Professional support in childbearing, a challenging act of balance
To women that give birth, to their partners that support them and to professionals that offer support in the process
Professional support in childbearing, a challenging act of balance
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Abstract


The overall aim was to contribute to the development of optimal quality care in childbearing through exploring how professionals learn to act and how they act in support of women and their partners and what supportive needs women and their partners have during childbearing, as well as how professional support influences parents’ experience during childbearing and their relation to the baby. I) Diaries from student midwives (n=11), about offering continuous support during childbirth, analysed with qualitative content analysis. II) An observation and interview study during childbirth with midwives (n=7), women (n=7) and their partner (n=7), analysed with hermeneutic text interpretation. III) First-time mothers (n=10) were interviewed three days after birth, as a step in the validation process of the “Mother to Infant Relation and Feelings” (MIRF) scale, analysed with qualitative content analysis. IV) A randomized longitudinal intervention study including a process-oriented training program for midwives and postnatal nurses. First time mothers with a caesarean or a normal birth (n=395) answered questionnaires at three days, three and nine months postpartum about professional support and their relation to and feelings for the baby, analysed statistically. Result: I) Offering continuous support made students aware of the importance to establish rapport, but needing reassurance could hamper their efforts to establish rapport. Experiencing a lack of confidence made students focus more strongly on their medical skills. II) Which ideology midwives adopted during childbirth influenced if the individual supportive needs of women and their partners were met. III) The MIRF scale appears valid to use in research and in dialogue with new mothers to support mother-to-infant interactions. IV) Trained professionals strengthened mothers’ perception of professional support which may buffer negative effects of caesarean birth in relation to the baby. Conclusion: Professional support in childbearing is a challenging act of balance which can strengthen women’s sense of ability in meeting the needs of the baby even in the additional challenge of caesarean birth. Training in support and reflection about one’s attitudes and ideology in practice improve supportive skills.

Keywords: Professional support, social support, education, attitudes, childbearing, motherhood, mother-infant interaction, caesarean birth, ideology in practice.

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List of publications

This thesis is based on the following four studies, which are referred to by their Roman numerals.


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Introduction
My interest for support in childbearing has developed through my working experience. As a midwife, I have met many women and their partners with ordinary or more complex supportive needs, expressing such varying feelings as anxiety, worry, fear or concern. However, when having to professionally deal with these situations, I have sometimes found myself uncertain. For example, in my work at the labour ward, I wondered if I as a midwife could have offered more adequate professional support to women and their partners, which included both practical and emotional aspects. When I understood that continuous support during childbirth by a doula (non-professional support person) could have such effects as a reduced risk for caesarean birth, shorter labour or positive influence on mother-infant interaction (Klaus, Kennell, & Klaus, 1993), I was amazed and became more interested in the phenomenon of support in childbearing. Being supportive has been described as a central idea of the midwifery profession since ancient times:

“Imagine that you are a midwife; you are assisting at someone else’s birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say: ”We did it ourselves!” (interpretation of Lao Tzus Tao Te Ching 2500 BC) by (Heider, 1986).

Despite increasing knowledge of the importance of support in childbearing, both women and their partners still experience a lack of support. When offering support, the provider needs knowledge about the actual situation. The provider also needs to understand the unique supportive needs of the individual. Therefore, there is a need for further knowledge about how women, their partners and health professionals perceive professional support in order to improve professional support during childbearing.

I am most grateful to have had the opportunity to further explore professional and social support in childbearing in order to improve the possibility to offer the requested support. There is a need to increase our understanding for professional support to promote wellbeing for women, their partners and families in childbearing.
Background

The concept of support

The concept of support is described as an interactive process between individuals that can facilitate a positive development for the individuals’ ability to cope with challenging or stressful situations in life (S. Cohen, 1992; House, 1981; Kahn & Antonucci, 1980; Langford, Bowsher, Maloney, & Lillis, 1997; Mander, 2008). The ability to offer and the ability to receive support are affected by a persons’ age, earlier experience of support and the social environment (Heller, Price, & Hogg, 1990; Kahn & Antonucci, 1980; Langford, et al., 1997). Support is linked to the attachment process and social roles and perception of support is affected by the relationship where the support is provided (Sarason, Pierce, & Sarason, 1990). For the health-related impact of support, there may be a difference between perceived support and perception of available support, and perception of available support seems to be most important (Uchino, 2004).

Acts of support can be divided into emotional, appraisal, informative or instrumental support. Emotional support involves providing empathy, love and trust and promotes a sense of safety and belonging. Emotional support is described as most important for a positive experience of support, which is essential for support to have a positive impact (Langford, et al., 1997; Mander, 2008) such as to buffer the negative effects of stress (S. Cohen, 1992). Appraisal support involves help in self-evaluation and promotes reassurance of the individual’s ability and competence. Informative support is offering information to help solve the actual problem, and instrumental support (also referred to as practical support) is practical help in solving the actual problem (Langford, et al., 1997; Mander, 2008). The different acts of support may not be distinctively different; for example informative support may also be perceived as emotional support. Receiving adequate support without having to ask for it seems important for a positive effect in reducing feelings of stress (Uchino, 2004). Asking for support might be difficult for individuals because the act of having to ask can instil a sense of not being competent in the actual situation (S. Cohen, 1992; Sarason, et al., 1990; Uchino, 2004).

Non-judgmental attitudes (Oakley, 1994), as well as understanding the unique support needs and knowledge of the specific supportive situation (Hupcey, 1998; Langford, et al., 1997; Oakley, 1994) are important when offering support. When providing support, it might be difficult to interpret
what support needs the individual has, since the situation may be complex, but the individual may also be vague in expressing supportive needs (Hertfelt Wahn, von Post, & Nissen, 2007; Schumaker & Brownell, 1984). Individuals providing support may hesitate to offer support from fear of inflicting harm (Schumaker & Brownell, 1984), or they may cease to offer support due to stress (Hupcey, 1998). Support can be provided by individuals within their own network or by non-professionals (social support) or by professionals (professional support) (Langford, et al., 1997; Mander, 2008; Rosen, 2004).

Social support and professional support
It is important in scientific studies to define and maintain the distinction between social and professional support (Hupcey & Morse, 1997; Logsdon & Davis, 2003). For example, this distinction will enable researchers to investigate the actual aspects of the professional’s role that influence possible outcomes (Hupcey & Morse, 1997). Social support is offered by relatives or friends within the individual’s own network (Langford, et al., 1997), while professional support is offered by professionals and is limited by professional knowledge. Professional support is directly available from professionals, while social support requires that some sort of private relationship needs to be developed. Reciprocity is not required for professional support in the same way as for social support (Hupcey & Morse, 1997)(Table 1).

Table 1 Comparison of the major characteristics of social and professional support

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Social support</th>
<th>Professional support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of services provided</td>
<td>Open</td>
<td>Delimited</td>
</tr>
<tr>
<td>Duration</td>
<td>Must be developed</td>
<td>Instantly available</td>
</tr>
<tr>
<td>Trust</td>
<td>Reciprocal (shared)</td>
<td>Unilateral</td>
</tr>
<tr>
<td>Obligation</td>
<td>Kinship/friendship</td>
<td>Professionally defined or surrogate</td>
</tr>
<tr>
<td>Expectations of relationship</td>
<td>Based on congruent expectations</td>
<td>Based on role expectations</td>
</tr>
<tr>
<td>Reciprocal action</td>
<td>Equivalent</td>
<td>Not required, services &quot;purchased&quot; or financially compensated</td>
</tr>
</tbody>
</table>

Hupcey & Morse 1997 page 273

Professional support has different characteristics compared to social support and interventions with professional support should also aim to strengthen social support in order to strengthen more aspects of support (Hupcey & Morse, 1997). During childbearing both social and profession-
al support are requested by women (e.g. (Hildingsson & Thomas, 2007; Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011).

**Childbearing**

Childbearing is a term labelling the life process from conception through pregnancy, childbirth and infancy (Macmillan, 2012) up to 9 months after childbirth for this thesis. Childbearing is described as a natural process that can be predictable but also uncertain (Leap, 2000). Childbearing involves the physical process of pregnancy and childbirth (Downe, 2010a) as well as the psycho-social change of becoming parents (Downe, 2010a; Raphael-Leff, 2005). In Sweden approximately 100 000 women are pregnant and give birth every year. Most of them have vaginal births, but an increasing number have caesarean births. For first-time mothers, caesarean births have increased from 6,4 % in 1974 to 13,3 % in 1994 and 18,8 % in 2010 (The Swedish national board of Health and Welfare, 2012).

**Becoming parents**

Becoming a parent is described as a major change of life event irrespective of it being biological or through adoption or other forms of parentage (Cowan & Cowan, 2000). This major change of life can be seen as happy and stressful at the same time (Choi, Henshaw, Baker, & Tree, 2005; Raphael-Leff, 2005).

Becoming parents starts for many during pregnancy and intensifies with the birth of the baby (Draper, 2003; Mercer, 1986, 2004). The idea of motherhood is described as having overall responsibility for the welfare of the child and putting one’s own needs behind (Olsson, Jansson, & Norberg, 1998). This idea of motherhood influence mothers’ expectations, and when these expectations meet reality, conflict and distress are often described (Choi, et al., 2005; Emmanuel & St John, 2010). The idea of fatherhood used to be that of the breadwinner (Draper, 2003). During the late 20th century, the idea of fatherhood in the Western world is shifting towards fathers being more involved with caring for the child (Deave & Johnson, 2008; Draper, 2003). As a consequence of this shift in the idea of fatherhood, new fathers seem to lack role models and social support (Deave & Johnson, 2008).

Parents interacting with the baby will initiate the attachment process (Cassidy, 1999). The attachment process is important both for the emotional and the biological development of the baby (Raphael-Leff, 2005; Shore & Shore, 2008). Parents’ interactions with the baby need to be ad-
justed to the baby’s needs in unique situations (Belsky, 1999), and parents’ interaction with the baby is affected by how they view their baby and their relationship with the baby (George & Solomon, 1999; Salonen et al., 2009). Caesarean birth may influence a mother’s ability to interact with the baby in a negative way; for example, she may not be able to respond to the baby’s signals (Garel, Lelong, & Kaminski, 1988; Karlström, Engström-Olofsson, Norbergh, Sjöling, & Hildingsson, 2007; Rowe-Murray & Fisher, 2001; Tulman, 1986). Having the baby skin-to-skin after birth has a positive influence on the parents’ interaction with the newborn baby (Bystrova, 2008; Velandia, Matthiesen, Uvnäs Moberg, & Nissen, 2010).

Motherhood is an on-going process, and the baby’s development and increasing independence in the first year impose new demands on the mother’s sense of competence (Mercer, 2004). Feeling competent as a mother and in relation to the baby is influenced by the mother’s state of mind, breastfeeding, social support and professional support (Bäckström, Hertfelt Wahn, & Ekström, 2010; Ekström & Nissen, 2006; Tarkka, 2003). A father also needs professional support to meet his individual needs as well as to learn to trust his ability when assuming his new role (Erlandsson, Christensson, & Fagerberg, 2006).

**A mother’s experience of support during childbearing**

A mother’s experience of childbearing follows her throughout life (Brodén, 2004; Brudal, 1985; Raphael-Leff, 2005; Simkin, 1996). In pregnancy, women experience a mixture of feelings, such as pride and insecurity as to their ability in this new situation (Darvill, Skirton, & Farrand, 2010). Women often experience vulnerability in relation to their own health and the health of the unborn baby, as well as in regards to the new relation with the baby and the new family situation (Bondas, 2002; Darvill, et al., 2010). Therefore, women may request social and professional support in order to cope with the challenges that pregnancy presents (Hildingsson & Rädestad, 2005; Hildingsson & Thomas, 2007; Seefat-van Teeffelen, et al., 2011).

Mothers experience childbirth as involving both a feeling of losing and remaining in control, and to cope with this complex situation, women need to feel safe (Dahlen, Barclay, & Homer, 2010; Halldorsdottir & Karlsdottir, 1996a, 1996b; Lundgren, 2004, 2005). An important aspect for women to feel safe during childbirth is the presence of professionals (providing mainly emotional support) (Kennedy & Shaw-Battista, 2010).
who can meet women’s unique individual needs\(^1\), such as being seen and listened to (Walsh, 2006, 2010). Furthermore if women experience that their needs are met and they feel safe to trust their own capacity to give birth (mainly emotional and appraisal support), it may lead to a positive childbirth experience (Halldorsdottir & Karlsdottir, 1996a; Leap, Sandall, Buckland, & Huber, 2010; Lundgren, 2004). A positive childbirth experience can strengthen mothers’ self-confidence as well as their trust in others, but if negative, the childbirth experience can initiate distrust and failure (Lundgren, Karlsdottir, & Bondas, 2009).

If women experience that their needs are not met or they do not feel safe during childbirth, it may lead to a negative childbirth experience (Dahlen, et al., 2010; Eliasson, Kainz, & von Post, 2008; Halldorsdottir & Karlsdottir, 1996a, 1996b; Nilsson, Bondas, & Lundgren, 2010; Somera, Feeley, & Ciofani, 2010). Women’s childbirth experiences can be negative whether childbirth is medically uncomplicated or not (Beck, 2004). Women with a caesarean birth often experience anxiety and feeling unsafe (Porter, van Teijlingen, Yip, & Bhattacharya, 2007; Somera, et al., 2010; Tham, Ryding, & Christenson, 2010). Feeling unsafe may lead to less satisfaction with the childbirth experience (Wiklund, Edman, Ryding, & Andolf, 2008; Wilde-Larsson, Sandin-Bojö, Starrin, & Larsson, 2011), and mothers with a caesarean birth may need more support after childbirth (Wiklund, et al., 2008).

The early postnatal period requires a woman to develop confidence and competence in her new role as a mother (Martell, 2001). Her sense of competence and healthiness, as well as a healthy new-born baby, are important for her to feel safe (Martell, 2001; Persson & Dykes, 2002; Persson, Fridlund, Kvist, & Dykes, 2010). First-time mothers often feel uncertain about caring for the baby (Martell, 2001), but first-time mothers can be strengthened in caring for the baby through social and professional support (Tarkka, Paunonen, & Laippala, 2000). It has also been described that mothers are disappointed when they mainly receive information while they also need emotional support in postnatal care (Ekström, Widström, & Nissen, 2003; Hildingsson & Thomas, 2007; Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). Professional support, such

\(^1\) All aspects of support, such as emotional, appraisal, informative or instrumental support, may be needed to meet individual unique needs depending on the unique woman and the unique situation
as informational or emotional, should be based on the unique individual mother and her needs; otherwise, the mother’s uncertainty may increase (Björk, Thelin, Peterson, & Hammarlund, 2012; Bäckström, et al., 2010; Ekström, Widström, & Nissen, 2003 a). Professional support during pregnancy improves the perception of being prepared for the parental role, which has a positive effect on the mothers’ relation to and feelings for the baby and breastfeeding (Ekström, Guttke, Lenz, & Hertfelt-Wahn, 2011; Ekström & Nissen, 2006; Ekström, Widström, & Nissen, 2006).

Mothers want a trustful relationship with their partners and appreciate partner support during childbearing (Gibbins & Thomson, 2001; Kainz, Eliasson, & von Post, 2010; Löf, Crang Svalenius, & Persson, 2006; Somers-Smith, 1999). Support from the partner contributes to the mother feeling safe (Ekström, et al., 2003 b; Raphael-Leff, 2005). The relationship to her partner may be strengthened after childbirth, which is expressed as a sense of emotional attachment. However, professionals do not always support the mother’s need for her partner and his supportive role (Ellberg, 2008). Therefore, professional support needs to focus on the father as well as the mother (Persson, et al., 2010).

A father’s experience of support during childbearing

Men becoming fathers often describes a positive experience during their woman’s pregnancy, but new father have mixed feelings related to responsibility, social change and development, as well as unreality and exclusion (Finnbogadottir, Crang Svalenius, & Persson, 2003). In antenatal care visits, a father may act like a stranger passively letting the woman answer for him (Olsson, Sandman, & Jansson, 1996). Fathers acting passively might lead to inadequate communication with health professionals. Inadequate communication may inflict feelings of distress and frustration in fathers (J. Fenwick, Bayes, & Johansson, 2012). Health professionals need to support the father and meet his unique individual needs during pregnancy (Finnbogadottir, et al., 2003; Olsson, et al., 1996).

Fathers most often want to be present during childbirth (Vehviläinen-Julkunen & Liukkonen, 1998) and want to offer support to the woman (Bäckström & Hertfelt Wahn, 2011; Chandler & Field, 1997; Johansson, Rubertsson, Rådestad, & Hildingsson, 2012; Somers-Smith, 1999). However, during childbirth, fathers describe mood swings between feelings of excitement and anxiety (Genesoni & Tallandini, 2009; Premberg, Carlsson, Hellström, & Berg, 2010). Fathers often feel excluded, and therefore they may not be able to offer support to their partner without support.
from others, such as professionals\(^2\) (Longworth & Kingdon, 2011). When health professionals’ are present and open to questions, fathers’ feelings of being included and supported increase (Bäckström & Hertfelt Wahn, 2011; Johansson, et al., 2012). Health professionals need to consider the father as part of the couple during childbirth, with needs of his own, without neglecting the needs of the mother (Bäckström & Hertfelt Wahn, 2011; Vehviläinen-Julkunen & Liukkonen, 1998).

Research on the postpartum period suggest that fathers need professionals to support their involvement with the baby; for example they need professionals to address them as well as the mother with questions about the baby, such as in health care visits at the child health care centre (Fägerskiöld, 2006; Montigny & Lacharité, 2004; Moore & Kotelchuck, 2007).

**Professional support and care in childbearing**

The overall goal of care in childbearing is to enhance the health and well-being of mothers, their children and families (World Health Organisation, 1996). Therefore, care in childbearing should be adjusted to parents’ needs in order for women’s experiences of childbearing to be positive (SFOG, 2008), and the ideology of care influences the quality of care (Soltani & Sandall, 2012). The organisation of health care in childbearing can emphasize different ideological perspectives. Care in childbearing can be organized with emphasis on trust in the mother’s capacity to give birth (Fahy & Parrat, 2006; MacKenzie Bryers & van Teijlingen, 2010) influenced by an ideology named “with woman” (Hunter, 2004). Or, care in childbearing can be organized with emphasis on efficiency and risk management (Hunter, 2004; Teijlingen, 2005), influenced by an ideology named “with institution” (Hunter, 2004). Professionals with an attitude influenced by the “with woman” ideology may face difficulties when working in an organisation influenced by the ”with institution” ideology. These differing models of care might impose contradicting requirements on professionals, and balancing them might require an emotional effort from professionals (Hunter, 2001, 2004).

The personal attitudes of health care professionals can affect how they act in care situations (Sauls, 2002), and professionals’ personal attitudes

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\(^2\) Support for the partner could here be offered by professionals but also by non-professionals, such as doulas, friends or relatives.
influence the perception of the support they offer (Ekström, et al., 2006).
Attitudes are based on feelings and a varying degree of knowledge about a
specific phenomenon (Zanna, 1986), and attitudes can be described as the
individual’s disposition to act or respond in a positive or a negative way in
relation to this phenomenon (Ajzen, 2005). In order to change attitudes, a
professional training program with a combination of evidence-based lec-
tures and reflection can be efficient (Jerlock, Falk, & Severinsson, 2003). In
one study, a process-oriented training program for health professionals in
offering professional support during childbearing was performed using
evidence-based lectures with collegial discussions and individual reflection.
Participating midwives and child health care nurses changed their attitudes
towards a more facilitating and less regulating manner (Ekström, Matthiesen, Widström, & Nissen, 2005; Ekström, Widström, & Nissen, 2005). The training program for midwives and postnatal nurses resulted in
mothers being more satisfied with both the emotional and the informative
support during the first nine months postpartum (Ekström, et al., 2006).

Professional supportive role in midwifery
Offering support in childbearing has historically been an important aspect
of the midwifery profession (Bryar & Sinclair, 2011). The English term for
midwife means “with woman”, and the midwife is responsible for working
in partnership with the woman/mother and promoting self-care and health
with respect for human dignity (International Confederation of Midwives,
2012). When women gave birth at home in the 19th century, the midwife
would support and care for her as well as offer support in relation to
parenting and how to take care of the baby (Öberg, 1996). During the 20th
century, childbirth was institutionalised, and midwives would care for
more than one woman in childbirth at the same time. During this period,
the technological development of care routines in childbearing also
increased (Jansson, 2008). Technological development may influence
midwives’ supportive role, as technological tasks might be more obvious
than traditional supportive tasks (Jansson, 2008; Kirkham & Perkins,
1997; Nicholls & Webb, 2006).

When offering support midwives need to be able to respond to the
unique needs of mothers and fathers (Kennedy, 2002; Lundgren, 2004;
Pembroke & Pembroke, 2008). However, support from midwives during
pregnancy may not always be adequate (Darvill, et al., 2010; Hildingsson
& Häggström, 1999) for noticing physical as well as psychosocial needs
(Darvill, et al., 2010) or may not attend to the fathers needs for support
(Hildingsson & Häggström, 1999). Essential to midwives’ supportive role
in childbirth is trust in the mother’s own capacity (mainly appraisal support) (Kennedy, 2000, 2002; Kennedy & Shannon, 2004; Lundgren, 2004, 2005). If the midwife takes charge of the situation without respect for the mother’s own capacity the mother may lose energy, and feel powerless (Hallgren, Kihlgren, & Olsson, 2005).

The midwife being supportively present is described as crucial in support of women and their partners during childbirth (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Dahlen, et al., 2010; Kennedy, 2000, 2002; Lundgren, 2004; Nilsson, et al., 2010; Wilde-Larsson, et al., 2011). Supportive presence is a key strategy, which midwives can consciously create (Kennedy, 2002; Kennedy, Anderson, & Leap, 2010; Kennedy & Shannon, 2004). Having a professional or a non-professional support person continuously and supportively present during childbirth (i.e. continuous support) has been shown to reduce the risk of medical interventions, such as emergency caesarean birth and to promote a positive birth experience (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011). Therefore, knowledge about professional support is an important part of midwifery education (Begley, 2001).

Midwifery education
The midwifery education area focuses on human reproduction and the childbearing period. The education is focused on the normal processes in childbearing and parenting development (Hermansson, 2003). Skills development is accomplished by integration between theoretical and clinical education through reflection of health care situations (Antonsson, 2000; Ekebergh, 2002; Lyons, 1999; Phillips, Fawns, & Hayes, 2002). When students are not sufficiently prepared for emotionally difficult situations, they describe feelings of anxiety or fear (Cavanagh & Snape, 1997; Chamberlain, 1997). Student midwives also explain that their prior training in nursing made them more focused on task performance than on interaction in encounters with the mother (Begley, 2001). Being task focused and not prepared for emotional demands could make offering support during childbirth difficult, since it requires a high degree of presence while not necessarily having tasks to perform (Dahlen, et al., 2010; Kennedy, 2000).

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3 Continuous support means that a person is continuously present during childbirth for the woman and her partner. This person could be professional such as midwife or nurse, or a non-professional such as doula or relative or friend, but it should be someone the woman feels secure with.
2000, 2002; Lundgren, 2004; Nilsson, et al., 2010; Wilde-Larsson, et al., 2011). In this educational situation, supervisors are important as role models for students’ professional development (Chamberlain, 1997; Hughes & Fraser, 2011). However, supervisors might not always act like role models in a positive way, such as not being likely to stay with the woman during labour (Jordan & Farley, 2008; Lange & Kennedy, 2006).
Rationale of this thesis

Professional support is important to promote a positive experience during childbearing and a positive development of mothering and fathering whether the childbirth is medically complicated or not. Regardless of this knowledge, women and their partners perceive a lack of support during childbearing. New parents also express that they need support in parenting, such as when developing skills in interacting and caring for their newborn baby.

In order to gain a deeper understanding for the interactive process of professional support, the mothers’, the fathers’ and the professionals’ experiences need to be clarified. Consequently, further exploration is needed about parents’ experiences and their need for support, as well as how professionals perceives parents’ need for support and how these needs can be met. Further exploration is also needed to understand how professional support can be designed and how it can be learnt.
Aims of this thesis

The overall aim was to contribute to the development of optimal quality care in childbearing through exploring how professionals learn to act and how they act in support of women and their partners and what supportive needs women and their partners have during childbearing, as well as how professional support influences parents’ experience during childbearing and their relation to the baby.

Specific aims were:

Study I to explore and describe student midwife’s experiences in offering continuous labour support during childbirth to women and their partners

Study II to explore midwifery professional support during labour in relation to the needs of the woman and her partner

Study III to explore first time mothers’ feelings for and their relation to the baby associated with how they responded to the “mother to infant relation and feelings (MIRF) scale” items as a step in the validation process of the scale

Study IV to evaluate the effects of a process-oriented training program for antenatal midwives and postnatal nurses on first-time mothers’ perceptions of professional support and on their relation to and feelings for their baby after a caesarean or a normal birth
Method

Overview of the studies

The studies included in this thesis were conducted using both qualitative and quantitative methods as has been suggested when exploring the complexity within childbirth (Enkin, 2006; Polit & Beck, 2011). The studies were designed to contribute to a deeper understanding of professional support from different perspectives as well as from the experiences from women and their partners and their need for support during childbirth. The studies were conducted in two different settings (I & IV in one setting and II & III in another setting) in the South West of Sweden. An overview of the studies is presented in table 2.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Method</th>
<th>Participants</th>
<th>Analysis</th>
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<tbody>
<tr>
<td>I</td>
<td>Qualitative</td>
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<td>Student midwives diaries from offering support during childbirth</td>
<td>Student midwives (n=11)</td>
</tr>
<tr>
<td>II</td>
<td>Qualitative</td>
<td>Explorative</td>
<td>Triangulation; observation during childbirth followed by individual interviews within one week after childbirth</td>
<td>Midwives (n=7) and the women (n=7) and their partners (n=7) that the midwives cared for during childbirth</td>
</tr>
<tr>
<td>III</td>
<td>Qualitative</td>
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<td>IV</td>
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</tr>
</tbody>
</table>
Study I

Setting
This study was conducted in the southwest of Sweden in a hospital that records approximately 2,500 births per year and serves urban, suburban, and rural districts. Continuous support during childbirth by professionals is not routinely offered in the labour ward. Around four to six midwifery students attend clinical education at the labour ward at the same time and there will be midwifery students in the labour ward for around 30 weeks annually.

Extra training in support
The study was inspired by the theories about continuous support during childbirth developed by Klaus et al. (1993). This theory was introduced in lectures and seminaries to professionals at the labour ward in 2002 by teachers of the University and Marshall and Phyllis Klaus (Klaus & Kennell, 1997; Klaus, et al., 1993). The professionals at the labour ward were also trained in how to create a supportive environment for the students to full fill their training in offering continuous support.

The extra training for the students in offering continuous support was performed as follows; First the students had lectures about research in offering continuous support including physical support techniques such as massage, emotional support techniques such as eye contact or appraisal support techniques such as verbal reassurance (Adams & Bianchi, 2008; Enkin et al., 2001; Miltner, 2002). The students would then offer continuous support during childbirth to five women/couples each during their clinical training at the labour ward. Offering continuous support included continuous availability to the woman and her partner and offering support to them as needed. During this pedagogical part of the midwifery education the students were asked to especially to focus on offering support to the expectant parents and to put aside other learning skills of a student midwife.

Participants
A voluntary sample of 11 student midwives from the midwifery program of 2002 to 2003 agreed to participate in this study. The students varied in age between 26 to 45 years, and their experience in nursing prior to midwifery education varied from 1 to 15 years. Altogether these 11 students offered continuous support during childbirth to 55 women and their partners.
Data collection procedure
Women and their partners in the catchments area of the hospital were informed about the project during their pregnancy by their antenatal midwife. When the woman and her partner arrived at the delivery ward the couple was asked if they wanted to be included in the study. Couples who accepted to participate in the study would have a student midwife offering continuous support to them until the birth of their child. Among the women accepting to be part of this study half were first-time mothers and half were multiparous mothers.

Written diary
The students were asked to write a diary about each of the five childbirth occasions where they offered continuous support, to encourage reflection and to explore their experience in offering continuous support. The diary should be structured with one part describing the situation, the woman and her partner’s reactions, and any action that was chosen to meet these reactions. The other part of the diary described the student’s own thoughts, feelings and reflections about the situation (Ekebergh, 2002). During and after the clinical training the students reflected their experience in forum plays (Byréus, 2001) and focus group discussions (Babour & Kitzinger, 1999). This pedagogical part aimed to improve the students skills development in their professional role accomplished by integrating theoretical and clinical knowledge through reflection (Antonsson, 2000; Ekebergh, 2002; Lyons, 1999; Phillips, et al., 2002).

Data analysis
The diaries of the student midwives were analysed using qualitative content analysis, which would allow the researcher to interpret the underlying meanings of the text, as suggested in the literature (Granheim & Lundman, 2004).

A clean copy of the written diaries was made and was then read through several times to get a grasp of the whole. After reading the text meaning units of the text were identified and the text of each meaning unit was concentrated close to the text. The concentrated text was used as a base for interpretation of the meaning. During interpretation sub-themes were identified (Table 3).
<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Concentration close to the text</th>
<th>Interpretation of the meaning of the text</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>L is so strong and works quiet and methodically. She is in deep concentration.</td>
<td>The woman is working quietly and methodically, deeply concentrated.</td>
<td>The student experiences that the woman has an ability to focus and thus to cope with intense labour.</td>
<td>Offering reassurance</td>
</tr>
<tr>
<td>We try massage on her lower back. E found it helpful.</td>
<td>Massaging the woman can help her.</td>
<td>The student can offer relief for the woman with her hands.</td>
<td></td>
</tr>
</tbody>
</table>

The main theme emerged at the end of this process. The interpretations and themes were discussed with supervisors and co-authors for comparison and validation.

**Study II**

**Setting**
This study was conducted in the southwest of Sweden in a hospital that records approximately 3200 births per year and serves urban, suburban, and rural districts. The labour ward is organized with a coordinating midwife having responsibility to handle all incoming communication, i.e. when women in labour call for advice or when they arrive at the labour ward. This organization will enable other midwives to care for the woman in their charge without having to answer when the phone or the doorbell rings. The ward has care memos stating that the staff should strive to establish a good communication with the woman to create security and trust. The staff should also strive to be present in the room as much as possible with the woman and special attention should be given to first time mothers.

**The physical environment in the labour rooms.** The labour rooms were quite similar in terms of environment. There was a front room that was delimited to the labour room by a curtain, which could be drawn to fully cover the view from the door if anyone should open it. In the labour room there was a hospital bed placed in the centre of the room. Along the right side were a wash basin, some stools and a shelf for weighing the babies. There were three windows and curtains in a variety of different colours between the rooms. There were two or three plants on the window sill. A
computer, an electric foetal monitor, a nitrous oxide apparatus, an arm chair and a bed side table were on the left side of the room. When entering the room a couple’s luggage could have been put in the window sill or placed over the baby cot. Male partners typically wore their own clothes, while mothers more often wore hospital clothes. The midwives wore more or less the same outfit – a blue dress or shirt together with blue trousers.

Participants
The participants for this study were midwives (n = 7) at the labour ward and the woman (n = 7) and her partner (n = 7) whom these midwives had cared for during the observation. The participating midwives were purposefully selected (Patton, 2002), on the basis of their years in the profession and experience of childbirth. The women and their partners were included on the basis of being cared for by the participating midwives during the observation. All participating midwives were women and they had from 9 to 30 years of practice within the labour ward and other areas of midwifery practice. Five of the seven women were first time mothers and two had their second child, their age varied from 20 to 37 years and their education from secondary school to university education. The women’s partners were four first time fathers and three had their second child, their age varied from 25 to 36 years and their education from secondary school to university education. All couples lived together, they were ethnically Swedish and their living conditions varied from apartments in towns to villas in the countryside.

Data collection procedure
For this study triangulation was used (Patton, 2002). An observation was performed based on the model “observer no participation” (Rees, 1997), followed by individual interviews (Kvale, 1997) capturing individual experiences and perceptions of the midwife, the woman and her partner. Obstetric and demographic data were collected in connection with the interviews. Data was collected from October 2009 to June 2010.

Observations
In order to agree on a date for the observation the observer (the author ST) initiated a contact with each of the midwives who had given their consent to participate in the study. These participating midwives then asked the woman and her partner for their consent to participate and a written consent was obtained. The observations started with the observer entering the labour room and ended after four to five hours, or if the baby was born. The observer remained in the room when the midwife left the room and
careful observation notes were taken continuously. A check list to capture
details and areas of importance (Rees, 1997) had been set up to remind the
observer what to especially focus on, but the observations were unstruc-
tured. The observation notes were transcribed within a couple of days from
the observation, and then completed from memory and with reflections
specifically noted.

Interviews
When the observation was completed the observation notes were read
through and notes of interest based on the aim of the study were marked.
These notes formed the basis of the interviews with the midwife, the wom-
an and her partner. The interview of the midwife also contained over all
questions, about the responsibility of the midwife in relation to support
during labour and the needs of the woman and her partner. The interviews
with the woman and her partner also contained overall questions, about
their experience of giving birth/being present when the baby was born and
what needs for support the woman herself or her partner had. The inter-
view questions were open and the interview persons were given space to
express their thoughts in their own words (Kvale, 1997), and when neces-
sary questions were posed aiming to encourage the interviewee to expand
their description. Interviewing the midwives was done within 24 hours
after the observation on the labour ward, in private. Interviewing the
women and their partners was done within a week after the observation on
the maternity ward or in their home. The interviews were digitally record-
ed and transcribed verbatim.

Data analysis
Observation note transcripts and interview transcripts were analysed using
hermeneutic text interpretation to explore professional support during
labour in relation to the needs of the woman and her partner. Hermeneutic
means understanding through interpretation, and important is the relation
between the whole and the parts and the movement in between, the “her-
menetic circle”. Hermeneutic text interpretation is characterized by its
focus on the receiver (Gadamer, 2002). The interpretation was done in
close dialogue with the text and keeping an open mind. Pre-understanding
could assist when interpreting the text. However, pre-understanding could
also obscure the meaning of the text and pose a hindrance to seeing some-
thing new (Gadamer, 2002). One way to identify if the pre-understanding
is dominating the result is to look for parts in the data and in the result
that are outstanding or surprising (Nyström & Dahlberg, 2001).
The interpretation started by reading the observation notes and the linked interviews with an open mind to gain a first general understanding of midwives professional support during labour. Then the texts were read through again and notes were made and any questions that arose were noted. Answer for the questions were then looked for in the data. The analysis continued interpreting the text in parts by identifying strophes of the same meaning and getting an idea of the horizon of the text and the horizon of the interpreter (Gadamer 2002). The questions asked to the text were *How can we understand midwifery professional support during labour, How will midwifery professional support present itself during labour, How will the woman and/or her partner experience these situations and What supportive needs does the woman or her partner express during labour?*

The results were organized in themes. Then the themes and the text were read through to search for a new whole, a main interpretation, moving from the whole to the parts and back to the whole again. The main interpretation was structured at a more abstract level (Dahlberg, Dahlberg, & Nyström, 2008) and the concepts “with woman” and “with institution” as described by Hunter (2004) were used in order to explore professional support during labour in relation to the needs of the woman and her partner.

**Study III**

**Setting**
This study was conducted in the southwest of Sweden in a hospital that records approximately 3200 births per year and serves urban, suburban, and rural districts. Mothers are usually moved from the labour ward to the maternity ward approximately two hours after birth. In most cases, first-time mothers leave the hospital within 72 hours after birth.

**The MIRF scale**
The Mother to Infant Relation and Feelings (MIRF) scale contained two parts, the first part investigated aspects of the mothers’ perception about their relationship with the baby (George & Solomon, 1999; Klaus, Kennell, & Klaus, 1995; Mercer, 2004). Participants were asked to respond to statements such as, “I talk a lot with my baby,” “I enjoy resting when my baby is with me,” “I enjoy breastfeeding,” “I feel that my baby is my own,” “I know what my baby wants,” “My baby is more beautiful than other babies,” and “My maternal feelings are very strong.” All the items were then rated on a Likert scale ranging from 1 to 7, with 1 signifying
“disagree” and 7 signifying “agree completely.” For all three sets, the end-
point, “agree completely,” sometimes represented a positive assessment
and sometimes a negative assessment, thus avoiding the risk of routine-like

The second part of the MIRF scale investigated aspects of the mothers’
perceived feelings for the baby (George & Solomon, 1999; Klaus, et al.,
1995; Mercer, 2004), and the participants were asked to respond to the
following emotions: “cold – warm,” “insecure – secure,” “not confident –
confident,” “difficult – easy,” “unstable – stable,” and “distant – close.”
The mothers were asked to grade their perception on a 7th-grade scale that
was occasionally reversed in order to avoid routine like response (L.

Participants
To ensure variation, a purposive sampling strategy was adopted (Patton,
2002) considering age, education and type of birth. Inclusion criteria were
first-time mothers with a full-term pregnancy and the baby should be one
to three days old. Ten first-time mothers accepted to participate in the
study, varying in age; from 18 to 40 years, education; from secondary
school or less to university and type of birth; five with normal births, two
with complicated vaginal births, and three with caesarean births. Their
babies’ age ranged from 1.5 to 2.5 days when the interviews were per-
formed. All ten mothers were living with the baby’s father.

Data collection procedure
Both interviews with open questions and questions guided by the MIRF
scale were used. This approach was inspired by the “Think aloud” method
(Drennan, 2003) and generated a combination of spontaneous answers to
open questions and answers guided by items from the MIRF scale. Data
was collected from December 2009 to January 2010.

Access to the informants was gained through a midwife at the maternity
ward. Mothers who met the inclusion criteria and who fulfilled the purpos-
ive sampling strategy were approached by this midwife who informed them
and obtained a written consent. Thereafter, the interviews were conducted
by the author (ST) at the maternity ward in private (Kvale, 1997). The
interviews were digitally recorded and all the recorded interviews were
transcribed verbatim before analysis.
Interview
To create a relaxed atmosphere, the interview started with a general open question about becoming a mother. After this, two specific questions were asked: Describe your relationship with your baby and Describe the feelings you have for your baby. These open questions were followed by questions aiming to encourage the mothers to freely elaborate on the description of their experiences. After the open questions, the mothers were asked to respond to the MIRF scale (described above), during which time the recorder was turned off. When the mothers had finished responding, the recorder was turned on again. The interviewer asked about the mothers’ overall experience in answering the MIRF scale; subsequently, the mothers were asked about their thoughts on each item and why they answered each item the way they did. When necessary the mothers were encouraged to elaborate on their description.

Data analysis
For the open questions, an inductive qualitative content analysis was used (Elo & Kyngäs, 2008) to explore the direct experience of the mothers. The analysis started with reading the transcripts of the open questions to get a sense of the whole. Next, the text was read thoroughly, highlighting relevant parts in the text and codes were made that captured the mothers’ relation to and feelings for the baby. These codes were derived close to the text. Working through the data, efforts were made to limit the codes as much as possible and new codes were created when necessary so that all relevant parts of data would fit into a code. When all data from the open questions were coded, the content of each code was examined and compared to other codes, and categories were identified. Finally, the identified categories were examined to identify how they were related as presented in the main category. During the analysis, transcripts, codes and categories were discussed and reflected on with the supervisors for comparison and validation.

Regarding the answers to the MIRF-scale items, a deductive qualitative content analysis was used (Elo and Kyngäs, 2008). The mothers’ answers for each item were read through and analysed to understand their thoughts for each item, and the meaning of each item was identified. When answers from mothers to the MIRF scale items were lower or higher, their individual description of these MIRF scale items was analysed (see Table 6 in the result section). This procedure allowed for comparison in order to understand what inference could be drawn (Streiner & Norman, 2008) from the
different items of the MIRF scale. Finally the results from the inductive and deductive analyses were compared to identify their coherence.

**Study IV**

**Setting**
This study was conducted in south-western Sweden. During their pregnancy women within each municipality at the time of the study met with the same midwife approximately 8 to 11 times. The labour ward of the area had around 2 500 births per year and midwives in the labour ward did not normally meet women during pregnancy. When the study was conducted length of hospital stay after birth for women was for at least six hours but rarely longer than four days. After the baby was discharged from the hospital, a postnatal nurse from the child health centres within the municipality assumes responsibility for the baby’s health care and continues to do so until the child is six years of age.

**Randomization**
This study is part of a randomized, longitudinal intervention study that was conducted between 1999 and 2003 (Ekström, Matthiesen, et al., 2005; Ekström & Nissen, 2006; Ekström, et al., 2006). The randomization was based on the findings of a baseline study about mothers experiences of support during childbearing and breastfeeding (Ekström, et al., 2003 a; Ekström, et al., 2003 b). The 10 largest municipalities in the selected area were grouped into pairs according to their size and the duration of breastfeeding. These paired municipalities were randomly designated to intervention (five municipalities) or control (five municipalities) groups. The antenatal midwives and postnatal nurses were allocated to either intervention group (IG) or control group (CG) depending on which municipality they worked in.

**Process-oriented training**
An intervention through a process-oriented training program in professional support during childbearing was conducted from September 1999 through to March 2000, including midwives and postnatal nurses working in the intervention municipalities. The process-oriented training program included seven meetings, which were composed of evidence-based lectures with collegial discussions on professional stance, reflective processes, problem-solving processes, and practical skills in relation to support during childbearing and breastfeeding. Both the literature and the lecturers raised parenthood, breast-feeding, relations, attachment, the baby’s ability as well
as complications around childbirth and the effect these might have. The intervention included continuity in parental education groups during pregnancy throughout the first year after birth with cooperation between the antenatal midwife and postnatal nurse. To evaluate effects of this intervention first time mothers from both IG and CG municipalities were asked to answer questionnaires regarding their experiences of professional support and their relation to and feelings for the baby.

Participants
Inclusion criteria were Swedish-speaking, first-time mothers, giving birth to a singleton, healthy baby at term, and who had received care at either the intervention site or the control site, as described above. Excluded were mothers who gave birth to children with life-threatening diseases or malformations. Information about mothers full-filling inclusion criteria were consecutively retrieved from the hospital registry. Mothers participating in the study had a caesarean birth (IG n=33, CG n=61, total n=94) or a normal birth (IG n=116, CG n=185 total n=301) in total n = 395 mothers. The mothers had either been cared for by healthcare professionals at the five intervention municipalities (IG), who had received process-oriented training as described above, or had been cared for by healthcare professionals at the five control municipalities (CG) who had not received training. The mothers did not know if their antenatal midwife and postnatal nurse had received process-oriented training (IG) or not (CG).

Data collection procedure
Mothers were invited to participate in the study from April 2000 through April 2002. Maternity staff members distributed the first questionnaire to mothers on the third day after childbirth. Follow-up questionnaires were sent to the mothers’ homes one week before the baby was due at three months and nine months old. One reminder was sent two weeks after the initial questionnaire to the mothers who did not respond. Obstetric data were collected from the birth records and demographic background data were collected together with the first questionnaire.

Questionnaires
The questionnaires were developed for the longitudinal study and included two scales; one scale assessing professional support and one scale assessing mothers’ relation to and feelings for the baby (MIRF) (described above study III). The questionnaires (including the scales) were pilot tested by 20 mothers and minor amendments were made accordingly. The questionnaires (including the two scales) were also controlled for face validity
(Bowling, 2002, 2005; Streiner & Norman, 2008) by a group of midwives, paediatric nurses, obstetricians and paediatricians.

Scale assessing mothers’ perceptions of professional support from the antenatal midwife and the postnatal nurse. The mothers were asked to reflect on their perception of two aspects of the professional support: emotional support and informational support. Emotional support reflects the individual’s emotional experience of receiving care (Oakley, 1994). In this study, the mothers’ perceptions of the following caregiver behaviours were assessed: the extent to which the caregivers “were sensitive,” “were understanding,” “were supportive,” “provided time,” and “were calm.” Informational support refers to the perception of practical advice given by healthcare professionals (Oakley, 1994). In this study, informational professional support included the mothers’ perceptions of “breastfeeding information” and “knowledge of the baby’s needs.” All items were then rated on a 7th grade scale that was occasionally reversed in order to avoid routine like response (L. Cohen, et al., 2009; Polit & Beck, 2004).

Data analysis
For the statistical analyses the Statistical Package for the Social Sciences (SPSS, Version 15.0) was used. Chi-square tests were performed on the categorical data. Central measurements were presented as mean (m) and dispersion by standard deviation (SD).

All items representing the mothers’ relation to and feelings for the baby (the MIRF scale) were entered into a principal component factor analysis using varimax rotation in order to reduce the amount of data tested. Three factors with an eigenvalue > 1 and a factor-loading > 0,4 were identified for all 14 items and one cross-loading was found. The first factor, “Taking in baby,” contained six items with item loadings ranging from 0,76 to 0,96. The second factor, “Confidence in relation to baby,” contained six items with item loadings ranging from 0,60 to 0,87. The third factor, “Feelings for baby,” contained two items with item loadings ranging from 0,65 to 0,83. The cross-loading between factor two and three was determined to belong to factor two due to the higher factor loading (0,62). To evaluate internal consistency for the factor analysis, Cronbach’s alpha was calculated (L. Cohen, et al., 2009; Polit & Beck, 2004) and determined to be 0,80 for Factor 1, 0,83 for Factor 2, and 0,61 for Factor 3 (Table 4).
Table 4 Factor analysis for the Mother to Infant Relation and Feelings (MIRF) scale items three days after birth.

<table>
<thead>
<tr>
<th>MIRF scale items</th>
<th>Components</th>
<th>Name used in analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold – warm</td>
<td>0,96</td>
<td>Factor 1; Taking in baby</td>
</tr>
<tr>
<td>I talk a lot with my baby</td>
<td>0,94</td>
<td>Cronbachs alpha 0,80</td>
</tr>
<tr>
<td>I enjoy resting when my baby is with me</td>
<td>0,93</td>
<td>Cronbachs alpha 0,80</td>
</tr>
<tr>
<td>I enjoy breast-feeding</td>
<td>0,92</td>
<td>Cronbachs alpha 0,80</td>
</tr>
<tr>
<td>Insecure – secure</td>
<td>0,87</td>
<td>Cronbachs alpha 0,80</td>
</tr>
<tr>
<td>I feel that my baby is my own</td>
<td>0,76</td>
<td>Cronbachs alpha 0,80</td>
</tr>
<tr>
<td>Not confident – confident</td>
<td>0,87</td>
<td>Factor 2; Confidence in relation to baby</td>
</tr>
<tr>
<td>Difficult – easy</td>
<td>0,82</td>
<td>Cronbachs alpha 0,83</td>
</tr>
<tr>
<td>Unstable – stable</td>
<td>0,78</td>
<td>Cronbachs alpha 0,83</td>
</tr>
<tr>
<td>Distant – close</td>
<td>0,70</td>
<td>Cronbachs alpha 0,83</td>
</tr>
<tr>
<td>Unpleasant – pleasant</td>
<td>0,62 0,44</td>
<td>Cronbachs alpha 0,83</td>
</tr>
<tr>
<td>I know what my baby want</td>
<td>0,60</td>
<td>Cronbachs alpha 0,83</td>
</tr>
<tr>
<td>My baby is more beautiful than other babies</td>
<td>0,83</td>
<td>Factor 3; Feelings for baby Cronbachs alpha 0,61</td>
</tr>
<tr>
<td>My maternal feelings are very strong</td>
<td>0,65</td>
<td>Cronbachs alpha 0,83</td>
</tr>
</tbody>
</table>

Extraction method: Principal component analysis; Rotation method: varimax with Kaiser normalization. Cronbach’s alpha was calculated for items within each factor.

Differences between groups were tested using an independent Students t-test, with two-tailed significance. P-values < 0,05 were considered significant (L. Cohen, et al., 2009; Polit & Beck, 2004). Cohen’s guidelines were used to calculate the effect sizes in order to interpret clinical change, and the effect was defined as small (> 0,20), moderate (> 0,50) or strong (> 0,80) (J. Cohen, 1988; Kazis & Andersson, 1989).

A forward multiple linear regression analysis was performed to explore the impact of the two obstetrical variables (1 skin-to-skin contact after birth, 2 mode of delivery,) the variable belonging to the intervention group or the control group and the seven variables for perceived professional support (1 were sensitive, 2 were understanding, 3 were supportive, 4 time provided, 5 were calm, 6 breastfeeding information, 7 knowledge about the baby’s needs) on the dependent variable the “Taking in baby” factor at three days after birth. All independent variables were entered into the model (L. Cohen, et al., 2009).
Ethical considerations

Childbirth is a sensitive time for women and their partners. Conducting research calls for sensitivity and openness in order not to cause stress for participants. Informed consent was obtained from all participants as well as consent from the head of the clinic and the head of the ward of the antenatal centres, labour and maternity wards and child health centres. Ethical approval from The Ethical Review board in Gothenburg was obtained for all four study’s: study I no 379-05, study II no 115-09, study III no 405-09 and study IV no 379 05.

An ethical consideration when performing research in childbirth is that the women and their partners should be prepared for the question to participate before labour starts. For study I and II information was provided at the antenatal visits so parents should be prepared if questioned about participation. In addition of this overall information every woman and her partner got individual information about the study before the support (I), observation (II) or interview (II & IV) began, as well as information about their option to decline to participate or to discontinue participation in the studies. When performing observations during childbirth situations could arise where the observer might feel ethically obliged to intervene. The observer had mentally prepared for such a situation but no such situation occurred (II). If a situation developed where the student midwife offering continuous support during childbirth and the woman/couple did not get along this could lead to unsatisfactory support. If this situation occurred it was decided that it could be resolved by allowing the student to withdraw and the supervising midwife would then replace her. This replacement would be done by increasing the midwife’s presence with the woman/couple (I). To Interview or to hand out questionnaires to first-time mothers close to birth could be an ethical dilemma since childbearing is a vulnerable period in life (III & IV). However, in the event of such a problem, appropriate professionals at the maternity ward would have been contacted (III). The written information provided to the mothers also contained information on where they could turn in such cases (III).

Both student midwives (I), midwives, women and their partner (II) and mothers (III), expressed that it felt important to reflect about the issues raised in the study and that it was overall a positive experience to participate. Many of the mothers answering questionnaires (IV) wrote comments which could mean that they found the questionnaires meaningful to answer.
Results

Study I
Student midwives’ experiences in offering continuous support during childbirth to a woman and her partner could be described through the main-theme, To establish rapport and the subthemes; To be present, A sense of confidence, To offer reassurance, The need for reassurance, A sense of powerlessness and A lack of confidence (Figure 1).

![Figure 1; The relation between the main theme and the subthemes describing the student midwives’ experiences in offerings continuous labour support.]

The main-theme
The student tried To establish rapport by talking to the woman and her partner and/ or offering practical support. The student experienced that to establish rapport was essential to make the support effective and she tried to make this work as best she could.

Subthemes
A sense of confidence; the student experienced a sense of confidence when rapport was established with the woman and her partner and when she felt she knew what her function was. The student’s feeling of confidence rested in her own sense of competence and security felt in the good relationship
with the woman and her partner. In this situation the student felt confident with her supportive ability.

**To be present;** the student experienced that the woman did not want to be left alone. In some cases the partner also had a wish for the student to be with them. The presence of the student helped to make the woman relaxed and feel more secure. The student felt that her presence was necessary to be able to establish rapport even when she did nothing but be present. She also was astounded by the fact that physical touch could establish emotional interaction with the woman.

**To offer reassurance;** the student experienced a growing ability to strengthen and reassure the woman of her capacity as well as her partner’s capability to assist her. Offering continuous support during childbirth reassured the students of women’s capacity to give birth. The student used this experience to reassure other women of their capacity. The student’s ability to offer reassurance to herself would also increase when she grew more experienced with childbirth and her own supportive ability.

A **sense of powerlessness:** the student felt a sense of powerlessness in situations when she tried to establish rapport with the woman and her partner but the response failed or was unclear. Sometimes the student suffered with the woman in great pain and felt powerless. After an epidural the woman could become more responsive. This helped the student feel that she was successful in establishing rapport and thus her sense of powerlessness would decrease or vanish.

**The need for reassurance;** the student had a need for tangible reassurance from the woman and/or her partner and this need for reassurance could make her less able to offer a good quality support. The student also needed reassurance from her supervisors about her ability to offer support in order to continue her efforts to establish rapport when this was difficult or failed.

A **lack of confidence:** the student described offering continuous support during childbirth as a task not normally included in the role of a student midwife and this created a lack of confidence. The student also found it difficult to know what the woman and her partner expected from her and if they wanted the support she could offer. Her sense of confidence seemed to be strongly connected with her medical knowledge as well as with her perceived role as student midwife.
Study II
Midwifery professional support during childbirth in relation to the needs of women and their partners could be described through the three themes; Support as professional task seems more unclear and less well-defined than medical controls. Midwives and parents express somewhat different supportive ideas about how to create a sense of security and Partner and midwife interacting in support of the woman. The main interpretation is presented after the presentation of the themes.

Themes
Support as professional task seems more unclear and less well-defined than medical controls. The midwives attention towards supportive needs was varying and seemed to be based in their own idea of what care during childbirth aimed for and on their own personal experience from childbirth. The midwives place their attention differently and this seems to affect what supportive needs of the woman or her partner that they meet. The midwives might only meet clearly expressed needs or they might also meet needs that were ambiguous or vaguely expressed by the woman or her partner.

Contraction – the woman breathes nitrous oxide. The midwife turns to the computer and writes. The woman puts her hand over her lower back. She let’s go of the nitrous oxide and takes a deep breath. (observation notes, woman first child)

Midwife; Well it is difficult to ... how can one know how ...// ... I could imagine that most perhaps want to be left alone...// ... yes I do not want other people to fuss with me when I have a contraction ... (interview midwife)

There seemed to be more consistency in performing medical controls than in offering support to the woman and her partner. This difference seems to be that the midwives varied in certainty or knowledge when addressing the unique supportive needs of the woman.

Midwives and parents express somewhat different supportive ideas about how to create a sense of security. The midwives and the woman/ couples agreed on the importance of continuous credible information when offering support to create a sense of security. However, when the information not was connected to the actual situation or contradictory to the idea of the woman or her partner the information was not considered supportive by them. One aspect of professional support is to invite the woman
to participate through awaiting her readiness before performing examinations and this was done by all midwives.

To the woman and her partner the presence or absence of the midwife seemed important to their sense of security in childbirth

*Woman:* ...well it was that last period when I started to feel the urge to push and she had this other patient to report and so... so then I got a bit frustrated that she disappeared I did because then I felt that now the baby is on the way and then it was still two more hours (she laughs) really... but... it did feel a bit... then it was a bit scary that she left actually... (interview woman first child).

*Midwife:*...eh.. I knew she had good support from her husband and that she would not give birth right now and I had this other woman that I had to attend to...//... I How do you think she experienced this that you left there? *Midwife:* she and many with her will first feel some panic because of their urge to push and they do not want to be alone but if I explain again so that she can understand ...//... it was the same with her or with them, they understood and she did not ring the bell but she was secure in this ... (interview midwife)

The importance of the midwives presence as supportive strategies to create security was not entirely acknowledged by the midwives. Likewise was joking and small talking considered as security creating by the woman and her partner but not entirely acknowledged by the midwives as supportive strategies to create security.

**Partner and midwife interacting in support of the woman.** The midwife and the woman’s partner interacted when offering support to the woman and this interaction looked almost like a “dance”. If the partner was first time parent the midwife may need to offer more guidance in how to offer support to the woman hence also making him involved in the process. Interaction between the midwife and the partner in offering support to the woman seemed difficult when the partner and the woman did not agree for example about her need for pain relief.

*She is breathing and groaning. He looks at her and says; what do you think, should you try nitrous oxide? She answers; I feel rather ok. He replies; You do not look ok to me...//... He asks the midwife; is it time to think about anaesthesia now? The midwife; yes if you (she turn to the woman) feel that you need something*
more then it is time for that now… (observation notes, couple first child).

The midwife may also interact with the partner in offering support to the woman as well as to the physical process. The midwife and the partner could interact to reach a contact with the woman if she was very tired or vague. However when the midwife was mainly focused at the woman and tasks to perform she might not interact at all with the partner in offering support of the woman.

The midwives’ seemed to vary in interacting, meeting and supporting the partners need to act supportive towards the woman. The partner could be seen as someone who was not really involved in the situation at one side of a continuum or the partner could be seen as important, involved and in need of guidance and support to full-fill his part on the other side.

Main interpretation
How professionals act supportive during childbirth could be understood as being mainly affected by the midwife adopting the ideology named “with institution” more than the “with woman” ideology as described by Hunter (2004). These ideologies could be seen as having different focuses; the “with woman” ideology focuses on creating and sustaining a relationship with the unique individual woman and her partner while the ”with institution” ideology focuses on efficiency in performing tasks and risk management. These different focuses could affect offering support. Within the “with woman” ideology offering professional support seems clear within midwives professional role and in co-operation with the partner, while within the ”with institution” ideology offering professional support seems unclear, vague and based on the midwives own personal experiences.

When the midwives adopt the “with woman” ideology their attention would be placed on the needs of the woman and her partner. This could be understood as making the midwife more aware of and prepared to meet both clear and ambiguous supportive needs that the woman and her partner might express during childbirth. When the midwives adopt the ”with institution” ideology their attention would be placed on performing tasks and on risk management, And this could be understood as making the midwife less aware of and prepared to meet ambiguous supportive needs which might then be addressed with uncertainty or not at all.

The ideologies “with woman” and “with institution” could be understood as illustrating a contradiction in emphasizing what professionals
should focus on during childbirth. However, the “with woman” ideology seems to be more adequate in meeting the supportive needs expressed by the woman and her partner than the “with institution” ideology.

**Study III**

First time mothers’ experience of their relation to and feelings for their baby was described in the open questions presented by the main category; **New mothers bewilderment and anticipation** and the four sub categories; **Natural and great but mixed, Maternal instinct and kinship, Ability and expectations** and **Not yet for real** (Table 5). Mothers descriptions in relation to how they responded to the MIRF scale is described below and finally coherence between the open questions and the questions based on the MIRF scale items are presented.

<table>
<thead>
<tr>
<th>Main category</th>
<th>New mothers’ bewilderment and anticipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-categories</td>
<td>Natural and great but mixed</td>
</tr>
<tr>
<td></td>
<td>Maternal instinct and kinship</td>
</tr>
<tr>
<td></td>
<td>Ability and expectations</td>
</tr>
<tr>
<td></td>
<td>Not yet for real</td>
</tr>
</tbody>
</table>

**The open questions**

The main category described; **New mothers bewilderment and anticipation.** The mothers described an overall situation of overwhelming feelings that were **Natural and great but mixed.** What they felt for the baby was both self-evident and contradictory at the same time. This situation is derived from wanting to protect—**Maternal instinct**—and feeling connected to—kinship—the baby. There is an anticipation to become a mother: they long for it but hesitate to engage in it at the same time. This new life as a mother is unknown to them but is also related to their feelings of **Ability and expectations.** This is based on their sense that it is **Not yet for real,** which stems from not really knowing what life as a mother or as parents will be like and not having experienced to have the baby by themselves in their home. All this creates a slightly chaotic situation that is bewildering (Table 5).

**Natural and great but mixed:** described emotional chaos and contradictory feelings for the baby. It included thoughts such as having this baby was the greatest thing that had happened to them, described as feelings of
love, warmth, and happiness but also as feelings of worry, tension and
erenity in relation to the vulnerable baby. At the same time, mothers
were astonished by the ability of their baby. Their baby was described as
different from all other babies, but they felt uncertain not knowing what
becoming parents would mean. It was described as feelings that were natu-
ral and great, not strange but mixed.

**Maternal instinct and kinship:** described feelings of being connected to
and wanting to care for and protect the baby and that the birth was some-
thing they had done together with the baby. Mothers described being pre-
pared to do everything to protect the baby and these feelings made it dif-
ficult for mothers to leave the baby with anyone else. They wished the best
for the baby and thus neglected their own needs. They described their feel-
ings as strong because the baby was part of themselves and therefore they
felt that they had started bonding.

**Ability and expectations:** described the experience of and expectations
for their perceived ability in relation to their baby, from both an emotional
and a practical perspective. They expected to feel incredible love for the
baby and expected the baby to love them back. The initial few days after
birth were occupied with their practical ability—how to hold and how to
console the baby. This new situation inflicted uncertainty, and it was de-
scribed as fearing that they would not be able to act appropriately. When
not being able to care for the baby, they described that it had a negative
impact on their developing relationship. But when being able to care for
the baby, they described that their engagement increased. The professionals
at the maternity ward were regarded as a safety net since the mothers were
free to seek advice whenever needed.

**Not yet for real:** described feelings of surrealism, which seemed to be
caused by not being at home. Even after two days, giving birth to this baby
was very unreal. It did not help to have been pregnant for nine months it
was still difficult to understand, even though the baby was born. Remain-
ing in the maternity ward and not taking full responsibility for the baby
contributed to this unreal feeling. It was difficult to understand that the
baby was not somebody else’s, and it felt strange to imagine coming home
with this baby that was supposed to live with them. There was a strong
reliance that this surreal feeling would sort itself out once they were home
and then all would become for real.
Questions based on the MIRF-scale

Examples of the mothers’ responses to items of the MIRF scale are presented in Table 6. In relation to the MIRF scale items mothers describe strong but mixed feelings for the baby together with feelings of wanting to care for and protect the baby. Their perceived ability to care for the baby is also reflected in the answers. Scoring low on the MIRF scale items reflected more uncertainty in relation to and feelings for the baby and to their own feeling of competence than scoring high (Table 6).

Table 6 Example of mother’s responses to the Mother to Infant Relation and Feelings (MIRF) scale items

<table>
<thead>
<tr>
<th>MIRF scale items</th>
<th>Range</th>
<th>Mothers’ described perception of the item</th>
<th>Low-score responses</th>
<th>High-score responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I talk a lot with my baby</td>
<td>3 - 7</td>
<td>Seeking a contact with and perceiving a response from the baby but not just verbally.</td>
<td>Lack of response from the baby or using skin-to-skin contact.</td>
<td>Talking a lot to the baby also before birth, to establish contact.</td>
</tr>
<tr>
<td>Difficult/easy</td>
<td>3 - 7</td>
<td>Getting in contact with and getting a response from the baby and to have the physical ability to meet the baby’s needs.</td>
<td>Having difficulties in understanding the baby’s signals or being physically unable to meet the baby’s needs</td>
<td>Perceiving that there is a response from the baby and the baby wanting to be near you.</td>
</tr>
</tbody>
</table>

The MIRF scale is composed of seven opposing statements and seven opposing word pairs that mothers respond to on a scale graded from 1 (disagree) to 7 (agree).

Coherence between open questions and questions based on the MIRF scale

When assessing coherence between the open questions and the questions based on the MIRF scale the overall descriptions were compared. The categories and sub categories identified from the open questions describe strong but mixed feelings together with wanting to care for and protect the baby and feeling uncertain about their ability. The identified meaning from the questions based on the MIRF scale reflect the same mixture of feelings and feelings of wanting to protect the baby combined with uncertainty related to their own ability. However, in the open questions, mothers described being astonished about the baby’s ability, and this was not reflected in their answers to the MIRF-scale. In the questions based on the MIRF scale the mothers describe talking to their baby but the mothers did not mention talking to their baby in the open questions. Overall, it seems as though when mothers answered the questions related to the MIRF scale it
helped them to differentiate between their own mixed feelings of becoming mothers and their relation to and feelings for the baby. Nevertheless an overall coherence between the open answers and the answers to the MIRF scale was found.

Overall, the mothers found the scale easy to understand and to answer, although the answer in itself was occasionally difficult to describe. They mentioned that it felt good to reflect upon the different perspectives that the MIRF scale presented.

**Study IV**

**Background data**
The demographic and obstetric data for the participants and the external dropouts did not differ significantly either within or between the Intervention Group (IG) or Control Group (CG) groups (data not shown). The response rates for this subsample were 75.7% for Questionnaire I (three days after birth), 61% for Questionnaire II (three months after birth), and 57.7% for Questionnaire III (nine months after birth). With regard to demographic and obstetrical data, no significant differences existed between the mothers in the IG compared to the mothers in the CG.

**Mothers’ perceived professional support**

**Caesarean birth: Intervention Group (IG) versus Control Group (CG).** When asked three days after birth, mothers in the IG with a caesarean birth reported significantly stronger emotional professional support (were understanding, $p = 0.005$; time provided, $p = 0.045$; and were calm, $p = 0.004$) from the midwife in antenatal care compared to mothers in the CG. At three months after birth, mothers in the IG with a caesarean birth reported significantly stronger emotional professional support (were sensitive, $p = 0.006$; were supportive, $p = 0.011$) and stronger informational professional support (breastfeeding information, $p = 0.008$) from the postnatal nurse compared to mothers in the CG. At nine months after birth, no significant differences were detected between mothers in the IG and the mothers in the CG with caesarean birth.

**Normal birth: Intervention Group (IG) versus Control Group (CG).** When asked three days after birth, mothers in the IG with a normal birth reported stronger emotional professional support (were supportive, $p = 0.008$; were calm, $p < 0.001$) and stronger informational professional support (breastfeeding information, $p = 0.006$; knowledge of the baby’s needs,
p = 0.011) from the antenatal midwife as compared to mothers in the CG. Three months after birth, mothers in the IG with a normal birth reported perceiving stronger emotional professional support (were sensitive, p < 0.001; were understanding, p < 0.001) and stronger informational professional support (breastfeeding information, p = 0.001; and knowledge of the baby’s needs, p < 0.001) from the postnatal nurse as compared to mothers in the CG. At nine months after birth, mothers in the IG with a normal birth reported perceiving significantly stronger professional support from the postnatal nurse in regard to all items used compared to mothers in the CG with a normal birth.

**Mothers’ relation to and feelings for the baby**

**Caesarean birth Intervention Group versus Control Group.** At three days after birth, mothers in the IG with a caesarean birth reported significantly more positive for the “Taking in baby” factor as compared to the mothers in the CG (p = 0.002), with an effect size of 0.57. At three months, no significant differences were found between the two groups. At nine months after birth, mothers in the IG with a caesarean birth reported significantly more positive for the “Confidence in relation to baby” factor (p = 0.004) and for the “Feelings for baby” factor (p = 0.004) as compared to mothers in the CG, with an effect size of 0.52 and 0.58, respectively.

**Normal birth Intervention Group versus Control Group.** At three days after birth, mothers in the IG with a normal birth reported significantly more positive for the “Taking in baby” factor (p < 0.001) and for the “Confidence in relation to the baby” factor (p = 0.013), as compared to mothers in the CG, with an effect size of 0.59 and 0.29, respectively. At three months after birth, mothers in the IG with a normal birth reported significantly more positive for the “Taking in baby” factor (p = 0.009), as compared to mothers in the CG, with an effect size of 0.32. At nine months after birth, mothers in the IG with a normal birth reported significantly more positive for the “Taking in baby” factor (p = 0.007), as compared to mothers in the CG, with an effect size of 0.36.

**Regression analysis**

For the dependent variable the “Taking in baby” factor at three days after birth, the independent variables belonging to the intervention group, perceiving the antenatal midwife as supportive and calm contributed positively to the factor and having had a caesarean birth, not perceiving the antenatal midwife as understanding and not having the baby skin-to-skin contributed
negatively to the factor. All together these variables explained 56,9 % (p < 0,001) of the variation of the factor (Table 7).

Table 7 Forward multiple linear regression analysis for the dependant variable the “Taking in baby” factor at 3 days after birth in relation to independent variables.

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>beta</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal midwife perceived as calm</td>
<td>0,53</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Antenatal midwife perceived as supportive</td>
<td>0,26</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Antenatal midwife perceived as understanding</td>
<td>-0,16</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Control-group (=0) Intervention-group (=1)</td>
<td>0,11</td>
<td>0,007</td>
</tr>
<tr>
<td>Normal birth (=0) Caesarean birth (=1)</td>
<td>-0,23</td>
<td>0,003</td>
</tr>
<tr>
<td>Skin-to-skin after birth no (=0) yes (=1)</td>
<td>-0,17</td>
<td>0,027</td>
</tr>
</tbody>
</table>

R-square 56,9 Adjusted R-square 56,0  p = < 0,001

Included independent variables from forward, multiple linear regression analysis.
Discussion
The ideologies "with woman" and "with institution" (II), will be used in the discussion in order to clarify the results of this thesis. However, even if ideologies are incommensurable at the ideological level, they often co-exist on the practical level (Teijlingen, 2005). The "with woman" ideology focuses on relationships with the woman and her partner, and professional support seems clear within the midwives’ professional role and is based on the individual needs of the woman and her partner. The "with institution" ideology focuses on efficiency in task performance and risk management and professional support seems unclear, vague and based on the midwives’ own personal experiences (II). It should be noted that the differing ideologies are not a choice between neglecting or stressing medical safety, but they illustrate different ideological perspectives in relation to childbearing.

Professional attitudes and role models influence the quality of support
Results of this thesis suggest that professional support during childbirth is affected by midwives mainly adopting the "with institution" ideology which created uncertainty in the professional role of support (I & II). The professional role of support could reflect personal attitudes, which have an impact on the quality of offered support (Ekström, et al., 2006; Sauls, 2002), while the attitudes within the organization influence which ideology is dominating (Ajzen, 2005; Teijlingen, 2005). If organisations and professionals adopt the "with institution" ideology more than the "with woman” ideology (I & II), knowledge about professional support may be tacit, i.e., not important to know, develop and sustain (Molander, 2004). Professionals would then have to rely mainly on their own personal experience when offering professional support in childbirth, which could create uncertainty in their professional supportive role (I & II). However, extra training in support (I) or process-oriented training (IV) could increase knowledge about supportive needs and affect professional supportive attitudes in a positive way (Ekström, Widström, et al., 2005).

Results from study I show that offering continuous support during childbirth may be emotionally challenging for students, and this emotional challenge can inflict uncertainty in their supportive role. When student midwives strive to establish rapport with a woman, but they feel that she is unreachable, the students experience a sense of helplessness. This helplessness rendered a decrease in the students’ supportive presence with the woman and her partner, while the students’ need for reassurance from...
their supervisor increased (I). These results point to the importance of preparing students for emotionally challenging situations (Cavanagh & Snape, 1997; Chamberlain, 1997), as well as stressing the importance of supervisors’ supportive role (Chamberlain, 1997; Hughes & Fraser, 2011). If the supervisors do not support the students in their task to offer continuous support during childbirth, the student’s supportive ability may decrease. Professional supervision and supportive role models seem to be especially important in emotionally challenging situations in order for students to develop supportive skills (I).

However, when the student midwives managed the emotional challenge of being supportively present, they described an increased understanding for the supportive needs of the woman and her partner, as well as gaining a stronger trust in a woman’s capacity to give birth (I). These results for the student midwives are in line with other research showing that midwives’ professional supportive role is strengthened when they are present and have trust in women’s capacity to give birth (Kennedy, 2000, 2002; Kennedy & Shannon, 2004; Lundgren, 2004, 2005; Olafsdotir, 2006). When support is continuous in childbirth, it has also been shown to have positive effects, such as reducing the risk of medical interventions and increasing the chance of a positive childbirth experience for the woman (Hodnett, et al., 2011). Results of this thesis suggest that extra training in support increased student midwives’ understanding for professional support and facilitated a development of professional supportive skills (I), i.e., an attitude influenced by the “with woman” ideology (II). Extra training will increase the chance that the supportive needs of women and their partners will be met (I, II & IV).

When the midwifery students experienced a lack of confidence in offering support, they were strengthened by their medical knowledge and actions (I). Furthermore, the midwives showed more consistency in performing medical controls than in offering support (II). Uncertainty while offering professional support may promote a focus towards performing tasks, i.e., an attitude influenced by the “with institution” ideology, which may lead to the supportive needs of women and their partners not being met (I, II & IV). These results indicate that practicing midwives do not always provide the professional support that is needed by women or their partners (Jordan & Farley, 2008; Lange & Kennedy, 2006). When midwives mainly focus on task performance, such as assessing cervix dilatation or measuring blood pressure, their function as role models in professional support is be affected (Fowler, 2008; Hughes & Fraser, 2011; Jordan & Farley, 2008).
However, students need to encounter supportive supervisors as role models to develop their professional supportive skills (Hughes & Fraser, 2011; Jordan & Farley, 2008; Lange & Kennedy, 2006). If midwives mainly adopt an attitude influenced by the “with institution” ideology (II), the students will lack professional role models for midwifery supportive skills (influenced by the ideology “with woman”) (I & II), and the supportive needs of the woman and her partner during childbearing may not be met (I, II & IV).

Regardless if the ideology is mainly focused on “with woman” or “with institution, the ideology demonstrates the attitude of the organisation as well as the attitude of the professionals (Ajzen, 2005; Zanna, 1986). These attitudes influence how students are trained to act as professionals during their clinical training (Molander, 2004; Rokenes & Hanssen, 2007). However, when students understand the positive effects of certain behaviour, such as supportive presence, they report higher self-efficacy in engaging in that behaviour (Jordan & Farley, 2008). If attitudes affect knowledge about professional support to be tacit, it suggests the importance of education programs to promote training in supportive skills (I & IV). If knowledge about professional support is promoted, it will facilitate more positive attitudes and role models in professional support (I & II) and strengthen professional support for the woman and her partner during childbearing (I, II & IV).

**Ways in which professionals interact with the partner in support of the woman**

Midwives varied in interacting with the partner in support of the woman, from close interaction “almost like a dance” to nearly no interaction at all (II). Student midwives described an increased understanding for the partner’s supportive needs when offering continuous support (I). Support from the partner has earlier been described as important for the woman during childbirth (Gibbins & Thomson, 2001; Kainz, et al., 2010; Lóf, et al., 2006; Somers-Smith, 1999). Typically the partner also describe wanting to support the woman, but he express the need for support from the midwife (Bäckström & Hertfelt Wahn, 2011; Johansson, et al., 2012). However, the midwife, adopting the “with institution” ideology, might fail to interact with the partner in support of the woman (II). When the midwife fails to interact with the partner, he may experience a feeling of being excluded (Bäckström & Hertfelt Wahn, 2011; Premberg, et al., 2010). If the partner feels excluded, it may be more difficult for him to offer support to the
woman (Longworth & Kingdon, 2011). Earlier research point to the importance of professional support aiming at strengthening social support (Hupcey & Morse, 1997). Hence, a professional challenge for midwives in support during childbirth is to find ways to interact with the partner in order to strengthen his support of the woman, and thereby adopting the “with woman” ideology (I & II).

Professional support was important to create a sense of security for women and their partners during childbirth (I & II). This is in line with other research implying that women’s perception of support and their sense of control is important for them to feel safe during childbirth (Oolde et al., 2005). Being in control includes not feeling anxiety or panic (Green, 1999). However, anxiety may arise from the altered state of consciousness described as frightening by women (II). This altered state of consciousness can also be frightening to her partner (Premberg, et al., 2010). If the partner feels frightened, he may ask for pain relief for the woman, even if she express that she is able to handle the contractions (II). This may indicate that he is unable to support the woman to cope with labour or that he needs professional support in order to continue offering support (I & II). If the partner feel frightened, or is not supportive during childbirth, it may influence the woman to feel anxious or less safe (Green, 1999; Kainz, et al., 2010). Professional support during childbirth involves providing support to the partner, aiming to instil confidence in him in order to strengthen his support of her (I & II).

However, women also describe that their altered state of consciousness could mean coping with and remaining in control during childbirth (Dahlen, et al., 2010; Thompson, 2002). Perhaps experiencing the altered state of consciousness as strengthening instead of frightening is when women feel supported, feeling that all power in the room (i.e., everybody being present) is aiming at her gaining strength and courage to follow her instincts and bodily sensations, that is, integrative power (Fahy & Parrat, 2006). To accomplish that, it seems important to offer professional support in creating an atmosphere that will enhance safety and instil confidence in both the woman and her partner (Fahy & Parrat, 2006; Halldorsdottir & Karlsdottir, 1996a, 1996b; Lundgren, 2004, 2005). An atmosphere that instils confidence and enhances safety may be what the woman and her partner experience when the midwife (adopting the ideology “with woman”) in interaction with the partner supports the woman as well as the physiological process (II) or when student midwives describe being able to offer reassurance to both the woman and her partner (I).
On the other hand, when midwives adopt the “with institution” ideology (II) or when midwifery students experience a need for reassurance when offering continuous support during childbirth (I), they may have difficulty in promoting integrative power, which could lead to women losing power and having a negative childbirth experience (Halldorsdottir & Karlsdottir, 1996a; Hallgren, et al., 2005). Consequently, a professional challenge is to instil safety for the partner in order to strengthen him in support of the woman (I & II). For this to be successful, it is essential for professionals to have trust in women and their partners as well as women’s capacity to give birth (Kennedy, 2000, 2002; Kennedy & Shannon, 2004; Lundgren, 2004, 2005). This would suggest that professional support in childbearing require a mutual trust to be efficient. These results seem to be in contrast with Hupcey and Morse (1997) (Table 1), who describes mutual trust as necessary for social support but not a necessity for professional support.

**Emotional professional support is important for support to be efficient**

Process-oriented training in professional support for health professionals improved mothers’ perception of professional emotional support which had an impact on how mothers “Take in the baby” (IV). These results suggest that the emotional aspect of professional support is important to consider. Emotional support is described as most important for support to have a positive impact for the individual (S. Cohen, 1992; Langford, et al., 1997). Professional emotional support could be understood as the part of care described as to “care about”. The concept of care is multi-dimensional and has been described as both to “care about”, in the sense of having an attitude of being interested in the wellbeing of the other person, and to “care for”, in the sense of actively performing caring activity (Jecker & Self, 1991). When midwives place their attention at task performance (II) or mothers perceive professionals as less understanding (IV), it could illustrate a lack of “to care about”, i.e., a lack of emotional professional support. On the other hand, when midwives meet a wider range of supportive needs for the woman and her partner (II), or when mothers perceive professionals as more sensitive to their needs (IV), it could be understood as the professionals offering emotional professional support adopting an attitude of to “care about”, in line with the ideology “with woman”.

The process-oriented training for health professionals (IV) and extra training in support for midwifery students (I) had an impact on professionals’ ability to ”act supportive”. Etymologically the verb phrase to “act
supportive” could be understood as the provider having “trust in the capacity” of the individual, expecting him or her to “take charge” of their own situation (Ernby, 2008; Hellqvist, 1980). This suggests an awareness of the importance of being present but not necessarily being active when acting supportive, which could be most important for emotional professional support. Student midwives offering continuous support describe being astounded about the influence their mere presence could have for the woman or her partner during childbirth (I). Women and their partners describe midwifery presence as supporting a sense of security for them during childbirth (II). These results describe the importance of professionals’ supportive presence, without necessarily performing (Kennedy, 2000; Lundgren, 2004). A professional supportive challenge is to strengthen women and their partners through being supportively present without performing tasks (until needed), i.e., adopting a “with woman” ideology.

Results from study II suggest that offering informational support also could be important to create a sense of security during childbirth. However, too much or in-adequate informational support was not perceived as supportive (II). Perhaps a wish to be efficient and actually do something, i.e., adopting the “with institution” ideology, impels professionals to offer more information than is really supportive for the woman and her partner in the actual situation. Instead, they should be offering emotional or appraisal support (i.e. adopting the “with woman” ideology), for example, which may be what the woman or her partner require. Being offered mainly information when needing emotional support renders disappointment in mothers (Ekström, et al., 2003 b; Razurel, et al., 2011). A professional challenge is to offer the aspect of professional support that is needed in accordance with the unique needs of the individual, whether it is emotional, appraisal, informational or instrumental, to strengthen mothers and their partners (I, II, III & IV). Emotional and appraisal support may also increase mothers’ sense of ability to meet the needs of their babies, which seemed important to first-time mothers (III). However, to promote well-being for the individual, an overall attitude of to “care about”, in line with the “with woman” ideology seems important (I, II & IV).

**Professional support strengthening mothers’ in relation to the baby**

As a result of process-oriented training for health professionals mothers’ perceptions of professional support improved, and their self-reported relation to and feelings for the baby were stronger despite the additional chal-
allenge of having had a caesarean birth (IV). First-time mothers describe varying levels of certainty in relation to the new baby and being able to care for the baby, seemed important for them (III). Having a caesarean birth seems to increase uncertainty in relation to the baby (Herishanu-Gilutz, Shahar, Schattner, Kofman, & Holcberg, 2009; Lobel & DeLuca, 2007; Rowe-Murray & Fisher, 2001; Tulman, 1986). However, mothers may be reluctant to show this uncertainty in relation to the baby (S. Fenwick, Holloway, & Alexander, 2009). For individuals to reveal a need for support may instil a sense of lacking competence in the actual situation (Uchino, 2004). This reluctance to show uncertainty may lead to mothers supportive needs being difficult to interpret (Hertfelt Wahn, et al., 2007; Schumaker & Brownell, 1984). Health professionals should support mothers to engage with their baby (Nelson, 2003), but to accomplish that health professionals need to be able to detect supportive needs, such as uncertainty in relation to the baby (III). All this put together points to the importance for professional support to strengthen parents, including the mother’s sense of ability in meeting the needs of the baby. This may be especially important in the additional challenge of complications such as caesarean birth (IV).

Emotional professional support seemed to improve mothers’ parental ability even with the additional challenge of a caesarean birth (IV). This point to a professional challenge to support women (and their partners) in becoming parents i.e. to support the mother to care for her baby after birth or support her in understanding the baby’s signals (III). This is important both for the process of becoming a mother (Mercer, 2004) and for the baby’s physical and psychological development (Cassidy, 1999; Gerhardt, 2007). However, midwives seem more oriented towards measurable and physical needs and may not succeed in supporting parenthood (Darvill, et al., 2010), adopting a “with institution” ideology (II). Process-oriented training for health professionals did improve mothers’ perception of professional support and buffered some negative effects of caesarean birth in relation to the baby (IV), indicating that trained professionals may be more open to the mother’s various needs during childbearing, adopting a “with woman” ideology (II). These findings suggest that professionals in the care chain involving childbearing need support themselves. Support for professionals could be extra training in order to provide an evidence-based aspect to their care together with collegial discussions and individual reflections, which would improve their professional supportive skills (I, II & IV).
To act supportive - the mutual challenge for organisations and professionals

Offering continuous support during childbirth increased midwifery students’ trust in women’s capacity to give birth as well as in the birth process itself (I), which are important aspects when offering support in childbirth (Kennedy, 2000, 2002; Kennedy & Shannon, 2004; Lundgren, 2004, 2005). However, in study II the midwives seemed mainly to adopt the "with institution" ideology with focus on efficiency and risk management. Having focus on risk management may create feelings of uncertainty in professionals (Teijlingen, 2005) as well as enhance uncertainty in women (Nilsson & Lundgren, 2009). Feeling uncertain may decrease professional’s ability to trust women’s capacity as well as their trust in the birth process itself, suggesting the need for a challenging act of balance. Enhancing trust (i.e., adopting the “with woman” ideology) while balancing feelings of uncertainty inflicted by the "with institution” ideology may increase the emotional effort required by professionals and increase their stress (Blaaka & Schauer, 2008; Hunter, 2001, 2004). Feelings of uncertainty and stress have been described as factors that decrease providers’ ability to offer support (Hupcey, 1998; Schumaker & Brownell, 1984). Uncertainty in the professional supportive role also seemed to promote a shift in focus towards performing tasks rather than offering support (I & II), which could mean that the needs of women and their partners are not met (I, II & IV), leading to parents perceiving professionals as less calm or less sensitive to their needs (IV).

Professional support, including all aspects of support, can be empowering for parents (De Plat-Jones, 1999; Hermansson & Mårtensson, 2011). Empowerment is described as professionals having power with instead of over individuals in order to strengthen the individuals’ own capacity to cope in different situations (Labonte, 1994). Empowerment is an important aspect of supportive midwifery care (Hermansson & Mårtensson, 2011), but for professionals to offer support and empower women and their partners, professionals need to be empowered themselves (De Plat-Jones, 1999). Therefore, the organisation needs to provide opportunity for professionals to offer support, and professionals themselves needs to be capable in offering support in order to achieve optimal quality care in childbirth (Downe, 2010b; Downe, Simpson, & Trafford, 2006). With optimal quality care, women and their partners may perceive adequate support, and the risk of women having negative or traumatic birth experiences would decrease (Beck, 2004; Nilsson, et al., 2010). Optimal quality
care with professional support may also reduce the risk of medical interventions in childbirth (Hodnett, et al., 2011) and buffer negative effects of having a caesarean birth in relation to the baby (IV).

The organisation is responsible for creating possibilities for professionals to offer support in order to deliver optimal quality care in childbearing (Bingham, 2010). Optimal quality care in childbearing includes acknowledging the importance of relationships within health care (Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008). A challenge for health care organisations is to organize care so that professionals have the opportunity and the ability to form relationships with women and their partners (II). This would enable professionals to offer improved professional support and to accomplish optimal quality care in childbearing. A challenge for the professionals is to reflect about their own individual attitudes, what ideology they adopt when caring for women and their partners and which ideologies should rule their practice (I, II & IV). One way to accomplish this could be through a combination of evidence-based lectures and collegial discussions together with individual reflections – process-oriented training (IV).
Methodological considerations and reflections

Researchers in childbearing need to consider the complex nature of processes in childbearing and use various methods in creative ways to understand them (Enkin, 2006). When exploring a phenomenon as professional support in childbearing, it was valuable to use both quantitative and qualitative data as well as such different data collection methods as diaries (I), interviews (II & III), questionnaires (IV), and observations (II). This approach provided the possibility of uncovering different perspectives of the phenomenon under study which enabled a deeper understanding (Patton, 2002).

In qualitative research trustworthiness is often used to attain rigor (Streubert Speziale & Rinaldi Carpenter, 2002), while in quantitative research, validity and reliability are used (Polit & Beck, 2004). However, it is debated that validity and reliability should be used within all kinds of research regardless of data. It is important to attain rigor throughout the data collection and analysis process and within qualitative research to adjust when appropriate to improve the quality of data (Morse, Barrett, Mayan, Olson, & Spiers, 2002). For this thesis validity, reliability and rigor will be used whether qualitative or quantitative data.

Qualitative studies study I, II and III

In qualitative research coherence between the research question and the data collection method is important to attain rigor (Morse, et al., 2002). For study I, written diaries were chosen to gain access to student midwives’ reflected thoughts and feelings about offering continuous support during childbirth. For study II, triangulation of observation and interviews was chosen (Patton, 2002) as a method to acquire both the reflections of participants and to actually observe directly what happened in the specific situation (II). For study III, an inductive and deductive approach inspired by the “think aloud” method (Drennan, 2003) was chosen to gain mothers’ spontaneous descriptions and their descriptions from the MIRF scale items (III).

Measures taken to assure good quality in data are important for rigor in qualitative research (Streubert Speziale & Rinaldi Carpenter, 2002). When collecting data through diaries (I), the participants first need to understand what to write about in order for the researcher to attain good quality data (Patton, 2002; Streubert Speziale & Rinaldi Carpenter, 2002). In study I, this was ensured by providing thorough information to participating students, and the data in the diaries did reflect a rich variety of student mid-
wives’ thoughts and reflections about offering continuous support during childbirth (I). However, a weakness when using diaries is the lack of spontaneity in data (Streubert Speziale & Rinaldi Carpenter, 2002). For study II and III, interviews were chosen as the data collection method, which would enable access to spontaneous responses and gave possibility to ask clarifying question. However, the interviewer interacting with participants could disturb the reflections of participants (Krag Jacobsen, 1993; Kvale, 1997). Efforts were made by the author (ST) to be open to the participants and to create a secure atmosphere during interviews (Kvale, 1997) as well as to pay attention to the researcher’s own reactions that may disturb an open and true answer (Krag Jacobsen, 1993). Reflections when interviewing and during transcription and discussions of the interview questions and the interview technique enabled both interview techniques and data to improve, hence improving validity (Morse, et al., 2002). Interviewing is more time consuming than using diaries as a data collection method (Streubert Speziale & Rinaldi Carpenter, 2002), but both methods contributed with rich data for analysis (I, II & III).

Another way to attain rigor in qualitative data collection is through triangulation (Patton, 2002), as was done in study II by combining observation and individual interviews. Observation is considered time consuming as a data collection method (Patton, 2002). Observations during childbirth (II) were also quite difficult since it was necessary to match the presence of a midwife, a woman and her partner who were willing to be included in the study with the woman being in labour. Careful observation notes made it possible for the co-authors to take part in the observations and to gain knowledge about what was observed. These notes also formed rich data together with the individual interviews. However, to observe is not possible without affecting what is happening, it is important to reflect about and be aware of observation effects (Patton, 2002). Possible observation effects were raised in the interviews when appropriate and also reflected upon with co-authors. Using video recordings for the data collection was discussed but decided against. Video would provide data with high detail and many hours of video recordings, which might be difficult to analyse. In qualitative research, too much data could be considered a threat to validity of the results (Patton, 2002). However, using video in certain situations with more action could have provided important insights into the results (II). Responsiveness of the researcher is important for rigor in qualitative research, meaning that the researcher should be vigilant towards the accuracy of data collection and alert to the necessity of making adjustments when necessary to attain the best possible quality of data ensuring the va-
validity of the results (Morse, et al., 2002). In study II and III, this was accomplished by continuous reflection and discussion with co-authors, and some amendments were made accordingly.

Purposeful theoretical sampling was used for study II and III in order to reach as great a variety in background data as possible among participants. This variation in participants strengthened the possibility of attaining a rich variety of experience and reflection and covering most areas of importance, which is described as an important strategy to attain validity in qualitative research (Morse, et al., 2002; Patton, 2002). For study I, a voluntary sample of student midwives was used. However, participants in study I varied in age, previous experience as nurses and private experience from childbirth which contributed to a variety of thoughts and reflections (I).

Different analyses were performed for the qualitative studies, study I, II & III. However, both design and analysis should be chosen to best answer the aim of the study (Patton, 2002). To reach validity of the results (Streubert Speziale & Rinaldi Carpenter, 2002), efforts were made to describe all steps in the analysis process, to move back and forth between data and results (I, II & III) and to apply theoretical thinking (Morse, et al., 2002). Some parts of data analysis can be difficult to describe in detail as to when themes emerge (I). This seems to be a process of processing results until a deeper understanding is formulated and a theme is disclosed. However, these results were discussed with a group of student midwives (I) and found to be in agreement with their experience, which could be considered as strengthening the results (Patton, 2002).

In research pre-understanding can be considered both hampering and strengthening in data collection and analysis, and our pre-understanding can aid us when interpreting and understanding the world (Alvesson & Sköldberg, 2008; Gadamer, 2002). When analysing using hermeneutic text interpretation (II), pre-understanding assists in the process and the researcher must challenge her pre-understanding in order to become aware of it, or pre-understanding can hamper the researcher in seeing something new (Gadamer, 2002). Coherence between the whole and the parts (searching for harmony) is important for validity in hermeneutic analysis. Equally important is to continuously reflect about pre-understanding and how interpretations develop (Ödman, 2004), looking out for the parts of the results that are surprising or outstanding (Nyström & Dahlberg, 2001).
Quantitative study IV

Randomization at the municipality level (IV) could be considered a weakness (Polit & Beck, 2004), but when intervention is about process-oriented training for health professionals, individual randomization could be difficult to accomplish. An important aspect of randomization on the municipality level was to strengthen the collaboration within the municipalities and between the midwives at the antenatal centres and the postnatal nurses at the child health centres. The mothers included in study IV were consecutively allocated to the study depending on what municipality (IG or CG) they lived in. When answering their questionnaires, the mothers were not aware of whether their antenatal midwife or postnatal nurse had received process-oriented training or not (IV), which could be considered as strengthening the results of the study (Bland, 2008; Polit & Beck, 2004). A weakness is that this is a sub-sample and the statistical power is weaker. Even if there is an overall tendency, the results should be interpreted with caution and considered explorative and hypothesis generating. However, the smaller sample size raises the possibility of not detecting real differences rather than obtaining false significance (Bland, 2008; Polit & Beck, 2004). To increase power in the results a factor analysis was performed to reduce statistical testing (Bland, 2008). Further research should be designed to also consider different types of births when assessing outcomes of different aspects of professional support.

In study IV, a quantitative design with questionnaires and scales was used and validity of a scale is important when inference is drawn. When acquiring validity for a scale, it is important to use creativity and a variety of methods (Streiner & Norman, 2008). The quantitative data (IV) and the qualitative data (study III) about a mother’s self-reported relation to and feelings for her baby contribute in different ways to our understanding of professional support, both in understanding the possible effect of professional support (IV) and in understanding how a mother describes the different items used (III). For the MIRF scale, high internal consistency was found (IV), which suggests reliability of the scale. However, it is important to take into consideration that if the phenomenon under study is heterogeneous, then high internal consistency (i.e., reliability) could mean less content validity since important aspects of the phenomenon may be missing (Streiner & Norman, 2008). Nevertheless, the MIRF scale items seem to reflect important aspects of mothers’ relations to and feelings for their babies with no indication of being so heterogeneous (III).
Conclusion

• Extra training in support and process-oriented training for health professionals seems to increase awareness of parents’ supportive needs and to improve professional supportive skills in childbirth. The challenge for professionals when acting supportive in childbirth is to reflect about their own individual attitude and what ideology rules their practice.

• Professional support from the midwife can interact with and strengthen social support from the woman’s partner during childbirth. The professional challenge is to find ways to support the woman’s partner in order to strengthen his support of her while maintaining professional support for the mother.

• To be supportively present is a key aspect of professional support in childbirth as a way to create a sense of security for the parents and to establish rapport with the parents as well as to increase professional supportive skills.

• Offering continuous support during childbirth increases student midwives’ trust in women’s capacity to give birth as well as their trust in the physiological process. However, if midwives as professional role models mainly adopt the “with institution” ideology, midwifery students may lack role models in supportive skills.

• Emotional professional support during pregnancy is important for a mother’s relation to and feelings for the baby and may buffer negative effects of having a caesarean birth in relation to the baby.

• Being able to interact with and meet the baby’s needs is important for a mother’s relation to and feelings for the baby.

• Professionals need to detect supportive needs, such as uncertainty in relation to the baby, and need to support a mother’s interaction with her baby. A professional challenge is to strengthen mothers’ sense of capacity in caring for their babies without neglecting mothers’ individual need, such as rest and recovery, especially after a caesarean birth.
Implications for practice

In order to offer optimal quality care and improve professional support during childbearing, the organisation needs to offer possibilities for professionals to increase their knowledge about supportive needs and actions. Professionals need to reflect about their own individual attitudes and which ideology is more consistently adopted in practice and by them. They should also reflect on what knowledge is talked about as important and what knowledge is neglected. It would be beneficial for both professionals and the organisation to offer process-oriented training in order to increase professionals’ individual awareness of the complex processes that interact in childbearing. Within health care education the use of extra training in support would be beneficial to increase professional supportive skills.
Sammanfattning på Svenska

Bakgrund


deras partner beskrivs av kvinnor som viktigt vilket kan stärka relationen mellan kvinnan och hennes partner.

Partnern beskriver barnafödande som en mestadels positiv men blandad upplevelse av både positiva och negativa känslor. De flesta partners vill stödja sin kvinna under förlossningen, men de upplever ofta ängslan, spänning och utanförskap. Dessa känslor kan leda till svårigheter för partnern att erbjuda stöd till kvinnan om han inte själv får stöd av t.ex. professionella. Partnern önskar få ett individuellt bemötande utifrån sina egna behov utan att kvinnans behov åtäckas. Efter förlossningen önskar pappan att professionella ställer frågor till honom också om babyn och inte bara till mamman.


Ett betydelsefullt mål för barnmorskeprofessionen är att främja hälsa kring barnafödande utifrån kvinnors kulturella och andra specifika, individuella behov. I barnmorskerollen ses barnafödande som en naturlig del av livet och barnmorskor arbetar för att främja en positiv upplevelse av barnafödandet. Barnmorskor erbjuder ibland inte det stöd som kvinnor eller deras partner behöver vid barnafödande. En stark fokusering på kvinnans fysiska behov kan innebära att de individuella behoven av stöd hos kvinnan och partnern inte tillgodeses fullt ut. Grundläggande för barnmorskors professionella stöd är tillit till kvinnans förmåga. Om barnmorskor underläter att respektera kvinnans förmåga kan kvinnan uppleva hjälplöshet och förlora kraft. Stödjande närvaro beskrivs som viktigt och kontinuerligt stöd under förlossning har visat sig inverka positivt på förloss-
ningsförloppet med lägre risk för medicinska interventioner som t.ex. kejssarsnitt och ökad chans till en positiv upplevelse som följd. Följaktligen är kunskap om professionellt stöd en viktig del av barnmorskors utbildning.

Barnmorskeutbildningens område handlar om livets början och mänsklig reproduktion och fokuserar på normala processer i barnafödande och föräldraskapet. Professionell skicklighet utvecklas genom integration av teori och praktik och då krävs handledning och reflektion kring olika situationer. Otillräcklig beredskap för känslomässigt svåra situationer beskrivs av studenter som ångestkapande. Studenter beskriver också att tidigare klinisk träning fått dem att fokusera på åtgärder och inte på att skapa relationer vilket kan göra det svårt att erbjuda alla aspekter av stöd i samband med barnafödande. I dessa pedagogiska situationer är handledare viktiga rollmodeller för studenter.

**Problemformulering:**
Professionellt stöd är en interaktiv process och både mammans, pappans och de professionellas upplevelser behöver belysas för att skapa en djupare förståelse för den. Mer forskning behövs därför kring föräldrar upplevelse av stöd och behov av stöd likväl som professionellas uppfattning av föräldrars stödbehov och hur dessa behov kan tillgodoses. Mer forskning behövs också för att belysa hur professionellt stöd kan utformas och hur det kan det kan läsas in för att vården i barnafödande ska kunna erbjuda det stöd som efterfrågas av föräldrar.

**Övergripande Syfte:**
Det övergripande syftet med denna avhandling var att bidra till utvecklingen av en optimal vård i barnafödande genom att undersöka hur professionella lär sig att agera och agera stödjande, vilka behov av stöd som kvinnor och deras partners har och får under barnafödande samt hur professionellt stöd inverkar på föräldrars upplevelse av barnafödande och deras relation till babyn.

**Delstudie I Syfte och metod**
Syfte var att utforska och beskriva barnmorskestudenters upplevelse i att erbjuda kontinuerligt stöd under förlossning. Barnmorskestudenter fick utbildning i och extra träning i att agera stödjande under förlossningen. Studenterna (n=11) erbjöd var och en kontinuerligt stöd till fem kvinnor/par under förlossning och fram tills dess att barnet var fött. Studenterna fokuserade vid dessa tillfällen att erbjuda alla aspekter av stöd (emotionellt, bekräftande, informativt och praktiskt), och de lade då tillfälligt
andra delar av sin träning till barnmorska åt sidan. De skrev ner sina upplevelser och reflektioner kring att erbjuda kontinuerligt stöd i dagböcker som analyserades med kvalitativ innehållsanalys.

**Delstudie II Syfte och metod**
Syfte var att utforska barnmorskans professionella stöd under förlossning i relation till kvinnan och hennes partners behov. Data samlades in genom observation under förlossning som följes upp med individuella intervjuer med barnmorskansen (n=7), kvinnan (n=7) och hennes partner (n=7). Data analyserades med hermeneutisk text tolkning.

**Delstudie III Syfte och metod**
Syfte var att utforska först-föderskors känsla för och relation till sitt barn i relation till hur de besvarade de olika delarna i skalan ”Mammans relation till och känsla för sitt barn” (MIRF) som ett steg i valideringsprocessen av denna skala. Valideringsstudie genomfördes med intervjuer i två steg. Först svarade mammorna (n= 10) på öppna frågor kring relation och känsla för barnet. Sedan fylldes mammorna i MIRF skalan och därefter intervjuades de om sina tankar om MIRF skalas olika delar samt hur de besvarat dem.

**Delstudie IV Syfte och metod**
Syfte var att utvärdera effekten av en process-orienterad utbildning för MVC barnmorskor och BVC sjuksköterskor gällande mammors uppfattning av professionellt stöd och mammors självrapporterade relation till och känsla för sitt barn efter ett kejsarsnitt eller en normal förlossning. Delstudie IV är en delanalys ur en större randomiserad, longitudinell intervention studie och fokuserade på mammor med kejsarsnitt (n=94) och mammor som fått barn normalt (n= 301). Data samlades in med enkäter vid 3 dagar, 3 och 9 månader efter förlossningen och analyserades statistiskt.

**Sammanfattning av resultatet;**
Huvudresultatet av denna avhandling var att professionellt stöd under barnafödande påverkades av att vilken ideologi som dominerade i barnmorskors agerande utifrån de beskrivna ideologierna ”med kvinnan” eller ”med institutionen”. I ideologin ”med kvinnan” var fokus relationen med kvinnan/paret och det professionella stödets alla aspekter ingick tydligt och baserades på kvinnan/parets individuella behov. Medan i ideologin ”med institutionen” var fokus risk-orienterat, inriktat på effektivitet i att utföra åtgärder och det professionella stödet var vagt, otydligt och till stor del baserat på barnmorskors personliga erfarenhet (II). När ”med institution” ideologin dominerade skapades osäkerhet i den professionella stödjande
rollen (I & II) vilket kunde leda till att de stödbehov som kvinnor eller deras partners hade inte tillgodosågs (I, II & IV). Professionellt stöd i barnafödande kunde stärka (”med kvinnan” ideologi) eller hindra (”med institution” ideologi) det sociala stödet från kvinnans partner (I & II). Dessutom var ett gott professionellt stöd under graviditet stärkande för mammas känsla och relation till babyn även efter kejsarsnitt (IV). Mammos självrapporterade känsla för och relation till babyn speglade även hennes känsla av säkerhet i att möta babyns behov och förstå babyns signaler (III & IV). Extra träning i stöd (I) och process-orienterad utbildning (IV) var pedagogiska metoder som främjade utvecklingen av en professionell stödande förmåga, en stärkning av ”med kvinnan” ideologin (I, II & IV). Förbättrat professionellt stöd stärkte mammors upplevelse av professionellt stöd i positiv riktning (IV).

Konklusion:
- Extra träning i att agera stödande och process-orienterad träning för vårdpersonal ökar professionellas medvetenhet om föräldrars stödbehov och förstärker deras stödande förmåga under barnafödande. För att kunna erbjuda det professionella stöd föräldrar efterfrågar är det betydelsefullt att professionella reflekterar över sina egna attityder likväl över vilken ideologi som dominerar praxis.
- Professionellt stöd från barnmorskan kan interagera med och stärka socialt stöd från partnern. Den professionella utmaningen är att finna väggar för att erbjuda partnern det individuella stöd som han behöver för att stödja kvinnan utan att som professionell minska stödet till kvinnan.
- Professionell stödsmässig närlighet är en nyckelaspekt av professionellt stöd i barnafödande som skapar trygghet för kvinnan och hennes partners och främjar relationen mellan paret och professionella men som också kan öka de professionellas stödande förmåga.
- När barnmorskestudenter erbjuder kontinuerligt stöd under förlossning så ökar deras tilltro till kvinnors förmåga att föda barn likväl som deras tilltro till den fysiologiska processen. Men om barnmorskor som professionella förebilder för studenter oftast utgår från ideologin ”med institutionen” i sitt arbete kan studenter sakna roll-förebilder i att agera stödande.
- Känslomässigt professionellt stöd till kvinnor under graviditet är positivt för mammas relation och känsla för barnet och kan mildra de negativa effekter som kejsarsnittförlossning kan medföra för mammans relation till babyn.
- Att ha förmåga att interagera med och möta babyns behov är viktigt för mammas relation till och känsla för barnet.
• Professionella behöver identifiera när mammor är osäkra i relation till babyn och erbjuda stöd för att stärka interaktionen med babyn. En professionell utmaning är att stödja och stärka mammans upplevelse av att kunna ta hand om babyn utan att negligena hennes eget behov av vila till exempel efter exempelvis kejsarsnitt.

Kliniska implikationer; För att utveckla professionellt stöd bör organisationen erbjuda möjligheter för professionella att öka sin kunskap om föräldrars stödbehov och därigenom stärka sin professionella stödjande förmåga. För professionella är det viktigt att reflektera över sina egna attityder och vilken ideologi som dominerar vården. Det vore värdefullt för både organisationen och för professionella med en process-orienteerad utbildning, som kan främja lärandet och medvetenheten om de komplexa processer som interagerar i barnafödande. Inom professionsutbildning kan extra tränning i att agera stödjande främja utvecklingen av professionell stödjande förmåga.
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