 1993). However, several studies show that stress and burnout is a problem in midwifery in the present day (Sandall 1997, Mackin & Sinclair 1998). Stress could lead to a task orientation in midwifery so that midwives only 'get through the work' (Hunt & Symonds 1995). According to Hunter (2001), there is a lack of research regarding midwives experiences of the relationship with women and of the emotional issues involved.

Could there be an imbalance between being a companion and anchored, and could this imbalance in part explain the problem of burnout in midwifery today? This means telling the midwife about her important role as a companion without focusing her role as anchored, by not focusing the professional limits as well as the limits of the woman's ability. Bergum (1997) verifies that a good relationship between caregiver and patient may prevent burnout. According to Dahlberg (1996a), in order to engage in such intersubjective meeting caregivers must develop knowledge of self as well as themselves have access to care.

Another example of continuity is use of birth plans, allowing options to be considered in advance, and choices to be made about some of the things that might come to pass during childbirth. According to our studies women's experience of childbirth are not improved by a birth plan. Women evaluated four out of eight aspects of the relationship to the first midwife they encountered during childbirth; listening and paying attention to needs and desires, support, guiding, and respect as less satisfactory. However some aspects of fear, pain, and concerns for the child were improved for some groups of women after using a birth plan. As in many Western countries, Sweden has problems with increasing demands from women wanting painless births with a caesarean section. The possibility that a birth plan may improve women's experience of pain and fear need further investigation.

When birth plans were introduced the intervention was expected to give the woman more control during childbirth (Kitzinger 1983). However, according to our studies there were no difference between the intervention group and the standard group concerning control during childbirth. Whitford and Hillan (1998) also verify that birth plans do not improve women's sense of control during childbirth.

Maybe the lower scoring for the first midwife the women encounter during childbirth is due to higher expectations after completion of a birth plan? This is not verified in a study of Green et al (1990), which shows that low expectations are related to a negative experience, but high expectations are not, per se, to be understood as detrimental to women. However, studies that evaluate women's expectation and experiences of childbirth are few (Gibbins & Thomson 2001, Green et al 1990).

Is it the uniform approach, birth plans to everybody, which result in a less positive experience for the intervention group? Small et al (2000) found that another intervention, debriefing after

childbirth, is not associated with a reduction of depression six months after childbirth. The possibility that debriefing may contribute to emotional health problems for some women cannot be excluded, according to Small et al (2000). One explanation here could be a 'secondary trauma', resulting from exposure to the experience during the debriefing session. Maybe the birth plan, as such, provokes the woman to answer questions about the future childbirth, questions, which she is not ready to think about?

According to Kitzinger (1992) a main objective for birth plans is to help to focus the relationship between the woman and her caregiver. According to the results from this study women scored the relationship to the midwife very high, over 90% scoring 5 or 6 concerning the different aspects. Maybe this explains why the intervention did not improve the relationship to the midwife, since midwives are already very good at establishing caring relationships to the women. It is possible that a birth plan may hinder the midwife to develop a unique encounter with the women. The birth plan then becomes just another piece of paper to deal with (Too 1996b) for the midwife. She may be more focused upon the birth plan than on the encounter with the woman. This is verified by Dahlberg et al (1996b), showing the possibility that documentation may result in fragmented care. Therefore, perhaps excellent care is the opposite of standardised care (Edmunds 1998); a care described in holistic terms, as a relationship between two subjects: the health care professional and the patient (Dahlberg 1992, 1996a).

Discussion of methods

In the present studies both quantitative and qualitative methods have been used. Since the objective has been to enter deeply into women's experiences a life-world approach grounded in phenomenology and hermeneutics was chosen. A common objection towards qualitative studies is that they offer neither generalisation nor theory development. The main assumption behind the demands for generalisation and theory development is that data analysis must be presented in the form of a general structure, which in phenomenology, roughly, would equal an essence and in hermeneutics a main interpretation (Dahlberg et al 2001). However, phenomenological and hermeneutic research is always contextual, and thus never to be understood as presenting universal claims. Consequently, the results from the present research must be evaluated in relation to an ABC-centre context. According to Waldenström (1993c) women birthing at ABC-centres were older, better educated, had better physical health and tended to be less anxious when contemplating the approaching birth and motherhood than

women giving birth at standard care. In interviewing women who delivered at an ABC-centre the focus was set on the encounter between the woman and the midwife as compared to a traditional delivery, which comprises diverse other professionals. However, the fact that the present results are contextual does not imply that they would be inapplicable and have no meaning in other contexts. Application of the results to new contexts could be understood as an entailing open-ended process of understanding, which is also depicted in the metaphor of the hermeneutic circle (Dahlberg et al 2001). Therefore, it is plausible that the results from this research may also be applicable for different periods. Hence, results from phenomenological and hermeneutic research can be understood as yielding a deeper understanding of the similarities and the common structure of women's experiences by describing the essence/main interpretation, without conveying the uniqueness of the persons. The results from my hermeneutic study must be considered in the light of some limitations. My choosing of this method can be read as an attempt to widen my knowledge of qualitative research methods. However, the main influence in my studies, comprising also the hermeneutic study, has been phenomenology.

The results from my research must finally be considered in the light of my experiences as a midwife. During the interviews all my theoretical and experiential knowledge, and my own experiences of the phenomena were held back as much as possible, in order to allow the experiences of the women to be manifest. However, such a dedication to openness, without allowing own experiences of midwifery to influence understanding can never be total.

The purpose of the present research has also been to determine if a birth plan could improve women's experiences of childbirth. In order to answer this question a quantitative method was considered most suitable. Quantitative studies can be intervention studies, involving an active change, e.g. changes in some aspect of maternity care (Beaglehole et al 1993). The major experimental study design is the randomised-controlled trial (Beaglehole et al 1993).

However, no randomisation could be done, due to the complex study design. A selection of control group was identified before the intervention, thus no influence from the intervention would influence theses women. Another limitation of the study was that the questionnaire was not validated beforehand, although the studied areas had been found to be essential in previous qualitative studies. Hence, the quantitative method used in the present research is to

be understood as grounded in a life-world approach, by a pursuit of a deep description of women's experiences. women's experiences. This does not mean that it is possible to describe the life-world by a quantitative approach. However by combining these two research methods this attempt of a be deep description of the experience could be both contextually and numerously widened. Finally, by relating the results to the context of maternity care a more consistent professional approach towards meeting the women's needs during childbirth may be reached.

The fact that experienced midwives and physicians have verified central findings in my research has, for me, constituted a kind of validation. Statements as 'this is familiar to me, even if I do not use your terms', have confirmed that the result are anchored in practice, which, in my view, is of relevance for all qualitative research grounded in a life-world approach. By a transformation from the subjects' descriptions to a language designed to be meaningful for midwifery, one could develop a new understanding of specifically understudied phenomenon. The fact that the present results can be anchored in practice also constitutes a confirmation the results as 'tacit knowing' (Polany, 1983); e.g., as a kind of knowing that individuals rely on and daily are aware of as founded in previous practical experience.

Conclusion and practical implications

In summary, this research highlights the complex nature of experiences of pregnancy and childbirth. According to the results there is no single solution that will give a positive experience for all women. A positive childbirth experience is related to the encounter between the woman and the midwife, the women themselves, as well as organisational factors. Therefore, there are no plain answers to questions about practical implications. However, different aspects of the encounter between the midwife and the woman, summarised as a *releasing and relieving encounter*, are shown as essential for a positive experience. By being *present* when encountering the woman the midwife can help her to recognise and have faith in her own abilities, to interpret the signals from her body during delivery, and to cope with pain, in sum *being one's body*. Hence, attention must be paid to the different aspects of the encounter in practice. This could be done by working context in which the complexities of the

encounter are valued, by daily discussion, as well as by an increased access to support for the caregivers. As the body is central in the encounter, introduction of different forms of physical support in antenatal care as well as care during the delivery would be beneficial for women. However, the positive experience cannot be understood as only an onus for the midwives. For the woman *a releasing and relieving encounter* is an encounter with herself as well as with the midwife. Therefore, attention must also be paid to the women themselves, to the development of their trust in their own capacity, and of their feelings of control, and, finally, of their understanding of the limits of their ability. By being an *anchored companion* midwives can help women to not pass the limits of their capacity, and also to prevent burnout for themselves. This knowledge has important implications concerning the organisation of maternity care, as stress and burnout are common problems in midwifery today. A daily debate on the women's owns role, on their responsibility, and on their limits of own capacity must be part and parcel of modern maternity care.

Maintaining a sense of control is central for women when meeting the unknown during pregnancy and childbirth, a situation that in some sense is inherently uncontrollable. Primary in this process is the relationship to people around the woman, especially to the partner. Therefore, a discussion on sense of control, on a preparation for the unknown, on women's own role during childbirth, and on the important role of the partner should be integrated in maternity care.

An attempt to help the woman to formulate specific needs and desires in a birth plan at the end of pregnancy does not improve women's overall experience of childbirth. Instead some aspects of the relationship to the first midwife the woman encounter during childbirth; listening and paying attention to needs and desires, support, guiding, and respect, are experienced less fulfilling after intervention, even though the women generally scored high for the relationship to the midwife, the physician and the partner/other relative. However, some aspects of fear, pain, and concerns for the child were improved for some groups of women after this intervention. This research also indicates the possibility that birth plans, as a routine may in fact hinder the midwife to develop a uniquely individual encounter with the women. This fact, once again, points to the importance to evaluate and discuss the encounter between the women and the midwives in maternity care.

More research is needed to evaluate different forms of physical support and preparation of the body during pregnancy and childbirth. The sharing of responsibility between midwives and women and the woman's ability limit during childbirth also need to be further investigated. Finally, more research is needed to evaluate if a birth plan may improve some aspects of the experience of childbirth.

Summary in Swedish/sammanfattning på svenska

Den moderna förlossningsvården, med rötter i det nya medicinska paradigmet som växte fram i samband med naturvetenskapens intåg på 1600-talet, har alltid haft som fokus komplikationer och risker i samband med barnafödande. Därför har forskningen varit mer centrerad kring förlossningsutfallet, ofta mätt i barna- och mödradödlighet än av kvinnors upplevelser i samband med graviditet och förlossning. Senare forskning visar dock att förlossningsupplevelsen är en central livshändelsen som har betydelse för kvinnans och barnets framtida välbefinnande, för morbarnrelationen, samt för relationen mellan kvinnan och hennes partner. Dessa studiers resultat pekar på stöd under förlossningen som en av de viktigaste faktorerna för uppnåendet av en positiv förlossningsupplevelse. Detta faktum gäller inom såväl modern västerländsk förlossningsvård som i utvecklingsländer, där fortfarande ca 50% av kvinnorna förlöses av traditionella barnmorskor. En annan faktor som påverkar förlossningsupplevelsen är vårdens organisation. En vårdform som innefattar kontinuitet från graviditet till förlossning har visat sig vara positiv för kvinnan. Ett exempel på kontinuitet är att under graviditet förbereda förlossningen genom författandet av en förlossningsplan, som uttrycker behov och önskemål inför förlossningen. Däremot saknas det forskning som beskriver kvinnors upplevelser av graviditet, speciellt med fokus på den normala graviditeten.

Denna avhandlings huvudsyfte har varit att beskriva upplevelser av graviditet och förlossning. Specifika delområden har varit dels kvinnors upplevelser av graviditet, dels har barnmorskans stöd under förlossningen fokuserats genom att mötet mellan den födande kvinnan och upplevelsen av förlossningssmärta har beskrivits från både kvinnans och barnmorskans perspektiv. Slutligen har en vårdform innefattande kontinuitet, en förlossningsplan, analyserats med syfte att undersöka om den påverkar förlossningsupplevelsen i positiv riktning för kvinnan.

I denna avhandling har både kvalitativ och kvantitativ metod används. Tjugosju intervjuer och 12 dagböcker har använts för att beskriva kvinnors upplevelser av graviditet (studie III), av mötet med barnmorskan (studie I), och av förlossningssmärta (studie II). Studierna utfördes på ABC-enheten (Alternative Birth Care), Sahlgrenska Sjukhuset, Göteborg, 1994-1997. 9 intervjuer beskriver barnmorskors upplevelser av mötet med den födande kvinnan och hennes förlossningssmärta (studie IV). Denna studie utfördes på Sahlgrenska Universitetssjukhuset

(SU)/Östra och Mölndal och inom primärvården, Göteborg, och på Karolinska Sjukhuset i Stockholm, 2000. Intervjuerna har analyserats enligt fenomenologisk ansats. Syftet med denna metod är att få en ökad förståelse för ett fenomen genom att lyfta fram dess essentiella innebörder. Dagböckerna har analyserat enligt hermeneutisk ansats. Syftet med denna metod är också att nå en fördjupad förståelse, genom att beskriva en tolkning av det unika i relation till helheten. Resultatet från ovanstående studier som beskriver kvinnors upplevelser, samt två studier som fokuserat kvinnors upplevelser av en komplicerad graviditet och förlossning ligger till grund för studie V, en interventionsstudie som utfördes inom primärvården, Göteborg och på SU/Östra, 2000-2001. Intervention bestod av en enkät i slutet av graviditeten (efter 33 graviditetsveckor) och en förlossningsplan. Utvärderingen utfördes via en enkät efter förlossningen. Både enkäter och förlossningsplanen var indelade i fem kategorier som visat sig vara essentiella i de kvalitativa studierna; relationen till barnmorskan; läkaren och mannen/annan anhörig, förlossningsrädsla, förlossningssmärta, känsla av kontroll samt funderingar kring barnet. Tvåhundrasjuttioen kvinnor som vårdats under graviditeten på sju utvalda mödravårdscentraler rekryterades som en kontrollgrupp. Inom en vecka efter förlossningen fyllde dessa kvinnor i enkäten som belyste upplevelser av förlossningen. Därefter infördes interventionen. Tvåhundrasjuttioen kvinnor från samma sju mödravårdscentraler rekryterades. Alla kvinnor inbjöds att delta förutom de som skulle förlösas med ett planerat kejsarsnitt och de som inte kunde svenska språket tillräckligt bra. Dessa kvinnor fyllde i enkäten i slutet av graviditeten. Med den som underlag författade kvinnan och barnmorskan tillsammans en förlossningsplan. Kvinnan tog med sig förlossningsplanen till förlossningsavdelningen som underlag för vården. Inom en vecka efter förlossningen fyllde dessa kvinnor också i enkäten som belyste upplevelser av förlossningen. En jämförande analys genomfördes av kontrollgruppens och interventionsgruppens enkäter. Materialet analyserade också med avseende på paritet och socioekonomisk klass.

Resultatet visar att upplevelser av graviditet (studie III) och förlossning (studie I, II, och IV) kan sammanfattas med begreppet *förlösande möten*. Ett *förlösande möte* innefattar för kvinnan både ett möte med sig själv och med barnmorskan. Det *förlösande mötet* består av ett tillstånd som innefattar både en stillhet och en förändring. Stillhet uttrycks som ett varande i detta nu, exemplifierat med närvaro och att vara sin kropp. Förändring uttrycks som en övergång till det okända och till moderskap. I *det förlösande mötet*, innebär stillhet och förändring för barnmorskan att vara en *förankrad följeslagare*. Att vara följeslagare innebär att vara tillgänglig för kvinnan, att lyssna till henne, att se hennes situation som speglar sig i

kroppen, samt att dela ansvaret för förlossningen. Att vara förankrad innebär att i övergångsstadiet respektera såväl kvinnans gränser som de professionella gränserna.

Ett varande i detta nu i det förlösande mötet innebär för kvinnan att under graviditeten möta sin livssituation och något oundvikligt utanför den personliga kontrollen. Under förlossningen innebär ett varande i detta nu ett möte mellan kvinnan och barnmorskan präglat av *närvaro*. Närvaro innebär för kvinnan en önskan bli sedd som den hon är och mött med respekt. Barnmorskan möter kvinnans önskan om att bli sedd genom att vara en följeslagare som lyssnar till henne och följer henne genom förlossningsprocessen. Barnmorskans närvaro innefattar också en förtroendefull relation som är grundad i vänlighet, öppenhet, säkerhet, personlig överensstämmelse, intuition och tillgänglighet. En förtroendefull relation grundad i säkerhet för kvinnan kan stärka hennes självtillit, fram för allt om hon upplever att barnmorskan tror på hennes förmåga att föda. I denna process, innebär barnmorskans stöd till kvinnan att hjälpa henne att våga möta det okända, att inte vara rädd, att följa med i förlossningsförloppet, att lita till sin egen förmåga, samt att lita till att kroppen klarar av förlossningen. En sådan öppenhet för kroppens signaler och närvaro i förlossningsprocessen, uttryckt som *att vara sin kropp,* kan hjälpa kvinnan att hantera förlossningssmärtan. Att vara sin kropp innebär också en icke-objektifierad kroppsuppfattning, dvs. att smärta ses som en naturlig del av processen i en förlossning och att styrkan och kraften att hantera den kommer inifrån den egna subjektiva kroppen. Att vara en följeslagare innebär för barnmorskan att se kvinnans situation såsom den speglar sig i kroppen. Den ordlösa kommunikationen via kvinnans kropp tilltar ju mer förlossningsprocessen fortskrider. Om processen störs och kvinnan är nära gränserna för sin förmåga kan barnmorskan märka detta på kvinnans kropp. Närvaro under förlossningen innebär också att få stöd och bli styrd på egna villkor, vilket innebär att få lyssna till sina egna känslor, att ges tid och att uppnå en känsla av kontroll. Att vara en följeslagare innebär för barnmorskan att möta kvinnans önskan om stöd och styrning på egna villkor med delaktighet och delat ansvar. Det innebär att kvinnan har ett ansvar att förmedla sig till barnmorskan, att vilja gå igenom förlossningen och att möta förlossnings-smärtan. Om barnmorskan tar på sig allt ansvar för förlossningen finns en risk för utbrändhet.

Ett förlösande möte innefattar också övergångar. Graviditeten kan beskrivas som en övergång till det okända. Det innefattar en resa från det förflutna, till det närvarande och mot framtiden och det okända. Redan i tidig graviditet kan en önskan om att möta det okända finnas samtidigt som en tveksamhet och rädsla för det okända kan existera i sen graviditet. Att gå

igenom förlossningen och möta smärtan kan för kvinnorna få en mening i övergången till moderskap, genom att uppnå en förändring som ger styrka i den nya livssituationen och kraft och förmåga att möta det nyfödda barnet. Barnmorskans följsamhet till kvinnan i förlossningsprocessen är präglad av en förankring. Att vara förankrad innebär för barnmorskan att respektera kvinnans gränser och de professionella gränserna. Att respektera kvinnans gränser är att hjälpa kvinnan att ej passera gränsen för sin förmåga eller att förlossningssmärtan blir övermäktig. Detta kan ske genom att barnmorskan blir ännu tydligare i sin kommunikation till kvinnan, att de använder ögonkontakt och på olika sätt försöker bryta tillståndet. Att respektera de professionella gränserna innebär att stödja kvinnan att se det naturliga förlossningsförloppet men även att se gränserna till den komplicerade förlossningen.

Det förlösande mötet förbättras inte för kvinnan genom en intervention innefattande en förlossningsplan (studie V). I stället upplevdes några aspekter av mötet med den första barnmorskan kvinnan möter under förlossningen, såsom lyssnande och hänsynstagande till behov och önskemål, stöd, styrning och respekt, sämre med en interventionen i jämförelse med en kontrollgrupp som ej erhållit en förlossningsplan. Som helhet skattade kvinnorna relationen till barnmorskan, läkaren och partner/annan anhörig högt. Över 90% av kvinnorna i kontrollgruppen skattade 5 eller 6, på en 6-gradig skala, relaterat till alla aspekter av mötet med den första barnmorskan under förlossningen, förutom tid. Emellertid förbättrades några aspekter av smärta, rädsla och funderingar kring barnet för vissa kvinnor med en förlossningsplan. I interventionsgruppen uttryckte omföderskor mindre rädsla för att föda och rädsla för smärta under värkarbetet i jämförelse med kontrollgruppen. Förstföderskor och kvinnor från låg socioekonomiskt status uttryckte förlossningssmärta mer positivt. Kvinnor från hög socioekonomiskt status uttryckte i lägre grad att förlossningen var svår för barnet.

Konklusioner: Sammanfattningsvis visar dessa studiers resultat att kvinnors upplevelser av graviditet och förlossning är relaterade till barnmorskans bemötande under förlossningen. Ett bemötande som utvärderades mycket positivt av kvinnorna. Detta faktum gällde även för relationen till läkaren och partner/annan anhörig. Men en positiv upplevelse för kvinnan är inte bara ett ansvar för barnmorskan. Forskningen pekar också på kvinnans egen roll, såsom ansvar, delaktighet, tillit till den egna förmågan, samt en vilja att föda som viktiga i mötet med barnmorskan. Under graviditeten är en övergång till det okända centralt för kvinnor, en process som innefattar att möta sin livssituation, något oåterkalleligt och det okända. Resultatet visar hur olika denna process kan vara för kvinnor. Redan i tidig graviditet kan en

önskan om att möta det okända finnas samtidigt som en tveksamhet och rädsla för det okända kan existera i sen graviditet och in i förlossningen. Centralt i denna process är kvinnans nära relationer, speciellt relationen till mannen. Resultaten visar på att upplevelsen av kontroll är central när kvinnor närmar sig det okända under förlossningen, en händelse som i sig inte går att kontrollera.

Under förlossningen kan barnmorskans *närvaro* i mötet med kvinnan hjälpa henne *att vara sin kropp,* dvs. att finna sin egen förmåga, att tolka sin kropp under förlossningsprocessen, samt och hantera förlossningssmärtan. Att vara en *förankrad följeslagare* innebär för barnmorskan att respektera kvinnans gränser och att hjälpa henne att ej passera gränsen för sin förmåga eller att förlossningssmärtan blir övermäktig. Kvinnans ansvar under förlossningen uttrycktes olika av barnmorskor och kvinnor. Barnmorskorna lyfte fram delat ansvar som en viktig beståndsdel för att förhindra utbrändhet. Delat ansvar var däremot inget som kvinnorna poängterade. I stället uttryckte de att de hade en viktig roll när det gäller att lita till sig själva och sin egen kropp under förlossningen, *att vara sin kropp*. Kvinnorna önskade också att barnmorskans stöd och styrning skulle ske på egna villkor.

En positiv upplevelse är också beroende av organisatoriska faktorer. Resultatet pekar på att en organisatorisk form som innefattar en förlossningsplan inte förbättrar kvinnors upplevelser av förlossningen. I stället upplevdes några aspekter av mötet med den första barnmorskan under förlossningen, såsom lyssnande och hänsynstagande till behov och önskemål, stöd, styrning och respekt, sämre med en förlossningsplan. Emellertid förbättrades några aspekter av smärta, rädsla och oro för barnet för vissa kvinnor. Som helhet visar dessa resultat på det komplexa i förlossningsupplevelsen, på betydelsen av att utvärdera nya rutiner innan de införes, samt på en rutins möjlighet att hindra ett unikt möte mellan barnmorskan och kvinnan.

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INDIVIDUAL BIRTH PLAN (an example) Appendix 1

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 as 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

-

Table Questionnaire after childbirth — Appendix 2

Category	Statements
Relationship to midwives (1 and 2)	Listening and paying attention to needs and desires; support; time; competence; guiding; trust; respect; support to cope with pain
Relationship to physician (1 and 2)	Listening and paying attention to needs and desires; competence; guiding; trust; respect
Relationship to partner/other	Support
Fear of childbirth	Trust in one's body during labour; trust in one's body during the second stage; on the whole, trust 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)
Pain during childbirth	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
Sense of control	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
Concerns for the child	Difficult delivery for the child; constant fear of complications to affect the child; suffer pain for the child's sake
Total experience	Confidence in own capacity; feeling of strength; too severe demands; feeling of failure; the childbirth experience on the whole.