**FIRST-TIME MOTHERS’ EXPECTATIONS OF THE UNKNOWN TERRITORY OF CHILDBIRTH: UNCERTAINTIES, COPING STRATEGIES AND ‘GOING WITH THE FLOW’**

**ABSTRACT**

**Objective.** To explore first-time mothers’ expectations of labour and birth, coping strategies they adopt during pregnancy towards childbirth and coping strategies they expect to use during labour and birth.

**Design.** A qualitative Straussian grounded theory methodology was adopted, with data collected through semi-structured interviews in the third trimester of pregnancy. Ethical approval was gained. Data analysis included the processes of coding and conceptualising data, with constant comparison between data, literature and memos.

**Setting.** Three National Health Service (NHS) Trusts in England offering the choice of various birth settings including home, Freestanding Midwifery Unit (FMU) and Obstetric Unit (OU).

**Participants.** Fourteen first-time pregnant women in good general health with a straightforward pregnancy (single fetus) and anticipating a normal birth.

**Findings.** Three themes were identified in regard to women’s expectations of childbirth and coping strategies: **a)** *the* *unknown territory of labour and birth*; **b)** *waiting for the unknown: coping strategies;* **c)** *going with the flow*. First-time mothers acknowledged labour and birth was an unknown territory, irrespective of the planned place of birth. While waiting for the unknown, the women put in place a number of coping strategies during pregnancy: preparing; avoiding; thinking about childbirth as a shared experience among women; relying on maternal instinct; relying on pharmacological pain relief; considering birth partner(s) as voice of reason. Overall, women were flexible in regard to their birth plan and open to change if needed, referring to this open-minded state as ‘going with the flow’.

**Key conclusions and implications for practice.** Women and their families may appreciate receiving accurate and realistic information from caregivers starting in pregnancy and continuing during labour and birth to alleviate the state of uncertainty typical of the childbearing event. The midwife should address the woman’s uncertainties and help her ‘go with the flow’ in the labour continuum. The birth plan should also be revised by the midwife and woman together if they can no longer adhere to the original one.

**Keywords:** childbirth; labour; birth; pregnancy; coping strategies; birth plan.

**INTRODUCTION**

Recent national reports of women’s experiences of maternity care in England highlight the importance of making service users’ perspectives more central to service development ([Redshaw and Heikkila, 2010](#_ENREF_39), [Birthrights, 2013](#_ENREF_3), [DH, 2007](#_ENREF_8)). The recent *National Maternity Review: Better Births* ([Cumberlege et al., 2016: 54](#_ENREF_6)) claims that care should ‘wrap around each woman’. The NMC ([2015](#_ENREF_32)) Code also identifies working in partnership with people and empowering people to share decisions about their care as essential components of the relationship between healthcare professionals and service users.

The importance of understanding women’s perspectives of childbirth is underlined by [Pembroke and Pembroke (2008)](#_ENREF_36), arguing that the woman is the principal actor who invites others to be with her as she gives birth. The authors introduce the concept of ‘genuine hospitality’, debating the appropriateness of referring to the midwife as a host. In fact, the midwife could be seen primarily as the invited guest to the woman’s experience. However, there may be a place for the appellation ‘host’ in relation to the midwife’s role: ‘the midwife is called upon to mentally establish an open space that will be filled by the woman’s needs and preferences’ ([Pembroke and Pembroke, 2008: 325](#_ENREF_36)). Women’s experiences of childbirth may be mainly dependent on their encounter with the individual midwife ([Fraser, 1999](#_ENREF_13), [Kirkham, 2000](#_ENREF_23)), with [Tinkler and Quinney (1998)](#_ENREF_48) suggesting that the midwife-woman relationship is an essential aspect of satisfaction which needs greater consideration. [Kitzinger (2006)](#_ENREF_24) and [Savage (2007)](#_ENREF_43) agree on the fact that healthcare professionals and regulatory bodies should listen more to women and take into account what they expect from maternity services and from their childbearing experience.

Despite the increasing interest in individualised approaches to maternity care seeking to promote women’s informed choice ([O'Cathain et al., 2002](#_ENREF_33), [Carolan and Hodnett, 2007](#_ENREF_5), [Newburn, 2012](#_ENREF_30)), woman centred care ([Berg et al., 2012](#_ENREF_2), [Lundgren and Berg, 2007](#_ENREF_26), [Page, 2003](#_ENREF_34)) and the midwife-woman partnership ([Fleming, 1998](#_ENREF_11), [Fontein, 2009](#_ENREF_12), [Freeman et al., 2004](#_ENREF_14), [Guilliland and Pairman, 1995](#_ENREF_18)), the reality of care provided within the National Health System is often far from this ideal ([Madi and Crow, 2003](#_ENREF_27), [Mander and Melender, 2009](#_ENREF_28)). In fact, although it is obvious that women’s expectations and experiences of midwifery care are of fundamental importance, maternity services and midwifery programmes sometimes seem more focused on competencies that the institutions and regulatory bodies require of healthcare professionals ([Avery, 2005](#_ENREF_1), [Fullerton et al., 2011](#_ENREF_15), [NMC, 2012](#_ENREF_31), [ICM, 2010](#_ENREF_22)). This may result in the apparent paradox of encouraging informed choices which are often limited to what is considered suitable for care providers and organisations. [Proctor (1998)](#_ENREF_37) conducted focus groups with women and midwives with the aim of identifying and comparing health care staff and users’ perception of quality in maternity services. Key differences related to midwives’ underestimation of the importance of continuity during labour and women’s need for control and confidence in adjusting to the maternal role and involvement of partners. This illustrates how providers’ and users’ perceptions of quality of maternity care might differ. Hence, it is crucial to understand existing gaps between childbearing women and care providers’ standpoints ([Proctor, 1998](#_ENREF_37)) in order to offer woman/family-centred individualised care ([Cumberlege et al., 2016](#_ENREF_6)).

The provision of antenatal care and education is key in shaping women’s expectations of childbirth and helping them develop their ability to cope with labour and birth. In relationship to dealing with pain or feelings of anxiety, [Escott et al. (2004)](#_ENREF_10) suggest women may benefit from antenatal support to develop coping strategies for labour and [Van der Gucht and Lewis (2015)](#_ENREF_50) acknowledge potential negative implications where this support is not provided. ‘Feeling safe’, ‘continuous support’ and a ‘positive outlook and acceptance of pain’ are crucial elements to enhance women’s coping ability during labour ([Van der Gucht and Lewis, 2015: 349](#_ENREF_50)). Whilst coping strategies implemented by women during labour have been previously investigated ([Escott et al., 2004](#_ENREF_10), [Spiby et al., 2003](#_ENREF_45), [Van der Gucht and Lewis, 2015](#_ENREF_50)), there is little evidence in regard to strategies adopted by first-time mothers during pregnancy in order to cope with uncertainties preceding the actual event of childbirth.

A literature review on what makes a good midwife and what women value in a midwife during labour and birth was presented in a previous paper (AUTHOR BLINDED, 2014). Following this review, gaps in the literature were identified and a qualitative grounded theory study was conducted to explore first-time mothers’ expectations and experiences of what makes a good midwife during childbirth in different birthplaces (AUTHORS BLINDED, 2016; AUTHORS BLINDED, 2017). In order to contextualise women’s perspectives of a good caregiver, their general feelings, anticipations, expectations of childbirth and associated coping strategies during pregnancy were also explored.

**METHODS**

**Aim**

The aim of the study was to explore first-time mothers’ expectations of labour and birth, including expected and adopted coping strategies during pregnancy towards labour and birth. The research questions were: *a) what are first-time mothers’ expectations of labour and birth? b) which coping strategies do first-time mothers’ expect to adopt during labour and birth? c) which coping strategies do first-time mothers adopt during pregnancy towards labour and birth?*

**Study design**

A qualitative Straussian grounded theory methodology was adopted. Straussian grounded theory is an iterative and inductive process based on the constant comparison between the literature, collected data, codes, categories and memos. Memos were used to map methodological issues and analytical activities, maintain the audit trail of the study, record reflections or questions and give the rationale for decision-making during interviews. It is not a linear process as data collection and analysis proceed simultaneously in order to constantly check that developing insights are grounded in all parts of the analytical process ([Strauss and Corbin, 1998](#_ENREF_47)). The philosophical underpinnings of this research combined constructivist ontology with interpretivist epistemology.

**Research sites and participants**

The research sites were three National Health Service (NHS) Trusts in England offering the choice of various birth settings including home, Freestanding Midwifery Unit (FMU) and Obstetric Unit (OU). The purposive sample consisted of fourteen first-time pregnant women, with sample size determined by data saturation. Five women were planning to give birth at an OU, seven at a FMU and two at home (one of these was undecided between home and FMU). The inclusion criteria were that women were first-time mothers in good general health with a straightforward pregnancy (single fetus) anticipating a normal birth and a minimum age of eighteen. Participants needed to be able to read and speak English sufficiently to understand the information leaflet and to participate in the interview.

**Ethical considerations**

Ethics committee approval was obtained before entering the research sites. Informed consent was gained from each woman prior to involvement, after a detailed explanation of the study by the researcher. Women were free to decline participation or to withdraw at any time. Pseudonyms are used to maintain confidentiality.

**Recruitment and data collection**

The recruitment process lasted five months, from June to November 2013. Eligible women were approached to participate in the study during the third trimester of pregnancy by the community midwives involved in their antenatal care. In the case of expression of interest, the principal investigator telephoned the woman to talk about involvement in the study and to arrange a suitable time to gain the first informed consent and conduct the interview. The set of data presented in this paper were collected through semi-structured face-to-face tape recorded interviews during the third trimester of pregnancy at the participants’ homes (one interview was done in a café on participant’s request). The average gestational age at the time of the interview was 38+3, ranging from 36+1 to 40+1 weeks. An interview guide was developed including key topics identified from the literature and contemporary policy around options for place of birth and agreed by the research team. Interviews were characterised by open-ended questions in order to encourage participants to share their perspectives while enabling a balance between making the interview open and focusing on significant areas ([Rees, 2011](#_ENREF_40), [Rose, 1994](#_ENREF_41)). The interview topics were iteratively guided by preliminary data analysis, which allowed the continuous adjustment of the interview guide, according to the identified themes and areas meaningful to the participants.

**Data analysis**

The interviews were listened/re-listened to, fully transcribed and analysed before undertaking the next data collection. The analysis of data was manually performed and memoing was used as a complementary analytical technique. Data analysis included the processes of coding and conceptualising data, with constant comparison between data, literature and memos. The data analysis was undertaken on the basis of the following phases identified by [Strauss and Corbin (1998)](#_ENREF_47): a) open coding; b) axial coding; c) selective coding; d) development of the theory. The various steps of grounded theory are not necessarily taken in sequence and do not form a linear process ([Strauss and Corbin, 1998](#_ENREF_47)). Data were collected, coded and analysed by SB, under DW and HS supervision, with regular discussion of emerging themes and consensus of final interpretation of findings.

Full methodological details of the study including ethical considerations, data analysis and reflective accounts are available from AUTHORS BLINDED (2016) and thus are not repeated here.

**FINDINGS**

Three themes were identified in regard to women’s expectations of childbirth: **a)** *the unknown territory of labour and birth*; **b)** *waiting for the unknown: coping strategies;* **c)** *going with the flow*. Themes and sub-themes are outlined in Table 1.

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| --- | --- |
| **THEMES** | **SUB-THEMES** |
| THE UNKNOWN TERRITORY OF LABOUR AND BIRTH | * Every woman is different * Never done it before * Uncertainty about emotional and physical reactions * Absence of guidelines on sequence of events * Lack of control over events * Filling time * Now and then * Excitement |
| WAITING FOR THE UNKNOWN: COPING STRATEGIES | * Preparing * Avoiding * Shared experience and maternal instinct * Relying on pain relief techniques * Birth partner(s) as voice of reason |
| GOING WITH THE FLOW | * Childbirth: a natural process * We are designed to do this * The way you go into it * Going with the flow * Rough guidelines |

**Table 1. Themes and sub-themes**

### The unknown territory of labour and birth

When thinking about labour and birth during pregnancy, the women acknowledged this was an unknown territory to them, wherever they planned to birth. This perception was related to several beliefs, with the most frequently mentioned by the participants being that every woman is different and therefore has a unique childbearing experience which cannot be foreseen:

*I am not really sure what to expect to be honest. […] everybody’s experience is different as well so I […] rather just sort of see what happens when it happens.* (Kate - FMU)

As first-time mothers, they had some general expectations of labour and birth but did not have a clear idea on what to expect in terms of sequence of events and their reaction in response to them, both in emotional and physical terms. Some women argued that this sense of unknown made them worry because they did not have any guideline to rely on, reporting a perceived absence of control over the events:

*Because it’s my first time I don’t know what to expect. It’s just all sort of ifs and buts or maybes… until I am there I don’t know because I’ve never done it before.* (Melissa - FMU)

*I don’t know what to expect and that’s worrying. I don’t know when it’s going to happen and how I am going to handle it.* (Rebecca - FMU)

*You don’t know exactly what’s going to happen because things can be taken out of your hands completely.* (Emily - HOME)

Sophia perceived as difficult to imagine the social gatheringsurrounding her during labour and the way time will be filled while she will be having contractions, arguing for the need for finding something to do or say during that *spare time*:

*What I am going to do in that spare time? Just sit there, talking to my mum, is there so much that you can talk about? [laughing] It’s like a social gathering while I’m having contractions! I can’t just see how it runs.* (Sophia - OU)

The majority of participants predicted that their birth experience may be different to or conflicting with their expectations, in terms of what they prefer, what is going to happen and how they are going to cope with the situation. This idea is encompassed by the sub-theme of ‘now and then’:

*I think I am going to surprise myself after the labour. […] I’ll probably find things that I am saying now are totally opposite to what actually happened and how everything was.* (Sophia - OU)

Despite the unknown terrain they were entering, some of the women (especially the ones planning to give birth in a FMU) reported feeling excited about their childbearing event:

*I am really looking forward to the birth. I am just excited because I just think it’s an amazing thing that’s happening, you think growing this little thing for 8 or 9 months and you’re going to meet it soon.* (Jayne - FMU)

### Waiting for the unknown: coping strategies

While waiting for the unknown, the women put in place a number of coping strategies in the course of pregnancy: preparing; avoiding; thinking about childbirth as a shared experience among women; relying on maternal instinct; relying on pharmacological pain relief techniques; considering birth partner(s) as voice of reason.

The participants reported that they were preparing themselves for childbirth in several ways. The most common sources of information were reading books, watching videos, attending antenatal classes and hearing stories about birth from others. In regard to this latter point, Louise stated that she had spoken with people with positive birth experiences, indicating her deliberate preference and selection of reassuring rather than discouraging comments about childbirth:

*I think I’ve been talking a lot to people who have had positive experiences and read articles and videos. So I think most of it is covered in my head and then we’ll see.* (Louise - HOME/FMU)

Four women completed a DVD-hypno-birthing course. The learned relaxation and breathing techniques were seen as useful tools to prepare for natural birth and a reassurance of being able to cope with the pain during labour:

*I’ve been doing lots of relaxation and breathing techniques. […] I’ve got all my tapes that I’ve been practicing so I will be fine.* (Louise - HOME/FMU)

Some women adopted a strategy of avoidance, banning themselves from the internet and other women’s narratives. The main reported reason was the fear of hearing negative recounting of birth that may have a daunting or frightening effect on them. Rebecca talked about feeling as if she was in a *protected environment*, hearing but ignoring ‘bad stories’ of childbirth:

*I sort of banned myself from internet and from listening to people. I sort of go ‘Yes, yes’ and then just ignore it and just sort of have to listen to the midwife really. So yeah, I attempted to ignore other people.* (Rebecca - FMU)

*It’s almost put me into a little cocoon, like a little protective bubble. I do hear stories, I hear good stories and I hear bad stories but I am in my little hypno-birthing bubble so it’s just rolling off me at the moment.* (Jayne - FMU)

Emma stated that she was trying not to think about childbirth too much and avoiding high expectations in order not to be disappointed by her real birth experience:

*I’m just trying to not think too much about it cause I think if you expect too much then you’re bound to be disappointed either way. So I’ll just kind of see how it goes when it comes to it!* (Emma - FMU)

Some participants felt reassured by the fact that childbirth is a shared and common experience among women all over the world. The interviewees pointed out that millions of women had given birth before and childbirth is typically considered such a natural event by women in third world countries, without great concerns about pain relief. Participants also referred to the maternal instinctive ability of giving birth:

*Up until the middle half of this century people did it without a great deal of pain relief. You go to other parts of the world and they get on with it and they’re back out at work the next day.* (Michelle - OU)

*I don’t know how my body is going to react. I want such a natural thing. Your senses I think just change, like everything is so mumsy, you’re more proactive, you just know what to do which I can’t believe that until it’s actually happening, just don’t know.* (Sophia - OU)

Sophia compared the current available pharmacological pain relief techniques with the absence of pharmacological pain relief in the past. Although this was an isolated incident and therefore represented disconfirming data in the context of the present study, it suggested that some women may rely on medical models of care and pharmacological pain relief techniques rather than on their innate ability to give birth, considering pain during labour as something to be avoided:

*All the stories back in the day when they just had their baby at their home on the sofa… you think ‘God, really?’. No pain relief or anything! So if they can do it then […] there’s more things out there to help ladies going into labour, all the pain relief, all the new things that are coming out. […] It’s getting better and better compared to what it used to be like, isn’t it?* (Sophia - OU)

Several women referred to the birth partner as a voice of reason and an advocate while they will be *away with the fairies* (Hannah - OU). Considering what the couple discussed and agreed during pregnancy, the birth companion was supposed to speak up for the rights and wishes of the woman in the case where she is not able to make decisions or if there will be something the midwife is doing or not doing accordingly. Jayne used the allegory of a *co-pilot* to describe her expectation of the partner’s involvement during labour:

*He is my voice and he can speak for me because he would know what I do and don’t want. But also the voice of reason and the communication between me and the midwife. […] So just to be like my co-pilot […]. That’s what I am hoping for!* (Jayne - FMU)

Michelle likened her partner’s support during the unknown territory of childbirth with his support with an everyday activity such as running. She expected her partner to know how to behave and to provide quiet support during labour:

*Everything I can relate it to is when we go running together… and when we go running and when I am at the limits of my ability to go any further, he knows that the thing to do is not to trying encourage me… it’s just be there, quietly with me […]. So he knows how to sort of quietly support me.* (Michelle - OU)

### Going with the flow

Regardless of the planned place of birth, all the women perceived childbirth as a natural process with a clear intent to have a birth as natural as possible, particularly in regard to the avoidance of pharmacological analgesics. The approach of the participants towards birth is well represented by these two comments in respect to the consideration of the woman’s body as *designed* to give birth by using its natural pain relieving system:

*Our bodies are designed to do this […].We weren’t designed with the ability to have pethidine and epidurals and things. We were designed to get on with it.* (Michelle - OU)

*I know it’s not going to be the most comfortable experience and it’s probably going to hurt but trying to get the body to use its own kind of pain relieving system is something that I would rather do.* (Emily - HOME)

Michelle used an analogy between the body and mechanical engineering:

*By being up and keep moving around and not being a patient effectively and lying prone on a bed you are giving your body the opportunity to do what it’s designed to do. If I put an engineering component in place and then ask it to do something that is not designed to do, by being constrained it will break and it will end up with more strain. Whereas if I put it into its natural environment and enable it to move and I help it, then things are going to happen more naturally.* (Michelle - OU)

The perception of the body as *designed* to go through labour and birth naturally while feeling in control is also raised by Sophia:

*I’d like to do it naturally if I can, just I don’t want to be dosed up on drugs that I can’t remember what is going on, I want to be able to see what is going on and feel the natural motion. I don’t want to be out of my face.* (Sophia - OU)

The interviewees believed that the way women go into labour and how they look at it mentally could make a big difference in experiencing childbirth. Effective approaches to face the unknown territory of childbirth anticipated by the participants were: being relaxed; not focusing on pain; taking control over labour; being reassured by having some knowledge about childbirth; concentrating on the idea of a manageable intense personal experience rather than thinking about birth as a *horrible ordeal* or a *degrading process*:

*I think a lot of it is psychological. If you stop focusing on pain you can get past it a lot more easily.* (Michelle - OU)

*Sometimes the way you go into it, the way you personally feel about it, that makes a big difference. […] Using your own control and taking control over your own labour.* (Emma - FMU)

*The best approach you can have is to be […] relaxed about it and I think that’s half the battle won then. […] It’s not a degrading process, it’s not something that’s a horrible ordeal. You can still have an intense personal experience. I think it’s just a part of life and it’s manageable. And I think if you’ve got knowledge’s power. […] having an understanding and an awareness […]* (Jayne - FMU)

The sub-theme of ‘going with the flow’ emerged from a recurrent phrase used by women to describe their open-minded and flexible attitude towards labour and birth. This expression was used by the participants regardless of their planned place of birth, in terms of following both the course of events and their emotional and bodily response. They anticipated that they may constantly review their expectations in the light of their actual birth experience (recalling the sub-theme ‘now and then’):

*I am quite open-minded and I am just going to go with the flow.* (Sophia - OU)

*I suppose I’ll deal with it when I get there sort of thing so I really don’t know. […] I’ll just go with the flow!* (Mary - OU)

In line with the idea of going with the flow, the women seemed to be quite flexible in regard to their birth plan and open to change if needed. They preferred to have general guidelines with basic points such as who was the birth partner, what sort of labour and pain relief they wanted, how they wanted the placenta to be delivered and indications for Vitamin K injection. Together with the partner, the birth plan was considered as a beneficial tool to communicate their preferences to the midwife during labour:

*I think I am kind of ‘These are the things that would be ideal but I’m open to change if need be’.* (Emma - FMU)

*I’ve got rough guidelines but I need to keep my mind open.* (Sophia - OU)

*I think a birth plan is a great idea because at least then when you go into the hospital, if I’m too uncomfortable or too flustered to talk I can just give it to the midwife.* (Jayne - FMU)

Some women stated they did not have a set birth plan because of the uncertainty of what may happen during childbirth. The fact that they could be upset or annoyed by unforeseen events or unmet expectations prevented them from writing a birth plan:

*I haven’t made a plan because I think that if it doesn’t go to plan I might going to get annoyed or upset because it’s not the way I planned it.*(Rebecca - FMU)

**DISCUSSION**

Uncertainties, doubts and fears preceding the birth experience have been highlighted by this and other research ([Dahlen et al., 2010](#_ENREF_7), [Melender, 2002](#_ENREF_29), [Laursen et al., 2008](#_ENREF_25), [Haines et al., 2012](#_ENREF_19), [Elvander et al., 2013](#_ENREF_9), [Stenglin and Foureur, 2013](#_ENREF_46)). The first-time mothers interviewed considered childbirth as a new and unknownevent, regardless of the planned place of birth. The women’s state of mind can be described as a period characterised by uncertainty while awaiting childbirth. This state of uncertainty was considered by participants as an ongoing condition through the entire duration of labour and birth. In particular, interviewees stressed their insecurity about emotional and physical reactions during labour and birth. Similarly, [Dahlen et al. (2010)](#_ENREF_7) found that first-time mothers’ experiences of birth at home and in hospital were all linked by the common process of reacting to the unknown. Three decades ago, [Greer (1984: 12)](#_ENREF_17) wrote ‘women who want the experience of childbirth are in the curious position of desiring the unknown’ and [Rubin (1984: 52)](#_ENREF_42) argued that labour and birth involve the woman exchanging ‘a known self in a known world with an unknown self in an unknown world’. The ambivalences and subtleties that emerged from the findings of this research highlighted the uniqueness of each woman’s expectations. For instance, the participants highlighted a variety of coping strategies adopted during pregnancy while awaiting for labour and birth, from preparing and reading to avoiding information. The apparently contradictory coping strategies of preparing and avoiding seemed to occur mainly in women planning to give birth at home or in a FMU. The interviewee that planned to rely on pharmacological pain relief was going to give birth in an OU. The integration of birth partners’ support and the consideration of childbirth as a shared experience were highlighted by the participants regardless of the planned place of birth. This is important for those preparing women and their supporters for childbirth and supports the provision of antenatal education in ways that do not segregate by planned place of birth.

The process of approaching the forthcoming birth experience was accompanied by individual expectations and beliefs. The women in the present study anticipated a gap between expectations and experiences of childbirth, for instance in relation to coping with pain. The relationship between the woman’s expectations and her actual birth experience may influence the overall satisfaction with childbirth, maternity care and caregivers ([Heaman et al., 1992](#_ENREF_21)). Although beliefs and expectations about labour and birth may vary from individual to individual, the women whose expectations are met are more likely to be happy with their childbirth experience ([Goodman et al., 2004](#_ENREF_16), [Hauck et al., 2007](#_ENREF_20)). Conversely, when expectations are unfulfilled, maternal dissatisfaction may occur ([Tumblin and Simkin, 2001](#_ENREF_49)), with potentially increased risk of adverse psychological outcomes ([Shub et al., 2012](#_ENREF_44)). In regard to parity, [Hauck et al. (2007)](#_ENREF_20) reported that unsatisfactory birth experiences due to unmet expectations may frequently occur amongst first-time mothers. Mothers may develop unmet expectations due to several reasons: they have no previous experience of labour and birth; appropriate preparation and information are not always provided and they do not feel supported in re-adapting expectations to the actual experience ([Dahlen et al., 2010](#_ENREF_7)). A fruitful approach could be to encourage women balancing optimism with flexibility when childbirth do not go according to plan. Every pregnant woman should be introduced to this type of narrative in advance of labour so that she can remain flexible if the need arises and all childbirth professionals could work within this framing as occasions arise ([Walsh, 2010](#_ENREF_51), [Callister, 2004](#_ENREF_4)). In the present study, women were generally open to adjust expectations in case expectations were unfulfilled. This is well illustrated by the idea of ‘going with the flow’, an expression used by a number participants to describe their open state of mind towards labour and birth, in terms of physical perceptions, emotional state and labour events. This inclination seemed to be in line with the participants’ flexibility in regard to their birth plan and openness to change if needed. Accepting changes as a coping strategy can be considered as a beneficial post-hoc adjustment, as highlighted by [Parrat (2008)](#_ENREF_35); by doing this, unachievable expectations and beliefs are released, ‘making room for new ways of being that are most appropriate to the context’ ([Parrat, 2008: 48](#_ENREF_35)). In fact, a woman’s state of mind during childbirth may set the stage for her satisfaction with the birth experience. For instance, a mind that remains open and accepts the inner experience is usually accompanied by a more positive recounting of the labour experience ([Whitburn et al., 2014](#_ENREF_52)).

**CONCLUSIONS AND IMPLICATIONS FOR PRACTICE**

This paper provides original insights into coping strategies adopted by first-time mothers during pregnancy while awaiting for the unknown event of childbirth, including the notion of ‘going with the flow’. It is acknowledged this is a relatively small qualitative study with a limited sample size not including minority ethnic groups and women with a pathological pregnancy conducted in one region in England. Moreover, due to a high birthplace transfer rate during pregnancy, it was not possible to explore in depth the experiences of women giving birth where they planned to both for home birth and FMUs birth. However, the study findings are relevant to maternity care services nationally and internationally. In fact, the variety of women’s uncertainties, doubts, expectations and fears preceding the birth experience seem to be universal and a common denominator in different settings as reflected in research in the last two decades from a range of settings ([Dahlen et al., 2010](#_ENREF_7), [Melender, 2002](#_ENREF_29), [Laursen et al., 2008](#_ENREF_25), [Haines et al., 2012](#_ENREF_19), [Elvander et al., 2013](#_ENREF_9), [Stenglin and Foureur, 2013](#_ENREF_46)).

The findings highlighted some shared aspects of women’s expectations of labour and birth irrespective of planned place of birth, including the belief in childbirth as a natural process; uncertainties about emotional and physical reactions; doubts about the sequence of events within the progress of labour; acknowledgment of a possible gap between expectations and experiences; lack of control and common coping strategies adopted during pregnancy. In regard to implications for practice, it is suggested that these shared elements are incorporated into antenatal care and education. Women and their families should be offered accurate and realistic information from caregivers starting in pregnancy and continuing during labour and birth to alleviate the state of uncertainty typical of the childbearing event. To promote realistic expectations of childbirth and to assist women in meeting their expectations, midwives should listen to the woman and consider individual preferences, wishes and beliefs. In line with recommendations from the contemporary *National Maternity Review: Better Births* ([Cumberlege et al., 2016: 54](#_ENREF_6)) on continuity of carer, being aware of and getting to know the woman’s expectations during childbirth could facilitate the midwife’s advocacy role ([Hauck et al., 2007](#_ENREF_20)) and the provision of woman-centred and culturally sensitive care ([Raines and Morgan, 2000](#_ENREF_38)) throughout the childbearing experience. Caregivers may become even more important when childbirth expectations cannot be realised ([Hauck et al., 2007](#_ENREF_20)), therefore the midwife should address the woman’s uncertainties and help her ‘go with the flow’ in the labour continuum. This may enable an environment that allows the woman and her birth partner to move forward despite the uncertainty and the fluctuating gap between expectations and experiences. The birth plan should also be reviewed by the midwife and woman together if they can no longer adhere or follow the original one.

Further research is required to identify how midwives should support women to ‘go with the flow’ and to investigate whether there are any specific coping strategies that would support women to achieve this.

**CONTRIBUTION**

The principal investigator (SB) is a midwife and was undertaking a PhD in Health Sciences at the time of the study. The co-authors (DW and HS) are midwives and academic supervisors of the principal investigator; they contributed to the design of the study protocol and provided significant insights during all project stages.

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