Childbearing Women's Experiences of Early Pushing Urge

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AIM: To explore childbearing women's experiences of early pushing urge (EPU).

STUDY DESIGN: A qualitative phenomenological study was undertaken in an Italian maternity hospital. The sample included 8 women that experienced EPU during labor. Data were collected through semistructured interviews.

FINDINGS: The findings are presented as three main themes: (a) *women's perceptions of EPU,* (b) *bodily sensations versus midwives' advice: struggling between conflicting messages, and* (c) *the "a posteriori" feeling of women about midwives' guidance during EPU*. The perception of EPU was characterized by sense of obstruction, bone pain, and different intensity of pushing efforts when compared with those of the expulsive phase. Women found it difficult to follow the midwife's suggestion to stop pushing because this contradicted their bodily sensations. However, the women recognized a posteriori the importance of the midwife's support while experiencing EPU. Women appreciated the midwives' presence and emotional support most of all because they seemed to be more concerned with the personal relationship they formed in labor rather than the usefulness or appropriateness of their advice.

CONCLUSION: Midwives should consider women's physical perceptions to help them cope with EPU, acknowledging that women may struggle when caregivers' suggestions are in contrast to their physical perceptions. The women's overall positive experiences of birth suggest that EPU might be considered as a physiological event during labor, reinforcing the hypotheses of previous research. The optimal response to the EPU phenomenon remains unclear and should be studied, considering EPU at different dilatation ranges and related clinical outcomes.

KEYWORDS: early pushing urge (EPU); push; women; experiences; Italy

INTRODUCTION

The second stage of labor onsets when the baby is visible, the dilatation of the cervix is full, and when these are in the presence of expulsive contractions or active maternal efforts (National Institute for Health and Care Excellence [NICE], 2014). However, some women might experience the phenomenon of early pushing urge (EPU). This is diagnosed through the woman's perception of an irresistible urge to push before full cervical dilatation, documented by vaginal examination (Downe, 2008). The prevalence of EPU as described in the literature varies from a percentage of 54% (Roberts, Goldstein, Gruener, Maggio, & Mendez-Bauer, 1987) to lower rates of 20% (Downe, 2008) and 7.6% (Borrelli, Locatelli, & Nespoli, 2013). Although EPU might be experienced by a significant number of women, there appears to be no agreement in the literature about its physiology, occurrence rate, and optimal response (Borrelli et al., 2013; Downe, 2008; Perez-Botella & Downe, 2006).

In the past, the dominant idea about EPU was mainly related to the pathology of the event and to the potential harm in bearing down before full cervical dilatation; possible risks included edema or cervical trauma and maternal fatigue (Benyon, 1957; Berkeley, Fairbairn, & White, 1931; Gaskin, 1990). In particular, Greenhill

http://dx.doi.org/10.1891/2156-5287.6.1.19

and DeLee (1951) and Bergstrom, Seidel, Skillman-Hull, and Roberts (1997) claimed that no voluntary pushing should be allowed in the first stage of labor because this may cause a swollen cervix that could obstruct labor and enlarge the possibility of tearing the cervix, thus causing hemorrhage. Similarly, Berkley et al. (1931) and Benyon (1957) highlighted the negative and harmful aspects of pushing before full dilatation and strongly discouraged this practice. However, there is no evidence supporting augmented rates of cervical damages and maternal exhaustion in the case of an EPU. The concept of EPU as a physiological event if occurring within good maternal and fetal conditions seems to be relatively recent (Borrelli et al., 2013; Downe, 2008; Enkin et al., 2000). Reed (2014) defines pushing as "physiological and instinctive" and claims that "a birthing woman is the expert regarding when and how she pushes." In some cultures, it is tradition for the woman to "push with each and every contraction from the beginning of labour" (Reed, 2014). Owen (2008) claimed that the significant occurrence of EPU may support the idea of the phenomenon as physiological in laboring women. The choice of using the adjective *early* to qualify the type of pushing urge perceived by the woman reflects the shift from pathological to physiological assumptions. Perez-Botella and Downe (2006) wrote, "the term early, rather than premature is used, as premature implies that the urge to push is pathological, i.e. it is taking place at the wrong time" (p. 636). However, while choosing to use the term *early* is in contrast with the traditional pathological definition of "premature pushing urge," it can also be affirmed that the term *early*, like the term *late*, implies a sort of deviation from what happens at the right time (Downe, 2008).

Regarding the management of EPU, authors found that midwives offer support to the woman by either letting her do what she feels or advising her to stop pushing by suggesting alternatives such as a change of maternal position, breathing techniques, pain relief, back massage, use of the bath and aromatherapy (Borrelli et al., 2013; Downe, 2008). However, there is still a clear need to investigate the optimal response to the phenomenon.

International guidelines seem to be incomplete in this area (NICE, 2014). Enkin et al. (2000) argue that if the laboring woman wishes to start pushing when the cervix is less than 8 cm dilated, she should be advised to find a comfortable position and try to resist the urge to push, using alternative practices such as breathing techniques. If the woman has an irresistible urge to push and there is only a rim of cervix left, she may feel better doing so as it is unlikely that any harm will come, unless she exhausts herself. However, the decision-making process during childbirth cannot be guided by clinical signs alone (e.g., centimeters of cervical dilatation). In fact, it is well known that psychosocial factors have a strong influence on the experiences of childbearing women (Baker, Choi, Henshaw, & Tree, 2005). It is, therefore, essential that the midwife works together with each individual woman to determine the best practice to be provided for each specific EPU case (Downe, 2003).

Few authors investigated the incidence of EPU, its characteristics, and midwifery practices in response to it (Borrelli et al., 2013; Downe, 2008; Roberts et al., 1987), and no research was conducted specifically on mothers' perceptions of EPU during labor. However, it appears relevant to understand in more depth what women's perceptions of EPU and related needs are to offer quality care through this delicate event during childbirth. The aim of this study was, therefore, to explore maternal experiences and views of the EPU to inform both local midwifery practice and international debates around the topic.

The findings discussed in this article are part of a larger research project investigating the prevalence, characteristics, and management of EPU through a prospective observational study (Borrelli, Locatelli, & Nespoli, 2013) and women and midwives' experiences of EPU using a phenomenological design.

METHODS

Study Design

A qualitative study using an interpretive phenomenological approach was undertaken. Phenomenology is used to describe rather than explain phenomena as they are perceived and experienced by the participants (Lester, 1999; Smith, Flowers, & Larkin, 2009), with the researcher gathering "deep" insights through inductive, qualitative methods such as interviews and reporting them from the participants' standpoint (Lester, 1999). The phenomenon under study was interpreted by considering the participants' personal and individual experiences. The researchers employed an interpretivist reflexive approach congruent with the Heideggerian thinking (Heidegger, 1927/1962) and considered themselves as involved and subjective actors in collecting and analyzing data. The researchers' personal and professional principles and beliefs were considered as valuable resources to enhance reflexivity through the research process. The study was conducted by three researchers with a midwifery background.

Setting

In Italy, intrapartum maternity care is mostly provided by the National Health System (Sistema Sanitario Nazionale—SSN) and free at the point of service, funded by taxation, with births taking place mainly in obstetric units (Lauria, Lamberti, Buoncristiano, Bonciani, & Andreozzi, 2012). The research site was a Maternity Hospital in Northern Italy with approximately 3,000 births per year, where one-to-one midwifery care is usually provided to all women during labor and birth. In the absence of local guidelines on EPU, it must be acknowledged that the midwives' management of the phenomenon might vary. For this study, the diagnosis of EPU was based on the woman's perception of an irresistible urge to push before full cervical dilatation, documented by vaginal examination. In-labor midwifery care followed local protocols, whereby the midwife is responsible for physiological labor and birth. In Italy, mother and newborn are usually admitted to the postnatal ward for 2–3 days after birth.

Sample

Following the phenomenological approach, a non-probability sampling was used to include participants with in-depth knowledge of the phenomenon under research (Carpenter, 2007; Smith et al., 2009). Women were considered to be eligible for participation if they (a) were diagnosed with EPU during labor, (b) were in good general health, (c) had a singleton physiological pregnancy, (d) completed 37–41 weeks of gestation, (f) spoke Italian language, and (g) were able to consent to participate. Exclusion criteria included preexisting or pregnancy-related conditions, women younger than 18 years or with serious maternal or neonatal complications at birth. According to these inclusion and exclusion criteria, the purposive sample included eight participants. The sample size was determined by data saturation. The sample characteristics are reported in the "Findings" section.

Recruitment

The midwives who worked in the labor ward approached the women initially after birth. Eligible participants were given the study information sheet which explained the research objective and what their participation would involve. The contact details of women willing to take part in the study were passed over to the researcher. Mothers were then approached by the investigator in the postnatal ward after birth.

Data Collection

Data were collected through semistructured interviews conducted in the hospital postnatal ward 2 days after birth. According to the interpretivist phenomenological approach, semistructured interviews were characterized by open-ended questions to encourage the participants to share their stories. This enabled a balance between making the interview open and focusing on significant topics. In fact, some standard questions covering the main topics were discussed with each participant, but the researcher also had the flexibility to investigate areas that seemed appropriate to the individual concerned (Rose, 1994). The first open question was related to the woman's general experience of labor and birth. In the case that she did not refer to EPU, the following question was more specific and investigated her experience of the phenomenon.

Data Analysis

All interviews were digitally recorded, listened/relistened to, and fully transcribed. These were analyzed using an interpretive phenomenological approach (Smith et al., 2009). Reading repeatedly through the transcripts helped the researchers get a feel for what was being said by the participants, identifying key themes and issues in each text. The researchers conducted a line-by-line analysis to identify emergent themes and relevant connections between them. According to phenomenology, the overarching question that primarily guided the analysis of the interviews was "What is this participant talking about?" The use of analytic notes facilitated the process of aggregating the emerging themes (Lester, 1999). The development of core themes was discussed by all members of the research team. Data analysis was conducted in Italian to maintain language nuances and only relevant quotes were translated in English by authors for data dissemination.

Ethical Considerations

The study protocol was approved by the local ethics committee. The informed consent of each participant was obtained by the researcher prior to participation. Confidentiality and anonymity of data were guaranteed, and women were free not to take part or to withdraw at any time. Pseudonyms are used in this article.

FINDINGS

To contextualize our findings, the characteristics of the sample of eight women are reported. The average age was 33 years with a range from 29 to 39 years. The enrolled women were five primiparae and three multiparae. All women gave birth at the full term of pregnancy, and the gestational weeks at delivery varied from 37^{+5} to 41 weeks. Spontaneous labor occurred in five women and, among these, labor was augmented in four cases; labor was induced in three cases. EPUs were diagnosed at various cervical dilatations during the first stage of labor: 5 cm ($n = 2$), 6 cm ($n = 1$), 7 cm ($n = 3$), and 8 cm ($n = 2$). Regarding the type of delivery, five women had a spontaneous vaginal birth, two had a cesarean section, and one had an operative delivery. Maternal and neonatal outcomes were good in all cases.

The findings from the interviews are presented as three main domains. These are (a) *women's perceptions of EPU,* (b) *bodily sensations versus midwives' advice: struggling between conflicting messages, and* (c) *the "a posteriori" feeling of women about midwives' guidance during EPU*.

Women's Perceptions of Early Pushing Urge

EPU perception was described by women as a sense of obstruction that made them feel as if their bearing down efforts were ineffective. Marta metaphorically described this sense of obstruction as a *bottle cap*:

> *When I was pushing, I put all of my efforts into that. And in the end, after I was exhausted, I felt like a bottle cap, as the baby's head was like a bottle cap. After the pushing there was the contraction and this feeling was still there, like I still had a bottle cap there.* (Marta)

The pain accompanying the EPU was reported as being different from that perceived throughout labor before the appearance of the phenomenon. Women defined it as a bone pain, variously described either as a general bone pain or concentrated on the sacrum:

> *It was really painful, I felt like something was pushing on my bones trying to move them. It caused a lot of pain to me.* (Laura)

> *I don't know why I had that sensation. I had that pain on the sacrum and I really had a strong urge to push, push, push! Then they gave me some epidural and little by little, the pain disappeared.* (Maria)

Some women argued that the intensity and characteristics of pushing efforts during EPU were different if compared with those typical of the second stage of labor, when the cervix was fully dilated. However, the nulliparous women realized the difference between the ineffective pushes during EPU and the effective pushes of the second stage only after having experienced the expulsive phase:

> *It was a matter of force and intensity. At the beginning, I didn't feel completely free, my body wasn't completely free to push. The sensation was exactly the same but the intensity was different, because it was absolutely impossible to hold it back at the end.* (Carola)

> *Instead, afterwards . . . either I understood how to do it or she [the baby] was pushing more to come out . . . I realized that my shout changed because it's a really instinctive thing that comes out from you.* (Elena)

Marta, a multiparous woman with a previous experience of natural birth, reported a clear difference between the two types of pushing efforts. She stated that, with her first baby, she felt a sense of relief and emptying after every push. Conversely, she felt nothing changed after the push during EPU and the sense of obstruction was still there (recalling for a second time the metaphor of a *bottle cap*):

> *With my first baby, I felt really like an emptiness feeling. Instead, with my second baby, I really felt that after the push, I still had that need of pushing, I felt like there was a bottle cap that didn't unblock.* (Marta)

Bodily Sensations Versus Midwives' Advice: Struggling Between Conflicting Messages

The women mentioned the midwives' suggestions in the case of EPU, which seemed to be a "stop-pushing"

approach in all cases. Specifically, they reported that the midwives suggested alternatives such as breathing techniques, vocalization, and change of maternal position:

> *At that moment, the midwife said to hold back the pushing and to blow and breathe, to allow the contraction to go away.* (Lisa)

> *When I had to hold back pushes, she [the midwife] told me to do some vocalizations like aaaaahhhhhh or ah ah ah ah.* (Elena)

> *When I was in the lateral position, I naturally felt like I needed to push. When I changed position and I was on my hands and knees, I was more able to control pushes by breathing.* (Maria)

In coping with EPU, women found it difficult to follow the midwives' advice to stop pushing because this was conflicting with what their body was suggesting them. Throughout their attempts to stop pushing, women were accompanied by the conflicting feelings of naturalness of going along with the pushes and discomfort of going against their bodily sensation. Women were confused by the contradiction between their physical perceptions and the need to hold back pushes suggested by the midwife at the same time. Moreover, they reported difficulty in realizing what was happening. This confusion was sometimes related to the feeling of not being believed by health care professionals:

> *I couldn't do that, I really needed to push . . . sometimes I was able to do it, sometimes not.* (Marta)

> *The midwife told me to blow out but I was not able to do it, I was really exhausted and I didn't have any air left to breathe.* (Lisa)

> *It was such an extremely natural thing, so I was thinking "I have to do something, if it is going to be born it's okay, if it is not going to be born it's okay as well." I wanted to push so hard.* (Maria)

> *It was such a strange thing because no one believed me. It was strange because my body was telling me to do something and I had to do the opposite.* (Sofia)

In some cases, the woman's pushing efforts were associated with the desire to speed up the birthing process. They were told not to push by the midwife, but they could not wait to finally meet their baby:

> *The desire to meet him soon was really strong. So when the midwife was telling me not to push I couldn't do it.* (Maria)

> *I was pushing that way because I wanted to speed up labor, but I know I shouldn't have done it.* (Lisa)

Elena reported that when the midwife eventually directed her to push during the second stage of labor, she felt unable to do so because she held back the early pushes for such a long time:

> *The baby had been pushing for a long time . . . I tried not to push, but I wasn't able.* (Elena)

Sofia felt believed by neither the midwife nor her birth partner while experiencing an irresistible pushing urge. She felt not understood by her partner who was trying to convince her to follow the midwife's advice which created the feeling of incomprehension in relation to the EPU appearance and the impossibility of holding back pushes:

> *It was such a strange thing because no one believed me . . . My husband didn't understand me because he kept saying, "The midwife told you should hold back the pushes." He didn't understand because he said, "Listen to the midwife."* (Sofia)

The a Posteriori Feeling of Women About Midwives' Guidance During Early Pushing Urge

Interestingly, mothers were overall very satisfied with their childbearing experience, even if they experienced

an EPU and found this difficult to cope with. All the women interviewed felt cared for by their midwives:

> *The midwife has been really an angel. The labor went very well, even if at the moment of birth there was a bit of panic.* (Marta)

> *The midwives were good. Yes, they cared about me a lot, there was always a midwife with us.* (Lisa)

In contrast with previously reported quotes about their struggle in following the caregivers' advice during EPU, it is curious that the participants recognized a posteriori the importance of the midwife's presence, support, and guidance while experiencing an EPU. The women reported that the midwife was able to empower them, especially when perceiving the impossibility of coping with the EPU:

> *After the shift changed, the second midwife gave me that determination that I needed because I was giving up, I couldn't do it anymore. And when she came with that energy, she gave me that strength that I lacked. She literally took it out of me.* (Laura)
>
> *Yes, yes, she helped me a lot with breathing throughout the birth, especially when I had that urge to push.* (Maria)

Elena associated her ability to strictly follow the midwives' suggestions during the EPU with the positive outcomes of birth:

> *I followed everything they [the midwives] told me and they have been amazing. I had no stitches, nothing.* (Elena)

DISCUSSION

There is no evidence in the literature about women's physical perceptions of EPU, and our data provide this new insight. The sense of obstruction, bone pain, and the intensity of pushing efforts that may accompany the phenomenon should be considered by midwives to help women manage the event. In particular, these perceptions might help the midwives recognize the clinical signs of EPU and, therefore, provide an early recognition of the event without the confirmation of a vaginal examination. Midwives should also acknowledge that women's perceptions might vary according to the cervical dilatation and the length of time between the appearance of EPU and birth.

Although the underlying mechanisms of EPU could differ among nulliparous and multiparous women, parity did not seem to make any difference in women experiencing an EPU for the first time. In fact, both nulliparous and multiparous laboring mothers go through a completely new and unknown experience every time (Dahlen, Barclay, & Homer, 2010). Because women might expect the urge to push to start with a full cervical dilatation, midwives should help them understand what is happening during EPU, keeping in mind that the gap between expectations and experiences may confuse the woman (Fahy, Foureur, & Hastie, 2008; Hauck, Fenwick, Downie, & Butt, 2007).

In helping women manage EPU, midwives should take into consideration that mothers might find it difficult to follow health care professionals' suggestions when these are in contrast with their physical perceptions. Therefore, midwives are advised to consider each woman's needs and perceptions, adopting an individualized and woman-centered care model. As claimed by Downe (2003), each midwife needs to work with the individual woman in the context of her childbearing experience to determine the best approach for each specific case.

Some women demonstrated they wanted to take an active part in the control and decision making of labor (Green & Baston, 2003). This seemed to be the case when women were experiencing an EPU and were struggling in coping with the conflicting messages between their bodily sensations and the midwives' advice. However, the laboring women often placed themselves in the hands of midwives because the latter are considered as experts who "know best" (Bluff & Holloway, 1994, p. 157). In fact, a posteriori, the participants recognized following the midwives' advice as a helpful aspect of coping with EPU. When the women accepted the midwives' admonitions to stop pushing as appropriate, they appeared to adopt the view that EPU should be suppressed against their bodily messages. Some of our findings are clearly in contrast with the traditional idea that pushing early in labor may bring to maternal fatigue and exhaustion. In fact, women that

were advised not to push during the first stage of labor sometimes felt unable to push when eventually directed by the midwife to do so during the second stage of labor. Hence, the difficulty to push when a complete cervical dilatation was reached seemed not to be related to maternal exhaustion due to early pushing but rather to the suppression of EPU.

Overall, women were very satisfied with the care provided by midwives, irrespective of the appearance of EPU, the midwives' advice, or type of delivery. This reinforces the fact that EPU might be considered as a physiological event if coupled with good maternal and fetal conditions (Borrelli et al., 2013; Downe, 2003, 2008). This also shows clearly that what laboring women need most of all is attention and individualized care by a trusted health care professional. Women appreciated the midwives' presence and emotional support most of all because they seemed to be more concerned with the personal relationship they formed in labor rather than the usefulness or appropriateness of their advice. Midwives should therefore take into account that a trusting woman–midwife relationship can increase the woman's self-esteem, especially if she perceives that the midwife believes in her abilities (Dahlen et al., 2010; Lundgren & Berg, 2007).

CONCLUSION AND IMPLICATIONS FOR PRACTICE

Few authors investigated the prevalence and characteristics of EPU and midwifery practices in response to it; there seems, however, to be a dearth of knowledge around women's experiences of EPU. This article aims to contribute new knowledge regarding childbearing women's experience of EPU, providing recommendations for local midwifery practice and further considerations for international dialogue.

It must be acknowledged that the small sample size of this study and the uniqueness of participants' stories suggest that the findings might not represent a complete picture of the topic and, therefore, cannot be generalized. In fact, although this article provides interesting insights on women's experiences of EPU, there might be a wider range of responses and sensations that was not captured among the participants involved. Moreover, the mix of nulliparous and multiparous women may confound the findings because the mechanism behind their urge to push may be quite different. Multiparous women may often feel an urge to push as the vertex is rapidly descending, whereas malposition could be more likely to cause an EPU in nulliparous women. This hypothesis should be further investigated. Given the mentioned limitations, this study brings some original knowledge that will be of interest and benefit to EPU midwifery care both locally and internationally.

In diagnosing and managing the EPU, midwives should consider women's physical perceptions to help them cope with EPU, acknowledging that these may vary according to influencing factors such as cervical dilatation and length of time between the appearance of EPU and birth. Because women might feel confused when the caregivers' suggestions contradict their bodily perceptions (e.g., in the case of a stop-pushing approach), midwives should help them understand what is happening during EPU, giving information and support and providing woman-centered individualized care. The women's overall positive experiences of birth suggest that EPU might be considered as a physiological event during labor, reinforcing the hypotheses of previous research (Borrelli et al., 2013; Downe, 2003; Enkin et al., 2000). The women highly valued the midwives' presence and emotional support while experiencing an EPU, and they seemed to be more concerned with the supportive relationship established in labor rather than the appropriateness of the advice given.

The optimal response to the EPU phenomenon remains unclear and should be studied, considering EPU at different dilatation ranges and related clinical outcomes. Further research into effective management strategies and more descriptive studies on the characteristics and mechanisms of EPU are needed.

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Acknowledgements. Special thanks go to the midwives who helped us identify EPU cases and to the women who gave their consent to participate in the study.

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