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The delivery room: Is it a safe place? A hermeneutic analysis of women's negative birth experiences

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ABSTRACT

Background: Women's negative experiences in the delivery room can have significance for later fear of childbirth. Therefore, it is important to critically evaluate the care during childbirth. The aim was to gain a deeper understanding of women's negative experiences in the delivery room.
Methods: This study is based on original data from three qualitative studies on Swedish women's experiences of fear of childbirth. Data were collected from interviews with 21 women; 15 pregnant women (6 + 9) with intense fear of childbirth, and six women who had experienced intense fear of childbirth 7–11 years prior to the interview. The analysis had a hermeneutic approach, with focus on the women's descriptions of their previous negative birth experiences.
Findings: The interpretation showed that in the delivery room the women were objects of surveillance, and they endured suffering related to the care during childbirth. This involves experiences of midwives as uncaring, feelings of being suppressed, unprotected and lacking safety, of feeling disconnected and of the body as incompetent in giving birth. The birth environments are understood as power structures, containing views of women's birthing bodies as machines, and delivery rooms as surveillance environments, involving interventions such as foetal heart monitoring, induction and augmentation of labour.
Conclusions: The delivery room was, for these women, a place creating fear of childbirth. To avoid negative birth experiences and future fear, women must be offered not only medical, but also emotional and existential safety in the delivery room.

Introduction

Giving birth is an important life event for women characterized as a multidimensional, complex and unique process, strongly influenced by the surrounding society [1]. Moreover, the birth experience is described by the woman as transcendent [2], as a journey [3], and as an encounter with herself as well as with the midwife [4]. Childbirth is a threshold, a transition for women; an existential event that always has involved a fear that something unexpected might occur [5]. Traditionally in Sweden, and many other cultures, birth has been surrounded by myths and rituals to ensure that the woman and her baby have a successful birth [5]. The room for birth had to be protected against "evil ghosts", and no uninitiated person was let in. Different rituals were performed as a way to reduce fear and channel anxiety, not only in the birthing woman, but also in those helping her [5].

The place for birth has shifted during the last 100 years, from women's home to the hospital. A delivery room within a hospital setting is the most common place for women to give birth in Western countries today. For some women, childbirth is an experience similar to their worst imaginable nightmare [6,7], and affects them in such a way that they become filled with fear of forthcoming births [8–10]. Although the labour room is structured to provide safe care for women and their babies, it has been criticized as too technological giving the impression of childbirth as a branch of biomedicine rather than an aspect of health. Women can see this as a stressful and fearful environment, which can have a negative impact on their birth experiences, as well as birth outcomes [11].

The relations between women's previous negative childbirth experiences and fear were explored in my thesis [12], using a mixed methods design including one quantitative and three qualitative studies. The findings demonstrated an association between previous negative birth experience and later fear of childbirth [10], but also the complexity in women's fear, where their previous experiences in the delivery room were central [13–15]. During a negative birth experience the women described experiences of not being present in the delivery room and an incomplete birth experience [14]. In a long-term perspective the women's earlier negative childbirth experiences had become birth narratives permeated by disharmony [15]. A central finding in all three qualitative studies was the women's negative experiences in relation to the care given

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Table 1
Characteristics of the included studies (n = 3).

Authors, year	Nilsson and Lundgren (2009)	Nilsson et al. (2010)	Nilsson et al. (2012)
Reference No	[13]	[14]	[15]
Aim	To describe women's lived experience of fear of childbirth	To describe the meaning of previous experiences of childbirth	To describe the meaning of fear of childbirth and of birth drawing on women's long-term perspectives
Setting	Special clinic for women with intense fear of childbirth	Special clinic for women with intense fear of childbirth	Special clinic for women with intense fear of childbirth
Sample size, characteristics	Eight pregnant women (24–37 gestational weeks), 27–34 years, with intense fear of childbirth (two women pregnant with their first baby[a], and six women pregnant with their second baby)	Nine women, all pregnant with their second baby (18–39 gestational weeks), 29–36 years, with intense fear of childbirth, and who considered their previous birth experiences as negative	Six women, 41–48 years, who had sought help for intense fear of childbirth because of a negative birth experience during their second or third pregnancy 7–11 years ago
Delivery outcome – previous births	Four women: spontaneous vaginal Two women: vacuum extraction	Four women: spontaneous vaginal Two women: vacuum extraction Three women: emergency caesarean section	Four women: all births were spontaneous vaginal One woman: one spontaneous vaginal, and one emergency caesarean section One woman: two emergency caesarean sections. The participants had 2–3 children each; altogether, they had 14 children from the ages of four up to 21 years (born between 1990 and 2007)
Data collection	Individual open interviews	Individual open interviews	Individual open interviews
Data analysis	Descriptive phenomenology: Dahlberg et al. (2008) [16]	Descriptive phenomenology: Dahlberg et al. (2008) [16]	Descriptive phenomenology: Dahlberg et al. (2008) [16]
Findings	Essential structure: to lose oneself as a woman into loneliness. Constituents: feelings of danger that threatens and appeals, feeling trapped, feeling like an inferior mother-to-be, on your own.	Essential structure: a sense of not being present in the delivery room and an incomplete birth experience. Constituents: having no place, not taking one's place, a memory etched in the mind, brief moments that made sense.	Essential structure: an effort to make all the pieces come together. Constituents: every childbirth is a narrative that lingers on, fear of childbirth is connected to the period of childbearing, the experiences of childbirth are central life experiences.

[a] Excluded in the actual hermeneutic analysis.

by midwives and other staff. For brief overview of the original studies, see Table 1.

These findings are in line with other studies demonstrating that important factors for experiencing birth as negative are often related to the care, involving experiences of uncaring attitudes from midwives, being treated in a dehumanizing way, lack of control and feeling invisible [17,18]. Conclusions drawn from the thesis [12] were that to avoid creating fear of childbirth it is important to focus on women's birth experiences, and critically evaluate the care given to them during childbirth. Consequently, the aim of this paper was to obtain a deeper understanding of the women's negative experiences in the delivery room.

Methods

The study was a hermeneutic analysis performed on original data from three qualitative studies in the context of women's experiences of fear of childbirth [13–15]. A hermeneutic approach [19] based on a lifeworld perspective [16] was used to obtain a deeper understanding of the women's negative experiences in the delivery room.

The analysis is based on lifeworld hermeneutics [16,19]. This approach implies a search for meanings through interpretation, which means understanding by looking at the data in a new perspective to "see something new" [16,19]. An understanding of human perception of everyday life as interpretative is central to this approach. When we understand a phenomenon, we expand our horizon of understanding [16,19]. The concept of pre-understanding is essential, which implies an awareness of our history and tradition [19]. Such awareness entails a continuous reflection of one's own understanding in relation to the studied phenomenon. Openness, an important concept in lifeworld research, is described as an open and discovering attitude towards the phenomenon during the entire research process [16]. The analysis has followed the hermeneutic spiral and was guided by Gadamer's methodological principles: the overall importance of scientific and methodological openness, an awareness of the power of history and tradition for our understanding, a cautious use of theory, and a search for "the otherness" [16,19].

Setting and participants

Maternity care in Sweden is free of charge and funded by taxes, except for some of those women who request a homebirth [20]. Consequently, almost all births take place in hospitals. Midwives in Sweden have an independent role in taking responsibility for care provided to women with uncomplicated pregnancies and labours. If complications occur a physician takes over, but the midwife is still involved in the woman's care. Midwives work for 8 hour shifts, and generally have responsibility for one or two birthing women during this time.

Continuity of carer is considered important. After a woman has been admitted to a maternity ward she stays in the same room during the whole of her childbirth. Usually, the woman and her baby will be moved to a postnatal ward 2–3 hours after the birth.

The participants had sought care during pregnancy in Sweden, at a special clinic for women with intense fear of childbirth between the years 2000 and 2012, for their second or third birth. This clinic consists of specially trained midwives that provide face to face meetings with the women [21,22]. The women had not experienced fear of childbirth before the birth of their first child. The women had given birth at hospitals, and all described one of their previous births in negative terms. See Table 1 for more detailed information of the participants.

The delivery room was the place for experiences and events described by the women. The rooms are situated in two maternity wards at two different hospitals, with the same setting, and are equipped for childbirth. Each maternity ward has approximately 4000–4500 births per year. Besides the birthing woman and her unborn baby, the delivery room also includes other persons involved such as her partner, the midwife and possibly a doctor. The bases for this paper are events, occurrences and experiences in the