
Characteristics of a Positive Experience for Women Who Have Unmedicated Childbirth

Amanda M. Hardin, RN, BSN

Ellen B. Buckner, RN, DSN

AMANDA HARDIN is a BSN honors graduate from the University of Alabama School of Nursing, University of Alabama at Birmingham. The study reported here was completed as her senior honors project. ELLEN BUCKNER is an associate professor of nursing at the University of Alabama School of Nursing, University of Alabama at Birmingham. She is the coordinator of the school's "Honors in Nursing" program.

Abstract

This qualitative descriptive study determined characteristics that women deem positive in their unmedicated childbirth experience. Seventeen women were interviewed and themes were identified. All of the women reported satisfying births, adding accompanying feelings of empowerment and well-being. An overriding theme in each woman's birth story that made the birth experience positive was the ability to control her body during labor and the ability to influence the environment in which she labored and gave birth. Being able to move and change positions freely were both key factors in determining a positive birth experience. Additionally, the women expressed comfort from the presence of a spouse or trusted individual. They found the help of an experienced woman or doula important. Many were willing to change care providers to gain support for their desire for an unmedicated birth.

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Introduction

For many years preceding the 1960s, women accepted routine hospital birth procedures and typically did not seek additional information concerning childbirth. Today, although few women in a typical hospital setting currently choose an unmedicated birth, some do. When labor-and-birth nurses are asked to support an unmedicated birth, some may be unprepared to assist. Furthermore, some physicians and labor-and-birth nurses express concern about a woman's choice, implying

women would be “better off” with anesthesia or medication.

How do individual women search for facts and make the decision to choose an unmedicated birth? How do they perceive the choice after birth? These factors may affect the mother’s subsequent discussions of the birth experience with friends, family, and professionals. A better description of elements that women find as positive about a planned, unmedicated birth experience could assist nurses and medical personnel in providing the best care for women making that choice.

The purpose of this qualitative descriptive study was to determine characteristics that women deem positive in their unmedicated childbirth experience and, from those characteristics, to identify the criteria of a satisfying and meaningful unmedicated birth experience. Results from this study may be used to better educate women on what to expect from unmedicated birth. The study’s findings may also give health-care providers further knowledge in assisting women who choose unmedicated labor and birth.

Review of Literature

A review of the scientific literature reveals numerous studies supporting the effectiveness of a variety of non-pharmacological strategies in managing the pain of childbirth. Women who choose to have an unmedicated birth typically use one or more of these strategies. The strategies fall into the following general categories:

1. social-support persons or birth attendants,
2. alternative management techniques (e.g., breathing or relaxation techniques), and
3. actions or interventions by the labor-and-birth staff.

Social Support

Multiple studies have provided evidence of the positive influences that mothers experience when receiving labor support from a companion present during birth (Campero et al., 1998; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996). One recent study revealed that mothers who received continuous support from an experienced

woman during labor and birth had fewer medical interventions and requested less pain medication (Hodnett, 2002). In this study, an experienced woman was defined as a woman who had given birth or had received special training to provide labor support (e.g., a labor-and-birth nurse or a doula). Continuous support included emotional support, such as advice and encouragement, as well as comfort support, such as providing massage or wiping the forehead with a cold washcloth. Hodnett concluded that continuous support of a laboring woman produced the following benefits: less use of medication for pain relief, less use of forceps during delivery, and less incidence of cesarean section.

Increasing numbers of review studies document the benefits of social support, alternative or nonpharmacological pain-control measures, and a strong role of the labor nurse in the hospital setting in facilitating birth experiences. Because accumulating evidence supports these benefits, the Cochrane Pregnancy and Childbirth Group conducted several reviews of published trials (Hodnett, Gates, Hofmeyr, & Sakala, 2004). In one review of 15 trials involving over 12,000 women, the continuous presence of a support person reduced the likelihood of analgesia for pain relief, reduced operative delivery, and reduced dissatisfaction of women with their birth experience. The review also found that continuous support favored a mother’s views, such as expressing satisfaction with the birth experience, practicing coping skills, and perceiving a level of personal control. The review concluded that all women should receive support throughout labor and birth. The Cochrane reviews are particularly noteworthy because the Cochrane collaborative study groups base their conclusions on a critical review of all available results and synthesize these into a formal conclusion or opinion. Their findings are considered among the most respected in the health-care community.

Another study, conducted by researchers in Finland, sought to determine specifically where pregnant Finnish women derive their forms of social support during pregnancy, labor, and birth (Tarkka & Paunonen, 1996). The researchers defined social support as “...intentional human interactions that involve one or more of the following elements: affect..., affirmation..., and/or aid” (p. 71). The authors found that, during pregnancy, Finnish women reported receiving most of their social support from their spouse or partner. During labor and

birth, however, the women indicated they sought social support from their midwife or other caregiver. Additionally, Tarkka and Paunonen found that specially trained caregivers not only provide needed social and emotional support to laboring women but also administer routine medical support. In a comparison between continuous and intermittent support, researchers found greater benefits from continuous support (Scott, Berkowitz, & Klaus, 1999).

Alternative Strategies for Pain Management

A review on alternative pain-management methods during labor and birth reported that women currently elect to use a greater variety of alternative techniques than in previous years (Smith, Collins, Cyna, & Crowther, 2003). The authors referred to alternative pain management as “practices and ideas that are outside the domain of conventional medicine in several countries, and [it] is defined by its users as preventing or treating illness, or promoting health and well-being.” The most widely used alternative pain-management techniques included mind-body relaxation, massage, and alternative medicine such as homeopathy. In a review of seven trials involving 366 women, alternative therapies (acupuncture and hypnosis) were found to be significantly beneficial; however, other techniques (music and aromatherapy) were not documented statistically as helpful in this review (Smith, et al., 2003). The review group noted the limitations of smaller sample sizes, which may not have been large enough to show that small differences are statistically significant.

Role of the Labor Nurse

Tumblin and Simkin (2001) conducted a qualitative study in the United States to learn from pregnant women what they believed to be the role of an intrapartal labor-and-birth nurse. The results of the study showed that the majority of pregnant women expected their labor nurse would provide physical comfort as well as emotional support along with routine nursing care such as monitoring the mother and baby. The authors logically asserted that, if nurses and hospitals work to fulfill women’s expectations of their birth experience, a greater chance exists that the women will have positive childbirth experiences and be satisfied with their care.

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Methods

The study described in this paper was approved by the University of Alabama at Birmingham’s Institutional Review Board (IRB) through an expedited application based on minimal risk to participants. The IRB expedited the researchers’ application to identify characteristics of a positive birth experience for unmedicated childbirth from the woman’s perspective. Approval was obtained to interview healthy postpartum women, 19 years of age and older, within 48 hours of having an unmedicated vaginal birth. Study participants were to be identified by a certified nurse-midwife. The nurse-midwifery program, however, was closed and stopped delivering babies before data collection began. The IRB approval was amended to allow the researchers to interview any woman who had had an unmedicated childbirth within the last 12 months. Thus, obstetricians, nurse-midwives, or childbirth educators were asked to identify potential study participants.

Seventeen women volunteered to be interviewed over a period of four months at a location specified by the study participants. Only persons allowed by the woman were present for the interview. For example, one study participant wanted her spouse present during the interview so he could add his thoughts and comments about their birth experience. The interviews lasted between 30 and 60 minutes. Demographic data was obtained. The researcher then asked the following three open-ended questions:

1. Will you tell me about your birth?
2. What, to you, defines a *positive birth*?
3. Did you have a positive birth according to your definition?

The women were allowed to elaborate on each question for as long as they needed. All interviews were conducted in person by one interviewer. Interviews

were not taped; however, detailed hand-written notes were taken. The 17 women interviewed talked in great detail about their birth experiences. If the interviewer needed more information about a particular aspect of the birth experience, the participant was asked to talk more on that particular subject.

Sample

The convenience sample included 17 women who had given birth within the previous 12 months and had not used any analgesic or anesthetic medication during their labor or birth. The mean age of the study participants was 32 years old, with the youngest participant being 20 years old and the oldest participant being 39 years old. Women were approached by letter through their primary caregiver or by e-mail by their childbirth instructor for participation in this study. Approximately 35% of the contacted women responded to the interviewer. Of the women who responded, 100% were interviewed. In this study, the word “unmedicated” means receiving no analgesia or anesthesia of any kind during labor and/or birth.

The study participants had an average of two children each, with a range of one to four children. The mean gestation length was 39 weeks and 2 days, with the shortest gestation being 34 weeks and the longest gestation being 41 weeks and 5 days. Hours from the onset of labor until birth ranged from 4 to 18, with a mean of 10 hours. All 17 labors were spontaneous. One woman received exogenous oxytocin during her labor when she “failed to progress” beyond 3 cm dilation. The time spent in the hospital before giving birth ranged from 45 minutes to 13 hours, with a mean of 5 hours and 20 minutes at the hospital.

The participants’ educational backgrounds were varied. Four women had attended some college, one woman had her associate’s degree, eight women had a four-year college degree, and four women had their graduate degrees.

Data Analysis

Detailed narrative-form notes were taken during each 30-minute to 1-hour interview. During the course of the interview, if an area needed clarification, then clarification was sought. If elaboration was required on a subject

of interest, then the woman was prompted to elaborate on that specific subject. As themes emerged during the interview, they were validated by the participants.

Results

The women relayed a variety of information when asked to respond to the first question (“Will you tell me about your birth?”). In every case, each of the 17 women interviewed stated her personal birth experience was a positive one. Detailed factors reported as contributing to a positive birth can be categorized as physical comfort, emotional support, and the ability to maintain control over one’s personal birth experience.

Physical Comfort

Physical comfort measures were provided by the woman herself, by support persons (husband, partner, friend, and doula), and/or by medical personnel (obstetricians, nurse-midwives, and labor-and-birth nurses). The laboring woman’s self-comfort techniques included walking, changing positions, hip rocking, and slow, deep breathing. Many women also stated they found great comfort in focusing inward on their contractions and on what was happening physically inside their bodies.

Support persons also tended to the laboring woman’s requests for physical comfort. Many women asked their support person to assist them while rocking on a birth ball, pelvic rocking, and walking. Support persons also provided relief measures such as drinks, snacks, cool washcloths, massage, and counterpressure on the small of the back. Women in this study who had received physical and emotional support from their labor-and-birth nurse were grateful for the support and felt it contributed to their birth being a positive experience. Other women, however, stated their nurse merely completed her paperwork and monitoring duties and

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provided no further support during the labor. These women also stated that they were not pleased with this type of care and would request to have a more supportive labor-and-birth nurse during their next birth.

Emotional Comfort

All of the participants stated they were emotionally comforted by the mere presence of their spouse and other trusted individuals. The women also found motivation and comfort in receiving verbal praise and encouragement during their labor and birth.

Maintaining Control over One's Birth

The overriding theme in each woman's birth story that made the experience positive was the ability to control her body during labor and influence the environment in which she labored and gave birth. This control was manifested in numerous ways, including having a birth plan that the woman had reviewed with her primary caregiver and stated her wishes and desires for the birth. Having whomever the woman chose present at the birth was very comforting to each of the women. Key factors in a positive birth experience were being able to move about and change positions freely and the ability to give birth in the position chosen by the woman. Since the women had chosen not to receive pain medication, effective nonpharmacologic pain-management techniques were crucial in having a positive birth experience. The four techniques utilized the most were walking, focusing inwardly, hip rocking, and counterpressure on the sacral area of the back.

Additional Findings

Other findings included the report that all 17 women interviewed here actively prepared to have an unmedicated childbirth. Preparation included attending non-hospital-based childbirth preparation classes that uniformly focused specifically on preparing for an unmedicated childbirth. Class information included the physiology of a woman's body during labor and birth, as well as methods of nonpharmacologic pain management that could be utilized during labor and birth. The classes could have been taken while the mother was pregnant with the current child or during a previous pregnancy. Some women attended classes that focused

on specific methods of childbirth—including the Lamaze method and the Bradley method—while other classes blended many methods of childbirth. Each woman also read books, magazines, and Web sites to find information on childbirth options.

In another finding, all 17 women concluded that an unmedicated birth was healthiest for themselves and their baby. Further, each woman also stated she would have an unmedicated childbirth again. During prenatal visits with her primary care provider, each woman discussed her desire to have an unmedicated birth. If she felt unsupported in her decision, the woman changed to a more supportive caregiver. Three of the women indicated they changed health-care providers due to a lack of support of their decision to have an unmedicated childbirth. They identified more supportive caregivers through word-of-mouth suggestions offered by other women who felt encouraged by their care provider in obtaining the birth experience they desired.

All 17 women commented on how, when an unmedicated woman delivers her baby and then the placenta, the birth is over and the woman feels wonderful. Consequently, she does not have to spend time waiting for the epidural anesthesia to wear off or for any other unpleasant effects of anesthesia to subside. Each woman also expressed a sense of accomplishment and empowerment for having had an unmedicated childbirth. Interestingly, each woman stated that she had received negative feedback at some point during her pregnancy for her decision to have an unmedicated childbirth. This negative feedback came from a variety of sources, including spouses, physicians, friends, mothers of the pregnant women, and other family members. The negative feedback received by some of the women included talk about unmedicated childbirth as being a decision that only an uninformed woman would make, as well as disbelief that someone would choose to have an unmedicated birth when medication is available.

Defining a Positive Birth Experience

When each woman was asked to give a definition of what she considered a positive birth experience, she drew upon characteristics from her own birth experience. Almost every woman included having a

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healthy baby in her definition of a positive birth. Other characteristics included meeting the woman's emotional and physical needs, as well as fulfilling the woman's expectations about her birth, the latter manifested by the medical staff respecting and acting on the information provided in the birth plan. Others expressed a variety of summary-type responses, such as:

- "Being able to get out of bed and move around, as desired."
- "Feeling physically good after the birth and not being bedridden."
- "An experience the parents are content with."
- "A healthy baby."

Limitations

A limitation to this study was the closing of the certified nurse-midwifery program due to a lack of appropriate funding. Originally, study participants were to be obtained through this program and interviewed within 48 hours of giving birth. When the program closed, the study was modified through the university's IRB to allow an interview with any woman who had had an unmedicated childbirth within the last 12 months. Another study limitation was that all the women interviewed planned and prepared to have an unmedicated childbirth. Women who did not plan an unmedicated childbirth and yet had one should be sought out and interviewed—as should those who planned an unmedicated birth, but subsequently used medications of varying types.

Discussion

The findings of this study support research in the review of literature. Just as the study by Hodnett and colleagues (2004) indicates, women who received con-

tinuous support from an experienced woman during labor did, in fact, request no pain medication and all had few, if any, medical interventions during their birth. Medical interventions that some women received included electronic fetal monitoring (continuous and intermittent) and intravenous fluids for hydration purposes. In this study, experienced women who provided the intervention of support were doulas, labor-and-birth nurses, midwives, and female friends who had given birth. Continuous support (e.g., emotional support in the form of encouraging the laboring woman and physical comforting techniques such as massaging) was also frequently reported.

In Tarkka and Paunonen's (1996) study, the researchers reported that women in labor seek social support from their midwife or other caregiver. This type of continuous support was described by Hodnett and colleagues (2004). The same finding was reported in this study. While each woman expressed great comfort in having her husband or partner present during the birth, the main support described was derived from the woman's midwife, labor-and-birth nurse, or doula. These supportive women had the experience and knowledge to help the laboring woman feel in control of her labor, as well as the knowledge to help the woman move into different positions during labor. While the presence of the husband or partner was emotionally comforting to the woman, these other caregivers had the practical knowledge the woman needed to help her stay comfortable during her birth experience.

The Cochrane study conducted by Smith and colleagues (2003) identified alternative pain-management practices that were similar to the alternative pain-management practices used by this study's participants during their labors. These techniques included mind-body relaxation and massage methods that eased labor pains. None of the women in our small sample, however, identified using acupuncture, hypnosis, or homeopathy during their labor.

This study also echoed the finding in Tumblin and Simkin's (2001) research, in which pregnant women anticipated that their labor-and-birth nurse would provide physical comfort and emotional support along with routine nursing. Thus, the findings in the qualitative study support findings in quantitative studies in the literature and add additional details about the view of these women.

Implications for Nursing Practice

One implication of this study for nursing practice is that labor-and-birth nurses may need education to provide effective nonpharmacologic pain-management techniques and emotional support to women who choose to have an unmedicated childbirth. In other words, they should know how to provide doula care. Having a labor-and-birth nurse fulfill these needs of the laboring woman seemed important in the woman's satisfaction with her birth experience in relationship to the hospital she delivered in and whether she would deliver another child in the same hospital. Having adequate nurses on staff with the skill and time to provide these comforts to women will likely influence some women's decisions to give birth at a particular hospital.

Many of the women reported they personally paid for a doula's presence at their birth because they felt they would not receive the support they needed from the nursing staff. From this study, one could infer that, if nurses are trained to provide doula-type support along with other nursing actions, a woman's satisfaction with her birth and with the hospital in which she delivers could potentially increase, especially without the added cost of hiring a doula from the community.

Implications for Childbirth Educators

From this study, it can be noted that preparation for an unmedicated birth is a critical part of a successful and positive birth experience. All participants stated that they had prepared for an unmedicated birth experience. Study findings indicate that childbirth educators should emphasize the importance of a woman in labor being able to remain in control of her body, physically and emotionally. Remaining in control of one's own birth was echoed repeatedly among study participants as one of the characteristics of a positive birth experience. Childbirth educators should also emphasize the importance of freedom of movement during labor, as well as how intermittent external fetal monitoring and minimal medical interventions can facilitate a woman's ability to move freely during labor and birth. Additionally, childbirth educators need to discuss with their clients the importance of choosing a supportive health-care provider when deciding to have an unmedicated childbirth. Discussing these topics in childbirth

classes can help couples better prepare for their unmedicated birth experience and increase satisfaction experienced during their unmedicated childbirth.

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