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A qualitative study showing women’s participation and empowerment in instrumental vaginal births

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A qualitative study showing women’s participation and empowerment in instrumental vaginal births

Abstract

**Background:** An instrumental birth with a ventouse or forceps is a complicated birth, possibly resulting in fear of childbirth which could influence the entire birth experience negatively. Patients who are actively involved in their care have a stronger sense of satisfaction and a sense of participation can contribute to shorter hospital stays.

**Aim:** To describe the experience of participation for women involved in an instrumental delivery with ventouse or forceps.

**Method:** Qualitative semi-structured interviews with 16 women who gave birth aided by a ventouse or forceps. Their answers were analyzed through qualitative content analysis. In addition the women were asked to evaluate their experience during the delivery. Using a numerical scale (NRS) the birth experience was graded by choosing a number between 0 (worst possible experience) and 10 (best conceivable experience).

**Findings:** Two themes were extracted from the data: *To be part of a team* and *To feel empowered*. Five categories were identified from the women’s descriptions of the experience of involvement during the instrumental delivery: *to cooperate; to understand; to have contact; to participate, and to not be involved*. Those women who rated their experience as low grade, described a lack of involvement in their childbirth compared to those women who rated their experience as high.

**Conclusion:** This study shows how cooperation and empowerment of the woman are two key factors in order for the women to have a positive experience of their instrumental vaginal
births. The study also shows that empowerment is created when the woman is actively engaged and participates in the birth process which gives her the feeling of being part of the team, creating an environment based on mutual understanding.

Keywords: Professional-Patient relation, patient participation, vacuum extraction, obstetrical forceps, qualitative research, qualitative content analysis

Introduction

Issue

To examine how women describe their experience of participation and involvement when giving birth instrumentally.

What is Already Known

Women who experience that they have participated in their care report a higher degree of satisfaction. Studies have shown that women who give birth aided by a ventouse or forceps run the risk of having a negative birth experience5,7,9.

What this paper adds

To be part of “the team” with staff and to feel empowered during childbirth aided by a ventouse or forceps was important for the women’s sense of participation.

An instrumental birth is an intervention where the woman gives birth aided by a ventouse or forceps. In Sweden, approximately eight percent of all obstetric births are performed with a ventouse or forceps and among primiparous women approximately 15 percent1. An
instrumental birth is used to expedite or facilitate the birth of the baby. Indications for usage of forceps or a ventouse include: a danger of fetal hypoxia, poor progress, contraction weakness, or that the woman cannot push properly due to exhaustion or illness.

The intervention with forceps or a ventouse could be an emergency situation when there is little or no time for the woman, her partner or hospital staff to prepare for it. All instrumental interventions involve an increased risk of complications for both the mother and child. The most common complications for the mother are vaginal tearing, sphinkter damage, perineal pain and dysparenuia.

For the child there is an increased risk of complications following forceps or a ventouse, such as head lacerations, cephalhematoma, subgaleal hemorrhage and very rarely intracranial hemorrhage.

Earlier studies show that an instrumental delivery influences the childbirth experience. Women commonly experience an instrumental birth as more traumatic than a vaginal birth. Severe fear of childbirth is more common in women whose earlier experiences of childbirth ended with a ventouse possibly resulting in the couple not wanting more children. Some fathers can even have a sense of the child having been harmed and therefore might demand to have a Cesaarean section in the future. Women whose birth ends with a ventouse or forceps generally have a worse birth experience compared to those who give birth vaginally spontaneously. Four percent fewer women who have experienced an instrumental birth subsequently birth another baby. An increased fear of childbirth is reported for 27.5 percent of those who give birth by a ventouse and 24 percent of them desired a caesarean section in a future pregnancy.
Henderson (2002) describe that a patient’s sense of having participated involve being part of the decision making process regarding implementation and evaluation of the care given. Patient participation is defined as a dynamic process which evolves over time and is an integral part of the work for the hospital staff\textsuperscript{11}. This reciprocal process occurs through partnership, understanding of the patient, and emotional work where partnership is seen as a necessary process as a basis for participation\textsuperscript{12}. The patient is participating when there’s a dialogue which can evolve over time and phases of illness, care and treatment between the hospital staff and the patient\textsuperscript{13,14}. Studies (National Board of Health and Welfare, 2015; Kiessling & Kjellgren, 2004) have shown that when a patient is involved in her own care, the outcome is better, for example a decrease in relapses and shorter hospital stays\textsuperscript{15,16}. It has also been shown that women who have not felt involved in their birthing care are less satisfied\textsuperscript{17}. There is a dearth of studies exploring women’s experience of participation during childbirth aided by a ventouse or forceps. To gain more knowledge in this field, the purpose of this study was to describe the experience of participation in connection with an instrumental birth.

**Method**

*Study design*

An interview based study of 16 women who had experienced an instrumental delivery (ventouse and forceps) was conducted aided by a semi-structured questionnaire. A content analysis was used to analyze the responses. Qualitative methods are used to describe and understand people’s experiences in order to gain deeper knowledge\textsuperscript{18}. 
Participants and ethics

Women who had given birth with the help of instruments were consecutively asked to participate in the study. The criteria for participants used was an instrumental vaginal birth as well as fluency in the Swedish language. Exclusion criteria was any birth mother whose child was treated at a neonatal ward.

Women were provided oral and written information about the study. All informants were told that participation was voluntary and that the interview transcripts would be treated confidentially. Furthermore, they were informed that they could withdraw from the study at any time without any consequence regarding their care and contact the research team if they needed to talk to someone after the interview. The interviews were conducted during the period 2012-05-11 and 2012-07-09 at a hospital in Stockholm where there were a total of 8832 births that year. A total of 19 women were asked to participate, and of those asked, two declined participation and one woman who initially had agreed to take part changed her mind before the interview. In total 16 women who had given birth aided by ventouse or forceps were interviewed two to five days after giving birth.

The study was approved by the Ethical Committee at the Karolinska Institute, (dnr.2012/399-31/4).

The interviews

Two midwives conducted the interviews (MS and SZ). The mothers were interviewed in either the postnatal ward, in the hospital room (single room), or in a private room during their follow-up appointment at the hospital. The interview questionnaire focused on the concept of participation. All interviews began with an open ended question in which the woman freely
could reflect upon and speak about her childbirth. Thereafter questions were posted regarding the respondents’ sense of involvement during childbirth and they were encouraged to describe their experience of participation.

Finally the women were asked to evaluate their birth experience. Using a numerical scale (NRS) the women graded their experience by choosing a number between zero (the worst possible birth experience) and ten (the best conceivable birth experience).

A pilot interview was conducted to test the interview questionnaire which later was included in the data material since it corresponded to the purpose of the study. The interviews were recorded in full and lasted between 24 and 63 minutes.

Data analysis

In order to analyze the interviews, qualitative content analysis with an inductive approach was used. The analysis was done according to the model of Granheim & Lundman\(^9\). In the inductive approach there is no prepared theory or model utilized in the analytical process. The recorded material was listened to in order to obtain a more holistic picture of the whole. Thereafter, the interviews were transcribed verbatim in their entirety. All interviews were read through several times to obtain the whole picture of the material.

Meaningful units, relevant to the study, were identified in the interviews. These units were condensed into codes where the core message was increased to a higher level of abstraction. The codes could initially fit under several subtitles to enable a comparative process with colour categorized codes. Finally, themes were formulated.

The preliminary analytical process was executed by the first author and the definitive analysis was discussed by the authors until an agreement was met to improve the validation.
An overview of subcategories, categories and themes is presented in Table 1. Finally a diagram illustrating how the women evaluated their birth experiences (Table 2). To be as transparent as possible, every citation chosen to evaluate our findings is marked with the woman’s evaluation of her childbirth.

Findings

Of those participating in the study, 14 were primiparous and two were multiparous, ages ranging between 18 and 34 years with an average age of 27. One woman was a student and the others had educational backgrounds in graduating from elementary school, high school and college. Five of the participants were immigrants. Out of the 16 women, 14 had given birth aided by a ventouse and two with forceps.

The concept of participation could be divided into two themes in the analysis; "To be part of a team” and "To be empowered".

Participation

The interaction between staff and woman during the instrumental delivery affected the women’s experience of participation. The woman’s sense of confidence and active involvement during childbirth was dependent on whether she conversed with staff and the physical presence of the staff.

Dialogue, participation, and physical contact with the staff throughout childbirth contributed to the woman’s sense of confidence which constituted the basis for her active involvement during labour and childbirth. For the woman, it was especially important to be listened to and to feel as an integral part of the team in order to be able to communicate her desires.
Participation resulted in the woman feeling a shared responsibility for the decisions that were made. To be part of a team meant, for the woman, to collaborate with the staff: To be spoken to, listened to and to be able to listen. The woman receiving information was also important in order to be able to understand what was occurring and a basis for the woman’s ability to collaborate.

**To be part of a team**

*To cooperate*

A condition for cooperation was, according to the women, to engage in dialogue with hospital staff to be part of a team.

"
they can’t just decide or make a decision without the patient herself having agreed to it"

(interview 13, birth experience 2).

The women collaborating with the staff meant that she felt heard and that aligned with the theme, “to be part of a team”. The woman speaks of the team including herself as ”we did”, ”first we had to”, ”then we decided”, ”let’s go”, when she described how they had worked closely together.

"I made most of the decisions since I had to push and then the doctor, since he had to get a good grip to pull it out, ...so I had to make sure it was in the right place so he could pull it out" (interview 12, birth experience 5)
The physical contact and the physical presence of the staff enhanced the feeling of having participated.

"she touched my belly and kind of helped me, now I think it feels like a contraction and now it is time to push" (Interview 16, birth experience 7-8)

To have contact

Being part of a team involves being heard and involved in all communication. When the woman felt that she was being listened to, she was able to receive the information and communicate her needs back to the staff.

"they listened so much and took things at my pace, so wait a little, I decided everything, they helped and gave me advice. It wasn’t as if they do this every day, it was as though I had to teach them. They really listened to how I felt and how I wanted things when I was in pain and everything” (Interview 3, birth experience 4-5)

To understand

Being part of a team involved mutual understanding between the woman and the staff.

"The physician was very good at speaking to me and informing me about what was taking place and why I should wait for the next contraction and not push on this one ... he was very good at speaking to me and the midwife was also very careful with that, ”think about what he is saying so you can participate”... they made sure I was involved” (Interview 5, birth experience 8)
A condition for having a feeling of involvement and to understand is to receive information about what is happening. Then the opposite occurs, especially in emergency situations, the women can feel traumatized where she could not raise her voice, did not have adequate pain relief and unable to participate in the decision making process.

“I do not think I dared [to ask] because I was so scared, I tried to ask what happened, I imagined the worst, this will not go- for it felt so... It was terrible; I thought I should break down and I didn’t want this. I was prepared it could be painful but this, this was more than ever expected...” (Interview 2, birth experience 1)

**To be Empowered**

**To participate**

Empowerment involves being part of the decision making process during the entire birth. If the woman is not able to be part of the decision making process or if she loses control she experiences a feeling of exclusion.

"I thought it was so bad, you might as well tell me, since there were so many people in there, one of them could’ve taken the time to say; you know this and that is what’s going on, so therefore we have to rush, instead of just telling me to be quiet and do as they say” (interview 12, birth experience 5).

To be part of the decision making process that means sharing responsibility and to participate in the decisions. In order to have a feeling of control and shared responsibility, no decisions should be made without the woman’s consent. Conversely, all decisions should be made jointly and in agreement.
”well, before the midwife does anything, kind of asking first, if one agrees to it, or how you want things or what are you thinking. Then you feel like you are taking part in the decisions that are being made”. (interview 13, birth experience 2)

Some respondents describe a feeling of being afraid during the birth. The fear could have been due to the fact that they were afraid of what would happen when it became clear that something serious was occurring since so many people were present in the birth suite. Some women were afraid that the baby would die and that they were fearful of the pain. One woman describes her fear that things wouldn’t go well but that she was too afraid to ask.

”actually I believe I didn’t dare because I was so afraid, I tried to ask what was happening, I was so set that this wouldn’t work because it felt that way” (interview 2, birth experience 1)

To not be involved

If the woman loses her sense of empowerment, which could happen in an emergency situation, through a lack of communication or physical contact with the staff, it resulted in the woman not understanding the sequence of events.

”actually, I was totally gone, I know there are tons of people in the room and they asked me simple stuff but I couldn’t even answer” (interview 7, birth experience 1)

Some women describe feeling introverted during the childbirth, i.e. they shielded themselves from the surroundings in order to focus on the labour of the birth. It meant that she focused inward and described it as being in a ”bubble”. This was sometimes a conscious choice in order to be able to focus on breathing and handling the pain. The women also described being
exhausted from the labour and not being able to care or communicate. The women who consciously chose to go into a "bubble" in spite of this were able to grade their childbirth experience higher.

"like I said, I was in my bubble, it almost felt as though I was gone at this point, I was somewhere else, I wasn’t here” (interview 4, childbirth experience 7-8).

**Birth experience**

The women evaluated their birth experience from zero to ten where zero corresponded to the worst possible birth experience and ten the best possible birth experience. All of the respondents evaluated their experience.

Six women (38%) evaluated their birth experience between zero to two. Another six women (38%) evaluated their experience between four to seven. Four women (24%) evaluated their experience from seven to ten.

Those respondents, who evaluated their experience low, describe a complete lack of involvement and those evaluating their experience higher were more positive and felt more involved during the instrumental delivery.

**Discussion**

The woman’s experience of involvement was very important for being part of the team. The women describe that co-operation with the hospital staff, and to understand what is occurring for the instrumental birth were key factors of involvement. In order to feel part of the team, the woman had to see herself as included that is depicted in her language as “we had to”, “we
decided” and ”let’s go”. Feeling empowered was important for the woman’s participation and a conscious strategy of being in control. Some women described a loss of control during the instrumental birth which led to a feeling influencing the situation of exclusion. Feeling empowered also signified the situation and co-determine. If the woman was able to influence the decision making process, she was able to feel involved. On the other hand, the women could also experience powerlessness due to a disappointment that the labour that ending with a ventouse, forceps or emergency had negated her ability participate.

The women being excluded from the decision making process during the labour and birth is a risk factor for being satisfied with the birth experience as a whole17. Women who have developed an intense fear of childbirth have reported feeling excluded from the childbirth with minimal participation and support from the midwife7. Being heard by the staff was important for active participation.

If the staff are responsive to the woman, this exchange of communication and ideas is reciprocal for the woman. This is supported by earlier studies of patient participation11,12 which show that a partnership between staff and patient is essential to the patient’s experience of participation. Our results also show that the woman can feel traumatized in emergency situations where she would not be heard or in instances of inadequate pain relief. In order to be able to meet patients’ need to participate, hospital staff ought to practice working in multidisciplinary ways and develop their competency and understanding of the different specific care situations20.

Trust, involvement, support, and acknowledgement have been shown to be of great importance during childbirth21. Those women in our study who during the birth consciously chose the
strategy of going into a “bubble” most likely had great confidence in the midwife and felt supported and acknowledged. Despite opting out of participating in the birth, they have ranked their experience highly. When the woman enters into her “bubble”, it is reason enough to investigate how she is experiencing the pain. A large number of women, who experience a ventouse birth, have inadequate pain relief. Hospital staff do not prioritize pain relief for an instrumental birth.

Some respondents described their experiences as traumatic. Sometimes the women experienced the entire situation as messy and confusing and difficult to understand due to a lack of information about the childbirth experience. A study by Waldenstrom (1999) shows that involvement in the birth, and a perceived sense of control is associated with a positive birth experience. Waldenstrom´s (1999) study also shows that in general an instrumental birth is associated with a negative experience. Women who experienced a traumatic birth experience with a ventouse had not been heard by the midwife. Communication and the behaviour of the staff are therefore essential for the woman´s participatory experience.

Earlier studies (2006) have found that in order to provide an opportunity for real patient participation, the employees needs to recognize each womens unique knowledge, and to respect the individual´s description of her situation rather than just invite a person to participate in the decision making process.

There are a lack of reports describing women’s involvement in the process of decision making during an instrumental childbirth but Blix-Lindstrom et al. have explored factors crucial in connection with augmentation of labour and concluded that midwives´ support and guidance are of great importance. Women need to be empowered by their midwives´. Our result also shows that “being empowered” influenced the women’s experience of whether they felt
involved or not. During the childbirth period, pre-, intra- and post childbirth, the key is issue
the verbal ability between the woman and the midwife for a trusting relationship\textsuperscript{27}.
Midwives have to reflect over the meaning of Midwifery; it is Anglo Saxon and means ‘being
with woman’; as Blix – Lindstrom\textsuperscript{26} stated, it could also include a more professional
understanding and trusting of women’s basic needs and vulnerabilities during this critical time
of encounter between the woman and her midwife.
All of the interviews were conducted three to five days after the woman had given birth, at the
hospital for reasons of convenience. An important question to reflect upon is at what point in
time after giving birth, it is best to conduct an interview study as we know the result can be
different if a different time had been chosen\textsuperscript{28}. Some respondents were still in the hospital
and some had gone home when the interviews were done at either the maternity ward before
they left for home or when they came back for a follow-up appointment. Whether the women
were influenced by varying distance to their experience depending on if they had gone home
or not from the hospital is difficult to determine. In order to strengthen the reliability, the
authors read through the interview transcripts and data material after the first few interviews
to ensure that the focus stayed on the theme of the study.

**Conclusion**

Our study shows how cooperation and empowerment of the woman are two key factors in
order for the woman to have a positive experience of her instrumental vaginal birth. The study
also shows that empowerment is created when the woman is actively engaged and participates
in the process which gives her the feeling of being part of the team, creating an environment
based on mutual understanding.
Acknowledgment and discloser

We would like to extend our sincere thank you to the women participating in this study for their willingness to share their experiences in depth. We also want to thank Lena Gabrielsen for her help translating the study into English. This study was not sponsored or funded by any organization. The study was done as part of a Master's degree.

References

Table 1. Subcategory, Category and Themes

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<thead>
<tr>
<th>Subcategory</th>
<th>Category</th>
<th>Theme</th>
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<tbody>
<tr>
<td>-Dialogue</td>
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<td>To cooperate</td>
</tr>
<tr>
<td>-To work together</td>
<td></td>
<td>To cooperate</td>
</tr>
<tr>
<td>-Physical contact</td>
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<td>To cooperate</td>
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<tr>
<td>-To be listened to</td>
<td></td>
<td>To be part of a team</td>
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<tr>
<td>-To be responsive</td>
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<td>To have contact</td>
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<tr>
<td>-To be informed of what is occurring</td>
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<td>To understand</td>
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<tr>
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<tr>
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<td><strong>Category</strong></td>
<td><strong>Theme</strong></td>
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<td>To participate</td>
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<tr>
<td>-To be part of the decision making process</td>
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<td>To feel empowered</td>
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<tr>
<td>-Loss of control</td>
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<td>-Introvert behaviour</td>
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Table 2. Birth experience

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<tr>
<th>Evaluated birth experience 0-10</th>
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<tbody>
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<td>0 corresponds to the worst possible birth experience and 10 to the best possible birth</td>
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20