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AN EXAMINATION OF PSYCHOLOGICAL ISSUES IN THE PREGNANCY AND BIRTH PROCESS WITH REFERENCE TO PERSONAL RESPONSIBILITY AND CONTROL

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A thesis submitted in partial fulfilment of the requirements for the degree of Master of Arts in Psychology

Rhodes University
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November 1990

ABSTRACT

This study examines the psychological issues of personal responsibility and control in the childbirth process. It examines the implications of the woman's preparation process and the choices she makes during pregnancy and childbirth. It also explores the way in which the birthing environment and the woman's interpersonal relationships affect her experience of personal control within the context of the childbirth period.

Use was made of the case study research design. This qualitative design involved indepth exploration, of cases in which the women had recently given birth to their first child in the local hospital of a small town. The data analysis involved the use of a "reading guide", established by the researcher to allow for the examination of the data specifically in terms of the themes in question.

Within the study the importance and value of the woman's

accurate and sufficient preparation for the birth was seen to facilitate a realistic sense of predictability, which led to an increased awareness and ability of the woman to remain in control. This, along with the active participation of the husband and supportive network in the hospital, allowed for a sharing of the responsibility within the labour situation. This taking and appropriately yielding of control and responsibility had positive effects on the woman's experience of the event and for initial mother - infant bonding.

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ACKNOWLEDGEMENTS

A woman's experience of pregnancy and childbirth is a very personal issue and I am extremely grateful to my subjects for their willingness to share their thoughts and feelings with me regarding this important time in their lives. I would also like to thank Trevor Hoek and Ina Roux of the Rhodes Department of Psychology for their supervision and encouragement.

... there is a Persian myth of the creation of the world which precedes the biblical one. In that myth *a woman creates the world, and she creates it by an act of natural creativity* which is hers and cannot be duplicated by men.

(Fromme-Reichmann and Gunst, 1974, p. 88. Emphasis added by present author)

CHAPTER 1

The experience of childbearing, of conceiving, carrying and bringing new life into the world is a fundamental part of human experience. It is a woman's unique function to give birth to new human beings. Many factors influence women's adaption and response to these events. Among these are individual motivations, religious affiliations, support systems, interpersonal relationships and the way in which she chooses to structure the event. Owing to cultural changes and developments in medical technology and personal needs and expectations, social attitudes to childbirth are changing. These changes have considerable implications for the individual as well as for society as a whole.

Birth as conceived of by the medical profession, should ideally take place in a hospital setting, where drugs and technology are close at hand. This might be because the doctor is viewed as an expert and the mother's innate knowledge often plays a minor role in the decision-making processes (Beels, 1980). The medicalisation of childbirth, therefore, plays a paramount role in women's experience of this central event.

Many, though believe that birth is an entirely natural process. Within this framework, medical interventions carry risks and, therefore, should never be applied routinely or without the woman's informed consent. Supporters of this point of view maintain that the doctor and medical personnel are vital in abnormal cases, but in most births, the midwife's encouragement and facilitation of this natural process is deemed to be appropriate. In this way each woman's knowledge and intuition regarding birth process is acknowledged (Blum, 1980; Kitzinger, 1981; Oakley, 1984). The issue of control and personal responsibility in childbirth is one of the most basic issues in question today, and health care consumer movements advocate a more active role in the decision-making process of the patient, in this case the pregnant woman (Holmes, 1980).

Common sense alone suggests that the beginning of motherhood is immensely important. The way a birth is managed and perceived will influence a woman's whole experience of being a mother. The aim of this thesis is to explore women's lived experience and attitude to childbirth. It is based on the findings from interviews conducted with women after the births of their first child in order to ascertain their thoughts and feelings before, during and after birth.

This first chapter involves the presentation of a "reading guide" set up for the reader by the researcher following Brown, Tappan, Gilligan, Miller and Agyris, (1989). This reading guide consists of theory or a perspective drawn together to assist the reader in the analysis of the interviews for the given themes. This is followed by a qualitative investigation into the experiences of childbirth described by eight women in a small town in South Africa. The findings of the research are then dialogued with the relevant literature and possible guidelines or recommendations are given along with the limitations and problems experienced in this study and possible future areas of investigation are discussed.

Use was made of the case study design (Bromley, 1986). This research strategy proved to be especially useful in exploring the experience of pregnancy, labour and delivery, the impact of the hospital environment, among others. The aim, therefore, was to collect data on pregnancy and birth in order to gain better understanding of the specific themes relating to women's preparedness, the birthing environment and various interpersonal relationships.

A REVIEW OF THE ISSUES PERTINENT TO THIS STUDY

The focus of the review is to examine the psychological experience of the birth process. In particular the stages before, during and after childbirth will be highlighted in terms of certain interrelated areas. These include the repercussions of the choices a woman will make both during the pregnancy and during the birth; the woman's attitude to herself and her relationships with significant others and the self. Altogether these interrelated areas constitute the source of her subjective perception of the global experience, whether positive or negative.

The birth experience

In examining the issues pertaining to the choices available to women in pregnancy and childbirth, it is useful to focus on the actual birth experience. It can be hypothesized that a successful beginning to parenthood will be reflected in an increased sense of well-being in both parents, as well as in the parent-child relationship (Entwisle, 1981). This is also proposed by Shainess who saw the first pregnancy in a woman's life as a "crucible tempering the self" and he recognised that if this tempering process went wrong, the results could damage

the "self" and by implication to the self's relationship with others (Levy, 1975)

In view of the importance attached to a woman's experience of the birth process, it is obviously of paramount importance to examine the responsibility of choices a woman has that determines the process of pregnancy and birth.

> Our choices now affect not only ourselves and our children and how they will be "allowed" to give birth and be born. Let us choose for our children to be born in the safety of strength and joy, rather than in the danger of passivity and fear (Squire, cited in Claxton, 1986, p. 59).

The choices suitable for each woman are complicated as no simple rule can serve as a guideline for all women. The issues of preparation, both emotional and physical (A); the control a woman has in the labour situation (B); and the interpersonal relationships she has with her partner and the medical personnel (C); all interrelate to form the basis of her experience.

Women today could be said to have a far wider choice in pregnancy and childbirth than ever before. Some of the initial

decisions that a pregnant woman is able to make include: choosing the person who will aid her in the delivery of her baby; deciding how she will be helped and on what terms; the extent and source of her preparation (For example ante-natal classes, literature searches and so on.) and the environment in which she chooses to give birth (Du Toit, 1986).

It is obviously not a simple matter for an expectant mother (in particular the woman facing her first childbirth) to approach the question of choices and examine logically all the factors which apply in her individual circumstances. Information and self confidence allow women to make their own informed choices in terms of the reality they face (Kitzinger 1978).

(A.) Preparedness in relation to both personal responsibility and control

Lipman-Blumen advocates that the feeling of being in control of a situation is directly related to the individual's perception of being able to make decisions, i.e. to plot his own preferred course of action. Averill divided the concept of "feeling in control" into two areas, the first being 'cognitive control', which he saw as the gathering and

processing of information to reduce stress and secondly 'decisional control', in other words the individual's feelings empowered by the ability to make a choice between alternate courses of action (Fisher, 1984).

Heide saw predicability, (a form of cognitive control) the ability to expect a certain course of action, as being an important means of reducing uncertainty in new situations, at the same time leading to a significant reduction in stress levels and an increase in the individual's ability to cope (Fisher, 1984). These theories of preparedness, the freedom or ability to make choices and predicability all have an important impact on evaluating the childbirth experience. A "work of worry" or realistic evaluation and preparation of the impending birth, allows women to feel cognitively in control. The concept of "work of worry", that is the seeking of information was addressed by the establishment of ante-natal classes (Levy, 1975). These classes allow a woman to increase her level of awareness and gain more active control in her labour as she is taught how to aid herself in the childbirth process.

These classes also provide an environment where women meet other pregnant women and their partners and are able to exchange and learn from others' experiences. These classes

have been shown to have a positive effect on the impact on the individual's subjective assessment of the experience (Entwisle, 1981).

The importance of these classes cannot be over-emphasized when one considers that a woman often exists within a nuclear family and is separated from her extended family she is therefore not in intimate contact with other pregnant women and has a relatively narrow knowledge on childbirth. Doering and Entwisle found in a cross-sectional study of women who had given birth that those who were prepared emotionally and/or practically, required less medication during labour, and found the birth to be a positive experience.

Women who were well prepared experienced significantly more positive feelings toward their babies. The results of this study point quite clearly towards a promotion of realistic anticipation, knowledge and adequate training during pregnancy. Women can be assisted in developing perceptions of the situation which will allow them to cope more adequately with the impending birth.

Decisional control is facilitated by the woman's perceived ability to make choices between alternatives. After having gathered information and prepared emotionally a woman is able

to decide the course that her pregnancy and birth will follow. A woman could be said to be gaining greater control over the childbirth situation by making decisions and obtaining the "decisional control" that Averill promotes. One way of plotting the expected course of action, is to devise an individual birth plan or framework. This can be in the form of a letter or an interview with the doctor/midwife, or a personal commitment to oneself, indicating the way in which the individual woman wants to proceed with childbirth. Issues such as medical intervention, medication, delivery position, choice of helpers and partner at delivery, immediate post-natal period, can be specified and negotiated (Bannister, 1987).

It has been shown that a sense of responsibility and partnership is also more likely to develop if parents are able to structure and choose the plans for the birth of their child (Prince, 1978). This structure or decisional process may prevent misunderstandings and needless trauma during childbirth (Claxton, 1986).

(B.) Choosing The Birthing Environment

When one considers the intimate link between a woman's emotional state and the progress or labour, one realises that it is important that she is in a place where she is able to relax and feel confident. If a woman is able to feel this at home, then home is the "safe" and appropriate setting for the birth, if the hospital setting is the "safe" place, then this is were childbirth should take place (Claxton, 1986).

As most births occur in hospitals it is appropriate that this setting is given prominence in this review.

The hospital setting : the effects of both medication and medical interventions on the birth experience

The ever increasing dominance of the medical profession in pregnancy and childbirth has had many tried and proven advantages. Some feminist critics, however, have defied this claim of dominance by the medical profession and submitted that this supremacy contained some problematic contradictions.

It seems that as women have become more liberated, the decisions they make and the choices they have are increasingly removed from the "natural" where the emphasis is

on intuition and feelings and are predominantly put in the hands of medicine and medical procedures where the emphasis is on objective, external control (Blum, 1980).

The limitations and sometimes inappropriate interventions in this medical setting are reflected in the changes of attitude of some leading obstetricians who support a more human and less technological approach. They are questioning the necessity and psychological impact of the "hi-tech" births and unnecessary intervention in what is, after all, a natural and inevitable process. This point has been articulated succinctly by Hofmeyer in his submission that:

> we have made enormous advances in obstetrics and have improved the kind of care we can offer mothers and babies. As a result, we think that if something is good for complicated deliveries it should be good for uncomplicated deliveries and that has led to technology being overused (cited in Bannister, 1987. p. 214).

The woman, unfortunately, is often left with a feeling of inadequacy. A feeling of not having been able to meet the physiological challenges of nature although she may not have been able to articulate her feelings to the extent here mentioned. This led Chalmers to describe how most medical inventions in labour and birth somehow produce a sensation of

failure in women.

> Not only is it (a feeling) of failure as a woman but it is a failure simply as a functioning physiological being. Your own body image, contributed to by your ability to function adequately on a physiological and psychological level - is threatened by the necessity for medical techniques (Chalmers, 1984, p. 54).

In the following examination some of these practices or medical interventions are considered from the perspective of a woman who is intent on successfully meeting the challenges of childbirth: a woman who wishes to accept the responsibility for her own and her child's safety in terms of their psychological and physiological well-being.

"Prepping"

Upon entering the hospital it is common for a women to undergo procedures which are intended to prepare her physically for childbirth. More than eighty per cent of the women who responded to the 1987 South African National Childbirth and Parenting Survey (Bannister, October, 1987) reported that they

were routinely shaved and given an enema upon admission to the labour ward. This practise, commonly known as "prepping", is being questioned and changes are gradually being implemented.

It can be argued that procedures are performed not simply because they need to be done, but because of ritual and tradition (Kitzinger, 1978). These procedures have significant implications for the woman psychologically. It has been reported that they not only are unpleasant but are found to be dehumanising and alienating. The perceived loss of control of that which is intimate and personal could have direct implications on the woman's ability to proceed with the labour with confidence (Claxton, 1986; Kitzinger, 1978; Brook, 1976).

Intravenous drips

Other procedures implemented during the labour also need to be considered in terms of their impact on a woman's sense of control and confidence. The position in which the woman labours and gives birth needs to be one in which she feels physically and emotionally comfortable. At times either due to necessity or routine, the woman is immobilised in a horizontal position (Leifer, 1980).

Intravenous drips are among the routine procedures used today.

In the N.C.E.P.A. survey it was shown that fifty-three per cent of women who responded to the survey were immobilised by a drip during labour (Bannister, 1987). Physically immobilising a woman can lead to feelings of psychological immobility. This, in turn, could lead to her being unable to implement her prepared strategies, feelings of entrapment and consequent sensations of loss of control.

It has been found that although labouring in bed may be convenient for the hospital staff, it can, on occasion, prolong labour and endanger the baby's safety. (Ahmed, 1981; Brook, 1976; Claxton, 1986; Kitzinger, 1981). If there is a medically valid reason for a procedure to be implemented, a balance between psychological and physical safety would have to be established.

Furthermore, it is not a new idea or technique for doctors to artificially initiate the labour contractions. As a result of the discovery of penicillin and the invention of the oxytocin drip in 1947, modern methods of induction have become routine (Holmes, 1980). Induction is used by doctors when there is danger in a prolonged pregnancy. This can become a threat to the unborn foetus as the placenta may cease to nourish the foetus adequately.

There are, however, inherent dangers in the process of induction. One has to bear in mind that some babies may need more time in the womb than others. The timing of delivery is controlled by complex natural mechanism within the foetus which are, as yet, not entirely understood (Kitzinger, 1981). Whether the foetus has reached full term or not can, seldom be diagnosed with absolute certainty.

One of the major dangers with the modern method of induction is that unless the dosage is carefully regulated the woman's uterus can go into a state of what is called hypertonic spasm. This spasm halts contractions and at the same time may reduce the blood flow to the placenta. This may in turn cause foetal distress and the possibility of death (Brook, 1976).

This procedure has significant implications for the woman in terms of her "felt" experience of the event. Not only is it found that the woman experiences an emotional let-down but also that induced labours are often reported to be painful and frightening since they cause strong and accelerated contractions (Claxton, 1986)

These contractions have been reported as being more closely spaced than those associated with unmedicated births,

preventing the woman in labour from preparing herself and adjusting to the intensity of the experience (Leifer, 1980). Beard points out that the extent to which perinatal mortality can be improved by the induction procedure is minimal and the determinants of perinatal mortality remain largely unknown and may not be primarily medical (cited in Kitzinger, 1981, p. 159).

Perhaps it is too soon to judge the long-term effects of artificially inducing and controlling a normal labour. It is now generally accepted that in natural labour the foetus itself may play a leading part in initiating contractions, as well as preparing the lungs to work (Dawes, cited in Brook, 1976). There is a gradual build-up in the intensity and strength of contractions in a normal labour, which allows each women time to adjust and accept each stage of labour in its natural sequence. Brook has put forth the point that this is a natural protective mechanism which benefits both mother and child.

Medication

The medical model views childbirth as being an inevitably painful process, with "labour = pain = pain-killers" (Brook, 1976, p. 69). Many doctors feel that it is their duty to

anticipate the pain and to relieve it as much as possible. This is based on the sound assumption that no woman should be expected to bear more pain than she is prepared to endure during labour. For this reason effective pharmacological pain relief is important, especially in those labours which are not routine (Kitzinger, 1978).

Those who are opposed to a hospital setting or have certain misgivings regarding the medical approach suggest that pain-killing drugs may at time induce drowsiness or stupor in the mother with the result that labour can take on a nightmare quality. A woman's ability to cope with pain is reduced and prevents her from making use of any coping methods or techniques she originally may have contemplated (Brook, 1976).

They also maintain that at present there is no effective drug which has neither the undesirable side-effects nor the absolute safety for both mother and child. All sedating and pain-killing drugs cross the placenta to reach the foetus with the same depressant effect which they have on the mother.

Brackenhill (1984), Professor of Obstetrics at Georgetown University, has stated that Pethadine (a commonly used analgesic) is used in eighty to ninety percent of all deliveries in Great Britain. Her study of mother-infant

interaction provides clear evidence that Pethadine produces substantial neo-natal impairment in the infant's ability to process information and that *a major obstetrical DANGER may be medication itself.*

In addition there appears to be a clear link between medication administered during labour and the feelings of separation between mother and infant after birth. It has been clearly established that at both thirty and sixty weeks after a medicated birth, mothers and their babies have less intimate contact. Furthermore, babies showed more self-stimulatory activities, like thumb sucking. It is very likely that there will be long-term effects due to the minimal intimate contact between mothers and their babies immediately after birth (Richards, 1974).

Trause's investigations into mother-infant bonding found that mothers who were awake in the first forty minutes after the birth of their children and had contact with their children were more attentive and affectionate to their babies one month after the birth. The group was compared to those women who did not have immediate contact with their babies (Klaus, 1978).

The bonding process involves eye contact, holding, touching, crooning sounds and maternal soothing. The process is seen as

helpful in orientating infants to their surroundings and establishing the bond with their caretaker. Klaus and Kennel (1978) explain, based on the results of their extensive investigations, that the technological approach to birth and the accompanying procedures in some instances stunt this vital bonding process.

Entwisle (1981) found that the higher the mother's awareness of the physical as well as emotional sensations of birth, the more positive her response to and interaction with her baby. The investigators compared the reactions of mothers towards their newborn infants. The women were divided into three groups: Group A received little or no medication or intervention during labour and birth and were therefore fully aware of the physical and emotional sensations of giving birth. Group B received medication which significantly diminished their sensations of birth but left them mentally aware. Group C were medicated to such an extent that both physical and mental awareness were diminished both during and after birth. Doering and Entwisle found in the results of their investigation that the strongest indications of affectional attachment occurred among those in Group A, the mothers in Group B scored significantly lower in their affectional attachment to their infants. The poorest attachment occurred amongst those women in Group C.

Ringer found in a five year follow-up study that the babies who experienced more intimate contact with their mothers after birth had achieved developmental milestones a lot earlier than those who were separated from their mothers at birth. At the age of five the IQ and language comprehension of the children in the first category was superior (Ahmed, 1981).

Episiotomy

Today an integral part of giving birth is the incision of the perineum, commonly known as an episiotomy. Such an intervention is based on the conviction that labour is being delayed by the skin of the perineum not "giving" enough. The N.C.E.P.A. Survey found the episiotomy rate in South Africa to be around seventy-two per cent (Bannister, 1987).

When surgical procedures are implemented, the woman's role in the childbirth arena is subtly changed, she becomes a patient who is undergoing a surgical procedure. In other words, the hospital birth is turned into a surgical experience, an event over which she has no control.

It is widely accepted that episiotomy sutures can cause emotional and physical discomfort not only at the time of the suturing but months later (Kitzinger, 1981). Until the mid-

sixties, British midwives were forbidden to do episiotomies unless the baby was struggling and in obvious distress, as an intact perineum was clear evidence of a skilled midwife. Midwives therefore prided themselves in their ability to keep the perineum intact. This was done by utilizing a variety of techniques including the massaging of the perineum with oil during labour, applying warm flannels to the perineum, allowing the labouring woman the freedom to move around during labour, and encouraging her to squat or kneel for the actual delivery of the child (Beels, 1980).

Today a few doctors in South Africa are also making use of these techniques. They too pride themselves not on the prowess of their surgical skills, but on the number of intact perineums (Du Toit, 1986). A study done by a British anthropologist, Kitzinger, indicated that women who tore during delivery suffered fewer traumatic emotional after-effects than those who had episiotomies. She further submitted that twice as many women with episiotomies still felt pain a week after giving birth and after three months, were also likely to experience pain during sexual intercourse (Kitzinger, 1981).

(C.) Interpersonal Relationships and their impact on the child birth experience

Having explored the relationship between women and the birthing environment, it is important to bear in mind the implications of the women's relationships with significant others during the childbirth period.

When a person enters into a situation, he or she brings in a set of beliefs, values and coping skills which have been both biographically modelled and socially integrated. This person is however confronted with other people in the world, who have their own characteristic set of world views (A. Schultz and T. Luckman, 1973).

In the case of a woman entering the phase in her life of pregnancy and childbirth, she 'sees' and interprets these events not only through her individual perspective, but is influenced by the reactions of those around her.

Therefore the woman's experience cannot only be seen in isolation, but is seen in relation to the interpersonal relationships present. This 'being with others' implies that although many individuals, for example the woman her, husband and the doctor may all be confronted with the same pregnancy and labour, the relevance and manner of approaching the experience may be different for each one. This section, is

therefore concerned with this particular aspect of existence.

The woman's familiar physical appearance, capabilities and physical sensations are all changed during pregnancy and post-birth recovery. If these changes are processed adequately they can contribute significantly to the development of a positive self-image, which in turn can possibly affect the woman's ability and desire to mother (Blum, 1980).

Bearing in mind these tremendous changes to the woman's body and self concept, the supportive relationships in her life play an important role. In fact, the degree to which the childbirth experience is perceived by the woman as positive, may be critically related to the quality and extent of social and interpersonal support. Studies all emphasize the importance of the relationships between the woman and the significant others in her life, and indicate how this directly influences the global experience of childbirth for the woman (Cohen, 1966; Gordon and Gordon, 1957; Gasel and Kaplan, 1972 cited in Leifer, 1980).

With the increasing recognition of the importance of fatherhood and the shifts in cultural definitions of male and female roles, expectations of men's involvement in pregnancy, birth and childcare are broadening. Proponents of prepared

childbirth stress the importance of the husband/partner involvement in all facets of labour and delivery (Claxton, 1986; Brook, 1976).

Results of Doering's and Entwisle's study investigating the importance of the husband's/partner's participation in the birth process suggest that by the partner encouraging and comforting the mother, anxiety is reduced. In addition, pain becomes more bearable. They point to several studies that have confirmed this idea, illustrating how husbands can serve as a means of coping with pain, thus enabling the experience to become one in which the couple take on an active role. In addition the husband's presence increases the woman's emotional experience of childbirth. More women described the birth as a peak experience who have their husbands present (Henneborn and Cogen, 1975).

Based on Janis's works, this level of awareness in the labouring woman enables her to derive more pleasure and satisfaction from the birth. Norr offered evidence to show that both preparation in pregnancy and the husband's/partner's presence and support were positively associated with the quality of the women's birth experiences (Entwisle, 1981). A positive birth experience can have a profound effect on parenting behaviour and therefore family life in general

(Prince, 1978).

The choice of the person who will aid in the delivery of her baby is important. It has been shown that the presence of a supportive network during the birth will enhance the woman's experience of the event (Du Toit, 1986).

It has been found that regardless of what relationship women expected to have and had with their doctor, he was considered a vital element in the pregnancy period. Women tend to have total confidence in the doctor's medical skills regardless of their actual relationship. What is interesting, however, is the secondary role doctors played in the actual delivery (Leifer, 1980).

Having examined the issue of choice and explored some of the major decisions a woman will make, it is apparent that even though the woman may not have been aware of it by her failing to take responsibility and make choices, a choice has been made.

A woman's confidence and ability to experience the birth of her child in a positive manner could be dependent upon such factors as:

- her emotional and physical preparedness,
- her self-concept as a woman and a mother,
- the quality and extent of her support systems.

However, it must be emphasized that any one or all of the aforementioned factors may lead to the woman's positive experience.

Having provided a backdrop against which to conceptualise and understand the issues raised by this study, we can now turn to a consideration of methodological procedures.

CHAPTER 2

METHODOLOGY

The case study design used in this study enabled the individual cases to be examined in depth. This examination of observations of an individual in relation to a set of circumstances, allows for a commentary or analysis of the significance of the events. The researcher attempts to eliminate inaccurate or irrelevant conclusions, until the most appropriate interpretation of the individuals experience is found. Theory or case law can emerge as successive cases are considered in relation to one another. (Bromley 1986).

This design aided the researcher in obtaining an account of the women experiences during the childbirth process. These individual accounts of this significant segment of a woman's life, were examined in depth facilitating an understanding the experiences, in relation to the issues of responsibility and control. Each case study was not all encompassing of the issues in question, they addressed some issues or themes and ignored others. However, the goal was to examine this, in other words how and why the woman behaved as she did during the childbirth period and being able to comment on the

significance of this experience. This detailed examination of the period of pregnancy and birth allowed the common themes related to personal responsibility and control to emerge. By exploring the experience of the women in terms of the interrelationship between their preparation, the choices she makes, the interpersonal structures available and the woman's self-image in relation to the event, it was then possible to enhance the understanding of the issue of personal responsibility and control. Initial insights gained from single cases were systematised and refined as successive cases were considered in relation to one another. The examination of a limited number of cases of a particular type is aimed at allowing theory to be applied to new cases.

Subjects

Eight mothers were interviewed, after being assured of confidentiality. In selecting a group of women to study the researcher selected those whose experiences highlighted the issues under investigation. The goal was therefore to select a group that was able to introspect and articulate their responses to the pregnancy and childbirth process.

The material in this thesis rests on the case studies of eight white women, who had had their first child. It is important to understand their experience in this light, as it is quite possible that some of their perceptions and experiences were coloured by the uniqueness of this event for them. All eight women were resident in a small town and were all in the upper middle class income bracket. They were all patients of local general practitioners and went through labour and gave birth in the local provincial hospital. They were all married and between the ages of 20 and 35.

No direct questions were asked of the women and their responses to the general topic were not commented upon. The researcher used only the prompts of reflection, clarification and encouragement. Time was also spent building rapport with the subjects.

To further ensure the smooth flow of the interview, all communication made by the respondents was tape recorded. The transcripts were abbreviated in the following manner: all initial rapport building, assurances of confidentiality, researcher's prompts and reflections, deviations and interruptions and finally the closure, were omitted. The original edited cases can be found in the appendix to this study.

Research procedures

The open-ended, non-directive approach which was followed in the interview situation allowed complex real-life accounts of the childbirth experience to emerge.

Initially the protocols were read through with an open-mind in order to get a sense of the content, and to become familiar with the experience as it is described (Wertz, 1985). This interpretative strategy involved an attempt to enter the woman's world and become part of it, through a careful reading of the subjects' own words.

The next procedure involved setting up a structure by which the reader was guided to search for specific themes. This

"reading guide" is the framework or perspective provided by the theory which the researcher has drawn together following the procedure outlined by Brown, Tappin, Gilligan, Miller and Aqyris, (1989). For example, Brown distinguishes a method of reading and interpreting complex accounts of moral conflict and choice. This method was useful in facilitating the extraction of the interrelated factors that influence the overall experience of childbirth.

The researcher read through the cases a number of times. The first reading, was done in a way to 'read' or 'listen' for the emotional and physical preparedness of the woman. Examining issues such as 'cognitive' and 'decisional' control. The second reading 'read' for the environmental influence of the hospital setting, and thirdly the researcher 'read' for the importance and impact of the interpersonal relationships on the woman's experience.

These multiple readings facilitate the amplification of the different themes. In other words, a given statement, can have different understandings or meanings for different reading foci.

Following this procedure the individual descriptions within each theme were divided into a temporal sequence. This was

done so as to accurately reflect the stages of the event (Wertz, 1985). Redundant data was discarded and the individual descriptions of the theme in the event, in relation to the sub-divisions, were listed. An emphasis on understanding and judgements of the relevance were of importance at this stage. During this process, a constant return to the original data was made to ensure that the original meanings were not lost.

This procedure was then carried out for each protocol and for each theme. The next step was to move towards a general psychological understanding of the birth experience. An attempt was made to understand the common features of the childbirth event, noting the extremes within and articulating the general experience. For example, while exploring the significance and importance of the relationship between the woman and her husband during this periods, it was found that most of the women had their husbands present during the entire labour and birth, with the exception of one woman whose husband had been sent home to rest.

These women regarded their husbands' presence as vital in making the labour an easier experience both emotionally and practically. The husband was seen as a buffer between herself and the alien environment of the hospital. His presence was therefore vital in helping the women emotionally in their

handling of the event.

The final stage comprises the discussion in which these findings are related to the world at large.

CHAPTER THREE

RESULTS

Various factors central to the process of pregnancy and birth comment on this complex and multi faceted theme of personal responsibility and control. Central in this regard are for instance, (A) issues surrounding the degree and extent of preparation undertaken by the women,(B) the influence of the birthing environment and (C) the interpersonal relationships present in this period of childbirth. The abovementioned sections will be recognisable by their upper case underlined and bold headings, whereas the subsections within these themes will be headed in bold script.

(A.) APPROPRIATE AND SUFFICIENT PREPARATION CAN INCREASE A WOMEN'S COGNITIVE AND DECISIONAL CONTROL IN THE CHILDBIRTH ARENA

The degree of preparation undertaken by the women played an important role in their experience of pregnancy and birth.

Most of the women engaged in some sort of activity to prepare

themselves for childbirth. Ante-natal classes and books on pregnancy increased knowledge and altered perceptions about birth itself.

This is demonstrated in the following examples:

Subject 6 "I went to ante-natal classes. I found them entertaining. I loved seeing women who were in the same boat as me." (line 14)

Subject 8 "The ante-natal classes I attended played a large role in my positive attitude towards pregnancy and childbirth." (line 12)

Also see appendix : Subject 2, line 22; Subject 3, line 32; Subject 4, line 13; Subject 5, line 21.

The consequences of emotional and practical preparation where in many cases positive. When the woman was informed and felt in control of the situation, she was able to proceed with confidence.

Subject 4 "Throughout the labour my husband and I worked at all the techniques we had practised... we worked together like an amazingly synchronised team."

(line 24)

Subject 6 "I actually knew that the only thing I could really rely upon was me and myself, only I knew what was needed." (line 44)

"The pain, well, yes, it got bad, but I knew each wave would ease, it could only go for so long." (line 47)

"It was exhilarating, an absolute high..." (line 64)

"I felt so self-contained and able, yes able." (line 72)

Subject 8 "... we were able to walk and "breathe" together as we had been taught in ante-natal classes." (line 33)

"My husband directed the breathing and relaxation exercise, this enabled me to regain control." (line 41)

Inadequate preparation may lead to loss of personal control

The results indicated that a vacuum in the woman's preparation, concerning medical procedures, medication and

choices available was evident. This in turn lead to increased anxiety and feelings of a loss of control. This is evident in the following examples.

Subject 1 "When my water broke I was really shocked at the amount of liquid which literally poured all over the floor." (line 18)

"No one told me just how strong the contractions could be.." (line 23)

"When the baby was born, all i could think of was how much blood there was, and what a mess it was." (line 39)

"I feel quite positive about the whole event, although I keep on remembering just how jolly sore and confusing it felt." (line 48)

Subject 2 "I never, never expected it (labour) to be so very painful, which was a shock as I expected the natural breathing methods to do their thing ... I remember feeling quite cheated and disillusioned..." (line 38)

Subject 3 "[my doctor] said I should have a caesarean because I had such a small frame. I felt okay about the decision, but now after reading about caesareans I

realise what an uninformed decision he made." (line 13)

"I was so distraught I ripped the drip out my arm and staggered to the phone." (line 52)

"I felt really disillusioned by everyone, everything around me and slumped into a depression that was plague with feelings of anger, disappointment and inadequacy." (line 67)

The results pointed clearly to the areas where preparation was inadequate these included inaccurate or insufficient information on the, physical workings of the body, and the medical procedures and the effects of medication. Examples of these are as follows:

Lack of information on the physical occurrences during labour;

Subject 1 "When my waters broke I was really shocked at the amount of liquid which literally poured all over the floor." (line 18)

"No one told me just how strong the contractions could be."

"When the baby was actually born, all I could think of was how much blood there was, an what a mess it

all was."

Subject 2 "I must tell you though, I never, never expected it to be so painful." (line 38)
"I remember feeling quite cheated and disillusioned because no one, not even my mom, had really made it explicit, I mean just how painful it really gets." (line 42)

Subject 8 "When it was necessary for me to "bear down" or push, I became frustrated, and felt inadequate and fearful." (line 43)

Lack of information regarding medical terms, procedures and the effects of medication;

Subject 1 "I was then given a Pethidine injection by a nurse to ease the pain, it took away most of the pain, but made me extremely drowsy, I was therefore unable to walk around any more. I wanted to squat while giving birth, but at the time I was just too tired." (line 25)

Subject 2 "I asked if I could have a painkiller... after a couple of minutes strange things started happening.

It's quite difficult to really explain - I seemed to lose control over things, the baby was pressing down and they kept on saying 'it's not pain, it's just pressure'." (line 52)

Subject 3 "...he [the doctor] said I should have a caesarean because I had such a small frame. I felt OK about the decision, but now after reading up about caesareans I realise what an uninformed decision he made." (line 14)

"Well being induced just freaked me out, being tied down [referring to the drip and the prone position] makes one feel trapped and out of control." The woman was first induced and only when this failed was the caesarean performed.

Subject 5 "Once he [the doctor] said he couldn't feel the baby's head. Well, it was weeks until I was entirely convinced I was not going to give birth to a 'headless baby'.." (line 16)

Subject 7 "I had used gas during labour, which had eased the worst pain, but it made me nauseous ... I just wanted to sleep and sleep." (line 71)

Subject 8 "The doctor intervened and decided to make use of forceps ... when they were inserted, I lost control, the pain just overwhelmed me, I just remember hearing screaming and realising it was me, it was so confusing ... I feel so angry with him [the doctor] for not telling me the pain involved in the use of forceps." (line 48)

(B.) BIRTH ENVIRONMENT

Medical intervention and medication can lead to a decreased sense of awareness and control in the labour situation

In the instances where medication or medical procedures were administered (with or without explanation or informed consent of the woman concerned) feelings of losing control and heightened anxiety were reported. The women who either declined to take control, or lost emotional and/or physical control due to unplanned for events found childbirth to be difficult and some were left with feelings of anger, regrets or generally feeling unfulfilled. This is illustrated in the following examples:

Subject 1 "I was then given a Pethidine injection by a nurse to ease the pain. It took away most of the pain, but made me extremely drowsy. I was therefor unable to walk around any more. Time seemed to be merging and all I can really say to explain it to you as I went gagga!" (line 25)

"When the baby was actually born ... I was given my baby, he seemed quite apathetic and tired. They took him away ... and left me to sleep, thank God!" (line 39)

"I feel quite positive about the whole event, although I keep remembering just how jolly sore and confusing it felt." (line 48)

Subject 2 [during labour]"I asked [the medical staff] if I could have a painkiller ... After a couple of minutes strange things started happening ... I seemed to lose control over things." (line 47)

"I couldn't scream but my body was making all these crazy motions." (line 53)

"For the last hour it was strange, I couldn't tell whether i was asleep or awake ... I felt so passive, everything was unreal." (line 55)

"Eventually my son was delivered. I felt so overwhelmed and excited ... I kept on asking 'is it

real?'." (line 60)

Subject 3 "Well being induced just freaked me out, being tied down makes one feel trapped and out of control." (line 35)

"Next thing I knew a catheter was shoved in which hurt like hell and before I knew it someone was asking me to count sheep." (line 55)

"I felt really disillusioned by everyone, everything around me and slumped into depression that was plagued with feelings of anger, disappointment and inadequacy, what more can I say." (line 67)

Subject 5 "I was hooked up to a drip and induced, well it was simply horrific. From that moment everything happened too fast, my contractions were suddenly too close together, altogether too painful and unbearable ... I felt all strung up like a chicken." (line 36)

"It was terribly difficult to believe she had come out of me. It felt strange, in fact I was quite shattered as I could only feel so much of what was happening." (line 60)

"The birth was too mechanised and controlled I feel

that I was just a spare part, an accessary, I mean as though they could have done without me." (line 79)

Subject 8 "The doctor intervened and decided to make use of forceps... when the forceps were inserted. I lost all control, the pain just overwhelmed me, it was so confusing." (line 47)

"I can't exactly remember the moment when the baby was born, I was in too much pain, I think." (line 61)

"I felt and still feel cheated and feel like I've failed in having a successful labour." (line 51)

Medical procedures and medication can have a negative effect on the bonding process

Subject 1 "I was then given a Pethidine injection to ease the pain. It took away most of the pain, but made me extremely drowsy. I was therefore unable to walk around anymore." (line 25)

"I did not hold the baby straight away, but my husband did which I was glad about. When I was given my baby, he seemed quite apathetic and tired.

They took him away to clean him up and let me sleep, thank God!" (line 40)

Subject 2 "I asked [the medical staff] if I could have a pain killer." (line 47)

"My relationship with my baby was slow to begin, as I only saw my baby about twenty two hours after the actual birth ... it took many weeks until I treated him as my baby and not a baby that needed looking after." (line 65)

Subject 5 "I was hooked up to a drip and induced, well it was simply horrific." (line 36)

"It was terribly difficult to believe that she had come out of me ... I wanted to feed her straight away, but I was feeling so sick and giddy ... they took her away. I found it difficult to feel love towards the baby." (line 60)

Subject 7 "When the baby appeared, they whipped him away and gave him to the doctor I had used gas... so I just wanted to sleep and sleep. It took me quite a while to love him." (line 67)

Subject 8 "The doctor intervened and decided to make use of

forceps ... when the forceps were inserted I lost all control, the pain just overwhelmed me, it was so confusing." (line 47)

"I cant exactly remember the moment when the baby was born, I was in too much pain, I think, yes, he was given to me, and that initial contact was extremely comforting and satisfying. Otherwise it was a bit of a blur, as I was give a large dose of painkiller which knocked me out." (line 65)

The less medication or procedural intervention used during labour the more positive the experience for the woman

The results of this study showed that the more confident and in control the women felt, the less medication was administered. This appeared to play an important role in the response of the women to the process of labour and their immediate reaction to the birth or their babies. The women who had no medication and restricted medical procedures to a minimum, spent time with their babies immediately following the birth, this was seen to be of significant importance to the family unit.

Subject 4 "I was in control from start to finish, and

withstood all pressures to take some sort of painkiller I really felt entirely and totally self-sufficient." (line 31)

"We thereafter spent at least an hour examining our beautiful baby. From this moment onwards he never left my side while we were in hospital ... I nursed him an hour after giving birth, which was yet again so utterly fulfilling like the whole birth experience." (line 48)

"When our baby was actually born, I was only aware of my husband and the baby... It was indeed a peak experience in both my life and my husband's... We were both so incredibly happy, it was an indescribable feeling of real joy. We kissed each other and just cried and cried." (line 39)

Subject 6 "I refused medication, I really knew that the only thing I could really rely upon was me and myself, only I knew what was needed." (line 42)

"I then examined her, for, it must have been hours. Well I was amazed this is a separate entity an individual. I can honestly say that giving birth to my baby was a peak experience in my life... I still feel strong and totally in control of my life." (line 70)

The results presented above point towards a close link between the degrees of satisfaction experienced by the women and the extent to which she experiences herself to have decisional control of the events. Feeling in control tended to be associated with a high degree of satisfaction. It is therefore suggested that the factors discussed, namely, the extent and accuracy of the woman's preparation, medication and medical procedures play a vital role in determining whether the woman felt herself to have both cognitive and decisional control of the events or not.

(C.) INTERPERSONAL RELATIONSHIPS

The importance of the husband during childbirth

All of the women in the study had their husbands present during the entire labour, with the exception of one, whose husband was sent home to "rest" during the initial labour period, and was not present during the caesarean section. These women regarded their husband's presence as critical in making labour an easier, more fulfilling experience. It appeared as if his presence was important in helping the woman emotionally in integrating the entire event. Examples of the

above are shown in the following accounts of the event:

Subject 1 "It was really reassuring and helpful having my husband by my side ... I would never have another baby without him being there as a support system. It brought us a lot closer together, and of course towards our new baby!" (line 54)

Subject 4 "Throughout the labour my husband and I worked at all the techniques we had practised. We improvised, made up a few of our own, and generally worked together like a synchronised team. We worked hard all night, my husband was an absolute angel, he rubbed my feet, my neck, my knees and anywhere else that even twinged and tried to ache! We didn't talk much, we didn't need to, just being there for each other was enough." (line 24)

"When our baby was actually born, I was only aware of my husband and the baby." (line 39)

"It was indeed a peak experience in both my life and my husband's." (line 41)

"We were both so incredibly happy, it was an indescribable feeling of real joy. We kissed each other and just cried and cried." (line 45)

Subject 5 "I was a bit nervous at being alone, but as soon as he (her husband) arrived I felt a lot better." (line 32)

Subject 6 "...I leaned against my husband and he supported me. The togetherness was so special." (line 41)
"My husband was a wonder. He seemed to ease so much tension and strain away." (line 50)
"(when the baby was born) It was simply exhilarating, an absolute high, my husband was weeping on my shoulder." (line 66)

Subject 7 "My husband was with me all the time. And, although I think he was bewildered by the whole scene, he was wonderful in that he held my hand and kept on telling me how brave I was and how much he loved me. His presence was invaluable and I would not have another baby without him experiencing the whole process with me. It was really nice having someone you know, who is a translator between you and everyone else." (line 57)

Subject 8 "I was then left with my husband. This privacy was really welcomed and we were able to walk and "breathe" together as we had been taught in ante-

natal classes." (line 32)

"I feel grateful that my husband was present, especially during "transition", when I was finding it difficult to continue "breathing" and remaining in control. My husband directed the "breathing", and relaxation exercises, this enabled me to regain control." (line 39)

It can be seen in the results that the presence of the husband was invaluable and formed an integral part of the birth experience for the couple. This sharing found expression in many different ways as was shown previously. However, the more the woman was able to share the responsibility and control of the situation with her husband the more the couple were able to unite in the experience. This is illustrated in the following examples:

Subject 3, was unable to have her husband present during the labour. "My husband and I had attended ante-natal classes together, so I was really excited to be working as a team. Well what a shock when they sent him home to rest." (line 32). The responsibility of the situation was unable to be shared, and the woman reports feeling out of control. The aloneness of the situation, without a support frightened the

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woman. "I pleaded with them to call for my husband. That is the single most thing that upset me. I was panicking for six hours and still they did not call him." (line 49) "I demanded they call my husband" (line 49). "I was so distraught I ripped the drip out my arm and staggered to the phone." (line 52). The whole experience of childbirth was viewed by this woman with regrets. "I felt really disillusioned by everyone, everything around me and slumped into a depression that was plagued with feelings of anger, disappointment and inadequacy." (line 67).

Subject 8 The woman was able, in the initial stages of labour, to share the experience with her husband. The responsibility of remaining in control was shared. At one point the woman was able to hand over the responsibility of the direction of the breathing exercise to her husband, thus maintaining control "I feel grateful that my husband was present, especially during transition, when I was finding it difficult to continue "breathing" and remaining in control. My husband directed the "breathing" and relaxation exercises, this enabled me to regain control. When however the doctor intervened, and took over the responsibility and control of the situation, the woman lost control and the husband's presence was no longer evident. "I lost all control, the pain just overwhelmed me." (line 49). The couple were unable to

maintain the support structure they had in the initial stages of labour, and did not experience the birth of their child together. The woman felt angry with her husband for not maintaining the responsibility for the situation. "I also felt angry with my husband for letting them intervene, but I realise at the time we were both intimidated and scared." (line 74).

Subject 4 and her husband worked as a team throughout the pregnancy and the birth, thus sharing the responsibility and remaining in control of the situation. "My husband and I attended ante-natal classes together, and we spent all our spare time practising and reading up on current methods of childbirth" (line 13) "Throughout the labour my husband and I worked at all the techniques we had practised. We improvised, made up a few of my own and generally worked together like an amazingly synchronised team. We worked hard all night; my husband was an absolute angel, he rubbed my feet, my neck, my knees and anywhere else that twinged and even tried to ache! We didn't talk much, at all, we didn't need to, just being there for each other was enough. I was in control from start to finish" (line 24). This intense sharing of the situation enabled this couple to exclude the alien hospital environment and maintain the privacy and intimacy they needed to fully experience the birth of their

child. "When our baby was born, I was only aware of my husband and the baby. Although there were many people around they all seemed insignificant, the doctor included. It was, indeed a peak experience in both my life and my husbands"

Subject 6 and her husband were able to experience the feelings of togetherness during the labour period, to share the responsibility and thus maintaining control. "I walked a lot, and when the contractions got really strong, I leaned against my husband and he supported me. The togetherness was so special... I actually knew that the only thing I could really rely upon was him and myself, only I knew what was needed" (line 40). This couple was able to exclude all distractions and use the privacy to work within the intimacy of the situation. "My husband was a wonder, he seemed to ease the so much tension and strain away" (line 50). The birth of their baby was experienced as a peak-experience, and as a couple they were able to experience the event fully. "It was simply exhilarating, an absolute high, my husband was weeping on my shoulder." (line 67)

In what ways was the husband or wife able to take responsibility and control of the labour situation?

Responsibility for the event was taken and lost in many different ways. **The husband's presence in itself was a form of sharing the responsibility which helped in making the potentially alienating environment a more comfortable and safe one.** As is seen in the following examples; subject 1 "It was really reassuring and helpful having him by my side" (line 54), subject 4 "Just being there was for each other was enough" (line 24); subject 5 "I was a bit nervous at being alone, but as soon as [her husband] he arrived I felt a lot better" (line 32), subject 6 "The togetherness was so special" (line 41), subject 7 "My husband was with me all the time .... his presence was invaluable (line 57). The husband was also able to be a **sharer of the responsibility by his ability to be supportive**, as is seen in subject 1 "I would never have another baby without him being there as support system" (line 54) "...I leaned against my husband and he supported me" (line 54); subject 7 "[my husband]... was wonderful in that he held my hand and kept on telling me how brave I was and how much he loved me" (line 57). Another and extremely important way in which the woman was able to share responsibility with her **husband was the husband's active involvement in the labour process.** This is seen in the following examples : Subject 4 "Throughout the labour my husband and I worked at all the techniques we had practised. We improvised, and made up a few of our own, and generally

worked together like a team." (line 24); subject 6 "my husband was a wonder, he seemed to ease so much tension and strain away" (line 50) "It was really nice having someone you know, who is a translator between you and everyone else" (line 57); subject 8 "My husband directed the 'breathing' and relaxation exercises, this enable me to regain control (line 39). By the husband actually taking over some or the responsibility in the labour process, the women is then free to focus on maintaining her emotional and physical control in the new and demanding situation.

The husband's presence, support and active involvement were all seen to be important in the sharing of the responsibility of the labour experience. As long as the couple were able to remain aware, control was maintained.

A positive relationship with the doctor during pregnancy does not always lead to a positive encounter with the doctor during the labour period

Given that pregnancy and birth are inherently personal processes, it follows that the woman's experience of the process is likely to be influenced by her relationship with members of the medical profession. In an examination of the

results, it appeared that this dimension of the birth process was experienced in a variety of ways by the women.

Expectations regarding the nature of the relationship between the doctor and the woman during pregnancy varied considerably. In some cases the relationship freed the woman to ask relevant questions and clear and comprehensible answers were offered. **These women therefore experienced the relationship during pregnancy to be satisfactory as is borne out by the following examples:**

Subject 1 "I had a good relationship with my doctor ..." (line 8)

Subject 2 "The doctor I chose, must have been the sweetest most gentle man, he treated me as the most important person in the whole situation. What did I want? How did I feel? He answered my questions thoroughly, leaving me reassured and informed, he was not in the least condescending." (line 13)
"I was worried the doctor world not arrive and I knew I would die if I had to have another doctor" (line 31)

Subject 4 "I chose a doctor whose work I respected at the

hospital. I was generally happy with our relationship ..." (line 13)

Subject 6 "My doctor was really a sweetie." (line 3)

Subject 8 "I asked my friends to recommend a doctor, and eventually decided upon a doctor whose attitude towards pregnancy coincided with my own..." (line 4)

This positive relationship did not always extend into the labour period, certain of the woman found their encounters with the medical staff to be unnecessary and an irritation:

Subject 4 "My doctor was unimportant in the entire event. I thought his presence would be important, but, in fact, his examinations were more of an irritation. They made me lose concentration, and besides I could feel it was ok." (line 34)

"Although there were many people around they all seemed significant, the doctor included" (line 41)

Others found the doctor's presence and intervention was an intrusion and that he affected their sense of being responsible and in control:

Subject 6 "... I felt entirely self-sufficient" (line 46) Until this responsibility was taken away and the doctor took over the control;

"At this stage I saw the doctor walk over with a syringe, and I said "Hold it I'm doing just fine. He said it was for the episiotomy and before I knew it, it was done. When I think back I get really pissed off about it." (line 56)

When the responsibility for the situation was taken from the woman, she was unable to maintain control as subject 1 illustrates:

Subject 1 "[after a painkiller] I was then given a Pethidine injection by a nurse ... it took away most of the pain, but made me extremely drowsy ... I went gagga." (line 25)

Subject 2 was able to retain control of the situation, after a painkiller was administered, her awareness of the situation was considerably reduced. "[after the painkiller] ... strange things started happening I started to lose control over things." (line 47)

Subject 5 "The doctor intervened and decided to make use of

forceps ... I lost all control" (line 45)

"I felt and still fee, cheated and feel like I've failed in having a successful labour. I had not finished it myself. If only he had reassured me and given me time and space, I'm sure I could have managed. I feel angry towards him (the doctor) for not telling me the pain involved in the use of forceps. I was given an Episiotomy as a matter of course, ... that's ok, but I do feel it should have been discussed beforehand." (line 51)

"But it was a sad turnaround of events when the doctor stole all this and intervened. What I keep asking was it all necessary?" (line 68)

Some women found, or viewed the doctor as the all knowing, unquestionable expert who would conduct the birth process. These women adopted a submissive attitude in their encounters with the medical world. These women found the support the medical staff gave them containing and gave them a sense of security.

Subject 1 "I had a good relationship with my doctor, he is a very kind and understanding man." (line 8) Yielding the responsibility to the medical staff and viewing them as the expert, "I attended ante-

natal classes as I wanted to try to have my baby naturally, if I was allowed." (line 11)

"I am really glad I gave birth in a hospital, as I would be really terrified at the thought of being alone without the expertise and support the hospital and staff gave me." (line 50)

"The hospital staff were all nice and very pleasant to me, they seemed unhurried and completely calm at all times." (line 37)

Subject 7 "I was nauseous all the time I didn't realise that the doctor could prescribe something...In about my sixth month my doctor asked if I had any trouble with 'morning sickness' well what a relief when I could go through a day without feeling ill." (line 6)

"I found that, because I hadn't got the confidence, that is required during classes, I was far more manageable. In the sense that when my nurse or doctor told me to do this or that, I did in immediately, without question, which made the whole situation far easier for all concerned." (line 25)

The woman gained more control through yielding the responsibility to the medical staff.

"I was quite confident about the sister's

capabilities to give birth to my baby. So I was not at all scared. After all she has been present at so many births." (line 53)

From the above it is evident that the nature of the contact between women and members of the medical profession played an important part in a women's experience of these events. If the woman felt secure in handing over the responsibility of the situation to the medical staff, the woman felt in control, whereas the women who attempted to maintain responsibility for the situation and found it being taken away, felt they were loosing control and feelings of dissatisfaction followed, and finally the women who were able to retain the responsibility themselves and retain control, report the unimportance of the doctor's presence and the intense emotions of pleasure at the birth of their child.

In the results, therefore, it appeares that in certain cases the doctor took responsibility away from woman. The responsibility to make decisions and understand the process of the intervention was not available to the woman, as no explanation or preparation was given. This is seen in the following example, subject 5. **"the doctor intervened** and decided to use forceps ... I lost control", the woman was no

take responsibility for the situation and states "if only he had reassured me, and given me time and space, I am sure I could have managed...I do feel it should have been discussed before hand." (line 51), realising how she could have possibly retained control through a sharing of the responsibility of the decision.

The responsibility of the situation was fully in the hands of subject 4 and the doctor was seen as being **insignificant**. It was seen in this example how the woman was able to retain control in this situation and share responsibility with her husband through their active sharing of the "work". "My doctor was unimportant in the entire event..." However subject 7 yielded the responsibility in the labour situation to the medical staff and was comfortable with this status quo and was thus able to feel in control. "I was far more manageable in the sense that when any nurse told me to do this or that I did it immediately without question, which made the whole situation easier for all concerned...I was quite confident about the sister's capabilities to give birth to my baby." (line 25 & 53)

SUMMARY OF RESULTS.

In the understanding the results of the women's experience of childbirth, it is important to understand how the concepts of personal responsibility and control were experienced in the study by the women. **Responsibility** in childbirth appear to be linked to the manner and extent to which a woman prepares both emotionally and practically for the birth of her child and is thereby able to respond in a way that is comfortable for her. This gathering and processing of information allows the woman not only to make decisions regarding her preferred course of action but also to imagine, or plot the course that she would like to follow during childbirth. This predictability of the situation and ability to make decisions is a way in which the woman gains and maintains **control** and awareness.

The responsibilities of childbirth are immense. During pregnancy a woman is faced with many decisions that she has to make and changes both physically and emotionally, that she has to cope with. The preparation was shown in the results to be of vital importance, the more accurate and encompassing the information building process is, the more responsibility a woman can take in the decision making process. The involvement of the woman not only builds self-confidence and

increases the predictability of the ensuing birth for the woman, but also allows her to make decisions that are most appropriate for her individual situation.

The environment in which a woman chooses to give birth plays a fundamental role in the woman's experience of childbirth. Within this study it was found that women who underwent medical interventions or received medication were unable to maintain a position where they could respond in a way they felt to be appropriate and comfortable. A loss of awareness or decisional control resulted and feelings of anxiety, disempowerment and apathy followed. This appeared to have consequences for both the overall feelings the women had looking back on the event, and on the initial bonding process between mother and child. Women in the study who had little or no medication found the experience to be a positive one. They were able to deal with the process in a way that was appropriate and comfortable for them, maintaining responsibility and control.

The husband's presence was at the labour found to be important in it itself and it also allowed the couple to share in the responsibility for remaining aware and in control. The relationship with the doctor and or medical staff was on the whole positive during pregnancy, however during the labour the

issues of responsibility and control emerged strongly. It appeared, that when the woman was able to remain responsible for her labour, or was able to share this with her husband or the medical staff, she was able to maintain control and experienced birth to be positive. However when her decision making power and ability to maintain the situation within her chosen parameters was lost due to the medical staff owning her responsibility, the woman lost control.

After having briefly discussed the findings above, a discussion will follow that details the results against the backdrop of the literature findings.

CHAPTER 4

DISCUSSION

In this final section it will be endeavoured to dialogue the results of the study with the literature, propose recommendations, discuss the limitations of the present study and suggest future areas of study.

Preparation

The importance of preparation is reflected in the literature illustrating that when an individual is able to gather information he/she is able to feel cognitivley in control of the situation. This process allows the person to have the responsibility of making informed decisions, and allows them the ability to plot their own course of action (Fisher, 1984). This "work of worry" or realistic evaluation of the impending birth reduces stress levels and through this sense of predictability allows the pregnant women to feel empowered and in control (Levy, 1975).

In this study, women who attended ante-natal classes found

them to be important in terms of coping techniques; Subject 4: "... practising and reading up on current methods of childbirth."; emotional support; Subject 8: "The ante-natal classes I attended, played a large role in my positive attitude towards pregnancy and childbirth. My fear of pain, a possible caesarean, the hospital environment, were all discussed and met with empathy and understanding in the classes."; a sense of comradeship; Subject 6: "I loved seeing women who were in the same boat as me, to talk, bitch and discuss possible names ...."; and an information source: Subject 5: "The ante-natal classes were invaluable ... it was really reassuring knowing something of what was to come. I learnt a lot about the technical side of birth, what was happening to the baby etc."

This realistic evaluation of the impending situation proved to be an important focus in this study. The preparation for birth proved at times to be insufficient, the consequences of this were serious. The areas in which preparation was inaccurate or insufficient, included information on the physical workings of the body, the medical terms, procedures and effects of medication. This vacuum in the woman's ability to realistically evaluate and thereby to take responsibility for the labour led to increased anxiety in the women and consequent feelings of a loss of control.

Women in this study, who appeared to be emotionally and/or practically prepared, were able to take the responsibility for the labour and remain in control. Doering and Entwisle confirmed in their study that women who were emotionally and/or practically prepared were able to take more responsibility in the labour process and their subjective assessment of the event was positive. (Entwisle 1981). Women in this study who were able to proceed through the labour in control, experienced the birth of the child as a positive and had intense feelings towards their babies.

The Birthing Environment

The woman's ability to take and to retain responsibility, and remain to in control within the hospital environment appeared to be linked with the administering of medication or the implementation of medical procedures. It was found that in this present study feelings of loosing control and helplessness were closely tied to medication or medical procedures being performed without explanation or informed consent. This break with the expectedness or predictability and loss of decision making power increased stress levels in the individual and the consequent loss of control decreased the ability to cope (Fisher, 1984). This feeling of

disempowerment prevented the woman from fully utilizing any coping/relaxation techniques she originally may have prepared for (Brook, 1976).

Women in this study that took responsibility and were able to maintain control; Subject 4 "I was in control from start to finish, and withstood all pressures to take some sort of painkiller I really felt entirely and totally self sufficient." Subject 6 "I refused medication, I really knew that the only thing I could really rely on was him and myself, only I knew what was needed", found this to have positive consequences for their experience of the event; Subject 4 "When our baby was actually born, I was only aware of my husband and the baby ... It was indeed a peak experience in both my life and my husband's" Subject 6 "I can honestly say that giving birth to my baby was a peak experience in my life... I still feel strong and totally in control of my life." This taking of control by the women had positive consequences for the early mother-infant bonding. The importance of this bonding period has been well documented and stresses the importance not only to the infant but also to the psychological health of the future family (Klaus and Kennel, 1976). Bonding in the study involved the time spent with the baby after the birth, and the mother's awareness and enjoyment of the interaction. This is illustrated in Subject 6's

experience of this period; "We thereafter spent at least an hour examining our beautiful baby. From this moment onwards he never left my side while we were in the hospital... I took a very active role in caring for my baby and nursed her an hour after giving birth." Klaus and Kennel (1976) stress that this process is helpful in orientating infants to their surroundings and establishing the bond with their caretaker. Both of these women had no medication administered, or interventions that prevented them from being fully present and able to retain decision making control during the birth. Women in this study who had medication or medical procedures during labour found these to either dulled their awareness of the event, or evoked feelings of panic and anxiety, this in turn lead to a loss of control; Subject 2 [after the medication] "strange things started happening ... I seemed to lose control over things ... I felt so passive, everything was unreal." Subject 5 "I was hooked up to a drip and induced, well it was simply horrific. From that moment everything happened too fast, ... the birth was too mechanised and controlled." This loss of control, with the responsibility then taken over by the medical staff had consequences for the bonding process. Subject 8 "The doctor intervened and decided to make use of forceps ... when the forceps were inserted I lost all control, the pain just overwhelmed, it was so confusing. I can't remember the moment when the baby

was born, I was in too much pain, I think."

Subject 2 reports "my relationship with my baby was slow, as I only saw my baby about twenty two hours after the actual birth ... it took many weeks until I treated him as my baby and not a baby that needed looking after." Subject 5 "It was terribly difficult to believe she had come out of me ... I wanted to feed her straight away, but I was feeling so sick and giddy ... they took her away. I found it difficult to feel love towards the baby."

These results are confirmed in Brackenhill and Trause's studies which showed the clear link between medication administered during labour and the feelings of separation between mother and infant after birth (Klaus, 1976).

Interpersonal Relationships

In the study the role of the husband's presence at the birth was reported as being invaluable. This importance of the husband/partner's presence and support throughout pregnancy and birth has been well documented (Brook, 1976; Claxton, 1986; Leifer, 1980; Wolkind, 1981). However the results of this study indicate that the involvement of the husband in the labour period, allowed a sharing of responsibility and a heightened awareness which then led to the couple experiencing

great pleasure at the birth. Varying degrees of husband and wife interaction took place.

From the results, it was evident that the three main ways in which the husband could and did share in this responsibility included, firstly, his presence as a form of sharing as seen in Subject 7 "My husband was with me all the time ... his presence was invaluable," secondly, the husband sharing the responsibility by his ability to be supportive, Subject 1 "I would never have another baby without him being there as a support system." and, thirdly, and most importantly, the husbands ability to share the responsibility by his active involvement in the labour process. Subject 4 illustrates this from of sharing well "Throughout labour my husband and I worked at all the techniques we had practised. We improvised and made up a few of our own, and generally worked together like a team." This ability of the couple to share in the responsibility allows them to remain aware and able to make decisions in a way that felt most appropriate. It has been established that the husband's presence increases the woman's positive emotional experience of the birth (Henneborn and Cogen, 1982, Entwisle, 1981).

The experience of Subject 3 indicated that most of her energy

during labour was involved in attempting to get her husband to the hospital. "I pleaded with them to call for my husband. That is the single most thing that upset me. I was panicking for six hours and still they did not call him." The responsibility of the situation was unable to be shared. The woman later reports losing control. "I was so distraught I ripped the drip out of my arm and staggered to the phone." Curry added to this by reporting how a woman going through alone suffer severe damage to her self concept and this can affect her subsequent evaluation of her experience, her later maternal behaviour and her future self-concept (cited in Klaus and Kennel 1976). "I had severe problems bonding with my child, I in fact didn't want to hold him for three weeks. I attribute his being a "problem child" to the traumatic way he was introduced to the world, and my feelings surrounding our first days together... I felt really disillusioned by everyone, everything around me and slumped into a depression that was plagued with feelings of anger, disappointment and inadequacy..."

In an examination of the relationship the women had with the doctor/medical staff, it was found that the relationships during pregnancy were on the whole positive. This did not always, however, extend into the labour period. Three themes of feelings emerged. Firstly, the doctor's presence was found

to be unnecessary. This couple was able to focus their attention on the birth, the medical staff was excluded. This is seen in Subject 4 "My doctor was unimportant in the entire event. I thought his presence would be important, but in fact his examinations were an irritation ... Although there were many people around they all seemed insignificant, the doctor included" This coincides with Leifer's (1980) Finding that doctors played a secondary role in the labour.

Secondly, women found the doctor's presence and intervention to be an intrusion. The responsibility to make decisions was taken from the women, resulting in a loss of control; "But it was a sad turn around of events when the doctor stole all this and intervened. What I keen asking was it all necessary" (Subject 8). Thirdly, women viewed the medical staff as the experts and gained control of the situation by giving or yielding the responsibility or decision making power to the medical staff. "I was quite confident about the sister's capabilities to give birth to my baby." (subject 7).

These results emphasise the importance of the choice of person who will aid the women in childbirth. Du Toit (1986) emphasises how important the need of the supportive network around the women during labour is, and therefore how vital adequate preparation and communication between the doctor and

women is. From these results, in conjunction with the literature provided, (Bannister, 1987; Claxton, 1986; Du Toit, 1986; Kitzinger, 1978) it can be said that women require birthing options falling on a continuum ranging from those involving little or no medical intervention to options involving a handing over of responsibility of decision making to the members of the medical profession. The emergence of two 'alternate' birthing units in South Africa suggests a move towards a more flexible, intervention free and personalised approach, being supported by some women and medical professionals. The midwives in this unit, are responsible for the ante-natal preparation including the teaching of breathing and relaxation techniques. The role of the midwife is seen as being of vital importance and the doctor is only called in, in an emergency (Du Toit, 1986).

What is therefore implied is a flexible birthing infrastructure which is able to accommodate a wide range of needs of different women. Facilitating the structure within which the responsibility to decide what is most comfortable and appropriate for each woman is available. These units could facilitate a supportive structure within which the woman can share the responsibilities of decision making with both her husband and the medical staff to the extent she feels most comfortable. This enables a focus of attention to be placed

on the woman's individual needs and thereby allows for an environment and atmosphere which encourages the maintenance of awareness and control.

RECOMMENDATIONS

In considering possible remedial steps to alleviate the problems outline in the discussion some recommendations will be briefly suggested.

The results emphasise the importance and implications of the preparation a woman chooses therefore it would seem of merit to engage in more appropriate and comprehensive ante-natal education. As was seen in the results there were two main areas in which the women seemed to experience a gap in their knowledge. These included the inadequate preparation for the physical reaction of the body during labour and insufficient preparation in the woman's knowledge on medical terms, procedures and medication. Without this opportunity to gather and process all necessary information the woman will not be able to feel empowered to make choices between alternate courses of action during the entire childbirth process. Through an accurate and adequate preparation process a woman can predict and fantasise how her child's birth will unfold. With this information she would be able to reduce uncertainty

in the new situation and this would lead to reduction in stress levels.

Bearing in mind the important role the doctor and medical staff played in the childbirth, the idea of a birth plan would be advisable. This individual framework or means of communication of the birth can be in the form of a letter or an interview with the doctor and/or medical staff or a personal commitment to oneself. This can indicate the way in which the woman wants to give birth, ensures that medical intervention, medication, delivery positions, choice and role of partner/husband and the immediate post-natal period can be specified and negotiated (Bannister 1987). This plan of action is an important way in which the woman and her partner can take or yield responsibility in order to manage the birth in a way that is appropriate and matched to their needs, in a way that they are comfortable with. It has been shown that a sense of responsibility and partnership is also more likely to develop if parents are able to structure and choose the plans for the birth of their child. (Prince 1978). This structure may prevent misunderstanding and needless trauma during childbirth (Claxton 1986). If through necessity the woman has to deviate from the prepared plan she will be in a position to choose the alternate course of action or give her informed consent. In being able to feel confident through her

knowledge or her confidence in the ability of others she and her partner can assume responsibility for the new course of the birth and remain aware and in control. In considering the various emotional responses of the women, the wide spectrum of emotions experienced suggests that childbirth is a personal and person-specific experience. Blum (1980) links this individual response of the physical and emotional experience of childbirth to the perceptions that a woman has of her self. This perception will influence her ability to perform as an active decision maker in the childbirth process.

The last recommendation would be a move towards encouraging the husband/partner being actively involved in every facet of the pregnancy, preparation, labour and post partum period. The ability of the couple to share in the responsibilities of the childbirth and parenting, provided a supportive structure. As was evident in the study the more involved the husband was able to be the more the couple were able to focus on the birth and the more satisfying the experience and the bonding proved to be.

LIMITATIONS AND FUTURE AREAS OF STUDY

The limitations and therefore possible future areas of study are linked to the selection of women in this study. The

specific group of women chosen were all white, from the middle income bracket who had recently had their first child in a local hospital, all attended by local general practitioners. They were all married at the time of the birth of their child and were between the ages of 20 and 35. Areas of future research could therefore examine the experience of birth with reference to issues of responsibility and control within different race groups, income groups and cultures. Of importance would be a comparative study of different birthing units for example the hospital, home birth option and alternate birth unit, examining the different experiences for the women, her partner and the bonding process. A possible step further would be a longitudinal study, assessing the long-term effects of the birth experience in the different birth places, for the women, her husband, the child and the family as a unit.

Bearing in mind that the women in the study were all married at the time of birth and between the ages of 20 and 35, it would be of interest to investigate the experience of the unmarried women, in terms of the absence of a supportive partner throughout pregnancy and the subsequent birth, and secondly the focus being placed on the older mother and the women who is having a child after the age of 35.

Lastly, the use of different methodologies to examine the issues in question, would possibly tap different and important dimensions of this childbirth experience.

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APPENDICES

THE INTERVIEWS

1. **DAWN** - 27 YEARS OLD

I fell pregnant two weeks after I stopped taking the Pill. I had hoped it would take at least three months,so I must say I felt emotionally unprepared and on a more practical level unorganised. I felt really negative about being pregnant, for at least the first three months and had no maternal feelings towards my unborn baby. I think all these feelings could have been due to the nausea, I felt as though I had cancer! I had a good relationship with my doctor, he is a very kind and understanding man. I saw him initially once a month progressing on to a twice a month and towards the end of the pregnancy three times a week. I attended ante-natal classes as I wanted to try to have my baby naturally <u>if I was allowed</u>.

I started labour at two o'clock, I felt quite nervous panicky and relieved, at last! When I arrived at the hospital it was nearing three o'clock, I was given all those yeuky things, you know, shaved, given an enema, an internal examination, I really get quite embarrassed at those kind of things. When my

water broke I was really shocked at the amount of liquid which literally poured all over the floor. I then bathed, which eased the pain, my husband constantly massaging my back which was wonderful I just couldn't manage the pain that seemed to be getting worse and worse. No one told me just how strong the contractions could be, I tried some of those breathing techniques, but it just made things so very much worse. I was then given a Pethidine injection by a nurse to ease the pain. It took away most of the pain, but made me extremely drowsy, I was therefore unable to walk around any more. Time seemed to be merging and all I can really say to explain it to you as I went gagga! I was then offered gas, which numbed all the remaining pain, I just wanted to curl up in a ball and sleep - I'm always such a coward though! I enjoyed using the gas as it gave me something to do. I wanted to squat while giving birth but at the time I was just too tired. I had an episiotomy, as I had always heard it was much better, while that was being done I remember worrying if it would be a boy or a girl. The hospital staff were all very nice and pleasant to me, they seemed unhurried and completely calm at all times.

When the baby was actually born, all I could think of was how much blood there was, and what a mess it all was. I did not hold the baby straight away, but my husband did which I was glad about. When I was given my baby, he seemed quite apa-

thetic and tired. They then took him away to clean him up and left me to sleep, thank-God! I am very glad and proud that I didn't fall apart during labour, I was awfully scared of losing control in front of everyone in the labour room. I've never really been at home in my body and I was quite astonished that my body took over in the labour situation. I feel quite positive about the whole event, although I keep on remembering just how jolly sore and confusing it felt. I'm really glad I gave birth in a hospital, as I would be really terrified at the thought of being alone without the expertise and support the hospital and staff gave me.

It was really reassuring and helpful having my husband at my side, especially before the injection, after which I sort of just "felt" his presence. I would never have another baby without him being thee as a support system. It brought us a lot closer together, and of course, toward our new baby!

2. **ELLA** - 23 YEARS OLD

My initial reaction to the pregnancy test was one of delight and enthusiasm, aside from the morning-sickness I had few other side effects. My fear actually arose out of a dislike

of the stereotypical roles that mothers seem to fall into - I really was warned that those around me would slot me into a category.

A wonderful thing kept on happening to me night after night, these almost life-like dreams of my baby. It was as though, we were already building up a relationship, a bond. Oh yes!, what was also quite strange, was just how long it took to tell my parents about my pregnancy, it was as though I didn't want to stop being a "baby" myself.

The doctor I chose, must have been the sweetest, most gentle man, he treated me as the most important person in the whole situation. What did I want? How did I feel? He answered my questions thoroughly, leaving me reassured and informed, he was not in the least condescending. I was unsure about what kind of delivery I wanted. My mother told me that her time in labour wasn't too bad, so I wasn't too scared. I was therefore quite confident, that I would be able to cope with any type of labour, with or without medication given to me.

Ante-natal classes were a bit of a drag, but were quite informative, thank-God there wasn't too much emphasis placed on exercises - hate exercise. I did feel slightly bored at the time spent in these classes, as I was sure I would know what

to do when the time came. 26

On the due date, sure as clockwork, my contractions began, I 27
was already feeling exhausted, as I had spent the whole morn- 28
ing vacuuming the house. Anyway I phoned the doctor, who said 29
I should go straight to Settlers. When I arrived, I was 30
examined by a sister, who then left me and my husband alone. 31
I was worried that my doctor would not arrive and I knew I 32
would die if I had to have another (doctor). My husband 33
and I played cards and talked. We "breathed" a little and 34
otherwise just waited. The doctor arrived, and explained that 35
I still had a long way to go. Hell that was't very promis- 36
ing! 37

I must tell you though, I never, never expected it to be so 38
very painful. Which was a shock as I expected the natural 39
breathing methods to do their thing. During that time I came 40
to the realization that all one could do would be to control 41
the pain, but not take it away. I remember feeling quite 42
cheated and disillusioned because no one, not even my mom, had 43
really made it explicit, I mean just how painful it really 44
gets. Nurses seemed to examine me and make inane comments 45
like, "Oh well, not moving very fast." As the contractions 46
got worse, I asked if I could now have a pain-killer, the 47
nurse gave me an epidural, thank-goodness because the pain was 48

unbearable. After a couple of minutes, strange things started happening. It's quite difficult to really explain - I seemed to loose control over things, the baby was pressing down and they kept on saying "it's no pain, it's just pressure." It was at this point that I couldn't scream but my body was making all these crazy motions. The anaesthetic really took effect and I seemed to slump into an exhausted stupor. For the last hour it was strange, I couldn't tell whether I was asleep or awake. It was like watching slides, a mixture of unreality and reality - I felt so very passive, everything was so unreal!

Eventually my son was delivered. I felt so overwhelmed and excited, it was incredible. I started to cry, it was a miracle. I kept on wondering if I was dreaming, or it was actually happening. My husband told me later I kept on asking "it it real?"

My relationship with my baby was slow to begin, as I only saw my baby about twenty-four hours after the actual birth. My recovery was long and painful. The healing of the episiotomy was slow and agonising. This seemed to really colour my stay in the hospital, which otherwise would have been a pleasant one. Although I do feel loving, caring and maternal - whatever that is supposed to mean - towards my baby, it took many

weeks until I treated him as my baby, and not a baby that needed looking after.

3. **LYDIA** - 25 YEARS OLD

I want to start of by saying how angry I am about the whole experience of pregnancy, labour and the post-partum period, so very angry! Even though Grahamstown is a very supportive place I still have not been able to work through my feelings. I miscarried in my first pregnancy, and threatened miscarriage three times during this pregnancy which is really sad, because it was the most looked forward to baby! I have never been ill a day in my life. In fact I have only ever been to a doctor when I was very young, so it was a new and alien experience for me, (seeing a doctor). This specific doctor had been know to my family for a long time, so it seemed the natural choice. We got along fairly well, until about the eighth month, when he said I should have a caesarean because I had such a small frame. I felt ok about the decision, but now after reading up about caesareans I realise what a uniformed decision he made. I was reassured however that my doctor would be there on the day!

Ante-natal classes really frightened me, I really don't think

they should emphasise the pain. I have quite romantic ideas of pregnancy and childbirth. I suppose in general you could say I am a romantic, I hate hearing the bad of things. When my labour pains began I, with great excitement and anticipation, called Dave who drove us to hospital. When arriving at Settlers, I was shaved and given an enema. Thereafter, feeling shorn and very vulnerable, I was taken to a hospital room. I was induced at about six o'clock, and as I was still really keen on having a natural birth, you know it must be the worst possible way to come into this world (referring to a caesarean), another doctor was called in to give a second opinion. The second doctor agreed that it would be possible to try and attempt a natural birth.

My husband and I had attended ante-natal classes together, so I really was excited to be working as a team. Well, what a shock I had when they sent him home <u>to rest</u>. Neither of us said anything, so he left. Well, being induced just freaked me out, being tied down (referring to the drip and the prone position) makes one feel trapped and out of control. I was put in a private room. The doctor came to see me, and the bastard explained nothing and was as cold as a fish! Damn it! I just did what I was told. My contractions were thirty seconds apart, and that is how they remained. I pressed the emergency button, but no one responded, I then called until

someone came. I pleaded with them to call for my husband. That is the singlemost thing that upset me. I was panicking for sic hours and still they did not call him. I was examined, and simply told "sorry dearie not dilating at all, by the looks of things." After another three hours I had had enough. I lay on the buzzer for fifteen minutes until eventually a nurse arrived. I demanded they call my husband. The nurse agreed only to call the doctor. When the doctor arrived, he said "Yup, just as I thought, caesarean!" At this stage I was so distraught I ripped the drip out my arm and staggered to the phone. I was stopped and put back in bed, but my husband was eventually called.

Next thin I knew a catheter was shoved in which hurt like hell and, before I knew it, someone was asking me to count sheep! When I awoke, my body ached, but I was immediately given morphine which really helped. The following day my internal stitches burst open, so I was back in the operating room. I had severe problems bonding with my child. I, in fact, didn't want to hold him for three weeks. I attribute his being a "problem child" to the traumatic way he was introduced into this world, and my feelings surrounding our first days together. I really wanted to breastfeed my baby, as I feel it is an important part of the whole bonding procedure. However, due to the stitches from the caesarean this was

impossible. I felt really disillusioned by everyone, everything around me and slumped into a depression that was plagued with feelings of anger, disappointment and inadequacy, what more can I say.

4. **HEATHER** - 25 YEARS OLD

I was exuberant, overjoyed, exhilarated and awed at the thought of being pregnant - a new life inside of me! I was a healthy pregnant lady, except for the constant fatigue which overwhelmed me. I am a former nursing sister, so I've had a wide experience with the medical profession. It was therefore important to me to make an informed decision with regards to every aspect of my pregnancy. I planned to have a natural birth, as I believe that any medical anaesthesia is potentially dangerous. I wanted to be wide awake, to participate actively in the birth of my child. I choose a doctor whose work I respected at the hospital. I was generally happy with our relationship, although the visits tended to be brief and routine. My husband and I attended ante-natal classes together, and we spent all our spare time practising and reading up on current methods of childbirth. A week before I was due to

give birth, the doctor found the baby to be in a breech position and this possible complication created considerable stress and doubt for me. I felt really moody an d on edge from then until the actual day of delivery. On the day before my due date, I started to bleed, and was admitted to hospital. The evening was uneventful until, just after midnight, I felt the first labour contraction. I was then drained of all fear and was replaced with energy and excitement.

Throughout the labour my husband and I worked at all the techniques we had practised. We improvised, made up a few of our own, and generally worked together like an amazingly synchronised team. We worked hard all night; my husband was an absolute angel, he rubbed my feet, my neck, my knees and anywhere else that even twinged and tried to ache! We didn't talk much at all, we didn't need to, just being thee for each other was enough! I was in control form start to finish, and withstood all pressures to take some sort of pain-killer. I really felt entirely and totally self-sufficient. I knew, I don't know how, but I knew exactly what to do. My doctor was unimportant in this entire event. I though his presence would be important, but, in fact, his examinations were more of an irritation. They made me loose concentration, and, besides, I could feel it was ok.

When our baby was actually born, I was only aware of my husband and the baby. Although there were many people around they all seemed insignificant, the doctor included. It was indeed a peak experience in both my life and my husband's. I was consumed with energy and a passion to bear down and deliver my baby. I wasn't tired or scared for one minute. When my baby actually appeared, I just burst into tears, I think my husband was crying too. We were both so incredibly happy, it was an indescribable feeling of real joy. We kissed each other and just cried and cried. We, thereafter, spent at least an hour examining our beautiful baby. From this moment onwards he never left my side while we were in the hospital. I recuperated quite quickly from the actual labour although the episiotomy stitches remained painful for quite some time. I took a very active role in caring for my baby, and nursed her an hour after giving birth, which was yet again so utterly, fulfilling like the whole birth experience!

5. **MAGGIE** - 29 YEARS OLD

I fell pregnant when I was quite ill with flu, so I must have overlooked all the symptoms indicative of pregnancy. Anyway by the time I eventually realised it, I was nearly tow and a

half months pregnant. I didn't have any morning sickness and, being very thin, seemed to slip through pregnancy, constantly reminding myself. I think its quite fun, because its like a present every time you are reminded of the baby inside.

The doctor I attended initially, emigrated, which upset me quit a lot because I felt unable to continue without him. The new guy was quite an authoritative stroppy chap who kept on giving me internals and scans at every available opportunity. "Just in case." He made me feel that I was delicate and extremely vulnerable to miscarriages etc. I myself felt most of this was completely unnecessary. Not only that, he would never really explain why he was going overboard. I eventually though he knew something terrible, I was really scared. Once he said he couldn't feel the baby's head. Well, it was weeks until I was entirely convinced I was not going to give birth to a "headless baby" - don't laugh - I really was very unstable and nervous.

The ante-natal classes were invaluable, I loved them; the support and reassurance that was given by both the teacher and the other women. I practised the breathing, even while shopping. It was really reassuring knowing something of what was to come. I learnt a lot about the technical side of birth, what was happening to the baby, etc.

When I went into labour, I was overjoyed and phoned everyone, staying at home until my waters broke. I then drove myself to Settlers and my husband arrived about an hour later. I think he was trying to stall as long as possible, he's really squeamish. I was examined, shaved, given an enema - not very pleasant - and sent to a private room. I was a bit nervous being alone, but as soon as he arrived, I felt a lot better. What happened next was really funny, my contractions just stopped. Yup, just stopped. I called in the nurse who called in the doctor. I was hooked up to a drip and induced, well it was simply horrific. From that moment onwards everything happened too fast, my contractions were suddenly too close together, altogether too painful and unbearable. I couldn't stand the pain, so I was given an epidural. I had so many tubes coming out of me, I felt all strung up like a chicken. I went numb after the epidural, but then I had even more to contend with: They wanted to use forceps - I horrified. So much for a natural birth.

I felt like I was having a bloody heart transplant! The doctor seemed to change into a monster - well not really but it was what he wanted that counted, not what I felt or wanted if you know what I mean. I was feeling really sad because I had realised I would not feel my baby slide out. I began to cry and cry - I think that really irritate the hospital

staff, they kept on asking if it was still painful and if not then why was I crying. The forceps really hurt when they were inserted. I really didn't prepare myself for the pain. I know I had an epidural, but it still hurt. Suddenly I was told I had a little girl, I can't remember where my husband was at this stage but I can't remember him being around at the time.

She looked alright, I mean everything was there. At that point I was so relieved, I just started crying again. I held her close the whole time they were stitching me up. It was terribly difficult to believe that she had come out of me. It felt strange, in fact I was quite shattered as I could only feel so much of what was happening. I wanted her to feed straight away, but I was feeling so sick and giddy I couldn't react to anything at that stage. They took her away, I was given another injection and fell into a deep sleep.

When I woke, it was really wonderful to feel again. I must admit, I was a bit nervous that I would be paralysed for ever. I had a headache and a pain in my back, but I was told that it was from the epidural and was normal. Between my legs was agony, when I made a wee I nearly leapt through the ceiling. I was a bit depressed, well, in fact, very weepy for about three weeks after the birth. To tell you the truth, I felt the

whole thing was a birth on an anti-climax and I wasn't really sure I wanted or knew how to be a mother after all. My mother stayed with us during that period, which was quite a relief. I found it difficult to feel love towards the baby, I wanted the love all to myself. All that has changed now though. I love my baby and am in fact a "natural" mother. The birth to me was too mechanised and controlled - I feel that I was just a spare part, an accessory, I mean as though they could have done without me. I was so sore for weeks after the birth, had headaches for months.

Afterwards my baby had bruises for weeks, along with a floppy disposition, an inability to feed or sleep properly - thank-God my mother was there. I wouldn't say it was a particularly satisfying experience, but worth it.

6. **DANA** - 22 YEARS OLD

I fell pregnant after stopping the Pill for nearly two years. I was worried I would not be able to conceive. So when I found out I was really relieved and excited. My doctor was really a sweetie. I just couldn't wait to get home to tell my husband as we were really eager to start a family. Being pregnant was alright, I thought I would really love it. but,

in fact, all the restrictions bugged me. I felt like and elephant and counted the days not until the baby was born, but until I could fit back into my clothes. My husband told me that I was still beautiful and extremely sexy, but I felt he was just saying it to make me feel better. So, to be quite honest, I relished the idea of having another baby, but only if I can skip the nine months and the labour day. I went to ante-natal classes. I found them entertaining. I loved seeing women who were in the same boat as me, talk, bitch and discuss possible names, nappy brands, indigestion and all those things no one else wants to spend any time talking about. Practically I understood and registered all that was said, but I had this strange feeling of "I'm special, and my labour will be different." Therefore wanting some other type of input, but considering I didn't really know what I wanted or where to get it, nothing was done. I don't mean to sound vain, but I didn't want what was being given digested and regurgitated by so many women day after day, month after month. By the time the labour day arrived, I was still unfulfilled in terms of choices available. It's only now, after the birth, would go for a home birth, or at least opt for a special unit at a hospital.

On the labour day I woke up at about five o'clock in the morning. I had an aching back and a runny tummy - so I put

two and two together and, well, I was really overjoyed. I 31
phoned everyone I knew, and. of course, the doctor whom my 32
husband had got to know quite well on a social level. I was 33
told to report at Settlers, which I then proceeded to do. I 34
had to keep on telling my husband to slow down, I think he had 35
seen too many movies. On arrival I was prepped and was left 36
alone with my husband. The doctor arrived shortly after, he 37
said it would take a while. We all had tea - really it was 38
bizarre - drinking tea on such an important day. As though 39
it's just another get-together. I walked a lot, and when the 40
contractions got really strong, I leaned against my husband
41
and he supported me. The togetherness was so special. I 42
refused medication, I actually knew that the only thing I 43
could really rely upon was him and myself, only I knew what 44
was needed. 45

There I go again sounding arrogant, sorry but that was one day 46
when I felt entirely self-sufficient. The pain, well, yes, it 47
got bad, but I knew each wave would ease, it could only go on 48
for so long. Well, I would recommend a good "back-rubber" at 49
any labour. My husband was a wonder, he seemed to ease the so 50
much tension and strain away. When it came near to the time 51
to push, I got really excited. Well at the ante-natal classes 52
they told me to push down from the top. What tripe, I tried 53

that, it was useless. So I just did what felt right and, yes it worked, there I go sounding arrogant again, but well, I'm proud I did it all myself! At this stage I saw the doctor walking over with the syringe, and I said: "hold it I'm doing just fine." He said that it was just for the episiotomy, and before I knew it, it was done. When I think back I get really pissed off about it. I didn't need to be cut. Not that it was painful, but you know they do it without even asking. If I had been give more time. I would have delivered without even a tear, I'm positive.

When I saw the head appear, I started laughing, she looked so curious, "what kind of world is this?" I placed her on my breast and she started nuzzling immediately. It was simply exhilarating, an absolute high, my husband was weeping on my shoulder. I then examined her, for, it must have been hours. Well, I was amazed this is a separate entity, an individual - well, my individual nonetheless. I can honestly say that giving birth to my baby was the most powerful peak experience in my life. I was so self-contained and able, yes able. I was able to make and bring this baby into the world without the help of anything that one is normally dependent on. I was changed as a person. I still feel strong and totally in control of my life. It was as though the birth experience taught me to tap hidden energies inside me.

7. **KEREN** - 27 YEARS OLD

I wasn't married when I fell pregnant. This wasn't a problem because we were engaged. I strongly believe that abortion is a sin, so I valued all life brought into the world. What was strange though was my hatred of pregnancy as such. I mean I was really glad to be pregnant but hated the feelings that went with it. I was nauseous all the time; I didn't realise that doctors could prescribe something. I thought any and all medication was taboo. In about my sixth month my doctor asked if I had any trouble with "morning sickness" - well what a relief when I could go through a day without feeling ill! I didn't relate very well to my doctor, although he was very casual. In fact he didn't do one internal examination throughout pregnancy. So I'm not really sure why we didn't hit it off. I enjoyed his overall attitude of "everything is fine and normal." I never insisted on scans or anything, as I had an innate feeling everything was ok. I took vitamin supplements all through pregnancy and besides the anit-nausea tablets that I mentioned earlier, I didn't take anything.

I didn't go to ante-natal classes, as I firstly didn't have time, and, secondly, I think it promotes a dependence on the

ante-natal teacher. I have heard stories of women telling the doctor "no, but my ante-natal teacher said this or that." I did, however, read up on different relaxation exercises. But it is difficult to put theory into practice without supervision. I found that, because I hadn't got the confidence, that is required during classes, I was far more manageable. In the sense that when any nurse or doctor told me to do this or that I did it immediately, without question, which made the whole situation far easier for all concerned.

I assumed that I would have a natural birth although on the actual day that I went into labour, I was just so excited, I didn't care how. I just wanted my baby. After so many months being confined, I just wanted it to be over. I started with mild contractions, and had a bath at home, before leaving for the hospital. I had butterflies. I think that not going to ante-natal classes puts you at a bit of a disadvantage because you actually had not been on the "hospital tour." When I arrived, the nurse examined me and prepared me. I was then sent to the labour ward. The bed was so soft, and the room was so small, I kept on getting the feeling the room was closing in and the bed was engulfing me. The doctor, after examining me, told me I was 4cm dilated, and said he would return later, nearly the time. I must say, I remember, during pregnancy, hoping he would be present all through labour. But

at the time, he was quite unimportant.

What happened next was really quite funny because, as he left, I started bearing down and the baby started to 'crown'. The nurse in charge of the labour ward was simply amazed because she couldn't believe the speed in which I had dilated. In fact, she said, that my labour was the shortest she had ever been present. You know I was in labour in total for only two hours. I must say that it was painful, but I didn't have much time to even consider all of it. I was quite confident about the sister's capabilities to give birth to my baby. So I was not at all scared. After all she has been present at so many births.

My husband was with me all the time. And, although I think he was bewildered by the whole scene, he was wonderful in that he held my hand and kept on telling me how brave I was and how much he loved me. His presence was invaluable and I would never have another baby without him experiencing the whole process with me. It was also really nice having someone you know, who is a translator between you and everyone else. And I wasn't exactly in a dignified position. The sister performed a quick episiotomy, which is really quite painful, especially the stitching up process. When the baby appeared, they whipped him away and gave him to the doctor, who had just

arrived, and the doctor suctioned all the stuff out of his mouth. I had used gas during labour, which had really eased the worst pain, but made me nauseous. So when the baby was born, I just wanted to sleep and sleep. The doctor tugged at my placenta as it was slow to come out, which caused hemorrhaging eventually. I was lying in a pool of blood. Injections were given, presumably to contract my uterus.
In summarising the whole event, I would say it was definitely fulfilling, but like the news of my pregnancy, really unexpected. I sort of didn't get a chance to catch my breath. Oh yes, I keep on remembering the room closing in on me, it was quite frightening. Otherwise I wish, I had been a bit more graceful and ladylike. Anyway the baby is worth all that. It took quite a while for me to love him. He was really ugly and shrivelled in the beginning. But now he really is mine and lovely.

8. **ANNE** - 28 YEARS OLD

After deciding the time was right to fell pregnant, I stopped using contraceptives, and fell pregnant almost immediately
The news of the pregnancy pleased me and my husband immensely

I asked my friends to recommend a doctor, and eventually decided upon a doctor whose attitude towards pregnancy coincided with my own. I believe that pregnancy should be viewed as a state of health, with tests being performed only when the need arises. Hearing that this particular doctor had an easy going and open approach, I felt happy to consult with him.

Apart from nausea, I found my pregnancy to be a time of contentment. The ante-natal classes I attended, played a large role in my positive attitude towards pregnancy and childbirth. My fear of pain, as possible caesarean, the hospital environment, were all discussed and met with empathy and understanding in the classes. The midwife told the class that if I remained in control, I would always have a choice about what would happen. I took no medication during my pregnancy, and, after my first ultrasonic scan, I vowed it would be my last. As, although exciting for "the audience", the baby was noticeably upset. Its movements became frantic and erratic. I hope that more research will be undertaken in the area of ultrasonic scan. Until such time I would not subject any future babies to it's possible dangers.

Although I was extremely anxious about "never" going into labour I was, in fact, a couple of days early when I started my first noticeable contractions. I had a hot bath after my waters broke

as I have been told by the ante-natal teacher, that it would speed up labour. I then phoned my mother, friend and doctor, excited to convey the news of the ensuing event. The day was finally there! After an embarrassing start on arrival at Settlers, I was "prepped" and examined internally by a nursing sister. I was then left with my husband. This privacy was really welcomed and we were able to walk and "breathe" together as we had been taught in the ante-natal classes. The doctor examined me once during the labour, otherwise we were left entirely alone, as the hospital was critically short staffed.

I feel grateful that my husband was present, especially during the "transition", when I was finding it difficult to continue "breathing" and remaining in control. My husband directed the "breathing" and relaxation exercises, this enabled me to regain control. When it was necessary for me to "bear down" or push, I became frustrated and felt inadequate and fearful. The doctor intervened and decided to make use of forceps. Apparently the normal procedure when forceps are used, is to anaesthetise the cervix. For some unknown reason this was not done when the forceps where inserted, I lost all control, the the pain just overwhelmed me, I just remember hearing screaming and realising it was me, it was so confusing!

I felt, and still feel, cheated and feel like Iv'e failed in having a successful labour. I had not finished it myself. If only he had reassured me and given me time and space, I am sure I could have managed. I feel so angry towards him (the doctor) for not telling me the pain involved in the use of forceps. It was even worse than the "transition" period of labour. I was given an episiotomy as a matter of course, as my doctor believed that a tear of the perineum is harder to to suture than an incision. That ok, but I do feel that it should have been discussed beforehand.

I can't exactly remember the moment when the baby was born, I was in too much pain, I think. Yes, he was given to me and the initial contact was extremely comforting and satisfying. Otherwise it was a bit of a blur, as I was given a large dose of pain killer which really knocked me out.

In summing up the labour, I must say, I enjoyed, yes I really I really enjoyed the initial stages of labour, I was the master I was the master of events. But it was a sad turn around of when the doctor stole all this and intervened. What I keep on asking was it really necessary? Another thing that really coloured the experience negatively was the pain I felt for months, which was caused by the episiotomy and bruising from from the use of forceps. I also felt angry with my husband

for letting them intervene, but I realise that at the time 74
we were both intimidated and so scared. 75