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The woman's birth experience—The effect of interpersonal relationships and continuity of care

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A R T I C L E I N F O

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A B S T R A C T

Objective: the aim of the present study was to gain a deeper understanding of how relational continuity in the childbearing process may influence the woman's birth experience.
Research design/setting: a Q-methodological approach was chosen, as it allows the researcher to systematically assess subjectivity. 23 women were invited to sort a sample of 48 statements regarding their subjective view of birth experience after having participated in a pilot project in Norway, where six midwifery students provided continuity of care to 58 women throughout the childbearing process. The sorting patterns were subsequently factor-analysed, using the statistical software 'PQ' which reveals one strong and one weaker factor. The consensus statements and the defining statements for the two factors were later interpreted.
Findings: both factors seemed to represent experiences of psychological trust and a feeling of team work along with the midwifery student. Both factors indicated the importance of quality in the relation. Factor one represented experiences of presence and emotional support in the relationship. It also represented a feeling of personal growth for the women. Factor two was defined by experiences of predictability in the relation and process, as well as the feeling of interdependency in the relation. According to quality in the relation, women defining factor two experienced that the content, not only the continuity in the relation, was important for the birth experience.
Key conclusions: relational continuity is a key concept in the context of a positive birth experience. Quality in the relation gives the woman a possibility to experience positivity during the childbearing process. Continuity in care and personal growth related to birth promote empowerment for both the woman and her partner. Relational continuity gives an opportunity for midwives to provide care in a more holistic manner.

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Introduction

In Norway, antenatal care is part of the primary health-care service, whereas the specialist health service is responsible for intrapartum and postnatal care. This leads to fragmented services where women encounter several different people and professionals instead of care based on continuity and trusting relationships.

The quality of relationships is fundamental for the quality of care provided during pregnancy, childbirth and the postnatal period (Lundgren, 2004; Olafsdottir, 2006; Hunter et al., 2008). The relationship between the midwife and the woman combines all the aspects of the midwifery service (Hunter et al., 2008). Several studies show that a trusting relationship between the woman and midwife is important for the emotional aspect related to the birth experience (Waldenstrøm et al., 2004; Lundgren et al., 2009; Leap et al., 2010; Lyberg and Severinsson, 2010; Aune et al., 2012). A woman's fear of childbirth is often a result of previous negative birth experiences. An important factor is a lack of quality in the relationship with the caregivers (Waldenstrøm, 2004; Nilsson and Lundgren, 2009; Lukasse et al., 2010; Nilsson et al., 2010). Midwives have highlighted the importance of establishing a trusting relationship in order to make the woman confident that the midwife care about her as a unique person and not consider her as just another woman in the crowd (Lundgren and Dahlberg, 2002). A trusting relationship represents a holistic perspective that involves opportunities for personal growth and development (Allgood, 1994/1995).

Dickson (1997) emphasised that caring in midwifery services is the best way for women to have a positive birth experience and that the presence of a midwife, her communication skills,

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knowledge and understanding are critical factors. According to Halldorsdottir and Karlsdottir's theory (2011), the quality of midwifery services is a key aspect of the woman's experience of childbirth. They highlight five principal factors in a midwife's profession: The professional caring, which is at the heart of midwifery, the midwife's competence and wisdom, the midwife's interpersonal skills and finally her personal and professional development. If any of these factors are missing, the services become insufficient. Professional and individualised care is emphasised as part of an ambition to promote long-term happiness and a good life.

'With Woman' and 'in partnership with women' are terms associated with good clinical results and a higher level of satisfaction. The emphasis is on a trusting midwife–woman relationship based on a phenomenological approach highlighting the woman's experience (Kirkham, 2000; Page, 2003; Carolan and Hodnett, 2007). Interdependency is essential in a supporting relationship (Allgood and Kvalsund, 2005). Interdependency underscores the mutual nature of the relationship and is characterised by trust (Allgood and Kvalsund, 2003), which is a measure of psychological confidence (Rogers, 1961).

Several studies show that women benefit from a consistent, continuing relationship during the childbearing process (Fontein, 2010; Sandall et al., 2010; Williams et al., 2010; Gagnon, 2011). The concept of relational continuity refers to a continuous process of pregnancy, birth and postnatal care. Haggerty et al. (2003) define relational continuity of care as 'an on-going therapeutic relationship between a patient and one or more providers'. This means that it is the same midwife or midwives who are responsible for following up the woman and her partner throughout the process. Continuity of care is associated with the fact that women feel better prepared for the birth and that they are more confidence and experience a positive birth (Sandall et al., 2010). National professional guidelines for antenatal care (The Directorate for Health and Social Affairs, 2005) emphasise that continuity and confidence are typical components of high-quality antenatal and intrapartum care.

This study is a part of a project at Sør-Trøndelag University College in 2009–2010, which was implemented in cooperation with the municipality of Trondheim and St. Olav's Hospital. Six midwifery students provided continuity of care to 58 women throughout pregnancy, childbirth and the postnatal period. They offered antenatal care and antenatal classes that enabled the students to develop a personal relationship with the women. One of the six students provided one-to-one care during the childbirth, and the same student was present during the postnatal home visit. The students were always under the supervision of a professional midwife. The women were not selected, but volunteered to participate in the project. They became involved during weeks 16–18 of the pregnancy after signing a written informed consent form. Inclusion criteria were low-risk pregnancy and the ability to speak Norwegian. The Regional Research Ethics Committee approved the project.

The aim of this study was to examine how relational continuity through pregnancy and childbirth may influence the birth experience.

Methodology

Design

A retrospective Q-methodology study involving 23 women from the project described earlier was conducted between three and eight months post partum. These women experienced continuity of care throughout pregnancy, childbirth and postnatal period. The Q-methodology is based on the principle that subjective views are communicable, and constitutes a tool for systematic study in order to obtain an understanding of personal experience (Brown, 1993). In this study, Q-methodology has the potential of discovering patterns or perspectives with regard to women's experience of the relational continuity of care and the birth experience. The methodology consists of five stages: (1) developing the concourse, (2) sampling the concourse, (3) constructing the Q sample, (4) sorting the Q sample, and (5) analysis and interpretation.

The concourse and representative sample

The 'Concourse' represents the universe of possible communication regarding a topic; in this case relational continuity and birth experience. A representative sample of the 'concourse' is responded to and in that process the underlying structure can be made visible and meaningful Discoveries emerge (Brown, 1993). The representative sample was derived from several sources. Statements were gathered from the women who participated in the project. Six to eight weeks post partum the 58 women answered a questionnaire and added comments and thoughts related to their experiences from participating in the project. Eight of the participants attended a group interview two months post partum where their experience of continuity of care was the topic. Theory and research on the phenomenon also provided source material from the concourse, which was used for the sample.

Constructing the Q sample

Experimental design is primarily a structured way for researchers to express their theoretical basis, and it also acts as a guide to select the Q sample from a population of statements (Brown, 1993). Fisher's experimental block design provides opportunities for systematic thinking about a phenomenon (Kvalsund, 1998) while creating a temporary structure and providing internal validity (Brown, 1993). The dimensions or criteria that are implicit in the design reflect the discussion about the phenomenon (McKeown and Thomas, 1988).

The design reflects a theoretical structure of continuity in maternity care, which is based on relational continuity and birth experience (Table 1). The selected foci or effects derived from the concourse are the Interpersonal relation, Psychological trust and View of man. The levels for the Interpersonal relation were dependency, independency and mutuality. The levels for Trust were positive trust and lacking trust. The levels for View of man were fragmented and holistic. Four replications of each cell were chosen, resulting in 48 statements that created a sample for Q-sorting. The aim at this stage is to select the number of statements per combination on the basis of balance. All effects must have the same presentation and heterogeneous representation, which mean that there should be as many statements as possible with the same structural logic (Kvalsund, 1998). The statements are numbered and randomised before being presented to the participant in the form of cards were each card represents a statement. On the basis of feedback from two pilot participants, changes were made in the formulation of some statements. Finally, the two researchers together assessed the cell placement and balance of the sample.

The P-set

Forty-six women in the project who experienced very good continuity of care and were satisfied with the care in general were invited by mail to participate in this study. Twenty-three women volunteered to participate and they became the population set or

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