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## 'Not enough people to look after you': An exploration of women's experiences of childbirth in the Republic of Ireland

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### ABSTRACT

**Objective:** women's experiences of childbirth have far reaching implications for their health and that of their babies. This paper describes an exploration of women's experiences of childbirth in the Republic of Ireland.

**Design:** a qualitative descriptive study consisting of focus group interviews (FGIs) identified important aspects of women's childbirth experiences.

**Setting:** four randomly selected maternity units in the Republic of Ireland. The pilot study unit was also included in the data collection.

**Participants:** a convenience sample of 25 women who volunteered to participate in five focus group interviews. Eligible participants were > 18 years, able to discuss their birth experiences in English, had experienced labour, and had a live healthy baby.

**Data collection:** approximately three months following the birth, data were collected using a conversational low moderator style focus group interviews.

**Findings:** three main themes were identified, 'getting started', 'getting there' and 'consequences'. Women experienced labour in a variety of contexts and with differing aspirations. Midwives played a pivotal role in enabling or disempowering positive experiences. Control was an important element of childbirth experiences. Women often felt alone and unsupported. The busyness of the hospital units precluded women centred care both in early labour and in the period following the birth. Some women would not have another baby due to their childbirth experiences.

**Key conclusions:** the context within which women give birth in the Republic of Ireland is important to their birth experiences. Although positive experiences were reported many women felt anxious and isolated. Busy environments added to women's fears and participants appeared to accept the lack of support as inevitable. Midwives play a pivotal role in helping women achieve a positive birth experience.

**Implications for practice:** excluding women's views from service evaluation renders an incomplete and somewhat distorted depiction of childbirth in Ireland. Although women appear to be satisfied with a live healthy baby, the process of 'getting there' has an emotional and psychological dimension that is important to the experience. Measuring the quality of maternity services must encompass recognition of psychological and emotional well-being alongside physical safety.

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### Introduction

The experiences of health-care system users should be fundamental to assessing quality of care and informing service planning (Berwick, 2002). In Ireland, as in other countries, the focus of the evaluation of maternity services has traditionally been through

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using mortality and morbidity data. Ireland, with birth numbers of 71,963 in 2007 (Economic and Social Research Institute, 2009), has one of the lowest maternal and perinatal mortality rates in the world (UNICEF, 2008) and is therefore considered to be one of the safest countries in which to give birth. The medical assessment of Irish maternity services as having the 'highest standard of care... and a worldwide reputation for excellence' (IOG, 2006: 1) is predicated on such evidence. From a midwifery perspective however, fixed clinical measures are inadequate to explain the complexity of human experiences, particularly childbirth. The emphasis on quantitative measures alone is such that women's

experiences can be marginalised (Walsh, 2007) and often ignored. Although satisfaction as an outcome of childbirth experience continues to be used, the methodological limitations and the complexity of measuring such a multidimensional concept is debated (van Teijlingen et al., 2003; Turris, 2005). Asking women about their childbirth experiences can also raise complex issues regarding the relationship with the researcher, the timing of the research and the juxtaposition of experiences of care and experiences of childbirth (Larkin et al., 2009).

An analysis of the experience of childbirth has identified the core concepts as: 'an individual life event, incorporating interrelated subjective psychological and physiological processes, which in turn are influenced by social, environmental, organisational and policy contexts' (Larkin et al., 2009: 49). Childbirth represents a physical and psychological challenge, a process from which women can derive profound feelings of empowerment and achievement (Lundgren, 2005), or, conversely, feelings of anger, guilt, violation and depression (Mozingo et al., 2002; Bailham and Joseph, 2003). In Ireland, the emotional and psychological consequences of labour and birth have received little attention. This is in the context of international recognition of the importance of identifying women's needs around the time of birth and the centrality of childbirth experiences to women's psychological health. (Simkin, 1991; Bailham and Joseph, 2003; Walsh, 2007). Women and health providers, especially in the maternity services, may have different views and interpretations of the meaning of 'success' (Graham and Oakley, 1981). Beck (2004) found such dissonance, leading her to deduce that the focus for clinicians is often solely related to clinical efficiency and a live healthy baby, to the exclusion of, and seemingly oblivious to, women's feelings about their experiences. Consequently, when 'safety' relates to physical elements only, other aspects of experiences such as psychological safety may be underestimated (Walsh, 2007). Although identified in international literature, in Ireland there are significant gaps in our knowledge as to whether or not maternity services are meeting women's needs and priorities in relation to childbirth experiences. In the absence of any substantial research on the subject, an exploration of women's experiences of childbirth was conducted.

## Methods

Page et al. (2006) stipulate a need to establish more complex indicators that encompass the reality of childbirth rather than simple physical 'events'. Oakley (1999), points out that phenomenological individual experiences are self-limiting, because the subjectivity of the researcher, as in all sciences, is a potential influence on the knowledge claims made. Yet, the ability to speak in the rhetoric of scientific inquiry is sometimes necessary to effect change in women's lives (Oakley, 1993; Patton, 2006) by augmenting the possibility of policy change. This study sought to provide evidence that could meaningfully engage the considerable literature on the experiences of childbirth in an international context and to contend with what Greene and Caracelli (2003) refer to as the intricacy of producing evidence that is positioned diplomatically so as to engage in debates whilst remaining impartial.

### Research design

This qualitative descriptive study used a series of focus group interviews (FGIs) to identify common areas of women's experiences. FGIs are 'group discussions exploring a specific set of issues' (Kitzinger and Barbour, 1999: 4), and are increasingly used in midwifery research (Parvin et al., 2004; Olsson et al., 2005; Ruppenthal et al., 2005; Hunter, 2006). The rationale for choosing FGIs is related to minimising and dissipating the hierarchical nature of research whilst maximising contextual meanings

(Wilkinson, 1999). FGIs potentially provide a unique access to norms and meanings of an increasingly privatised present day society, which is less open to observational methods (Bloor et al., 2001). Wilkinson (1999) suggests that 'consciousness raising' through sharing experiences is particularly advantageous enabling participants to realise commonalities and gain a sense of the social and political contexts through which experiences are construed. Although no discourse or method is inherently emancipatory, FGIs produce women's knowledge that is situated and localised through a synergy of debate and discussion (Montell, 1999; Wilkinson, 1999), and are therefore appropriate to the research design.

Common concerns about FGIs include producing information that lacks depth, over-emphasising group consensus, and silencing voices of dissent (Carey and Smith, 1994; Sim, 1998; Bloor et al., 2001). Group dynamics such as 'dominance' may occur (Henderson, 1995; Twinn, 1998) and hostility or suspicion between members can hamper discussion (Bloor et al., 2001). There may be a tendency towards 'polarisation' where participants express more extreme views than in private or may impart more information than intended (Morgan and Kruger, 1993). Judicious moderation can, however, minimise such possibilities.

### Recruitment

A stratified sampling technique was used to identify one hospital from each of the four groups according to the number of annual births (Table 1). Four maternity units were randomly selected from within those groups, comprised of the 20 maternity units in the Republic of Ireland. The sample was recruited from two city and two rural hospitals to obtain views from differing geographical and organisational contexts and differing levels of activity. The provision of services such as epidural pain relief, ability to perform caesarean section, and availability of medical personnel was similar in all units apart from high dependency neonatal care, which was only available in the city hospitals.

A convenience sample consisted of participants who fulfilled the following criteria:

- $\geq 18$  years old
- English speaking
- had experienced labour
- birth of a live baby
- willingness to participate

### Number of participants

There is little consensus about what is the most appropriate size for a successful focus group. Smaller groups are easier to manage (McLafferty, 2004) and fewer participants promote interaction (Carey and Smith, 1994). Focus groups should however be large enough to include enough participants to generate a range of views and provide a synergy of debate (Kitzinger and Barbour, 1999). Participants talking about a particular aspect of an issue can stimulate ideas in other group members engendering new and original perspectives (van Teijlingen and Pitchforth, 2006). Authors have worked with groups of five or six participants and as few as

**Table 1**  
Sampling frame for randomly selected units.

| Group A<br>n=3                   | Group B<br>n=6                      | Group C<br>n=4                       | Group D<br>n=7                   |
|----------------------------------|-------------------------------------|--------------------------------------|----------------------------------|
| City population<br>> 6000 births | City population<br>3000–6000 births | Rural population<br>1500–3000 births | Rural population<br>< 1500births |

three (Twinn, 1998; Kitzinger and Barbour, 1999; Lane et al., 2001). A pilot study was conducted to assess recruitment strategies, sample size, and collect preliminary data (Polit and Beck 2004). Van Teijlingen et al. (2001) suggest that pilot study information may be of value, the rich data that arose from this pilot were therefore incorporated into the main study findings.

#### Number of focus groups

The number of focus groups reflects the research plan, its purpose, variability of responses and the influence of time and money (Bloor et al., 2001), but three to five groups are suggested (Morgan, 1997). In this study, although individual experiences are unique there was a consensus on the range of topics in relation to experiences of childbirth that were important to women across all five groups.

#### Participants

Women were recruited from the postnatal wards by clinical staff prior to their discharge. An information leaflet was given to women who met the eligibility criteria explaining the purpose of the study. Postal details were requested to invite participants to the FGIs approximately three months later. Many participants volunteered their mobile phone numbers as a means of contacting them. A voucher for €40 was offered to women as an acknowledgement of their time, and to cover travel expenses. Women were encouraged to bring their babies if they so wished. Two weeks prior to the FGIs a letter was sent to each potential participant reiterating the invitation enclosing the date time and venue of the proposed FGI. Participants were requested to respond by text or by telephone within a week so that the venue could be prepared and refreshments ordered. The number of women invited to take part and the number that attended are identified in Table 2.

#### Group process

The group process included the on-going process of consent, debriefing, and access to relevant personnel if participants became upset or identified issues of concern. The FGIs were held within or close to each hospital as the location was known and relatively convenient to most participants. The numbers of participants ranged from three to seven (Table 2). All FGIs lasted approximately one hour. Although women did not know one another prior to the FGI, conversation flowed easily in all groups. Larger groups gave women less time to have their 'birth story' heard. Five participants appeared to be the optimum number. If babies cried, participants fed them or stood and rocked the babies whilst participating in the group. Women pointed to their babies when they recounted various aspects of their labours and this contributed to the discussion.

A semi-structured interview guide focussing on women's childbirth experiences was used and a conversational approach and a

**Table 2**  
Number of mothers and babies in each focus group.

| Unit                        | No. of mothers invited | No. of mothers attended | No. of Babies |
|-----------------------------|------------------------|-------------------------|---------------|
| Rural hospital <sup>a</sup> | 12                     | 5                       | 3             |
| Rural hospital              | 12                     | 6                       | 3             |
| Rural hospital              | 17                     | 3                       | 2             |
| City hospital               | 19                     | 4                       | 4             |
| City hospital               | 13                     | 7                       | 2             |

<sup>a</sup> Pilot study.

low intervention moderating style (Millward, 1995) was used. Everyone had an opportunity to relate their experiences of childbirth. The opening question asked women about their baby's names and ages. Participants who did not bring their babies had photographs on their mobile phone, which they showed to the rest of the group. Following introductions, an open question, 'tell me about your childbirth experiences', was followed as appropriate by probes and prompts. At the end of each FGI, the main issues that women identified as being important to their childbirth experiences were summarised.

Most participants were married, Irish, were between the ages of 30–39, and had higher education qualifications (Table 3). Women had given birth 10–18 weeks prior to the interview. The percentage of participants who were married (92%) was higher than the national average of 66.9% (CSO, 2010). Most participants (80%) described themselves as Irish nationals, which is similar to the national average of 81.1% (CSO, 2010). Participants were slightly above the national average age of mothers at 31.1 years (CSO, 2010). The FGIs sought to explore childbirth experiences therefore groups were not stratified in terms of parity, socio-economic or other variables.

#### Rigour

Rigour of the study was established through a process of trustworthiness (Koch, 1994), which is based on care and accountability, open communication throughout the inquiry, and ethical conduct. FGIs were conducted whilst scrupulously upholding ethical principles of privacy, confidentiality, rigour, and fidelity. Fittingness or applicability was demonstrated by asking participants to read and verify or critique the researcher's interpretation of the interviews and the emergent themes. Credibility was demonstrated by 'blind' inter-rater reliability by one author (C.B.), who coded three transcripts and independently identified similar categories and themes to the first author (P.L.). Auditability was established using the raw data, field notes, and a reflective diary documenting decision-making leading to the analysis and findings. The field notes and reflective diary also considered personal reflections on the process and conduct of each FGI.

#### Analytical approach

Analysis strategies for FGIs are adapted from a broad spectrum of qualitative data analysis methods (Wilkinson et al., 2004). This

**Table 3**  
Characteristics of participants ( $n=25$ ).

|                               |    |
|-------------------------------|----|
| <b>Age group</b>              |    |
| 20–29                         | 10 |
| 30–39                         | 15 |
| <b>Ethnic groups</b>          |    |
| Irish                         | 20 |
| Asian                         | 1  |
| White North American          | 3  |
| Eastern European              | 1  |
| <b>Parity</b>                 |    |
| First labour                  | 9  |
| More than one labour          | 16 |
| <b>Education</b>              |    |
| Higher education (university) | 16 |
| School education (secondary)  | 9  |
| <b>Marital status</b>         |    |
| Married                       | 23 |
| Partner                       | 2  |
| <b>Rural/city</b>             |    |
| Rural                         | 14 |
| City                          | 11 |

study used thematic analysis within a structured framework (Colaizzi, 1978).

*Analytical process*

All FGIs were transcribed verbatim, including words and emotions, as soon after the interviews as possible (Morrison-Beedy et al., 2001). This helped to retain contextual meaning. The transcripts were read and reread. Significant statements were identified and numbered, followed by clustering of emergent categories and sub-categories from the data and the formulation of themes. Participants were identified numerically and interactions between participants were included in the analysis. Similar sub-categories and themes were identified across all groups. Participants were contacted to ascertain that they agreed with the themes and categories and to make any additional comments. The approach, although presented in a linear form, was one of interface between an iterative and a reflexive process that ensured that the themes were developed from the original source. Analysis categories from each FGI were noted. Because no significant group differences were noted, all the sub-categories were grouped together and treated as a single data set from which the themes were derived.

**Findings**

The main themes were ‘getting started,’ ‘getting there’ and ‘the consequences of the experience’. Due to word limitations, the sub-categories of ‘perceptions of reality,’ ‘memory,’ and ‘effect on future pregnancy’ are omitted (Table 4).

*Theme 1: Getting started*

This theme referred to women’s experiences of being in early labour prior to and during admission to hospital. The sub-categories related to this theme consisted of ‘expectations for labour’ and ‘the twilight zone’.

*Expectations for labour*

Women expressed powerful emotions and feelings as they recounted a variety of experiences. In general, women’s expectations of becoming established in labour were described by women themselves as being unrealistic and were considered naive in retrospect. A discussion in one of the FGIs recounted a participant’s bewilderment following two visits to the hospital, thinking she was in labour, and being sent home on each occasion until labour was ‘established’. One participant who had experienced a previous spontaneous onset of labour had been induced in this pregnancy and was shocked at how unprepared she was:

...well, it didn’t (meet expectations) ‘cos I was two weeks overdue and I didn’t expect that ...was a big shock (FG8.1).

...it is all this expectation that it is going to happen on your due date and then you think, ok ... you are going into hospital for an induction. Nothing happens straight away either, *that* was very upsetting, you know, that was the only thing (FG8.1).

Other participants in the group recounted similar unanticipated experiences that did not meet their expectations:

...yes, you have a certain plan in your head about how it is going to go ... (FG8.3).

Part of the advantages of the FGIs is the potential for the individual experience to be collective, the ‘me too’ element of interaction (Montell, 1999). Women shared stories about a spectrum of experiences, identifying similarities in their feelings of bewilderment when childbirth did not progress according to plan.

In all the FGIs, participants felt that their expectations had not been realised. The uncertainty and feelings of vulnerability and loneliness that many participants expressed at the onset of labour were characterised as ‘the twilight zone’.

*The twilight zone*

Some women in the FGIs were confused as to whether they were actually in labour or not and sought advice from the hospital:

I rang the hospital to say would I come in or what and they said stay at home as long as possible you will only be waiting around (‘yeah’ from others). They (contractions) weren’t regular, like, so I thought they might ...not be the real thing, like (FG7.3).

Many participants felt lonely and unsupported at this time in the ‘twilight zone’ between ‘being in labour’ and ‘not in labour’. Professional uncertainty about the diagnosis of labour has affinities with women’s feelings of doubts as to whether or not labour had actually started or whether to attempt admission to hospital or not. A clear-cut distinction between women being in labour and admitted to hospital, or sent home (Cheyne et al., 2006) is required by many institutions. This distinction caused apprehension for participants in the study and their expectations of this phase of labour were sometimes described by participants as naive and unrealistic.

Women who felt they were in labour often experienced delays before they were assessed in relation to their labour ‘status’. One participant described with disbelief how she waited for two hours prior to admission sitting in a public corridor, in pain and unable to move. Other participants in the group were not surprised and were matter of fact about this type of delay:

Yeah, you have to wait your turn ... (FG6.5).

Another participant recounted her admission to the labour ward and her disappointment when, due to pressure on bed availability, she was sent back to the antenatal ward:

...I was 2 cms and they brought me up to delivery suite and I was still the same and they put me back out... (rolls her eyes). (chorus of ‘oh no!’) (FG6.5).

...somebody else needed the room obviously (FG6.6).

Again, this seemed to be accepted by women as the ‘norm’ and participants were unsurprised as pressure on beds seemed to be accepted. Participants in all groups often found becoming established in labour a time of uncertainty and loneliness when partners were not allowed to stay with them.

*Theme 2: Getting there*

The second theme describes women’s experience of the process of labour and their feelings once they were established in labour.

*Anxiety*

Women experienced a variety of simultaneous emotions both positive and negative during labour. Many women in the postnatal

**Table 4**  
Main themes and categories from FGIs.

| Getting started   | Getting there          | Consequences               |
|-------------------|------------------------|----------------------------|
| Expectations      | Anxiety/uncertainty    | Memory                     |
| The twilight zone | Perceptions of reality | Isolation                  |
|                   | The control continuum  | Effect on future pregnancy |

FGI expressed anxieties about specific interventions. Some anxieties were related to procedures during labour although others related to more general concerns such as the clinical environment. In the primigravid groups, a particular concern in relation to episiotomies was expressed by one participant who had undergone an episiotomy for an instrumental birth:

It was my worst nightmare when I was about four months pregnant, I said to her (consultant) 'I have horrors about an episiotomy' (whispers) and she said (brightly) 'we'll try and avoid it' (laughter from others) (FG6.6).

In another FGI, participants expressed anxiety about the uncertain length of labour and their vulnerability to interventions and hoped that the labour would progress quickly to minimise the likelihood of such interventions:

...luckily, it was quick but if it wasn't quick that I was going to be forced into having something that I didn't want.... I had this fear all the time (FG9.1).

Participants in the FGIs felt that their anxiety was heightened by the physical environment in the labour ward, particularly when they could hear others in labour.

...when I came in I could hear a woman roaring as well and I said: 'I don't want to hear it, shut the door' (FG9.1).

Many of the participants commented on the loudness of the noise from other women in labour. Participants in three FGIs found that the physical environment increased their feelings of anxiety, particularly if they had experienced a different environment in another hospital:

Gawd, what is happening here...in the room it was like a veterinary surgeon like they had that silver thing for washing your hands (FG10.3)

The midwifery system is so different, it is like a hotel you just feel really relaxed, a homely environment and you could go and ask midwives anything..... it was such a huge change, you know (FG10.4).

A number of participants in the FGIs who had experienced maternity services in other countries thought the environment felt threatening and non-welcoming:

The building itself, you know, it is so claustrophobic and give me a weird feeling, emotions of this kind of, almost a.....feeling of foreboding about the building (FG9.2).

Well, I don't agree (FG9.4)

This member of the FGI defended the hospital and said that staff were doing the best they could. Other members of the group did not agree either but the participant reiterated her point:

The care services were fantastic.....listen.... I would not knock a nurse, any midwife, any doctor, *no one*..... but it is *extremely unsettling* to come into the room with the paint coming off the ceiling (FG9.2).

#### *The control continuum*

Women identified a feeling of control as being important to their experience and this aspect permeated the gamut of the experience. Rather than impose any particular meaning on the concept of control, which has been widely debated in the literature, the intention is to report what women said in relation to their perceptions of control. There were many areas of overlap where women's perception of control was related to other issues such as choice and relationship with professionals. Women felt that being out of control

was 'scary' but for individual women the issue of control encompassed a range of contexts or sub-categories, two of which are discussed here: 'information' and 'relationships with professionals'.

#### *Control and information*

Women felt that if they received information during the course of labour it helped them to feel in control: those who were 'left in the dark' felt that information was being withheld for no particular reason. One participant, who had been moved from a midwifery model of care to a consultant-led model due to having meconium-stained liquor, found that the information-giving in the hospital left a lot to be desired as she was not quite sure what the significance of the meconium was for her baby:

I was worried that he (baby) would be poisoned and the woman at the machine didn't tell me ..... I wanted to know that he was ok it was just on my mind *all the time*, you know (FG10.4).

Some members of the group were annoyed by this situation and felt that they should have received better information:

...you shouldn't *have to ask*....what you are saying and your experience or your reaction should be triggering the person caring for you to offer..... whatever ....or advice (FG10.3).

This interaction is one of the few that directly addressed what women felt 'should have been done'. Participants were annoyed that information had been withheld and at how distressed the participant was. Women in the most part, however, believed that what was done had to be done and that it was in their best interest. As with van Teijlingen et al. (2003), women were reluctant to criticise caregivers and did not aspire to different models or aspects of care that were outside their experience.

#### *Control and relationship with professionals*

This category was discussed explicitly and implicitly across all groups. Feeling in control was related to women's relationships with professionals who could enhance or detract from their experiences. Participants referred particularly to midwives and student midwives. Advocacy by midwives was encountered by some:

and there was another midwife who came to the delivery suite she didn't know me but she ...told the doctors *to back off* and let me have another push and it only took me about three or four pushes to actually get him out.... it made such a difference (FG6.3).

Another participant described her relationship with the midwife whom she described as 'old school' and her struggle to maintain her mobility despite the midwife's wishes:

but no.... the midwife insisted that I should have the drip and I was not happy at all because this meant that I would not be able to move around and I just sat on the side of the bed and *she* wanted me to stay *in* the bed (FG9.1) (murmurs from others).

Although continuity of care was not explicitly mentioned, for some participants the fear of intervention and a midwife who appeared to use a continuously medicalised approach detracted from their experience:

.... I had this threat hanging over my head that if things didn't progress quite quickly I would have the hormone so that really annoyed me .... but it's just this being....rigged up again... I didn't want that, I did not see the need for it and I tried to argue... but they were not having it (FG9.1).

The third theme that emerged related to women's descriptions of the consequences of their experiences.

### Theme 3: Consequences

This theme referred to the feelings and consequences of labour experiences for women. Although women did not remember many of the details of the physical experiences, the emotional feelings were remembered, and women believed that these memories would affect future pregnancies. The sub category 'isolation' is described.

#### *Isolation: 'there are just not enough people to look after you'*

Participants discussed their feelings after the labour and birth and the rationale for their being left in situations where they felt vulnerable. Women were reluctant to blame individuals and actually empathised with staff. It was the organisation or 'the system' that they were critical of. There were affinities between women's feelings in early labour and those immediately after the birth when the excitement of the labour and childbirth was over and they were again left feeling isolated and alone:

...they were like, 'your husband will have to go home' I was like ... 'you are kidding me' (incredulous) 'I just had a baby and I can't feel anything' ... (gasps from others) (FG6.1).

The lack of time for staff to attend to them was a feature of all groups in all areas. Two participants had experienced labour during quieter times and had what they called the 'luxury' of having a midwife with them at all times. Shortcomings in care were attributed to lack of staff by most women. Women who had experienced care in other countries were more critical, indicating that the shortage of staff in Ireland was unacceptable. Consequences of women's experiences meant some women would eschew further pregnancies:

It made me think about you know....having another... (FG6.5).

...well I *never* would' ....(FG16.6) (laughs from the others).

### Discussion

This study presented a synopsis version of women's experiences of childbirth. Themes are presented in a linear fashion however they were often interwoven, interrelated processes. Participants availed of maternity services within diverse organisational and geographical contexts in the Republic of Ireland. The findings are limited to a sample of women within which most participants were married and well educated, with little ethnic diversity. Qualitative researchers do not purport to produce generalisable data but should produce explanations that are not purely idiosyncratic rather have a wider resonance beyond the immediate context of the study (Mason, 2002). The study presented provides an important 'snapshot' of childbirth experiences that have been previously unexplored in an Irish context and by adhering to the principles of rigour as described can be compared with examples of similar studies carried out in other contexts.

Although some women were empowered by their childbirth experiences, others said they felt anxious, lonely and unsupported prior to the professional judgement that they were in labour. Participants did not establish relationships with professionals until they were officially 'in labour,' when the tenor of their care changed. Isolation was also a feature of women's experience following the birth when they felt alone and unsupported. Similar findings emerged from a qualitative study of 19 first-time mothers in Australia, which found that they benefited from preparation, communication and support (Dahlen et al., 2010).

Some FGI participants who had expressed 'explicit expectations' were disappointed and participants felt they had aimed 'too high'.

Unlike Green et al. (1990) who found that having high expectations did not lead to feelings of failure, these women felt disappointed that their expectations had not been met, particularly in relation to interventions. A few women had negative childbirth experiences which affected them greatly, in common with many others across the world (Fenwick et al., 2005, Olde et al., 2006).

The interaction in the FGIs between women who had experienced maternity care in other contexts revealed that they had higher expectations of staff and maternity services. However, most women's experiences and expectations appeared to be shaped by and limited to what they knew, and what they believe to be possible, with limited aspirations beyond what is the 'norm'. Similar to van Teijlingen et al. (2003) women were inclined to say they preferred the care they had received. Most participants attributed shortcomings in attention to staff shortages and a busy unit in addition to organisational rules that did not allow partners to remain with them.

The constituents of 'good' childbirth relate to an unhurried atmosphere, a feeling of staff presence and having a 'fair share' of the caregiver's time (Melender 2002). For participants in this study, the physical environment, combined with the busyness of the unit, exacerbated their anxieties. The busyness of the hospitals and lack of attention were appraised as being 'part of the system' that everyone appeared helpless to address.

As with previous studies (Green et al, 1990; Gibbons and Thomson, 2001; Dahlen et al., 2010), women within the FGIs said control was an important issue for them. Withholding or giving information could contribute to an empowering or disempowering birth experience. Relationships with professionals had a pivotal influence on women's experiences of control, and women felt that you could be 'unlucky with your midwife'. Having a midwife as an advocate enabled women to achieve their desired experiences, whilst in other instances midwives could engender feelings of helplessness, similar to findings in other recent work (Gibbons and Thomson, 2001; Dahlen et al., 2010).

There was a reluctance to criticise professionals, and a sense that, to them, having a live healthy baby was the ultimate goal and the experience of the process was secondary. Women accepted mostly what was done and what happened to them and believing it was the best that could be offered (van Teijlingen et al., 2003). Women who had experienced other systems of maternity care spoke about the possibilities of other models; however, they were in a minority in the FGIs.

Although midwives in Ireland articulate midwifery philosophy, they encounter difficulties where the obstetric medicalised model prevails (Keating and Fleming, 2009). There was evidence that midwives could confront obstetricians and avoid interventions as demonstrated by the midwife who told the obstetrician to 'back off' facilitating the possibility of a physiological birth. Other midwives had, themselves, used a more medicalised approach of monitoring and surveillance. A medicalised model of care persists in Ireland although a substantial body of evidence has established that other models of care such as birth centres, and midwifery-led units, are at least 'as safe' in terms of mortality and morbidity with additional advantages of improving women's assessments of their experiences (Walsh, 2007; Begley et al., 2009). Government policies in the Republic of Ireland aspire to woman centred care (DOH, 1997; DOHC, 2001). However implementation is inconsistent. Just two midwifery led units exist in Ireland (Devane et al., 2007). These were not included in the study as they were not in place at the time the research commenced. The provision of maternity services continues to emphasise a model of care that prioritises mortality and physical morbidity to the exclusion of other factors. There is increasing centralisation of services to larger hospitals as a means of providing more 'effective' care emphasising the availability of 'specialist services such as neonatal and medical facilities'

(KPMG, 2008:69). This report advocates that social models of care including community based services should be instituted on the basis of contemporary evidence based practice (KPMG, 2008).

In the context of such changes there is little research in Ireland about what women want from their childbirth experiences, and what their concerns are, hence there are significant gaps in our knowledge to refute claims of the benefits of centralisation and institutionalisation. A recent study of priorities for midwifery research in Ireland found that women centred care was ranked highly as an important area for investigation (Butler et al., 2009). The challenge for midwives therefore, is to accumulate convincing evidence about what is likely to be effective care (Page et al., 2006).

## Conclusion

This study provides important data about women's experiences of childbirth that would otherwise be ignored or hidden amongst mortality, morbidity or satisfaction figures. The framework used in the process of facilitating and analysing the data sought to make women's voices heard. The study demonstrated that women's feelings about their childbirth experiences were diverse but that childbirth was a powerful event about which women expressed strong emotions. The consequences of their experiences could mean empowerment or such disappointment that women would reconsider having another baby. The synergy of the FGIs enabled women to see different possibilities in relation to the potential for their experiences. Communication and information-giving to women needs to be addressed, and more support given, particularly in the latent and early stages of labour. The deficiencies of care caused by shortages of staff and the busy medicalised hospital culture in Ireland are intolerable and require urgent improvement. It is no longer acceptable for Ireland's success in mortality figures based on quantitative measures to short-change women of emotional care. Until women's childbirth experiences are recognised as a vital component of that evidence, services will continue to be 'measured' with an incomplete picture that legitimises and perpetuates their exclusion. Perhaps offering different models of care will go some way towards addressing these issues. Most importantly midwives need to be aware of the possible consequences of the increasingly medicalised structure and culture of the maternity services for women's childbirth wishes and aspirations. More research is required to further explore women's, needs and priorities regarding their birth experiences

## Conflict of interest statement

The authors have no conflict of interest that could bias this work.

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## References

- Bailham, D., Joseph, S., 2003. Post-traumatic stress following childbirth: a review of the emerging literature and directions for research and practice. *Psychology, Health and Medicine* 8, 159–168.
- Beck, C.T., 2004. Birth trauma: in the eye of the beholder. *Nursing Research* 53, 28–35.
- Begley, C.M., Devane, D., Clarke, M., 2009. *An evaluation of midwifery led care in the HSE North Eastern Area*. The report of the MidU study, Trinity College, Dublin < [http://www.hse.ie/eng/services/news/2009\\_Archive/dec09/MidUstudy](http://www.hse.ie/eng/services/news/2009_Archive/dec09/MidUstudy) > (accessed January 2010).
- Berwick, D.M., 2002. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs* 21, 80–90.
- Butler, M.M., Meehan, T.C., Kemple, M., Drennan, J., Treacy, M., Johnson, M., 2009. Identifying research priorities for midwifery in Ireland. *Midwifery* 25, 576–587.
- Bloor, M., Frankland, J., Thomas, M., Robson, K., 2001. *Focus Groups in Social Research*. Sage, London.
- Carey, M., Smith, M., 1994. Capturing the group effect in focus groups: a special concern in analysis. *Qualitative Health Research* 4, 123–127.
- Central Statistics office, 2010. < [http://www.cso.ie/releasespublications/documents/vitalstats/2007/chapter2\\_2007.pdf](http://www.cso.ie/releasespublications/documents/vitalstats/2007/chapter2_2007.pdf) > (accessed September 21, 2010).
- Cheyne, H., Dowding, D.W., Hundley, V., 2006. Making the diagnosis of labour: midwives' diagnostic judgement and management decisions. *Journal of Advanced Nursing* 53, 625–635.
- Colaizzi, P.F., 1978. Psychological research as the phenomenologist views it. In: Valle, R.S., King, M. (Eds.), *Existential-phenomenological alternatives for psychology*. Oxford University Press, New York, pp. 48–71.
- Dahlen, H.G., Barclay, L.M., Homer, C.S.E., 2010. The novice birthing: theorising first-time mothers' experiences of birth at home and in hospital in Australia. *Midwifery* 26, 53–63.
- Department of Health, 1997. *Report of the Maternity and Infant Care Scheme Review Group*. Department of Health, Dublin.
- Department of Health and Children, 2001. *Quality and Fairness: A Health System for You*. Government Publications Stationery Office, Dublin.
- Devane, D., Murphy-Lawless, J., Begley, C.M., 2007. Childbirth policies and practices in Ireland and the journey towards midwifery-led care. *Midwifery* 23, 92–101.
- Economic and Social Research Institute, 2009. *Perinatal Statistics Report 2007*. Economic and Social Research Institute, Dublin.
- Fenwick, J., Hauck, Y., Downie, J., Butt, J., 2005. The childbirth expectations of a self-selected cohort of Western Australian women. *Midwifery* 21, 23–35.
- Gibbons, J., Thomson, A., 2001. Women's expectations and experiences of childbirth. *Midwifery* 17, 302–313.
- Graham, H., Oakley, A., 1981. Competing ideologies of reproduction: medical and maternal perspectives on pregnancy. In: Roberts, H. (Ed.), *Women, Health, and Reproduction*. Kegan Paul, London.
- Green, J.M., Coupland, V.A., Kitzinger, J.V., 1990. Expectations, experiences, and psychological outcomes of childbirth: a prospective study of 825 women. *Birth* 17, 15–24.
- Greene, J.C., Caracelli, V.J., 2003. Making paradigmatic sense of mixed methods practice. In: Tashakkori, A., Teddlie, C. (Eds.), *Handbook of Mixed Methods in Social and Behavioral Research*. Sage, Thousand Oaks, CA, pp. 91–110.
- Henderson, N.R., 1995. A practical approach to analyzing and reporting focus groups studies: lessons from qualitative market research. *Qualitative Health Research* 5, 463–477.
- Hunter, B., 2006. The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery* 22, 308–322.
- Institute of Obstetrics and Gynaecology, 2006. *The future of maternity and gynaecology service in Ireland 2006–2016*. Report from Institute Subgroup, Institute of Obstetrics and Gynaecology, Dublin, pp. 1–58.
- Keating, A., Fleming, V.E.M., 2009. Midwives' experiences of facilitating normal birth in an obstetric-led unit: a feminist perspective. *Midwifery* 25, 518–527.
- KPMG, 2008. *Independent review of maternity and gynaecology services in the Greater Dublin Area*. Final Report, 2008, pp. 1–236.
- Koch, T., 1994. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 19, 976–986.
- Kitzinger, J., Barbour, R.S., 1999. Introduction: the challenge and promise of focus groups. In: Barbour, R.S., Montell, F. (Eds.), *Developing Focus Group Research: Politics, Theory and Practice*, Focus Group Interviews: A New Feminist Method. National Women's Studies Association Journal 11, 44–71.
- Lane, P., McKenna, H., Ryan, A., Fleming, P., 2001. Focus group methodology. *Nurse Researcher* 8 (3), 45–59.
- Larkin, P., Begley, C.M., Devane, D., 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery* 25, e49–e59.
- Lundgren, I., 2005. Swedish women's experience of childbirth 2 years after birth. *Midwifery* 21, 346–354.
- Mason, J., 2002. *Qualitative Researching*, 2nd edn Sage Publications, London.
- Melender, H.L., 2002. Experiences of fears associated with pregnancy and childbirth: a study of 329 pregnant women. *Birth* 29, 101–111.
- McLafferty, I., 2004. Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing* 48, 187–194.
- Millward, L.J., 1995. Focus groups. In: Breakwell, G.M., Hammond, S., Fife-Schaw, C. (Eds.), *Research Methods in Psychology*. Sage Publications, London, pp. 274–292.
- Montell, F., 1999. Focus group interviews: a new feminist method. *National Women's Studies Association Journal* 11, 44–71.
- Morgan, D.L., 1997. *Focus Groups As Qualitative Research*, 2nd edn Sage, London.
- Morgan, D.L., Kruger, R.A., 1993. When to use focus groups and why. In: Morgan, D.L. (Ed.), *Successful Focus Groups: Advancing the State of the Art*. Sage Publications, Newbury Park, CA, pp. 9–13.
- Morrison-Beedy, D., Côté-Arsenault, D., Feinstein, N.F., 2001. Maximizing results with focus groups: Moderator and analysis issues. *Applied Nursing Research* 14, 48–53.
- Mozingo, J.N., Davis, M.W., Thomas, S.P., Droppleman, P.G., 2002. "I felt violated": women's experience of childbirth-associated anger. *American Journal of Maternal Child Nursing* 27, 342–348.
- Oakley, A., 1993. *Essays on Women, Medicine and Health*. Edinburgh University Press, Edinburgh.

- Oakley, A., 1999. People's way of knowing: gender and methodology. In: Hood, S., Mayall, B., Oliver, S. (Eds.), *Critical Issues in Social Research*. Open University Press, London, pp. 154–170.
- Olde, E., van der Hart, O., Kleber, R., van Son, M., 2006. Posttraumatic stress following childbirth: a review. *Clinical Psychology Review* 26, 1–16.
- Olsson, A., Lundqvist, M., Faxelid, E., Nissen, E., 2005. Women's thoughts about sexual life after childbirth: focus group discussions with women after childbirth. *Scandinavian Journal of Caring Sciences* 19, 381–387.
- Page, L., Corkett, M., McCandlish, R., 2006. Evidence-based Midwifery: finding, appraising and applying evidence in practice. In: Page, L.A., McCandlish, R. (Eds.), *The New Midwifery. Science and Sensitivity in Practice*. Churchill Livingstone, Philadelphia, pp. xiii–xx.
- Parvin, A., Jones, C.E., Hull, S.A., 2004. Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practice* 21, 254–260.
- Patton, M.Q., 2006. Foreword: trends and issues as context. *Research in the Schools* 13, i–ii.
- Polit, D.F., Beck, C.T., 2004. *Nursing Research: Principles and Methods*. Lippincott Williams and Wilkins, Philadelphia.
- Ruppenthal, L., Tuck, J., Gagnon, A.J., 2005. Enhancing research with migrant women through focus groups. *Western Journal of Nursing Research* 27, 735–754.
- Sim, J., 1998. Collecting and analysing qualitative data: issues raised by the focus group. *Journal of Advanced Nursing* 28, 345–352.
- Simkin, P., 1991. Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I. *Birth* 18, 203–210.
- Turris, S.A., 2005. Unpacking the concept of patient satisfaction: a feminist analysis. *Journal of Advanced Nursing* 50, 293–298.
- Twinn, D.S., 1998. An analysis of the effectiveness of focus groups as a method of qualitative data collection with Chinese populations in nursing research. *Journal of Advanced Nursing* 28, 654–661.
- UNICEF, 2008. Progress for children: a report card on maternal mortality. <[http://www.childinfo.org/files/progress\\_for\\_children\\_maternalmortality.pdf](http://www.childinfo.org/files/progress_for_children_maternalmortality.pdf)> (accessed June 29th 2010).
- van Teijlingen, E.R., Med, M.A., Hundley, V., Rennie, A.M., Graham, W., Fitzmaurice, A., 2003. Maternity satisfaction studies and their limitations: "What is, must still be best". *Birth* 30, 75–82.
- van Teijlingen, E.R., Pitchforth, E., 2001. Focus group research in family planning and reproductive health care. *Journal of Family Planning & Reproductive Health Care* 32, 30–32.
- Walsh, D., 2007. *Evidence-based Care for Normal Labour and Birth. A Guide for Midwives*. Routledge, London.
- Wilkinson, S., 1999. How useful are focus groups in feminist research?. In: Barbour, R.S., Kitzinger, J. (Eds.), *Developing Focus Group Research: Politics Theory and Practice*. Sage, London, pp. 64–78.
- Wilkinson, S., Joffe, H., Yardley, L., 2004. Qualitative data collection: interviews and focus groups. In: Marks, D., Yardley, L. (Eds.), *Research Methods for Clinical and Health Psychology*. Sage Publications, London, pp. 39–55.