ANTENATAL MIDWIFERY CONSULTATIONS
A qualitative study

Pia Olsson
ANTENATAL MIDWIFERY CONSULTATIONS

A qualitative study

AKADEMISK AVHANDLING

som med vederbörligt tillstånd av Rektor vid Umeå universitet för avläggande av medicine doktorsexamen kommer att offentligen försvaras i Aulan, Vårdvetarhuset, fredagen den 10 mars 2000 kl 09.00

av

Pia Olsson

Umeå 2000
Antenatal midwifery consultations. A qualitative study
Pia Olsson, Department of Nursing, Umeå University, Umeå, Sweden.

ABSTRACT
The overall aim of this thesis is to gain a deeper understanding of antenatal care by disclosing aspects of topics, meanings and the participants' ways of relating in midwifery consultations in a Swedish primary care setting. To accomplish this video recordings were made of five antenatal midwives' consecutive consultations with one expectant/new mother/father from the initial 'booking' in early pregnancy, throughout the pregnancy and the follow-up consultation after the childbirth (n=58). The data was analysed using a quantitative content analysis, qualitative content analysis and phenomenological hermeneutic approach.

The results show that physical aspects of pregnancy, childbirth and parenthood dominated the consultations (I-IV). Pregnancy was the most frequent topic discussed followed by childbirth while the topic of parenthood was mentioned comparatively seldom (II-IV). In the consultations the situation of the expectant/new mother is the main focus. The expectant/new fathers' relations and concerns regarding the period of pregnancy, childbirth and parenthood were only discussed occasionally. The midwives led the consultations by taking and keeping the initiative and by their ways of relating, with which the expectant/new parents, with a few exceptions, complied (I-V).

The complexity of meanings connected with pregnancy (II), childbirth (III) and parenthood (IV) disclosed in the consultations shifts between understanding the processes of transition to parenthood as trustworthy or as unreliable. The understanding of the woman's physical processes as unreliable is predominant in the studied consultations. The hazards and the deficient capacity of the woman's body to meet the various demands are focused on. Risks of deviations from an optimal development are central. The unborn/new-born child appears to be endangered by the processes. When trustworthiness towards the transitional process dominates the consultations, the possibilities and strengths of the processes and the woman's, baby's and the family's ability to meet the physical changes and challenges are emphasised. There is openness to the uniqueness of the expectant/new parents' ways of resolving the varying demands of the process.

The midwives' ways of relating in the consultations are understood as moving between 'distanced surveillance' of the expectant/new mother and 'caring about' the expectant/new parents (I, V). 'Caring about' is distinguished by the midwives' involvement in the unique life situation of the expectant/new parents. 'Distanced surveillance' is characterised by impersonal, generalised ways of relating where the uniqueness of the expectant/new parents and their life situation are disregarded.

In summary this study indicates that within antenatal care transition to parenthood can be understood as a feminine bodily risk project. The transition could also be understood as a trustworthy physical, emotional, existential and social process involving the whole childbearing family. Midwives were found to relate to expectant/new parents both in a distanced and a caring way.

Key words: Antenatal care, Pregnancy, Childbirth, Parenthood, Midwives, Expectant parents, Video recordings, Phenomenological hermeneutics, Qualitative content analysis, Quantitative content analysis, Caring, Transition to parenthood
ANTENATAL MIDWIFERY CONSULTATIONS

A qualitative study

Pia Olsson

Umeå University Medical Dissertations
New Series No 643 - ISSN 0346-6612

From the Department of Nursing, Umeå University, Umeå, Sweden

Umeå 2000
To caregivers of families in transition to parenthood
CONTENTS

ABSTRACT 7

ORIGINAL PAPERS 8

INTRODUCTION 9
  Transition to parenthood 9
  Antenatal care 12
  Midwifery consultations 13
  Caring 16
  The investigator’s experience of antenatal care 17

RATIONALE FOR THE STUDY 17
  The aims of the study 19

MATERIAL AND METHODS 20
  Setting 20
  Proceedings and participants 20
  Video recordings 23
    Transcription 24
    Ethical considerations 25
  Analysis 26
    Quantitative content analysis 26
    Qualitative content analysis 27
    Phenomenological hermeneutic interpretation 28
      Metaphoric language 30

RESULTS 31
  Conversation topics 31
  Meanings of pregnancy 32
  Meanings of childbirth 33
  Meanings of parenthood 33
  Ways of relating 34
ABSTRACT

Antenatal midwifery consultations. A qualitative study

The overall aim of this thesis is to gain a deeper understanding of antenatal care by disclosing aspects of topics, meanings and the participants' ways of relating in midwifery consultations in a Swedish primary care setting. To accomplish this video recordings were made of five antenatal midwives' consecutive consultations with one expectant/new mother/father from the initial 'booking' in early pregnancy, throughout the pregnancy and the follow-up consultation after the childbirth (n=58). The data were analysed using quantitative content analysis, qualitative content analysis and a phenomenological hermeneutic approach.

The results show that physical aspects of pregnancy, childbirth and parenthood dominated the consultations (I-IV). Pregnancy was the most frequent topic discussed followed by childbirth while the topic of parenthood was mentioned comparatively seldom (II-IV). In the consultations the situation of the expectant/new mother is the main focus. The expectant/new fathers' relations and concerns regarding the period of pregnancy, childbirth and parenthood were only discussed occasionally. The midwives led the consultations by taking and keeping the initiative and by their ways of relating, with which the expectant/new parents, with a few exceptions, complied (I-V).

The complexity of meanings connected with pregnancy (II), childbirth (III) and parenthood (IV) disclosed in the consultations shifts between understanding the processes of transition to parenthood as trustworthy or as unreliable. The understanding of the woman's physical processes as unreliable is predominant in the studied consultations. The hazards and the deficient capacity of the woman's body to meet the various demands are focused on. Risks of deviations from an optimal development are central. The unborn/new-born child appears to be endangered by the processes. When trustworthiness towards the transitional process dominates the consultations, the possibilities and strengths of the processes and the woman's, baby's and the family's ability to meet the physical changes and challenges are emphasised. There is openness to the uniqueness of the expectant/new parents' ways of resolving the varying demands of the process.

The midwives' ways of relating in the consultations are understood as moving between 'distanced surveillance' of the expectant/new mother and 'caring about' the expectant/new parents (I, V). 'Caring about' is distinguished by the midwives' involvement in the unique life situation of the expectant/new parents. 'Distanced surveillance' is characterised by impersonal, generalised ways of relating where the uniqueness of the expectant/new parents and their life situation are disregarded.

In summary this study indicates that within antenatal care transition to parenthood can be understood as a feminine bodily risk project. The transition could also be understood as a trustworthy physical, emotional, existential and social process involving the whole childbearing family. Midwives were found to relate to expectant/new parents both in a distanced and a caring way.

Key words: Antenatal care, Pregnancy, Childbirth, Parenthood, Midwives, Expectant parents, Video recordings, Phenomenological hermeneutics, Qualitative content analysis, Quantitative content analysis, Caring, Transition to parenthood.
This dissertation is based on the following papers, which will be referred to in the text by their Roman numerals:


V Olsson P, Jansson L. Patterns in midwives’ and expectant/new parents’ ways of relating to each other in ante- and postnatal consultations. Manuscript submitted for publication.

Reprints have been made with the permission of the publishers.
INTRODUCTION

In Sweden almost all expectant/new parents attend antenatal consultations (Lindmark 1992). This activity takes place during the transition to parenthood, a period of life characterised by many and at times profound alterations in the expectant/new parents’ lives especially the first time a child is expected but also on subsequent occasions. These consultations could be one of the many factors that influence the way expectant/new parents understand themselves and the transition they live through. The attempt in this thesis is to deepen the understanding of antenatal care.

Transition to parenthood

To expect a child and to experience childbirth and early parenthood imply considerable physical, psychological and social change and upheavals in the lives of people in Western societies today (Moore & Delieu 1997). The whole of their life could be perceived as changed (Bondas-Salonen 1995). A process of transition, as the transition to parenthood, is characterised by changes over time involving movements or flow from one state to another (Imle 1990) comprising changes in the person’s identity, roles, relationships and abilities (Schumacher & Meleis 1994).

The experiences of the transition to parenthood on the whole and of its phases - pregnancy, childbirth and early parenthood - are culturally coloured, highly individual and influenced by family, organisations and institutions. The transition includes possibilities for the people involved to develop but also risks to the health and life of the mother and the baby (Raphael-Leff 1991 pp 3-28, 183-208, Schumacher & Meleis 1994). Factors influencing transition include; expectations and meanings of the transition for those involved, level of relevant knowledge, skill and planning, resources within the environment, emotional and physical well-being (Schumacher & Meleis 1994) and previous experiences of the transition to parenthood (Jordan 1989, Sammons 1990). The preparation for parenthood continues throughout the pregnancy and constitutes an important basis for the experiences of childbirth and the development of the parent-child relationship after the birth of the child (Raphael-Leff 1991 pp 45-149, Bergum 1997 pp 27-64). Exactly
when during this process one experiences oneself as a parent varies and does not necessarily coincide with the time when society acknowledges the parenthood (Bergum 1997 pp 13-26, Hagström 1999 pp 250-263). The meaning expectant/new parents create out of their situation is important for how they understand and handle their transition (cf. Pridham & Chang 1992, Schumacher & Meleis 1994).

The relationships within the couple and with their families of origin are often affected, for better and for worse, during this period (Belsky & Rovine 1990, Belsky & Kelly 1994, Sullivan-Lyons 1998, White et al. 1999). Social support of a practical, emotional or informational kind is regarded as important (Mercer 1986 pp 1-24, Oakley 1992 pp 93-116, 143-186) and insufficient psychosocial resources can increase the risk of an unhealthy life style such as when pregnant women smoke thus increasing the risk of their babies becoming small-for-gestational age (Dejinkarlsson 1999). Discussions of the uniqueness of family dynamics with both partners antenatally may help families to negotiate the transition successfully (White et al. 1999). Swedish childbearing families are supported by government financed parental leave for the 330 days in connection to the birth. Some portions of the allowance are dedicated to the mothers while others are exclusively for the fathers (Swedin 1996, Gårdmark 1997 pp 114-119).

All the systems in the female body are affected in pregnancy (Moore & Delieu 1997). A sense of physical unfamiliarity with a body no longer exclusively their own is described by pregnant women (Berk 1993) and both increased and reduced well-being are reported during pregnancy (Kirwan & Olah 1997, Moore & Delieu 1997). The wide array of experiences of pregnancy embrace; enjoying it as a ‘culmination of womanhood’, being depressed and worried and seeing it as a tedious ‘job to be done’ (cf. Raphael-Leff 1991 pp 45-133, Moore & Delieu 1997). The pregnancy could be accompanied by mood swings, intense urges, heightened emotionality and altered states of consciousness (Raphael-Leff 1991 pp 45-133). Expectant fathers are also reported to experience physical changes such as nausea, headaches and indigestion during this period (Bogren 1983, Raphael-Leff 1991 pp 153-175, Swedin 1996) and to experience their partner’s pregnancy as a period of happiness, powerlessness, increased ill-health, vulnerability and insecurity (Jordan 1990, Swedin 1996, Hagström 1999 pp 250-263). Many expectant fathers consider it their responsibility to support and protect their pregnant partner and some also claim that

To give birth to a child is described as a personal, intimate, intense and complex experience, which women remember vividly and accurately for many years (Simkin 1992) if not for ever. Swedish first-time mothers who expected childbirth to be threatening, joyful, frightening, a challenging process or a trustworthy life event reported that they experienced the birth both as better and as worse than expected (Hallgren et al. 1995). Women’s more detailed expectations of childbirth are described as being concerned with pain, analgesia, interventions, control, involvement in decision making and assistance from staff and companion (Beaton & Gupton 1990, Bluff & Holloway 1994, Brown & Lumley 1994, Green et al. 1998 pp 218-256, Waldenström 1996a, 1999a). It has become routine in Western societies for the expectant/new father to be present when his partner gives birth to their child. Men report that experiencing childbirth can be positive, negative or stressful (Nichols 1993, Hallgren et al. 1999). They describe their role during childbirth as coach, teammate or witness (Chapman 1992, Wikander & Theorell 1997) and their difficulty in participating in congruency with their personality and their relationship with the woman (Chandler & Field 1997, Hallgren et al. 1999).

Being a new mother is not only described in terms of happiness and fulfilment. Descriptions also include dealing with contradictory processes such as giving of self and redefining self, relationships and professional goals (Sethi 1990, Bäck-Wiklund & Bergsten 1997 pp 167-197, Elvin-Nowak 1999 pp 41-42). Modern Swedish motherhood is described as being accompanied by guilt while creating calm and balance in the face of demands and expectations arising from the responsibility for children, home and work (Elvin-Nowak 1999 pp 13-52). New fathers in Western societies report experiencing themselves as labouring for relevance in the absence of models of involved fatherhood (Jordan 1990, Bäck-Wiklund & Bergsten 1997 pp 142-153, Hagström 1999 pp 250-263), feelings of joy and trouble (Hall 1995), sadness, anxiety and ambivalence (Henderson & Brouse 1991) and changes in their relation to their partners and themselves (Osofsky et al. 1985, Swedin 1996). Swedish men describe ‘The good father’ as being there in everyday life, which could not always be considered fun, easy or self-fulfilling- but was nevertheless important (Hagström 1999 pp 250-263).
Antenatal care

Swedish antenatal care was introduced on a large scale in the 1930s along with a series of social interventions to support motherhood, such as maternity care free of charge and a maternity allowance. One background component in this was that the low birth rate at the time was considered problematic (Höjeberg 1991 pp 304-306). Its organisation followed the pattern of contemporary British practices and has since changed little in structure. The aim was to reduce maternal morbidity and mortality through the early detection and treatment of preeclampsia, infections and anaemia. The provision of health education and indicating those women who should give birth in hospital were other components in the care given at district level (Lindmark 1992).

The creation of such extended health care was in accordance with the Swedish ideal of the ‘People’s Home’ (Swedish: Folkhemmet) at the time, with its notion of society’s care of families (Myrdal & Myrdal 1935 pp 245-333). Antenatal care is, however, also described in terms of the medical profession assisting the state in its social control of women’s bodies and in educating ignorant women to become good mothers (Oakley 1984 pp 250-256). The transmission of intrinsic cultural ideas within a medical framework also implies a cultural influence on immigrant expectant/new parents (Olin Lauritzen 1990 pp 171-172). Comparisons between antenatal care and rituals are made both by referring to rituals as something useful in a transitional process (Raphael-Leff 1991 p 137) and as a number of routine procedures of dubious value (Steer 1993).

Since the 1970s antenatal care has been the point of departure for a parental education program that continues at maternity hospitals, child welfare centres, the childcare system and at school. At antenatal clinics the education is generally conducted in midwife-led groups with expectant parents and embraces both preparation for childbirth (Hallgren et al.1994) and parenthood (SOU 1997 pp 99-101). Along with this program a psychosocial working method was launched aiming at integrating psychological and social aspects with the predominantly somatic (Gustafsson & Kaplan-Goldman 1981, SOU 1997).

There has been a disinclination for change in antenatal care, which might be based in the notion that antenatal care is beneficial both for individuals and society. However, it has not been completely clear what its effective components might be (Lindmark 1992). Medical screening programs have been reconsidered during the
last few years aimed at scientifically motivated actions (Berglund & Lindmark 1996, Gårdmark 1997, Villar & Bergsjö 1997, Berglund 1999). A moderate reduction in the number of routine consultations compared with the traditional schedule has not changed the physical outcome for mothers and their babies. To be seen by a midwife in routine antenatal consultations has proved to be as safe as to be seen by a doctor (McDuffie et al. 1996, Sikorski et al. 1996, Villar & Kahn-Neelofur 1999). Sikorski and co-workers (1996) initially found poorer psychosocial outcomes among women allocated to a reduced schedule of visits. However, no long-term adverse outcomes were found (Clement et al. 1999).

Today Swedish antenatal care is part of maternal healthcare (Swedish: mödrahälsovård), which has an extended role embracing various aspects of healthcare for women in the fertile ages and their partners. The professional antenatal team includes obstetricians, general practitioners, midwives, psychologists and social workers (Kjessler 1991 pp 10-13, Gårdmark 1997 pp 19-20). In this thesis the expression antenatal care, as in everyday language, also embraces the routine post-natal follow-up consultations.

**Midwifery consultations**

Midwives conduct most antenatal consultations in Sweden (Berglund & Lindmark 1998). The aims of the care during pregnancy are, according to the national guidelines, to prevent complications through a screening program focusing on somatic aspects of the health of the mother and the foetus. Additional aspects of the care are health education, psychosocial support, preparation for childbirth and parenthood (Kjessler 1991 pp 9, 16-25, 65-66, Gårdmark 1997 pp 9-15). In uncomplicated cases the care consists of a series of consultations with the midwife, one or two visits to the general practitioner or obstetrician, one ultrasound examination in early pregnancy and midwife-led group encounters for first-time parents, focusing on preparation for childbirth and parenthood. One postnatal visit to the midwife is recommended in the national guidelines. When complications occur the midwives consult appropriate specialists (Kjessler 1991 p 11, Gårdmark 1997 pp 9-16). The compliance of pregnant women with the medically based routine schedule is judged to be almost total (Lindmark 1992). The mean number of visits to the midwife in 1990 ranged from 10.5 to 13.2 (local variations) and 2.7 visits to a general
practitioner or obstetrician (Åberg & Lindmark 1992). Since 1996 the number of antenatal visits recommended on a medical basis has been 8 to 9 for women expecting their first child and 7 to 8 for subsequent pregnancies. The national guidelines further recommend that the number and timing of the visits should be individualised and that the notion of risk should not be given too dominant a role in the consultations (Gårdmark 1997 p 14). The participation of expectant fathers is encouraged (Kjessler 1991 pp 20-25). Usually expectant parents see the same midwife throughout the pregnancy (Waldenström & Nilsson 1993).

The ideology of the midwifery association emphasises that in all midwifery care the primary tasks should be to support the woman and the man in developing their parental role and considering their resources faced with the prospect of childbirth. Respect, integrity, dignity and the uniqueness of the woman, the child and the family are highlighted as important in working with childbearing families (Ekberg 1995 pp 21-23, 29).

Antenatal midwifery consultations have different structures depending on the topics dealt with (Bredmar 1999 pp 74-75) and the tasks of the health professionals (Olin Lauritzen 1990 pp 70-74). The antenatal booking interviews include interviewing and information regarding medical, social, emotional matters, lifestyle and the practical aspects of pregnancy and routines of antenatal consultations and parental education. Blood samples are taken and blood pressure is measured. The following consultations during the pregnancy consist of discussions about how the woman feels, health-related advice, test results and the execution of examinations such as measurement of blood pressure and fundal height, pelvic and abdominal palpation and auscultation of the foetal heart rate. The women ask their questions and information is given about coming tests or examinations. The postnatal consultation embraces discussions on the experiences of being a mother and of the birth, contraceptives and a gynaecological examination is usually performed (Bredmar 1999 pp 73-130).

A closer look at how these consultations are carried out demonstrates that the surveillance and health education programs appear to be carried out, as ‘taken for granted’, regardless of the background of the individual family. Interactional dilemmas are created since the implicit message of medical doubt inherent in health surveillance is not made explicit in the contact with the families (Olin Lauritzen 1990
pp 170-171). The midwives' aims in their communication are described as being to facilitate expectant mothers' understanding of their pregnancies with trust and confidence and to avoid their experiencing anxiety. The development of the babies is covered in the talks about the expectant mothers' perception of their bodily changes (Bredmar 1999 p 136). Midwives reported that they become intuitively aware of which pregnant women needed extra support (Hildingsson & Häggström 1999).

In British antenatal consultations the midwives are found to control the agenda and the nature of the information available to the women, despite their stated intention to help women to make informed choices regarding their care during pregnancy (Levy 1999a). The development of a trusting relationship is obstructed, at booking interviews, because of the governing role given to the medical record (Methven 1989). The communication style of midwives during abdominal palpation leaves some expectant mothers more worried than before while others find the examination reassuring (Olsen 1999).

Expectant/new parents' experiences of and opinions about Swedish antenatal consultations are not studied in any depth but are assumed in the literature to be positive, with reference to the high frequency of attendance (Gårdmark 1997 pp 9) and unpublished reports (Kahn & Marklund 1989, Marklund 1990, Hertfelt-Wahn 1997). One study revealed that pregnant women were generally satisfied with antenatal care and felt respected and cared about. Dissatisfaction is reported, however, regarding the caregivers' lack of interest in the family and psychological, sexual and existential issues (Wilde Larsson et al. 1997). Pregnant women perceive non-authoritarian antenatal midwives, who support them in their role as future mothers, as helpful in their attempt to stop or reduce smoking (Arborelius & Nyberg 1997). Women report that professional care during the transition to parenthood could both confirm and strengthen them or obstruct the integration of the changes and even offend them (Bondas-Salonen 1995 pp 168-169). Other international studies on satisfaction with antenatal care highlight the importance of availability of information, expectant parents' expectations, possibilities to make choices and be involved in the care, physical and mental health and social network (Omar & Schiffman 1995, Clement et al. 1996, Tinkler & Quinney 1998). Dissatisfaction with antenatal care appears to be connected with impersonal care, poor communication and lack of continuity of caregivers (Reid & Garcia 1992).
Women's and men's highly personal expectations and experiences of the transition to parenthood motivate individual follow-up of the content in parental education groups e.g. in midwifery consultations (Hallgren et al. 1995, 1999).

Caring
The signification of the terms care and caring are undergoing development and at present they are used in the literature and in everyday language with a variety of meanings. In the case of ‘antenatal care’ for instance, care is used to comprehensively embrace all activities irrespectively of their caring content. Caring (Swedish: omvårdnad) is a complex phenomenon that risks loss of dimension and depth if defined. Some important characteristics of caring can, however, be described. Caring is naturally human (Eriksson 1992), has ethical dimensions (Norberg et al. 1992 pp 22-37), its expressions, processes and patterns vary among cultures (Leininger 1988 pp 3-15) and it is a component of the activity of all health professionals (cf. Jecker & Self 1991). The aim of professional caring is the growth and health of persons who seek assistance because of illness, injury or life transitions, such as transition to parenthood through pregnancy, childbirth and early parenthood (cf. van Manen 1998). Health is seen as the person’s process of balancing her or his needs and resources. Carers can help to reduce difficulties and suffering in the process of health (Norberg et al. 1992 pp 67-81) but can also worsen things or cause suffering (Halldórsdóttir & Karldóttir 1996, Eriksson 1997). The body and the experience of the lived body i.e. embodiment are recurrent and central concerns in professional caring (cf. Lawler 1997). Both observable and measurable aspects of bodily changes as well as the persons subjective and embodied experiences of the changes are important in caring (Madjar 1997).

Two integrated aspects characterise caring i.e. the task or activity and the relationship between the care provider and those she or he helps. The relationship is the framework within which the task is performed (Norberg et al. 1992 pp 73-81). Knowledge and skills of a physiological, psychological, existential, social and medical nature and understanding of the person’s experience of her or his health problems, resources and circumstances are prerequisites for good care (van Manen 1998). A care provider’s openness and sensitivity to the uniqueness of the persons are important for an understanding of the life world of the person and the meaning she or
he makes of the situation (Drew & Dahlberg 1995, Eriksson 1997, van Manen 1998). Being comfortable with ambiguity and complexity and avoiding reductionism facilitate the care provider's seeing the uniqueness of the person (van Manen 1998). Care providers who 'see' the existential meaning of the situation of the person while doing something practical are perceived as helpful (Åström 1995 pp 129-149). The perspective of caring within this thesis emphasises the caregivers' execution of adequate tasks based on the needs and resources of the specific person, with respect for the uniqueness of the person's situation and recognising physical, psychological, social, existential and medical aspects of the transition to parenthood.

The investigator's experience of antenatal care

When I embarked on clinical work as a midwife in Swedish antenatal care my background included midwifery practice from Sweden, Mozambique and Angola, together with the experience of becoming a mother while living in Angola and Sweden. My years abroad have given me a deeper understanding of the strength and fragility of life, the importance of midwives' interaction with childbearing families and the advantage of medical maternity care in complicated cases. Above all I learnt that most things could be done differently, for better or for worse.

I enjoyed being an antenatal midwife and was very proud of the women-centred work with careful medical screening, extensive information giving and the way expectant/new parents' accounts were listened to with interest. Nevertheless antenatal midwifery consultations left me concerned. What were we really doing to the pregnant women and their partners? Many expectant/new parents appeared to be unprepared for the experiences of pregnancy, childbirth and early parenthood. How did the consultations contribute to their experiences and what possible understanding of their actual and forthcoming situation during the transition to parenthood did antenatal midwifery consultations promote?

RATIONALE FOR THE STUDY

People's awareness of the meaning of a transition is essential for their understanding of the experiences of the transition as well as its health consequences (Schumacher & Meleis 1994). Hence meanings embedded in antenatal consultations could
influence the expectant/new parents' understanding of meanings of the phases of the transition to parenthood such as pregnancy, childbirth and early parenthood, which in turn could influence their health.

In a WHO study on care of pregnant and birthing women in Europe it is concluded that:'... in all forms of care, little is known about what really goes on when helper and pregnant woman are face to face' (WHO 1985 p 81). To date the literature regarding the content of antenatal consultations from the perspective of transition to parenthood and caring is remarkably sparse. Bondas-Salonen (1995) describes antenatal consultations linking the activity to the transition to parenthood and caring, focusing primarily on the mothers' experiences. Literature on the care during the transition to parenthood in obstetrics (cf. Jonson & Reiser 1992, cf. Marsál & Grennert 1998), sociology (cf. Symonds & Hunt 1996) and psychology (cf. Raphael-Leff 1991, cf. Clement 1998) addressed each specific aspects, more or less separated from the others. Medical screenings and organisation of antenatal care were highlighted and the literature on satisfaction with care tended more often to be linked to its organisation and medical outcome (Villar & Kahn-Neelofur 1999) rather than to what happened during the consultations. The growing stock of research by midwives is mostly related to childbirth (Berg & Dahlberg 1998, Kopare 1999, Waldenström et al. 1996b, 1999a), preparation for it (Hallgren et al. 1994, 1995, 1999), to the newborn (Widström & Thingström-Paulsson 1993, Christenson et al. 1998) and sexually transmitted diseases (Rahm et al. 1992, Jonsson et al. 1997, Tydén et al. 1998). Studies on antenatal midwifery consultations (Olin Lauritzen 1990, Sydsjö 1992, Bredmar 1999, Levy 1999b) studied other aspects of the consultations.

A deeper knowledge about antenatal consultations could contribute to an understanding of its possible influence on expectant/new parents. The absence of such knowledge and insights into this activity obstructs a critical discussion and a rational development of antenatal care. The intention with this study is to create a basis for reflection and to inspire care providers, care planners, politicians, educators and expectant/new parents to engage in creative dialogues and, when needed, initiate changes in order to improve antenatal care.
The aims of the study

The overall aim of this thesis is to gain a deeper understanding of antenatal care by disclosing aspects of topics, meanings and the participants' ways of relating in midwifery consultations in a Swedish primary care setting. This overall aim is divided into the following specific aims:

Paper I.
- to describe the content of the antenatal booking interviews
- to illuminate the meaning of midwives' and expectant parents' ways of relating, at midwifery clinics in Sweden

Paper II.
- to describe the conversational topics concerning pregnancy
- to illuminate the meaning of pregnancy with reference to expectant mothers and fathers, as revealed in the discourse of ante- and postnatal midwifery consultations in a Swedish primary care setting

Paper III.
- to describe the conversational topics concerning childbirth
- to illuminate the meaning of childbirth disclosed in the discourse of ante- and postnatal midwifery consultations in a Swedish setting

Paper IV.
- to describe topics of conversation concerning parenthood
- to illuminate the meaning of being a mother and a father as disclosed in Swedish ante- and postnatal midwifery consultations

Paper V.
- to describe patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal midwifery consultations in a Swedish primary health care setting.
MATERIAL AND METHODS

Video recordings of antenatal midwifery consultations were made. The content of the recordings was transcribed into text, which was analysed using both qualitative and quantitative approaches.

Setting
In the district of northern Västerbotten, where this study was carried out, the antenatal care is based at health centres in primary health care. Each health centre has one or two midwives depending on the number of women in the fertile age within the centre’s catchment’s area. All such midwives however are employed by the Department of Gynaecology and Obstetrics at the county hospital. These primary care midwives, the nursing director of the county and the obstetrician responsible for antenatal care meet regularly to discuss professional and administrative matters. At one of these meetings they were informed about the background, aims and methods of this study and were told that some of them would be asked to participate. Such participation would be voluntary, could cease whenever desired and no individual would be identified in the reports.

Procedures and participants
To give prominence to established and accepted ways of working within antenatal care strategic selection was used when recruiting midwives. The nursing director of the Department of Obstetrics and Gynaecology of the area was asked to indicate five midwives considered to be ‘good and experienced’ in antenatal care. She was asked to use criteria for ‘good and experienced’, which would fit with the policy of the department. When interviewed after the selection the nursing director described antenatal midwives as ‘good’ when they took responsibility, were careful, independent, thoughtful, created confidence, did not push their own opinions but gave of themselves in their encounters with expectant mothers and the families. The criteria for being ‘experienced’ were the number of years the midwife had worked in antenatal care and additional experience from other workplaces. To grasp different ways of working and to allow data to be gathered longitudinally while keeping the
amount within reasonable bounds it was decided to include five midwives in the study. As two of the midwives invited did not wish to participate in the study, for personal reasons, two others were invited and accepted the invitation. The midwives were between 41 and 52 years of age and had from 6 to 27 years of working experience in antenatal consultations.

Prior to the initiation of the data collection the five midwives who agreed to participate met three times with the investigator, who had also worked with antenatal consultations in the area and, thus, was well known to them. They were informed orally and in writing about the details of the study, ethical aspects were discussed, the video camera was introduced and a written consent form was signed.

The participating midwives recruited the expectant parents/mothers from within their ordinary work at the respective health centres. From a starting day agreed on women/couples who made an appointment for a booking interview in early pregnancy and who met the inclusion criteria for the study (Table I), were informed about the study and invited to participate. The expectant mothers in their turn informed their partners about the study and invited them to participate. The participation would include being video recorded at midwifery consultations and being interviewed four times during the study period about their experiences of the transition to parenthood and their views concerning the consultations. The analyses of the interviews have not yet been finalised and thus not included in this thesis.

<table>
<thead>
<tr>
<th>Table I.</th>
<th>Inclusion criteria for participants in the study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>Expectant fathers</td>
</tr>
<tr>
<td>Speaks Swedish</td>
<td>Speaks Swedish</td>
</tr>
<tr>
<td>Less than 14 weeks into pregnancy</td>
<td>Pregnant partner is willing to enter the study</td>
</tr>
<tr>
<td>Does not suffer from serious or chronic disease</td>
<td></td>
</tr>
<tr>
<td>Has/ has not experienced childbearing</td>
<td></td>
</tr>
</tbody>
</table>
The expectant parents who were interested in participating in the study after the midwife's initial information were informed by mail and later telephoned by the investigator. After a week the investigator met the prospective participants to get acquainted, answer questions, give further information and to obtain a signed written consent. Women/couples both with and without previous experience of pregnancy, childbirth and early parenthood were included in order to grasp variety in the process to transition. The first three midwives recruited pregnant women who already had this experience so the two remaining midwives were asked only to recruit women without the experience. In total 14 women were approached to find five pregnant women willing to participate. Seven women did not want to participate for personal reasons. Of the five women who initially entered the study, two withdrew later, one because she found the interview after the first recording too intrusive and the other because she had a miscarriage. Two other women/couples were recruited. The participating women's occupations were; cashier in a food shop, secretary in a local political organisation, assistant in a workshop, assistant nurse in home care, and assistant nurse at a nursing home. Three of the five expectant/new fathers attended video recorded consultations. Since all participants were asked to attend and act, as they would have done if they had not been recorded the presence of the 'two missing' partners could not be required. Further characteristics of the participating expectant/new parents are given in Table II below.

<table>
<thead>
<tr>
<th>Table II. Characteristics of the participating expectant/new parents (5 women, 3 men)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
</tr>
<tr>
<td>during the study</td>
</tr>
<tr>
<td>Couples living together</td>
</tr>
<tr>
<td>Expecting child number:</td>
</tr>
<tr>
<td>one</td>
</tr>
<tr>
<td>two</td>
</tr>
<tr>
<td>three</td>
</tr>
<tr>
<td>Have met the midwife</td>
</tr>
<tr>
<td>before the study started</td>
</tr>
<tr>
<td>women</td>
</tr>
<tr>
<td>men</td>
</tr>
<tr>
<td>unemployed/partly employed</td>
</tr>
<tr>
<td>employed/sick leave</td>
</tr>
<tr>
<td>unemployed/partly employed</td>
</tr>
<tr>
<td>parental leave/employed</td>
</tr>
<tr>
<td>employed/employed</td>
</tr>
</tbody>
</table>
**Video recordings**

Video recording was chosen as the method for data collection as it captures and documents the consultations as completely as possible (Bottorff 1994). The recordings allow repeated viewing and focusing on various aspects in the same recorded situation. Various methods of analysis could be applied to the same sequence. Reliability could be enhanced, since the video recording could be analysed several times by different researchers (Bottorff 1994). A video camera was thought to be less disturbing to the participants during the consultation than an observer in the room. Audio recording would have been less intrusive but would have reduced the documentation of non-verbal information to an unacceptable level.

Informed consent was obtained from all participants. The growing popularity of video cameras in Swedish homes and in public life has made video recording a familiar phenomenon for many people, thus making informed consent meaningful.

The video camera was so placed in the consultation room as to be inconspicuous but still able to record the participants’ movements, facial expressions and conversation. After starting the recording the investigator left the participants alone. If the midwife wanted, the investigator re-entered to change the position of the camera. In some consultations the midwives dealt with the video camera themselves. Of a total of 61 consultations 58 were recorded, two were not recorded for technical reasons and one because the midwife participating in the project was absent and another midwife saw the expectant mother. The recordings from the consultations were ordered chronologically for each of the midwife-woman/couple constellations, thus five films were created.

<table>
<thead>
<tr>
<th>Table III. Characteristics of data (video recorded midwifery consultations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of consultations</td>
</tr>
<tr>
<td>Consultations/women (nos.)</td>
</tr>
<tr>
<td>Consultations including men</td>
</tr>
<tr>
<td>Analysed consultations (no)</td>
</tr>
</tbody>
</table>


Transcription
Living human beings cannot avoid communicating (Watzlawick et al. 1967 p 48-51). Video recordings of human activity capture more verbal and particularly non-verbal expressions of communication than most methods used for data collection and contain large amounts of information. Despite being only a representation of the event recorded the richness and density of the data can be overwhelming. To facilitate analysis the recorded information can be fixed as a text (Sandelowski 1994). This was achieved in the current study by transcribing the major aspects of the content of the recordings into a written text, which implies a reduction of data. First all verbal information was transcribed by a secretary who only heard the recorded conversation but could not see the picture. An attempt was made to transcribe everything that could be heard on the recording including ‘uh-humms’ regional accents and words, half utterances and new beginnings of utterances, as well as interruptions and overlapping. Names of people and places were changed to safeguard anonymity.

The investigator then validated this text by comparing the full video recording with the text, adding missing words and utterances. This validation was done word-by-word and utterance-by-utterance for all the recorded consultations. Some discrepancies in the first transcription were identified and corrected, facilitated by the full video recording and the investigator’s familiarity with antenatal consultations. These discrepancies consisted primarily of mistaking words and phrases and the beginning and ending of sentences. The text was thereafter supplemented, by the investigator, with notes on the non-verbal communication, such as positions in the room, activities, pauses, intonations, tempo, looks, laughter, gestures, movements and other bodily expressions.

The process of transcription implies interpretation by the transcribing investigator, especially with regard to the non-verbal communication (Poland 1995, Kvale 1996 pp 163-172). The transcription of intonation could serve as an example here. More often than not the intonation of words and sentences indicates emotions, which in their turn give specific or multiple values and meanings to the utterance. The amount of non-verbal communication in the recording meant they could not be transcribed in total. The notes were limited to those communication cues that stood out, in the view of the investigator, as the most prominent and related to the overall
aim of the study and the aims of the respective papers. Transcription is problematic in a fundamental way. The difficulty of adequately representing some features of speech, from audio recorded data is even more pronounced in the dense data from video recordings (cf. Mishler 1991). The time-consuming process of transcription gave the investigator a close knowledge of the recordings regarding both their verbal and non-verbal content as well as the nature of the transcripts. This, to some extent, narrowed the gap between the recordings and the text. In the initial phase of each process of analysis (I-V) the recordings were watched and additional notes on the non-verbal content were added (cf. Riessman 1993).

**Ethical considerations**

Being video recorded could be experienced as a threat to integrity (Bottorff 1994) and it has been seen as vitally importance to protect the rights of the participants in this study. It was presumed that a careful and trustworthy management of ethical aspects would also contribute to the high quality of the data collected. It was assumed that once the participants trusted the research team, they would concentrate on the consultation and worry less about the video recording. Before initiating the video recordings the investigator met with the participants once or twice to inform them about the study orally and in writing. They were given time to think over their participation before starting. All participants were informed that, at any stage of the study they could withdraw their participation, fully or partly. One woman withdrew after the first video recording and the recording was excluded from the study. One gynaecological examination was not recorded at all and only sound recordings were made during five such examinations. Confidentiality was guaranteed by restricting access to the video recordings to members of the research team. For reasons of integrity the participants could not have copies of the recordings. They could only watch the recordings from consultations in which they themselves had participated. The use of the recordings was restricted only to the analysis within this specific project and no frames of any recordings will occur in reports, teaching situations or other situations. The rights of the participants and the restricted use of the video recordings were certified in writing. Permission to carry out the study had been given by the head of the Department of Gynaecology and Obstetrics at the county hospital and the head of the Primary Healthcare of the district. The Ethics
Committee of the Medical Faculty, Umeå University (§ 63/93) approved the study.

**Analysis**

In order to create and mediate understanding of the discourse of antenatal midwifery consultations three methods for analysis of the transcribed text were used; quantitative content analysis (Berelson 1952), qualitative content analysis (Downe-Wamboldt 1992, Morgan 1993) and phenomenological hermeneutic interpretation inspired by the writings of Ricoeur (1976). All three methods of analysis involve interpretation, which is seen as a dialectic process encompassing both explanation and understanding (cf. Ricoeur 1976 pp 71-82). Interpretation could be done at different levels with different foci for analysis in the text, motivating the use of different methods. In quantitative content analysis (I-IV) manifest contents *i.e.* the visible, surface or obvious components in the text are focused on (Downe-Wamboldt 1992). In the qualitative content analysis (V) the focus is on patterns in participants’ ways of relating searched for in both manifest and latent content (Morgan 1993). In phenomenological hermeneutic interpretation (I-IV) the analysis focuses on the utterance meaning in the text *i.e.* what the text means and not primarily what the intentions of the actors were (cf. Ricoeur 1976 pp 12-18).

The data used in the analysis of the ‘booking interviews’ (I) *i.e.* the initial consultation for each of the five films (see page 23), consisted of four hours of video recordings. For the subsequent papers (II-IV) all recorded consultations (n 58), including the ‘booking interviews’ were used, *i.e.* 24 hours of video recordings.

**Quantitative content analysis**

Quantitative content analysis proved efficient in creating a straightforward understanding of what was going on during the consultation. Quantitative content analysis has its roots in communication research into the mass media. It can be used to analyse *what* is communicated and *how* it is communicated (Berelson 1952 pp 13-25). In the current thesis this is elaborated to focus on what was said, who said it and when. Quantitative content analysis in this thesis is used primarily to describe aspects of the manifest content of the communication in which meanings, that are further analysed using the phenomenological hermeneutic approach, are imbedded.
In Paper I the transcribed text from the five ‘booking interviews’. (4 hrs) was read and the topics were marked, assembled, described, compared and labelled. In the analysis of Papers II-IV the whole text was read and units of analysis i.e. parts of the text relevant to the main topics respectively pregnancy, childbirth or parenthood were identified and marked. Since the denomination ‘meaning unit’ in Paper I is not in accord with the methodology used it will be referred to hereafter as ‘unit of analysis’. Some parts of the text could belong to more than one main topic and were thus used twice. Almost all of the text was marked and used in the analyses. That part of the text, which was not included consisted of greetings and social talk concerning the weather and constituted approximately one page of text out of a total of 1200 pages. After this division of the text the analysis was performed for each main topic separately (II-IV).

The numbering of the parts of the analyses differs among the papers although the design is basically the same. Firstly, a short description of the conversational content was made. These descriptions were then brought together into topics, based on similarity of content (II-IV). Secondly, the distribution of the occurrence of the main topic over the study period was calculated (II-IV). Thirdly, the frequencies of the initiatives in talking about the topic were counted (II-IV). Fourthly, the extensions of the three main topics in the consultations were quantified and compared with each other (II-IV). Fifthly, the bio-medical complications of pregnancy that the women experienced during the study period, were identified and described, according to the transcribed text (II).

Qualitative content analysis
A qualitative content analysis (cf. Berelson 1952 pp 111-128, Downe-Wamboldt 1992) was performed so that patterns in the participants’ ways of relating to each other in the consultations could be described (V). ‘Pattern’ was defined as similar ways of relating that recurred within a consultation or in a series of consultations (cf. Baxter 1994). Patterns were searched for in both the manifest and latent content regarding both verbal and non-verbal aspects of the communication (Downe-Wamboldt 1992).

The analysis was based on the texts transcribed from the video recordings from all (58) consultations. The guiding question through the analysis was ‘How do
midwives and expectant/new parents relate to each other in the consultations?’ Units of analysis based on similarities and differences in participants’ ways of relating in the text were identified and described (cf. Downe-Wamboldt 1992). These descriptions were reflected on and patterns were searched for, described and labelled. In presenting the patterns a metaphoric language (Ricoeur 1976 pp 45-69) was used to facilitate the grasping of the quality and complexity of the patterns.

**Phenomenological hermeneutic interpretation**

A phenomenological hermeneutic method was chosen to illuminate meanings in the video recorded midwifery consultations. This method for the interpretations of texts is being developed at the Department of Nursing at Umeå University (Jansson et al. 1993, Rasmussen et al. 1997 Söderberg et al. 1997) and the Nursing Science Unit at the University of Tromsö (Udén et al. 1992, Lindseth et al. 1994). It is inspired by the writings of the French philosopher Ricoeur (1976, 1981). Despite the fact that his writings are concerned with other types of texts, written to be read as texts, aspects of his method seem helpful in analysing texts emanating from everyday activities in healthcare.

Phenomenological hermeneutics can be understood as a descriptive interpretative approach (Rasmussen 1999 pp 33-37, Söderberg 1999 pp 18-20). According to Ricoeur (1981 pp 114-128) phenomenology and hermeneutics presuppose each other. Hermeneutics, which deals with mediation of understanding *i.e.* interpretation, is linked to phenomenology by its need for explication. Phenomenology aims to examine and describe the meanings of lived experiences of phenomena (Ricoeur 1981 pp 101-128).

According to Ricoeur (1976 p 1-16) an event or experience as lived cannot be passed directly from one person to another, what can be transferred is the meaning of it. Meanings can be disclosed by studying the discourse. Speech is characterised by being addressed to someone, realised in the present, referring back to its speaker and to the world. When the content from the video recorded consultations were transcribed to text it seemed reasonable to apply methods of interpretation of text. In the text both the utterer’s (what the author wants to say) and the utterance meaning (what the text says) can be found. To understand the utterer’s and utterance meaning is a circular process. The attempt in this thesis is to discern what the text
points to, i.e. the world that is opened up in front of the text. No distinction is made in the forthcoming interpretation regarding which of the participants in the consultations generated the meanings. Meanings are created in interaction. ‘What we want to understand first in a discourse is not another person, but a project, that is, the outline of a new being-in-the-world’ (Ricoeur 1981 p 202). In this thesis the ‘project’ is the disclosure of the meanings of pregnancy, childbirth and parenthood that are created in antenatal midwifery consultations by the midwives and expectant/new parents. If we gain a deeper understanding of current meanings we reflect on and refine our ways of working accordingly.

In an interpretative analysis of the text dialectic of explanation and understanding of the text as a whole and of its parts and between what the text says and what it points to, is productive. A series of meanings can be unfolded when explaining. In understanding, the whole of these partial meanings can be grasped or synthesised (Ricoeur 1976 pp 71-88).

The phenomenological hermeneutic interpretation (I, II, III, IV) aims to illuminate the meanings of pregnancy (II), childbirth (III) and parenthood (IV) and the participants’ ways of relating to each other (I) as disclosed in the studied midwifery consultations. There are three main steps in the process of interpretation.

To gain a preliminary, global understanding of the studied meaning within the consultations, the video recordings were viewed and the whole text was read several times. Special attention was paid to the parts of the text previously identified in the quantitative content analysis as dealing with the studied phenomena. A surface or naive understanding of the studied phenomena was formulated.

This was followed by a thematic structural analysis, i.e. a detailed examination of the text in order to explain its meaning formulated in themes. The whole text was read and meaning units, i.e. parts of the text that disclosed a meaning of the phenomena under study, were identified. Thereafter a transcription, i.e. a shortened description of each meaning unit, was formulated to make the meaning more salient. Meanings of the phenomena under study related to women and, when applicable, to men, were formulated for each meaning unit. In the process of discerning the meanings different possibilities or alternative meanings were tested. The formulated meanings were then brought together into sub-themes and themes based on similarities and differences in meaning. This was a process that entailed going back
and forth between formulated meanings and preliminary sub-themes and themes that were created, changed shape or disappeared until all formulated meanings were captured in final sub-themes and themes. The original text and the transcriptions were kept in mind and, when needed, reviewed in order to clarify a formulated meaning in its context.

The structural analysis in papers II, III and IV embraced primarily the parts of the text that were identified in the previous quantitative content analysis as dealing with the phenomena pregnancy (II), childbirth (III) and parenthood (IV). However, the whole text was kept together during the procedure of formulation of meanings during the structural analysis. Therefore the parts of the text under study were easily seen in their context also when this context concerned one of the phenomena that were not analysed at the moment. Altogether these three structural analyses embraced almost the whole text. Only a few phrases of greetings and talks about the weather were not included.

Finally the text as a whole was studied again in order to achieve and formulate a comprehensive understanding of the meaning of the pregnancy (II), childbirth (III), parenthood (IV) and the participants' ways of relating (I) revealed in the consultations. A thoughtful and reflective reading of the whole text, the formulated naive understanding and the results from the structural analyses, was made. The reflection also comprised periods of repose and distance to the study and an attempt to look at it from new angles and imagine what could have been there but was not. During this process metaphorical presentations were developed (II, III, IV). The tentative presentations were compared with the text and the themes of the structural analysis. They were slightly reformulated and developed into a comprehensive understanding, in the form of metaphorical presentations.

Metaphoric language
The metaphoric language (I, V) and presentations (II, III, IV) developed in this thesis made it possible to encapsulate the complexity of meanings found in the consultations. In ordinary language the multiple meanings of words and sentences are reduced and made more precise by the context. In metaphoric language multiple meanings are used to create new meaning (Ricoeur 1976 pp 45-69, Ricoeur 1978 pp 216-256).
A metaphor is characterised by bringing together an explicit and an implicit meaning in a relationship. There is tension in a metaphoric utterance between two opposed interpretations of the utterance and it is the conflict between these interpretations that sustains the metaphor. New meaning springs up within it. The discord in a metaphor is what makes new meaning visible. In the metaphoric presentations in this thesis the tension mentioned above works at the level of the presentation as a whole and not as it usually does, within a sentence. Repetitions of metaphors tend to deaden them i.e. they no longer create new meaning, but instead represent established meaning. The value of a ‘living’ metaphor is that it tells us something new about reality and it is not simply language decoration (Ricoeur 1976 pp 51-52).

Metaphors highlight certain features while suppressing other (Lacoff & Jonson 1980 p 10). The metaphoric presentations of this thesis represent the meanings of pregnancy, childbirth and parenthood found in the consultations studied. Other metaphors occur in the literature emphasising other features of the phenomena. The metaphorical presentations allow us to grasp the variety of meanings found in this study. Meanings found to be prominent in the data could be emphasised within the presentations and connections between meanings could be made, resembling their relationship in the consultations.

The intention in using such condensed re-writing of reality is to invite the reader not only to see the understanding of the investigators but also to embark on creative reflection and to see new and differing meanings and relations of meanings in well-known situations.

RESULTS

Conversation topics (Papers I-IV)
The conversation topics, studied as what was talked about in a manifest way, were found to embrace the predominantly physical and medical aspects of pregnancy childbirth and parenthood. Emotional and social aspects were given comparatively little space and were delineated with fewer details and less depth. These findings
are consistent in the ‘booking interviews’ (I) as well as in the studies on the whole series of consultations (II, III, IV).

Comparing the distribution of the main topics of pregnancy (II), childbirth (III) and parenthood (IV) over the study period showed that pregnancy dominated, relatively constantly over the period, decreasing though in the postnatal visit. Childbirth (III) was actualised mostly at ‘booking’, in the two last months of pregnancy and postnatally. Parenthood (IV), had a comparatively low frequency throughout and appeared most at ‘booking’ and postnatally.

The midwives held the initiative throughout the consultations regardless of topical content (II, III, IV). Expectant/new mothers took very few initiatives. The expectant/new fathers took hardly any initiatives and when they did speak it was mostly on the invitation of the midwife.

**Meanings of pregnancy** (Paper II)

The multitude of meanings of pregnancy with reference to women disclosed in these consultations could be sorted into two features based on similarities in meanings. One feature embraces the understanding of pregnancy as a problematic physical project. The pregnant woman’s body was revealed as unreliable, failing and difficult to understand. The foetus/baby appeared as contributing to this bodily incapacity and seemed to be endangered by it. As long as the check-ups were ‘normal’ the pregnancy appeared uninteresting, a non-phenomenon. The other feature comprises the understanding of pregnancy as a trustworthy physical, emotional, existential and social process emphasising confidence in the capacity of the women and the foetus/baby. The first feature predominated in the consultations studied.

In accordance with the view of pregnancy as primarily a feminine physical process, meanings of pregnancy with reference to expectant fathers were rarely found in the consultations. The meanings encountered were related to the men’s worry over and striving to understand and support the pregnant woman and family life.

A comprehensive understanding of the meanings of pregnancy disclosed in the consultations was formulated in the metaphor ‘Being pregnant is like being a captain whose ability is often questioned, sailing unknown waters by night usually in a scarcely seaworthy vessel, with a fragile or robust cargo and a helpful dockhand on board’.
Meanings of childbirth (Paper III)
The complexity of meanings of childbirth in this study can be brought together into two main features based on similarities in meaning. The most prominent feature indicated an understanding of childbirth as a spontaneous and risky process, which needed to be controlled and to which the woman had to adapt. Professional care during childbirth can be understood as depersonalised control of the safety and assistance with pharmacological pain relief. The less prominent feature pointed to an understanding of the woman’s power and ability in a trustworthy process. Glimpses of personalised caring of birthing women on the part of their men and the staff occur in the studied consultations.

In the conversations about childbirth in the consultations no prominent role was given to the expectant/new fathers. Meanings of childbirth with reference to expectant/new fathers indicated an understanding of them as obviously present but consigned to the shadows only occasionally to be called on to assist their women and the staff.

A comprehensive understanding of the meanings of childbirth as disclosed in the consultations was formulated in the metaphor ‘Giving birth is like being in a boat descending a rapid with an unknown passenger on board, usually without knowing how to navigate or how torrential or rocky the rapid will be, and with the husband on the riverbank’.

Meanings of parenthood (Paper IV)
The meanings of parenthood disclosed in the consultations indicate that the relationship between the parents was important for the experience of parenthood. The mother was depicted as the prime parent. Being a mother was understood to be a complex balancing of responsibilities and the handling of a multitude of considerations and activities, which were often difficult and overwhelming. The support a mother received was important for how she experienced motherhood.

Being a father was discussed less than being a mother. The meanings of being a father that were revealed indicated a struggle between a closely caring and enriching relationship with the child and a distanced relationship with the child focusing on the father’s economic and practical responsibilities and his assistance to the mother. His relationship with the mother of the child appeared to be important in
determining which meaning of being a father became most prominent.

A comprehensive understanding of the meanings of parenthood disclosed in the consultations was formulated in the metaphor ‘Being a mother is like being a spider in a web, keeping together a number of threads, depending on its quality, bearing the child on its back and letting the father of the child in on her condition’.

Ways of relating (Papers I, V)

Studying the participants’ ways of relating in the ‘booking interviews’ (I) and over the period from early pregnancy till after the birth of the child (V) revealed two main features. In the study of the ‘booking interviews’ (I) the midwives’ ways of relating were summarised as either considering or disregarding the uniqueness of the expectant parents. The expectant parents’ ways of relating to the midwives were with a few exceptions, characterised by passivity and docility. Studying the participants’ ways of relating over the whole period five patterns were revealed (V). The extent, to which the uniqueness of the expectant/new parents’ personalities and social situations is taken into account, differentiates the midwives’ ways of relating (I) and the patterns (V) into two features.

The first feature, is characterised by the midwives’ concerns about the personality and social situation of the expectant/new parents. This feature is formed by the results from paper I showing that the midwives’ considered the uniqueness of the expectant parents (I) and three of the patterns revealed in paper V. Firstly, there is the pattern designated ‘the respectful gardener and her developing plants’. This is characterised by an active, open and personal exchange of information and ideas among all participants. Secondly, there is the pattern called ‘the mediating counsellor and the discreet seekers of guidance’, which is recognised by the questions individually put and the ‘committed’ giving of explanations and advice. Thirdly, there is the pattern named ‘the personal women-friends’ that includes personal discussions on a fairly equal footing.

The second feature, is characterised by the midwives’ disregarding of the expectant/new parents’ personality and social situation. This feature is evident in paper I and in two of the patterns revealed in paper V. Firstly, there is the pattern called ‘the propagandist teacher and her ignorant pupils’ that includes distanced urging, impersonal and standardised one-way communication. Secondly, there is the
pattern designated ‘the steering inspector and the representatives of the population at disposal’, which is recognised by generalised, technical checking and instructing of the expectant/new mother/parents.

The individual midwives appeared to keep to one basic pattern and occasionally to adopt others. The patterns of ‘the gardener’, ‘the teacher’ and ‘the inspector’ appear to be basic.

**METHODOLOGICAL CONSIDERATIONS**

The intention in using this qualitative study is to deepen the understanding of a variety of aspects of antenatal care. The interpretations presented could be reflected on and recontextualised in other care situations and thus contribute to the ongoing discussion concerning the quality of antenatal care.

**Trustworthiness of video recordings**

In order to come to grips with and study accepted ways of working in antenatal care the recruitment of five midwives was based on the judgement of their nursing director as to what was considered ‘good’ and ‘experienced’ in antenatal care. This resulted in the participation of five midwives who had many years of professional experience and good reputations.

The fact that the participating midwives themselves recruited the participating expectant/new parents from within their ordinary work at the various health centres implies the possibility of their being, consciously or unconsciously, more or less ‘eager’ to recruit specific participants. Possibly, the midwives were more ‘eager’ in their recruitment when they expected a good relationship with the expectant/new parents. Two of the participating expectant mothers had been seen by the recruiting midwife during an earlier pregnancy. Their previous experience of antenatal care is likely to have influenced their decision to participate. The woman who dropped out after the first recording indicated that she found the subsequent interviewing too intrusive. Those who chose to participate could be assumed to have anticipated a good relationship with the midwife and frankness about concerns related to childbearing.

The expectant/new fathers’ frequency of attendance at the consultations varied considerably. Two expectant/new fathers who were expecting their second
child never attended the consultations. One man came every time except once when he was ill, and the two remaining expectant/new fathers attended two and three consultations each. The pattern of men’s attendance at the consultations contributes to the rich and varied content of the contents in the video recordings.

Being video recorded during one’s antenatal consultation or while doing one’s work is not likely to pass unnoticed. The expectant/new parents commented, however, after the recordings that they soon forgot the video camera during the consultations. The experience of the transition to parenthood and the consultation, per se, appeared to overshadow the presence of the video camera. The experienced midwives, on the other hand, were more aware of the presence of the camera. They themselves described how in the initial consultations they strove to cover as much as possible. A more ordinary approach was adopted in the subsequent consultations even if the ongoing recording was never forgotten. Participants’ declining awareness of being video recorded is also something that was found in other research projects (Alexandersson 1994 pp 81-82). It can be assumed that the participants made an effort to bring out what they found important in the consultations. Having viewed a sample of the recordings the midwives commented that these realistically mirrored their daily work. The transcripts of talks during antenatal midwifery consultations in Bredmar’s study (1999) and the descriptions of consultations by Olin Lauritzen (1990) show great similarities to the transcripts from the consultations in this study. This indicates that the video recordings mirror fairly realistically aspects of everyday antenatal care.

The video recordings for this study were made to serve the purpose of qualitative analysis, i.e. to permit a deep analysis resulting in a new understanding (cf. Sandelowski 1995). For a detailed analysis the number of participants must not be too large. Kvale (1996 p 179) claims that 1000 pages of transcribed text are usually too extensive to overview. The transcriptions used in this study amount to 1200 pages. To overcome this obstacle only parts of the text were focused on in Papers I-IV. The analysis presented in Paper V embraced all the text but this was made possible by the in-depth knowledge of the text gained during the preceding analyses. To achieve variation of participants five expectant parents, both with and without previous experience of childbearing, and five midwives were recruited (cf. Sandelowski 1995).
Validity of interpretations

Kvale (1996) claims that in qualitative research ‘Validation comes to depend on the quality of craftsmanship during investigation, continually checking, questioning, and theoretically interpreting the findings’ (p 241). Continually checking involves a critical outlook not only regarding the data but also the analytical procedures and the results of the analysis.

The checking of the accuracy of the transcripts in relation to the video recordings when initiating each analytical process contributed to the high quality of the transcripts. It also sensitised the investigator to the data and to the aspect to be studied. The going back and forth between the parts of the text and the text as a whole implies that checking constitutes a general characteristic of this thesis. The co-investigators (AN, LJ, AH, POS) are experienced both in analysing video recordings and carrying out qualitative analyses. Throughout the study they assisted me in my analyses and interpretations by giving general instructions and asking critical questions in order to enhance their quality (cf. Sandelowski 1998). The co-investigators who were not midwives were able to provide a more external perceptive on the texts and the results of the analysis. According to Ricoeur (1976 p 91-92) the aim of all hermeneutics is to ‘make one’s own’ what was previously ‘foreign’. Such appropriation of understanding is gained by the researcher following a prolonged and deep immersion with the text and video recordings.

Becoming totally aware of one’s preunderstanding of such phenomena as pregnancy, childbirth, parenthood and antenatal midwifery care is beyond the reach of a mother of three children and a practising antenatal midwife. However, throughout this investigation efforts have been made to achieve a certain distance to the ‘field of research’. The actions taken to enhance distanced reflection include: ceasing to work in antenatal care, studying literature related to the phenomena from diverse perspectives and having regular discussions about preunderstanding and earlier experiences of the phenomena studied with co-investigators. Trying to pay attention to one’s own feelings during the process of interpretation has been one way to become aware of preconceptions and to try to relate to them. To have worked with antenatal care is also an advantage because it implies a direct knowledge of the tasks in the consultations and often an understanding of the intentions of the participating midwives in doing what they did. My own experience of childbearing
gives insights that facilitates the understanding of the situation of the expectant/new parents.

During the structural analyses results were revealed that both were and were not in accordance with the investigator's expectations. I never imagined that I would find in the texts from the consultations that the transition to parenthood was predominantly delineated as an unreliable process. From ‘take off to landing’ in the hermeneutic spiral of this analysis my understanding of antenatal care has developed and become more nuanced and deeper compared to what it was initially.

Ricoeur (1976 p 79) describes validation in phenomenological hermeneutics as an argumentative discipline where it is always possible to argue for or against an interpretation, to confront different interpretations and to arbitrate between them. During the development of this thesis the completed studies (I-V) were presented and interpretations discussed within the research group, the larger group of researchers at the department, the participating midwives and later with other professionals in antenatal and maternity care. The participating midwives were informed in detail about the results of the analysis and the interpretations and generally judged them to be feasible. Encounters with the participating midwives revealed both direct recognition and the opinion that the interpretations were too negative. Further reflection within the group of participating midwives generated such conclusions as -'I can see that it could be understood that way, but I do not like it'. Other caregivers reported that they found the descriptions and interpretations recognisable and that their reflections on the results have contributed to their seeing themselves as caregivers and to viewing the conditions of care in a different light.

During the development of this study the investigator's understanding of methodological issues has developed. This is particularly true with regard to the phenomenological hermeneutic interpretation. In the course of this process the investigator's knowledge was enhanced with regard to the character of the text but also with respect to theories of interpretation, the transition to parenthood and antenatal care. This has gradually led to more skilled and creative interpretations. The first analysis carried out (I) is characterised by being closely related to the manifest or explicit content and not to meanings of phenomena as in the subsequent analyses (II-IV). With my present understanding the preferred denomination of the analysis applied in Paper I would have been qualitative content analysis, as the
analysis is characterised by rather linear descriptions of the content of the text. In Paper I the analysis carried out was called 'qualitative content analysis' with the motivation that the data consisted of 'qualitative communication'. Since the denomination of methods of analysis should refer to the procedures of analysis and not primarily to the nature of the data the denomination would have been 'quantitative content analysis' with reference to the method of analysis.

COMPREHENSIVE UNDERSTANDING AND REFLECTIONS ON THE RESULTS

The comprehensive understanding of the five studies in this thesis is that the complexity of the meanings of pregnancy (II), childbirth (III) and parenthood (IV) as revealed, shifts between understanding of the process of transition to parenthood as a trustworthy or as an unreliable and risky process. The midwives' ways of relating (I, V) in the consultations are understood as shifting between 'distanced surveillance' of and 'caring about' the expectant/new parents while expectant/new parents are mostly passive and compliant. 'Caring about' is distinguished by the midwives' involvement in the unique life situation of the expectant/new parents. 'Distanced surveillance' is characterised by impersonal, generalised ways of relating where the uniqueness of the expectant/new parents and their life situation are disregarded.

Understandings of the body
The woman's bodily processes are to the fore both when the transitional processes are regarded as trustworthy and as unreliable (II, III, IV).

The understanding of the woman's bodily processes as unreliable is prominent in the consultations studied. The hazards and the defective capacity of the woman's body to resolve the various demands are focused on. Risks of deviations from an optimal development are central. The steering of the process is important and the check-ups in the antenatal consultations and the possibility of referral to higher levels in the health care organisation are understood as necessities for an optimal development of the bodies/physical well-being of the mother and the child. The ability of women to carry and nourish their un-bom, give birth and care for their
newborn babies appears to be overlooked. The expectant/new father is primarily regarded as a ‘support’.

When the consultations are dominated by trust in the transitional process, the possibilities and strengths of the process and the ability of the woman, baby and the family to meet the physical changes and challenges are emphasised. There is openness towards the uniqueness of the expectant/new parents’ ways of resolving the bodily demands and of expressing their experiences. The role of healthcare is delineated as supportive of the processes of transition. The women’s ability to carry and nourish their un-born, give birth and care for their newborn babies is both made explicit and appears as taken for granted when in the process of transition is uppermost.

The body could be experienced in a variety of ways, delineating some of them could further our understanding of the body as disclosed in this thesis. Despite a certain fixation on the body in Western society it is commonly taken for granted, is simply lived and is not a primary preoccupation in our daily lives - simply ‘is this body’. When changes occur in the habitual or familiar body, as happens in illness, injury or transitions to parenthood one tends to turn one’s attention to the new experience and seek to understand it. In such a situation a distancing could occur between the body and the self. This implies an objectifying attitude towards the body. The body is understood as ‘something one has’, an object. The way a person is regarded by other people influences how the body is experienced. A person can be seen in a participatory way which corresponds to the understanding of the body as taken-for-granted and that the person is this particular body. The look of the other person can also remain on that person’s body so that it is objectified and made into a thing and the fact that it is a person who has this body is forgotten and the person is disconnected from the body (cf. Madjar 1997, cf. van Manen 1998).

Transferring the understandings of the body and person above outlined to antenatal care I argue that pregnant women tend to abandon the taken for granted attitude towards their bodies and embrace a more self-observing attitude because of the new sensations brought into their lives by the pregnancy. The woman becomes sensitive and hitherto unknown sensations, capacities and limitations present themselves. In the antenatal consultation the midwives assumed more objectifying or participatory ways of looking at the woman and/or her body. The objectifying look,
which verged on seeing the body or body parts as things apart from the person, can be recognised in the ‘distanced surveillance’ way of relating (I, V). A participatory look can be understood within the ‘caring about’ way of relating that was revealed (I, V). Here the physical body and the lived body are both acknowledged, seeing the persons in a transition towards (new or renewed) parenthood, in a specific life situation including highly individual experiences and in relationships with others.

Exploring women’s mothering experience, Bergum (1997) claims that the relationship with the child transforms the woman into a mother. A woman’s experience of the physical presence of the child in her body opens her to the child. She also states that: ‘Being with child moves a woman to motherhood in a unique, dramatic, and complex fashion. It is through her pregnant body that a woman comes to know herself as mother’ (p 35). Giving such importance to the pregnant women’s bodily experiences both in relation to their babies and to the development of themselves as mothers highlights the importance of the expectant/new parents’ way of understanding their bodily experiences during the transition. It also points to the necessity of caregivers being conscious of their influence on the expectant/new parents’ perceptions of the body.

There is growing concern in society over the high frequency of interventions, pain medication and fear of childbirth among women (WHO 1996, Guirgis 1997, Sandberg & Rydhström 1998, Waldenström 1999b). In discussions on how to deal with the situation - the way in which caregivers relate to the physical capacity of childbearing women must not be overlooked.

Distrust in the processes of the transition (II, III, IV) and the midwives’ ‘distanced surveillance’ ways of relating to expectant/new parents (V) are prominent in the studied consultations. This gives rise to the reflection that the much debated dualism of body and mind after Descartes, described as characterising Western societies and particularly recognisable within the field of medicine (Martin 1992 pp 25-67), underlies these consultations. Martin (1992) and Lawler (1991) argue that one of the central understandings within health care is of the body as an object, which needs to be controlled and manipulated and is only of interest when it does not work properly. Working in terms of such an understanding entails a risk that other aspects of a human being, such as the body viewed as an integral part of the person and her/his relations with other people (cf. Martin 1992) will be ignored. Furthermore
it might promote alienation between women and their bodies and the ‘offspring’ of their bodies i.e. their babies. Non-involvement on the part of the expectant/new father could easily follow from disregarding most aspects apart from those concerned with the woman’s body. A narrow-minded focusing on physical aspects and a disregard of the expectant/new fathers and of the transitional process towards parenthood as a complex venture for the expectant/new parents could promote estrangement between the couple. There is a risk that this could counteract the overall aim of society to support parenthood via institutions such as antenatal care (SOU 1997 pp 80-81).

Contradictory results have been reported regarding the understanding of pregnancy as an unreliable process (II) in Swedish antenatal midwifery consultations (Bredmar 1999). Bredmar (1999) claims that midwives, through communicative caution portray pregnancy in terms of normality thus making the unusual normal. She acknowledges that ‘it is obvious that the communicative projects take place against a horizon of risk and of pregnancy as a hazardous project’ (p 331) but does not find that this is reflected in the understanding of pregnancy conveyed. The results of this thesis, however, indicate that in addition to results similar to Bredmar’s (1999) understandings of pregnancy as an unreliable and risky process do occur in antenatal midwifery consultations (II). According to Olin Lauritzen (1990 p 170) ‘an implicit message of medical doubt’ is recognised in health surveillance in antenatal care. The phenomenological hermeneutic interpretation applied in this thesis also embraces implicit messages. It is probable that the less directly obvious meanings also influence the ways in which expectant/new parents understand themselves and the process in which they are engaged.

Understandings of the transition to parenthood
In the consultations studied the notion of risk appears to underlay the understanding of the transition to parenthood as being unreliable. The danger and the drama in the process appear to occupy the attention while the possibilities, strengths and smoothness of the process retreat to the background. Blåka Sandvik (1997 pp 59-86) proposes an alternative understanding of the risk in relation to childbirth, relevant also to the processes of pregnancy and parenthood. Departing from the notion that this part of life is rich of detail and can not be fully controlled, she argues that an
alternative to the predominant risk-view is to meet each situation with a broad register of knowledge, see its possibilities and challenges and be prepared to ‘tackle the storm’ there and then (Blåka Sandvik 1997 p 86). Such attempt to balance the strengths, possibilities and risks while supporting the former and detecting and guarding against the latter is recognised in this thesis in the midwives’ way of relating designated ‘the respectful gardener and her developing plants’ (V).

It follows from the unreliability of the transitional process that it needs to be controlled; such control is a recurrent activity in antenatal care as well as during childbirth and postnatally. The attempt to control the physical course and experience of childbirth is said to be a major characteristic of hospital care during childbirth (Blåka Sandvik 1997 pp 59-86). An alternative approach based on the trust in the process of childbirth is held by Bergum (1997 p 50) who claims that the woman needs to abandon herself to the process, feel free to abandon inner control and follow the ‘out-of-control-ness’ of her labouring body. Odent (1996) argues, starting from the physiology of hormones, that women do not need support during childbirth, their bodies will lead them if they feel private and secure. In the consultations investigated in this study the trustworthiness of the processes appears to be overshadowed by its unreliability and the linked need for control, which also appears to be the case in other forms of maternity care (Blåka Sandvik 1997 pp 59-86) and society in general (Foucault 1991 pp 195-228).

The approaches of expectant/new parents to pregnancy and early parenthood are also connected with their understanding of the process as trustworthy or unreliable. Raphael-Leff (1991 pp 80-90, 167-175) describes such approaches and designates the expectant/new mothers’ approaches ‘facilitators/regulators’ while she calls the expectant/new fathers’ approaches ‘participators/renouncers’. The ‘facilitator’ trustingly submits herself to the bodily and emotional upheavals of the process while the ‘regulator’ holds out against them and strives to remain unchanged. The expectant/new fathers with the ‘participators’ approach to pregnancy and early parenthood are typically eager to be as actively involved as possible in pregnancy and childcare. The ‘renouncers’ are characterised by not empathising with their partners’ experiences of the process and by a reinforcement of their masculine identity. Both the ‘facilitators” and the ‘participators” approaches have some similarities to the trustworthiness to the process of transition delineated in
this study. The ‘regulators” and the ‘renouncers” approaches are reminiscent of the view of the process of transition as unreliable in this study. The midwives studied were seen both to directly probe the expectant/new parents’ view of the process and to not ask about their views directly (V).

Guiding the consultations
The midwives occupy a leading role in the consultations (I-V) and they appear to determine whether the ‘distanced surveillance’ or the ‘caring about’ will be most prominent and whether the ‘trustworthiness’ or ‘unreliability’ of the process of transition will be conveyed. A look at what leads the midwives might help us to understand this better. The consultations can be seen as being guided by two differing views about the care. The national guidelines for antenatal care (Kjessler 1991, Gårdmark 1997) are mainly concerned with medical screening and health education. Psychosocial support and the importance of the fathers’ involvement are only briefly mentioned and are dealt with superficially. The issues concerning preparation for childbirth and parenthood are not linked to the consultations but are assigned to the parental education in groups. The concept of caring is neither referred to nor developed. The ideology of Swedish midwifery (Ekberg 1995) values caring and claims that childbearing embraces expecting and giving birth to a child and becoming parents. The care should be based on the needs of the childbearing woman and her family and aimed at supporting their resources. The latter view of the childbearing process and the care (Ekberg 1995) shows similarities to the ‘trustworthiness’ of the transition to parenthood and to the ‘caring about’ the expectant/new parents. The former view (Kjessler 1991, Gårdmark 1997) essentially emphasises the ‘unreliability’ of the physical aspects of the transition and ‘distanced surveillance’ of the expectant/new parents.

The results from this thesis (IV) indicate that there are close points of similarity between the meanings of being a mother and being a father disclosed in the studied consultations and what is found in the literature regarding the lived experience of being a mother (Elvin-Nowak 1999) and being a father (Hagström 1999). It should be noted that the issue of parenthood is not treated in any depth in the national guidelines (Kjessler 1991, Gårdmark 1997) with the exception of the topic of breast-feeding, which is given a few pages of attention (Gårdmark 1997 pp...
111-113). This fact, and the assignment of the preparation for parenthood from the consultations to the parental groups, may underlie the limited space given to the question of parenthood in the consultations. The limited attention the midwives pay to the expectant/new fathers in the consultations is unexpected in view of the many years midwives have met expectant/new fathers in antenatal consultations, parental groups, intra- and postpartum care. Lacking comprehension and knowledge of the transition to parenthood and men’s concerns and needs during this phase may underlie the lack of attention given to the expectant/new father. The reasons for this are to be found in the medical domination of antenatal care. Designing antenatal care aimed at supporting the transition to parenthood requires an interdisciplinary approach.

The low activity and compliance of the expectant/new parents in the consultations compared to the midwives’ activity are consistent findings throughout this thesis (I-V). Possible reasons for this might be the expectant/new parents’ perception of midwives and/or healthcare institutions as being authoritarian and the relatively low social class of the participating expectant/new mothers, judged from their professional occupations (cf. Isohanni et al. 1995). Other reasons might be that the consultations were video recorded and that the passivity was an act of politeness toward the midwife, not embarrassing her by talking and asking too many questions. This latter reasoning is contradicted by the fact that the participating midwives judged the consultations to be ‘how they usually are’ after having watched a sample of the recordings. The transcripts from audio taped Swedish antenatal midwifery consultations in Bredmar’s (1999) thesis show similar patterns regarding the activity of the expectant/new parents.

Antenatal midwifery consultations could not be understood in separation from the society, which creates them. Foucault (1991, 1994) has delineated a historical background to the development of knowledge, power, and social control in modern Western society. He claimed (1991 pp 170-194) that surveillance of the population, in factories, schools and healthcare, has become an instrument of power. The joint action of hierarchical observations and normalising judgement in ritualised examination establish ‘the truth’. In healthcare practice the medicalisation, with its focus on the body as an object and the examination of the body, is given knowledge, power and state acceptance to medicine in order to control the social order. This
development is accompanied by a commonly shared medical ‘gaze’, that is, a way of looking at people (Foucault 1994 pp 107-146, 195-199).

Comparing the studied antenatal midwifery consultations with Foucault’s ideas, several similarities can be observed. The commonly shared idea that antenatal care is useful makes it almost impossible not to accept it when expecting a child. The hierarchically organised healthcare organisation examines the women’s bodies in a ritualised manner, at appropriate levels of care, where the level above controls the one below. The results of the examinations and other kinds of knowledge concerning bodies give rise to a series of normalising judgements regarding the way the expectant/new parents should live. All this is in accordance with ‘the truth’ established by higher levels in the hierarchy and is supported by a commonly shared way of looking at people.

The idea of surveillance easily leads to thoughts of a negative form of steering the population. This is recognised in Oakley’s (1984 pp 250-256) criticism of society’s disinclination for viewing women as competent mothers. A more positive perception of surveillance can be found in the ideals of the Swedish ‘People’s Home’ (Swedish: Folkhemmet) in the 1930s (Myrdal & Myrdal 1935). The idea was to ‘design away unhappiness’ in people’s lives, in particular in the lives of mothers and their children, by rational, scientific reason (Hirdman 1990 pp 9-32). Society should care for its citizens by providing free healthcare for pregnant women and children, access to contraceptives, parental education and childcare centres (Myrdal & Myrdal 1935 pp 245-333).

**Caring for and about**
The British sociologist Oakley (1992 p 13) argues that ‘Antenatal care has increasingly lost its ‘care’ component and become a package of other things - surveillance, monitoring, social control’. The results of this study indicate that ‘caring about’ does not predominate in the consultations studied. The relation between caring and ‘distanced surveillance’ needs further reflection, more precisely the issue is whether ‘distanced surveillance’ should be considered as caring at all.

The existence of ‘caring about’ might be regarded as unexpected in antenatal care, since it is not supported by the national guidelines (Kjessler 1991, Gårdmark 1997). The view of caring as something naturally human (Eriksson 1992) and as
basic to the midwives’ own ideology (Ekberg 1995) invites the reflection that one might have expected ‘caring about’ to be the main characteristic in all sequences of consultations. The main argument for claiming that ‘caring about’ is not recognised throughout the studied consultations is the disregard of the uniqueness of the expectant/new parents and their life situation (I, V).

The distinction between ‘caring about’ and ‘caring for’ described by Jecker and Self (1991) might be helpful in understanding the difference between the ‘caring about’ and ‘distanced surveillance’ of this thesis. According to Jecker and Self (1991) ‘caring about’ indicates an attitude, involving feeling interest and concern for a person. ‘Caring for’ involves the exercise of a task without such attitude or feeling of interest and concern about the person. Jecker and Self (1991) claim that these two aspects of caring can occur together or individually. They also describe the existence of uncaring health professionals who neither care for nor about the person.

The ‘distanced surveillance’ of this thesis and the ‘caring for’ of Jecker and Self (1991) are similar. When ‘distanced surveillance’ is prominent the midwife does her duty, executes her tasks concerning tests and examinations and gives out information in a correct but indifferent manner, not showing much interest or concern for the individual expectant/new parent. The ‘caring about’ as described by Jecker and Self (1991) is close to the ‘caring about’ delineated in this thesis because of the midwives’ commitment to the uniqueness of the expectant/new parents in their life situation while executing the tasks related to the consultations. When the midwives relate to the expectant/new parents as ‘respectful gardeners’ (V) they combine ‘caring about’ and ‘caring for’ since they execute the appropriate tasks in an involved manner and proceed to act from the unique situation of the expectant/new parents. When the midwives relate to the expectant/new parents as ‘propagandist teachers’ or a ‘steering inspectors’ they are only ‘caring for’, using the terms of Jecker and Self (1991) since they execute their tasks in a distanced and generalised way. In the ‘personal women friends’ way of relating the midwives appear to be primarily ‘caring about’ since their activity is limited to interested listening. When adopting the ‘mediating counsellor’ way of relating the midwives appear to both ‘care for’ and ‘about’ since they willingly respond to the expectant/new parents’ call for guidance arising from their situation. No ways of relating in the consultations point towards uncaring in the sense of Jecker and Self (1991).
The expectant/new parents', perceptions of the consultations were not studied in this thesis. Preliminary results from interviews indicate that they mostly received what they had expected and that they felt satisfied (Olsson, unpublished results). According to van Manen (1998 p 16) people in the Western world live ‘in a scientized culture and cannot help but adopt the diagnostic attitude of medical science’. This implies that there is a high probability of accord between the care given and the expectant/new parents’ understanding of what they need and desire in antenatal care, especially when they are still dependent on the care (cf. Simkin 1992). Consequently, what in this thesis is categorised as ‘distanced surveillance’ could very well be much appreciated by the expectant/new parents.

Irrespective of whether the ‘distanced surveillance’ way of relating is tolerated by expectant/new parents such way of relating could influence them negatively. We know from earlier research that British mothers report that they take into account not only the expertise of the antenatal midwife giving them information but also her commitment to the individual interest of the woman, when evaluating information and making choices in pregnancy (Levy 1999a). Swedish mothers are reported to find antenatal midwives who confirm them as mothers-to-be helpful in their attempts to stop or reduce smoking (Arborelius & Nyberg 1997). These two examples illustrate that adding a ‘caring about’ dimension to ‘caring for’ could enhance the quality of antenatal care, especially when done within a transition to parenthood perspective.

Concluding remarks
This study indicates the importance of caregivers reflecting over meanings of pregnancy, childbirth and parenthood developed in encounters with expectant/new parents and how caregivers' ways of relating can be understood by and influence expectant/new parents. Of special importance are understandings promoted regarding bodily capacity during pregnancy, childbirth and early parenthood since there is a tension between the general striving for control in society, the striving for control inherent in the medical screening program and the difficulty in fully controlling the development of these processes.

The tendency revealed in this study to reduce the transition to parenthood to a feminine physically and risky project, implies a disregard of the woman’s bodily capacity and the complexity of the emotional, social and existential uniqueness of the
whole childbearing family. Such a tendency risks counteracting society’s attempt to support parenthood in general where antenatal care is the starting point. Thus, interdisciplinary co-ordination is needed in designing antenatal care, starting from the question of whether the aim of the care is only to provide medical screening or also support in the transition to parenthood.

The results indicate that midwives do not always or fully live up to their ideals of caring. However, the participating midwives also demonstrate a capacity to integrate the above mentioned aspects of the transition to parenthood in a unique and committed way, despite the lack of support for such an approach in the guidelines. Such professionalism in antenatal midwifery care deserves recognition.

More research is needed to explore how different approaches to the transition to parenthood and caregivers’ ways of relating in antenatal care influence expectant/new parents’ transition to parenthood.
Barnmorskebesök i samband med graviditet. En kvalitativ studie.

Syftet med denna avhandling är att nå djupare förståelse av mödrahälsovård genom att beskriva barnmorskebesöks samtalsämnen, belysa innebörder av graviditet, förlossning och föräldraskap som utvecklas under samtalen samt beskriva deltagarnas förhållningssätt till varandra under barnmorskebesöken.


Samtalen under besöken domineras av fysiska aspekter av graviditet, förlossning och föräldraskap. Graviditet är det vanligaste samtalsämnet följt av förlossning medan föräldraskap belyses mera sällan. I besöken uppehåller man sig huvudsakligen vid kvinnornas situation medan männens förhållande till graviditet, förlossning och föräldraskap endast undantagsvis behandlas. Barnmorskorna styr besöken genom att hålla initiativet och genom olika förhållningssätt som de blivande/nyblivna föräldrarna med ett fåtal undantag anpassar sig till.
Den mångfald av innebörder av fenomenen graviditet, förlossning och föräldraskap som speglas i de studerade barnmorskebesöken rör sig mellan förståelse av övergångsprocessen mot föräldraskap som tillförlitlig och förståelse av den som otillförlitlig och riskfylld. Mest framträdande i besöken är förståelse av övergångsprocessen (graviditet, födande och förälderaskap) mot föräldraskap som på olika vis otillförlitlig men tilltro till dess styrkor och möjligheter speglas också. Risker och avvikelser i utvecklingen av den fysiska processen är framträdande. Både kvinnan och barnet förefaller att löpa betydande risker. Kvinnors kroppsliga kapacitet att lösa de utmaningar som processen medför framstår som begränsad.


När de studerade barnmorskorna beaktar fysiska, emotionella, sociala och existentiella aspekter av denna livsfas och visar engagemang för det unika i båda de blivande/nyblivna föräldrarnas situation framstår övergången mot föräldraskap som ett livsprojekt för både kvinnan och mannen.

När barnmorskor ensidigt fokuserar fysiska aspekter av graviditet, födsel och föräldraskap och förhåller sig ’distanserat övervakande’ mot föräldrarna tenderar den blivande/nyblivna pappan att framstå som exkluderad från övergångsprocessen mot föräldraskap. Detta riskerar att motverka samhällets allmänna stöd i föräldraskap via institutioner som mödrahälsovården.

Denna avhandling visar på betydelsen av att personal inom mödravården reflekterar över de olika sätt att förstå graviditet, förlossning och föräldraskap som utvecklas i deras möten med blivande/nyblivna föräldrar och hur olika förhållningssätt kan uppfattas och påverka föräldrarna. Som särskilt betydelsefullt framstår hur man förstår och förmedlar kvinnors kroppliga kapacitet under graviditet, födande och tidigt föräldraskap. Detta är viktigt och mångfacetterat eftersom det finns en spänning mellan samhällets allmänna strävan efter kontroll, den kontroll som mödravårdens medicinska screening innebär och svårigheterna att helt styra och kontrollera den kroppliga utvecklingen under denna livsfas. Reflektion över vården förmedling av förståelser av kvinnors kroppliga kapacitet har också sin plats i diskussionen om den ökade frekvensen av obstetriska interventioner.

Mer forskning behövs för att utröna om och hur olika uppfattningar om graviditet, förlossning och föräldraskap samt mödravårdspersonals förhållningssätt påverkar blivande/nyblivna föräldrars övergång mot föräldraskap.
ACKNOWLEDGEMENTS

This thesis has been carried out at the Department of Nursing, Umeå University, Umeå. Several people have given me valuable help and. It is with great pleasure that I express my gratitude to:

The expectant/new mothers and fathers and antenatal midwives who participated and so generously gave their time and shared their experiences with me.

Astrid Norberg, professor and head of the Department of Nursing, Umeå University, my supervisor and co-author, for letting me into your ‘garden’ of extraordinary knowledge and creativity, for guidance in the world of research and for inspiring me to take one more step.

Lilian Jansson, assistant professor, my second supervisor and co-author, for knowledgeable, constructive, creative and joyful supervision in the theory and practice of phenomenological hermeneutics, caring and writing.

Anita Hallgren, research adviser at the Research and Development Centre, Gävle my co-author and friend for fruitful co-operation, enriching discussions and support throughout this project.

P-O Sandman, associate professor, my supervisor and co-author for help with the design and initial stages of this project.

All the staff and colleagues at the Department of Nursing, Umeå University for support. I have particularly appreciated the discussions at our seminars and the kind helpfulness of the secretaries Inga Greta Nilsson and Anita Sjöberg.

Ulf Oscarson, obstetrician and head of the Department of Obstetrics and Gynaecology and Nils-Olov Gustavsson, antenatal obstetrician Skellefteå Hospital for support and encouragement throughout this project.

Karin Brännström and Christina Orvet head midwives at Skellefteå Hospital for fruitful discussions and support.

All my co-workers at the Department of Obstetrics and Gynaecology at Skellefteå Hospital and at Health Centres in Northern Västerbotten for your support and interest in this project. To share thoughts about care and research, to have cups of tea with you in joy and sorrow has been a great help.
Jeanette Båysen and Kerstin Lundström, Skellefteå Hospital for skilled help with transcription of texts.

Patricia Shimpton and Jan Robbins, Umeå University for linguistic help and advice.

Christer Feldt at the Hospital Library, Skellefteå for excellent service in providing literature from far and near.

My husband Martin Björck for our fruitful discussions and practice regarding pregnancy, childbirth, parenthood and research. Our children Lisa, Kalle and Anja Björck for being the most wonderful children the world ever saw. Our relatives and friends nearby and far away for concern and encouragement.

I am grateful for the financial support from the County Council of Västerbotten, the Department of Obstetrics and Gynaecology at Skellefteå Hospital, the Joint Committee of the Northern Health Region of Sweden, the Foundation Barnens Lyckopenning and the Fund for Medical Research at Skellefteå Hospital.
REFERENCES


Berglund A (1999) *Consequences of Programme Changes in Antenatal Care*. Doctoral thesis. Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine 888, Department of Women's and Children's Health, Uppsala University, Uppsala

Bergum V (1997) *A Child on Her Mind. The Experience of Becoming a Mother*. Bergin & Garvey, Westport


Dejin-Karlsson E (1999) *Psychosocial Resources, Life-style Factors and Fetal Growth. With Special Reference to Small-for-gestational Age (SGA) Infants.* Doctoral thesis. Department of Community Medicine, Lund University, Malmö


Doctoral thesis. Department of Psychology, Stockholm University, Stockholm


Eriksson K (1997) Understanding the world of the patient, the suffering human being. The new clinical paradigm from nursing to caring. *Advanced Practice Nursing Quarterly* 3, 8-13


Guirgis R (1997) Women's choice is a major reason for the increase in the numbers of caesarean sections performed in the recent years. *Acta Obstetrica et Gynaecologica Scandinavica* 76, 29


Hertfelt-Wahn E (1997) Kvinnors röster. Förstagångsgravida kvinnors upplevelse av mötet med barnmorskan på mödravårdscentralen. (Swe). [The voices of women. The experience of women expecting their first child in their encounters with the midwife at antenatal clinics]. (Unpublished students paper). Department of Pedagogics and Didactics, Göteborg University, Göteborg


Morgan D (1993) Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research* 1, 112-121
Myrdal G, Myrdal A (1935) *Kris i befolkningsfrågan.* (Swe). [Crisis regarding the population issue]. (Folkupplagan) Albert Bonniers Förlag, Stockholm


Poland B (1995) Transcription quality as an aspect of rigor in qualitative research. *Qualitative Inquiry* 1, 290-310
Pridham K, Chang A (1992) Transition to being the mother of a new infant in the first 3 months: maternal problem solving and self-appraisals. *Journal of Advanced Nursing* 17, 204-216


Rasmussen BH (1999) *In Pursuit of a Meaningful Living Amidst Dying. Nursing Practice in a Hospice*. Umeå University Medical Dissertations, New Series No 592, Department of Nursing, Umeå University, Umeå


Sandelowski M (1995) Sample size in qualitative research. *Research in Nursing and Health* 18, 179-183


Söderberg A (1999) *The Practical Wisdom of Enrolled Nurses, Registered Nurses and Physicians in Situations of Ethical Difficulty in Intensive Care.* Umeå University Medical Dissertations, New Series No 603, Department of Nursing, Umeå University, Umeå


van Manen M (1998) Modalities of body experience in illness and health. *Qualitative Health Research* 8, 7-24

Villar J, Bergsjö P (1997) Scientific basis for the content of routine antenatal care. I. Philosophy, recent studies, and power to eliminate or alleviate adverse maternal outcomes. *Acta Obstetrica Gynaecologica Scandinavica* 76, 1-14


Waldenström (1999b) Kejsarsnitt ger inte bättre förlossningsupplevelse. (Swe.) [The experience of labour does not improve following Caesarean section]. Läkartidningen 96, 4544-4547


Åström G (1995) *The Meaning of Caring as Narrated, Lived, Moral Experience.* Umeå University Medical Dissertations, New Series No 428, Department of Advanced Nursing, Umeå University, Umeå