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Primiparous women's expectations and experiences of early labour: A qualitative study

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ABSTRACT

Objectives: To gain a deeper understanding of primiparous women's preparation for early labour as well as their expectations and experiences of symptoms of onset of labour.
Methods: A qualitative study using focus group discussion was conducted with n = 18 first-time mothers within the first six months of giving birth. Discussions were transcribed verbatim and coded and summarised into themes by two researchers using qualitative content analysis.
Results: The statements of the participants revealed four themes: 'Preparing for the unpredictable', 'Expectations and reality', 'Perception and wellbeing' and 'Experiencing the beginning of birth'. Many women could not distinguish the preparation for early labour from that for the whole birth. Relaxation techniques to prepare for early labour were found to be very helpful. For some women, it was a big challenge that expectations often did not correspond to the experienced reality. Pregnant women faced many different physical and emotional symptoms of onset of labour with striking variability. Emotions ranged from positively excited to having fears. Not being able to sleep for hours was a huge problem for the labour process of some women. While early labour at home was experienced positively, early labour in hospital was sometimes difficult, because women had the feeling of being in the second rank.
Conclusion: The study clearly identified the individual character of experiencing onset of labour and early labour. The variety of experiences highlighted the need for individualised, woman-centred early labour care. Further research should investigate new paths for assessing, advising, and caring for women during early labour.

Introduction

Early labour care is challenging and can only be provided with high quality if the individual needs of the women are assessed and addressed. Since early labour is perceived very differently from woman to woman, care and support needs might differ as well [1,2]. The knowledge about women's experiences must be increased to meet individual needs satisfactorily [2,3].

In the transition between pregnancy and established labour, different biochemical processes take place leading to various physical and emotional symptoms experienced by the parturient [4]. Pregnant women recognise symptoms such as contractions, irregular pain, watery loss, bloody show, gastrointestinal symptoms, emotional discomfort, sleep alterations and others at the onset of labour [5,6]. The perception of these symptoms is highly individual and varies from woman to woman [1,5]. Furthermore, large differences can also be observed in terms of the length of early labour with less favourable perinatal outcomes in cases with a longer latent phase [7]. Dealing with early labour without professional support is difficult and frightening for up to 30 percent of pregnant women [8–11]. This is especially true for primiparous women, who for this reason often seek care early [7,12,13]. However, women who were admitted to hospital before labour had progressed, especially those with prolonged early labour, were more frequently confronted with intrapartal interventions [7,14–16].

Early labour care is often not satisfactory for the parturients and challenging for health care professionals [8]. Measures and interventions during early labour such as early labour assessment, home visits and one-to-one structured care were found to increase birth satisfaction but did not improve labour and birth outcomes [17]. It seems that the individual needs of women is a major challenge [2],

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which could not be addressed with standardised measures and pathways. Previous studies have emphasised the complexity of early labour care and highlighted that new paths are necessary [3,17]. Furthermore, expectations and experiences of birth were related to satisfaction with care in several studies [18,19]. Therefore, assessing women's expectations and their physical and emotional experiences during early labour might give information about their individual needs. However, more knowledge about these expectations and experiences is needed to develop an assessment instrument for this purpose. The aim of this study was therefore to gain a deeper understanding of primiparous women's preparation for early labour as well as their expectations and experiences of physical and emotional symptoms of onset of labour.

Methods

Study design and setting

We conducted a qualitative study using focus group discussions with groups of four to five participants discussing their early labour experiences interactively [20] and qualitative content analysis with an inductively and deductively generated coding scheme [21]. We decided to conduct focus group discussions because this allowed us to include more participants and profit from their interactions [20], and also because several previous studies have already explored women's early labour experiences using individual interviews [8–10,22]. Content analysis seemed appropriate to extract clearly structured codes because the study was part of a larger project to develop a tool for advising primiparous women during early labour [23]. We followed the Consolidated criteria for reporting qualitative research (COREQ) guidelines for this scoping review [24].

Data was collected in the German part of Switzerland between August and October 2021. Switzerland has a high quality but expensive health care system [25]. Maternity services are paid by mandatory health insurances and most women give birth in hospitals [26,41]. At the onset of labour, pregnant women in Switzerland usually contact a mostly unknown hospital midwife before admission and seek advice whether they can still stay at home or should come in. However, women giving birth in birth centres or those having organised a caseload midwife for the hospital birth contact the midwife they have already met before (around 2,000 births each out of a total of almost 90,000 birth in 2021 [27,41]). Restrictions due to the Covid-19 pandemic in Switzerland were less strict than in neighbouring countries [28]. In the hospitals, wearing masks and keeping a distance was mandatory and visitors were limited over a longer period of time. Partners were periodically not allowed to attend outpatient check-ups.

Participants and recruitment

First-time mothers who gave birth to a singleton at term in the previous six months after spontaneous onset of labour were included in the study using a purposive sampling strategy. Women who had an elective caesarean section or medically induced labour were excluded. All women who met the inclusion and exclusion criteria and agreed to participate in the study were eligible. The study focused on primiparous women because they are admitted to hospital during early labour confronted with interventions and negative outcomes more frequently [7,12,13]. Participants were recruited through independent midwives providing postpartum care after hospital discharge or postpartum regression exercises. Midwives either asked all the mothers they had cared for who met the inclusion criteria or put the request in group chats of exercises courses so that women could register interest themselves. One participant was known to one researcher through a previous working relationship, but was also recruited by an independent midwife. This existing relationship was not considered an obstacle for the discussion or an exclusion criteria. A total of n = 21 women were approached by telephone and email and n = 18 were recruited. The researchers informed potential participants about the aim of the study, the study procedure and their right to withdraw at any time during the interviews. Women were included in the study after oral and written informed consent. Ethical approval was obtained by the Ethics Committee of Zurich, Switzerland (BASEC-Nr. 2021–00687).

Development of the interview guide

We developed a literature based, semi-structured interview guide (Appendix 1) [2,5,8,9,17,29,30]. The guide included questions addressing the following topics: preparation for early labour, expectations of early labour, experience of physical and psychological symptoms of onset of labour as well as experiences of early labour at home and in the hospital. Additionally, early labour care related aspects were discussed and were considered for a second article published elsewhere. Each topic included an open main question and several optional sub questions.

Data collection

Four focus group discussions were conducted to enable women to interact with each other, exchange information and encourage each other to reveal in-depth details of their experiences [20]. Three interviews were held face-to-face in independent rooms, and one was conducted online because of the COVID-19 pandemic situation and the availability of participants. All interviews lasted approximately-one and a half hours. Due to a technical problem with one participant, an additional subsequent short telephone interview was conducted. In the focus group discussions on site, maintaining social distance and wearing a mask were compulsory. Discussions were led by SG-B, a female midwifery researcher with a PhD and supported by ANM, a female midwifery researcher with a MSc or vice versa. The second researcher provided technical support and wrote the protocol. The discussion leader opened each topic with an open question. Participants were also encouraged to discuss with each other. Sub questions were asked if topics were not addressed spontaneously or only superficially. If there was any ambiguity, the discussion leader and in the final interview phase also the second researcher asked for more in-depth answers. All interviews were audio recorded.

Data analysis

Focus group discussions were transcribed verbatim and a qualitative content analysis according to the methods of Mayring [21] was applied. At the beginning of the analysis process, transcripts were read and re-read repeatedly to gain a deeper understanding of the data. A clearly structured coding scheme was first developed deductively based on the interview guide and consequently extended using inductive open coding. The first coder (AM) read and coded the first interview. Codes and the coding scheme were then checked by a second coder (SG-B) and subsequently discussed by both researchers to reach consensus. Thereafter AM read and coded all interviews and SG-B checked the coding again. Codes were then summarised into themes during several analysis meetings. Repeated reading and coding of the transcripts as well as the close exchange between researchers enhanced rigor. Data was analysed with the German written transcripts and citations were translated into English for publication. A multi-stage translation procedure was applied as suggested by Acquadro et al. [31]. One researcher performed the translation which was subsequently checked by a native English-speaking teacher and translator as well as a native German speaking researcher. Data was analysed using Atlas.ti 9.

Results

Characteristic of participants

A total of n = 18 primiparous women participated in four focus group discussions. Two groups consisted of n = 4 and two of n = 5 mothers (Table 1). The median age of participants was 32.0 years and the median participation in the focus group discussion was 19.6 weeks after giving birth. Due to the postponement of one interview and some incorrect information provided by the women before the interview, it was determined that one participant gave birth a few days before 37 gestational weeks and one participated 6.5 months after birth. Due to the late detection of these inconsistencies and the interaction between the women, these quotes were not subsequently excluded. More than three quarters of the women (77.8 %) gave birth spontaneously, whereas two (11.1 %) had an instrumental birth and two (11.1 %) an unplanned caesarean section during labour. Seven women (43.8 %) mentioned complications during pregnancy such as hyperemesis, gestational diabetes, preterm labour, thigh cramps and social burdens. Ten participants (55.6 %) indicated particularities during labour and birth such as rapid birth, malposition of foetal head, pathological foetal hart rate, cervical prolapse, placental retention, high blood loss or transfer to the neonatal intensive care unit.

Overview of themes and codes

A total of 13 codes consistent with the aim of this article have been derived from women's reports. These codes were summarised into four themes: 'Preparing for the unpredictable', 'Expectations and reality', 'Perception and wellbeing' as well as 'Experiencing the beginning of birth'. Table 2 provides an overview of the themes and their corresponding codes.

Preparing for the unpredictable

Although the participants were asked to focus on the beginning of birth, they had difficulties distinguishing labour phases when discussing antenatal preparation for early labour. Women mentioned different preparation measures such as writing a birth plan, acupuncture, yoga, hypno-birthing courses but also perineal massage and steam baths to avoid perineal injuries during birth. Whereas some women regularly did relaxation exercises, others had not prepared mentally and let things happen. For some women it was very important to be positive about giving birth, especially at the start of the process. The partners and their support were mentioned as a very important aspect for the antenatal preparation for several participants.

"… I don't know how much this affects the start, but I did yoga and perineal massage and Epi-No…" (FGD2)

Statements on handling information about early labour were mostly positive. Information received during antenatal courses helped to assess the situation correctly.

"… but I have been glad that … I have heard, just how it could be so in theory or often is…" (FGD3)

However, there was also information that participants had difficulties coping with and that they could not apply to the situation experienced. Additionally, symptoms that women were aware of caused uncertainty or excitement.

*"… [the midwife said] it could take up to three days. … I thought to myself 'Jesus Christ for three days, no (*laughs*) and then get through a birth, I don't think I can do that'. And because everything went much faster for me afterwards, that I didn't have to do it over a longer period of time, um, for me it's like, yes, I heard it, but I couldn't apply it like that to myself, to my situation somehow."* (FGD3)

Table 1
Characteristics of the interviews and the participants.

Characteristics	Group 1	Group 2	Group 3	Group 4 online	All participants
Number of participants	5	4	4	5	18
Weeks after birth, median (min–max)	17 (8–25)	18 (4–23)	18 (8–24)	25 (13–29)	20 (4–29)
Age, mean (min–max)	31 (29–34)	32 (29–34)	33 (29–34)	34 (29–41)	32 (29–41)
Marital status					
Married, n (%)	3 (60)	4 (100)	1 (25)	2 (40)	10 (56)
Partner, n (%)	1 (20)	0	3 (75)	3 (60)	7 (39)
Single, n (%)	1 (20)	0	0	0	1 (6)
Pregnancy weeks (min–max)	41. 42.	39.-42.	38.-42.	37.-42.	37.-42.
Mode of birth					
Spontaneous, n (%)	5 (100)	3 (75)	3 (75)	3 (60)	14 (78)
Instrumental, n (%)	0	1 (25)	1 (25)	0	2 (11)
Caesarean section, n (%)	0	0	0	2 (40)	2 (11)
Place of birth					
Public hospital, n (%)	3 (60)	3 (75)	4 (100)	5 (100)	15 (83)
Private hospital, n (%)	0	1 (25)	0	0	1 (6)
Birth centre, n (%)	2 (40)	0	0	0	2 (11)

Table 2
Overview of themes and codes.

Themes	Codes
Preparing for the unpredictable	• Antenatal preparation for early labour • Handling information about early labour
Expectations and reality	• Expectations of the onset of labour • Expectations of early labour • Reality in the context of expectations
Perception and wellbeing	• Physical symptoms • Emotions • Sleeping behaviour • Exhaustion
Experiencing the beginning of birth	• Realising that labour was really starting • Experiencing early labour at home • Experiencing early labour in hospital • Experiences of early labour by the accompanying person

Expectations and reality

Women had a variety of expectations of the onset of labour such as the rupture of the membranes, contractions or the discharge of the mucus plug. A special focus was on the rupture of the membranes, which several women considered to be the most common start.

"I was also always waiting for the water to break, because I had the feeling that this is the most common thing, so *every-one always says 'yes, the waters break' …."* (FGD1)

Regarding the expectations of early labour, women thought about the symptoms and complaints but also how to deal with them or how long this phase would last. Some participants thought they could tolerate pain well. Others resolved to use the breathing techniques they had learned during pregnancy and stay at home as long as possible.

"I had not imagined that it could go on for days. I was not aware of that, because I thought it would be so intense over *a shorter time or with longer intervals over several days."* (FGD 4)

The reality in the context of expectations could be very challenging. For some participants, expectations were met, but others were very surprised by the severity of the pain and how long it lasted before labour progressed. A few women had imagined that everyday life could be managed normally during this time and were surprised how quickly this was no longer possible. In contrast, one woman stated that she imagined the pain to be much stronger than it actually was.

*"I really couldn't have imagined this pain before … so I couldn't have imagined that something could hurt like that (*laughs*). Because I thought I was a pain-resistant person."* (FGD4)

"… yes, I just imagined it very differently. The way I heard it, I thought it was somehow, well…, I thought it was much more intense. But they always told me it was so individual, you couldn't really compare *it with each other, and … you immediately imagine something, how it will be, and I somehow always waited for the rupture of the membranes. I always thought that would be THE sign, um, yes, and that did not happen for me either, so, hm (laughing)…"* (FGD2)

Perception and wellbeing

Participants perceived very different physical symptoms of onset labour, just at the beginning or during the last few hours before it. They mentioned signs such as contractions, vaginal discharge, loss of amniotic fluid, pains similar to menstrual pain, back pains or leg pains, tremor in the legs, more or less appetite, circulatory disturbances, feeling more energy just before the onset of labour, feeling fit, feeling cold, hot flushes or engorgement of the breast. The variability with which the women described the symptoms was striking. For example, contractions were felt by some participants as only a slight pulling in the initial phase, while others found them to be really violent very quickly. In some women, the intervals between contractions were quite long over a longer period and in others they followed each other very quickly after a short time. Also, large differences were observed in the length of the contractions.

"… then yes, … I have already *had a lot and very fast contractions, so it was two and a half minutes intervals, but only very short always … about 20 s."* (FGD3)

"Two hours before the waters broke, I had milk coming out, I had a small breast engorgement. Before, this *never happened …"* (FGD2)

Women mentioned positive and negative emotions related to the onset of labour and early labour. Some women were surprised how calm and composed they remained, and several felt very happy. Other participants felt a positive excitement. In contrast, some women expressed great fears, others were worried, anxious, nervous, restless, felt uncomfortable or under pressure. Women were concerned about the pain, the journey to hospital, not making it to hospital in time but also what was going to happen.

"… I was already so scared *in my head, I got even more into it and even more scared. …"* (FGD1)

"But I also knew that I would have to take the car to go to the hospital at some point, which I couldn't really imagine with having contractions. Fortunately, I didn't have to do this [making the travel having contractions] …. But regarding the emotional state, I didn't really want it to start, well yes, to start then. I was very nervous about what was coming, because you don't know what's happening now." (FGD2)

Several women talked about their sleeping behaviour at the onset of labour and the previous nights. Physical discomfort such as menstrual-like complaints, pain and contractions, but also the mental state with nervousness and restlessness hindered women from getting a restful sleep, or from sleeping at all. One participant noted that she had taken precautions and slept very much and well during the nine months of pregnancy.

"…when the contraction came, it was really intense, so I could not have slept any more, but because I had long breaks in between, I could lie down again, shut down a bit, um, … so of course the adrenaline also went up, so I do not think I would have been able to sleep psychologically anymore either*…."* (FGD2)

As a result of not sleeping for hours or days, some women felt exhaustion during early labour. Being exhausted was also a big problem for the further course of labour and birth.

"Yes, that was a huge problem, because if you do not sleep for a night and then have non-stop pain throughout the day and then *the next evening, after 24 h, you're just completely knocked out."* (FGD4)

Experiencing the beginning of birth

For some participants, there was a clear point in time, when they realised that labour was really starting. Others only recognised that the time had come as the contractions increased. The feelings which accompanied the realisation that labour really started could be relief, but also nervousness.

"I woke up in the night with my waters *breaking and I actually woke up laughing because I thought 'oh, now something is finally happening'."* (FGD2)

"For me, it was more like a switch, so we had breakfast and then it went from zero to one hundred, so, yes, (laughs), I went into labour very quickly, so for me, the starting signal was like a fixed moment, yes." (FGD3)

The participants discussed experiencing early labour at home at length. While many women felt very comfortable, others could not cope with labour at home. Some women felt safe at home, but for others this time was associated with great insecurity and feeling lost. The experiences at home were dependent on how quickly or how slowly the contractions became stronger and women could adapt to the contractions or if the pain took them by surprise. Many women had planned to stay at home for a long time, but not all of them were successful with it.

"It was very difficult for me, because from the moment when the contractions became stronger, I had a hard time *dealing with the pain at home."* (FGD1)

Experiencing early labour in hospital was perceived very differently by the participants who had experienced it. While some of them were very happy about the professional support, the empathetic midwife and the safe environment, others had the feeling of being second rank. They were left alone a lot, heard other women cry during contractions, stayed in a small room for a long time or did not feel comfortable on the birthing bed. Participants appreciated it very much if the partner also got a chance to sleep and something to eat. One woman could no longer cope with the pain although the cervix was barely open and made clear that she wanted a caesarean section.

"They told me 'Yes, with these two *to three centimetres, you are early' and so I did not have any priority. I understood that they just looked after others."* (FGD1)

Participants in the focus group discussions also had a lively discussion about the experiences of early labour by the accompanying person, which was either the husband, the partner or the mother. The women described the nervousness of their accompanying person and how they pressed them to go to hospital. Some birthing partners felt the need to document the contractions. Most women were very happy that the accompanying person was there and also felt sorry that he or she could not do much.

"… it was actually my husband who *… started to track [the intervals between the contraction] and was already saying 'they [the contractions] are already coming so fast, we have to call now'. And I thought 'it's way too early'."* (FGD1)

Discussion

This study investigated how pregnant women prepared for early labour, what they expected and how they experienced it. The participants used different methods of antenatal preparation, which often did not focus specifically on early labour but on the whole birth process. For some women, expectations often did not correspond to the experienced reality, which was a big challenge. Pregnant women faced a huge variety of physical and emotional symptoms of onset of labour. The range of very mild to very painful contractions or positive emotions to fear was striking. The study clearly showed the individual character of experiencing onset of labour and early labour.

Despite preparing themselves for labour and birth with various methods, some participants in the current study had difficulties distinguishing the preparation for early labour from preparation for whole birth process. The challenge of preparation for early labour was also one

of the main conclusions of a qualitative study in Norway [32]. Participants of these focus group discussions who had practiced relaxation techniques such as yoga or hypnobirthing usually found these very useful right from the beginning of birth. Hypnobirthing and yoga are well-known techniques to reduce anxiety as well as labour pain and to shorten labour duration, including the latent phase [33,34]. As anxiety leading to increased pain perception was found to be a common challenge during early labour in several studies [11,35], it is not surprising that relaxation techniques reducing anxiety were rated very positively as a preparation for early labour in the current study. Myhre et al. [32] emphasised the need of pregnant women for trustworthy information. The current study showed that getting information and being able to deal with it are two different aspects. Some information might increase anxiety instead of leading to realistic expectations; and anxiety in turn was found to have a negative impact on the perception of pain [11]. Particular attention should therefore be paid to the content of the information transmitted and the way in which it is communicated.

Participants in these focus group discussions had difficulties imaging the onset of labour as well as early labour beforehand. Although only about 8 % of all pregnant women experience prelabour rupture of membranes [36], remarkably many participants imagined labour would start with it. This could be explained by expectations about the onset of labour which might be more dependent on narratives than on facts. Additionally, many participants in the current study had difficulties imagining the length and intensity of early labour. Shub et al. [37] also found that first time mothers did not have realistic expectations of labour and birth. Pregnant women were more than twice as likely to expect an uncomplicated labour and birth than the official statistics in Victoria, Australia showed [37]. Nevertheless, some women in the current study were pleasantly surprised by early labour, which was less severe than feared. However, expectations are not only about the physiology of birth but also about being in control, coping well and having choices [38]. Expectations of birth in relation to birth experience and satisfaction is a complex construct which needs further investigation regarding onset of labour and early labour.

Gross et al. [5,6] described a variety of physical and emotional symptoms of onset of labour such as regular or irregular pain, vaginal discharge, emotional upheaval, sleep alterations and others. These observations were congruent with the current study and stressed the very different perceptions of basically similar symptoms such as contractions and pain. It also showed that emotions could be positive or negative and that they could be symptoms of onset of labour but also a consequence of other signs. The current study confirmed the very distinctive recognition of the onset of labour and early labour found in previous studies [1,5]. This individual perception might also be the leading cause for the individual care needs of pregnant women at the beginning of birth [2].

The importance of support from the accompanying person for dealing with early labour was also emphasised by Eri et al.[10], who stressed that family members could be support and pressure at the same time. Even though many participants of this study found the home environment comfortable, which is congruent with other studies [39,40], an important finding was that some women felt neglected during early labour in hospital. Eri et al. [10] also highlighted that some women did not feel well treated by health professionals. The associated feelings could then have a negative impact. Ängeby et al. emphasised that women, especially those with a prolonged latent phase, preferred woman-centred and more individualised care that could prevent the feeling of being neglected [2]. New paths in early labour care are urgently needed as also proposed by Janssen et al. [3].

A strength of this study was the conduct of four focus group discussions in the recruitment areas of different hospitals and birth centres. This led to a heterogeneous sample with 18 primiparous women experiencing different labour and birth processes. Furthermore, the dynamics of the focus group discussions led to very interesting and in-depth interviews. Rigour of the study was enhanced by peer-debriefing the coding process and determining themes in analysis sessions with persons who were familiar with the interviews and the topic. As is usually the case in qualitative research, a limitation of the study was the ethnic and cultural homogeneity and the difficulties of assessing whether discussions would have been different in other countries and other cultures. Additionally, the groups sizes were limited due to the Covid 19 pandemic, and one interview was held online. Nevertheless, the discussions were very lively and inspiring, and the information received very rich, but data saturation may not have been reached.

The current study showed an in-depth insight into how women prepared for early labour and what they expected and experienced during this labour phase. The variety of experiences which often did not meet the expectations highlighted the need for individualised, woman-centred early labour care. Further research should investigate new paths for assessing, advising and caring for women during early labour.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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