View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by UKM Journal Article Repository

International Journal of Public Health Research Special Issue 2011, pp (131-138)

A Heideggerian Hermeneutic Study: Malaysian Chinese Women's Expectations and lived Experiences of Childbirth

LeeNa

INTRODUCTION

Pregnancy and childbirth are generally regarded as a turning point for women even though it is not an illness. This is because the physiological and psychosocial adaptation can bring about stress and anxiety. Ontologically a pregnant woman is not merely an object that can be classified as a primigravida or according to her obstetric condition. The contention is that she is also a daughter, a working woman, and a wife with her past, present and future. All these determine who she is and influence how she thinks, acts, feels and behaves during childbirth (Polt, 1999).

BACKGROUND

Numerous studies are being conducted to explore women's expectation and experiences of childbirth. Most of these studies used quantitative methods, which focused on pain relief, labour support, women's sense of control, and midwifery care. The findings of these studies reported that women have positive and negative birth expectations and experiences. Generally women are fearful of pain and prolonged labour (Eriksson et al. 2006) and they have no confidence in the midwifery care that they received during intrapartum period (Oweis & Abushaikha 2004, Eriksson et al. 2006). In a phenomenological study, Mozingo et al. (2002) uncovered that women experienced anger and disappointment about their childbirth and perceived their caregivers to be incompetent and uncaring. These women also perceived that they have no sense of control as they are not allowed to participate in decision making and not being given adequate information.

Despite the negative experiences of women's childbirth reported in many of the studies above, several studies reported that women with positive attitude, realistic expectation, and adequate information coped better with their labour. Being involved in decision making during labour, women felt that they have personal control, which can contribute significantly to their positive labour experiences (Homer et al. 2002, Lundgren & Dahlberg 2002, Gibbins & Thomson 2002, Ip et al. 2003, Parratt & Fahy 2003, Callister et al. 2007). Women are highly concerned about their ability to cope with labour pain and the type of care that they are receiving (McCrea & Wright 1999, Wright et al. 2000, Goodman et al. 2004). They expected midwives to provide them with professional and emotional support (Parrat & Fathy 2003). In addition, they also expected their significant family members to be with them and to provide support too (Gibbin & Thomson 2001, Ip et al. 2003).

The labour rooms of the hospital where the researcher has worked and other local hospitals are practicing the medical model of care, which emphasizes active management of labour. Hence, the women in labour are subjected to undergo routine medical interventions, to name but a few, vaginal examination every two to four hours, artificial rupture of membranes, continuous fetal monitoring, intravenous infusion, and blood specimen collection. Besides that, they are also instructed to be kept nil orally and confined to bed. The dorsal position is the only birthing position prescribed to them. There is limited choice of pain relief for women in labour. Entonox and Pethidine are the pharmacological pain reliefs commonly used. Women have no control over the choice of pain relief that they are receiving as this decision is normally made by the doctor.

The scarcity of qualitative study on the women's expectation and experience of childbirth, particularly on the Chinese women in Malaysia, the contention that socio-cultural values and beliefs and health care system do vary from one ethnic group to the other, and the researcher's experiences in caring for women in childbirth in one of the hospital described above have culminated and provided her with the question at hand to seek an answer.

AIM

The study aimed to describe and construct a possible interpretation of the Chinese's women expectation and lived experiences of childbirth in hospital.

METHODS

The methodology selected for the study was that of hermeneutic phenomenology explicated by Martin Heidegger (1889 – 1976). The key concepts from his masterpiece '*Being and Time, Division I'* informed and guided the research process of the study. Heidegger's philosophy is centered on the interpretation and understanding of human experiences. Thus, in hermeneutic phenomenology the researcher interprets the meaning of *Being* and illuminates its significance (Heidegger 1962, Warnock 1970, Allen & Jensen 1990, van Manen 1990, Leonard 1994, Dreyfus 1999, Polt 1999, Cohen et al. 2000, Moules 2002). This approach

enables the researcher to describe and interpret the meaning of an experience from the inner perspective of those who have had the experience (Jasper 1994, Cohen et al. 2000). The phenomena are examined through the eyes of people in their lived situation to elicit the "elusive qualities of human nature" (Robin 1999, p.1032) and described using phenomenological writing to "creatively make facets of the lived experience of the participants more vibrant and intelligible (Chang & Horrocks 2006, p. 436).

Participants and Setting

The study data was collected from eight criterion-selected participants based on a set of criteria, which includes: (a) Chinese woman who could communicate in either Mandarin or English; (b) primigravida aged 18 and above; (c) completed at least eight sessions of antenatal follow up; and (d) delivered her baby in the labour room of the hospital where the study was conducted. The participants' age ranged from 20 to 33 years (average age = 24 years), and their education level ranged from secondary to tertiary level. Six of the participants were working women while the other two were housewives.

Data collection

The researcher conducted face-to-face in-depth interviews with the participants individually in the naturalistic setting. The first face-to-face interview was conducted in the maternal and child health clinic. The questions that the researcher asked were mainly non-directive and open-ended, such as: "What is your expectation on your delivery?" "What do you want your delivery to be like?" "How do you feel when you think about the upcoming delivery?" The second interview was conducted soon after the participant had delivered in the postnatal ward. The questions asked during the second interview focused on the participant's childbirth experiences, such as: "What your labour experience was like?" "How was your labour pain?" "Describe any incident that made you feel sad, disappointed, upset or happy?" "What does this childbirth experience mean to you?" Besides conducting face-to-face in-depth interviews with the participants, the primary researcher also recorded field notes about the participant's body language, tone of voice, facial expression and social interaction with others. Field notes provide important information that cannot be heard through conversation and served as a valuable tool for the researchers to reflect and evaluate their interactions with the participants. (Cohen et al. 2000).

The face-to-face interviews were audiotape recorded, and inter translated and transcribed in the English language. Transcription of the shared conversation was based on the guidelines suggested by Carter (2004) and Woods (2006). The transcription convention used was adapted from Silverman (1993) as recommended by Cater (2004). The transcription was typed directly into the computer using Microsoft Word then the text was imported into NVivo 7. Face-to-face interviews were stopped when data saturation was reached.

Rigour

The rigour of the study was estimated by being explicit about the conceptualization and generation of the research question and the data management and analysis of the collected study data. However, the researcher did not take the analyzed data back to the participants for validation as this was antithesis to the Heideggerian philosophy, which emphasized on the notion of fusion of horizon between the researcher and participant (Koch 1995, Walters 1995b, Moules 2002).

Ethical considerations

All participants were fully informed about the study objectives and their roles and rights as a participant. They were also assured of their anonymity and confidentiality of the data collected from them. Formal ethical approval and administration clearance were obtained before the study commenced.

Data management and analysis

The transcribed data were thematically analyzed together with field notes from the Heideggerian perspectives, particularly the notion of hermeneutic circle of understanding as explicated by Allen and Jensen (1990), van Manen (1990), Walters (1995b) and Carter (2004). A computer software known as QSR Nvivo 7 (QSR, La Trobe, Australia, 2006) was used to assist in the management and analysis of the collected study data. The transcripts and field notes were read several times from whole to part and part to whole in a no fixed direction and reflected upon in order to fully understand the *being-in-the-world* of the women in childbirth, which were deeply embedded in the rich and dense data. The researcher ensured that there was a balance between flexibility and consistency in the analysis of the data as the former was necessary for capturing accurately the uniqueness of each participant's lived experience, whereas the later ensured the narratives collected was about the participant's lived experiences.

RESULTS

Five major themes that illuminated the ontological-existential meanings of the participants' lived experiences of childbirth emerged from the study: *being apprehensive about childbirth, being enduring of the labour pain, being supported by midwives, being compliance with institutional rules, and being thrown out of the crisis of*

childbirth. The names of the participants mentioned in this study are fictitious so as to maintain confidentiality.

Being apprehensive about childbirth

The participants had vague ideas about the actual process of childbirth and labour pain. Hence, they were scared that their labour might turn out to be a complicated one. Their feelings were clearly depicted in the two sub-themes below:

i) Fear of uncertainty

The participants held the Chinese traditional belief that labour complication occurs as a result of the destiny of women. Hence, they strongly believed that it is their own destiny if labour complication happens to them and they have no control over it. The participants also could not imagine how their own childbirth experience would be like and they were fearful that their own labour might end up with complication. This is well reflected in Cecelia's anecdote below:

> I heard people talked about childbirth, it is horrifying. They talked about incision, wound breakdown, and could not sit after childbirth. Ah! The feeling is just horrifying.
> [Documents\Interview\Cecelia\36]

Besides this, Caroline, an elderly primigravida was also fearful that her labour would turn out to be a difficult one. She was reluctant to talk more about it for fear that it might become a reality. Her tone of voice turned soft as she was expressing her feeling. She whispered to herself softly:

> Scared of the outcome of the delivery, don't know mah…because of the age, can't predict…with the increasing age, of course scare. Can't predict…(*may have*) difficult labour lah.
> [Documents\Interview\Caroline\53]

ii) Fear of being alone

The participants were afraid of being left alone or unattended during their delivery. They were also fearful that they might be attended by strangers. They expressed that they need their family to provide them with emotional support and to make decision for them if unexpected situation arise. Lydia remarked:

> (*I wish that*) there is somebody besides me to give me strength, to reassure me. Otherwise, I will be very lonely facing the pain and the delivery process like dilate how many cm (*cervical os dilatation*). I can't tolerate that kind of mood alone.
> [Documents\Interview\Lydia\39]

Most of the participants were aware that the hospital does not allow family members to be with them during their delivery. Nevertheless, they were still hopeful that the hospital authorities might consider their request for family to accompany them. The participants remarked that the mere presence of their husband meant immense support for them even though they were only accompanying them in the labour room. The anecdote of Joyce illuminated this well:

> If you are comfortable with that person (*Husband*), and that person is around you, you feel at ease already. Ya, at least at ease, even though he cannot do much.
> [Documents\Interview\Joyce\61]

Being enduring of the labour pain

The theme of being enduring the labour pain depicted how the participants in labour endured the intense and unbearable labour pain. Although the length of their labour pain was only several hours long but they perceived it as being endless. Most participants thought they could tolerate the pain at the early stage of their labour but as their labour progresses they felt the pain has become more intense and hard to remain calm and focused. In their endeavour to tolerate the labour pain, they tried hard to exert self control, like trying to cooperate with the midwives and tolerating the pain quietly.

Most participants described their labour pain as intense and shearing in nature, which caused them to loose concentration and unable to think properly. They felt the labour pain unbearable as the contractions became stronger and more frequent towards the active phase of labour. Some informants felt like they were being literally sawn apart by some shearing forces and some even felt the lower part of their body being pulled apart forcefully. The participants perceived their body as being no longer intact and not belonging to them anymore. This is clearly illuminated in the anecdote of Cecelia's interview transcript:

> The pain was like people using hammer to knock on my pelvic bone and my bones were in pieces. The pain was bad, like my lower part of the body being chopped off by people. Feeling was like being knocked into pieces, it was really really painful.
> [Documents\Interview\Cecelia\109]

In a trembling voice, Jenny also similarly described her terrifying experience:

> It was really painful, I don't know how to describe it, it was awful. The pain was like….was like tearing at the buttock, like something was coming out and I have the feeling of being tearing apart.
> [Documents\Interview\Jenny\100]

Being supported by the midwives

The participants reported the midwives who cared for them during their childbirth provided them with the most physical and emotional support. They felt comfortable whenever the midwives were by their side to listen to them and attend to their needs, like cleaning them up, or rubbing their aching back. Joyce remarked that she was very grateful to the midwife who rubbed her back when she was in pain:

> ….they (*midwives*) knew which part was painful and they helped me to rub the back pain. When the contraction was there they rubbed my back, it relieved me a lot…. They really helped me a lot.
> [Documents\Interview\Joyve\149]

In addition to providing physical and emotional support, the midwives also provided reassurance and encouragement to the participants. Thus the participants reported that the midwives communicated patiently with them, taught them how to cope with the pain and told them what to do during the second stage of their labour. They claimed this had helped to boost up their confidence and strength. Theresa recalled how the midwives communicated with her to ease her tension:

> The nurse reassured me, told me that I must talk. If I talk my energy will come back, she communicated with me slowly, reassured me.
> [Documents\Interview\Theresa\159]

Being compliance with the institutional rules

Being compliance means that the participants need to adhere to the rules and regulations of the labour room, which determine whether they could receive pharmacological pain relief, or their husbands could accompany them when they were in labour. Lydia requested for injection pethidine but the attending doctor turned her down without any explanation. She was given enthonox inhalation instead of injection pethidine. The anecdote below depicted Lydia's disappointment with her hospital's rules and regulations:

> I asked them (*doctor and midwife*) to give me injection, they only asked me to take deep breathe…When they gave me that gas (*Entonox*), I did not feel any effect.
> [Documents\Interview\Lydia\83]

Jenny delivered her baby by ventouse extraction and felt severely traumatized it. She still strongly believed that the ventouse extraction was unnecessary and her doctor should had allowed her to deliver her baby naturally. This was well portrayed in her anecdote below.

> I am just thinking may be they (doctors) should not rupture the membranes, let it be natural. I think it will be better because I have blood show, the dilatation was 3 cm, definitely it would dilate slowly then the pain would be less… For me, the membranes did not rupture naturally. They ruptured it for me. Then they told me that they can't wait for too long, have to deliver the baby fast.
> [Documents\Interview\Jenny\114]

Being thrown out of the crisis of childbirth

The experience of childbirth and labour had profound psychological effects on the participants. The participants in this study were primigravida, hence, they did not had any past experience to inform them about what to anticipate. Their first childbirth experience, therefore, served as a valuable learning process for them and it would influence how they would view childbirth in the future. Some of the participants felt that they had performed well during the childbirth and labour, which they felt was much easier than what they had initially expected. This is well reflected in the transcript of Christina who had expected at the very outset that her labour would be prolonged but it only lasted for five hours. She was delighted with the whole experience, which gave her more confidence to face her future pregnancies. Christina remarked joyfully:

> I never think that my delivery was smooth and uneventful; I never think that I can make it.
> [Documents\Interview\Christina\131]

However, a few participants perceived their childbirth and labour as traumatic or an ordeal. Hence, they reported that it was as painful, scary and awful. They also blamed themselves for not putting enough effort during the second stage of their labour. The unpleasant experience has thwarted their self confidence to cope with future childbirth. With tearing eyes, Jenny uttered repeatedly:

> I feel that childbirth process originally should be tough; I think it should be tough.
> [Documents\Interview\Jenny\112]

Theresa was frightened by the severe labour pain. As a result, she planned to have caesarean section for her second delivery.

> I don't dare to think of the second baby. If I have the second one, I may want to consider operation.

DISCUSSION

The finding of this study uncovered that pregnant women are generally fearful of being left alone during their childbirth because they are worried that something may happen to them during that critical period. The pregnant women are also anxious and unable to relax. This feeling is intensified when they are transferred to the labour room. Study conducted by Gibbins and Thomson (2001), Ip et al. (2002), Oweis and Abushaikha (2004) Ayers and Pickering (2005), and Beebe and Humphreys (2006) also reported that pregnant women experienced certain level of anxiety about their delivery. This feeling is mainly associated with the pregnant women's childbirth and labour expectations, and fear of negative events like unmanageable labour pain, difficult labour or complication to the baby.

Most pregnant women in this study viewed labour pain as intense, horrifying and highly challenging. They described their labour pain as shearing in nature, distressing and unbearable. Labour pain also affects the women cognitively and causes them to act irrationally. Hence, they lie passively on the delivery bed and respond to the pain by shouting and pulling whatever things that they can grab. Some pregnant women also fight quietly with the pain by tensing their muscles. The finding of this study is contrary to that of Callister et al. (2007) and Johnson et al. (2007) who reported that most pregnant women viewed labour pain as a normal physiological process that can yield rewarding result. The pregnant women in their study also expressed that they can trust themselves to cope with labour pain. Hence, they worked with their labour pain instead of fighting with it. The finding of this study also illuminated that women's pain perception is further aggravated by the rather rigid hospital rules and regulations, which normally do not have any provision for women to have their husband or close relative to accompany them in the labour room or request for pharmacological pain relief.

Heidegger asserted that *dasei*n's *Being* is *Being-in-the-world* wherein it is always interacting within a context (Heidegger 1962). Thus pregnant women in this study have an understanding of their own *Being* by ascribing meaning to the world wherein they are dwelling in. *Dasein* also interacts with its world based on past experiences (Dreyfus 1999, Polt 1999). Hence, the pregnant women in this study developed certain expectation regarding their childbirth and labour. This finding concurred with that of Caton et al. (2002) who also found that the experience of labour pain is highly individualized. Thus they reported that woman's interpretation of her labour pain is greatly influenced by her own emotion, motivation, cognitive, social and cultural circumstances. As a result, the woman cannot anticipate her labour pain before delivery. Perception of pain is individualized; therefore standard management cannot meet the needs of every woman. Understanding a woman's background, individual needs and experiences can assist midwife to plan care that meets the woman's needs. The hospital environment is strange to the women and the lived space is very much different from the home that they dwell in. The unfriendly atmosphere, the peculiar smell in the air, the unknown machines, unfamiliar faces, health care providers asking them a lot of questions using medical jargon and exposing their body, and the heartbreaking cries of other women make up the environment of their labour room. This kind of lived space makes the woman experience a sense of lost, anxiousness and vulnerability. In addition, the woman also has to succumb to the rules and regulations of the hospital. She can not exercise her freedom to do whatever she feels like doing. She also encounters deficiency in her *facticity* and this can further increase her level of anxiety and apprehension and intensify her labour pain.

The pregnant women in the study appreciated the good companionship of the midwives who have accompanied them throughout their labour. They felt that these kind and understanding midwives are their greatest support when their husbands are not with them. Heidegger (1962) stated that *Dasein* is a social being and its world is always *Being-with* other *Dasein*. This means that we are social being who always relate ourselves with another person. A midwife is the person whom a pregnant woman often comes in contact with during her pregnancy and childbirth. There are a lot of opportunities for the midwife to establish close relationship with the pregnant woman and assert positive influence on her. In the pregnant woman's *lifeworld*, the lived relation between her and the midwife can be personal and significant in nature. The pregnant woman can feel the support and encouragement that the midwife gives to her and this support inspires her to cope with the labour stress. *Dasein's Being-with-other* is described as s*olicitude* by Heidegger (1962). There are two possible mode of *solicitude*. Dasein may show indifferent mode when *Being-with-other.* A midwife may only focus on the ontical understanding of a pregnant woman. Hence, she may just regard the woman as a primigravida with normal history or a gravida two para one with anemia. This midwife merely performs the *leaping*

in role by instructing the woman what to do and what not to do during delivery. The second mode of *solicitude* is the ontological interpretation of the *Dasein's Being* wherein a midwife shows interest in the pregnant woman's *Being-in-the-world*. Heidegger (1962) stated that our most fundamental way of *Being-in-the-world* is *sorge* or care. In this mode, a midwife performs the *leaping ahead* role to guide the pregnant woman during her pregnancy and childbirth. She also imparts relevant knowledge and information like the process of childbirth and how to cope with labour pain to the pregnant women. The midwife also involves the pregnant woman in decision making and provides her with genuine support and encouragement. This can gives the pregnant woman a sense of control and empowers her to manage her childbirth with positive attitude. Pregnancy and childbirth then become *ready-to-hand mode* for the woman instead of remaining at the *present-at-hand mode* and set the woman to face childbirth with the right attunement and not in the fearful mood.

Finding of this study indicates that it is imperative that the midwives educate the women regarding childbirth. A systematic and well planned childbirth preparation programme can be designed to enable pregnant women to view childbirth with the right attitude. They should be made to understand that labour is a normal physiological process and the purpose of contraction pain is to bring the baby to the world and it is not destructive in nature to them. Besides childbirth education classes, pregnant women support group is another approach that can be used to address issues related to childbirth. The main role of this support group is to counsel women who have developed fear of childbirth or being traumatized by childbirth experience. It is also imperative that pregnant women are given the avenue to express their feelings and share their experiences with others.

Hospital labour room normally emphasizes on obstetric technologies and interventions. Hence, women undergoing childbirth are usually being aggressively and actively managed. The midwives are usually busy carrying out procedures and therefore they have very little opportunity to be with the pregnant women and to promote normal delivery to them. It is crucial to promote and strengthen the midwife-led units so that midwives are able to conduct midwifery practices autonomously. Pregnant women with low risk factor should be encouraged to deliver in midwife-led birth centres under the care of midwives only. It is timely that the maternal and child health services set up delivery rooms in all the maternal and child health clinics. This type of birth centre can provide a relaxing and homely environment and one-to-one midwifery care with minimal intervention to pregnant women. Midwives have the autonomy to provide midwifery practices, at the same time work in partnership with pregnant women to provide them with cultural congruent care.

The Ministry of Health Malaysia has a set of criteria to identify pregnant women who are suitable to give birth at maternal and child health clinic. The midwives are also given the autonomy to identify and influence women to have physiological birth in midwife-led units. However, women with medical or obstetrical risks are encouraged to give birth in the hospital. Nevertheless, the number of women who choose to deliver at maternal and child health clinic is still not that encouraging and they increasingly prefer to give birth in hospital. This is because they have the notion that it is old-fashion and unsafe, whereas hospitals have the latest obstetric technology that can provide the best management for both the pregnant women and their babies. The benefit of physiological birth in midwife-led units should be made known to the women. Similarly, pregnant women undergoing childbirth in midwife-led units are encouraged to share their positive lived experience with other pregnant women. To increase the rate of childbirth at the maternal and child health clinics, midwives have to work an extra mile to bring about a paradigm shift in the provision of midwifery care from institutional birth center to midwife-led unit.

Study limitation and recommendation

The finding of this study reflected only the Chinese woman's childbirth expectations and lived experience in the hospital setting. As Malaysia is a multi-ethnic country, similar study with other ethnic groups need to be conducted to examine whether there is any differences in their childbirth expectations and lived experiences. It is known that other alternative place for women to give birth is at the midwifery-led centres. Therefore, similar study also needs to be conducted to examine whether there is also differences in women who have their childbirth at the birth centre.

CONCLUSIONS

This study explored the inner feeling of the women undergoing childbirth. Their lived experiences have created a deeper understanding of the meaning that women ascribed to their lived experiences. The findings also pointed to several important implications for midwifery practice in the community as well as in the hospital. There is a need to improve women sense of control by providing appropriate childbirth information and involve women in decision making. In addition friendly hospital environment is equally important to enhance women confidence and comfort. Good companionship of the midwives served as valuable support for the women during labour. To strengthen this aspect, midwives should strive for

autonomous midwifery practices by setting up more midwife-led unit and encouraging physiological birth. This improvement of midwifery practices aim to enable women to have positive birth experiences as the meaning that they attached to their birth experiences will determine their *potentiality-for-Being*, especially the *Being-in-the-world-of-childbirth.*

REFERENCES

1. Allen N.M., & Jensen L. 1990. Hermeneutical inquiry meaning and scope. *Western Journal of Nursing Research 12*(2): 241-253.
2. Ayers S. & Pickering A.D. (2005). Women's expectations and experience of Birth. *Psychology and Health 20*(1), 79-92.
3. Beebe K.R. & Humphreys J. (2006). Expectations, perceptions, and management of labour in nulliparas prior to hospitalization. *Journal of Midwifery and Women's Health 51*(5), 347-353.
4. Callister L.C., Getmanenko N., Garvrish N., Eugenevna M.O., Vladimirova Z.N., Lassetter J. et al. (2007). Giving birth: the voices of Russian women. *The American Maternal and Child Nursing 32*(1), 18-24.
5. Carter B. (2004). How do you analyse qualitative data? In *Demystifying Qualitative Research in Pregnancy and Childbirth* (Lavender T., Edwards G. & Alfirevic Z. eds), Cromwell Press, UK. pp.87-108.
6. Caton D., Corry M.P., Frigoletto F.D., Hopkins D.P., Lieberman E., Mayberry L. et al. (2002). The nature and management of labour pain: executive summary. *American Journal of Obstetrics and Gynecology 186*(5), 1-15.
7. Chang K.H. & Horrocks S. (2006). Lived experiences of family caregivers of mentally ill relatives. *Journal of Advanced Nursing 53*(4), 435-443.
8. Cohen M.Z., Kahn D.L. & Steeves R.H. (2000) *Hermeneutic Phenomenological Research. A Practical Guide For Nurse Researchers*. Sage Publications, Thousand Oaks, California.
9. Dreyfus H.L. (1999). *Being-in-the-world: A Commentary on Heidegger's Being and Time, Division I.* MIT, London.
10. Eriksson C., Jansson L. & Hamberg K. (2006). Women's experiences of intense fear related to childbirth investigated in a Swedish qualitative study. *Midwifery* 22, 240-248.
11. Gibbins J. & Thomson A.M. (2001). Women's expectations and experiences of childbirth. *Midwifer* 17, 302-312.
12. Goodman P., Mackey M.C. & Tavakoli A.S. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing 46*(2), 212-219.
13. Heidegger M. (1962). Being and Time (J. Macquarrie & E. Robinson). Harper, San Francisco. (Original work published 1927)
14. Homer C.S.E., Davis G.K., Cooke M. & Barday L.M. (2002). Women's experiences of continuity of midwifery care in a randomized controlled trail in Australia. *Midwifery* 18, 102-112.
15. Ip W.Y., Chien W.T. & Chan C.L. (2003). Childbirth expectations of Chinese first-time pregnant women. *Journal of Advanced Nursing 42*(2), 151-158.
16. Jasper M.A. (1994). Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing* 19, 309-314.
17. Johnson T.R., Callister L.C., Freeborn D.S., Beckstrand R.L. & Huender K. (2007). Dutch women's perceptions of childbirth in the Netherlands. *The American Maternal Child Nursing 32*(3), 170-177.
18. Koch T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing 21*(5), 827-836.
19. Leonard V.W. (1994). A Heideggerian phenomenological perspective on the concept of person. In *Interpretive Phenomenology: Embodiment, Caring and Ethnic in Health and Illness* (Benner P. eds), Sage Publications, Thousand Oaks. pp. 43-63.
20. Lundgren I. & Dahlberg K. (2002). Midwives's experience of the encounter with women and their pain during childbirth. *Midwifery* 18, 155- 163.
21. McCrea H. & Wright M.E. (1999). Satisfaction in childbirth and perceptions of personal control in pain relief during labour. *Journal of Advanced Nursing 29*(4), 877-884.
22. Melender H.L. (2002). Experience of fears associated with pregnancy and childbirth: a study of 329 pregnant women. *Birth 29*(2), 101-111.
23. Moules N.J. (2002). Hermeneutic inquiry: paying heed to history and Hermes – an ancestral, substantive, and methodological tale. *International Journal of /qualitative Methods I* (3), Article 1. Retrieved 10/10/2006 from http://www.ualberta.ca/~ijqm/.
24. Mozingo J.N., Davis M.W., Thomas S.P. & Droppleman P.G. (2002). "I felt violated": women's experience of

childbirth-associated anger. *The American Maternal Child Nursing 27* (6), 342 – 348.

25. Oweis A. & Abushaikha L. (2004). Jordanian pregnant women's expectations of their first childbirth experience. *International Journal of Nursing Practice* 10, 264-271.
26. Parratt J. & Fathy K. (2003). Trusting enough to be out of control: a pilot study of women's sense of self during childbirth. *Australian Midwifery*: *Journal of the Australian College of Midwive 16*(1), 15 – 22.
27. Polt R. (1999). *Heideggar: An Introduction*. UCL Press, London.
28. QSR, La Trobe, Australia (2006). QSR NVivo 7.
29. Robin W. (1999). Natural science and nursing science: where do the horizon fuse? *Journal of Advanced Nursing 30*(5), 1027-1033.
30. van Manen M. (1990). *Researching Lived Experience: Human Science For An Action Sensitive Pedagogy.* The Althouse Press, Ann Arbor.
31. Walters A.J. (1995). The phenomenological movement: implication for nursing research. *Journal of Advanced Nursing 22* (4), 791-799.
32. Warnock M. (1970). *Existentialism*. Oxford University Press, Oxford.
33. Woods P. (2006). *Successful Writing for Qualitative Researchers*(2nd ed.). Routledge, London.
34. Wright M. E., McCrea H., Stringer M. & Murphy-Black T. (2000). Personal control in pain relief during pregnancy. *Journal of Advanced Nursing 32* (5), 1168-1177.