

ORIGINAL ARTICLE

Long-term memories and experiences of childbirth in a Nordic context—a secondary analysis

INGELA LUNDGREN¹, Associate Professor, SIGFRIDUR I. KARLSDOTTIR² PhD Student, & TERESE BONDAS¹ Professor

¹University College of Borås, Department of Caring Science, Borås, Sweden, ²University of Akureyri, Iceland

Abstract

The experience of childbirth is an important life experience for women. However, in-depth knowledge about long-term experiences is limited. The aim of the study was to describe women's experiences two to 20 years after birth. This study is a part of a meta-synthesis project about childbearing in the Nordic countries. Methodologically, the study was a secondary analysis performed on original data from three selected qualitative studies by the authors, in three Nordic countries, Finland, Iceland and Sweden, and in two different forms of care, birth centre care and standard maternity care. There were 29 participants, both primipara and multiparous women. The result from this study shows that women, in a long-term perspective describe childbirth as an encounter with different participants and the most important is with the midwife. The midwife is also important in connection to the atmosphere experienced during birth. The childbirth experience has a potential to strengthen self-confidence and trust in others or, on the contrary, it can mean failure or distrust. Impersonal encounters linger feelings of being abandoned and alone. This dimension is in particular demonstrated in the description of the woman who had given birth at standard maternity care. The conclusion of this study is that childbirth experience has a potential to strengthen self-confidence and trust in others or on the contrary failure or distrust. Maternity care should be organized in a way that emphasizes these aspects of care.

Key words: *Childbirth, long-term experiences, secondary analysis*

Introduction

The experience of childbirth is an important life experience for women (Simkin, 1991; 1992). It is an ambivalent bittersweet and transcendent experience, and it has an impact on maternal self-efficacy (Callister, Vehviläinen-Julkunen & Lauri, 2001; Callister, 2004). It changes life forever in a process that is renewed with every child that the woman gives birth to (Bondas-Salonen, 1995; Bondas, 2005), and extends far beyond the specific experience in birth (Brathwaite & Williams, 2004; Simkin, 1991, 1992). A transformative experience implies victories and strength, healing and short- and long-term outcomes (Kennedy, Shannon, Chuahorm & Kravetz, 2004). A traumatic birth experiences could have a long lasting effect on the woman's health and well-being and the relationship to the baby (Beck, 2006).

Women's overall experiences are an important outcome of labour (Waldenström, 2003). Features, such as pregnancy-related factors, complications, expectations, pain, the organisational form of care, and support, all influence women's experience of childbirth (Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996a; Kennedy et al., 2004; Lundgren, 2002; Parrat & Fahy, 2003). All in all, the most pivotal factor for a positive childbirth experience is support (Hodnett, Gates, Hofmeyr & Sakala, 2007). An organizational form that emphasizes support from midwives is birth centre care that provides continuity of care, restriction of medical technology, parental responsibility and self-care (Kirkham, 2000; Waldenström & Nilsson, 1993; Waldenström, 1998).

There are knowledge and understanding of the experience of childbirth from data collection that has mostly been done shortly after birth (Beck, 1994;

Hodnett et al., 2007; Lundgren, 2002). Simkin's studies (1991, 1992) had an interest in the accuracy and consistency of the long-term memories as long as 15–20 years after birth. However, the change is as important to understand in order to develop care during birth. According to Waldenström (2004), more negative aspects may take longer to integrate.

To summarize, several studies describe women's experiences of childbirth, shortly after the birth. However, in-depth knowledge about women's long-term experiences in different contexts is limited. The aim of the study reported here was to describe women's memories and experiences of childbirth in a long-term perspective; i.e. two to 20 years after birth. This study is a part of a meta-synthesis project about childbearing in the Nordic countries (Bondas & Hall, 2007a, b; Lundgren & Berg, 2007).

Method

The study was a secondary analysis (Heaton, 2004; Thorne, 1994) performed on original data that were interviews, from three selected phenomenological studies by the authors (Lundgren, 2005; Bondas, 2005; Halldorsdottir & Karlsdottir, 1996b), in order to understand women's experiences of childbirth in a long-term perspective (Table I). Secondary analysis is a method for condensation of either quantitative or qualitative studies. In qualitative secondary analysis, the potential of re-using one's own data has been recognized. The focus of qualitative secondary analysis on data derived from previous studies distinguishes it from other qualitative methodologies (Heaton, 2004). The studies in this analysis concerned women's childbirth experiences in three Nordic countries, Finland, Iceland and Sweden, and in two different forms of care, birth centre care (Lundgren, 2005) and standard maternity care (Bondas, 2005; Halldorsdottir & Karlsdottir, 1996b). Thereby, this secondary analysis is a form of amplified analysis (Heaton, 2004) with the potential to enlarge a sample, and to compare differences across the data. The design in the study reported here may be compared to retrospective interpretation (Thorne, 1994) in which existing data material were tapped to develop themes that emerged but were not fully analysed in the original studies, and to amplify samplings by using data collected in three different countries and different ideological contexts of care which permit a broad analysis.

The three original studies have a lifeworld perspective based on phenomenological philosophy. Humans and their living conditions can never be completely understood if they are not studied as

living wholes (Husserl, 1979). In the everyday world, humans have access to the world through their own lived bodies habiting history, tradition, space, time and relations with others (Merleau-Ponty, 1995). Consequently, in phenomenology it is stated that the meaning of a phenomenon can only be understood through the study of humans' experiences. The research seeks to understand meanings in humans' everyday world of experience, i.e. lifeworld, without prior application of any theoretical framework (Dahlberg, Nyström & Drew, 2001).

The Finnish study (Bondas, 2005) was analysed following the descriptions of Colaizzi (1978). The dialogical interviews (Colaizzi, 1978) focused on the present moment at the time of the interview, but the women were also asked to recall their earlier experiences as well as their thoughts, dreams and plans for the future in relation to the birth of their child. The Swedish study (Lundgren, 2005) was analysed following the descriptions of Giorgi (1997) and Dahlberg et al. (2001). The open interviews focused on women's experiences of childbirth. In the Icelandic study (Halldórsdóttir & Karlsdóttir, 1996b) phenomenology was chosen as a research approach. The Vancouver School of doing phenomenology (Halldórsdóttir, 2000) was used to analyse the in-depth interviews.

Participants

There were a total 29 participants in the three interview studies (Bondas, 2005; Halldórsdóttir & Karlsdóttir 1996b; Lundgren, 2005). The original Swedish study (Lundgren, 2005) was performed in a birth centre in Gothenburg, Sweden 1996–1997. Ten women who had received antenatal care at the centre participated. Five of the women were primiparous, two had had their second baby, two their third and one her fourth. Seven of the women gave birth at the birth centre and three at the standard delivery ward. Two primiparous women were transferred to the standard delivery ward during delivery due to prolonged labour. One of the multiparous women did not give birth at the birth centre due to a breach position. The research question was about women's experiences of childbirth, two years after the birth (Lundgren, 2005).

The original Finnish study (Bondas, 2005) was performed in a health care district. The organisations covered both town and countryside. The respondents were 40 Finnish women, who had given birth to one or up to six children in different hospitals. They represented different educational backgrounds, ages, types of housing and occupations. The women were interviewed before, during and after delivery in the health care centres, hospitals

Table I. Overview of including studies.

Study	Objective/study phenomenon	Data/sample/period of sampling	Results	Data analysis method	Context
Lundgren, I. (2005) Sweden	Swedish women's experience of childbirth two years after birth.	Interviews with 10 women 1999–2000	<p>Essential meaning: An unavoidable situation, which was demanding for both control and loss of control, as going with the flow and at the same time taking command of oneself</p> <p>Constituents: To be in a situation without return To receive help To be changed To have a different experience The experience is not in agreement with expectations</p>	Phenomenological Giorgi and Dahlberg	Birth centre
Bondas, T (2005) Finland	Women's experiences of childbearing and care from pregnancy to the baby's first year and reflecting on the period 2½ years after	Interviews with 9 women 1996–1997	The new meaning of the woman's life is that the child will always be there in her lifeworld, she will always be a woman "with child". The women experienced a paradoxical combination of joy and suffering which accompanied the profound changes in health and life, which created a need and longing for someone to share the new situation with. The sharing is termed family communion, sisterly communion and professional communion.	Phenomenological Colaizzi	Standard maternity care
Haldórsdóttir S. & Karlsdóttir, Sl. (1996b) Iceland	Womens' perception of caring and uncaring encounters during childbirth	Interviews with 10 women 1994–1995	The midwives that are perceived as caring are professionally competent, skilful and responsible, attentive and cooperative, and communicate caringly and effectively with the woman and her partner. Alternatively, the midwives perceived as uncaring perceived as lacking in professional competence, as being insensitive and even rough when giving care, ineffective in standing and flexibility.	Phenomenological The Vancouver School	Standard maternity care

and their homes depending on the respondent's wish. Nine of the 40 women participated in a follow up study 1996–97 with interviews two and a half years after birth. The secondary analysis in this study is based on these nine follow up interviews. The dialogues were about experiences of health and care during pregnancy, delivery and puerperium as part of the research programme. Their parity varied from one to six. They all had a normal birth, and one of the women was delivered with the help of vacuum extraction. The research question was about women's experiences of childbearing and care from pregnancy to the baby's first year and reflecting on the period two and a half years after (Bondas, 2005).

In the original Icelandic study (Halldórsdóttir & Karlsdóttir, 1996b) 10 respondents were recruited through a network of colleagues. The respondents had one to four children each; altogether, they had 21 children from the ages of two to 20.

All of them had given birth at a hospital and had normal pregnancies and births. Most of the births were two to 10 years ago. One woman, who had four children, had given birth 20 years ago. The respondents decided themselves where the interviews took place and most were interviewed in their home but some in the researcher's office, 1994–1995. The interviews were unstructured in-depth interviews and were tape-recorded and transcribed verbatim for each participant. The research question was about women's perception of caring and uncaring encounters during childbirth (Halldórsdóttir & Karlsdóttir, 1996b).

Setting

In the Nordic countries, almost all women give birth at hospitals. The Nordic welfare countries include every citizen in their social security system in a typical hospital, which routinely provides conventional medical care, and has rooming-in facilities. At the hospital, professional midwives are in charge of women with normal pregnancies and deliveries. An obstetrician takes over the responsibility if there are complications or risk factors during the pregnancy or the delivery. Home-birth is not an option in public care in Sweden and Finland, and the homebirth rate is very low, approximately 0,2% in Sweden (in national statistics planned and unplanned homebirths are not separated) and 0,1% in Finland. However, in Iceland 1% of the women choose to give birth at home.

In the 1980s, there were requests for a more natural maternity care with fewer interventions, such as pharmacological pain medication (Waldenström, 1993). Birth centres were developed as a response to these requests to move away from institutionalized

maternity care. The characteristics of birth centres are that they provide midwifery-led care, continuity of care, a home-like environment, and restriction in the use of medical technology (Kirkham, 2003). If complications occur, the women are transferred to standard care in hospitals. There have been three birth centres in Sweden but they are now closed. In Finland, there has been no birth centre, and in Iceland, there is a unit in a university hospital that resembles the birth centre in relation to their ideology of care. The birth centre in the Swedish study (Lundgren, 2005) was situated at a hospital and had two delivery rooms and some family rooms for postnatal care. Antenatal care was not provided at the birth centre; instead, a preparatory visit before the delivery was integrated in the service. However, as a project in 1996–1997, women were given an opportunity to receive antenatal care at the unit.

When the original study was performed (Bondas, 2005) the Finnish hospital had a few private labour rooms, and no family rooms. Antenatal and birth care were separated. The care was midwifery led; however, medical interventions required a consultation with a physician. The care was characterized by medical technology and pain medication, and women most often gave birth lying on their backs. Fathers were encouraged to be present and they had participated in childbirth classes together.

When the original Icelandic study was performed (Halldórsdóttir & Karlsdóttir, 1996b) antenatal care took place in a Health care clinic separated from the hospital. The hospitals had all private labour rooms and many of them had family rooms where fathers could stay at least during the first night after birth. In all three countries, fathers were encouraged to be present during birth, and to participate in childbirth education classes.

Data analysis

The data analysis in our study was based on the same perspective as the original studies, i.e. phenomenology. One suggestion for secondary analysis, according to Heaton (2004), is to follow the same qualitative method as the original studies. Therefore, in our analysis, we followed some basic steps for phenomenology; meaning units, clusters, essential structure and themes (Colaizzi, 1978; Dahlberg et al., 2001; Halldórsdóttir, 2000; Giorgi, 1997). In the analysis of the interviews from the three studies, the overall question was what meaning components are central for women's experiences of childbirth. The analysis included the following steps: (1) Reading the text from the original studies to gain a general sense. (2) The following question was then posed to the data: what is essential in the women's

experiences? Meaning units answering the questions were marked, read through, brought together in clusters and titled. First, two of the researchers (IL, TB) read the other researcher's original texts (IL, TB), and marked meaning units. The Icelandic study was only read and marked with meaning units by the primary researcher (I.K), due to the fact that the text was in Icelandic. In the next step, all researchers (IL, TB, IK) analysed together. All meaning units were read and clusters were made in order to find the essential structure and its themes.

Ethical considerations

Secondary analysis is a research strategy, which makes use of pre-existing research data for the purpose of investigating new questions or verifying previous studies. The re-use of data for purposes other than which it was collected—whether this is by the same researchers, which were involved in the primary research or by other researchers—raises a number of ethical and legal issues. For instance, if the researcher should search and obtain informed consent for a secondary analysis and if so, when would be the best time for this? In this present study the research phenomenon, women's experience of childbirth, is close related or even part of the primary research focus of each primary study.

Ethical approvals and permissions to undertake all the original studies were obtained from the local Research Ethics Committee.

Results

With the aim of illuminating an essential structure of women's long-time memories and experiences of childbirth in a Nordic context, we first found that the phenomenon is a complex and even ambiguous one. Childbirth in reflection after two to 20 years is experienced as an encounter with several co-actors beside the woman and her baby. There is the midwife or several midwives and sometimes also physicians, and her partner. Childbirth is also an encounter with other aspects of the lifeworld, not least an encounter with existential experiences of notable depth. The women's feelings range from stormy, abrupt feelings of shock to calm reflection. The childbirth experience has a potential to strengthen self-confidence and trust in others or, on the contrary, it can mean failure or distrust. These experiences are not limited to the birth situation but radiate to other dimensions of women's lives, especially to family life.

The quality of the encounter with the midwife is the one that is experienced as most important during birth. In impersonal encounters with the midwife, a

feeling of being abandoned and alone lingers. This dimension is in particular demonstrated in the description of the woman who had given birth at standard maternity care. The midwife is also important in connection to the atmosphere experienced during birth. Continuity, to know the environment before birth and a homelike atmosphere can help the woman to relax during birth.

It is noteworthy, that the father-to-be is not noticed in the descriptions to the same extent as the midwife. According to our data, the presence of the partner cannot replace the presence of the midwife. The woman can feel lonely and insecure even though her partner is there when she feels abandoned by the midwife. The partner is experienced as the protector of her and the baby but may also, paradoxically, be seen as vulnerable and having no place of his own although he is the father-to-be and is present in his own right. However, women who describe a bad relationship to the midwife regard the father-to-be as their most important support.

The birth is also an encounter with the woman's own resources. This dimension is in particular demonstrated in the descriptions of the women who have given birth at a birth centre. Giving birth is experienced as part of a life period, a landmark that means a profound change in experiencing self and life. Encountering pain might mean learning more of oneself as a human being and a whole person with trust in one's own abilities, and also trust in help from other persons in a time of need and when not being able to manage on one's own. However, the experiences could also be disintegrated and not part of the life period and be remained as a traumatic course of events. For these women a feeling of loneliness and vulnerability is a central aspect of the birth experience.

The birth also meant encountering other women in a communion characterized by sharing their birth experience, comparing and integrating their own birth story.

The essential structure could further be explained by the following themes: encountering the midwife, encountering the environment, encountering the partner, encountering the baby, encountering pain and suffering, encountering oneself, and encountering togetherness with other women.

Encountering the midwife

Memories of the encounters with the midwife are long lasting. Women express that they will always remember the midwife "although I am 99 and totally disoriented" and "in my heart always". The midwife is also often remembered as "someone that you

always will be very fond of". The midwife is "a person who gives so much of herself". The midwife's personality is important and is noticed by the woman. Women hope for an experienced and competent midwife and they hope to be admitted to the hospital as an expected, invited and unique person. However, they recognize that she is one of a large number of women: "She is unique to me but maybe I am not that unique to her". The woman hopes that the midwife will be interested in her as a person "expected, special and unique", and she does not want to be another routine patient.

The midwife can instil strength, confidence and safety in the woman. The midwife encourages the woman to express her needs and wishes and explains interventions and alternatives. The women wish that the midwife will have "seen how it was because I did not know"; the midwife will put things into order, and is strong and competent. The woman hopes that the midwife understands but also takes care of her, "to be understood and maintain dignity although I did not know what I wanted or what could be helpful" The midwife acts and is "the rally driver", that intervenes if needed and "she will strike a wall if needed" or the woman senses that the midwife is "just like a power station".

The midwife makes decisions but also listens to the woman after having informed her about alternatives. She also knows the strength and weakness in birth and tries to know the woman and dares to stretch the woman's limits and provides room for the expressions of pain 'allowing contact with all that is wild and chaotic'. Women remember 'strong midwives' with gratitude. Genuineness is important, and an attitude of spurious dashingness violates rather than creates hope. A midwife who instils hope is a person "to grow with", and the midwife is someone that "knows all the technical things but also is good at relationships".

Women also thought that they were "lucky to meet a good midwife" and said, "she made everything so nice". Some women found it important that their midwife was "lively, high spirited and positive", and some talked about that they sensed a "kindness, sangfroid and peace" when their midwife was with them.

The anti-pole to an inspiring and empowering midwife is the midwife who disempowers the woman by transferring to her that she is making a poor effort during labour and that she is not good enough. "I wanted to perform well, and I remember my feelings when she said I did not push hard enough". There are experiences of giving birth "as lying on an assembly line" and the midwife as "a robot, not human at all". A passive midwife, who is quiet, and who does not take responsibility, and who lets time

slide away doing nothing while the woman suffers is also experienced as disempowering. "Not knowing who will come when and what will be done". The negative contact may be etched forever in the memory,

"she left marks forever on my retina, and I still see her when she threw my legs upon her shoulders and said shut up and what is this and blame you".

The women who have experienced uncaring or even a violating attitude and behaviour often started to talk about their birth accompanied by their memories and flashbacks. The women also tried to understand the behaviour of the midwife and connected the shortcomings in care to "lack of time, lack of staff". They have a need to tell and retell their stories and get over the negative experience through a better birth and care. For some women it meant that they never wanted to go through another birth. These experiences were common among women who had given birth in traditional care. These women often started their stories as "it was not my birth" and "I was left all alone". There are many descriptions of lacking support from the midwife, especially from women giving birth in traditional care, "nobody understood" and "I would have needed somebody to trust".

Women recall that it was devastating not to have any relationship to the midwife. Women also describe an experience of not being part of the decisions for interventions that were made during birth "I did not know what they had put into me" and "had to accept and be content". Women feared the midwives' power in decision-making. Alternatively, the right words and concern had the power to encourage the woman to try even harder and to endure. The women described the importance of their midwife giving information to their partner "It was important to give information to my partner . . . and that he was encouraged to take part when the baby was born". Even women who were satisfied with care thought they had too little knowledge of birth and interventions. "Nobody said you should take this or do that, you have to find out yourself, why can't they tell you?"

Encountering the environment

One important aspect of the birth experience is to encounter the environment before birth and it is also important to know where to go, "I just did not know where to go when I came to the hospital and from my point of view I should have had that information before". Not knowing the environment beforehand can lead to a feeling of being a stranger, "I had not

visited a hospital before and the environment is so strange ... if you had been there before maybe it would have been better". For the women, who gave birth at a birth centre, it was also a feeling of security to meet the midwife before birth. The midwife is experienced and stays with the woman "whatever happens". To meet the same midwife gave a sense of being at home and a feeling of familiarity "to be able to meet the same midwife again". To return to the same hospital as the previous birth can also make her feel safer, "For me it was important to give birth at the same hospital, even in the same room ... it gave me a feeling of security".

The environment is also described in connection to the atmosphere. A calm, relaxing and quiet surrounding is important "somehow the atmosphere was so calm in the birth room". Central aspects of the atmosphere are the midwife's way of talking calmly and clearly. A calm atmosphere can help the woman to relax and cope with pain "everything was calm and of course it had effect on me". The women express how the atmosphere is mediated by the midwife and how it influences them. "Everything was so calm but then suddenly the staff changed and then I felt more stressed". The midwife can also mediate a feeling of coldness towards the woman, "cold and impersonal midwife", "I miss the human aspect ... it was so up-tight and impersonal". A cold atmosphere can also lead to a lack of connection with the midwife, and a feeling of loneliness, "being on my own in a strange surrounding not knowing the way out", "I did not feel any connection". The women who gave birth in traditional care more often expressed feelings of loneliness and a cold atmosphere. They experienced that the midwife was not there for them and instead supervised the technical equipment: "The midwife believed in the equipment and measures, not in me". Somehow, the women found the strength on their own "They were in charge and I had to switch off my brain and rely on my instincts". A woman described the meaning of giving birth at the hospital: "I had to find the answers myself ... of course it is safer to give birth at the hospital but otherwise I could have been at home". Women lost their belief in the midwife when they were not taken seriously. The midwife had the power to hurt the woman.

"I was in a place that was called 'the cosy room', and when the midwife came in she said ironically, well, isn't this cosy, and I was in such pain ... just that comment. I was so angry".

The women described how the environment influenced both themselves and the staff: "I thought we were in a cellar even though we were on the third

floor ... in that environment it must be hard to get people motivated", and "The little room with the armchair was nicer ... and when I got there everything was different". A request for a nicer birth room was expressed "It would be possible to make the birth room more cosy", and "the environment could be softer, more colourful curtains, it was nice with the jacuzzi room with a pink carpet, it was totally different to be there, more homelike", even if the room was not so important in some phases of labour: "At the end I was not aware of the surroundings, but I remembered the midwife". The women asked for a more homelike environment, were the technical equipment was not the focus.

It was a boring surrounding, brown curtains with orange flowers, bare white walls and a lot of instruments, a little room filled with cords and things and two clocks ... it is certainly important with all instruments but does it have to be scattered all over the room?

However, for another woman the environment was not so important. She trusted the physician. "I totally trusted the physician. The machines mean trust for me. I do not need the new things such as family rooms and jacuzzis". Some women also experienced that the staff did not, in a right way use or suggested them to try equipment such as the delivery chair and the bean bag.

I did not get any alternatives, just do as we say ... that bean bag was not filled, and then was not possible to use. The delivery chair did not work ... they did not even dare to say that they had a delivery chair and you may try it.

Encountering the partner

Women describe how the partner perceived the birth differently than them and they thought that he did not completely understand what an effort it was and how much pain they felt. "It was important that he was present, and it is not just here you are, here is the baby for you and it is our child and he has a responsibility." Women described how it was difficult for him to witness her pain and see how pain and the experience made her different and changed her. They expressed gratitude for having their partner beside them although he could not do much for her.

"I would not have made it without him, he was the only one there for me ... although he was very tired

and sat occasionally asleep on the bed ... he was such a good support for me”.

The partner acted as an advocate.

“He was both my advocate and took care of me when they rushed in and out again ... he said stop; we have something to tell you, it was rather difficult to contact the midwives”.

He was also a protector especially when the midwife was not accessible or unfriendly. They talked about the birth afterwards and felt that they would have needed preparation also for the father-to-be: “he lacked knowledge, he was too little prepared, a concrete preparation and detailed information would have been helpful”. He also needed to be informed: “he should have gone out and had some food, they should teach men to be fathers not only from the mother’s perspective” and taken care of during birth, and he was not allowed to be with the woman all the time: “he felt abandoned, there was a stop mark on the door and he was not allowed to be with me”. There were women who did not feel that their husband could give them support “He is too emphatic to be able to support me” and “He was too passive”.

Encountering the baby

There is a positive basic tone about the birth in relation to the baby, and the women described how they forgot and wanted to forget the bad things: “There are no negative feelings when I look back”. Women talked about how they would always remember the first sound of their baby as “a wonderful symphony”. A powerful feeling of

“having a baby in your arms gives you the sense that is so precious and everything else is worthless compared to that little gold nugget that you hold in your arms”.

The change hit them: “I recognized that life will never ever be the same.” The baby is “a being” that comes into women’s lives and brings unavoidable changes and the paradox of joy and agony. “I remember that they put him on my chest, I felt satisfied that it was all over”. The first thoughts concerned the sex and health of the baby and it is difficult to differentiate the thoughts but the performance, a perfect baby: “I remember that they said ten points, and I, yippee, it is a ten-point-baby”. Some women also described it as a terrible moment when they saw their baby for the first time. “I was so afraid, he had a big bump on his head, and his face

was blue” and some of them thought that their baby was not healthy. “I asked it he was in some way malformed”. When the pain is hard to endure and it has continued for hours and hours, the baby turns into something to “just get out”. However, some women describe concern for the baby, and what it has gone through. “He had to lie on a cold table with instruments when they cleared his airways”. They have thought about being afraid that their pain alleviation and medication may have hurt the baby. Women who did not have the baby on their chests after birth expressed disappointment and sadness years afterwards “they took her away immediately after birth, and I missed the moment. It was different with my boy, it was another contact.” The women felt disappointed and angry at themselves because they did not ask and did not express their wishes.

I did not nurse him I would have wanted to but maybe the midwives did not trust me. I should have fought more to get him; I did not understand that I could have asked for him and the moment just passed.

Women also express worry for the negative impact on the relation to the baby and they longed to go home. “I felt that it was the hospital’s baby until we got home”. It was different to become a mother the second time and women worried about managing and being able to love the baby to the same extent as their firstborn.

Encountering pain and suffering

Pain is an individual experience that is hard to describe. There are different pictures of pain, varying during the birth and between births, “every part of the birth has its picture of pain” and “pain is hard to describe”. Pain is fading by time, “I don’t remember the pain the cosy is dominating”, and the woman has hard to remember the feeling of pain in her body. “You don’t remember the pain and when it is at its worst you may think that you don’t want it to be like this for several hours.” Pain during birth differs from other pain. “I didn’t know what pain was until I had given birth.”

Pain is described as a movement that is leading the process of birth forward. “Something creative is born by the pain”, “you are growing as a human being and pain is a part of that”. Pain has its time, “pain has its time and is temporary”, and is remembering of values in life “the important things in life”. Pain gives a “presence in life”. To manage pain is experienced as a resource in life, “pain and the dangerous is a resource afterwards”. It may give

strength. The woman is happy about the pain that gives life. There is a huge relief afterwards when the baby is born and a movement, “from disgusting to pleasant afterwards” when there is no pain.

Pain may also be described as a non-movement if nothing is happening and the process of birth is not continuing, “to have severe pain all the time without anything happening”. Then, the woman may experience pain as ‘evil’ and the pain becomes too much for her. “Fear that the pain is leading you to the ‘borderland’, out of normality’, and ‘pain at a certain level is pushing you forward, but if it is over the limits then it is a hindrance.” Pain may also reduce power, focus and thoughts from the woman. “The pain is consuming your power”, and “when I was weak the pain was worse”. Since only the moment of pain exists, there can be problems for the woman to ask for pain relief. “I was so absorbed that I didn’t think about pain relief”. A bad circle is created when pain is an all-consuming power, and is even harder to endure. The woman cannot stand any longer and may “scream right out”; even if beforehand she had other thoughts “give me everything to relief pain”. To cope, is an expression used by the women, when they are describing birth. Afterwards, the birth is experienced as “too far away from my limits” and “it was too hard to manage”. There could be problems to ask for help since the woman is trying to be capable.

I have an ability to hide myself and pretend that everything is OK, I should have told them and spoken out. Beforehand, I thought that I should manage in a better way that I should handle the birth but I couldn’t.

The woman is handling pain by entering the process of birth and the unknown. To experience control was important. “I felt that I had total control all the time”, and “I don’t like losing control over my body”. When the woman is entering the process of birth, she may experience that she is in another world, and she may feel lonely if there is no supporting relationship. Sometimes it is difficult to speak out, “it was difficult to speak out and speak up for yourself”. The woman must feel that “it is OK to be mad, OK what ever happens”. There is also an experience of being emerged in birth. “I was so totally emerged by it all the time”, and “I was so focused, could not think about anything”. Details may be exaggerated, the watch on the wall may be an enemy and time is experienced differently. The woman act in a way she does not recognize. “Nothing happens, here I am waiting, when will it end, going from hopelessness to hope and a feeling

of forever being in this process”. “To get this out of me”, describe the suffering a woman may feel during birth. However, for some woman a long birth may not be negative since there is time to be ready to meet the baby.

In some situations pain could not be relived, and the woman may feel frustrated and panic, “why is no pain relief helping me”, and “I felt that nothing helped me”. There were also experiences of not being involved in the decision of pain relief, and not getting the pain relief the woman wished for. These experiences were in particular demonstrated by women, who had given birth in traditional care. “I did not get any pain relief even if I asked for it, they said that everything should be over soon and that I didn’t need anything”, and

“I wanted etnonox but the doctor said that you should be intelligent to handle it . . . I got Pethidin and I have read that it is not good for the baby”;

“We think that you need pain relief”. There can also be a defeat for the woman if she has been prepared for a birth without pain relief. “If you had decided to give birth at the Birth centre and have a natural birth then it can be a defeat if you cannot manage.”

Alternatively, the woman may forgive herself. “I chose the technical way for survival” and “I understand that sometimes you need technology”.

Encountering oneself

Encountering oneself means to see birth in wholeness. Birth is described as “living a whole life in a few days” and some of the women described it as “one of the most wonderful events in their whole lives”, or “just a miracle”, that is remembered for the rest of their lives. As time goes by, important aspects have come up and are quickly updating in details by reflection, and when somebody is pregnant or the woman want a new baby. “I use to read around the child’s birthday, otherwise it is fading”. Wholeness also means to integrate the experience of birth with earlier births. The woman is returning to earlier pregnancies and births compare and have “a rucksack with experiences and feelings” that could be aroused. A memory of being strong “I was so strong and it just felt wonderful” seemed to be a feeling that was long lasting. Some of the women sensed afterwards that they were too young to have a baby “afterwards I was not a woman, I just felt as a girl”.

Wholeness also means to accept the birth or change the picture of it. Some women think that their birth experience could have been different. Next time, they would like to have a more positive

experience. "I will have more requests next time as I know more now". There are also women feeling that there is nothing to change with the birth, "the horrifying should be nothing to change". A positive birth can also compensate for an earlier bad experience, "the second birth over-shadowed the first". The women express a wish to talk about the birth afterwards.

Afterwards I would like to talk to the staff, why did you do that when you wish women to have more that one child ... to quickly put away bad memories ... it would be nice to be finished with the latest birth.

Wholeness also means to reflect about expectations and experiences of birth. Birth is unpredictable, and one dimension is to react in a new way, "It was not as I had thought beforehand". Some women blamed themselves for not preparing enough. "Before I had a wrong idea about birth." There are also women who think that it is wrong to prepare by reading before birth, "people have always giving birth without a lot of books ... authors have so different opinions and if you read everything you only become hysteric", and "I had no clear picture about birth beforehand". There are also statements about advantages by preparing,

I felt prepared ... the book about giving birth without pain helped me and I used it ... otherwise I think I should have panicked. I was not afraid before birth and it is important to work on the earlier birth and be ready with it.

For the woman, birth can be a starting point for the future. The woman has gone through a trial, which she has managed. She has grown as a human being and has received strength and is better prepared to encounter painful things in life. "I'm proud that I managed—better self confidence, I have grown as a human being, a milestone". There is also happiness about the painful and dangerous in birth, life and death make reality more living, "life is worth living", "the dangerous and painful are resources afterwards", by meeting the fear and growing by the birth, resources are developed for the rest of life. "You managed the birth even if there was fear of a breakdown". Some of the women described that immediately after the birth they felt "in some way different" and also that they sensed "very soon after the birth a new responsibility".

Women express happiness towards the child and towards themselves. Some sensed themselves, in some ways, "much more as a woman" and that

they have a more important role, "I had much more important role", in their life after the birth. Birth is a reference; nothing is difficult after this experience, "a point of reference towards everything". Birth as a new starting point for the future is especially described by the women who have given birth at a birth centre. A negative experience of birth can however have the opposite effect. "I had a feeling that I was doing everything in the wrong way" and some of them even experienced that they had failed in some way. "After the birth I had the feeling that I was somehow a failure." Birth teaches women something about themselves, "I learnt something about myself, I could take control over the situation", and "I am mostly proud of not losing myself again".

Encountering togetherness with other women

Women also have a need to speak about their birth. "You need to talk to somebody" and "You need to talk to somebody before next birth". The communion sometimes last long after birth and for some have continued as friendship involving their babies and sometimes the whole family. By talking to other women, they get different stories about birth. "You can hear that next time is different" and "you may hear that you cannot compare births". However, there are also statements that too many stories may frighten the woman. "You may frighten other women by all stories, and then they get afraid of the pain and want every pain relief there is". Women are relating their own birth to their mothers and other relatives.

"You think and explain in relation to your own mother's birth and pain threshold—compare to women having lots of children like my grandmothers, who gave birth to 10 and 13, what kind of help did they get."

Some women mentioned that they almost envied the women who seemed to have an easy birth because "it always took such a long time for them to give birth".

A special togetherness with other women is sometimes experienced on the postnatal ward. "I would like to re-establish that special contact with another woman after birth," and "I really entered her birth and I almost remember it better than my own". The togetherness could also been felt as "millions of women have given birth just like I did". There could also be other women working on the ward, such as cleaners that gave a feeling of togetherness:

“there was a cleaner and she entered the room and told me that I could breastfeed . . . I really remembered her and she represented all normal things, and not at all complicated, as the caregivers.”

Some women expressed that they did not feel a special togetherness with other women. “I was marked as a freak because I gave birth at the Birth centre” and,

When I talked to other about the book [Give birth without pain] and nobody had read it or wanted to . . . they just want to walk in and give birth . . . and I cannot understand that, for I would be afraid of panicking without preparation.

Criticism concerning being a “super mummy” is also expressed, and reflections about own experiences of birth in relation to other women. “It should be natural and you should not pay so much attention to it” and “I don’t believe other women when they say that they slept through almost the whole birth”.

Discussion

The result from our study shows that the importance of the support and care provided by the midwife seemed to grow strong two to 20 years after birth. There is a lot of research describing the significance of the midwife support, information, comfort and encouragement to the woman (Berg, Lundgren, Hermansson & Wahlberg, 1996; Blix-Lindström, Christensson & Johansson, 2004; Fowles, 1998; Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996b; Hodnett et al., 2007; Kennedy et al., 2004; Kirkham, 2000; Lundgren & Berg, 2007; Matthews, 2004; Tarkka & Paunonen, 1996; Waldenström, 2004). This is also shown in extensive reviews of studies from 1985 to 2000 (Hunter, 2002) and 1990 to 2001 (Bowers, 2002). Most of the research is conducted near the birth, but the study by Waldenström (2004) shows that supportive care may have long-term effects and may protect some women from a long-lasting negative experience. Her finding is verified by our study.

Unique for our study is that the focus is on women’s long-term experiences in different settings, at birth centres and standard maternity care, in three Nordic countries, and that it has a qualitative approach. As mentioned by Kirkham (2003), more qualitative studies are needed examining the experiential domains of differing birth environments. Our findings show that women who had given birth at a birth centre in particular had deep reflections and descriptions about birth as an encounter with

themselves that was empowering and led to positive personal development. It is verified by earlier research that there is a difference in experience depending on the birth environment. Women giving birth at a birth centre have more positive childbirth experiences (Waldenström & Nilsson, 1993; Waldenström, 1998), an increased maternal satisfaction (Kirkham, 2003; Hodnett, 2006; Walsh, 2004), and a raised self-esteem (Waldenström & Nilsson, 1993), compared with women giving birth with standard care. According to Melender and Lauri (2002) and Parrat and Fahy (2003) women are more likely to be enough trustful to let go of mind control and release control of their bodies when supported within a midwifery model, such as a birth centre rather than when cared for in the medical model.

Our findings show that impersonal encounters linger feelings of being abandoned and alone. Earlier research has similar findings describing the midwife as uncaring with a rude behaviour, and with undesired interactions (Baker, Choi, Henshaw & Tree, 2005; Berg & Dahlberg, 1998; Bondas-Salonen, 1995; Halldorsdottir & Karlsdottir, 1996b). Further, these painful memories of birth may persist months after the birth (Bondas, 2000; Fowles, 1998). Our study shows that painful memories persist even in a long-term perspective. Impersonal encounters were especially demonstrated in the description by the woman who had given birth in standard maternity care. Parrat and Fahy (2003), show that midwifery models of care mean the women’s containing control over the environment, positive affirmation, and effective communication and that that mutually trusting relationships are empowering the woman. However, a medical model of care may lack these caring dimensions, which our findings are indicating.

Our study also shows that giving birth can lead to a feeling of failure and mistrust. In those cases, the women seemed still to ponder on the process of childbirth, and they had very detailed descriptions of the birth. For them, birth had not made them feel complete and had not been a natural part of their lives. A central aspect of birth as a failure or distrust is a bad relationship to the midwife. These descriptions may be compared to “suffering due to care” (Eriksson, 1994), which include the patient’s perception of having been deprived her dignity, of not being understood or taken seriously or being reduced to only a physical body—an object. Our study shows that when the midwife does not provide support, the woman has to put her energy to struggle with the midwife or she is being abandoned by the midwife. “Being with woman”—midwifery in its original meaning—could

include a deeper professional understanding and trusting of women themselves as emphasized also in previous research (Blix-Lindström et al., 2004). However, also the partner needs to be included. "With" is a form of accompaniment, implying an interaction, a relationship or connection whereby participants display the same opinion or conviction, and a spatial sense of proximity (Hunter, 2002). Caring with the woman may not be compared to providing care to the woman (Kennedy et al., 2004). The woman may easily become an object for care instead of participating in care according to her needs and wishes as this study shows especially in the traditional care settings. It seemed to be important that the women felt they were really cared for as unique human beings. Being angry for as long as two to 20 years after the birth indicates deep violation of human dignity being worthless, not seen, not believed, unreliable.

Our study also shows that the women experienced an encounter with the partner during the birth. This study supports the findings from other studies describing the partners' role as practical support, encouragement, and simply being there for women during labour (Bondas-Salonen, 1998; Somers-Smith, 1999; Gibbins & Thomson, 2001; Gungor & Beji, 2007). There are, however, also descriptions of experiences of loneliness and distrust even if the man in some way was a mouthpiece to the midwife, and a protector of the woman. The findings indicate that the support of the partner and the midwife is different, and both are needed. Even if prospective fathers made their entrance in the delivery room during the 1970s, there has been little research about the role of the husband/partner during childbirth (Hodnett et al., 2007). In a study from the US, women rank partners or husbands after doulas, midwives, and other family members in terms of the quality of supportive care (Declercq, Sakala, Corry, Applebaum & Risher, 2002). It has also been reported that men feel uncomfortable and preferred to be spectators during pregnancy and labour, leaving the midwife to support the woman (Chapman, 1991; Johnson 2002; Kaila- Behm & Vehviläinen-Julkunen, 2000) and that they have a secondary role during childbirth (Premberg & Lundgren, 2006). This supports Raphael-Leff's (1991) opinion that men in western society are left alone in their transition to parenthood. The findings of this study raise questions, and more research is needed from different perspectives of the fathers' role during birth.

Implications for practice

There is a need to reconceptualize childbirth. In studies months and years after birth, the memories of care during birth persist. Therefore, midwives and other caregivers need to be aware of the content and impact of their care of women and their families in childbirth. An implication for practice means to use the knowledge of the six encounters with midwife, environment, partner, baby, self, pain and suffering, and other women as a basis for caring for women after birth. Based in our research we want to emphasize the value of a constant dialogue with the woman before, during and after birth about her expectations and previous and on-going experiences and sensations, needs and wishes. We also want to focus on the father-to-be as not only a support person, which requires a new outlook on maternity care where the father also is treated as a parent-to-be with his own needs.

The findings of this study show that it is important for birthing women that it is not enough to focus on the medical and physical aspects. A question arises, why findings from numerous studies about the importance of the midwife-woman relationship have not influenced the organization of maternity care. This study gives another research finding about the importance of the encounter in a long-term perspective. Therefore, maternity care should be organized in a way that emphasis good relationships between midwives and women.

Conclusion

Building upon experiential reflections of one's childbirth after 2-20 years, the phenomenon can be understood as a many faceted encounter with several co-actors beside the woman and her baby. The childbirth experience has the potential to strengthen self-confidence and trust in others or, in the worst case, failure or distrust. The quality of the encounter with the midwife is an important one, with meanings that are emphasized long after the childbirth. The midwife is also important in connection to the atmosphere experienced during birth. In the impersonal encounters feelings of being abandoned and alone lingers. Encounters of this type appeared particularly for women who had given birth in traditional medical care. The partner is experienced as the protector of the woman and the baby but may, paradoxically, be seen as vulnerable and having no place of his own. Women who do not find a good relationship to the midwife instead regard the father-to-be as their most important support. The birth

also means an encounter with the woman's own resources. This dimension shows especially in the descriptions of the women who had given birth at a birth centre.

Acknowledgements

This study was partly supported by Nordforsk.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

- Baker, S. R., Choi, P. Y. L., Henshaw, C. A., & Tree, J. (2005). "I felt as though I'd been in jail": Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology*, 15(3), 315–342.
- Beck, C. T. (1994). Women's temporal experiences during the delivery process: a phenomenological study. *International Journal of Nursing Studies*, 31(3), 245–252.
- Beck, C. T. (2006). Pentadic cartography: Mapping birth trauma narratives. *Qualitative Health Research*, 16(4), 453–466.
- Berg, M. & Dahlberg, K. (1998). A phenomenological study of women's experiences of complicated childbirth. *Midwifery*, 14(1), 3–29.
- Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women's experience of the encounter with the midwife during childbirth. *Midwifery*, 12(1), 23–29.
- Blix-Lindström, S., Christensson, K., & Johansson, E. (2004). Women's satisfaction with decision-making related to augmentation of labour. *Midwifery*, 20(1), 104–112.
- Bondas-Salonen, T. (1995). *Hela livet förändras. En longitudinell studie av kvinnors upplevelser av hälsa och vård i mödravårdskontext (The whole life is changed. A longitudinal study of women's experiences of health and care in maternity care care)*. Licentiatavhandling. Institutionen för vårdvetenskap, Åbo Akademi.
- Bondas-Salonen, T. (1998). How women experience the presence of their partners at the birth of their babies. *Qualitative Health Research*, 8, 784–801.
- Bondas, T. (2005). To be with child: a heuristic synthesis in maternal care. In R. Balin (Ed.), *Trends in midwifery research* (pp. 119–136). New York: Nova Science.
- Bondas, T., & Hall, E. (2007a). Challenges in the approaches to metasynthesis research. *Qualitative Health Research*, 17(1), 113–121.
- Bondas, T., & Hall, E. (2007b). A decade of metasynthesis research: A meta-method study. *International Journal of Qualitative Studies on Health and Well-being*, 2(2), 101–113.
- Bowers, B. B. (2002). Mothers experiences of labor support: Exploration of qualitative research. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31(6), 742–752.
- Brathwaite, A.C. & Williams, C.C. (2004). Childbirth experiences of professional Chinese Canadian women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31, 33(6), 748–755.
- Callister, L.C. (2004). Making meaning: women's birth narratives. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31, 33(4), 508–518.
- Callister, L. C., Vehviläinen-Julkunen, K., & Lauri, S. (2001). Giving birth-perceptions of Finnish childbearing women. *The American Journal of Maternal Child Nursing*, 26(1), 28–32.
- Chapman, L. (1991). Searching: Expectant fathers experience by parents during pregnancy. *Journal of Perinatal and Neonatal Nursing*, 4(4), 21–29.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48–71). New York: Oxford University Press.
- Declercq, E., Sakala, C., Corry, M. P., Applebaum, S., & Risher, P. (2002). *Listening to mothers: Report of the first national US survey of women's childbearing experiences*. New York: Maternity Centre Association.
- Dahlberg, K., Drew, N., & Nyström, M. (2001). *Reflective lifeworld research*. Lund: Studentlitteratur.
- Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology*, 28(2), 235–260.
- Eriksson, K. (1994). *Den lidande människan (The suffering human being)*. Stockholm: Liber.
- Fowles, E. R. (1998). Labor concerns of women two months after delivery. *Birth*, 25(4), 235–240.
- Gibbins, J., & Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery*, 17(4), 302–313.
- Gungor, I., & Beji, N. K. (2007). Effects of fathers' attendance to labor and delivery on the experience of childbirth in Turkey. *Western Journal of Nursing Research*, 29(2), 213–231.
- Halldorsdóttir, S., & Karlsdóttir, S. (1996a). Journeying through labour and delivery: perceptions of women who have given birth. *Midwifery*, 12(2), 48–61.
- Halldórsdóttir, S., & Karlsdóttir, S. (1996b). Empowerment or discouragement: women's experience of caring and uncaring encounters during childbirth. *Health Care Women International*, 17(4), 361–379.
- Halldorsdóttir, S. (2000). The Vancouver school of doing phenomenology. In B. Fridlund & C. Hildingh (Eds.), *Qualitative Methods in the Service of Health* (pp. 47–81). Lund: Studentlitteratur
- Heaton, J. (2004). *Reworking qualitative data*. London: Sage Publications.
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2007). *Continuous support for women during childbirth*. Cochrane Database Systematic Reviews. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub2
- Hodnett, E. (2006). *Home-like versus conventional institutional settings for birth*. Cochrane Library (4).
- Hunter, L. P. (2002). Being with woman: a guiding concept for the care of laboring women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31(6), 650–657.
- Husserl, E. (1979). *The crisis of European sciences and transcendental phenomenology. An introduction to phenomenological philosophy*. Evanston: Northwestern University Press.
- Johnson, M. P. (2002). An exploration of men's experience and role at childbirth. *The Journal of Men's Studies*, 10(2), 165–182.
- Kalia-Behm, A., & Vehviläinen-Julkunen, K. (2000). Ways of being a father: how first-time fathers and public health nurses perceive men as fathers. *International Journal of Nursing Studies*, 37(3), 199–205.
- Kennedy, H. P., Shannon, M. T., Chuahorm, U. M., & Kravetz, K. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery Women's Health*, 49(1), 14–23.
- Kirkham, M. (2000). *The midwife-woman relationship*. Basingstoke: Macmillan.

- Kirkham, M. (2003). Birth centre as an enabling culture. In M. Kirkham (Ed.), *Birth centres: A social model for maternity care* (pp. 249–260). London: Books for Midwives.
- Kirkham, M. (2003). *Birth centres. A social model for maternity care*. China: Books for Midwives.
- Lundgren, I. (2002). *Releasing and relieving encounters—experiences of pregnancy and childbirth*. Doctoral dissertation, Department of women's and children's health, Uppsala University.
- Lundgren, I. (2005). Swedish women's experience of childbirth two years after birth. *Midwifery*, 21, 346–354.
- Lundgren, I., & Berg, M. (2007). Central concepts in the midwife-woman relationship. *Scandinavian Journal of Caring Sciences*, 21(2), 220–228.
- Matthews, R. C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *JOGNN*, 33(4), 498–507.
- Melender, H.-L., & Lauri, S. (2002). Experiences of security associated with pregnancy and childbirth: A study of pregnant women. *International Journal of Nursing Practice*, 8(6), 289–297.
- Merleau-Ponty, M. (1995). *Phenomenology of perception*. London: Routledge.
- Parratt, J., & Fahy, K. (2003). Trusting enough to be out of control: a pilot study of women's sense of self during childbirth. *Australian Midwifery*, 16(1), 15–22.
- Premberg, Å., & Lundgren, I. (2006). Fathers experience of childbirth education. *Journal of Perinatal Education*, 15(2), 21–28.
- Raphael-Leff, J. (1991). *Psychological processes of childbearing*. London: Chapman & Hall.
- Simkin, P. (1991). Just another day in a woman's life? Women's long-term perceptions of their first birth experience part 1. *Birth*, 18(4), 203–210.
- Simkin P. (1992). Just another day in a woman's life? Part II: Nature and consistency of women's long-term memories of their first birth experience. *Birth*, 19(2), 64–81.
- Somers-Smith, M. J. (1999). A place for the partner? Expectations and experiences of support during childbirth. *Midwifery*, 15(2), 101–108.
- Tarkka, M.-T., & Paunonen, M. (1996). Social support and its impact on mothers' experiences of childbirth. *Journal of Advanced Nursing*, 23(6), 1202–1206.
- Thorne, S. (1994). Secondary analysis in qualitative research. In J. M. Morse (Ed.), *Critical issues in Qualitative Research Methods* (pp. 263–279). Thousand Oaks: Sage.
- Waldenström, U. (1993). *Föda barn på ABC (Giving birth at an ABC unit)*. Malmö: Team Offset.
- Waldenström, U., & Nilsson, C. A. (1993). Women's satisfaction with birth centre care: A randomised controlled study. *Birth*, 20(1), 3–13.
- Waldenström, U. (1998) Continuity of carer and satisfaction. *Midwifery*, 14(4), 207–213.
- Waldenstrom, U. (2003). Women's memory of childbirth at two months and one year after the birth. *Birth*, 30(4), 248–254.
- Waldenstrom, U. (2004). Why do some women change their opinion about childbirth over time? *Birth*, 31(2), 102–107.
- Walsh, D. (2004). Birth centre care: a review of the literature. *Birth Issues*, 13(4), 129–134.