Women’s Perspectives on Supportive Care
during Labour and Delivery

by

Melanie Joy Simpson

R.N., Douglas College School of Nursing, New Westminster, 1993
B.S.N., University of British Columbia, 2001

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Abstract

Women's perceptions of the support that they received during labour and delivery is the focus of this study. Its purpose is to document a sampling of women's experiences with supportive care during childbirth. Vivid descriptions from the women provided information on when support was most essential, the types and levels of support that they required, and from whom.

The interviewees were eight primiparous women who gave birth at the same labour, delivery, recovery, and postpartum (LDRP) unit in a major metropolitan hospital, and who were supported by teams that they had chosen. Each woman had her husband present and an LDRP nurse assigned to care for her. Each participated in one open-ended, semi structured interview, conducted at her home; all interviews were audio taped, transcribed verbatim, and analyzed for themes and patterns. A qualitative, interpretive, descriptive methodological approach included theoretical and snowball sampling.

The outcome of this study indicates that there are intricacies surrounding the various kinds and degrees of supportive care that women require and receive during childbirth, and that meaningful support is multifaceted. Supporting women during childbirth is complex, as each woman and her supportive team are unique and come to the LDRP unit with their own distinctive dynamics.
Among the predictors of a quality birth experience is the woman’s capacity for self-support, along with the support team’s mindfulness that she may need to draw on her inner strength, and that her requirements for support might change from one moment to the next. Some of the contextual factors of effective supportive care during childbirth include: the woman’s sense of having some control over the experience of labour and delivery; her inner strength and confidence; privacy; intuitiveness of the support team; and the encouragement, compassion, and empathy of supporters.

The results of this study demonstrate the need for further exploration of the supportive care that women receive during childbirth. To help gain a better understanding of the support needs of all women, research should take in women from other cultures and lower socioeconomic backgrounds, those with high-risk complications, women who do not have partners, and those living with abusive partners or otherwise enduring unusual hardships.
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Chapter 1

Introduction to the Study

Childbirth is one of the most extraordinary and meaningful events a woman experiences. Labour and delivery, the prelude to birth, is a time that women should feel supported emotionally, physically, and psychologically. Medves (2002) claimed that positive birth outcomes (physical well-being of the mother and the fetus) and a decreased need for analgesia will result if constant support from a health care professional is provided. There is evidence that support, and merely the presence of a supporter, during labour and delivery is of benefit to the physical safety of the woman and her unborn child (Simkin, 2002; Gilliland, 2002). There is, however, limited research and documentation regarding women’s perspectives on the meaning and advantages of having supportive companions present during labour and delivery.

This study explores women’s experiences with their labour support teams. The major emphasis is on women’s perceptions of the support, and the aim is to discover their needs during childbirth and to gain an understanding of what supportive measures enhance their experience. Further research beyond this study should be conducted to gain further knowledge and insights into the supportive care that all members of the support team provide. This chapter introduces the study by providing the background to the
problem, explaining the study’s purpose and significance, identifying the research question, and revealing assumptions and limitations.

**Background to the Problem**

While supportive care of the woman appears to be an important aspect of intrapartum nursing, health care professionals should be mindful that the support given should be controlled and instructed by the woman according to her needs. From my experience as a researcher and LDRP nurse on the unit from which the women in the study were recruited, it is evident that managers and educators involved in perinatal care believe that the constant presence of a nurse is a fundamental aspect of the childbirth experience, regardless of the stage of labour the woman is in or what she herself may want.

Much of the literature claims that constant support is a critical aspect of childbirth and that it will increase the probability of a positive and safe outcome for the physical well-being of the mother and the newborn (Brown, Nikodem, Garner, & Hofmeyr, 2000; Klaus, Kennell, Robertson, & Sosa, 1986; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980; Wilcock, Kobayashi, & Murray, 1997). This one-to-one ideal for nursing has become the recommended standard of care on labour and delivery wards in Canada (Society of Obstetricians and Gynecologists of Canada [SOGC], 1995). Not only do many obstetrical health care providers agree that a woman will benefit from a constant companion during labour, but a number of labour and delivery units have implemented an unwritten policy, whereby the LDRP nurse must spend almost all of her time with the
labouring woman once she has been admitted to the hospital—whether or not the woman wants or needs such attention.

From my own observations as an LDRP nurse, I have found that nurses, at times, hold narrow beliefs regarding the nature of their supportive role during childbirth. Often, they perceive themselves as the most qualified of anyone present to provide the required support for women in labour. However, while a nurse plays an integral role in ensuring the safety and physical well-being of a woman and her fetus during childbirth, she may not be a woman's preferred source of emotional support. Other members of the support team, such as husband, doula, family, or friends, may be more suitable emotional supports than a nurse. And this, perhaps, is a determination that the woman should make as the labour progresses.

One study has shown that “a central feature of support in childbirth is the promise that the labouring woman will not, at any time, be left without available support” (Enkin, Keirse, Neilson, Crowther, Duley, Hodnett, & Hofmeyr, 2000, p.247). Indeed, active support, with a nurse constantly or frequently present, should always be available, but it is also important that, as long as there is no risk factor, the woman receives care appropriate to her individual needs and desires. In other words, as much as is safe and possible, supportive care should be defined by the woman who is experiencing the event of childbirth, and given as she requires.

In caring for labouring women and working with their support teams, I have observed that women who receive support during labour and delivery often describe it differently than do those who provide it. Nurses, midwives, doulas, husbands, family, friends, and other support providers tend to define labour support according to their own
perceptions of what they believe is most beneficial to the woman giving birth. As a result, they may inadvertently offer support that is not in the woman's best interest. Any inclusive definition of labour support should thus incorporate the differing perspectives of the women who will go through, or have gone through, labour and birth.

Only the labouring woman herself can truly determine who would be a worthy companion to provide her with emotional support. Similarly, only she can answer the question of how this supportive care would manifest itself. While it is commendable to conduct research regarding the correlation between supportive care during childbirth and mortality rates for the mother and baby, inquiries that aim to explore what women desire from their support providers—as voiced by the women themselves—are also necessary.

There is evidence of partners' feelings of inadequacy regarding the giving of support (Chapman, 2000). How women react, perceive, and cope with their partners' feelings of inadequacy is not fully understood or researched. This must be reviewed further with the intention of discovering what women endure during childbirth in relation to their partners' presence, and to what extent they really want and need their partners for physical, emotional, and spiritual support. As researchers, we should therefore ask, what do women perceive to be the main objective(s) of having their partners with them during childbirth?

The evidence in a study by Hodnett, Gates, Hofmeyr, and Sakala (2007) also demonstrates that the presence of a support person is essential for positive outcomes for the mother and baby; thus my study began with a consideration of the increased pressure on nurses to be the one constant presence, responsible for ensuring the safety of mother and baby. It is interesting to note, however, that Hodnett et al. found that the support
person giving the greatest benefit was not part of the hospital staff. Women should thus be asked whether they view a nurse’s habitual presence as an intrusion, and to what degree such a perception would, or would not, extend to other supporters.

Convoluted dynamics may be present within the supportive team, and members may hold conflicting views of what support should be and what the woman needs. This may or may not be invasive for the woman. How the members of the support team relate with each other and with the woman may have an influence on her view of the birthing experience. This study’s results help unravel some of the complexities regarding women’s perceptions of support, and expose contributing factors that may ultimately affect their individual experiences with labour and delivery. Such factors might include: pressures that a busy nurse may wrestle with to be there persistently; the personalities and qualities of other supporters; and their behaviours, which the women may or may not find to be beneficial.

**Significance of the Study**

Documented for decades as pivotal to the outcome of a *safe* childbirth, support is not a new concept. Yet little inquiry has focused on the labouring woman’s personal perception of support. Hence, there is a need to uncover experiences, as the women themselves recall them, so that members of support teams can better understand what is required of them. Researchers must therefore ask women what, from their perspectives, is the true meaning of support during childbirth, and give them the opportunity to respond. The responses and findings may assist other primiparous women to discover what their potential needs may be during childbirth.
In cases where formal or informal support is provided, each person—the woman and any of her supporters—brings to the experience particular expectations that might change as the labour progresses, and as the woman discovers and communicates unforeseen needs. How each person involved understands the overall idea of support might thus change. For the women receiving support and the people giving it, the reality of childbirth can vary greatly from what they imagined prior to the commencement of labour. The concept of support therefore needs to incorporate an element of flexibility, in order to recognize the possibility of changing perceptions on the part of both the woman in labour and her supporters.

This study’s findings are aimed at contributing to awareness of women’s needs during childbirth among the following groups: nurses; members of the supportive labour and delivery team, including friends, doulas, midwives, husbands, and family members; pregnant women who are preparing for their labour and delivery experiences; and postpartum women who may be able to use the findings of this study to reflect on their childbirth experiences.

**Purpose of the Study and the Research Question**

The purpose of this qualitative interpretive study is to explore and describe women’s perceptions of the support they receive throughout labour and delivery. The research question is: What are women’s experiences of, and perspectives on, supportive care during labour and delivery?
Definition of Terms

Support during childbirth can be defined as the constant emotional, physical, and psychological advocacy that a woman receives from companions of her choice (Enkin et al., 2000). All women and caregivers have different, individual definitions of support during childbirth, but for the purpose of this study, support is whatever the woman experiencing it wants it to be.

The following definitions were used for the purpose of conducting this study:

Labour: The onset of regular uterine contractions causing dilatation of the woman's cervix leading to the physiological process by which the fetus is expelled from the uterus into the vagina and then to the outside of the body (Taber's Cyclopedic Medical Dictionary, 1989).

Labour support: The emotional and/or physical presence and comfort provided by a person or several people of the labouring woman’s choice; and a nurse that has been assigned to her. Support will be further described in the words of the women that experienced it.

Assumptions

When I began this study my assumptions were that the women interviewed would have the ability to respond to questions and that the responses would be honest and lead to in-depth descriptions of their experiences. I also assumed that all of the women had chosen their informal supportive companions and been assigned a nurse that they had not chosen. Lastly, I conducted the interviews on the assumption that even though I am an
LDRP nurse, the women would still give frank answers regarding whether or not they found the constant presence of an LDRP nurse to be intrusive.

Limitations to the Study

This study's findings were obtained from interviews of eight women who experienced childbirth at a major metropolitan hospital; the data, therefore, may not be consistent with a majority of the population, due to the small sample size and the clientele that a hospital such as this may draw.

The women who volunteered for this study were primiparous, financially stable, and healthy; results may only be relevant to individuals of similar backgrounds and are not generalizable to women who may deliver at a tertiary hospital, women with lower socioeconomic backgrounds, and women of different ages and cultures. Consequently, as with many qualitative studies, the findings of this study lack generalizability.

Only women who were low risk for complications during labour and delivery, and who were known to have a term infant were interviewed; therefore, the results of this study would not pertain to women at high risk for complications, women going through labour with their second child, or women giving birth to a premature infant. In these cases, the levels and types of support may or may not be different, and may or may not need an enhanced or lesser degree of support.

It is important to note that, as the interviewer, I am also a perinatal nurse working in the LDRP unit where the women gave birth. Although I did not take care of the women who were interviewed, they knew I am an LDRP nurse and might have responded differently to an interviewer who was not an LDRP nurse.
For a broader perspective, further research should be conducted with women of various socioeconomic backgrounds, women from different cultures, women experiencing higher-risk pregnancies, women who are having their second or third child, and women who delivered in tertiary hospitals. It may also be beneficial to have an interviewer who does not work within the ward from which the participants are recruited.

Limitations of this study are as follows:

1. The women who responded to this study may not be representative of all primiparous women; the results therefore do not pertain to all primiparous labouring women.

2. As the study sample was obtained through one health care institution, the results only pertain to that institution and findings might be influenced by its particular standards.

3. The perceptions of the women were captured only at the point and time of the interview. Any of their perceptions that might have changed over time are not taken into consideration.

4. The women who volunteered for the study were financially stable at the time; therefore, significant socioeconomic issues that may affect supportive care for childbearing are not captured in the findings of this study.

Summary

As an introductory overview, this chapter has described the purpose and significance of the study, explained the background to the problem, outlined the study’s assumptions and limitations, and posed the central research question, what are women’s
perspectives on supportive care during labour and delivery? The following chapter will review and analyze literature related to this question.
Chapter 2

Literature Review

This chapter’s purpose is to survey the knowledge acquired from other studies and to examine published literature on the supportive care of women during labour and delivery. The analysis and presentation takes in both qualitative and quantitative research. Prior to embarking on this review of the literature, my intention was to gain a better understanding of what women believe are the essential attributes of labour support and to discover the further potential of supportive care from the labouring woman’s perspective.

This literature review begins with definitions of labour support then assesses claims that such support improves outcomes for the mother and fetus. The phrase “improved outcomes” refers to decreased mortality and morbidity of the mother and fetus during labour and birth. The review further addresses literature on supportive care from health care professionals, as well as support from nonprofessionals, such as spouses, partners, or family members; it concludes by considering the state of the research on women’s own views of various labour support experiences.

This literature review indicates a deficiency of research regarding women’s perspectives on supportive care during childbirth. Related gaps in the literature and specific directions for further research also become apparent.
Methods

Using the terms “labour support,” “childbirth,” and “women’s perceptions”—and including literature published in English from the years 1978 to 2008—a search of the CINAHL and Medline databases identified a number of articles. I then narrowed the focus to women’s perceptions of labour, support from others, and experiences with their supportive teams. Articles chosen met the criteria for the following categories regarding support: defining labour support; improving outcomes; support from nurses, doulas, midwives, husbands, and lay women; and women’s perceptions. The articles were then separated into each category and analyzed.

Defining Labour Support

For centuries, and in all of the continents of the world, women have received support during labour. But while it is common practice, such support is not a simple concept to define. A number of factors associated with the real-life experience of labour and its support need to be taken into account to ensure optimum care for the woman and to improve her experience of the support that she receives during labour.

To conceptualize labour support, it is important to acknowledge individual differences. Each woman who goes through labour, with or without one-to-one continuous support, has an experience unique from that of any other woman. It cannot even be assumed that any two experiences are necessarily similar, let alone identical (Carlton, Callister, & Stoneman, 2005; Nystedt, Hogberg, & Ludman, 2006). Additionally, in a qualitative study using hermeneutic inquiry, MacKinnon, McIntyre,
and Quance (2005) explored the phenomenon of nursing presence during childbirth and found that women attribute multiple meanings to the care that nurses provide. The point is that women must devise and formulate their own personal requirements for childbirth, and supporters should follow their lead. A fully comprehensive definition of labour support would recognize that, ideally, the nature of support should vary according to individual need. Women need shifting levels and types of care as they progress through the stages of labour. They often require different types of support from different persons, depending on which stage of labour they are in (Yim, 2000).

If the concept of support were being practiced to the fullest extent, each woman could choose the amount and type of her support, as well as who provides it. To meet her needs as they evolve, she would also be encouraged to request alterations in the care given by her supporters during labour and delivery. With that said, in no way am I suggesting that women should dictate their own supportive needs at the expense of their safety or that of their babies. If their safety is not in question, however, women should be able to orchestrate their own supportive care. Generally speaking, women would be empowered to exercise control over both their labour and the support that they receive during it. In a qualitative study using a phenomenological approach, Kontoyannis and Katsetos (2008) found that women decided on home births primarily because they wanted to be in control of the birthing experience, and the familiarity of being at home gave them a sense of reassurance, enhanced their self-esteem, and bestowed feelings of confidence.

Zhang, Bernasko, Leybovich, Fahs, and Hatch (1996) defined labour support as the continuous emotional support to women undergoing labour and delivery. Klein, Gist, Nicholson, and Standley (1981) described it as the presence of a valuable companion
during childbirth but did not clarify what aspects of the companion’s behaviours are helpful. Sosa et al. (1980) defined it as human companionship during labour and delivery. Scott, Klaus, and Klaus (1999) characterized it more precisely as support for a woman in labour from those close to her and from specially trained caregivers (nurses, midwives, or laywomen).

The literature reviewed here demonstrates many attempts to define labour support as a concept and to clarify what it is, and what it should be, in practice. Some authors have defined labour support as the one-to-one continuous presence of an “experienced” person during labour (Bowers, 2002; Hodnett & Osborn, 1989; Kardong-Edgren, 2001; & Wilcock et al., 1997). Enkin et al. (2000) stated: “a central feature of support in childbirth is the promise that the labouring woman will not, at any time, be left without available support” (p. 247). In their systematic reviews of data from the Cochrane Library, Enkin et al. discovered that the mere physical presence of a support person is not sufficient, and that the supporter must also perform actions that promote physical comfort and emotional well-being. More specifically, McNiven, Hodnett, and O’Brien-Pallas (1992) determined that providing the reassurance of touch is one aspect of labour support. Touch, though, is supportive only as long as the woman receiving this form of reassurance actually wants it.

In a study by Corbett and Callister (2000), women were invited to write, within 72 hours of their labour, about nursing behaviours that they had found particularly helpful during labour. Eighty-eight low-risk women agreed to participate, and the return rate was 100%. Nursing behaviours perceived to be beneficial included: making the woman feel cared about; answering questions; carrying out the woman’s wishes; making her
physically comfortable; including the woman in making decisions; and communicating the woman’s needs and wishes to other health care professionals.

Sleutel (2003), in her analysis and interpretation of Rubin’s framework of social support, gives examples of how intrapartum nurses could provide emotional and other labour support by staying with the mother continuously, making eye contact, and using physical touch and reassuring words. “Supportive care may be defined as non-medical care that is intended to ease a woman’s anxiety, discomfort, loneliness, or exhaustion, to help her draw on her own strengths, and to ensure that her needs and wishes are known and respected” (Simkin, 2002, p. 721). In some instances, responding to a woman’s wish to have a few moments to herself, or some privacy with her husband or family might be the best supportive care that the nurse could give. This is further suggested by the fact that the women in Corbett and Callister’s (2000) study did not include the continuous one-to-one presence of a nurse or labour support person among their list of helpful nursing behaviours.

Elsewhere in the literature, there is much discussion about nurses’ continuous presence as part of labour support. To help clarify the issue, Osterman and Schwartz-Barcott, (1996) discovered that the term presence is used to “characterize a nurse’s physical presence, while, at other times, it is used in a highly metaphysical sense to depict a nurse’s full physical, psychological, and spiritual presence” (p. 23). Osterman and Schwartz-Barcott further explained that presence is much more complicated than this and can be quite confusing. For instance, a nurse could be considered to have minimal presence if she is sitting in the room with a labouring client, documenting care procedures, and paying more attention to the technological support that the woman is
receiving than to the labouring woman herself. A nurse might sit in a darkened corner and consider herself present, but does the woman really feel that presence? Conversely, a nurse might demonstrate physical presence sparingly when caring for a labouring woman, but the supportive measures that the nurse displays during these times could be more beneficial to the woman than the inaction of a nurse who is only present in body. Social support during labour and presence are virtually the same concept, in that each suggests a willingness of physically "being there" and psychologically "being with" (Hunter, 2002). Variations on the definition of social support include references to actions such as physical touching, offering words of comfort and emotional support, and giving information (Hunter, 2002). However, some may argue that presence may or may not include the attributes of social support.

In their exploratory qualitative study, MacKey and Stepans (1994) interviewed 61 Lamaze-prepared, married, multiparous women between 21 and 37 years of age who had an uneventful labour and delivery. They conducted the interviews during the postpartum hospital stay and discovered that labouring women expected their nurses to make them comfortable, keep them and their coach calm, provide reassurance that everything would be all right, and give them assistance with breathing and relaxation techniques. Nurses referred to in McKay and Stepans’ study were viewed favourably if they had the ability to discern when their presence was needed and when women desired privacy. Interestingly, Tumblin and Simkin (2001) gave questionnaires to nulliparous women in the last trimester of pregnancy during their attendance at childbirth classes. The questionnaires requested that the women list their expectations of the nurse’s role during labour and delivery. From the 57 questionnaires that were collected, Tumblin and Simkin
concluded that women wanted to have the continuous *presence* of a nurse and expected the nurse to leave the room only to notify the physician of the labouring woman’s status. The women also expected the nurse to provide informational support and emotional and physical comfort. Throughout the literature, the diverse, sometimes opposing views about the constant presence of a labour and delivery nurse, and the women’s perceptions regarding it, suggest a need for further research into this aspect of support.

A descriptive survey conducted by Miltner (2000) sought nurse’s perspectives on nursing actions that best characterize labour support. Five hundred intrapartum nurses were asked to participate in the survey and 166 agreed to participate. Nurses noted the following actions as the most supportive: remaining with the mother if she is fearful or in pain; coaching the mother during pushing efforts and relaxation; and praising the mother for her efforts in labour. Most of the actions that Miltner described in her study are actions of nurses during the pushing stage of labour and are strictly perceptions of what the nurses feel are most supportive to the women. The women themselves were not asked if these actions were comforting to them. From this study it is clear that nurses feel that it is their responsibility to provide constant presence if the woman is in pain, whether or not this is part of the nurses’ practice, and whether or not the woman wants this type of support.

VandeVusse (1999) undertook a qualitative descriptive study that analyzed women’s birth narratives. Eight primiparous and seven multiparous women provided spontaneous responses to the request to tell their birth stories however they wished. This study discovered that, in relation to labour support, women indicated that nurses have a profound impact during labour and are in a position to make positive changes by working
with women to encourage them to remain in control of their labouring experiences. From the women’s responses, VandeVusse discovered that nurses bring a unique blend of knowledge, observations, communication skills, and caring—all attributes of labour support. At the same time, they need to use their professional knowledge and power to be encouraging but not overly directive of the birthing process.

In summary, labour support is not defined well in the literature, most likely due to the inability to generalize it to all individuals—including those who receive the support and those who provide it. Each person receiving and giving labour support will define it differently and uniquely. Each woman should define labour support according to her needs during labour. How a woman defines labour support in the early stages of labour may change as her labour progresses. And the same woman’s definition may change again during the postpartum period. She may even want to seek a completely different type of support for future births.

**Improving Outcomes of Childbirth**

The decrease in the mortality rates for the mother and baby during childbirth is among the most significant findings in the literature on supportive care. Standards developed by the SOGC (1995) have the aim of enhancing patient care and improving outcomes for the mother and fetus. One such standard is that labouring women should have one-to-one continuous support during the active phase of labour until delivery (SOGC, 1995). Several studies have supported the notion that the continuous one-to-one presence of an experienced support person leads to improved outcomes for women and neonates (Callister & Hobbins-Garbett, 2000; Enkin et al., 2000; Hodnett, 1996; Rooks,
In a study by Brown et al. (2000), a randomized control trial (RCT) in South Africa utilized focus groups made up of nursing staff, along with interviews of over 2,000 women. The focus groups were conducted at 10 different maternity services in and around Johannesburg, although it is not clear how many staff members participated from each site. The findings of Brown et al. illustrate that the nurses believe strongly that labour support is necessary in order to contribute to better health in the mother and newborn. Brown et al. concluded that nurses should “encourage a partner, friend, relative, or layperson to support women during labour” (p. 31). These results come from the nurses’ focus groups, and excerpts from the interviews of the women are not provided. From the analysis of the women’s interviews, Brown et al. found that it was not more or less perceptively beneficial to the mother or the fetus that the supportive team were experienced professionals. Hodnett et al. (2007) confirmed in their subgroup analysis that it was actually more beneficial to the woman if the person providing the support was not employed by the hospital. The conclusion was that women had better experiences and were more likely to have a vaginal birth if an experienced female supporter, such as a doula, supported them. In a qualitative descriptive study by Price, Noseworthy, and Thornton (2007), 16 women were interviewed and described the support offered by loved ones as far beyond what health care professionals could offer; such personal support might include being a voice for them or relaying concerns on their behalf.

In the Cochrane Library review (1999) of evidence regarding the beneficial effects of providing continuous one-to-one support throughout labour, 13 RCTs included almost 5,000 women. From this meta-analysis, the Cochrane Library, as cited by Rooks
(1999), lists the benefits as:

Fewer caesarean sections; less use of forceps and vacuum extraction; shorter labours; less need for pharmacologic pain relief, including fewer epidurals; fewer low Apgar scores; fewer women who did not cope well or viewed their labour as worse than expected; greater overall maternal satisfaction and increased sense of control during labour. Individual trials have found continuous support during labour to be associated with: longer breastfeeding; less postpartum depression; fewer women who had difficulty accepting the baby or adapting to motherhood (p. 360).

In contrast, a previous Canadian study, performed in a teaching hospital in Toronto by Hodnett and Osborn (1989), examined the effects of continuous labour support by intrapartum professionals on outcomes of childbirth. The women in this study were predominantly Caucasian, obstetrically low risk, educated, middle class, married, and primigravid. This study did not find that caesarean section rates or the duration of labour decreased as a result of one-to-one professional supportive care. It did, however, indicate a decrease in episiotomies and reduced need for analgesics.

An analysis of a RCT performed by Gagnon and Waghorn (1999) recruited 100 nulliparous women who were similar in age and gestation and who were considered low risk. The purpose of the study was to view caesarean section rates in relation to labour support. The women in the study were stimulated with oxytocin and given one of two kinds of support. The experimental group received one-to-one care, which is defined as “the presence of a nurse during labour and birth who provided emotional support, physical comfort, and instruction on relaxation and coping techniques.” The control group in the trial had usual care, which is defined as one nurse to “care for two to three labouring women with supportive activities varying by each nurse” (Gagnon & Waghorn, 1999, p. 371). The results established a 56% reduction in total caesarean deliveries among the experimental group. Interestingly, in a more recent study, Gagnon, Meier, and
Waghorn (2007) discovered that each additional nurse caring for the same labouring woman was associated with a 17% increased risk of having a caesarean section. However, correlation of other patterns of care variables with caesarean births was not sufficiently accurate to be informative.

Somewhat contradictory to Gagnon and Waghorn’s (1999) study, a RCT by Hodnett, Lowe, Hannah, Willan, Stevens, Weston, Ohlsson, Gafni, Muir, and Myhr (2002) compared an experimental group who had the constant presence of a nurse and a control group who received usual care or had the intermittent presence of a support person. The purpose of Hodnett et al.’s study was to evaluate the effectiveness of nurses as providers of labour support in North American hospitals in relation to caesarean delivery rates. A total of 6,915 women at 13 United States and Canadian hospitals with annual caesarean delivery rates of at least 15% were enrolled during a two-year period and followed up until six to eight weeks postpartum. Inclusion criteria were women who had a live singleton fetus or twins, were 34 weeks' gestation or more, and were in established labour at randomization. Hodnett et al. found that there was no difference in the outcomes of the two groups in relation to caesarean section rates, intrapartum events, and neonatal or maternal morbidity immediately or six to eight weeks postpartum.

The literature related to labour support has shown an indirect positive impact of support on breastfeeding. Lavin (2001) reviewed and analyzed various research studies to assess the impact of labour support on breastfeeding outcomes. The studies were predominantly quantitative. However, it is not evident if the studies were RCTs. Furthermore, Lavin did not give details of the outcomes of each study but, rather, provided common findings, such as narcotics given for pain relief during the intrapartum
period, decreased neonatal alertness, inhibited suckling, lowered neurobehavioral scores, and delayed effective feeding. Lavin concluded that breastfeeding is negatively affected by the use of analgesia during labour.

Claims have been made that when a woman has been supported during childbirth, her need for analgesia decreases (Forster & McLachlan, 2007; Riordan, Gross, Angeron, Krumwiede, & Melin, 2000; & Romano, 2005). Furthermore, Pascali-Bonaro and Kroeger (2004) claim that continuous support by a doula during labour strengthens mother-infant bonding and increases breastfeeding success, thereby significantly reducing many forms of medical intervention. Based on the findings of their study, Klaus, Kennell, and Klaus (1993) discovered that advocacy and information, as well as emotional and physical support, greatly reduced the need for analgesia during labour. Lavin (2001) claimed that because labour support decreases the need for analgesia during labour, breastfeeding outcomes improve if labour support is provided. This is Lavin’s interpretation of the studies that she reviewed; she has not tested this claim. We could conclude from this that supportive care might indirectly improve breastfeeding success, due to the decreased need for analgesia when support is provided.

Contradictorily, in a prospective study by Halpern, Levine, Wilson, MacDonell, Katsiris, and Leighton (1999), performed at six weeks postpartum, a correlation between breastfeeding success at six to eight weeks and the exclusion of analgesia during labour could not be demonstrated. Halpern et al. concluded that analgesia during labour does not impede breastfeeding success. Women that are given choices, and thus control, during labour may also have a decreased need for analgesia regardless of the amount of support that they receive during labour. These claims must be tested further. From existing
research, it is difficult to ascertain whether women who seek out support during labour because they want as natural a childbirth as possible are more likely to have success with breastfeeding because of their holistic philosophy of childbirth, and not necessarily because they did not have analgesia.

**Support from Doulas, Laywomen, and Nurses**

"Continuous labour support results in decreased epidural use when the support is provided by trained doulas but no difference when the support is provided by nurses" (Romano & Lothian, 2008, p. 98). Consequently, a woman who receives the unwanted presence of a support person may require analgesia that she may not have needed had she been allowed periods of privacy or had the continuous support of a person she had chosen. It is also interesting to note that although the studies discussed above indicate that the utilization of doulas decreases the use of pain medication and increases the likelihood of a vaginal birth, one point may have been overlooked: That is, a woman who chooses to pay for an alternative supporter, such as a doula, might likely have the mindset that she does not want to use pain medication and may have prepared herself to do everything possible to avoid it; she might additionally be more motivated than average to have a vaginal birth.

Women are increasingly seeking assistance from doulas. Education for doulas consists of approximately 18 hours of instruction, and attendance at labours and births is encouraged but not required (Gilliland, 2002). Doulas assist women during labour and birth, and remain with them constantly until delivery. A doula’s role is to provide information, give perspective, allow choices, assist with physical comfort, and offer
encouragement (Wingate, 1998). Many women, especially those that feel that they will need a constant labour support companion other than their partner, are hiring doulas.

Many articles concerning care by doulas note that women seek outside assistance for labour support in the belief that having an experienced person during labour can help them cope. Wingate (1998) notes that women in labour must trust their bodies to signal needs. Unfortunately, however, women who have never been in labour cannot know exactly what their bodies need until they are actually experiencing labour. Thus, in the belief that she might not be able to cope without a constant presence, a woman might seek assistance from a doula or a friend—only to discover that she really would have liked some time to herself, without such constant support. But by this point, the woman might feel uncomfortable requesting that the doula or supportive companions leave the room so that she is able to have some private time, alone or with her spouse.

Although doulas and nurses can undoubtedly complement each other in the care that they give their clients, power struggles between nurses and doulas could also develop. At times, the nurse might feel frustrated by what the doula is doing, yet uncertain about how to intervene (Gilliland, 2002). For instance, the nurse may question whether or not the doula is overstepping her boundaries into the nurse’s domain and vice versa. Such conflict and tension in the labouring room could be a source of anxiety for the woman and possible detriment to the outcome of her labour and to her overall childbirth experience. The difficulties might arise when nurses and doulas perceive philosophical differences as obstacles and fail to see the caring hearts that motivate the actions (Gilliland 1998).

Thus, for all their growing popularity, doulas present certain potential
disadvantages and are likely to remain one support option among several. Additionally, because the individual needs of each woman require different types and amounts of support (Demianczuk, Okun, & Chari, 1997), support from a doula is not beneficial for all women. Because one woman has a positive experience with her support person or team during labour and delivery, this does not mean that another woman will also experience the same positive effects, regardless of similarities in age, gestational age, parity, or other variables.

In a 1996 survey, Hanvey, Levitt, and Chance sent questionnaires to 572 Canadian hospitals to discover which of them were providing family-centred maternity and newborn care. Out of the 572 questionnaires that were sent out, 523 were returned. Family-centred maternity and newborn care is defined as the freedom of the patient in the hospital to have support from her family in the way that she herself deems necessary. The philosophy of this type of care requires:

- open communication between a woman, her family and health professionals; that the woman be able to choose people to support her, and have those people present during labour and birth; and that the mother and infant remain in close contact whenever possible following birth (Hanvey et al., p. 16).

It is noteworthy that in a study mentioned earlier, Brown et al. (2000) found that it was not more or less beneficial to the woman's experience that the support team was made up of experienced professionals. Moreover, according to Brown et al., some women explained that having a detached support person was comforting, as that person would not judge or discuss the labour as a friend or relative might. In contrast, in examining the benefits of who provides labour support, a selective review of various studies by Chalmers and Wolman (1993) found that the presence of "untrained" laywomen significantly reduced the length of labour in women. They also reported that, of the
experienced labour supporters, support from a doula resulted in positive effects of social support on health outcomes such as stress and pain in labour, while attention from medical staff was more of an adjunct to labour support from "trained" and "untrained" labour supporters.

In conducting an exploratory descriptive meta-analysis, Gale, Fothergill-Bourbonnais, and Chamberlain (2001) believed that birthing units are generally staffed to provide one-to-one nursing care during labour and delivery. However, in my experience as an LDRP nurse, educators and managers may stress the necessity of continuous one-to-one support from nurses for women during childbirth, but the LDRP unit is not staffed accordingly. Likewise, as Gale et al. also pointed out, in many Canadian and American hospitals, a ratio of two labouring women to one nurse is more likely. With these statistics, it seems almost impossible to require nurses to provide emotional support of the labouring woman for more than 50% of the time, due to nursing shortages and heavy patient workloads. This would inevitably mean that the other labouring woman under the nurse's care would have the constant presence of the nurse less than 50% of the time. It is necessary to undertake further research to discover whether or not women have a more positive experience if the nurse-to-patient ratio is one-to-one or one-to-two.

**Presence of Partners**

Partners can also be a source of support for labouring women. Male and female partners are staying in the delivery room to be a part of the childbirth experience and to be of assistance to the woman. Partners may be of great support to the woman or they may give little support. This depends on the partner, the woman, and the dynamics of
their relationship.

A partner is often the only family member available to give support to the labouring woman and has a place in the delivery room, even though his or her usefulness as an effective support individual can be variable and inconsistent (Demianczuk et al., 1997). Price et al. (2007) found that the women they interviewed never thought of a husband as a visitor—it was “a given” that he would attend the delivery and be an essential part of the birth experience, because he was witnessing the birth of his own child.

The partner’s role in the labour room is not clearly defined. Not only the woman but also family, friends, and health professionals expect the partner to be there, yet there is not a definitive role for him or her (Longworth, 2006). Is a presence all that is needed from the partner for the labouring woman? Longworth (2006) found that partners were most often needed as support and not necessarily to provide interventions. In an experimental and prospective design study in Turkey, Gungor and Beji (2007) found that the women considered the support of a partner to be crucial to a fulfilling experience, and that the presence of a partner could alleviate the loneliness, pain, and uncertainty during delivery and give a woman the strength to endure the suffering.

**Women’s Perceptions**

As mentioned in a previous section, the study by Miltner (2000)—which surveyed intrapartum nurses—discovered that intrapartum nurses believe that they must remain with the mother if she is in pain. The interesting contradiction is that women’s perceptions of labour support in terms of one-to-one continuous attendance are not
overwhelmingly evident in the literature. Surprisingly, nurses express the importance of one-to-one care more often in the literature than do women. In Corbett and Callister’s (2000) descriptive study, 88 women rated 25 selected nursing behaviours on a Likert scale of perceived helpfulness. In the resultant list of supportive behaviours, ranging from number 1 on the list being most helpful to number 25 on the list being the least helpful, the women make no mention of constant presence during labour; nor do they give any other indication that they expected their supporters never to leave them.

Results are similarly suggestive in a qualitative analysis of birth stories, by Hanson, VandeVusse, and Harrod (2001), which merges data from two qualitative studies of women’s combined birth experiences. Studies by VandeVusse in 1993 (n = 15) and Harrod in 1998 (n = 22) were used for the analysis (Hanson et al.). One woman speaks of her experience of having many people distracting her during her painful labour:

I just didn’t want to focus on anybody else. There was some point at which a lab technician came in to draw my blood, and I just was wailing at that point. I just thought, “Oh, no, another person,” and “I can’t deal with it.” That disturbed me, every time the contractions got harder and another person would come in or would change shift, or whatever. They changed nurses it seemed like two or three times during the night, and none stayed around and did much. But by the time they introduced me to another nurse, that seemed really distracting to me (Hanson et al., p. 23).

It seems clear from this excerpt that not all women can tolerate the interruptions involved in providing continuous support. Nurses, whether or not they practice constant presence, seem to believe that it is their responsibility to be present for most of a woman’s labour. With the turnover in nursing staff every 8 to 12 hours, however, the same nurse is not able to consistently care for a woman who labours for 24 to 48 hours or longer.

In an exploratory qualitative study using open-ended, intensive, tape-recorded interviews (n = 61), Mackey and Stepans (1994) determined that multigravidae women,
aged 21 to 37 years, viewed nurses favourably if they were present only when needed: “They just checked in every so often . . . They didn’t inconvenience us at all. So they didn’t over pester me by any means. She was in and out when nothing much was happening, but she was there through transition and through to the end” (Mackey & Stepans, p. 416). This study concluded that acceptance of each woman as a unique human being may be a nurse’s most important characteristic.

Price et al. (2007) agree that the inclusion of more than one support person should be based on each woman’s unique needs. While each participant in Price et al.’s study described the value of the nurse’s presence, the women did not view the nurse as having the same ability as their loved ones to provide the level of intimate support that they required. The women explained further that support provided by caregivers who were not healthcare professionals, and had no task other than to focus exclusively on their needs, had added benefits. For instance, they spoke of the importance of someone who genuinely knew them giving them support.

In a descriptive research design using a structured questionnaire, Manogin, Bechtel, and Rami (2000) asked 31 childbearing women who had gone through an uncomplicated childbirth to rate their nurses’ caring behaviours. Manogin et al. found that the women perceived demonstration of professional competence, monitoring of the mother’s condition, knowledge of equipment, and treating women as individuals to be among the beneficial caring behaviours. The women in the study also mentioned that caring involved the nurse being there, if the woman required her. No one expressed the need for a nurse’s constant presence. The results from this study support the idea of the woman as an individual and the importance of this concept to labouring women. Women
want nurses to know that they are unique and that they do not want the same things that other women might want. It is also clear from the study by Manogin et al. that women understand caring differently than nurses define it. For instance, in the study, women were primarily concerned about the nurses’ competence and respectful attitude and felt that these were what constituted caring behaviour.

For a qualitative study in Taiwan, Chen, Wang, and Chang (2001) interviewed 50 mothers (36 primiparous and 14 multiparous) within 48 hours of delivery, for the purpose of discovering women’s perceptions of helpful and unhelpful nursing behaviours during labour. This study concurs with that of Manogin et al. (2000) that women found nurses to be helpful when they offered informational support, performed technical duties efficiently and effectively, and comforted the women when it was needed. Strategies that nurses used to comfort their clients included praise, companionship, empathy, consoling, and encouraging (Chen et al., 2001). Contrary to Manogen et al., Chen et al. found that at least one woman felt that it was important that the nurse remained at her side: “Had it not been for the nurse who supported me, stayed with me, and gave me courage, I would have almost given up on having a natural birth” (p. 184). Adams and Bianchi (2008) found that women felt nursing presence to be beneficial when nurses established a trusting relationship early in the labour and were truly present with the woman and not merely performing tasks. Once again, this shows that recognizing the importance of uniqueness and individuality is the key to supporting women through labour. Nurses must be intuitive about who needs their constant support and who finds their intermittent presence to be helpful.

In a study in Zambia, Maimbolwa, Sikazwe, Yamba, Diwan, and Ransjo-
Arvidson (2001) questioned women about their views on involving a social support person during labour. Out of the 84 primiparous and multiparous women interviewed, only 60% wanted a supportive companion to be present during labour. Preferences of supportive companions included mothers, sisters, cousins, and sisters-in-law. Partners or spouses were not the preferred support persons. The women, who were interviewed within 8 to 12 hours of delivery, felt that their social support person provided practical and emotional support, guidance, security, and company. But Maimbolwa et al. also reported some opposing views, such as lack of confidence in inexperienced family members who might not know what to do, concerns about invasion of privacy, and the belief that the hospital was responsible for maternity care. One woman said, “I prefer to deliver alone, relatives would just be watching me” (Maimbolwa et al, p. 229). The researchers did not specify how the results differ between multiparous and primiparous women.

Many women believe that childbirth is an intimate event that should be experienced only with a partner or with others that are closest to them. Price et al.’s (2007) study, however, found that some women did not want relatives or friends with them at all. One woman in the study stated, “It’s not a concert,” and another said, “I don’t want to let anyone into the birth room just to say they were there.” Many women may feel this way, while other women may want several people there for support and comfort.

Women also express the need to feel in control of their decisions and may experience a lack of control during labour and delivery. Nurses, physicians, and other members of the health care team often dictate to women what they should be doing or what is best for them. In VandeVusse’s (1999) qualitative descriptive study, eight
primiparous and seven multiparous women were asked about the concept of control in relation to nurses: “Women indicated that nurses have a profound impact during labour. Nurses are in a position to make positive change by working with women to share control” (VandeVusse, p. 178). Other studies agree; women were disappointed at not being permitted to manage their own labour and found that nurses often wanted to take over the situation, thus leaving the women feeling as if they had no control (Bryanton, Fraser-Davey, & Sullivan, 1994; Mackey, & Stepans, 1994; & Callister, 1993).

Questionnaires that were developed by Tumblin and Simkin (2001) requested nulliparous women, during the last trimester of pregnancy, to list their expectations of the nurse’s role in relation to labour support. It would be interesting for Tumblin and Simkin to interview the nulliparous women again during the postpartum period to discover whether or not the women’s expectations were met or maybe even altered after the labouring experience. After going through labour, the women may have found that they did not want their nurse’s constant presence. It is difficult for women who have never experienced labour to know exactly what they need prior to going through it. Labouring women must be encouraged to voice their needs and what they feel would be helpful for them both before and during the active and pushing stages of labour. Their wants and desires would provide crucial information for a widely applicable concept of labour support that would include the ideas of individual differences and control during childbirth.
Future Research Directions

It is evident from the review of the literature that it would be beneficial to perform further research relating to what women desire during labour, as there is little documentation of women's perceptions during their childbirth experiences. It would be valuable to conduct a study to discover what prenatal women want for labour support and then to follow up with a postnatal inquiry, in order to discover how the women's requirements transformed over time.

This literature review demonstrates that many nurses perceive labour support as a matter of their constant presence, whereas most of the women appear to equate effective nursing support during labour with more intermittent presence or presence only when assistance is unquestionably required. In the interest of providing the best possible labour support, these opposing perspectives need to be reconciled, and directions for doing so determined through further research. The interaction of the individual woman and her chosen supportive care team is ultimately the meaning of support. This idea, moreover, is a promising basis on which to build further knowledge related to labour support.

Summary

In exploring findings related to supportive care of women during labour and delivery, this literature review has taken in definitions of supportive care during labour, as well as evidence that labour support may improve outcomes for the mother and baby. It has further addressed research on various members of the supportive team, including nurses, and analyzed existing documentation of women's perceptions of the support that
they received during childbirth. The review indicates that there is a need for further research into women’s perspectives on support. The following chapter will outline my research in this regard. It will describe the research design, data collection, and sampling methods; demonstrate rigor and validity; and address ethical concerns.
Chapter 3

Methodology

This study of women’s experiences and perceptions of labour and delivery uses an interpretive descriptive approach to gain a better understanding of what women require as they are going through the various stages of childbirth. This chapter describes the qualitative, interpretive descriptive method I have used, and explains sampling, data collection, and data analysis procedures. It further considers issues of rigor, validity, and ethics.

Research Design

The purpose of this study is to gain a better understanding of women’s perspectives on supportive care as they are living through it. A straightforward way of accomplishing this was to ask women to describe their experiences; I then analyzed the responses in order to identify meaningful themes and patterns, as well as differences in experiences and perspectives.

In conducting this study, I used an interpretive descriptive approach. This qualitative design is particularly appropriate for exploring the supportive environment through the perceptions of labouring women, because it offers a way to document how, subjectively, “people experience their health and illness” and provides direction as to “what nursing can do to make a difference” (Thorne, Kirkham, & MacDonald-Emes,
This kind of design not only gives the researcher the freedom to collect data from people who are living through particular phenomena, but it also facilitates description, analysis, and interpretation, so that other health care professionals can learn from the findings.

For the purpose of gaining meaningful data, the essence of interpretive description is the researcher’s analysis of the participants’ experiences. “As many nurse researchers have discovered, the nursing profession’s unique knowledge mandate may not always be well served by strict adherence to traditional methods as the ‘gold standard’ for qualitative research” (Thorne et al, 1997, p.169). I therefore chose interpretive description as the most suitable method to answer the research question, obtain subtle contextualized data, and disseminate the women’s emic perspectives. Interpretive description also meets the applied, or purposeful, needs of nursing and, in particular, the need to acknowledge the aggregate without negating the individual, thereby enhancing individualization in practice (Thorne et al). It was my intention to generate data from the women’s responses that would contribute to understanding how women perceive the experience of labour and delivery, and thus to identify new possibilities for nurses’ interaction with the women they care for.

The interpretive descriptive design obtains data with a logical and systematic approach, thus maintaining coherence and epistemological foundations (Thorne et al, 1997). I have adopted this methodological approach with the rationale that it would reveal an emic perspective of the women’s experiences, while contributing to knowledge of the philosophical underpinnings of nursing.
Sampling

Initially, I recruited the participants in the study through the use of purposeful, theoretical sampling. This method involves selecting a group of individuals who can offer relevant information, and then continuing to seek appropriate participants who meet the inclusion criteria (Coyne, 1997). For instance, only women who had just experienced labour and childbirth for the first time were invited to participate in this study. Theoretical sampling offers a way to focus on the immediate experience of those who have lived it (Polit & Hungler, 1999). For the purpose of developing nursing knowledge, a theoretical sampling makes a useful contribution to the interpretive descriptive method (Thorne et al., 1997), as it allows for considerable flexibility, since the sampling can be ongoing throughout the study (Coyne, 1997). That is, who is sampled next would depend on who had been sampled already and what information was obtained (Polit & Hungler).

Snowball sampling is a research sampling technique whereby future participants are recruited by current participants (Faugier & Sargeant 1997). In this study, participants who were recruited using this method were acquaintances of those gained through theoretical sampling. The last five participants volunteered for interviews after they had learned about the study from existing participants.

Recruitment Procedures

Participants for this study were recruited from an LDRP unit in a major metropolitan city. Prenatal instructors at the hospital inserted an introductory letter (Appendix A) into each of the prenatal information packages that are supplied to expectant women. The letter provided a telephone contact number and women interested in participating in the study contacted me independently and on their own initiative.
I made an appointment with each participant, obtained informed consent (Appendix B), and conducted the interview once consent was given. According to the women's wishes, all of the interviews took place at their own homes.

**Participants**

Although it was difficult to recruit women for this study, eight volunteered and were interviewed intermittently over a four-month time frame. They heard about the study at prenatal reunion classes or through acquaintance with another participant. The women were English speaking and one spoke English as a second language, but her English was fluent. They were between the ages of 25 and 39, and all were primiparous. Seven had vaginal births; one baby was delivered with forceps and one via vacuum extraction. One woman had a caesarean section. The length of their labours was anywhere from 5 to 40 hours, and all of the women had uncomplicated pregnancies. The original plan was that interviews would take place two to three weeks after birth, but no one volunteered that soon, and at the time of the interviews, participants were seven weeks to seven months postpartum.

All of the women in the study gave birth at the same LDRP unit within the hospital. This means that the women laboured, delivered, recovered, and then spent two to three days of the postpartum period in the same room within the ward. Five of the women lived within a two-mile radius of the hospital and two of the women lived in the suburbs. All eight women had a husband present, and six had a female supporter as well. Only one woman had a second female supporter, a doula who was orientating with another doula that the labouring woman had recently hired. All of the women had at least one nurse and one doctor involved in their care.
Criteria for Inclusion

When recruiting participants for the study, I adhered to predetermined criteria. The introductory information letter (Appendix A) stated that women must be 36 to 40 weeks' gestation at enrolment, to ensure that the study would be completed within the allotted time line, and that the women must speak English for the purpose of communicating throughout the interview process. In order to give rich and in-depth descriptions of being supported, the women must have had supportive companions, as defined by them, and been cared for by a nurse who was assigned to them. All of the above criteria were met. Gestational ages of the infants at birth were 38 weeks to 40 weeks plus 3 days gestation. Each woman had at least one supportive companion of her choice with her during labour and delivery.

The women were asked to be willing and to give consent to participate in one interview—with the possibility of follow-up interviews. Though I am an LDRP nurse who works on the LDRP unit where the sample was obtained, I did not at anytime care for any of the women who were interviewed. Furthermore, I was on an educational leave of absence during the period when the women were pregnant and when they gave birth, and I do not therefore know which health care professionals looked after the women who were interviewed.

Setting

It was my intention to recruit study participants via the hospital from prenatal classes. Prenatal educators gave a brief description of the study and the commitment that would be required and handed out the information letter (Appendix A) to each woman. However, no one volunteered for the study at this point. Prenatal educators then handed
out the information letters at prenatal reunion classes, and women were then willing to volunteer for the study. Other participants were acquaintances of these first volunteers.

After they had reviewed information regarding the study, and consented to between one and three interviews, the women were invited to attend an interview at a mutually agreed-upon time and place. Each chose her own home as the most comfortable place to be interviewed, and all of the interviews were therefore conducted at the women’s homes.

Interviews conducted soon after delivery, I thought, might gather more diverse data than interviews obtained when the women were further away, in time, from the actual experience and perhaps unable to remember pertinent events. I also believed that gathering data in a comfortable home setting might encourage the women to reflect on their experiences with their support systems during childbirth. I had originally speculated that two interviews of each woman—one within the first week and another three weeks postdelivery—might provide more depth and richness of data than what I might obtain from just one interview in the earlier postpartum period. That is, the most vivid memories might be the earlier ones, but a later interview could yield added details and meaning to the women’s experiences. But since the interviews occurred much longer than three weeks after the births, they may not have captured the essence in the same way as if the interviewees were closer in time to the birth events. Arguably, however, having a greater length of time between the birth events and the interviews may have provided greater opportunities for reflection and made it possible to capture other meaningful data for the purpose of this study.
Data Collection

With the intention of eliciting natural and spontaneous responses, I obtained data through informal interviews, structured only by a set of preplanned interview questions (Appendix C). My idea was to gather pertinent data by asking open-ended questions that encouraged the women to give rich and personally meaningful descriptions of their experiences. I welcomed pauses in the conversation, with the objective of obtaining reflective and symbolic data. As an interviewer, I found that pausing after the woman stopped talking allowed her time to reflect and therefore elaborate and discuss her descriptions in a much deeper way.

With an interpretive descriptive design, the interview process is used as a means to explore and gather experiential narrative material from participants, which is to some degree shared by others (Thorne et al., 1997). Within the first few interviews, themes and patterns began to form. Women spoke of similar experiences with various members of their supportive team, and some interesting differences also became apparent. Views that various women shared and the noteworthy differences are documented in Chapter 4’s presentation of the findings.

During the interview, taking brief notes allowed for further probing once the interviewee had finished responding. The rationale for this was to avoid interrupting the woman and to assist with exploring the comment further when there was a break in the conversation. As the researcher conducting all the interviews, I took field notes after each, about the setting, nonverbal communication, and my impressions of the interview. Subsequently, I shared the information with a three-member research committee.
It was apparent that themes, patterns, and differences of data occurred within the first few interviews. There was one interview with each woman, which lasted one to two hours. I obtained clarification of excerpts and responses during and directly after each interview to elucidate potentially salient points. I believed that the data was adequate for a sufficient analysis, and I did not have any further queries for the women that would have added significantly to the information already received.

Before an interview began, I took measures to ensure that the interviewee would be as comfortable as possible during the session. I explained to the woman that she could stop the interview at any time and, if something that she said was too personal and she wanted it omitted, it would be erased from the audiotape immediately. The women were aware that names and identifying information would not be included in the study. I explained confidentiality measures to the women, each of whom, as indicated above, signed a consent form (Appendix B) prior to the initiation of the interview. I audiotape recorded and transcribed the interviews verbatim. The audiotapes have been kept in a locked filing cabinet since the interviews took place, and only committee members and I have accessed and reviewed the transcripts.

Having six to ten participants was the ideal for my study, and the eight participants gave rich data regarding their experiences. Furthermore, data collected from the first few women in the study were utilized to probe into the various findings with subsequent participants.
Data Analysis

Data collection and data analysis occurred simultaneously. Accordingly, analysis of the interviews began after the first interview and continued throughout the study. To begin with, I analyzed each interview and examined data to determine whether there was a necessity for further probing and clarification of questions to elaborate the themes and patterns that were developing. I then analyzed the interviews for emerging themes and patterns and coded these into categories. Each category was then coded into subcategories within each broader category, and patterns that were significant and valid for the study were grouped together and included in the findings.

Thorne et al. (1997) explained that for inductive analysis to produce sound and usable knowledge, efforts must be made to engage in both the abstractions of theorizing and the concrete realities of the practice context. It was my intention to analyze the women's experiences in an attempt to take what they had lived through and translate its meaning into implications for nursing practice. To attain the most honest and natural themes and patterns possible, I encouraged the women to speak freely about their experiences and allowed them time to reflect back. In qualitative research, it is truth and honesty according to, and from within, the participants' own reality that should be sought, whatever their lived reality might be.

Data analysis utilized the processes outlined by Morse and Field (1995):

1. Intraparticipant analysis: listening to the tapes and extensive reading and rereading of the transcripts.
2. Interparticipant analysis: seeking and discovering commonalities among participants and ultimately discovering familiar and similar words and phrases.

3. Interrelationships between themes: seeking interrelationships between the metathemes, using quotes from the interviews as concrete illustrations to provide a realistic and accurate portrayal of the phenomena. Writing and rewriting increases the insights and the reflections of the reader, facilitating interpretation (p. 211-212).

The above steps did not occur in a linear manner but rather concurrently. In a line-by-line review of the transcripts, I sorted through patterns and then reviewed the material again to find any further themes and patterns missed during the first review. The analysis of data and identification of themes led to a deeper description and enhanced understanding of the women's experiences. Being at this stage of comprehension, and having sufficient data, enabled me to write what, I believe, is a complete, detailed, and rich description of the women's experiences (Morse & Field, 1995).

Because only eight women were interviewed, I was able to undertake a deeper analysis of each interview and focus on the details of each woman's story more intently than would have been possible with a larger sample in the time frame available. This is not, however, to say that a predetermined sample size was mandatory; in fact, as the study progressed, participants were added until rich descriptions of the phenomena were obtained.
Rigor

In a qualitative, interpretive, descriptive methodology, attention to rigor is fundamental (Thorne et al., 1997), and my intention was to uphold trustworthiness and credibility throughout the study. I did this by carefully reviewing the data and maintaining a verifiable audit trail with the use of field notes and reflective journaling. I reviewed the in-depth interviews of the participants and performed repeated analysis and comparison of each interview, thus providing a check on validity (Broussard, 2006). Ensuring credibility entails asking the question, “Are these results believable?” According to Sandelowski (1986), the essence of credibility is the presentation of descriptions of human experience that the people having the experience would immediately recognize.

Maintaining confidence in confirmability involved ensuring that informants had experienced labour and birth, and that they had met the inclusion criteria. An additional concern was to minimize researcher bias by attempting to remain neutral as much as possible (Guba, 1981). The topic of bias must be broached, especially in view of the fact that I am an LDRP nurse who gives supportive care to childbearing women. In an attempt to leave preconceived notions at bay, I did not discuss my philosophy of supportive care with the women, and I reacted to their responses as objectively as possible without offering my knowledge of the subject under discussion. However, as I am a practicing LDRP nurse, and even though I was not practicing at the time of the recruitment or interviews, it is possible that my education and prior experience may have influenced the interpretation and analysis of the women’s perspectives.
Ethical Considerations

Ethics committees from the University of British Columbia and the major metropolitan hospital reviewed and approved a research proposal outlining all of the procedures that would occur prior to the initiation of the study and prior to the recruitment of the participants (Appendix D & E). An introductory information letter (Appendix A) advised participants of the purpose of the study, reassured them of anonymity, and requested their voluntary involvement. The letter informed each woman that she could have access to the results of the study once it is completed and could decline involvement in the study at any time without jeopardy to the conduct of care for herself or her infant. The letter did not provide knowledge that I am an LDRP nurse on the same unit where the women had their babies; however, the women were made aware of this at the time of the first phone conversation, and their knowledge of this was verified again just prior to the first interview.

In addition to obtaining written consent (Appendix B) from each woman, I received verbal consent over the phone prior to the interview and answered any questions that came up. At the commencement of each audiotaped interview, the participant had a chance to ask further questions regarding the nature of the study. In all cases, the interview only started once the woman was comfortable with the process and with me as the interviewer.

The women were assured that the audiotapes and the transcriptions would be kept in a locked filing cabinet and that only the members of the thesis committee and I would hear the tapes and see the full transcripts. The women were also made aware that the audiotapes would be erased after the study was completed and that the transcriptions
would be kept for five to ten years and destroyed after that time. I further informed them that names, numbers, and signed consent forms would be kept in a separate locked drawer.

At my request, the women refrained from using names of health care providers, relatives, or other labour support members. If names or identifying data inadvertently slipped out during the interviews, they were omitted from the transcripts. Confidentiality has been assured throughout the study, and the women were aware that the rights of all of the individuals involved in the study would be protected.

Summary

In describing the interpretive descriptive research method used for conducting this study, this chapter has discussed sampling methods, data collection, and data analysis. It has also cited measures to maintain trustworthiness in relation to confirmability and credibility, and noted ethical considerations. The following chapter will document the study’s findings and, although these are not generalizable, the intent is to offer data that will elicit significant insights.
Chapter 4

Presentation of the Findings

This chapter presents the results of my field research on women’s perceptions of the support that each received during the birth of her first child. The purpose is to demonstrate findings and themes, similar and unique—as revealed through analysis and interpretation of the transcribed data—and to provide representative excerpts from the interviews. The women gave accounts of helpful behaviours from members of their supportive teams, and this chapter explores the most significant elements of the women’s experiences.

As the interviews progressed, it was clear that the dynamics of each supportive team and each woman were distinctive; however, similarities also became evident during the analysis of each interview. The similar and individual aspects of the data are intertwined and captured in the women’s expressions of thoughts, feelings, and intricate details of their experiences.

Preparing for Birth

Support during labour and delivery goes beyond the one-way dynamic of women receiving assistance from their supportive teams. In each case, the team is chosen by the woman and consists of whomever she believes has the ability to successfully help her
through labour. While members of the supportive team do their best to assist and to make
the birthing experience as comfortable as possible, the woman still needs to rely on
herself to learn about the process of labour and what it all means for her and her baby.
She is not a passive participant despite the supportive care that she receives. This was
evident from discussions with the women about the importance of being prepared for
their labour and delivery. They felt that reading books, participating in prenatal classes,
and discussing childbirth with those who have experienced it helped them prepare for
labour. One woman said that she learned breathing techniques during prenatal classes and
then practiced at home to prepare for the pain of labour. Although she planned to have
her mother and husband at the delivery, she knew prior to going into labour that she
would need to prepare herself for what could be “the worst pain of my life.”

Other Women’s Stories

One woman said that she was aware of her mother’s experience and surmised that
her labour would be similar. She researched the topic of mothers’ and daughters’ labours
and discovered that daughters’ experiences tend to resemble those of their mothers. In the
end, however, this was not the case with her. Her delivery was markedly longer than all
three of her mother’s deliveries. The woman knew it would be exhausting but did not
believe that it would go on for as long as it did. Another woman called her mother a “die-
hard realist,” who provided descriptive excerpts of her own labour. Her mother told her,
“It’s like really bad period pains, and it is the worst work of your entire life.”

Several of the interviewees described other women’s experiences. The knowledge
of how labour and delivery might feel seemed to help them prepare for their own
deliveries. The more chaotic, painful, and traumatic the stories, the better they perceived
their own experiences. One woman was expecting the delivery to be much worse than it was, but when labour started at home, she didn’t feel that she needed any outside support—she was doing well without it. At the hospital, after the delivery, the nurses were surprised that she had delivered her baby within seven hours. The woman did not need pain medication and attributed her experience of coping well to the stories that her mother had told her; she added that television shows and other media prepared her in a similar way: “I would rather expect the worst and be mentally prepared for that than have rose-coloured glasses on and be disappointed.” Although she had anticipated “put-a-bullet-in-your-head pain,” her experience turned out to be “not as bad as I thought.”

Similarly, when another woman had her mother-in-law with her during labour, the older woman told stories of the birth of each of her sons and gave tips on how to best get through the experience. Her mother-in-law’s experience had occurred 27 years ago in another country, and she described it as horrible, dwelling on the pain, fear, and difficulty of labour. The woman thought she would have a similar experience but was pleasantly surprised: “In comparison to my mother-in-law’s labour, everything that was happening to me was like a fairytale. It was actually fun!” When probed further, the woman stated:

I expected something stressful and something terrible, but here in Canada when I was preparing for my delivery and reading books, I understood that the attitude to labour and delivery is quite different....I said to myself, why not try to make some fun out of this experience...because I thought about it as...a very important part of my life, and a unique experience.

One woman had a different situation with friends and relatives; she did not hear stories of the problems and excruciating pain of childbirth. On the contrary, she heard about how effortless it would be: “You always hear people saying, oh, they pushed for 15 minutes, and I was pushing for four hours and I was saying, is she ever coming out or is
she just going to stay?” Because of these stories, she couldn’t help worrying that her experience was uncommon, but then she recalled the information she had gathered from books and prenatal classes, and she was able to convince herself during the pushing stage that, “this is normal. It’s OK that you’re pushing for so long… it’s OK that you don’t have an epidural… it’s OK that they’re using the vacuum.” Thus, reading and prenatal classes not only educated her, but helped her accept that the birthing process can be long and not always easy.

Alternative Techniques

While some of the women gained knowledge from books, family members, and friends—and accordingly developed an attitude, positive or otherwise, toward the labouring experience—other women tried less conventional techniques for preparing themselves. One woman, for example, spoke of her experience with a hypnobirther who supported her by teaching self-hypnosis to help with the pain of labour and delivery.

The process of self-hypnosis starts well before labour begins, with meditative audiotapes, as well as weekly, one-to-one consultations with the hypnobirther. The woman’s hypnobirther explained to her that friends and family would tell stories of how terrible the labour would be and offer opinions on how to cope with the pain: “People are going to tell you their horror stories. Don’t buy in. Just listen to them or cut them off—whatever you choose to do.” The woman took the hypnobirther’s advice and listened but did not get caught up in conversations relating to someone else’s birth story. Because of the hypnobirther’s supportive coaching, she realized that her experience would be unique. The woman’s friend was telling her, “Oh my god, it’s going to be hell. Ask for an epidural.” She explained, “I was just kind of smiling and humouring her but I was not
buying in.” While her co-worker was talking, she thought to herself, “This is your stuff—this is not my stuff—you figure it out. You know this is your process. Mine is going to be exactly what I want it to be.” She added, “So this is what I was visualizing…in terms of a child…you know…he’s very calm…he’s very easy going…the labour was going to be empowering. It was not perfect, but it was within the guidelines of what we wanted.”

Her hypnobirther was successful in supporting the woman during her pregnancy, preparing her to make the labour experience meaningful, and most important, the effect of this support continued into the labour and delivery room.

*Knowledge Is Empowering*

Knowledge of what to expect and preparation during the pregnancy is in itself a means of supportive care for women during the birth of a child. The women interviewed tended to be proactive after conception, and each found resources and methods to make her labour and delivery as positive an experience as possible. For the most part, they sought knowledge about pain relief methods during the birth and, to some degree, during their pregnancies all of the women took responsibility for learning as much as they could about labour, delivery, and the options available. In addition to alleviating the discomfort of labour, having a healthy baby was also a motivating factor for prenatal research. One woman said, “I tried to prepare myself for this experience because I understood that if I am prepared, everything would go well, and…that it’s up to me how I will go through…the labour. I think that it is a psychological issue as well—not only a physical one.” She was therefore open to what turned out to be useful advice from her mother-in-law:

She said that it’s helpful not to think about yourself all the time—think about the baby…It really helped because I thought I should be very strong. I should do my
best not to damage the baby while pushing...and there were moments that I forgot about the pain because I was thinking about my baby first.

Another woman, a nurse, read numerous scientific research articles about childbirth toward the latter part of her pregnancy. She was extremely busy at work during her pregnancy, but toward the last few months, she became keen to prepare herself for birth and to decide how she wanted it to go:

Finally, when I sat down and looked at the statistics, I said, no, I’m not going to have an epidural and so that’s why I started looking for alternatives and I finally said, fine, let’s look at hypnobirthing and so we were scrambling to find someone. We found her and she was great. The energies connected and she was someone I could work with.

**Making an Informed Decision**

The woman who decided to practice hypnobirthing as an alternative to having an epidural also came to believe that standard practice in other respects was not for her. She felt that she made informed decisions for the safety of herself and her baby, but she did not feel that she was fully supported by the nurses, and especially the doctors, at the hospital. She realized the concerns of the health care professionals were valid: She was about 10 days past her due date and the medical staff encouraged her to have an induction, a standard of practice within the SOGC (2007) guidelines when a pregnant woman advances 10 days past her due date. Unfortunately, her membranes ruptured soon after and the fluid was stained with meconium—the baby had a bowel movement in the water within the amniotic sac. According to the SOGC (2007), this meets the criteria for immediate induction; the baby must be delivered as soon as possible. The woman, however, felt that she was being pushed into being induced against her and her husband’s wishes.
She felt that she had learned what could potentially go wrong, and induction went against how she wanted her labour to initiate. She advised the doctors and nurses:

I understand the statistics...5 to 7%...based on the study in the United Kingdom, that could potentially develop into stillbirth. We know that once you go over 40 weeks the risk for stillbirth increases and then increases even more after 42 weeks. It is not as if we’ve made an uneducated decision.

She felt as if the health professionals were not listening to her and not supporting her in her decision: “It was just push, push, push, and that was the hard part.” The health professionals kept saying to her, “You’re putting your child at risk. These are the stats.” She was in tears by the time she left the hospital to make her final decision. She decided not to be induced and opted to go home. She had her hypnobirther practice Reiki on her and went into full labour later that day. She delivered without an induction, much to the health care professionals’ amazement. She felt that her preparation and research was crucial to how she successfully coped with the labour. It is important to note, however, that her experience is rare, and in no way am I suggesting that other women should go against the SOGC (2007) guidelines if they are in a similar situation.

Before researching the statistics of childbirth, this same woman had not planned to have a hypnobirther or to use alternative therapy to cope with the pain of labour:

I was going to do the mainstream. I actually was going to do the epidural and the pain medication and then I did some research and I said, absolutely no way in hell. What was I thinking? I am not going anywhere close to this.

The research convinced her that alternative methods and going through the process as naturally as possible would be ideal for her. She maintained that women have been giving birth longer than obstetricians have been around and obstetricians focus on “worst case scenarios.” After all the preparation she had done to prevent an induction, she declared, “I was jaded before I went in. I had been tainted even before the process started.”
Providing Options

The woman discussed previously expressed the view that health professionals and educators of prenatal classes should give more choices regarding methods to manage pain, and more information about alternative supports to assist women in coping with childbirth:

I think a lot of women are not even aware of...what is possible out there in terms of...you can do this...you can do that...you can work with this person. I think we are doing a disservice to our women by not giving them the knowledge of what is available....Women have been doing this for a long time, and until the beginning of the last century, midwives were doing this. You know, women helping women. Women need to be empowered and realize that their bodies know what to do and just be in the process and to trust themselves. That's what I want to say...really trust themselves.

Seven of the eight women interviewed for this study used a more typical approach to managing the process of labour and delivery. Although two had a doula supporting them, one of them hired the doula because, due to extensive traveling, her husband might not have been available for the delivery. She wanted to ensure that she had another option for supportive care and an advocate when the time came.

The woman who had the hypnobirther said that she would hire one again and start self-hypnosis even earlier for her next pregnancy. In light of all that she learned through the hospital experience, she decided that she would have a home birth with her second child. She felt that, despite her preparation, the hospital staff did not support her decision-making. She was so intently focused on the labour process that she did not learn until after the delivery that her husband’s trust had been broken. He explained that the health care professionals had been planning to give her medication that her birth plan specifically requested not be given. She was all the more disillusioned because she felt
that her preparation and research justified her opting against the medication that is
routinely given:

   With the medication incident it was the final straw. And so next time...we will do
   a home birth with a midwife. We just do not trust the mainstream because we did
   not get what we requested and they did not care about our wishes. We have done
   our research. Do not treat us like idiots.

*Retention of Knowledge in the Labour Room*

   One woman said that educating herself was a form of support. Because of the
knowledge that she gained during her pregnancy, she was more aware and felt comfort in
knowing what was happening to her body and the baby:

   Reading and education helped a lot because... when they said this or when this
was happening, I knew...how far along we were. I knew as soon as they said x
amount of centimetres, here’s what my body was going through and here’s what I
could expect.

   Although one woman researched the physiological changes that occur during
labour, she did not think that she would retain the information and was surprised when
she did:

   I had asked my doula...when they check me, remind me—here’s what you might
be experiencing soon or here’s what you’re going through and here’s what your
body is doing....[But I was] very analytical and clinical and I remembered, OK,
transition...I might get a surge of adrenalin. I might experience that fight or flight
and that’s normal and it’s not because there’s anything wrong...and just little
details like that, that I had remembered, kept me going...things that I didn’t think
I would remember at all.

   At one point during labour, she was contemplating the insertion of an epidural for
pain control. Due to knowledge that she had gained during her pregnancy, however, she
was confident in declining the epidural:

   Prior to the possible epidural, they checked me first and, at that point, I was eight
to nine centimetres dilated and fully effaced, so I knew in my mind that, OK, this
is the start of transition and it wasn’t as bad as I had anticipated. So, we just kept
going.
She said that one of the most helpful things during the birth was her own prior knowledge, while the nurses' explanations were equally supportive: "My knowledge previous to going in and the nurses discussing...what’s going on and...what’s going to happen...was helpful, but my reference helped as well."

The women in this study wanted to be informed about what was happening with their bodies and what was happening with their babies during childbirth. They accomplished this by gathering information during pregnancy and requesting details from doctors and nurses during labour and delivery. The knowledge that they obtained prior to labour commencing empowered them during childbirth.

**Early Labour Support**

Some of the women interviewed would have appreciated the option of staying home in the early stages of labour. They felt that the comfort of being in their own surroundings normalized childbirth and decreased anxiety levels. For others, being in the hospital in the early stages gave them a sense of security that they would be monitored closely, and the safety of the baby would be protected. In retrospect, some of the women who went to the hospital soon after contractions started would have preferred to stay home longer.

**Being at Home**

One woman admitted, "I wouldn’t go to the hospital as early as I did...because we went in way too early." One woman, whose membranes were ruptured, was asked to come in for an assessment to ensure the safety of the fetus:
Although they wanted us to come in just to check in... I would stay home a lot longer because when you’re at home, you’re in your own surroundings...you feel better...more relaxed. When you’re at the hospital, you feel a little bit more uptight even though there weren’t a lot of people there...but you still feel a little bit more anxious.

The woman said that early labour is the ideal time to be at home and to be alone; later, in the active stages of labour, women want and need the nurse’s support. When asked if the constant presence of a nurse was an intrusion, the woman answered, “Yes, I think in the early stages...if you could stay home, that’s the best way to do it for sure. I would definitely do that.”

Another woman explained that in the early stages she didn’t feel like she needed support. In early labour, she had little communication, even with her husband:

We were both kind of doing our own things when we were at home. I don’t think I communicated to him...it wasn’t until 7:30 a.m. when we called the hospital that I thought, OK...this is a go...and let’s make some phone calls. We really have to go and I didn’t communicate to him much about how fast [the contractions] were coming or how their intensity was progressing until then. So when things were going the way they were, I didn’t feel like I needed any support at home.

Another woman intended to labour in the early stages at home. She said, “I didn’t want to labour at the hospital. It was my intention to labour at home and to go in just when I needed to.” Because her membranes had ruptured, she had to start antibiotics immediately as she was found to be positive for Group B Streptococcus—a kind of normal bacteria that can be life threatening for the fetus if the mother is not treated with intravenous antibiotic therapy. She was adamant that she wanted to be at home during the early stages of labour; the health professionals were supportive of her wishes and enabled her to do so between doses. She had to return to the hospital every four hours until she was in active labour.
The SOGC 72006) set guidelines to ensure the safety of the mother and the baby, and some require the mother to stay in the hospital—possibly even before she goes into labour. Due to the guidelines, the woman who used hypnobirthing techniques had to stay in the hospital during the early stages of labour, because she was past her due date and had meconium in her amniotic fluid. She felt that she had been robbed of an option that she would have valued: “I wish I could have done more of the labouring at home. I really, really wish I could have had that choice. I was not pleased when that was taken away from me.”

**Ambivalence**

Comments regarding whether or not to stay at home or go to the hospital were common amongst the women in the study. Although, ideally, women might wish to stay at home, they can also be apprehensive about it once labour has commenced. They want to ensure the safety of the baby and sometimes believe the best way to do this is to be in the hospital. After the birth, while thinking back on the labour experience, some of the women interviewed felt that the early part of labour may have been better spent at home with their partners. The woman who would have liked to stay at home as long as possible remarked:

I was at home with my husband and we were watching TV and we were sitting here kind of anxious...do we go...what do we do? “I don’t know. I’m feeling a little bit of pain but I’m not really feeling much...is this what labour is?”

This type of dilemma can cause women to go into the hospital sooner than necessary. They generally realize after the birth that it is safe and preferable to stay home when the first mild contractions start.
Because one woman’s membranes had ruptured, the nurse asked her to come in for an assessment. She was told that she could go home if she was not in labour yet. The couple did go in to the hospital and they were given the choice to stay, which they opted to do. The woman later felt that it would have been better had they gone home and laboured in a familiar environment. When asked if she would do anything differently, she said, "I would stay home longer."

Another woman was also confused as to whether or not to go to the hospital when her contractions first began. When she phoned and spoke to one of the labour and delivery nurses, she was told not to come unless the baby was not moving. After speaking with the nurse, she was concerned and slightly confused. She was at home thinking to herself, "Is she moving? Is she moving? I don’t know….How can I tell? How long do you wait?" She was not given further instructions so was unsure whether she was putting her baby at risk. The baby did stop moving for an hour, as the baby had many times during the pregnancy. Further explanation from the nurse would have been helpful. As the woman remarked, "It just seemed a little bit weird that they said, if the baby’s not moving, come in then, so that was a little bit scary to hear that."

*The Decision to Stay or Go*

From the interviews with the women, it is evident that they were unsure about when to go to the hospital and, once there, whether to stay. Quite often, given the choice, they stayed in the hospital, even if they were in early labour. The anticipation of more pain than they had already experienced made them feel that for their safety and the safety of the baby, the hospital was the best place to be.
One woman was offered morphine and then given the opportunity to go home during early labour. When asked if she would still have chosen to stay if she could have gone home without the morphine, she said, “Absolutely! Going home was not a good option. If it had been busy, I would not have had a choice but to go home. It wasn’t busy…I had the option to stay—which made me very happy.” To her mind, staying was crucial—she didn’t want to have pain medication at that time but wanted to be at the hospital in case she did need analgesia. Unlike the other women who would have preferred to have been at home, seven weeks after her delivery she felt that she had made the right decision: “Given the same circumstances, I still would have stayed.”

Another woman did not have a choice. She was induced with cervidal, because she was past her due date. She was not dilated but was in pain and so it was decided that it would be safer for her to stay. The health professionals told her that returning home was not an option and she was happy with that. “I didn’t want to go home. I wanted to stay. I wanted to make sure everything was right…the way it was supposed to be, so I basically sat and waited.”

Choices

Most women do want choices and, in order to empower women, health care professionals need to offer choices, albeit based on guidelines that minimize risk to the mother and the fetus. Despite being given the choice to stay in the hospital or go home with morphine, one woman still would have welcomed other alternatives:

Even if those are technically the only two major options, in your decision-making process, it could even be, OK, it’s a beautiful sunny morning, why don’t you go walk outside for a bit...or in my mind, I could think of other options as well that maybe weren’t as black and white and no in-between.
When asked, if offered another option, would she still have stayed in the hospital, she said, “I would stay but I would have liked to be given other options.”

Another woman also felt that she lacked sufficient control of her early labour. She was going back and forth from the hospital to her home for antibiotic administration and, on her third time back, her contractions became more intense. She felt that she should be admitted to the hospital, but the health professionals thought it better for her to go home:

This is the least positive part of my experience. They kind of brushed it off and said, oh no, you’re fine...no big deal...go home...even though I had voiced quite openly that when I am ready to stay, I’m going to stay and it means things are getting pretty intense.

She attempted to leave, but was in excruciating pain, and felt unsupported by the health care professionals who insisted that she return home. As she was walking out of the unit, she saw a nurse and said, “I really think I should be staying; this is not what I had been experiencing. It’s intense...it’s regular’...and she said, ‘No, no. I think you should see your doctor.’” At that point, even though she had urged the health care staff to admit her, she got nothing but resistance. As she walked a little further down the hall, she fell to her knees in pain and was only then taken to a room via stretcher. In the early stages of labour, she felt some tension and wondered what care from the nurses would be like after that. She felt reliant on herself, her husband, and her doula to provide the support and comfort that she required during early labour. “I wasn’t sure how things were going to go, or if the nurses were going to help me when I needed it.”

**Nurses versus Family Members**

In early labour, the women generally preferred the presence of their husbands and close female supporters. When labour became active, they became more reliant on the health care professionals. While nurses are educated to stay with their patients during all
stages of labour, this may not be necessary or wanted at all times. During early labour, many of the women found a nurse’s constant presence intrusive.

One woman, who was induced with oxytocin, was under constant observation by a nurse, and a fetal monitor was attached to her abdomen to record contractions and the fetal heart rate during the early stages of labour. She did not have labour pains and yet there was constant supervision. The SOGC (2007) requirement is for constant monitoring to ensure the safety of the mother and fetus during an oxytocin induction. While the woman understood the reason for this requirement, she still found it awkward to have a health professional with her all the time. When asked whether she found the nurse’s presence intrusive, she replied:

Sometimes…especially at the beginning when there were no contractions or they were very faint. Yes, at that moment, I thought it would be nice to stay with my husband and my mother-in-law alone without the nurses, but then I got used to it.

Another woman, past her due date, was admitted to the hospital early and was also monitored closely but, in early labour, did not have a nurse constantly present. She had her husband and her hypnobirther available to her at all stages as she had planned, and this worked well for her. When asked if the nurses were always in the room, she replied, “They were coming in and out…and that was perfect…especially at the beginning. In the more active stage, I thought, “You know what…I’m being monitored. I don’t need you. Just go away.”

With a monitor tracking her uterine activity and the fetal heart rate, she wondered why there was a need for such close observation by a health professional. Although the nurses and physicians were coming and going, she believed that they were bothering her more than necessary. However, she stated, “I realized it wasn’t her as a nurse…because
the nursing staff especially...gave great support....all of them. My aversion was more the physicians.” Regarding the nurses, she said, “I was more opposed to what she needed to do, versus her as a person....It was more, oh no, here she comes again—checking monitors, making sure everything was working...That was kind of bothering me.”

Another woman said that the nurse was with her most of the time. When asked if that was helpful, she replied:

Well, I shouldn’t say she was there all the time. She would come and go. She would say, OK, I’ll put you here...I’m going to go and do this....and I’ll leave you but if you need anything, just press the button and I’ll come. So that was good for me. Like I said, I didn’t want a lot of people. That’s just my personality. I just wanted to be left alone at that point. So I think that my partner respected that too.

When probed about her partner’s presence and support during early labour she stated, “He would come and go, too....He just left me alone (laughing). I’m laughing because sometimes I was just there by myself...having a baby...it sounds funny. I was OK with him coming and going, too.” The women in this study believed that it is the norm that other people support them during all the stages of labour and thought it unique that they felt a need to be alone.

One woman, who was at home after her membranes ruptured, and yet had no contractions, said that her husband was a great support: “He came home from work and asked me, ‘can I get you this, can I get you that?’ He was great.” Most of the women needed and required their partner’s presence and support in the early stages of labour.

The findings presented in this section indicate that the women in this study preferred family and nonprofessional support over nursing support in early labour. As subsequent discussion will show, their needs changed as their labours progressed.
Nurses

Many of the women in the study felt that support from nurses was essential during their labours. However, the level of nursing support they required depended on which stage of labour they were in. As labour progressed, so did the need for an increased level of support by the nurses. In comparison to the early stages of labour, when the women tended to want less attention from health professionals, support from nurses became more important in the active stage and essential during the pushing stage. Some women described the nurse as a good resource during these stages. Others, however, recalled the pain of labour as so intense that, at times, they did not know who was and was not there.

Positive Affirmations

The women interviewed stated that the positive feedback that nurses gave them during the active stage of labour motivated and assisted them during childbirth. As one woman put it, “They came in and said, ‘you’re doing really great...you’re doing excellent. They gave a lot of positive affirmations, which made me feel really good and it kind of helped me get through it.” Toward the end of labour, she said that there was a nurse there cheering her on: “The nurse was saying, ‘OK, one more centimetre...you’re closer...you’re closer.’ She described labour as not only a physical, but also a psychological process, and during the pushing stage, she focused on the doctor and nurse to help her through:

The nurse got really excited and said, “Oh you’re doing great...come on push... ...come on, you can see the head...one more push! That really motivated me to keep going, because as soon as I saw the head, I was like...OK, we’re just about there.

Another woman found that, along with her family members, the nurses were also emotional supporters. She stated, “The nurses always told me that I’m doing great...that
I’m great. It was so helpful.” And as yet another commented, during the active and pushing stages of labour, “The nurses gave me the most support...just their words of encouragement.”

Another woman felt that the most helpful part of her labour occurred when she was in the second stage of labour and pushing. She was not sure if she was pushing properly, and the nurse’s feedback was motivating. When asked what was most helpful, she responded:

Probably the nurses continually telling me, you’re doing a good job...you’re doing it right...because you always wonder, am I pushing right...Especially your first baby...and especially once I couldn’t feel anything with the spinal. I kept saying, am I pushing...I don’t know...am I pushing? And the nurse kept saying, “You’re doing a great job...you’re doing it right. We can see her coming down.” If I didn’t have [the nurse] I wouldn’t have known what I was doing.

Another woman had a similar experience while pushing. She was offered a mirror so that she could see the baby’s head but she declined and said that the nurses’ reassurance was motivating enough for her: “They were saying, ‘Oh, we see the head...keep going...you’re doing great’...I didn’t know what was going on....and they would tell me, ‘OK, push,’ and, yeah, it was good.”

Genuineness

The women wanted the support and feedback that they received to be meaningful and sincere. One woman commented that the nurses’ positive feedback was motivating but, more importantly, the motivation needed to be genuine. One woman stated, “They were just wonderful and helpful and really supportive and...I guess it was just in the sincerity behind everything they were saying and doing.” She wholeheartedly believed the nurses when they told her how well she was doing. When asked what was the most helpful in coping with the pain, she said:
Number one, hands down, the nurses’ confidence in my abilities... because even if you go in confident, because of a lack of experience, you have no idea if you’re doing OK or not. You’re just getting by... you know. Whereas their confidence directly and indirectly... and I would say their indirect confidence, had just as much, if not more, of an impact than the actual direct interaction.

The woman recalled that the nurses spoke amongst themselves or discussed her progress with the doctor in a positive way: “It sounds kind of funny, but for me the thing that kept me going was actually the odd bit of conversation that I would hear around me. Because I think I had my eyes closed the entire time.” She found that, “just their comments and their confidence in my abilities” were a motivating factor in how she coped during childbirth. When asked what was being said, she replied, “Just that I was doing really well! And they were surprised that I was progressing this well and that I was coping this well this far in.” Because she assumed that the nurses were not aware that she was listening, her confidence was boosted even further, as she believed that they would not say these things if they were not true. “If I had heard concern around me, I probably would have fed off that... and I would have been on a downward spiral.”

Another woman also spoke of the genuineness that the nurses displayed, even though she felt that it was their job to encourage her. “On one hand, I understood it is a part of their job, but on the other hand, I realized that I was not so bad.”

Expectations

Many of the women found that the LDRP nurses exceeded their expectations in kindness and empathy. One woman stated, “I need to say that [the nurses] were absolutely lovely. It was a great experience for me because I hadn’t even expected that medical personnel... nurses, could be so friendly... so open, and I was really surprised and pleased.” When the woman was questioned further regarding what she did expect, she
said, "Maybe more formal... I don't know... not so empathetic. But they were friendly. They were empathetic and they were open." It was surprising for many of the women to discover how nonjudgmental the nurses were.

One woman said that she was expecting to dislike the nurses. Past experiences with hospitals and friends' stories may have influenced her thoughts toward nurses.

When asked how her labour experience had affected her, she stated:

It's affected me a lot, because I was expecting to not like the nurses, to be frankly honest. I was talking to friends that said the nurses are not going to be nice to you... just don't expect niceness... just expect them to do their job. And so I think that has changed me in the sense that, wow, these people don't even know me, and yes, it's their job to do certain things but it's not their job to sit with me for ten hours and become part of my world during that time and not just be there. They were in it... they were totally entrenched in it. I think I'm a friendlier person myself, afterward, from seeing that generosity of self during the process, because I didn't expect that at all.

**Expertise and Knowledge**

A nurse's experience, expertise, knowledge, reassurance, and calm demeanour were among the women's criteria for positive labour experiences. One woman said that the nurses gave her more support than any of her other supporters during labour. When asked in what way the nurse provided that support, she replied, "It just felt like they were on top of everything. They were monitoring everything and it just felt like they knew what was going on. It was just reassuring." She believed that having the nurse present and in control was fundamental to the safety of herself and her baby. "I felt a lot of support from the nurses. They felt very calming and in control.... I thought, wow... that to me was comforting and kind of what I felt was the best part of the whole thing."
A woman, who was being induced with oxytocin, and required a nurse with her constantly, couldn’t help wishing for more privacy, but at the same time, she felt a sense of security:

They were with me all the time because they said that when you are induced, they should stay. It also was helpful because...they monitored the heart beating of the baby and it made me feel more relaxed and quiet about the baby because I knew that everything was under control and it was supportive as well.

Another woman spoke of how relaxed the nurses were, and that was reassuring to her. Although she had a hypnobirther, and her husband was her main support, she also had one nurse whom she described as laid-back and calm. She felt that this nurse’s manner was integral to her ability to have a trusting relationship with other nurses:

She was so laid-back...it was awesome...she was amazing. It was truly critical thinking that was going on. She really explained to me...instead of talking down to me and really talked to me as a fellow professional. I think having a good experience with that one nurse made that it wasn’t all bad dealing with the hospital.

The experience and expertise the nurses conveyed to the women created an atmosphere of comfort and reassurance. One woman was therefore dismayed when, unlike the other seven in the study, she did not have a nurse one-to-one with her, due to excessive workload on the unit: “Not that you felt like you weren’t being attended to...I was...but it would have been sometimes nice to have them there for support, too, because they have the experience, right?” She understood the demands on the nurses but still wished for more attention in the active stage of labour—“not constant but a little bit more than I had.”

When the nurse was with her continually through the pushing stage, she found the guidance that she received was invaluable and instrumental for labour support:
The nurses started the pushing before the doctor even got there...The nurse was excellent. She told me, this is what I need you to do and I was looking for instructions from her the whole time....My mom and my husband were there and they were sort of supporting me, but they kind of went out of the picture and the nurse and the doctor...I would focus on them as to what I needed to do I just listened to what they had to say. I think that’s another key thing...listening...and that’s what helped me through.

Another woman had a similar experience with the nurse who supported her during labour:

The nurse...was really good in that she told me every step of the way what was going on...like, OK, this is why we are doing this and this is what’s going to happen....She was really informative. She wasn’t just kind of pushing me, you know, do this...do that. She was telling me why things needed to be the way that they were.”

At times, though, she felt the nurses offered too much information. “She kept me...knowing what was going on all the time.... Because I was in so much pain, it was almost too much information—kind of...but it was helpful at the same time.” The woman felt that the nurses communicated effectively—she knew how her labour was progressing throughout the entire process and that everything was going well. While the women generally welcomed the nurses’ efforts to keep them informed, it is important that health care providers assess women’s readiness to learn, provide knowledge accordingly, and not overwhelm them with too much information.

**Active Stages of Labour**

According to seven of the women, nurses were much more valued and necessary for support during the active and pushing stages of labour than in earlier phases. The other woman had her husband and her hypnobirther as her main support throughout the entire experience; she appreciated the nurse’s support, but it was not crucial for her as it was for the other seven women. A woman who was admitted to the labour and delivery
unit when she was already in active labour described the nurses as her emotional supporters during the entire process: “They’re the only ones I remember seeing and hearing directly…through the whole experience.”

One woman had a doula with her throughout her labour, and while the doula was vital during the early, as well as active, stages of labour, once it was decided that the woman would need to have a caesarean section, the nurses, along with her husband, became the main supporters. She said, “The doula was my key support, my husband was sort of my emotional support, and the nurses were somewhat on the periphery until the very end. Things got more intense and so the nurses got more involved.” She did not elaborate whether this support was essential, but she did explain that there were tasks that the nurses needed to perform prior to surgery. Because of that, they were much more involved and in the forefront for the final moments of her labour:

 Someone had to do the catheter and all that kind of stuff, so they got more involved. The nurses then became my focal point. I looked to them to make sure everything was the way that it should be and that things were going to be alright.

During the stage of labour just before the baby is born, the women looked to health professionals for the assurance that they would be protected and their babies delivered safely. When the intensity builds up in the labour room, family members and others who have been part of the supportive team tend to fade into the background and the health care professionals take on the supportive role. It is interesting to note that when the women were in the most intense pain, it did not matter to them who was, or was not, with them; they seemed to be somewhat ambivalent about what they needed or who they wanted with them. One woman commented:

 When the pain became really strong, I couldn’t think of anything else except pain relief, and there were moments where it didn’t matter if they [the nurses] were
there with me or not... it was great that they were... because I could ask them for help.... In the later stage of delivery I really needed them.

A woman who was in active labour when she was admitted had at least one nurse with her constantly. She said, for the most part, there were two nurses with her—one of the nurses was orientating back to work. She did not find the nurses' presence an intrusion. When asked if she would have liked a break from the constant attention, she said, “No, not at all. The environment itself was very relaxed. As far as the nurses being there the whole time, I'm glad they were.”

**Continuity**

Continuity is something that the women appreciated in their childbirth experience, and something that can be lacking in the culture of the LDRP unit—no: merely because of the different nurses that may come and go, but on account of the information that is provided to the women. One woman said that she had different nurses throughout her labour. She understood that one nurse could not be with her for the entire 40 hours, but she had an expectation that her nurse would return if she were on shift the next day.

I had a different nurse the second day of my labour and the nurse that I had the day before came to see how I was doing, but she wasn’t my nurse that day. I thought that was odd. I had a different nurse who I felt I had to get to know all over again.”

One woman said it was great when she did get the same nurse. “It was nice because the nurse that admitted us...we spent two nights at the hospital and that second night, she was the night nurse. So it was nice to have her back.”

Another woman said that the information that she got from various nurses was inconsistent. When asked if she would change anything about her labour, she said:

There is some discrepancy on what they will allow and what they won’t allow. I know that sounds kind of silly but my first nurse said no to everything. Can I take
a bath? No. I really want to have something to eat. No, you can’t eat...And then another nurse came on and she said, “Yeah, go ahead, have some juice...have some candy,” and I was like...bring on the candy. I remember eating skittles through the whole thing and just focusing and that was great...it would be nice if there was a little more consistency between them.

Small Gestures

Even the smallest gestures have an impact. The women spoke of little things that nurses did that they thought were significant and would never forget. Nurses may do these things routinely without knowing the full impact for the women. One woman appreciated the control that the nurses gave her, allowing her to do whatever she needed to cope with the pain.

They said I could do everything I’d like to do—everything. Cry if I would like, laugh, sing...anything. One of them gave me her hand and said that I could squeeze it if it would help me. Even such small signs of support were important for me. Just squeezing her hand...it was helpful...also from the emotional point of view.

A woman who required constant fetal monitoring spoke of the critical thinking and flexibility of one nurse:

One of the things that was really helpful was...I kept asking...please leave the sensors off or maybe not check as frequently because I was tired of being poked and prodded. And she had enough knowledge and experience...even though the doctor had written down that it had to be on...she made a nursing judgment. She said, OK, I will monitor, but I will not make this an uncomfortable process and she basically let go until I got into active labour. And at that point, she basically balanced my needs against the baby’s needs and came to a common ground, which was safe for both of us. So, it was a win-win... because I felt I was being heard and she was still able to do her job.

Another woman also appreciated the flexibility of the nurses and commented about the nonjudgmental attitude that they displayed: “My doula recommended different positions and moving around the room and the nurses were really accommodating with that.” She also spoke of the small gesture that she will never forget:
There was one point that was quite funny... we were in the bathroom and my doula and husband were there and the lights are out... I am having an exorcist moment (laughing) where I am deep in this focused place, having this contraction, sitting on the toilet and the nurse is shining a flashlight in at me to see how things are going. And everyone is there... sort of just in the zone and it was pretty cool. That is the moment that is permanently imprinted in my mind.

This incident made her feel special and genuinely cared for by the nurse. The idea that a nurse would care enough to use a flashlight to sustain the atmosphere, and not turn on the bright bathroom light, was a small gesture that had a big impact on the woman.

Comments from the nurses also had a big impact:

They saw me labour and they were cheering me on and they wanted me to try and deliver vaginally and then when I couldn’t... they said, “Ah, she tried so hard.” Even after it was all said and done, the one nurse came back to me and, it even gives me goose bumps now.... [She] said, “I have never seen anyone labour like you laboured... I couldn’t leave. It was so empowering to see someone just keep at it and be so focused.” And so that was motivating... that just made me feel good to know that someone even cared enough to have those thoughts.

She went on to say that the porter who came to take her to the operating room also had an impact on her experience. “He could see that my epidural was wearing off. I was in a ton of pain and I’m sure normally he doesn’t care... but he was super gentle and very nice.” It is evident even the smallest action of kindness can have a lasting impact on the women that we, as nurses, care for.

Negative Aspects

Overall, the women in the study had good experiences with the nurses during labour; but even so, they recalled some negative experiences. One woman was in the early stages of labour and the nurses did not want her to stay in the hospital. It is interesting to note that this did not affect her entire experience. She states, “That small snippet was the only even remotely negative piece of my labour experience. From there on in, it was all very positive.” However, she also described a false labour experience that
occurred three weeks prior to true labour starting. The false labour experience was
disconcerting and during the three weeks that it took for “real” labour to begin, she had
visions of having conflicts with the nurses when finally admitted to the hospital:

I had one false labour experience where the nurses pissed me off, the doctor was
horrible, and I thought if this is the way it’s going to be during my labour, we’re
going to have problems. I’m going to have to tell them all to leave and it will just
be my doula and my husband. So, that was not a positive experience.

This woman also had nurses who were relieving her primary nurse and found
them to be, at times, condescending, but she did not feel that it had a big impact on the
experience that she ultimately had:

There were a few points when I first came in, and then a couple of points during
shift change— when a new nurse came in or someone who was only coming to
see me because my primary nurse had to go do something else—where there was
a little bit of a condescending attitude and they just assumed you were an
idiot...really and that you didn’t know anything. So, there were a few of those
moments but they were very minimal. As you can see, I am having a hard time
recalling them but there were definitely a couple of points where...some of the
nurses...had a different bedside manner. They just weren’t as empathetic and as
helpful as some of the others.

Another woman, who had a positive experience with her primary nurse, had an
issue with the nursing protocols, lack of critical thinking, and failure to provide her with
the power to make an informed decision:

I mean, I understand safety and I respect that, but at the same time, there’s
following the book and then there’s being in reality.... And I understand that they
feel the need to protect themselves because of the potential that they could leave
themselves open to being sued, etcetera...but at the same time...even [with] the
policies and procedures that give them leeway...it’s almost like being a robot.
Where is the critical thinking? That’s number one, and number two is: really read
the birthing plan and listen to what the parents have to say. Now, of course, if
something goes wrong, and something did go wrong, talk to the parents and say,
“OK, this is potentially what could happen and this is what we will do.” He [the
baby] came out—he was flaccid. His first Apgar was six and, of course, they’re
cutting the cord even though we wanted to delay clamping. We understood
that...it’s an emergency...that’s fine—but do not give me pitocin against my
wishes. And this is what they were doing. They were getting it ready and they
were just going to give it to me, even though we had requested for it not to be given.

Because the woman wanted to maintain control of her birthing experience, she felt that the negative aspect stemmed from the failure of health care professionals to disclose what was being done and to include her or her husband in the decision-making process.

The women characterized the nurse as a communicator, the expert who knows when something is wrong and can intervene, an educator who can instruct them on what to do, an advocate who will stand up for them if necessary, and a motivator who will cheer them on when appropriate. This view of the nurse’s multifaceted role was the general consensus among the women interviewed and, for the most part, the nurses had a positive impact on their perceptions of the birth experience.

**Husbands**

In North America, it is becoming increasingly socially unacceptable for men to be absent from the births of their babies. The women in this study wanted their husbands there and believed it was essentially mandatory that they attend. Most couples, nurses, physicians, and family members take it for granted that the father will be present during the labour and delivery. All the women in this study felt it necessary for their husbands to be present for the birth of their babies, whether or not they thought they would be helpful and supportive during childbirth.

**Fear, Anxiety, and Helplessness**

The women believed that their husbands, especially with the birth of the first child, had little knowledge and experience; therefore, their expectations regarding support from their husbands were limited. One woman stated:
I really found my mom was a really big support throughout the whole thing. My husband was, too, but he was a little bit more freaked out because it was his first baby. He didn’t know...you know...they don’t know as much because they haven’t gone through it. My mom’s gone through it three times.

Another woman, whose mother did not want to be present during labour despite her requests, had her husband as her sole family support:

At the beginning when he was kind of in and out of the room a lot...it did kind of irritate me after a while because he was running around. He was getting food and making sure he had the TV and I was saying, you should stay...but when it actually got right down to it during the active part, he was there and very helpful.

It is likely that her husband was displaying anxiety, fear of the unknown, and insecurity at not being able to help her cope with the pain of labour. It is difficult to see a stranger going through the pain that women endure; therefore, during childbirth, it must be that much more difficult when the person experiencing the pain is your wife. It is not surprising that men may feel fearful. According to the women, each expectant father manifested the fear differently and each couple dealt with the repercussions of this fear and anxiety uniquely.

One woman appreciated the help that her husband attempted to give her. However, due to his fear and anxiety, she was not able to connect with him emotionally during labour:

My husband was great. He was doing the counterpressure and just trying to help with everything... but he was scared with all of it...wondering what the heck is going on...my wife is in so much pain, and everything. He wasn’t as good with the mental support, as much as...my mom was, because my mom was more relaxed.

Women want someone present who can convey a sense of calm and relaxation. Instead, in the active stage of labour, the women’s husbands tended to create a sense of anxiety in an already intense environment.
Most of the women believed their husbands were overwhelmed during childbirth.

One woman, who had a doula and her husband supporting her, discussed the greater need for her doula’s support during the active stage of labour:

She [the doula] kept me going. I was sure that if she left... that as much as my husband would have supported me... he was so concerned about my level of pain and how things were going and what he was seeing come out of me, fluid-wise, that he was overwhelmed... I don’t think he could have kept his calm... as I would have needed, to stay focused.

While some women may ignore, or be unaware of, the fear and anxiety that their husbands are experiencing, this woman did think about the impact of her husband’s anxiety on her ability to cope with the pain of labour. The woman’s doula needed to leave for an hour and, although she did not want her husband to leave, she stated, “If I had to choose, I probably would have chosen him to leave [instead of the doula] for sure (laughing).”

A woman, who was from a country where it is not as common for husbands to be with their partners during childbirth was touched by her husband’s concern for her:

My husband looked scared and I saw that he was really worried about me... and when we were reflecting on this experience after, he told me that when I was pushing, he went away and he had the feeling that he would like to damage something (laughing). Yes, to hit the wall... whatever... to release his anxiety... maybe his fear... his stress.

Her husband felt helpless, but she did not know to what extent until they discussed it once they were home. “I didn’t know about it during the delivery. He told me about it after... He said, ‘the worst thing was that I could do nothing... I could just be with you, but I could not help in any other way,’ and it was stressful for him.”
The woman and her husband discussed his level of participation prior to labour starting. She wanted him there, but he did not want to be there for the second stage or delivery, and they decided that he would do whatever was comfortable for him:

My husband went away only when I was pushing. He preferred not to look. He was a little bit scared...maybe. I think it's quite natural for men. It was fine because we discussed it before the delivery had started. I said he was free to do anything he likes. I understand that it could be quite stressful for him. Maybe even more stressful than for me, because I think we are designed for this much better than men.

Reflecting back, one woman tried to think of solutions that might assist her and her husband with their next childbirth:

Having the husband there is great but sometimes...they feel helpless.... My husband...said, “You’re in all this pain, I don’t know what to do...I don’t know what the pain feels like...I don’t know how to fix it.” I think men have that concept of we want to fix it for you. So [for] female support...I might consider...if I ever did it again...maybe a doula.

Being Present—Passively and Actively

The women believed their partner’s anxiety was one more thing to cope with during labour. Five of the eight women in the study felt their husbands wanted to fix what they, in fact, could not fix. The women wanted emotional support and a presence, but not necessarily a solution to what they were experiencing. They wanted their husbands to experience the moment with them, not to solve every issue that arose.

It is interesting to note that the woman who used self-hypnosis during her labour explained that her husband was part of the process. She felt he was an integral part of her labour support team. The support that he gave her was positive and she welcomed it: “It was just awesome that he felt that he was part of it and didn’t feel left out...because a lot of men feel disempowered...but he really felt that he was helping.” It was important for this woman to have her husband participate in the birth of their child; she wanted to
ensure that he felt useful and valuable as the father of the baby. While her husband also wanted to fix things, unlike the other women in the study, she found that her husband was an excellent support who helped her stay in control. “There were a few times actually...I almost felt like I was losing control and that’s where my husband was able to refocus me.” She was speaking of the process of self-hypnosis: “He would just say, start deep breathing....Go back within your process. So, every once in a while I would kind of lose track and then he would get me right back on track.” Another woman said that the presence of her husband was pivotal to the experience they shared during labour and delivery; another woman noted that her husband was touching her back to let her know “he was there.”

As nurses, we need to be sensitive to women from other cultures. One couple who was not from Canada had the impression that in Canadian culture it was compulsory that the father be in the delivery room for the birth of his child. The woman commented:

Actually, I was OK that my husband wouldn’t stay with me. Here in Canada, we understood that it is not even the usual experience—it is the mandatory experience for fathers to be with their wives during labour. My husband said, “I probably have no choice...so I have to be with you.”

Although it has become particularly unusual for a partner to be absent, as nurses, we need to keep in mind that some women may make a choice not to have their partners with them for various reasons and, as health care professionals, we should support this decision.

Unwanted Support

Six of the eight women experienced unwanted support from their husbands during the active stage of labour, prior to pushing. For example, a woman who arrived at the hospital in active labour spoke of her husband’s urgent attempts to have the health care
professionals provide her with pain relief. Although she was not opposed to interventions to decrease the pain, at that time she did not need medication. “My husband said, get her an epidural, get her an epidural, as soon as we walked in. I thought I was doing OK at that time and I wanted to wait or maybe even try something else.” His anxiety might have decreased if the woman were not in such severe pain. This is one of the concerns for women possessing the inner coping mechanisms to manage the pain of labour. Women deserve the right to feel the pain of labour and cope with it as they wish, without the interference of their support person or people. The women in this study wanted their husbands to be present, but they did not necessarily want them to make suggestions or to take action to assist with their birthing process.

Another woman said her husband was hovering during labour and, once she returned home with the baby, she discovered that this was common amongst men in the labour room:

I’ve heard quite a few men explain it. They see this person that they love in complete agony and they don’t know what to do about it… I think men… are all about fixing things. And so my husband… he didn’t know how to fix it. He felt bad, he felt guilty. So they try to compensate by hovering, I think… by like, what can I do, can I do this, can I do that?

When asked what kind of impact this behaviour had on her during labour—whether she was aware of how her husband was feeling or if she was concerned about his feelings of helplessness—she responded, “We talked about it after the delivery. At the time, I really didn’t care to be honest with you (laughing).”

Some of the women set limits for their support team in anticipation of labour. They discussed scenarios with their husbands to coach them about what might be needed during labour—for instance:
My husband was never annoying, but there were certainly a couple of points, like I said, with the massage, where I said, we need to trade off. I need the doula (laughing) to do the massage and you [her husband] can do something else…and he was fine with that. He expected that and we even talked about that beforehand. She [the doula] is an expert—that’s what she does and it’s not personal. It’s not a slight against you if I say, you [her husband] hands off, you [the doula] in.

This woman felt that she had control over the situation; she made the decisions regarding her needs during labour.

The woman whose husband requested an epidural for her was also frustrated with his touching her:

My husband…poor guy…was trying to rub my back like we practiced in the prenatal class and I was like, don’t touch me. That was really bothering me because he kept wanting to…because I had back labour, too….But, you know…I found that really irritating, but I mean that wasn’t anyone’s fault. It was just how my labour was going. I didn’t want to be touched.

Another woman wanted help from her husband in relieving the pain and she was upset that he didn’t at least offer to help: “I think I had to ask him, would you please…. And then he kind of did it [massage]…. And then I said, yeah, it’s OK, don’t bother…go find a TV, man, or whatever (laughing). And he was quite happy to.” Each woman seemed to believe that she was unique in preferring such limited interaction, but this theme came up with all eight women in the study.

Two women asked their husbands to massage their backs and then had second thoughts. One of the women said, “Actually, I asked him to massage my back while I was sitting on the ball, but I felt that it was distractive. I told him to stop (laughing).” The other woman also requested a massage and then requested her husband stop. Another woman stated: “Physically, I just didn’t want anyone really touching me. It’s funny because we took our prenatal class and there was the massaging and the this and the that,
and I just didn’t want any of it.” One woman found that massaging helped, but not from
her husband:

I had a lot of back labour, so she [the doula] was right in there, giving me back
massages. She knew exactly how much pressure and what to do. And that’s where
there was a separation between my husband and the doula because my husband
would try...he said, is this right? I didn’t want to be asked questions. I didn’t want
to be asked how much.

Despite some of the unwanted physical and verbal contributions from their
husbands, the women appreciated their partners providing tangible necessities to make
them more comfortable. Five of the eight women remarked on their husbands’ diligence
in meeting their need to stay hydrated and described this as a useful way to provide
support. The comment of one woman reflects what others in this group also had to say:

All my needs were being met. I mean even needs I didn’t know I had in terms of
fluid. He would tell me, OK, drink...because literally, I had tuned everything else
out and he knew I had to get my fluid up, so he would say, have this Popsicle, or
have this drink, or whatever...and really he was there.

Advocates

When labour became intense during transition and the second stage, the husbands’
support became much more critical and the women needed them as advocates and
gatekeepers. Some couples planned for eventualities prior to labour. They discussed
different scenarios and how they would communicate with each other and with health
care professionals. They anticipated decisions they would make in various circumstances.

A woman who had a doula as one of her supporters discussed her husband’s role as an
advocate:

His purpose was to be the person there who knows me better than anyone else in
the world. So, if I got to the point where I couldn’t really vocalize something, he
could vocalize. We had talked about it enough....The doula was there to be my
advocate as well, but he knows me....So, he’s the person to speak on my behalf if
he needed to. I could look in his eyes for two seconds and know if things were
good or bad... And so... when it got to the c-section and stuff like that, it switched from the doula to him being my primary support and the person who kept me grounded.

She spoke about the disappointment that she and her husband felt when a c-section became necessary and they realized that a vaginal delivery was impossible: "He knew how deeply I wanted [a natural birth]... So he was disappointed as well... and once the labour was over and the c-section was decided upon, my focus switched from the doula to my husband."

Two women commented that their husbands didn’t do much while they were in the early stages of active labour, but once they started pushing, they really needed the advocacy and encouragement their husbands could provide. One woman said:

I knew he was there, but I was in so much pain that I didn’t really care one way or the other... and then just before I started pushing, it wasn’t as if I wanted him for support, but I wanted him to be there if things went sideways and he needed to make the decisions.

The other woman stated:

This sounds awful but... if my husband couldn’t make it, I don’t think I would have been upset (laughing). I just thought, hey whatever, I’m going to give birth and that’s that, you know. It was nice that he was there, but I got the support that I needed from the nurses and the doctor... but when I started pushing, my husband was encouraging... but before that I was just like, OK, I’ve got to get through this.

One woman said that her husband was in and out of her room during the early and active stages of labour and she did not feel that he was of great help, nor did she find that she needed his support. In the more active stage, she felt an increased level of presence from him: "He kept coming in and out for the first part and then during the pushing part he was just kind of there and then it was really good... he was good with everybody."
It is instructive to note that while some women require an increased level of support from their husbands, and some husbands provide this, when it becomes more intense in the labour room, husbands, family members, and friends often fade into the background, and the health professionals become the main source of support. However, although their husbands were, at times, in the background, the women were at some level aware of their presence and put trust in them to advocate on their behalf.

Two women made similar comments: “My husband was encouraging me when I was pushing and I knew that he was there, but he was in the distance, and I was really focusing on the nurse and the doctor and what they were telling me to do.” The other woman said:

I know my husband was there because he was touching my back...outside of that, the nurses were the ones that I remember explaining what was going on and giving me that emotional support. He was behind me the whole time rubbing my back while I was pushing on hands and knees, so I wouldn’t have seen his face pretty much until she was born and didn’t care if I did or not (laughing). I don’t remember a word out of him.... He was just rubbing my back and watching in awe, I think.

Explaining how the self-hypnosis process worked, one woman said they planned their method of communication, and her husband was to speak on her behalf. She explained:

The doctor would ask questions and he would answer, which is exactly how we had set it up. This is how I wanted it because I am not here to answer your questions. I am here to be in my process. And at one point she [the doctor] got really upset and my husband said, either you take my answers or you get no answers. This is how we’ve set it up. I would nudge him. I would just kind of push him, so he would know to answer because we had gone through every possible scenario. So there wasn’t anything that he wasn’t aware of at that point in time. I knew I was completely supported because we had discussed every possible angle of anything going wrong.
This woman had a birth plan, and her husband felt that, in some instances, it was not being followed. But, because he did not want to cause her anxiety and potentially diminish her focus, she only found out after delivery, the extent to which he had stood guard over her: "He would not let me out of his sight because there was no trust. He was the gatekeeper. Whenever they asked me a question, I would tap him and he would talk."

One doctor encouraged her to have an epidural for pain and wanted her to verbally acknowledge the question and say whether or not she wanted it: "My husband told her, 'Look, I'm answering the questions and she doesn't want it...she will ask for what she wants and she has chosen not to do this.'"

During the most intense stages of childbirth, the women put their trust in, and to some degree depended on, their husbands—knowing that their husbands had a vested interest in what happened to them and their babies. While the women did not necessarily lose control at the intense stages, they were so focused on what they needed to do that they gave up some of the control to their husbands.

**Presence: A Shared Experience**

Five of the eight women experienced a stronger emotional connection with their husbands after the delivery. One woman stated, "You feel closer...we were always a really close family, but you feel even more of a bond...especially with your husband. You feel, wow, you’ve experienced this together." As another woman tried to explain it, "Our relationship was already great, but it just moved onto a totally different level because I really felt supported." The woman from a foreign country said:

After delivery, I understood that it was really important for me that my husband was with me. If he wasn’t, I think it could affect...what I would think about him.... I think it wouldn’t be so nice because I really needed his help in that moment, and that he did stay in spite of his concerns, it was really important for
me. He overcame his own fears...he stayed with me and it was very important for our relationship.

Whether or not the husbands were supportive during any of the stages of labour, the women required their presence. For example, the woman who said that she did not need her husband with her during her labour did in fact want him there for her:

Actually, he was out when my water broke and then he didn’t come home for about an hour and a half or whatever. I said why didn’t you come home right away? He said, “Well, because at our prenatal class they said it could be hours, so I just thought I would finish the driving range and then come home.” I said, “What! Are you crazy? What were you thinking?”

Similarly, another woman, whose mother was a big support for her while her husband displayed anxiety and fear, said, “If I had to choose between the two of them, I would have to say I would choose my husband for sure. I mean it’s your child together...you’re experiencing the birth of your child.”

When asked, another woman described how her husband’s support affected her physically and emotionally during childbirth:

Well, I think the two are really closely linked because obviously the physical support that he did for me the entire time...just lightly rubbing my back...it’s not like that was a major support....It’s not like it took pressure off a spot where I desperately needed it or he helped me cope with the pain physically. I think it was more of an emotional connection that came with that sense of touch perhaps.

The woman who thought that her husband would not be with her during labour and delivery said:

He was determined to stay with me...he wasn’t there for the pushing but when the baby actually came out, he came back in. I needed my husband’s presence and his support. It was very important for me from the emotional point of view.

Finally, the woman who practiced self-hypnosis described her husband as being her greatest supporter. And, at the opposite end of the spectrum, was a woman, who was
only intermittently aware of her husband’s support. But at those times she was glad of his presence—“when I did notice…yes…definitely.”

Support for the “Supporter”

The women felt that their husbands needed support, and some made arrangements with this in mind in the prenatal period. One woman mentioned that a nurse offered support to her husband and the woman was thankful for it. She had a female friend with her for the sole purpose of supporting her husband, as she knew that she would be concerned for him while she was in labour. She felt he might be forgotten, so she was grateful that the nurse made a point of reassuring him: “I think they [the nurses] were a big help because, not only were they supporting me, but they were helping my husband as well…telling him things he could do.” This support for her husband could be viewed as an indirect method of supporting her.

While the husbands did their best to assist their wives, it is noteworthy that three of the women arranged a support person in the antenatal period particularly to support their husbands. They recognized that their husbands would also be going through a completely new and foreign experience. A woman who hired a doula observed, “This was new for him as well…we got the doula…so that he could experience things and not think that he had to solve every issue….there was someone else there who could help and had done it before.”

Another woman asked a friend to be at her delivery and explained her friend’s role: “She was there to help him and indirectly that helped me, because I knew that there was someone there for him and that was a relief.” Another woman’s support person also gave support to her husband; this was not something that she thought about prior to
labour, but it was welcomed: “My husband would make sure that I would be taken care of but not take care of himself. She would make sure that we were both supported.” Three of the eight women acknowledged the support they felt by having their husbands’ needs met.

The women believed that their husbands had altruistic intentions regarding supporting them. At times the women appreciated their husbands’ efforts, but at other times the support was not warranted and quite often a nuisance. Regardless, the women wanted their husbands with them during childbirth over and above all of the other supporters that they invited. They wanted their husbands’ presence mostly to share in the experience of the birth of their child. Their level of need for their husband’s presence and support changed with the stages of labour. Generally, this need was greatest in the early stage of labour and then again in the latter stages.

**Family, Friends, and Doulas**

Seven of the women in this study believed that they would need support from family, friends, or doulas, and not just their husbands. Consequently, six of the women arranged for their mothers, friends, and other supporters to assist them. One woman wanted her mother to be present but her mother declined and, as a result, she had her husband as her only support, which in retrospect she felt was best for her.

**Mothers**

Other than their husbands, the women in this study most often wanted their mothers as supporters during childbirth. Five of the eight women expressed a desire to
have their mothers with them for support. But only one woman actually had her mother present during labour:

My mom was a really big support through the whole thing...more so than my husband. She was more of a mental support and she’s gone through it three times, so she knew what I was going through. I would hold my mom’s hand and squeeze her hand and she would say, “OK, you’re that much closer to getting to the end of the road...I’ve been through that contraction with you before”....That really helped a lot.

Reflecting back on the experience, she said, “I would definitely have my mom there again, yeah, because I found her really quite supportive. I have always been close to my mom, but now we have even more of a bond.”

Other women would have liked their mothers present, but due to different circumstances, it was not possible. One, who at age 11 had lost her mother, said that if she had been around, “I probably would have had her there with me.” A second woman’s mother lived out of town; had she been nearby, the woman would have liked her support during labour. Even though her husband’s mother was available, she did not want her there: “His parents [are] wonderful, but it’s not the same as your own mom. So that’s not someone that I would consider as a support person during my labour or delivery at all. If my mom were here, she would have been there with me....absolutely.” She also commented that she would still have hired a doula—“you know...someone a little bit more removed...my mom and I are so close but you don’t know how people are going to interact during that time.”

Initially, a woman whose mother was in another country also missed having maternal support. But, on reflection, she changed her mind, “because my mother is a very emotional woman and she would be worried about me, I think. Maybe it would even be stressful for me and for her.” Yet another woman’s mother was in the hospital waiting
room while she gave birth. The woman wanted closer support, but her mother declined to be in the room with her during the delivery:

I wanted my mom there but she was a little bit weird about being in the room with me....At first when she said she didn’t want to be in there... I said, “I need that support...She’s got to be there for me.” But then during it was OK. I think it was fine. You know, they were right there right after...I look on [that] now as being more important than the actual labour part.

As this example indicates, some of the women tended to rationalize the absence of their mothers at such an important event. This was perhaps to offset disappointment, for there was regret in the tone of each woman who recollected her mother’s absence.

**Experienced Females**

The women believed that support from another woman, especially another woman that has been through childbirth, was a great benefit. Six of the eight women had female supporters. One woman felt that the support from her mother-in-law was a great benefit: “She was with me the whole time. Oh, she was excellent. I saw in her eyes that she was worried about me. She was really tender with me...maybe because she’s a woman. I am very grateful to her.”

For women, there are different reasons that an experienced female support is necessary. Among the most important is the knowledge that they bring to the situation. This is why one woman in the study, who did not have a doula at her delivery, said that she might hire one next time:

The way it works now is the nurse comes in and checks on you every once in a while. It might be nice to have someone like a doula or a midwife or someone there that’s experienced it...that really knows what they’re doing and what to expect a little bit more. I always look to someone that’s experienced.

Another woman had a female friend with her to support her husband, because she felt that would enable him to better support her through labour:
My friend was there, more for my husband because he was worried and he wasn’t sure what was going on... So, she was supporting him a bit more and the nurses were supporting me. He was very happy she was there. I didn’t really interact with her as much. She was kind of leaving and getting water and wetting face cloths and that kind of stuff so that my husband could stay with me.

A third woman hired a doula because her husband traveled frequently for work: “I was worried if she [the baby] came early... there was this fear, oh, what if he’s not here... and I don’t have any family here.” The doula was mentoring a second doula who was also present, but this support did not have the impact during labour that the woman had expected, and she hardly noticed that they were there:

The nurses were the ones that I interacted with and I think, to give the doulas all the credit come due, I think they could tell that the nurses were doing a great job and we had a really good rapport and what we were doing was working, so they were in the shadows most of the time.

Although she did not need the doulas for direct support during labour, the woman would still hire a doula again in the event that her husband was absent. “If my husband was still traveling, absolutely! Again, if it was busier [in the hospital], I would have been sent home or would have been labouring in admitting by myself and I wouldn’t want that to happen.” She recognized that every labour is different and what did not work this time might work well for her next delivery.

Another woman had an excellent experience with her doula, who was her major support until a c-section became necessary:

My doula was amazing.... So when things really got intense with the contractions, she was my key person. She was the one where if I needed to make eye contact with someone and I really just needed to hunker down... she was the person that was keeping me really, really focused.

At one point, when her doula wanted to leave to care for her dog, the woman panicked, believing that her focus would be broken without the doula’s help: “She was that thing
that kept me in the zone.” But when the woman realized that she would not be having a vaginal birth, her focus shifted from the doula to her husband and the health care professionals.

One woman’s experience with her hypnobirther was unique. She believed the process assisted her in achieving the initiation of labour and dilation without an induction, as recommended by health professionals. The hypnobirther was present during pregnancy and throughout all of the stages of labour. At the hospital, the doctor explained the importance of delivering the baby as soon as possible because of advanced gestational age and meconium-stained amniotic fluid, which can have a negative impact on the health of the baby, leading to an increased risk of mortality. The woman went home to consult with her husband and hypnobirther: “She did some Reiki on me and [the baby’s] head engaged during that process. It was a half an hour to an hour. They confirmed that when we went back to the hospital—that his head was engaged.”

Although the head was engaged, the labour had still not started and the doctor strongly recommended immediate induction. Against medical advice, the woman declined and waited for labour to begin, which it did, within six hours:

Over the next four hours, I was completely dilated because of the hypnobirthing…. And according to them [health care professionals] they haven’t seen anything like that because it’s not normal for it to happen that fast and that easy.

While the health care professionals did not understand the process of hypnobirthing, the woman’s husband and the hypnobirther had been working together with her for months. They knew what she needed and, because it was important that she have limited interaction with those around her, they communicated with others on her behalf. She therefore found it stressful when either of the two left her side:
I actually panicked because they both had to move their cars at the same time. And even though I had a nursing student with me plus I had the nurse...it was more them understanding the process that I had been training myself for, so they knew when I needed something...you just develop that whole rapport.... They were only gone for ten minutes—but it felt like forever.

She said that she would hire a hypnobirther again for her next birth, as well as other experienced female supporters: “I would deliver at home and have one, maybe two midwives...and probably a doula or two.” She added that she did not want a lot of people around during labour and delivery, but those she would choose next time would be into “the whole holistic thing.”

**Family: A Negative Distraction**

While the women were going through childbirth, essentially the most painful and difficult work imaginable, they still felt compassion toward their supporters. For this reason, having family members in the waiting room during the birthing process can be a negative distraction for women. At times, the two women who had family members in the waiting room felt guilty, especially if the labour took a long time and their family had to wait for hours for the delivery. One woman recalled that her father was sitting in the waiting room, because he was so excited to see his first grandchild: “I was just a little worried about him waiting, of course, and everyone’s waiting by their phone.” She also shared her feelings about her mom and husband, who were her supporters:

I felt that he was so exhausted and that my mom was exhausted, you know...standing on their feet, helping me the whole time...and my dad...everyone that was there was so exhausted being up all night. So emotionally, I felt a little bit...bad for them.

This woman was not alone in her feeling. Another woman’s remark similarly suggests that, even while in labour and terrible pain, many women still feel empathy toward their supporters and family members: “I was thinking about my family in the
waiting room. I thought, god, they're waiting so long to see this baby. That's terrible, but I do remember thinking that during my labour.”

The other five women did not have family members waiting in the hospital, so they were not able to say for sure how it would have impacted their experience. However, four of the women commented on the idea of having family and friends at the delivery, and most did not want a large contingent at their deliveries. As one woman put it, “I just wanted people that were closest to me. I would have found everyone else a nuisance… My sisters didn’t even come in.” Another laughed and said, “I love my family but don’t want them there.” “It was just my partner and another nurse,” was the recollection of a woman who “didn’t want a whole slew of people in there. I just wanted it to be calm and quiet and so, yeah, just two people… I didn’t want it to be chaotic. I didn’t want a bunch of people going blah, blah, blah—with lots going on.”

This observation suggests that women may feel that childbirth is an intimate and private occasion. The women in this study preferred only the presence of one or two family members other than their husbands. One woman did not want a family member present at all. The rationale for her feelings was that she wanted to maintain her personal space and to experience childbirth with her husband; she saw this as a special and sacred moment in their lives. Having lost her own mother when she was young, this woman expressed her feelings about her in-laws’ request to be at her delivery: “I didn’t want anyone else other than my husband. I know my in-laws wanted to be there the whole time and I said, ‘No, you’re not coming until after.’” One of her best friends, a nurse, volunteered to be at the delivery, but the woman similarly refused, holding firm to her
need to spend the time during and immediately after birth with her husband and baby: "I just felt like I wanted that moment as a family by ourselves."

But this same woman also said that she would have had her mother with her during delivery if she had not passed away. This is somewhat contradictory to the woman’s desire for intimate time just for her husband, herself, and their child. But it may be that she felt loyalty toward her mother and might therefore have experienced a sense of guilt and betrayal had she allowed others to intrude. She is the only woman in this study who did not want a female support person with her.

**Doctors**

Overall, the women who were interviewed expressed respect for their doctors and were grateful for the support that they provided during pregnancy, labour, and delivery. For the most part, the women placed a lot of trust in their doctors, yet required reassurance that everything was progressing as it should. Only one of the eight women interviewed mentioned the support of her doctor in the prenatal period:

She always told me that everything would be fine and that’s very important when the doctor says it….It was my first pregnancy and I was a little bit worried. I asked a lot of questions and every time she calmed me down. She said, everything will be fine…so you shouldn’t be afraid…you shouldn’t worry at all. This was comforting for me.

**Presence Required**

Most of the women believed that the doctors were absent from the delivery room more than they should have been. They wanted their doctors to check in more frequently, even for a few moments, while they were labouring. Three women expressed their disappointment in the infrequent visits from their doctors prior to the delivery. One
woman stated: “I would have been reassured if the doctor came in and said, everything is progressing exactly as it should...the nurses were telling me that, but it would have been nice to hear it from the doctor too.” Another woman, who had a different doctor for her delivery than the one she had seen in the antenatal period, agreed:

As I understand, the doctors...had special screens with all the information about me and all the indicators, so they did control the labour but distantly, but probably it would be more supportive if they came and talked to me.

A third woman also had a doctor she did not know for delivery and felt similarly:

I thought, oh, who’s this person going to be? I haven’t even seen her before and she is going to deliver my baby...actually...she was there for just the delivery. It would have been nice to have at least met her before the delivery, but she didn’t come and check on me at all. I thought that could be improved on.

The women did not expect doctors to spend large quantities of time with them during labour, but they did expect to meet the doctor and have them available to discuss their progress periodically. One woman had a doctor that she had never met, but this doctor checked on her periodically, which built a rapport that she really appreciated.

Second Stage

The women described doctors as motivating, and encouraging during the pushing stage of labour. They appreciated the knowledge that their doctors passed on to them, listened intently to instructions, and followed their advice in hopes of having the best outcome. The doctors’ words of encouragement were equally helpful. One woman recalled that, during the pushing, the doctor was “amazing”: “She [the doctor] said, ‘you can see the head...you’re doing great...keep going....’ You know, just that positive reinforcement really helped me get through it.”

During the pushing stage, the women were inclined to listen to the doctor rather than to their family members. One woman said, “My mom and my husband were making
positive comments on the side, but I wasn’t really looking to them, to be honest. I was really focusing on the doctor telling me what to do.” Another woman agreed: “The obstetrician—she was great. She wasn’t my regular OB, but she was on call that night. She was very helpful. She just kept encouraging me and encouraging me.”

One woman appreciated the flexibility that the doctor displayed. She explained that the baby’s heart rate was dropping during contractions, “so I did most of my pushing on all-fours and I was impressed too because that was the doctor’s recommendation. And for some reason, I think of doctors as being more traditional.”

Sharing Information

Even though the women wanted minimal interaction with others during childbirth, communication was still important at critical stages and equally so when between the doctors and nurses. Most of the women found it comforting when doctors and nurses interacted with each other with a level of respect and were in agreement regarding the progression of labour and the decisions being made. Women also wanted to be given explanations and information regarding what was happening with their bodies and their babies.

One woman spoke of the interaction between health care professionals this way:

I just felt like I was in really good hands....There was a level of confidence the nurses had in me the whole time...the doctor comes in and it just seemed like they were all on the same plane regarding how things were going, regarding how I was doing. If there had been some kind of contradiction...meaning if the doctor came in and perceived something that was or wasn’t going on that conflicted with my perception of the confidence that the nurses had in me, that would have thrown it all for a loop....It would have taken away what confidence I had in myself at that time when I probably needed it the most.

Another woman was grateful to her doctors for their even demeanour and openness: “My doctor and my GP were a great support for me. The OB too...was really calm and she
said, ‘OK this is what we’re doing’...always letting me know what was going on and, yes, very supportive. I just felt better knowing what was happening.” A third woman had a resident who was able to speak her native language—which gave her a great sense of support and decreased her anxiety:

She started speaking with me and it was...I would say, a present for me. It was special and she gave me wonderful tips...and what was very, very important—she told me.... she was also induced and... how she came through this, and she relaxed me because I understood that it’s not so scary.... I was worried, but when she told me about her own induction experience, it helped me to calm down.

One woman, however, had the opposite experience. Because she used self-hypnosis throughout her delivery, she was unaware of what was going on around her and had almost no interaction with anyone. Her husband told her later that the doctor did not inform or explain what was happening or what was being done at various stages of the second stage. While she didn’t know about it at the time of the delivery, when she found out later, she was disappointed and untrusting of the health care professionals. Reflecting back, she offered her opinion: “Of course if something goes wrong, talk to the parents and say, OK this is potentially what could happen and this is what we will do and that’s fine.”

Unlike the seven other women who spoke of the excellent communication that they had with their doctors, this woman felt the doctor at her delivery was intentionally trying to keep information from her and her husband. According to the woman, the doctor asked the nurse to administer a drug after the delivery:

She [the doctor] was very quietly saying it under her breath to the nurse to get it.... And when my husband asked her, what are you doing? She wouldn’t answer and then at that point my husband questioned her again, and he said, “This is what I heard, am I correct?” And she finally...finally, reluctantly, said, “Yes, this is what we are doing.” And my husband said, “Absolutely not...under no circumstances.”
This experience was in stark contrast to the experience of the other women. It is difficult to know why, but there may have been a misunderstanding between the husband and the doctor at the time of the delivery. There may be a fine line in many situations where the doctor must take into consideration the safety of the woman and/or the baby. This could entail contemplating the consequences that might ensue if interventions are not carried out and then abandoning a birth plan that is potentially at odds with the well-being of the mother and baby. That said, doctors should inform women of interventions that may be necessary and, according to the woman, this did not occur in her situation.

*Humour*

Women expressed their appreciation of a sense of humour in their medical team. Three of the women mentioned the sense of calm and reassurance that they felt when the doctors joked with them. Because why would a doctor be cheerful and make jokes if things were not going well?

One woman explained how extraordinary it was to have a doctor with a sense of humour and how it put her at ease and made her feel safe:

> She had kind of a dry sense of humour that might not have worked well for all people, but for me it was perfect...As I was pushing on all fours and basically ready to deliver, she said, I’m going to run upstairs and do the fastest c-section on earth and I’ll be right back (laughing)....It was great.

Another woman spoke in a similar vein of the doctor who helped her deliver: “She...was teasing me sometimes and it also helped...during the delivery....It distracts you from the pain and you try to reply.” A third woman also expressed her appreciation of the support that humour can provide:

> It was the one thing that kept me going. Maybe it was a false sense of security, but when the doctor was joking, I felt reassured that everything was going better
than what was to be expected. I remember thinking that at the time. It was excellent for my confidence.

**Holistic Approach?**

Only one woman described what was, in her judgment, an inexcusable experience with a doctor. The woman recalled having to deal with unwanted questions that she would have preferred her husband answer. She felt that the doctor wanted to control her birthing experience and that she was focused on the medical model and treated childbirth as a disease. When asked what kind of questions came from the doctor, she replied:

> Are you having any pain? Do you want any pain medication? Do you want an epidural? How are you feeling? Any of those types of questions and we had discussed it—that I wanted no epidural; I wanted no medication of any sort...and I didn’t want to answer questions.

She felt that the health care professionals, and especially the doctor, were not supportive of the use of self-hypnosis and a hypnobirther. “They were having a very hard time with that because they really wanted to control the situation and I refused; this is my process. I’m in control.”

Her experience was unacceptable enough that she is contemplating a home birth for the future, with midwives, doulas, and a hypnobirther:

> I know that I can do it on my own with the proper professionals around me. I am not averse to going to the hospital if it does come to that point....but I would not have...OBs. I mean these guys are trained to be surgeons, so they think in worse-case scenarios all the time...and they forget that women have been doing this for many years. It’s almost like they forgot that this is a holistic process. It’s not a disease, but they treat it like a disease.

The woman offered some advice for the obstetricians that care for women during childbirth: “They get so into the medical model that they forget the patient. I really wish that the doctors would be less of a doctor and more of a human being.”
As health care professionals, we are instructed that questions must be directed to the patient and not the family members; the patient must provide the answers. In considering women’s health care, we are told that when the man is giving all the answers, and never leaves his partner’s side, this can be a sign of a controlling husband—a “red flag” of potential domestic abuse. However, this woman insisted that her husband answer the health care professional’s questions and she actually set things up this way prior to labour.

In general, the other women expressed appreciation of doctors as important supportive members of the health care team. From the women’s perspectives, doctors should not merely deliver their babies but also provide support, especially in the final stages of labour. And if they managed to do so while offering a mix of knowledge, encouragement, and humour—so much the better.

**Self-Support**

An interesting finding of this study is that the women expressed the notion that they were their own supporters and that each individually was a fundamental member of her support team. While I have seen women show amazing coping skills during labour, it was extraordinary to discover that the women in the sampling believed in themselves and were able to motivate and support themselves through labour. The self-supportive measures that they mentioned include techniques for visualization, distraction, and pain relief. The women also discussed differences that they believe they have from one another.
**Inner Strength**

The women described themselves as the most important and effective support person. The feeling was that they were going through the experience and had to find a way to cope. They said that they found an inner strength to assist them with managing the discomfort and tension of labour. As one remarked:

> You can have all the people telling you what to do...but it’s not the same as if you try to think of it yourself. You’re the one that has to do it, right? You’re the one that’s feeling the pain and the contractions. You’ve got to pull from your strength inside in order to get the job done.

Another woman said that she tends to cope with pain or discomfort on her own. During labour, she found it “easier to come through the pain and contractions by myself. I was concentrating on myself and on the baby.” Another woman stated, “You do kind of find an inner self that you didn’t necessarily know was there to tap into.” And one other woman who spoke in comparable terms about her experience said simply, “I drew from an inner strength.”

**Aloneness, Empowerment, and Control**

The woman who used self-hypnosis defined the process as “deep meditation.” She explained:

> It’s not like someone else does it to me...I do it on myself. Because of the hypnobirthing, I was completely calm and my body just did its thing. The process really relaxes you and you are really in control of what’s happening to you. It’s very empowering. I really thought through the entire process—I knew I could do this.

The women described wanting to be alone or feeling separated from others when they were in the most painful moments of childbirth. The need to be alone may not necessarily be a physical need, but a need to bring a sense of serenity to their environment. "I felt like I was... on my own,” said one of the women, “not in a negative
way, but I was doing my own thing and zoned out. I was in my own world.” Another stated, “I didn’t want a lot of people. I think that’s just my personality. When I’m in pain or when I’m sick, I just want to be left alone.” She discussed how she felt when her brother was with her during labour: “I was in pain and I wanted to be left alone, but he wasn’t really talking...he was just kind of sitting there and he wasn’t really asking questions, so it was fine.”

**Self-Talk and Being “in the Zone”**

The concept of being “in the zone” came up more than once. “The contractions were getting quite intense,” an interviewee remembered. “I didn’t want any drugs and I was still sort of in my zone...I was pretty much into myself at that point.” This state of mind inevitably changed her view of those around her. “I certainly felt their [husband, doula, and nurse’s] support, but that was not part of my thought process. So as much as it was helpful to have positive people there, I was not thinking about them.”

The women spoke to themselves during labour; they tried to stay in control of their emotions and what was happening to them physically. In their heads, they said things that their family and friends also said to them. Some claimed that this inner monologue was just as helpful as the encouragement from their supporters, if not more so. They told themselves that they were doing well, that they could do it, and that there was an end in sight:

I tried to keep control over myself....I didn’t cry. I just breathed intently and it was really helpful and I tried to speak to myself, [saying]...that this is just temporary and I will come free and it’s fine...and it did help when you talk to yourself...not out loud. I think I...myself was one of my supporters.

Another woman said, “When I was pushing, I tried to mentally prepare myself and I said to myself, I can do this...it’s not forever...I’ve got to get through this...this is
just me getting through this.” One woman, who also spoke to herself, compared her labour to her exercise routine:

You mentally say, OK I can finish it...I’ve got 20 more reps to do. Same thing...I’ve got one more contraction to do...do another...it’s getting closer...one more centimetre...we’re closer, closer. It makes you feel that there’s that end goal in mind. So you feel you can get through it.

During the entire labour and delivery process, the women reminded themselves what it was really about: “It’s painful but once you get through it, you know, this is what you get in the end—a beautiful little baby, right, so...[that’s] the whole purpose of what you’re doing.” Another woman concurred: “I think the one critical thing that helped me, above everything else, was why I was doing this; and it was for my child. This was why, and whenever I would lose control, I would refocus.”

**Disconnection from Supporters**

It is evident that while the women held to an awareness of the purpose of labour, they could at times become so focused and deep within themselves that they disconnected from their surroundings and other people, especially when labour intensified: “I was in my own world and ...if I had kept my eyes open the vast majority of the time, I may have been more aware.” Although it was mentioned earlier in this chapter that certain members of the support team became more involved when labour intensified, the women still experienced a certain sense of disconnect. One woman said, “At times I was conscious of his [her husband’s] support and other times ...the pain and trying to push and you just didn’t notice anyone in the room really.” As the woman who practiced self-hypnosis explained, “You’re focusing on the breathing—not on what else is happening outside. You’re not really paying attention to anything else.”
The interaction that the women needed or wanted during childbirth was limited to communication that was pertinent to their progress and well-being. A woman’s friend arrived when she was starting to push: “I didn’t really interact with her,” she recalled. Another was similarly detached from people in the room: “I was just zoned and focused. But like I said, I did hear and feed off of what was going on around me in a big way.”

When asked if she felt there were too many people in her room, the woman using self-hypnosis replied:

No, because I was able to shut down quite a bit. I felt like I was on my own anyway, so it didn’t matter. With hypnobirthing you actually go within yourself. Your focus is to truly, really truly relax...truly connect, in an almost spiritual level with your child....It’s not about anybody else....All hell could break loose and you really don’t care.

She further explained that the “objective is...not to interact with the people. Your job is to really be there for yourself because, I mean, it’s stressful as it is and you don’t want to deal with answering any questions.” Another woman echoed the sentiment:

I just wanted to conserve my energy. And I just wanted it to be calm and quiet. And I guess I’m the type of person that when I’m in pain, I don’t want to carry on conversations and people to ask me questions.

The women seemed to connect with and disconnect from their supporters at various times, and their wishes and requirements relating to support changed from one minute to the next. Thus, as women experience it, support from other people may be as simple as just being a presence or offering encouraging words and phrases that don’t require an answer.

**Visualization, Breathing, and Distraction Techniques**

To access their inner strength, tune out the immediate environment, and get on with the job of childbirth, some of the women used visualization, breathing, or distraction
techniques. One woman “kept visualizing the baby. We had that 3-D ultrasound, so you kind of got a picture of what he might look like.... And so, I just kept picturing that.” Another woman said: “I really visualized and focused on him [the baby] coming out...as quick as possible....on having him naturally.”

Breathing techniques also contribute to focusing and thus assisted the women through labour:

I think it was around the transition point. He [her husband] had recommended that ...I make noise as I breathe through it. And maybe he said, it’s OK to make some noise and that’s when I started moaning through my breaths...and that did help too...just that rhythmic...sound and feeling with the breathing as well.

Another woman also commented on her breathing: “The nurses recommended entenox or an epidural, but I managed with the pain by myself. I used breathing techniques and they were very helpful.” She explained that breathing during self-hypnosis was part of the process and helped to “make sure that you’re oxygenated and the baby is oxygenated. I’ve done meditation before and it’s the same type of thing where you’re really focusing on your breathing.”

One woman thought of the process of labour as a personal challenge and tried to truly experience it and remove herself from what was happening to her body. She explained:

What kept me going personally was my focus. I almost thought of it as a bit of an experiment to see how far I could push myself. So, I was sort of removing myself a little bit from the fact that, yeah there’s pain...this is what labour is all about...versus being so caught up in the pain. My doula helped prepare me with that mindset.

Another woman had a similar technique and explained her process as letting your body experience what it needed to experience: “When you’re having a bowel movement and your body is just kind of wanting to do its thing...you just have a bowel movement...it’s
that kind of thing. Where you're...more as an observer than really participating.” While
this woman also focused on, and visualized, the baby throughout her labour, another used
her language skills as a distraction:

English is my second language and all the time I was speaking English and it was
helpful for me because it’s quite different than speaking my native language. I had
to think. I had to choose the right words and it helped me. So, it is my advice to
immigrant women to speak English while delivering.

**Physical Support**

For the most part, the women felt that they coped better when independently using
a method comforting to themselves, and that physical support from others was not
especially beneficial. One woman said, “When it comes to physical support, I did my
own thing.” Another woman remarked that when her husband tried to massage her during
the contractions, she preferred to cope on her own: “I didn’t need physical support from
him.”

The women quite often insisted that they did not want to be touched while they
were labouring. Five of the eight found massage and counterpressure unhelpful. One
woman explained that a very light touch was all she required:

We just sort of rubbed my back very, very lightly...more in a hi-
really kind of touch than anything. And anything else that the doula tried for
counterpressure was more annoying than anything. I just wanted that really, really
light touch. In my case, less was more.

As their responses to physical support indicate, the women in this study believed
that they were their own essential providers of support. They inspired, encouraged,
motivated, and pushed themselves throughout their labours, especially during the most
intense stages. While supporters became unnecessary at times and imperative at other
times, the women themselves were the most focused and consistent supporters within their supportive teams.

Everyone Is Different

One theme that surfaced in this study was the women’s shared belief that their experiences were all different. Throughout the interviews, they made statements such as, “But that’s just me. So I think everyone’s different,” and “Everyone is unique and deals with pain differently.” The women also felt that personality and attitude have a lot to do with how an individual copes with labour. “I think you have to look at yourself and look at your personality and how you are and how you handle things and what kind of person you are. You have to assess yourself first because then you know going into it.” Although each labour was unique—and despite the interviewees’ belief in individual difference—the findings presented here also reveal notable similarities in the women’s use of self-coping mechanisms.

Comfort Measures

Most of the women in the study used both invasive and non-invasive pain relief interventions. Some of these were helpful and some were not. The health care professionals made many suggestions as to what would work well for pain relief at various stages of the labour, and the women tried different methods.

Hydrotherapy

The use of hydrotherapy can be effective for pain relief. However, the women in this study who used the Jacuzzi and the shower did not find it helpful, and the women who were not able to use hydrotherapy for pain desperately wanted to try it, but couldn’t
because of labour inducement. One woman said, “Some people say the warm bath and stuff helps with the contractions...it didn’t help me and then we tried the shower, and I just found it irritating getting all wet and everything.” Another stated, “I was thinking about the Jacuzzi, which was in the room. I was dreaming about it...how I would take it during delivery. It was impossible with the IV.” And a third woman similarly recalled her frustration: “I really wanted to go into the shower or the bath, but they wouldn’t let me because I was overdue and they were checking his [the baby’s] heart rate all the time.”

**Epidurals**

The epidural is a method of pharmacological pain relief that some of the women opted for. Five of the eight received an epidural at some stage of labour. All of the women had planned to have as natural a childbirth as possible, however, and thus no one decided without forethought to have an epidural.

Two women wouldn’t recommend it. One said:

I was dilating so slow that it was just getting to the point where it’s been a day and a half and you’re exhausted...and you’re at your wits end, so I did go for it.... In the future I wouldn’t do it. Actually, the epidural wore off in 20 minutes, so it didn’t really do much. I went through the pushing and everything after the epidural wore off. I felt everything, which was OK. Then you could feel when to push.

The second woman stated, “The epidural wasn’t great. My epidural actually wore off. It just wore off. It wasn’t done right or something...there was a problem.” A woman who did not have an epidural said that she would not rule it out next time: “Every experience is so different. So, if I did it again, I wouldn’t go in there again saying no epidurals...but again, see how things go.”
Choices within Limits

It is apparent from the women interviewed that they had choices and control of their physical needs during childbirth. Of course, some situations, such as labour inducement, impose limits on what comfort measures can be taken. But these limits aside, the findings of this study suggest that women know what they require to help them cope with the pain, and they make requests accordingly.

It is also important to note that although some of the women in this study did not find pain relief interventions greatly effective, other women, may, in fact, discover that such interventions may be helpful for them. It is of great benefit to try nonpharmacological pain relief methods first, as they may be successful in easing pain, and then, if necessary, utilize pharmacological pain methods under the supervision of health care professionals.

Postpartum Support in the Hospital

Women had mixed feelings about the care and support that they received in the postpartum period. Some of the women recalled great support during this time, while others felt that interactions during the postpartum period could have been more informative and helpful.

A Positive Impact

One woman found the postpartum care that she had in the hospital gave her the confidence that, once back home, she would be able to care for her baby:

It had a really positive impact, especially on that first week where... everything is new... ...and they really did instil a lot of confidence in me.... I think that goes a long way to coping when you get home.
Another woman also felt that the postpartum care she received was invaluable: “After the delivery, the nurses came one by one to look at the baby, to check her, to give me advice, and it was very encouraging because...I didn’t know...how to deal with babies.” She concluded with the observation that the nurses’ advice was “very, very, important for me.”

One woman had a lot of support in the postpartum period in the hospital, so much so that she felt apprehensive when she returned home and no longer had access to this guidance: “I remember the first couple of days... I was a little bit...oh my god! I don’t have that now and it was hard....I appreciated the help and was thankful for it and then I was on my own.”

**Inconsistencies**

One woman had the opposite experience. She felt completely supported during labour and delivery and then, after she delivered, the support seemed to dissipate. She was confused and frustrated:

> It was funny, because the nurses were there 24–7 before I gave birth and then, as soon as I gave birth, they were gone and no one was around. There were a few times where I would go to the nurses’ station and be like, where’s our nurse? So that was a little bit frustrating. Sometimes, I would think, am I doing this right? It’s just a little bit scary. I understand that their focus is to make sure that the patients that are giving birth are taken care of and I’m sure it was busy, but I said, “We haven’t seen our nurse for six hours.”

The women criticized the inconsistencies they discovered during the postpartum period. They found that, at times, nurses and doctors alike might give inconsistent information. This is especially evident with instruction related to breastfeeding. Three women discussed their dissatisfaction in the postpartum period. One woman who was given advice about breastfeeding from her nurse during the day was given contradictory
advice from the nurse who was on nights: “At first I was told to feed my baby on
demand…and then the night nurse came on and said, ‘Make sure you wake him up every
three hours and feed him’….It was so confusing.” A second woman said that her nurse
and the paediatrician gave conflicting information about breastfeeding:

One nurse said, “I will show you how to breastfeed lying down,” and the
paediatrician came in and said, “What are you doing? You shouldn’t be lying
down…this child needs food…you’re not doing it properly…. That was the kind
of frustrating thing that happened.

Another woman described the care during labour as “fantastic” but found support
in the postpartum period to be “inconsistent and sparse”:

I think every nurse that came in, when they did come in, told us something
different. It was really busy, so we didn’t see our nurse very much. On the second
night, the nurse told us that she had six postpartum patients and one who was in
labour!”

As this observation suggests, overall, the women perceived lack of supportive care during
the postpartum period to be based partly on the workload on the ward at any given time,

as well as on the differing advice that doctors and nurses offered as individuals.

Memory Lapses

During the interviews, it became apparent that, in the postpartum period, the
women had memory lapses. They could not easily recall everything that they had
experienced during labour and often failed to remember some events altogether, until
partners or family members filled them in following delivery. The women were aware of
these lapses and, in the interviews, referred to their recollection of some episodes as hazy,
blurry, or foggy. One woman discussed not being able to remember whether or not her
primary nurses were at the birth:
I think they missed the actual delivery. I think they went for lunch maybe...maybe not. Maybe it was just after...yeah...I think it was just after I delivered and the head nurse actually came to just cover for them during that time...I'll correct myself...I think they [primary nurses] were actually there for the delivery and then switched.

Another woman said, "I know the duration from when water broke to when he [the baby] arrived and the main milestones in between, but whether a certain phase took one hour or four hours, that I can’t really pinpoint.” Yet another woman also said the timeline was unclear: “Yeah, it was three a.m....or a few hours later...my husband knows...we can ask him afterwards.” When trying to think back to specific incidents during her labour, a fourth woman said, “Again, my concept of time goes out the window really fast because you’re so focused on getting through the contractions.”

When asked who her key support person was, one woman replied, “Mmm...that’s a tough one...because there are definitely moments in labour that are hazy...there’s just a blur of people around.” One woman had a forceps delivery and was hazy on the number of people present: “There were a lot of people there...maybe six...I mean at that point it was fine...it didn’t bother me...it was all a big blur.” These comments are somewhat contradictory, as the women also mentioned specific people who were at the forefront when the intensity of labour overcame them. This might be because they had one or two specific people that they focused on, while others faded into the background, making them difficult to recall later.

**Women’s Perceptions of Labour and Delivery**

It is evident that the women in this study needed and appreciated support during childbirth. However, the level of support and who provided it differed from one woman
to another. The women recognized personal differences and the uniqueness of each labour and delivery; at the same time, common patterns of coping are also present in the data. At different stages of labour, the support level that the women required changed and the significance of each support person accordingly shifted from essential to passive, and vice versa. The women appeared to experience an altered level of consciousness—going deep into their “inner selves”—when they were enduring the most intense labour pains and, perhaps for this reason, had later memory lapses. However, they tended to remember specific incidents that were especially poignant or significant to their individual experiences.

Despite all the pain, confusion, frustration, and difficulties that these women endured throughout labour, delivery, and the postpartum period, many still said that their experiences were mostly positive. Surprisingly, even the women who spoke of negative occurrences with the health care professionals described their overall experience as positive. The women used terms such as amazing, miracle, great, and extraordinary, while also acknowledging how painful and difficult it all was: “There are parts, of course, where you’re, oh my god, this is painful, but you get through it and afterwards you forget the pain.” A different woman observed:

I’d say I look back on it... I mean it was very painful and at the time you’re thinking, oh my god, how can I get through this? But I look back on it as a positive experience.... I’m glad... it’s one of those miracles that... was amazing.

Another said, “I don’t think I could have asked for more or for better support. I really don’t.” Still another was “delighted” and “satisfied.” Even one woman who had a negative experience with the health care professionals was surprised: “I didn’t anticipate how positive I would feel about it afterward.” Another found it to be “a really good
experience...despite all the pain, which is to be expected anyway," and another had
“nothing but good things to say.” One woman also spoke for several others when she
said, “I really was happy with the way everything transpired. I felt like it went well.”

Summary

Based on data extrapolated from interviews, this chapter has presented eight
women’s perceptions of the supportive care that they received during labour, delivery,
and the immediate postpartum phase. Major topics covered here include: women’s use of
support and resources before and during labour; members of the supportive team and
their roles at various stages of labour; and the types of support that the women found
meaningful (or otherwise). A significant theme that has emerged is women’s capacity for,
and reliance on, self-support during intense parts of their labours. The following chapter
will discuss the findings presented here in relation to a review and analysis of relevant
literature.
Chapter 5

Discussion of the Findings

In further exploring salient points and claims made in the preceding chapter, this discussion offers a review and analysis of literature bearing on labouring at home, roles of the various members of the support team, and the extent to which women are their own supportive care givers. Subsequent discussion takes in literature and ideas pertaining to comfort measures, sharing of information, support given in the postpartum period, and the women’s inability to remember pertinent details of their labours.

Normalizing Childbirth

Health professionals who work with childbearing women should research supportive care and natural interventions that are safe and helpful for women coping with the pain of labour; such measures may enhance women’s perceptions of the supportive care that they receive during labour and delivery, and improve their experiences of childbirth.

In her work as a perinatal nurse, Callans (2006) described many “aha” moments that occurred to her in the highly structured, “hi-tech” environment in which she worked. She found that it was a challenge for her and her co-workers to hold onto a philosophy of natural birth, especially when they witnessed very few normal birth experiences, and a
high level of intervention was routine. Supporters, including nurses, may find it difficult to witness the pain that women go through during labour. However, as health care workers, we must recognize that this emotional response of ours is a personal concern and should not affect the care and support we provide a labouring woman. Health care professionals should avoid encouraging the use of pharmacological interventions that a woman may not want. Each woman must decide, without pressure from supporters, the comfort measures that she requires and sequentially be in control of her labour.

A descriptive comparative study by Kao, Gau, Wu, Kuo, and Lee (2004) found that most expectant parents anticipated a normal spontaneous delivery, and they had a high expectation that the labour surroundings would provide a user-friendly, safe, and comfortable care-giving environment. Today’s parents assume that unnecessary medical interventions, including the use of avoidable pharmacological interventions, would be discouraged in order to facilitate the progress of labour and diminish the chance of having a surgical or instrumental delivery. Another outcome of Kau et al.’s study showed that expectant mothers anticipate the ability to participate in medical decision-making during the course of labour. They do not want to be told what they should do.

A woman in my study voiced concerns regarding the lack of ability to be a part of the decision-making process and the loss of control that she felt, at times, during her labour. She also discussed her disappointment at the ongoing offerings of pharmacological pain relief when she would rather have decided on and requested medications for pain when she needed them.
The Optimum Environment in Early Labour

If the woman requires support from others during the early stages of labour, close family members or husbands may be the most effective at providing that support. When the woman has a low risk of complications, the early stages of labour are usually better spent at home, and the women reported that they would have been, or were, most comfortable at home. One woman stayed at home as long as she was able and found it pleasant to be in her own surroundings while she was experiencing early contractions.

If it is necessary for a woman to be admitted to the hospital during early labour, it is prudent for the nurse to give the woman as much privacy as she desires. This should be assessed on an individual basis and the rationale for early admission should be carefully considered. For instance, one-to-one care by a nurse during early labour should be provided if such constant attention is optimum for the safety of the mother and the fetus.

Early labour supportive care from health care professionals should be discussed with the woman. Confer with her to determine the level of privacy she wants or to explain the reasons for constant monitoring—the safe care of her or the baby, for instance. Individual circumstances should dictate the health professional’s response; some women may require a nurse present at all times and others may prefer to spend time alone with their families. At the early stage of labour, most women do not generally need to be admitted to the hospital. As long as there is no medical or social indication, they should normally not be admitted early. From my experience working on the LDRP unit where the women that were interviewed had their babies, when women are extremely anxious and want to stay in the hospital, or it is not busy on the LDRP unit, the general
trend seems to indicate that they are welcome to stay. But this may be detrimental to the progression of their labour and may offer little benefit to the woman, as it could possibly lead to unnecessary interventions.

In a qualitative study using semistructured interviews, Cheyne, Terry, Niven, Dowding, Hundley, and McNamee (2007) discovered that feelings of uncertainty regarding being at home or in the hospital were a large part of women's experiences during first-time labour. They were anxious about whether or not their labour had started and also questioned their ability to cope with the pain. Three of the women in my study acknowledged that they went to the hospital prematurely. In hindsight, they felt that this was because they had never experienced labour before, and anxiety and the anticipation of pain dictated their decisions.

In the study by Cheyne et al. (2007), the women said that uncertainty, pain, and anxiety influenced their early labour decisions. While many felt they were coping well with their labour on admission, women often wanted to be in hospital “just in case” and lacked the confidence to cope with labour at home. One woman in Cheyne et al.'s study, who was sent home, stated, “I'm just glad, in reflection, that I probably spent a bit more time at home because at least I had the comfort of that” (p. 607). Some of the women in their study, nevertheless, raised concerns about staying at home and risking their own or their baby's safety. One such woman declared, “If somebody had examined me earlier on and I would have known things were OK, I'd have been quite happy to be at home, but it's just to this day I don't know if I was left at home and things were going wrong, I could have endangered the baby” (607). The women would have been more confident about
returning home had they been given more thorough explanations of the benefits of labouring in familiar surroundings.

**Choices**

In the findings of my study, three women who went to the hospital early, and were kept there, opted to stay in the hospital even though they had a choice to go home to labour in the early stages. At the time, two of them felt that the best thing for them was to stay in the hospital, but in retrospect at the time of the interviews, they realized that early labour would have been better spent at home. This coincided with Cheyne et al.'s (2007) study, as some of the women felt that they would have been happier to go home if they had been given more information about the advantages of going home.

One woman who was interviewed said that she would have liked more choices, and another woman explained that she was given the option to remain at the hospital or go home. She decided to be admitted to the hospital because she thought it was the safest thing to do. However, if she had received some reassurance and an explanation of the benefits of being at home, she might have opted for just that.

**Nurses**

It is evident from the literature that nurses play a significant role in the supportive care that they provide women. To gain a better understanding of the influence that nurses may have on women’s perceptions of their birthing experiences, this section will focus on the beliefs and attitudes that nurses’ hold and how their reactions and actions may influence the women’s experiences.
False Labour

“Cervical dilation with regular contraction traditionally has been used to differentiate between true and false labour” (Jain, Earhart, Ruddock, Wen, Hankins, & Saade, 2007). However, false labour is still real to the woman; therefore, health care professionals must support women with the same level of care, respect, and empathy that they would when women present in true labour. If it is a woman’s first birth experience, false labour can be just as frightening and anxiety provoking as real labour.

False labour and the negative connotation that the word false brings can be disheartening for a woman. To find out that she in fact is not going to have her baby, despite the painful contractions that she is experiencing, can be quite disappointing for the woman. That, coupled with the scepticism that a health care professional may demonstrate when a woman presents at the hospital, may be demoralizing.

In the previous chapter, one woman who experienced false labour a few weeks prior to delivering her baby found the experience as intense as when she went into real labour. While at the hospital, she felt that the nurses and the physicians exhibited condescending behaviour when she was in distress and she came to believe that when she finally did go into labour, they would treat her similarly:

Well, yeah, that [false labour experience] was definitely a little bit of my apprehension about the nurses—not positive—the resident wasn’t good, the nurses weren’t good. It was just bad all around. [It was] very real; as I’m walking up the street vomiting, having contractions for 12 hours straight, you kind of think, this is real—you kind of think you’re going to have a baby at some point in the not-too-distant future.

While she did have a good experience when she finally delivered her baby, she could still have been spared the worry that she felt during the two weeks prior to the
delivery. In this case, unfortunately, the health care professionals were partly responsible for her fears.

There is limited research on women’s experiences with false labour. However, in a commentary in the *New York Times*, Kovach (2001) shared her experience as a labour and delivery nurse:

> We must be careful before labelling something that is happening "false." If I ever work maternity again, I might just say to a patient who seems to be hurting, but not dilating, "You’re having important, early contractions that help get you ready to deliver, but we just haven’t figured out what exactly is important about them." I’ll tell her they are real, essential, necessary, early, subtle—anything, but false.

While Kovach did not conduct a study relating to reactions of nurses who may work with women who present with painful noncervical-dilating contractions, her personal viewpoint is well taken and worth taking into account when we, as nurses, are working with childbearing women. Kovach suggested some ideas for what these contractions could be called: UCL, Undetectable Change Labour; or ITS, Invisible Transition Shifts; or finally, IPC, Important Preliminary Changes. This type of terminology may prevent the negative implication of false labour. Health care professionals should put a positive spin on the changes occurring in a woman’s body, instead of using the term false to describe very real pain that women experience.

The impact of disregarding a false labour experience can affect the woman emotionally. As a result of such an experience, the woman’s last weeks prior to delivery may be more stressful than necessary. Health care professionals must instil a sense of security in women, whatever the type of labour with which they present.

It is advisable to steer away from the term false labour and use a different vocabulary. The term puts a negative connotation on labour and contractions that are not
going to produce a baby within 48 hours. Avoiding labels like true and false labour might help to validate the various types of painful contractions a woman experiences. When a woman comes to the hospital with painful contractions, but her cervix is not dilating, then health professionals need to provide accurate information about what is happening. Women should not be dismissed without a clear understanding of these preliminary labour pains. For instance, you might tell the woman: “You are in labour; however, your cervix is not dilating and these contractions may not be the type that will result in cervical dilation. They may go away now and return tomorrow, in a few days, or next week.” Knowing they have alleviated the women’s fears and explained that early pains are part of the process, health care professionals can send the reassured woman home. With her new knowledge, the woman will be more confident in her body’s process and be able to wait for the initiation of cervical dilation.

There is limited research on the topic of painful tightening and false labour prior to birth. Further research on this topic must be done to assist health professionals toward a better understanding of a woman’s physical and psychological feelings during this phenomenon.

**Attitudes and Behaviours**

Being satisfied, and having a positive childbirth experience, is possibly related to the attitudes and behaviours that health professionals display and is not necessarily due to successful pain relief. Therefore, communication, caring, competency, and advocacy early on foster the development of a trusting relationship through which emotional and physical needs can be met (Adams & Bianchi, 2008). It is important to make a personal connection with the woman before reaching for and focusing on monitors or making sure
the equipment is functioning. This connection helps to build trust between the health professional and the woman in the early part of labour. The relationship that is cultivated with the woman will carry forward to the more difficult stages when the support of a qualified health professional is essential—as seven of the eight women that were interviewed for this study acknowledged.

In a qualitative study by Hardin and Buckner (2004), women who had nurses that merely focused on paperwork and monitoring duties were disappointed with the type of care they received. These women said that they would request a more supportive nurse during their next birth.

One recurring theme of the interviews was that the women felt most secure with family members or with persons that knew them well at their deliveries. It follows, then, that if nurses take the time to learn about the patient and her needs, they can create a climate that is conducive to a positive birth experience. In a qualitative exploratory study by MacKinnon et al. (2005), women said that their experience was greatly enhanced by having the opportunity to get to know the nurse, and because the nurse knew them and the particulars of their situation. Although nurses will not have as close a bond with the woman and cannot know her as well as her family and friends do, a nurse can still work to gain an understanding of the dynamics of the relationships within the supportive team, in order to foster a trusting relationship with the woman.

**Husbands**

Today, it is a social norm that husbands or partners are present during childbirth. Nevertheless, there is limited research relating to what women perceive as their partners’
roles and responsibilities during childbirth. It is uncertain whether societal pressure is persuading women to have their husbands with them for childbirth, or whether women really do need their husbands for active support, or whether they want them present simply to experience the birth of their child as a family and to be part of the meaningful experience. According to the eight women who were interviewed for this study, they wanted their husbands with them more than they wanted any other supporter. Retrospectively, they did not want active support from their husbands, but they did want them there as a presence and, to some degree, as an extension of themselves—someone who is actually going through the process as well.

**Being Present**

In this study, one woman, from a country where a husband's presence during childbirth is not common, did want her husband with her. However, because in their culture it was not customary, her husband did not want to be at the birth. The couple believed that in Canada it was mandatory for the husband to be present. The women who were interviewed explained that having their partners present at the birth was to enable them to share the experience; it was not necessarily for the active support they might provide. Longworth (2006) discussed the notion that fathers should be in the labour room for support and not for intervention; if the father is at the birth, he should not be “doing.” This conclusion is consistent with the comments of seven of the eight women—they did not want their husbands fixing things or actively intervening. At the same time, all eight of the women said that their husbands were the most important support person at their labour and delivery.
It is interesting to note that several of the women described their husbands as the least helpful of their supporters, but if they were allowed only one supporter, all of them would have chosen their husbands. During pregnancy and childbirth, women consider their husbands to be the most important source of support and, in some cases, their support is rated more highly than that offered by midwives (Tarkka & Paunonen, 1996).

Gungor and Beji (2007) concluded in their experimental prospective study that fathers' support in birth helped mothers to have more positive experiences in all aspects of childbirth, although there was no relationship between fathers' support and length of labour, use of pain-relieving drugs, or obstetric interventions in birth. One can conclude that it is important for women to have their partners present and included in the experience of the birth of their child, but their role is not necessarily to assist with the progression of labour.

Keinan and Hobfall (1989) found that the mere presence of partners during labour does not necessarily help women cope better with the pain of labour. They also concluded that the partner's support during childbirth is useful only when he or she is able to help the woman meet her personal needs during labour. Interestingly, Keinan and Hobfall found that women who had husbands present required more pain-relieving medications, which may be a reflection of the partners' difficulty in being a witness to their spouse's pain during labour. In providing support during labour, a father's role may be as a coach, a teammate, or an observer, and Yim (2000) found that observer is the role expectant fathers are most likely to adopt. She also states that fathers who take on a more active role in the labour and delivery process are more likely to have a higher degree of understanding and empathy within their relationship.
When the women who were interviewed for this study reflected back, they described their husbands’ presence as essential. Each one said that they would choose their husbands over any other supportive person, regardless of the level of support provided. In most cases, in the early stages of labour, a husband’s presence is all that is needed. The husband’s role is more to be there to experience the birth of his baby than to be there for the wife.

Also, because it was a new experience for each couple, the women believed that their partners needed as much support during childbirth as they themselves did. Hodnett (1996) found that women were grateful for the support that nurses gave their partners and they had an enhanced birth experience because of it. Adams and Bianchi (2008) found that nurses could alleviate maternal stress by being aware of the labouring woman’s partner and providing him or her with encouragement, praise, and reassurance.

**Doctors**

Women and their families may at times view doctors as the experts that come in to deliver the baby and to give direction to nurses. From this perspective, the doctor may not appear to be part of the support team. However, doctors can be of great support to women in labour, especially in the final stage.

*The Final Stage of Labour*

Some of the women in this study transferred their focus from their support team and themselves to their doctor, once they reached the crowning stage of delivery. The women expressed their appreciation for the direction the doctor gave at that time and welcomed the guidance and encouragement. At this stage, a few of the women recalled,
their supporters faded into the background and the doctor became the main source of support.

It is vital for doctors to provide detailed instructions about when to push and when to cease pushing and pant. This support allowed the women to concentrate on what needed to be done. Generally, the women appreciated this one-sided interaction at this stage of labour. They listened to their doctors’ instructions, and yet they did not need to respond verbally.

Other supporters who have been cheering the woman on up to this point may now need to step back and allow the health care professionals coach the woman through the final stage of labour. The women that were interviewed knew that their supporters were present; they could sense them in the room, but they concentrated on the physician’s instructions, which were now essential, according to some of the women. There is limited research on physicians’ support and involvement during childbirth, in particular when the baby is about to be delivered. Further research is needed to fully understand the effect that the coaching of their physicians has on labouring women.

**Humour**

Three women in this study spoke of their doctors displaying a sense of humour, which they appreciated even at critical moments. During the interviews, they discussed the sense of ease they felt when the doctor joked with them or teased them. When the women reflected back, humour in the labour room was a welcome and refreshing diversion. When the doctor lightened the mood with humour, the women said they felt a sense of security in their progression and the safety of the baby, because they reasoned that the doctor would not make jokes if there were cause for concern.
There is limited research regarding humour in the labour room; however, Godfrey (2004) discusses the use of humour in other areas of medicine, and the conclusion is that laughter can be good medicine. Godfrey mentioned growing evidence, both scientific and observational, of a clinical association of humour with health and immune response, as well as with coping with pain perception, discomfort threshold, and stress.

**Communication**

The women appreciated doctors and nurses who shared information with them. They wanted to know how they were progressing and what was happening throughout the labour and delivery. Instruction and information sharing provide women with an opportunity to be part of the decision-making process and foster a positive birth experience (Adams & Bianchi, 2008). The women interviewed appreciated the ongoing information that the nurses and health care professionals provided during the labour process. Informational support is reassuring. Hottenstein (2005) claims that one-to-one care, with information sharing and physical, nonmedical comfort is the true meaning of continuous labour support.

Interaction between nurses and doctors should be professional and respectful. The women in the present study appreciated the nurses and doctors interacting with each other in a mutually respectful way. When health care professionals related to one another in this manner and used a team approach, it built the women's confidence. If everyone is in agreement on how the labour is progressing, and that she and her baby are doing well, it may enhance a woman's sense of security. If she becomes aware that her doctor and nurse are disagreeing with each other, this can cause stress. An overt conflict situation
could break the trusting relationship that has been built between her and the health care professionals. Failure of physicians and nurses to interact in a synchronized and positive manner results in unhealthy work environments and poor patient outcomes (Larson, 1999).

As health care professionals, we must respectfully discuss the situations that may arise. When a disagreement on how to proceed occurs, and as long as a critical situation is not occurring, doctors and nurses need to remove themselves from the labour room for the discussion, leaving the woman to labour in peace. Unfavourable information should be presented in a considerate, nonthreatening way, and the woman should be encouraged to make an informed decision based on the facts.

**Self-Support**

Many women do not want a lot of interaction during labour and childbirth, especially when the pain of labour becomes intense. While they may welcome their husbands, nurses, doctors, and other supporters cheering them on through the final stages, they generally prefer not to be asked questions that force them to interact with others. The women in this study expressed a need for quiet and calm during labour. Price et al. (2007) found that women want to maintain control of their environment and, during the most painful instances of labour, to be left alone.

**Limiting Interaction**

In the later stages of labour, some of the women in this study utilized supporters as advocates to speak on their behalf, so that they did not have to interact with health care professionals and others when they were feeling the intensity of labour. In the Price et al.
study (2007), women expressed the need for a communication system whereby family members could act as intermediaries with health professionals. The focus for the women was to get through the present contraction and then the next one and not to try to answer questions. Interacting with others and answering questions may break a woman’s focus and prevent her from concentrating as necessary to get through each contraction.

A woman in the study by Price et al. (2007) stated, “My sister was my voice and she knew me and knew my needs. She gave me that sense of security.” While some health care professionals may view this as a family member taking control, it was quite common in my study for women to request this type of intervention from their supporters. Some women said that the effort to speak diminished their energy. In having a supporter/family member speak for them, it could be concluded, women are controlling their environment to meet their needs.

Prior to entering the delivery room, it is important that the supportive team be aware of the uniqueness and complexities of each woman. They should bear in mind that women may require calm and privacy, and the development of intuitiveness will assist with this. In the typical hospital environment, however, labouring women are often disturbed by machinery, intrusions, strangers, and a persistent lack of privacy (Lothian, 2004). As supporters, it is important that we minimize interruptions to the best of our ability and encourage a tranquil environment if that is what the woman requires.

Much of the existing research points to a need for women to labour in peace, and with as much privacy as possible. For example, Odent (1987) found that we are able to learn a lot from animals that search for privacy and often labour alone. In fact, Odent said that if animals are disturbed during labour, the labour process ceases due to the release of
stress hormones and only continues once the animal again finds seclusion. Odent deduced
that this could be relatable to women. Lothian (2004) claimed that when a labouring
woman does not feel safe or protected, or when the progress of her normal labour is
altered, catecholamine levels rise and labour slows down or stops. Alehagen, Wijma,
Lundberg, Melin, and Wijma’s (2001) study demonstrated that childbirth is a very
stressful event and that the stress responses vary considerably among women. Alehagen
et al. concluded that the substantial increase of adrenaline and cortisol, compared with
noradrenaline, indicates that mental stress is more dominant than physical stress during
labour.

In my study, the women found that interruptions by lay supporters or hospital
staff were negative distractions and stressors when they were focusing on their breathing
or on a visual distraction. They voiced concern about having to come out of the “zone” in
order to deal with the distraction and then needing to work diligently to get back to the
place “within themselves.” If we follow Odent’s advice, valuable labour support can be
achieved if we offer a woman protection of her privacy and a calm, peaceful environment
if that is what she chooses.

**Inner Strength**

Lothian’s (2004) study is consistent with Odent’s work and with my findings, as
she claimed that an environment with the fewest possible distractions is necessary so that
the woman can tap into her inner wisdom and dig deep to find the strength she needs to
give birth. The women in the present study also spoke of finding an inner strength.
Although they said that it was great to have supporters offer positive affirmations and
words of encouragement, when they reflected back, they realized that they themselves
had to find it inside themselves to “get through it.” A personal birth story, recounted by Hotelling and Hotelling (2006), spoke of a young woman’s experience and how she used her inner strength to get through labour. The woman’s birth story corresponds with the findings of my study, as the woman believed that she was able to delve inside of herself and do whatever was necessary with her own psychological processes, in order to get through each contraction and have the strength to move on to the next.

The women that were interviewed for this study felt that they coped with the pain of labour mainly in a self-supportive way. They believed that they were indeed one of the most important members of their support team. They also expressed a need for solitude, although not necessarily in the form of being left completely alone in a room. Rather, being able to “go within” without distraction was what they wanted. In order for women to tap into their own self-supportive coping mechanisms, health care professionals must assess the benefits of privacy and give it as needed during childbirth. Lothian (2004) stated:

Can labour support create a bubble, a cocoon, around the labouring woman? Within the bubble, privacy is protected: Strangers are kept away (as much as possible), information is filtered, and questions, interruptions, and intrusions are kept to a minimum. Continuously supported, protected, and cared for, but not disturbed, the labouring woman can let go of fear even in a busy maternity hospital. However, she will be disturbed if she feels she is in a fish bowl being observed and evaluated. She will also be disturbed if she feels pressured to progress quickly because the clock is ticking. Ideally, she is surrounded by family and professionals who listen, watch, and quietly and patiently encourage her, making sure that she is not disturbed and has the privacy she needs to do the work of labour (p. 6).

The women that were interviewed in my study said that they wanted limited interaction with others during labour, which supports Lothian’s contention. Solitude may be beneficial to the labouring woman, because when she has no overly concerned
observers to comfort her, she can be free to look within herself for support and direction (Shanley, 2000).

**Disconnecting from Surroundings**

The women in this study believed that they should have supporters available to them and, prior to labour commencing, believed that they would interact with them during labour. However, during the intensity of labour, interactions with supporters were often not warranted and most of the women realized a need to draw on their own resources and strength to have a successful delivery.

The women interviewed for this study appreciated their husbands’ presence during labour. Six of the women commented that there was a lack of active support from their husbands, to which they reacted impartially during labour and in hindsight. They felt that in the end they did the work of labour and coped by empowering themselves to find an inner strength that some had not realized they possessed. The discovery of this inner power appeared to assist the women in experiencing a satisfying childbirth. Hardin and Buckner (2004) found that for women who chose not to receive pain medications, the technique of focusing inward was crucial to having a positive birth experience.

The need to be alone in a peaceful, calming environment during labour is common. The women in this study, for the most part, did not want stimulation during the active stages of labour. Although there may have been many people present for support, the women felt that their personal energy and drive was paramount and utilized their own coping mechanisms to get through each contraction. The women described a need for solitude and disengagement from the people and activity that surrounded them during labour in order to cope with the intensity of each contraction. There is limited research on
labouring women who disconnect from the supportive team. It would be interesting to discover if this feeling of disconnection is widespread.

**Comfort Measures**

In addition to what the labouring woman can do for herself, providing other forms of comfort is an important aspect of the supportive team’s role. The supportive team generally volunteers or is recruited by the woman for a common purpose: to assist in making the labour as comfortable as possible. From the women’s responses in this study, it is evident that what they thought might work prior to the initiation of labour did not always work during the labour.

**Massage**

Six of the eight women interviewed said that physical support such as massage and counterpressure techniques were irritating and unwanted. Two women found tactile stimulation helpful when performed by female supporters, but not by their husbands. Having learned about the benefits of massage in prenatal classes, the women thought it was something that they could look forward to during labour, but when coping with contractions, massage was an annoyance and they quickly asked their husbands, and in one case a doula, to stop.

In contrast to the women in this study, a lot of research has found that massage therapy offers a benefit to women in labour. However, in a randomized control trial by Chang, Chen, and Huang (2006), one group of labouring women received massage therapy and a control group received no massage therapy. The study demonstrated that massage could effectively decrease the intensity of labour pain in the first and second
phase of cervical dilation. However, massage therapy offers no significant difference in the final stage of cervical dilation.

In a retrospective descriptive study, Brown, Douglas, and Flood (2001) discovered that the majority of the women found massage therapy to be an effective strategy to cope with the pain of labour. However, one woman in Brown et al.'s study said that massage did not help her, because it was distracting and intensified her pain. Although she did enjoy massage/touch when she was not in labour, she found that it was not helpful for her during her recent labour or her three previous labours.

Prenatal educators should continue to teach tactile stimulation and massage techniques; however, it is equally important that the women and their partners know that these techniques may not alleviate labour pain. Women and their partners should be prepared for the possibility that massage may not work for them. It is essential that they understand that planned strategies for pain control may or may not be successful. It is also important to recognize that nurses, doulas, and even partners may provide ideas for other techniques not previously thought of. It is vital to be open to a variety of strategies during labour.

Women need to be encouraged to be open to suggestion, and simultaneously they need to listen to their bodies, so that they can have the best childbirth experience possible. If a particular method of support is not helpful, they should feel comfortable enough to state, “This is not working.” Supporters need to be prepared to alter their method of support and to comply with the woman’s needs as expressed during each stage of labour.
Epidural Anaesthesia

Epidurals are not a direct method of support, but it is important to recognize the correlation of epidurals to direct support. It is also important to be aware of women’s experiences of epidurals when they reflect back on their use. Women’s stories about epidurals provide polarized opinions. Women offer extremely positive or extremely negative responses (Sinclair, 2006). There is limited research regarding the use of other comfort measures, such as distraction, visualization, breathing techniques, or support of self, and how these methods affect the rate of epidural use. However, in a randomized control trial that was conducted with 413 nulliparous women who were at more than 37 weeks' gestation and carrying singletons, the finding was that one-to-one support did not make a significant difference in the use of epidurals (Gagnon, Waghorn, & Covell, 1997).

Five of the eight women interviewed received an epidural at some point during labour. Only one of the women thought it worked well. The other four women said it was not effective and they would not request it for future births. Education about the use of epidurals is essential during pregnancy. Physicians and prenatal educators must make women aware of the pros and cons of epidurals. Nystedt, Edvardsson, and Willman (2004) claim:

This form of pain relief has been proven effective and is widely used, with a considerable amount of women expressing satisfaction with it and while waiting for cumulative knowledge to further clarify this issue, we suggest that midwives and doctors can recommend this form of pain relief. However, information about possible associations with adverse effects in mothers and infants must be provided to expectant couples (p. 245).

When labour has started, if the woman has expressed a desire for an epidural, she should be provided with information about it, including the risks and the possibility that it may not work effectively. Health care professionals need to alert women to the negative
aspects of this procedure. Failure to provide all the facts may have a detrimental effect on the preparatory support the woman receives in the prenatal, as well as the intrapartum, period.

In preparation for labour, women must be made aware of the drawbacks of epidurals. In addition to the information provided by health care professionals, they can research the subject on their own and become fully aware of the risks. This information will allow the woman to make an informed decision. Even when she is experiencing the immense pain of labour and, in that context, makes the decision to opt for an epidural, the anaesthetist must methodically explain all of the associated risks and give the woman the chance to accept or decline.

It is challenging for the anaesthetist to reduce the pain associated with childbirth without interfering with the natural progression of the labour process. An epidural must not be thought of as a purely benign procedure, as complications may occur even in the hands of skilled anaesthetists. A vigilant anaesthetist who follows basic guidelines can significantly reduce many of these complications (Nicolson & Ridolfo, 1989).

There is one obvious advantage to an epidural insertion, and that is pain relief. Sinclair (2006) lists the numerous disadvantages of epidurals:

- Diminishing strength of contractions prolonging labour; temporary paralysis of pelvic muscles making it less likely for the baby's head to turn forwards, increasing the likelihood of forceps delivery; a dropping blood pressure causing less oxygenated blood to the baby leading to decelerations of the baby's heart rate; back pain that lasts for weeks or months after the birth; severe headache when sitting or standing that can last for a week; and itching (p.355).

There are numerous research articles that recognize the negative effects of epidural anaesthesia for labouring women (Kukulu & Demirok, 2008; Buckley, 2007; Anim-Somuah, Smyth, & Howell, 2005; & Durham, 2003).
The Postpartum Phase

After the delivery of the baby, the postpartum phase begins. Women have concerns about the consistency of information relayed to them by nurses and physicians during this phase. During their hospital stay, seven of the eight women found the information imparted to them by physicians and nurses was contradictory. The main concern was disparate information regarding aspects of the postpartum period. This is a time when women want to go home feeling confident about the care that they will give their babies. In the postpartum period, women can be overwhelmed with advice and information they receive from nurses and doctors. When that information is inconsistent with the advice of another health professional, this can be frustrating and confusing for the women.

Much of the contradictory information provided has to do with breastfeeding. In an article related to the inconsistent information surrounding breastfeeding, Simmons (2003) explains that busy wards, with little time for teaching, create fragmented information leading to a lack of continuity in breastfeeding advice. This results in uncertainty in the learner. In addition, the different teaching styles and the different personal experiences of nurses factor into the opposing views.

One woman who was interviewed said that her nurse was looking after six postpartum patients and had another patient who was in labour. This opposes the SOGC guidelines (1995), which state that the nurse-to-patient ratio should be one-to-one during labour and delivery. Some of the women interviewed indicated that they felt abandoned
in the postpartum period, but they recognized that the workload issues on the LDRP unit were largely the cause.

**Memory Lapses**

During the interviews for this study, when the women reflected back on their childbirth experiences, they had difficulty recalling in great detail some of what had transpired. Using such terms as *blurry, foggy, unclear,* and *hazy,* they spoke of the difficulty of remembering timelines and key events only two months after the birth.

In a multiple regression quantitative study, 60% of mothers were not able to accurately recall at least one major labour management event; the researchers found that recollection was more likely in mothers who were white, older, and had a delivery that was more recent (Elkadry, Kenton, White, Creech, & Brubaker, 2003). Conversely, in a qualitative study with 20 open-ended interviews taken from the author’s childbirth classes from 1988 to 1990, Simkin (1992), discovered that, even years later, women’s memories are generally accurate, and many are strikingly vivid, especially of onset of labour; rupture of the membranes; arrival at the hospital; actions of doctors, nurses, and partners; particular interventions; the birth; and first contact with the baby. Simkin concluded that most memory lapses or instances of confusion were minor. It seems as if Simkin is only discussing key events in the labour, which may, in fact, be embedded in women’s memories.

Had women been aware prior to labour that memory lapses might be an issue, they could have arranged for a support member to jot down milestones, so that they would have a better idea of what occurred, and when. Some supporters may already do
this for women, but only one of the women in this study had a doula who made notes while she laboured. She referred to this several times during the interview: “I will have to check my doula’s notes. I don’t recall but she has everything written down.” Pascali-Bonaro and Kroeger (2004) found that continuous support by laywomen during labour and delivery facilitates birth and enhances the mother’s memory of the experience. The authors did not, however, indicate whether anyone had taken notes to help enhance the mother’s independent memory.

Most of the literature on this phenomenon is based on women’s memories relating to pain. In particular, the studies explored how women remember labour as less painful with the passing of time (Terry & Gijsbers, 2000; Niven & Murphy-Black, 2000; Waldenström, 2003; & Waldenström, 2004).

Further research is recommended on memory so that women can be aware of this phenomenon. The information could be used to develop ways to record the timeline and the milestones of childbirth. A written record of events may or may not enhance the perception of childbirth experiences but is a good tool if the woman believes that she may want to look back on events. The woman whose doula had transcribed events felt that the result was a meaningful record to look back on when she wanted to remember specifics of her labour. The record might also suggest important strategies for future birth experiences.

A journal of events can offer women a way to look back periodically at one of the most important times of their lives. With that said, this may not be a positive tool for every woman, and some women may not want to recall some of the events that occurred. Further research may assist to clarify whether these memory lapses are a protective
mechanism to assist in forgetting some of the most painful moments of labour or whether
the memory loss is simply from extreme pain and the emotional stress that goes with it.

Summary

Through discussion and analysis of related literature, this chapter has expanded on
the data gleaned from interviews, offering additional observations on: the various
supportive team members and how they assist women during labour, delivery, and the
postpartum phases; the role of self-support; indirect methods of support, pharmacologic
as well as nonpharmacologic; and memory lapses following childbirth. The discussion
has additionally noted similarities and differences between the results of this study and
findings in the published literature. The following chapter will provide a summary of this
study as a whole; offer conclusions; examine implications for nursing in relation to
practice, education, and policy; and further discuss implications for the multidisciplinary
support team.
Chapter 6

Summary, Conclusions, and Recommendations

This chapter provides a summary of this research project; reports the conclusions; examines implications for nursing with regard to practice, education, further research, and policy changes; and offers observations about implications for the multidisciplinary support team.

Summary of the Study

This study has explored the supportive care that women received during labour, delivery, and the postpartum period. I was particularly interested in obtaining the women’s perspectives and analyzing their perceptions of the support that they received during labour and delivery. My goal was to gain and communicate a better understanding of the art of supporting women through childbirth. I used an interpretive descriptive study design to capture evocative accounts of women’s childbirth experiences.

I obtained the sample via theoretical sampling and then, unintentionally, via snowball sampling. Eight participants came forward voluntarily and contacted me on their own initiative. I explained the process to each woman and made each aware of the purpose of the study. I ensured that the women knew that their participation was completely voluntary throughout the study and that they could withdraw from it at any point.
A literature search relating to women’s perceptions of supportive care during labour and delivery revealed a significant amount of research on supportive care and how it affects outcomes for the mother and the baby (Campbell, Lake, Falk, & Backstrand, 2006; Gagnon & Waghorn, 1999; & Hodnett et al. 2007). The literature also discusses a wide variety of supporters and how supportive care can make a difference in the outcomes and effects of labour itself. There is, however, limited research relating to women’s own perceptions of their birth experiences, as well as their views on the supportive care they receive and how helpful it actually is.

In one of the few studies of women’s perspectives, Bryanton et al. (1994) conducted interviews of women within 72 hours of their labours. The participants rated 25 nursing support behaviours and their degree of helpfulness; they perceived all 25 as helpful to some extent. The highest rated behaviours included: making the woman feel cared about as an individual, giving praise, appearing calm and confident, assisting with breathing and relaxation, and treating the woman with respect. Behaviours in the emotional support category were the most valued. The conclusion of Bryanton et al.’s study supports the findings of this study, whose participants found supportive care from nurses to be generally helpful and encouraging.

The literature also reflects limited research on whether or not family, friends, or partners make a significant difference to how women perceive their childbirths. In this study, I hoped to discover an answer to the research question: What are women’s perceptions of the supportive care that they receive during labour and delivery? My aim was to clarify the helpful and unhelpful behaviours of various members of the supportive
team. I also wished to determine whether, and how, women's need for support—from family, friends, and health care professionals—changed over the course of the labour.

**Fluctuations**

The women interviewed for this study, it is evident, believed that they required support during childbirth. It was interesting to discover that their preferred supporters, as well as the degree, scope, amount, and type of care they required, did indeed change as labour progressed. Women often require different types of support from different persons, depending on which stage of labour they are in (Yim, 2000). While the support that participants in this study required generally increased as labour intensified, the women indicated that some of the supporters faded into the background, while another supporter became more prominent or each woman became her own supporter. A given supporter might thus be essential in the early stages of labour, then become less significant, and take on importance once again in the later stages. To some degree, the supportive teams that the women chose influenced their perceptions as they looked back on the birthing experience. The women who felt that they were in control of the labour seem to have had the better experiences. The supportive team assisted in this regard by relinquishing control to the woman and honouring her needs throughout labour.

Not surprisingly, the degree and kind of support that each woman received varied somewhat according to individual situations and personalities, but at the same time, patterns and themes became apparent. For instance, many of the women tended to need their husbands at the early stages and end of labour, but not as much in the active, middle stages; most of the women did not require a nurse in the early stages but did need one in the active and latter stages. Most of the women would have liked to have a physician
come to see them more often throughout the labour, whether or not the physician actually visited the labour room. In any case, most of the women looked to the physician for support at the final stages of labour. Moreover, when supporters changed their level, degree, and depth of support as the women’s requirements changed, the women retrospectively believed that this enhanced their experiences with childbirth.

In hindsight, the women who presented at the hospital in early labour, without complications, would have appreciated going home to labour in more familiar surroundings and to spend time with their husbands while they did not yet need the level of support the nurses and physicians would have provided in the hospital. At the time, and when given the choice, they decided to stay in the hospital but realized after the delivery that it would have been a better experience in those early stages, had they gone home.

In the postpartum phase, most of the women would have appreciated more educational support than what was on offer. Many of the women felt that the support they received after the baby was born was deficient. They expressed their disappointment in the lack of attendance, despite requests to have their nurses come to see them. Reflecting back, the women realized that the LDRP unit was busy with many other labouring women and, because of this, the nurses were busy; however, a few of the women indicated that they felt somewhat neglected. One woman in particular expressed feelings of being abandoned.

Another area of concern in the postpartum period was the issue around the varying information that different health care professionals provided. Both of these issues left the women feeling confused and disappointed. The other women who did receive
educational support and more consistent information were satisfied and grateful for the support they received in the postpartum period and, on going home, felt more confident and better able to care for their babies than did the women who felt their postpartum support was lacking.

Self

Prior to labour initiating, most of the women in the study did not think about the private time, or time with their own thoughts, that they might need during childbirth. Because the women would be experiencing their first labour, they did not realize in advance that they would periodically require limited interaction with others, especially during the more intense phases of labour. They discovered during the events of childbirth that they did need time for their own thoughts, in order to coach, support, and encourage themselves.

Interestingly and poignantly, the women described themselves as their own supporters. They felt as though they were not merely one of the supporters in their respective teams but were, in fact, the most important and necessary members. The women in the study expressed their gratitude to their supporters for the assistance and for the willingness to do almost anything in their capability to get them through the labour; however, most of the women believed that it was they themselves who gave the greatest support and assistance.

Women spoke of themselves in terms typically used to describe a person who is in charge or someone who is an expert at what needs to be accomplished. During the interviews, it was remarkable to witness the empowerment that the women seemed to have regarding the ways that they coped emotionally and physically during the intense
aspects of labour. The esteem and pride that they emanated was unmistakable as they spoke about their confidence that they could get through labour regardless of the intensity and pain they felt. They spoke of filling themselves with positive thoughts and speaking words of encouragement that they expressed only to themselves.

Each woman used a different method but followed a similar concept. For instance, one woman told herself that, with each contraction, she was one step closer; another woman thought of herself doing push-ups with each contraction and told herself, “three more; two more; one more,” until the contraction subsided. The other women had their own individual methods of getting through a contraction or coping with the labour. In Hotelling and Hotelling’s (2006) account of one woman’s birth story, the woman discussed how she overcame the contractions in much the same way, as she told herself that each contraction would be one less that she would have to conquer.

The women expressed the importance of a positive outcome for themselves and their babies. Altruistically, their main goal was not necessarily to have a positive experience and to perceive the labour itself as a great and rewarding event, but rather they emphasized the importance of the “end goal”—in other words, the safe delivery of the baby—as the most important objective that they needed to achieve.

Female Presence

Other than their husbands, the women wanted a female presence during labour and at the birth. The women in this study found a female supporter to be one of the most helpful. Five of the eight women in the study wanted the support of their mothers, and six out of the eight had a female supporter other than a nurse. Reflecting back, these women
were convinced that their mothers and other female supporters provided the best support during labour.

This support from other women was generally more sustaining than the support they received from their husbands. Price et al. (2007) concur that, in addition to partners, women chose female relatives as their main supporters; they believed that these supporters would be able to provide tangibly beneficial assistance during labour. The women in this study wanted female relatives or friends with them who “knew them best.” With that said, if they only had the choice of one supporter each, they all said that they would have chosen their husbands over all other supporters. The women believed that their husbands were there to experience the occasion with them, while female supporters were there to be more of a physical and emotional support for the woman and, in some circumstances, for the husband as well.

In their study, Walsh, Green, and Shields (2007) concluded that support from a doula reduced the need for pain medications, decreased the length of labour, and reduced obstetrical interventions; furthermore, the women’s perceptions of birth were found to be more positive. Some of the women in the present study believed that a supporter who had experience and had been through childbirth was a valuable asset to guide them through the experience. Most of the women had someone who was experienced in childbirth and provided excellent support and guidance through the labour and delivery process. They expressed the view that, with this experience, the supporter provided pertinent assistance and was in tune regarding when they needed to restrain themselves from saying or doing too much. The women found that this restraint on the part of their female supporters was caring and beneficial.
When reflecting back on the experience, the women appreciated the insight and awareness that their labour teams possessed. Women greatly value the emotional support and experiential knowledge gained from female friends and family members (Semenic, Callister, & Feldman, 2004). Quite possibly, when female supporters are experienced, they may gain a sense of the various levels of support that women need, and an instinctive awareness of when it is needed—for instance, when they need to be more active and, equally important, when they need to be more passive in their support measures.

Conclusions

The results of this study support several significant conclusions regarding women’s perceived experiences in relation to the supportive care that they received during labour and delivery. One of the most interesting and noteworthy findings is the discovery of self-support; the women received support from themselves in various ways and described themselves as a member of their supportive teams. Furthermore, the methods by which they supported themselves are unique to each woman but the women all similarly viewed themselves as the most important supporter. Specific conclusions derived from this study are as follows:

1. Varying levels of supportive care may be beneficial for women to perceive a positive birth experience.

2. Preparing for labour and delivery during pregnancy, and increasing the knowledge of what happens during labour and birth, may enhance the meaningfulness for the woman of the events as they occur during childbirth.
3. Supportive care in the early stages of labour may be better accessed at home in the comforts of familiar surroundings. With further options, information, and knowledge regarding the safety and benefits of being at home in the early stages, women may be more inclined to want to labour at home. In retrospect, women agreed that being at home in the early stages would have enhanced their perceptions of those stages of childbirth.

4. Privacy and time alone to enable the women to go “within themselves” and find their inner strength was beneficial at the intense phases of labour, and women found that this assisted them to “get through” the most painful and intense stages and to believe, “they could do it” and they “could keep going.”

5. Women obtained support from themselves, nurses, their husbands, female family and friends, and physicians at different times and in varying levels. Each supporter brought a unique attribute to the supportive team. Whether or not a specific supporter was particularly necessary, the woman was able to go into a “zone” if she needed to and “tune out” distractions.

6. Women described the supportive contributions of nurses as: giving encouragement; displaying confidence and having confidence in the woman; having a calm demeanour; being knowledgeable; being kind; and adopting a respectful approach.

7. Women wanted their husbands to be a part of the childbirth experience and did not necessarily want or need them during labour and birth to “fix” things. They wanted their husbands to experience the birth of their child and be
present for the occasion. Even though women did not view their husbands as
the most useful of supporters, each believed her husband, other than herself, to
be the most important member of the supportive team.

8. Women generally did not find massaging or physical interventions from their
supporters beneficial for assisting with pain relief. Two women received
tactile stimulation from female supporters and found it helpful, but the other
six women did not want massaging in the active, most painful stages of
labour.

9. Humour was beneficial even at the most intense final stage of labour. The
labouring women who encountered someone who used humour found it put
their minds at ease and assisted them in feeling calm and secure.

10. Women appreciated encouragement and remarks from supporters that did not
require an answer. Many of the women expressed their appreciation for a
supporter who was unobtrusive. Moreover, if the supporter were to speak, the
women appreciated when a response from them was not needed. The women
expressed the feeling of having little energy to even say a few words.

Implications for Nursing

This study’s findings are suggestive for nursing practice and education, as well as
for further research and policy-making. When a labouring woman is admitted to the
hospital, the nurse inevitably affects the dynamics of the supportive team that the woman
has created for herself. With luck, the nurse will be a good match with the woman and
her supportive team. However, this may not always be the case, and nurses’ actions in relation to the supportive care that they and others provide must be carefully examined.

**Practice**

Fundamentally, nurses play an important role in the childbirth experience of perinatal women. A nurse’s verbal and nonverbal actions may quite possibly be the deciding factor, for women and their families, in perceiving a positive or negative birthing experience. It is vital that nurses are aware of the significant impact they can have as they care for childbearing women. As health care providers, nurses must realize that they are taking part in, quite possibly, the most important event in a couple’s life.

The women said that they were motivated to keep going when there was positive feedback, especially from nurses, regarding their efforts to cope with contractions or while pushing. Offering positive reinforcement may assist a woman with more effective pushing efforts and confirm the confidence that she has in herself, so that she can keep going. What a nurse says to a woman may have a lasting impact, increasing her satisfaction with her birth experience (Hottenstein, 2005).

From the first admission of a woman to the LDRP unit in early labour until discharge home in the postpartum phase, it is important for nurses to view the opportunity to care for her as an honour and a privilege. It is up to health care professionals to reassure women—especially during a first pregnancy—that for a healthy, low-risk, primiparous woman, labouring during the early stages may be best accomplished at home where there are fewer distractions, and surroundings are familiar. The nurse should provide information and spend time explaining the benefits of being at home. As supporters of women during labour and delivery, the health care professional’s
responsibility is to reassure women of the rationale for labouring at home during the early stages, and to provide useful clues about what to expect physically that will indicate the best time to return to the hospital.

Women need to be aware that staying in the hospital during early labour can lead to a prolonged labour, unnecessary interventions, instrumental birth, and a higher chance of a negative birth experience (Homer, Brock, & Matha, 1999). In order to truly support women, health care professionals need to provide accurate information, so that women will feel confident about going home to wait for active labour to commence. If a woman still does not want to go home after the benefits have been explained and if it is, in fact, an option for her to stay in the hospital, then as a minimum, she will be able to make an informed decision.

Nurses have a unique opportunity to enhance the childbirth experience for women, especially as it relates to the supportive care that women receive from family members, friends, and qualified labour support professionals. The findings in this study will enable nurses to better understand the care that women need, whom women require as supporters, and the levels of support needed at the various stages of labour. This awareness can engender the best possible experience for women in their care.

The support that women receive during each phase of labour is complex and in constant flux. It is imperative for the nurse to understand the transitional needs of the woman in her care, so she can assist in enhancing the childbirth experience. This supportive care will help increase the woman’s comfort during labour and quite possibly improve outcomes for the mother and baby. It is possible that providing appropriate support for a woman may increase the likelihood of a normal vaginal birth and improve
her perception and experience of labour. Hodnett et al (2007) found that women who had continuous intrapartum support were likely to have a slightly shorter labour, more likely to have a spontaneous vaginal birth, and less likely to have intrapartum analgesia or to report dissatisfaction with their childbirth experiences—if the supportive person was not a member of the hospital staff. Hodnett et al.’s study implies that nurses may need to modulate the active support that they may want to give and, alternatively, give encouragement to the supportive team that the woman has chosen. This may be where the intuition of the nurse may help decipher what the woman’s supportive needs are, related to who is best for active support at a particular moment—and it may, or may not, be the nurse.

Nurses must ensure that they provide supportive care during all aspects of the childbirth experience, from preliminary, or false, labour to the final discharge from the hospital when the woman leaves with her baby. Nurses need to focus first on the woman as an individual, make eye contact, explain what is being done, and acknowledge that the mother, the baby, and ultimately the family are the main focus. In the early stages, this approach is fundamental to building a relationship with the woman and her partner, which will almost certainly translate to more genuine supportive care.

The supportive team, including the nurses, must be aware of and willing to adapt to the woman’s needs as labour progresses. Depending on the individual, some women may need to be alone or to disconnect from the support team periodically throughout labour. It is important to remember that if a woman is not answering questions or acknowledging the support team, including the health professional, she is doing what she needs to in order to remain focused. The support team must understand that, to work
through each contraction, a woman must find her inner strength; this process may require her to disconnect. Not wanting to be rude, a woman may feel obligated to engage with nurses even though she needs all of her strength to cope with a contraction. As supporters, we must remain mindful of her effort and facilitate and support her ability to stay focused. Nurses should act to assist rather than to impede her progress.

In order to accommodate women in their quest to draw on their inner strength during labour, nurses should discuss strategies to assist in this effort prior to the commencement of labour. One strategy for supporters may be to wait for the woman to make requests, rather than to invade her concentration with questions. If this was not discussed in anticipation of labour, the nurse can make it clear to the woman that she only has to ask and, to the best of her ability, the nurse will accommodate the woman’s wishes. Ideally, when the time comes, the nurse will intuitively sense the woman’s need to focus. Taking cues from the woman, and responding to her needs as her labour progresses, might offer the greatest form of support. The nurse can ultimately relay this information to the other supportive team members as the occasion demands.

Every woman is different and supporters must intuit her needs as labour progresses. This insight will ultimately provide crucial support during childbirth. The findings in this study indicate that, as supporters, we need to hone our skills related to intuitiveness so that we may better appreciate the supportive needs of the woman as her labour progresses and offer those skills to her. It is also apparent that it is beneficial for nurses to allow women to orchestrate their own requirements of support as the labour unfolds. During labour and delivery, there is little harm, and many positives, when nurses
enable women to direct the type of support they will have and the way in which it is delivered.

**Education**

Nursing education is constant and perinatal practice is continuously changing in order to provide safe, effective, and the best possible care to women and families. To provide effective support to enhance women’s experiences of childbirth, nurses must welcome further education and seek out educational opportunities to improve practice and further develop their supportive skills.

Most of the education related to perinatal nursing encompasses teaching related to interventions that support the improvement of physical issues and enhance mother and baby outcomes. While these educational workshops are essential, in-services and instruction related to support that nurses and health care professionals provide are necessary too. There are limited educational programs related to supportive care and best practice for enhancing women’s perceptions and experiences during labour and delivery. Educational programs should be put in place to help nurses and members of the supportive team better assist women during labour and promote the best experience possible.

Nurses skilled in supportive care, and who are proficient in satisfying the emotional and physical needs of a woman during labour and delivery, should be recruited to teach these qualities to other health care professionals, as well as laywomen and husbands. It may be beneficial to offer workshops in the hospital setting to health care professionals and in-services in the community to laywomen and husbands who are planning to provide supportive care to women. It may also be beneficial for the women
who will experience childbirth to attend these workshops prenatally, as this could be
useful for planning the support that they will receive and for becoming aware of the many
choices available and of the control they can have regarding support during childbirth.

It is difficult to give women standard advice in the postpartum period, as every
woman and baby couplet is different. Expecting each mother and child to adhere strictly
to an imposed standard would be disadvantageous to their well-being. However, because
health care professionals often impart conflicting advice about postpartum care, standard
guidelines should be promoted in workshops for perinatal nurses. Nurses need to keep up
to date with recent research regarding postpartum care, so that they can provide reliable
advice. The teachings should offer advice regarding consistency but to a certain degree
should also be flexible, taking into consideration each unique situation. Health care
professionals must realize that new mothers are looking for factual information that will
give them the confidence to provide the best care for their newborns when they return
home.

Research

The findings of this study indicate the need for further research regarding the
supportive care that women receive, and which women’s supportive teams give, during
childbirth. There is limited research on women’s perceptions of the support that they
receive during labour and delivery and on self-coping mechanisms and the need for
privacy during labour. Further research is needed to enable women to realize that self-
support and inner focus may be an excellent strategy for coping with the experience and
pain of labour. Further qualitative research is needed to obtain descriptive interviews of
women’s perceptions of the support that they receive during childbirth.
Further qualitative and quantitative research on this multifaceted phenomenon is essential so that nurses can understand the complexities of supportive care for labouring women. More needs to be learned about how to care for women, how their individual needs should be met, and how the nuances of the supportive team affect the situation. The relationship of the support team to the woman they are caring for must be taken into account in order to provide sustaining, relevant care during labour. Women need to feel that they have a certain amount of control over their environment during childbirth.

Studies relating to the experiences of the supportive team—nurses who give support; husbands who provide a presence for their wives and become part of the experience; friends, family, and doulas who care for women—may also assist us to gain a better understanding of the perspectives of the supporters and what it means to give support. Qualitative research relating to the experiences of the supportive team may assist nurses to obtain meaningful data to discover the dynamics of the team and, in so doing, to be of benefit to the woman.

Nurses are beginning to welcome the support that lay people can give women during labour and delivery, partially due to the nurse’s inability to provide the necessary physical, social, and emotional support (Perez & Herrick, 1998). Gagnon and Waghorn (1999) found that only 6% of nurses provided constant supportive care to labouring women, despite the fact that research has deemed labour support necessary. This is largely due to the shortage of nurses and insufficient funding at health care institutions to support the one-to-one continuous presence that is recommended by the SOGC (1995). When a doula is present during labour, however, the nurse can concentrate on the patient to the fullest extent that patient load allows but, in relation to the woman’s psychological
requirements, does not have to feel concern about leaving her during an intense moment in labour to care for another patient in need. In such instances, the doula can focus on the mother’s emotional needs (Perez & Herrick, 1998) and play a key role in supporting women who need this extra care. This leaves the nurse free to attend to the physical safety of the mother and fetus. It would be beneficial to study the improvement of outcomes with women who receive the continuous one-to-one supportive presence of a doula, complemented by the labour and delivery nurse’s monitoring of the physical concerns of the mother and fetus.

A study by Maimbolwa et al. (2001) concluded that not all labouring women want a social support person. It is not apparent, though, whether or not the women who would have preferred not to have a social support person would have wanted to have the nurses’ support instead. Or would the women who chose not to have a supportive companion rather be left alone during labour? This study brings up other questions for women in North America. Among them are: Have women been socialized to believe they need a supportive person? Has the research that supports the improvement of maternal and fetal outcomes influenced women’s decisions to seek out a supportive person? Do women feel pressure from family members, friends, and health care staff to have the presence of a support team? Do health care professionals give women little choice but to have the constant presence of a nurse during labour?

The outcomes of labour and childbirth are unique to each woman; these depend on numerous variables, including supportive care. To date, there are no studies that suggest that the choices made for supportive care by women and women’s positive feelings about their birth experiences have a correlation. In addition, further research
should be conducted on the impacts of providing women with conflicting advice in the postpartum period. Research related to supportive care during the postpartum phase might assist health professionals to change the current practice that causes added stress to their patients. It may demonstrate that support and education for women in the postpartum period is a significant tool for them to gain the self-assurance and confidence to care for their babies when they go home from the hospital.

Studies are needed to question women after the birth to discover if experiences of labour support from a doula, or from other kinds of continuous support, actually met their expectations. Possibly, after the birthing experience, women who originally felt that they would need constant support might discover that they would have been better left alone for short, or even longer, periods. As an obstetrical nurse working on a labour and delivery unit, I have witnessed few multiparous women with doulas or many family members other than husbands giving continuous support. Is this due to the realization that during their first experience with birth they might have had a better experience without constant supportive companions? Or could it be that the women did not previously have a supportive companion and preferred this method of labouring? Could the support have been more helpful to women if it was limited or intermittent, and not constant? All of these questions need to be addressed. There is minimal research on women’s subjective opinions about labour support. More investigation must be undertaken to answer these important questions.

Changing Policy

Policies and procedures are constantly changing to keep up with research that is conducted. Change is inevitable and should be welcomed within the realm of nursing.
The nature of the work that nurses do is motivation enough to stipulate change in order to improve care for patients and families, and to make the work environments of nurses better.

Policy change in the LDRP unit relating to workload issues may be necessary in order to enhance the supportive care that women have available to them from nurses. As well, this change may also improve a nurse’s satisfaction and make the supportive care that she provides to a woman more rewarding for herself if the issues related to understaffing are addressed. To provide a compelling argument for policy change for issues relating to supportive care in the LDRP unit, workload, patient satisfaction, and nurse burnout, nurses should be encouraged to fill out incident reports and professional responsibility forms when they are forced to take on unsafe workloads. This type of feedback has the potential to raise awareness and provide incentive to hospital administrators to find ways of addressing workload issues. Improvements in the nurse-to-patient ratio would enable nurses to provide the supportive care necessary to improve each woman’s labour, delivery, and postpartum experience.

Educators, managers, and clinical nurse specialists on maternity units must rethink the unrealistic demands that they have made on the LDRP nursing staff of many birthing units. Unless staffing and funding issues can be suitably addressed, nurses might not be the most helpful or the most suitable group to support women in labour (Hodnett, 1997). Would all women really want to have a different nurse’s constant presence every 8 to 12 hours? A woman in a study by Hanson et al. (2001) regretted having one-to-one care during labour by various different nurses. Women may prefer to be supported by a labour support person—such as a doula, friend, family member, or husband—who does
not leave but, rather, says for the entire labour and delivery.

Using the data from a survey by Hanvey et al. (1996), the conclusion was that “Canadian hospitals still have a long way to go before putting family-centred care into practice” (p. 16). This research further indicated that it is important for women to choose the support person that they wish to have during labour. Supportive companions could be health care professionals, a partner, doula, family, friends, or anyone of the woman’s choice. Somewhat contradictorily, Hanvey et al. also concluded that, “a woman must never be left alone during childbirth; this includes physical comforting and emotional support in accordance with the woman’s own wishes” (p.18). One question that must be asked is: What if the woman wishes to be left alone? Respecting a woman’s choice of her support team also means respecting her need for privacy during labour. What women want in this regard must be investigated further to promote a change in guidelines.

Hospital administrators and supervisors in LDRP units must also be aware of current guidelines and have a strategy in place to ensure that safety and consistency of care is provided. To ensure adequate and timely care in all stages of the childbirth experience, including the postpartum period, administrators need to consider increasing the number of nurses for each shift or diverting women to alternate hospitals to maintain serviceable nurse-to-patient ratios. Diversion policies must be clearly outlined to sustain a systemic process that health care professionals on LDRP units must adhere to for the purpose of, not merely giving excellent supportive care, but also to ensure the safety of the mother, the baby, and the nurse.

During clinical guideline implementation the need to increase nursing staff’s awareness of changes to policies and procedures is crucial. Strong organizational support
may have a positive influence on modifications to policies and procedures developed from clinical guideline recommendations that are research-based.

Implications for the Multidisciplinary Team

The multidisciplinary team members ultimately work together with the goal of providing a safe and positive experience for the childbearing woman. There are many different people with different skills that care for women from the early prenatal stage of pregnancy until the postpartum period. The entire team encompasses the knowledge, caring, information, and support that, ideally, the woman will receive during all stages of labour. Women of lower socioeconomic levels, no less than those more privileged, should have resources that they can obtain and tap into for the purpose of receiving support from the multidisciplinary team.

Generally, a woman will contact a childbirth educator in the early stages of her pregnancy. Preliminary education, especially for a woman who is pregnant with her first child, is essential to prepare for the pain that labour and delivery inevitably bring. Prior to the initiation of labour, health care professionals should encourage women to research effective coping methods for pain control during the birthing process. Through this proactive research, women can take control of the care and support available to them, allowing them to make informed decisions for themselves and their babies. Health care professionals, such as childbirth educators, nurses, and physicians, must support women’s quest for information, as this will assist in achieving the best possible childbirth scenario.

Childbirth educators should be available to all women, and subsidy provisions should be considered to allow women from lower socioeconomic backgrounds to access
the same resources as other women. Childbirth educators can assist women by providing strategies to cope with pain and other discomforts of pregnancy, labour, and delivery. Women should be made aware of massage techniques, hydrotherapy, breathing techniques, and other traditional and nontraditional methods of pain control. However, women also need to be aware that some of these methods are not effective for everyone, and they may need to experiment with a variety of strategies to find what works best for them. Birthing educators and health care professionals need to remember that coping strategies and supportive behaviours should reflect the individual needs of each woman.

Health care professionals that are particularly involved, directly as well as indirectly, with the supportive care of a woman during the antepartum, intrapartum, and postpartum periods should encourage couples to make the choice that is best for each of them. Men should not be forced or shamed into being a participant during labour if the couple decides that it is not right for either of them. Once a couple makes that decision, whatever it may be, it should be supported and encouraged wholeheartedly by health care professionals and prenatal educators. The couple’s decision should not be judged. Every family situation should be treated uniquely.

Physicians, too, are an important part of the multidisciplinary team and the support that they give a woman may also be a vital component for the purpose of enhancing a woman’s experience during labour. Physicians, nurses, and other members of the multidisciplinary team must continue to work closely and amicably together to enhance the women’s perceived experiences of childbirth.

Childbirth is a natural process. Health care professionals, to some degree, have transformed this event into a condition or even an illness; in other words, we have
medicalised the process. As today's women have changed the way they view childbirth, so must we, too, begin to alter our thinking and allow women to labour and deliver as they would like, without causing harm to the woman or the fetus. As health care professionals, we ought to provide the type of support that women want—with the supportive person or team that they have chosen—and give them the opportunity to change both the support that they receive and their support persons as their labour progresses.

The people who provide support to the labouring woman are made up of various, unique members with diverse personalities and skills that might, or might not, assist her. The members of the team, moreover, will have different and individual ideas of labour support and what they perceive to be helpful to the woman. More important, women themselves will have varying, unique beliefs about what is supportive to their individual needs. If a woman and her supporters have similar ideals of labour support, the woman is more likely to have a satisfying experience than if she is not well matched with her team. Achieving a good match can be complicated by the fact that perceptions and expectations formed in the antepartum period can change in the intrapartum period, and what the woman thought would be helpful to her might, in fact, turn out to be unhelpful. As nurses, we must encourage and welcome the choices that women make during labour and delivery. On behalf of the women we care for, we must encourage natural forms of support that in no way compromise the safety of the mother or the baby.
Summary

This chapter has summarized the findings and conclusions of the present study; explored the implications for nursing with respect to practice, education, further research, and policy; and addressed implications for the multidisciplinary labour support team.

This study’s purpose has been to explore the supportive care that a group of women received during childbirth and to reveal their personal perspectives on this care. Through the analysis of the women’s reflections and descriptions of their experiences, I have attempted to contribute to the awareness of supportive teams regarding women’s feelings and needs during childbirth.

This kind of research must continue and expand, in order to bring greater knowledge to childbearing women and supportive team members, and to facilitate continuing improvements in the care of women in the LDRP unit. Through conducting this research, speaking with the women who offered their stories, learning their desires, and hearing the intimate details of their birthing experiences, I have gained many new insights. These have helped me change my practice and care for women differently and, I hope, in a more supportive way, whether by direct or indirect support. Because of the generosity of the women in this study, and their willingness to share their labour experiences, I am optimistic that, to some degree, I have improved the experiences of other women that I have supported through childbirth. My hope is that nurses, supporters, and women who seek support will similarly benefit from this study.
References


Gungor, I., Beji, N. K. (2007). Effects of father’s attendance to labour and delivery on the


Appendix A

Information Letter

To Whom It May Concern:

If you are expecting your first child and you are considered low risk during pregnancy by your physician, you are invited to participate in a study as part of a graduate thesis on the supportive care that women receive from their labour support person or team. The reason that women who are expecting a second child or greater or who are moderate to high risk during pregnancy are excluded is due to the fact that these women may need a different level of support and more or less skilled supporters than women who are included in the study. If you are considered low risk and have complications during labour or delivery, you will still be eligible to participate in the study.

This study will be conducted by me, Melanie Simpson, graduate student and Roberta Hewat, graduate thesis supervisor, at The University of British Columbia. The purpose of this study is to gather information regarding effective and ineffective strategies of labour support that women experience during labour from their labour support person/persons.

Participants will be interviewed by me, Melanie Simpson, at a mutually agreed upon time and location. The interview will last 60 to 75 minutes and will be tape-recorded. Subsequent interviews may be requested if further information is required and will occur between two to four weeks from the previous interview. The completed interview of your knowledge and experience of your labour support person or persons during your childbirth experience will be transcribed onto a computer disk. A hard copy will be obtained for analysis of similarities and differences of interviews with other participants.

Any information resulting from this research will be kept confidential. Participants will not be identified by name in any report during or after the study. The data records that are kept on a computer hard disk will only be accessible by me, Melanie Simpson, the investigator, Roberta Hewat, the principle investigator and two other participants of the thesis committee, Patti Jannsen and Marion Clauson. All taped interviews will be destroyed one month after the completion of the study. The written transcripts will be kept for five years in a locked cupboard as required by the University of British Columbia and destroyed after that time. Participants will be free to withdraw from the study at any time without influence to the care that they receive as a member of the community.

If you would like further information regarding this study or would like to participate, please call me, Melanie Simpson, at xxx-xxxx or Dr. Roberta Hewat at xxx-xxxx

Sincerely,

Melanie Simpson, Graduate Student
The University of British Columbia
School of Nursing

Version date: Oct, 2006
Appendix B

Consent Form

Women’s Perception of Supportive Care During Labour and Delivery

Principal Investigator: Roberta Hewat, Ph.D
Melanie Simpson, graduate student.
University of British Columbia, Department of Nursing
Contact telephone number: xxx-xxxx

Thesis Supervisor: Roberta Hewat, Ph.D
University of British Columbia, Department of Nursing
Contact telephone number: xxx-xxxx

This study forms part of Melanie Simpson’s graduate thesis.

Introduction

You are being asked to participate in this research study as you are a woman who is pregnant with your first child and will be experiencing labour and delivery. Your responses in a taped interview will provide valuable information to health care professionals regarding the supportive care that you received during labour and birth of your child.

Your participation is entirely voluntary. You have the right to refuse to participate in this study. If you decide to participate, your decision is not binding and you may choose to withdraw from the study at any time without any negative consequences to the medical care, education, or other services you may receive from this hospital.

Purpose of the Study

The purpose of the study is to acquire information regarding the support that women receive during labour and childbirth. This information may assist health care professionals in understanding the physical and emotional needs that women require during childbirth.

Study Procedures

You understand that you are being asked to participate in a study that requires a tape-recorded interview of your knowledge and experience of the labour and birth of your child. You will be asked to participate in one and possibly two 60 to 75 minute interviews that will be conducted at a mutually agreed upon location and time. The second interview will occur two to four weeks after the first interview, if further information is needed. The interview will be tape-recorded and will then be transcribed onto a computer disk. A hard copy will be obtained for analysis of your responses. Similarities and differences of your experience will be compared with other interviews conducted with women who have also experienced childbirth.
Confidentiality

The findings resulting from this research study will be documented and available to the public. However, your confidentiality will be respected. Information that discloses your identity will not be released without your consent unless required by law or regulation. All transcribed documents and taped interviews will be identified only by code number and kept in a locked filing cabinet. Participants will not be identified by name in any report of the completed study. The data records that are kept on a computer hard disc will require a password for access and will only be known to the four members of the thesis committee. All taped interviews will be destroyed after completion of the study. All transcribed documents will be kept for five years in a locked cabinet as required by the University of British Columbia and will be destroyed after that time.

Benefits of Participating in this Study

You may benefit from participation in this study by having the ability to tell your story of your experience of childbirth. Many women find it therapeutic to discuss their experiences. There may or may not be direct benefits to you from taking part in this study. The information learned from this study may be used in the future to benefit other women who will go through childbirth and assist healthcare workers in gaining a better understanding of supportive care during labour and delivery.

Risks

There are no physical risks associated with the participation in this study. One risk might be that you accidentally disclose something in the interview that you did not want to share with anyone. This information will not be included in the research study at your request.

Rights and Compensation:

You understand that you will not be compensated monetarily for this interview and there will be no monetary costs to you associated with this research.

By signing this form, you in no way give up any of your rights and you do not release the healthcare professionals or other participating institutions from their legal and professional responsibilities.
Contact

If you have any questions or desire further information with respect to this study, you may contact Melanie Simpson at 604-838-0533 or Roberta Hewat at 604-822-7464. If you would like information related to the findings of this study after completion, you may contact Melanie Simpson.

Rights as a Research Participant

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, contact the Research Subject Information Line at the University Of British Columbia Office Of Research Services at 604-822-8598 or the Chair of the UBC/PHC Research Ethics Board at 604-682-2344 ext 62325.

You are not eligible to participate in the study if:

You will be giving birth to a second child or greater.
You have experienced labour before.
You are 36 1/2 weeks gestation or less at the time of delivery.
Your pregnancy is considered moderate to high risk as discussed with and confirmed by your physician,
You are expected to labour but do not labour due to complications with the pregnancy.

The reason for these exclusion criteria is that women who are moderate to high risk or who have experienced labour before may require an increased or decreased level of support.
Consent

I understand that my participation in this study is entirely voluntary. I do not waive any of my legal rights by signing this consent form.

I may terminate the interview at anytime. At my request, the tape will be turned off at anytime during the interview if I am not comfortable. If I discuss an incident that has been recorded and do not want the incident to be included in the study, it will be erased immediately. If I complete the interview and decide that I no longer want to be a part of the study, the tape will be destroyed immediately.

By signing this form, I in no way give up any of my rights and I do not release the health professionals or other participating institutions from their legal and professional responsibilities.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

Participant (Printed Name) ____________________________

Participant Signature ____________________________ Date ____________________________

Signature of Investigator/Designate ____________________________ Date ____________________________

Page 4 of 4

Version date: January 29th 2007
Appendix C

Interview Questions

1. Please tell me about your labour and delivery and the support you had throughout this experience?

2. What was most helpful for you regarding the support you received?

3. What was the least helpful for you regarding the support you received?

4. How has the experience of support during labour affected you?

5. Reflecting two weeks later, would you change anything if you had it to do over?

6. If so, what would you change and who would you want with you or not want with you?

7. There are many kinds of support, e.g., physical, emotional, spiritual. Please describe the kinds of support you experienced and what it was about each that you found helpful.

8. If you would have liked more support during labour or delivery please tell me what kind of support would be most helpful to you during the different stages of your labour and delivery.

9. Who do you feel gave you the most support, when did this occur, and what was it?

10. What kind of "non-support" did you experience?
Appendix D

UBC Behavioural Ethics Board Approval Certificate

Certificate of Approval

Theresa Rout, R., Nursing
B06-0432

The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approved on behalf of the Behavioural Research Ethics Board by one of the following:

Dr. Peter Suedfeld, Chair,
Dr. Susan Rowley, Associate Chair
Dr. Jim Rupert, Associate Chair
Dr. Armineh Kazanjian, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
# Appendix E

## Institutional Approval Certificate

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### Providence Health Care

**Institutional Certificate of Final Approval**

<table>
<thead>
<tr>
<th>Principal Investigator:</th>
<th>Department:</th>
<th>Reference Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roberta Hewat</td>
<td>Nursing</td>
<td>PHC Reb H06-03417</td>
</tr>
</tbody>
</table>

Sponsoring Agencies:
- Unfunded

**Project Title:**
Women's Perspectives of Supportive Care During Labour

**Date Ethical Approval:**
January 31, 2007

**Date Institutional Approval:**
FEB 08 2007

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The UBC-PHC Research Ethics Board granted ethical approval for the above-referenced research project on the date stated above. I am now pleased to inform you that all necessary hospital department/facilities approvals and institutional agreements/contracts are now in place and that you have permission to begin your research.

[Signature]

Dr. Yvonne Lefebvre
Vice President Research and Academic Affairs, Providence Health Care
President, Providence Health Care Research Institute

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St. Paul’s Hospital
Holy Family Hospital
Mount St. Joseph’s Hospital
St. Vincent’s Hospital-Brock Fahrni Pavilion
St. Vincent’s Hospital-Langara
Youville Residence