



# Swedish women's experiences of seeking care and being admitted during the latent phase of labour: A grounded theory study

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## Abstract

**Objective:** to gain a deeper understanding of how women who seek care at an early stage experience the latent phase of labour.

**Design:** a qualitative interview study using the grounded theory approach.

**Setting:** the study was conducted at a hospital in the southwestern part of Sweden with a range of 1600–1700 deliveries per year. The interviews took place in the women's homes two to six weeks after birth.

**Participant:** eighteen Swedish women, aged 22–36, who were admitted to the labour ward while they were still in the latent phase of labour.

**Findings:** 'Handing over responsibility' to professional caregivers emerged as the core category or the central theme in the data. The core category and five additional categories formed a conceptual model explaining what it meant to women being admitted in the early stage of labour and their experiences of the latent phase of labour. The categories, which all related to the core category, were labelled: (1) 'longing to complete the pregnancy,' (2) 'having difficulty managing the uncertainty,' (3) 'having difficulty enduring the slow progress,' (4) 'suffering from pain to no avail' and (5) 'oscillating between powerfulness and powerlessness.'

**Conclusions and implications for practice:** findings indicate that women being admitted to the labour ward in the latent phase of labour experienced a need for handing over responsibility for the labour, the well-being of the unborn baby, and for themselves. Midwives have an important role in assisting women with coping during the latent phase of labour, and in giving the women opportunity to hand over responsibility. This care should include validation of experienced pain and confirmation of the normality of the slow process, information and support.

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## Introduction

The latent phase, i.e. the initial phase of labour, is often a slow process, with little progress and varying levels of pain. Research indicates that

the latent phase is a sensitive period that can be influenced by the pregnancy and may in turn influence both the active and the expulsive phases of labour (Wuitchik et al., 1989, 1990).

The Swedish Ministry of Health recommends that women who seek care but are not in active labour should return home and wait for further developments in order to avoid unnecessary interventions (State of the Art, 2001). Previous research has shown that women who were admitted to hospital early in labour ran an increased risk of being subjected to obstetric interventions and complications, compared with women who were admitted later in the active phase of labour (Hemminki and Simukka, 1986; Malone et al., 1996; McNiven et al., 1998; Holmes et al., 2001; Jackson et al., 2003; Bailit et al., 2005). The most frequent interventions were labour augmentation with oxytocin infusion and application of intra-uterine pressure gauges. The unborn babies had more scalp electrodes applied for fetal monitoring and more intra-uterine blood-tests taken from their scalps (Hemminki and Simukka, 1986; McNiven et al., 1998; Holmes et al., 2001; Bailit et al., 2005). Reported complications included a higher frequency of prolonged labour and more operative deliveries such as caesarean sections (Hemminki and Simukka, 1986; Malone et al., 1996; Jackson et al., 2003; Bailit et al., 2005). It was not clear, though, whether the increased number of operative deliveries was caused by the tendency to intervene more often during early admission or if women seeking care at an early stage were more prone to develop complications (Bailit et al., 2005).

McNiven et al. (1998) compared two different management regimes of the latent phase. They found that women in the labour assessment group, who mobilised in the vicinity of the hospital or returned home, had a shorter duration of labour, were subjected to less labour augmentation and needed less pain alleviation. Moreover, their labour and birth experiences were more positive than those of women who were admitted directly to the labour ward.

Several studies have explored women's birth experiences (Halldorsdottir and Karlsdottir, 1996; Waldenström, 1999; Gibbins and Thomson, 2001; Lundgren, 2005). To our knowledge, however, none has solely explored women's experiences of the latent phase of labour, or women's reasons for seeking care during this phase of labour. It was therefore considered pertinent to obtain a deeper knowledge of this phenomenon, as such knowledge can be used to improve support and information during pregnancy and also improve management and care during labour and birth. The purpose of this study was thus to gain a deeper understanding of how women who seek care at an early stage experience the latent phase of labour.

## Methods

Grounded theory was considered an appropriate method to explore the phenomenon. Originally, grounded theory was developed by Glaser and Strauss (1967), as a systematic guideline for qualitative research.

In this study, a constructivist mode of grounded theory was used, which facilitated an investigation of what subjects believe is essential in their experiences and how they construct their realities. According to Charmaz (2000), this approach enables researchers to gain entry to the subject's worlds of meaning. A constructivist grounded theory emphasises that data are created and analysed through interaction between the participants and the researchers and therefore constructs an image of a reality, as opposed to reality per se (Charmaz, 2000).

## Setting

The study was conducted at a hospital in the southwest part of Sweden with a range of 1600–1700 deliveries per year. The labour ward follows a medical model of maternity care and provides care to low-risk, uncomplicated deliveries as well as to complicated. Approximately 150 women per year seek admission at this unit during the latent phase of labour, which is the only place mothers in labour can be assessed.

Women seeking admission to the labour ward are individually treated, but a labour admission test, i.e. monitoring of the fetal heart rate and contractions, is always performed. If the woman seeks admission for contractions with intact membranes, a vaginal examination will be performed by the midwife. If it can be concluded that the woman is in the latent phase, she receives appropriate information and advice and can return to her home. At times the woman wants to remain at the hospital due to anxiety, need of pain relief or because she is suffering from sleep deprivation. Non-pharmacological treatments such as massage shower, a warm bath, light heating pads and acupuncture are commonly used to mitigate the symptoms. These treatments are, however, not always sufficient and the woman requires medication to alleviate painful contractions and to secure rest and sleep. If the woman returns to her home or is medically treated the obstetrician is always involved in the decision.

## Participants

In line with grounded theory methodology a purposive sample was recruited in order to inform

variations in demographic and obstetric characteristics and to form a heterogeneous group. The sample was composed of eighteen women with uncomplicated pregnancies. All but one had participated in antenatal education classes where they had been informed about the latent phase and how to cope during this stage. All participants had been admitted in the latent phase of labour in line with existing criteria (State of the Art, 2001), which states that to be in an active stage of labour, two or more of the following criteria must be met for both primiparous and multiparous women: (a) regular painful contractions, 3–4 per 10 minutes, (b) ruptured membranes and (c) dilatation of the cervix 3 cm or more.

None of the participants were diagnosed as having a prolonged latent phase, but nine of the participants had artificial oxytocin due to prolonged second stage. The labour outcomes were either vaginal or operative delivery such as vacuum extraction (two participants) or by emergency caesarean section (one participant), at 37–42 weeks of gestation. Other complications were blood loss more than 1000 ml (one participant) and one had a postpartum infection. All the participants both understood and spoke the Swedish language. The principal investigator (I.-M.C), who is a midwife at the clinic, had not taken any part in providing care for the women during pregnancy and/or labour.

### *Data collection*

Midwives working on the postnatal ward asked the women about participation. Data were collected through audio-taped interviews, which were conducted in each woman's home two to six weeks after birth. The interviews lasted 45–75 minutes and were transcribed verbatim.

An interview guide applying open-ended questions designed to follow the onset of labour to the active phase of labour was used. Questions such as 'could you please tell me about your experience when the labour started' and 'could you please tell me about your experiences after you arrived at the hospital' initiated the interviews. Probing was done according to the participant's expressed thoughts and feelings. In line with constructivist grounded theory (Charmaz, 2006), the principal investigator emphasised the participant's definition of situations and events and consequently probed her assumptions and the implicit meanings of these.

### *Data analysis*

Following grounded theory's guidelines, data collection and data analysis were conducted simulta-

neously. The method emphasises comparison of data from one interview to another and parallel use of theoretical memo writings (Charmaz, 2000), which was also done in the actual study. In the first stage of the analysis, initial coding, the interviews were read line by line, and codes were identified and labelled. The coding process helped the researcher to remain close to the data. By making the codes active and specific they also became explicit (Charmaz, 1995). When comparing each code with other codes, those with similar content were pooled together and formed preliminary categories. This process included abstraction and conceptualising of data. For example, the category labelled 'suffering from pain to no avail' was composed of codes such as '*becoming a victim of pain*' and '*having endless pain*'.

After having conducted 14 interviews the sampling became more theoretical, which means that emerging findings guided new interviews and additional questions were asked to saturate the categories. In the subsequent analysis, the categories were developed in terms of properties, conditions, consequences, maintenance and changes and in relationship to other categories. After 18 interviews theoretical saturation was met, i.e. new data did not give additional information. All interviews and memos were then read through again and compared with one another before the analysis was completed. A core category was identified, which was found to be central in the data and also related to all identified categories.

### *Ethical considerations*

The study design was approved by the local ethics committee at Halmstad University, Sweden. The women gave their written informed consent to participate in the study before they were contacted by the principal investigator. They were assured of confidentiality of the data and that they could withdraw from the study at any stage without offering explanations.

### *Findings*

#### *Characteristics of the participants*

Eighteen women aged 22–36 (average 31 years), participated in this study. All women were born in Sweden and none had an immigrant background. Nine participants had completed a high school education and nine had university education. Various professions were represented; three women were unemployed at the time of the interview. The women lived either in the city or in the

countryside up to 100 km from the hospital. All but one of the participants cohabitated with the baby's father. Eleven had given birth to their first baby, four to their second, and three to their third baby.

### *Core category and five related conceptual categories*

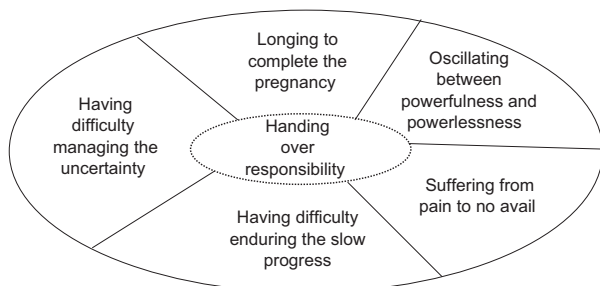
Handing over responsibility to professional caregivers was identified as the core category or the central theme in the data. The core category and five additional categories formed a conceptual model explaining what it meant to women being admitted in an early stage of labour and their experiences of the latent phase of labour. The categories related to the core category were labelled (1) 'longing to complete the pregnancy', (2) 'having difficulty managing the uncertainty', (3) 'having difficulty enduring the slow progress', (4) 'suffering from pain to no avail' and (5) 'oscillating between powerfulness and powerlessness'. The core category and related categories are further described and exemplified by quotations from the interviews and in Fig. 1.

### *Handing over responsibility*

The core category describes women's experiences of security and control as they entered the hospital and someone else took over responsibility for the labour, the well-being of the unborn baby and for themselves as individuals.

I have confidence in you, that you will solve it all for me. I cannot control this and therefore I may as well let it go. Well, in a way it is not my responsibility any longer; even if it is my body that shall manage to deliver the baby, it is not my responsibility. (Participant no. 4, third baby)

When the women arrived at the hospital in the latent phase of labour, the midwife suggested that they should go back home and return later, but most women opted to stay at the labour ward. One



**Figure 1** The conceptual model explaining what it meant to women being admitted in the early stage of labour and their experiences of the latent phase of labour.

reason given was the long distance from one's place of residence to the hospital and a consequent fear of giving birth at home. Another reason for staying was a sense of being safe, as someone with competence and experience was in control of the situation. A contributing factor was the possibility to call for assistance in case they were anxious and in pain, knowing that the caregivers were close by.

As for me and my soul it was like honey. Yes, now I was here (at the labour ward) and they kept me safe in their hands all the time. (Participant no.1, first baby)

The women's respective need to hand over responsibility varied from a total release of control to partial participation and active decision-making. It was deemed important that they were given the opportunity to either partially or totally hand over responsibility. If the women felt that this option was not theirs to choose, they experienced feelings of loneliness and helplessness. This occurred when they sensed that the midwives did not have enough empathy and accordingly did not fully understand their situation. In this situation women felt they were being questioned.

They did not understand that it hurt really badly and that I ought to be more open. Rather. . what are you doing here, you could be at home instead. (Participant no.9, second baby)

### *Longing to complete the pregnancy*

The women strongly emphasised the experience of having completed the pregnancy and consequently wanting to bring it to an end. The reasons given were partially the physical inconveniences such as pelvic pain, back pain and oedema. However, psychosocial conditions such as fatigue and sleeping disorders also played an important role, as did the women's desire to regain a normal body.

I wanted to have the baby now! I wanted to get it done. I thought it had been tough; the womb in this pregnancy was heavy compared with the first one, not at all the same. I felt that I wanted to get rid of this now. (Participant no. 6, second baby)

For different reasons women expected to give birth prior to the estimated due date, which caused impatience and an unwillingness to wait. When contractions started, the hope for an imminent labour therefore rose immediately. For the multiparous women it was a common experience that contractions subsided, which was a great disappointment to them. Once having decided to go to

the labour ward, the women felt it was 'time to give birth' and they intended to stay until the baby was born.

I will not go home! You can say whatever you want, I will not go home. (Participant no. 18, first baby)

Once admitted, the women felt that the midwives should act in order to accelerate the progress of labour. If the midwives proposed actions to accelerate the labour, women considered them as kind and helpful. Caring actions and procedures were thus equalled to coming to a closure. However, at times midwives were considered insensitive if they stated that no treatment would be given, as the woman was 'only' in the latent phase.

### *Having difficulty managing the uncertainty*

This category reflects the sense of uncertainty that influenced women to seek care at an early stage of labour. The uncertainty was based in not knowing when labour would start, what a true onset of labour should feel like or if it really had started. Women who delivered their first babies described the experience as difficult to manage, as they had never gone through labour before.

I am very thankful for being allowed to be admitted, as I was giving birth for the first time, I did not know what this meant for me or for my child. (Participant no. 2, first baby)

However, the amount of time women remained at home after the first appearance of onset of labour varied. A prominent feature was frequent telephone contact with the labour ward. On the other hand, admittance was also sought without having asked for advice first. The women were also uncertain how far the labour process had progressed. Once the women were informed about progress of labour they felt safe.

...it rather calmed me, when I got the answer of how far it had progressed. I think that psychologically it was good for me to be admitted and to get the knowledge. (Participant no. 13, first baby)

It was considered difficult not knowing, and confusing not getting firm answers, as to what would happen in the near future. Lack of concrete answers therefore made women feel very frustrated, impatient and irritated, as shown in the following quotation:

I felt that I did not get any feedback of where I was in the process. I am this kind of a person; I want to know where I am! It was confusing and this was very hard to manage. (Participant no.11, first baby)

Information helped women to manage their uncertainty and thereby positively influenced their motivation. To be told what was going to happen, what was considered normal and what the possibilities were made the uncertainty easier to handle.

### *Having difficulty enduring the slow progress*

Time was obviously important, as women often referred to specific hours. Being admitted in the latent phase of labour, even if that was what they wanted, caused women to feel that the labour lasted for a long time.

It was just irritating that nothing happened, or that it (the contractions) did not stop. The pain was not so hard; it was just arduous and frustrating, the long hours of waiting. (Participant no.16, first baby)

Despite being informed during pregnancy that the initial stage of labour could take quite some time, women's time expectations were different from their actual experiences. This dissonance negatively influenced the women's respective ability to cope with the situation, degree of motivation and ability to maintain mental strength. If the perceived mental image of themselves did not equal reality, both disappointment and feelings of helplessness were experienced.

I had been practising a lot of mental training and I felt completely prepared for it, I even knew that it should be that painful. It is rather the time, I mean, you can handle that for twenty-four hours, but as it comes to nearly forty-eight hours, then it becomes quite tough and, the mental strength is running out. (Participant no.1, first baby)

The latent phase was considered by the women to be the toughest phase of labour, as no or very little progress was made and they felt there was nothing to fight for. It was deemed important that the labour was progressing, even at a slow pace, as this prevented them from resigning. One way of regaining strength and faith in the actual progress of labour was through hearing encouraging words from the midwife, as illustrated below.

Just that she (the midwife) said that she had felt the hair. I lived through it all; she said it directly

when I was admitted. I think it will be one with much hair. It doesn't matter how much pain I had, I knew that soon someone is coming out. You know, it becomes real in some way. (Participant no.4, third baby)

If the women were being informed of a deadline to a planned augmentation, it also made the labour more bearable. If, however, the woman was informed that delivery would occur at a certain time and this did not happen, it was described as mentally devastating.

### *Suffering from pain to no avail*

Suffering from pain to no avail describes the dilemma of the slow and painful progress of the latent phase. The pain was a common reason why women arrived at the maternity ward. It was not always the women's decision to go to the hospital, though; it could be the initiative of the partners or the women's mothers, as they were concerned about them having so much pain.

When the women were informed that they still were in the latent phase of labour a common reaction was astonishment, combined with concern for what would happen next, as the pain was considered to be difficult to endure, as shown below.

Then you think; if it is just one centimetre now, then I still have many hours left. Can I really bear this and I began to doubt my own strength. (Participant no.1, first baby)

When fetal heart rate and contractions were monitored upon admission, it was not unusual that the display showed few and weak contractions. If the midwife could not confirm any progress, the women doubted their bodies to be normal, as shown below.

All along I felt that something was wrong, I was completely sure of that. There is something wrong, how can I have had this pain for such a long time, and still nothing happens. (Participant no. 9, second baby)

Women did not only doubt their bodies, they also doubted their own ability to manage the labour. The latent phase was described as a never-ending process with painful contractions to no avail, in which the women sensed they were being captured by and victims of pain.

I felt as if I was a victim of my pain. (Participant no. 12, first baby)

### *Oscillating between powerfulness and powerlessness*

The latent phase was described as a phase where strength and weakness co-existed. The metaphor applied to describe this experience was a pendulum moving back and forth, oscillating from powerfulness to complete powerlessness. It was, above all, the progress of labour that influenced the pendulum.

I was completely exhausted during the latent phase, I was very tired, and I was very worried about the labour. But when it finally started, I felt that I had the strength. (Participant no.8, first baby)

Many hours without rest or sleep resulted in exhaustion and the need for rest was considered extremely important. Medical treatment to regain strength was described as positive and rest was regarded as the turning point, which would make the pendulum oscillate from total exhaustion to new strength.

A contributing factor to powerlessness was illness and vomiting. Getting help from others with eating, drinking or glucose infusion helped women to get some energy. Support from the caregivers, but above all, from the women's partners and mothers was described as crucial during periods of powerlessness, as it helped them regain strength. Feeling powerless worried women and contributed to a sense of helplessness and thoughts of total dejection. Caesarean section was contemplated as a legitimate way out by letting somebody else take over the responsibility for the labour.

I felt so helpless; please help me, I am at a hospital. Do something! (Participant no. 12, first baby)

Women who experienced feelings of helplessness during the latent phase felt bad afterwards, as it influenced the overall birth experience negatively. It was consequently common to avoid thinking and talking about the labour during the immediate postpartum period. Fear of having more babies due to a traumatic latent phase of labour was also expressed.

When I now look at pregnant women I feel sorry for them, it is horrible, really horrible. I do not want to feel like this because I would like to have more babies. But I do not think I can go through this again. (Participant no.3, first baby)



## Discussion

The purpose of this study was to gain a deeper understanding of how women who seek care at an early stage experience the latent phase of labour. Childbirth is a multi-faceted process and it might therefore be difficult to clearly define the labour experience within a specific stage. In this study, however, women described the various stages and recalled detailed memories from each one of these.

Research has shown that women remember their experiences of labour for a long time (Simkin, 1991; Lundgren, 2005). Waldenström (2003), however, suggests, that satisfaction related to childbirth might be coloured if experiences are measured soon after birth. She found that women who experienced their deliveries as painful and complicated, more often changed their opinions from positive to less positive. In the current study the interviews took place two to six weeks after birth in order to avoid intrusion during the initial vulnerable days. We further decided that this would give women time to reflect upon their experiences and how to share these with us. One woman confirmed that the timing of the interview did matter, as she would not have been able to talk about her traumatic labour during her stay at the maternity unit.

A potential limitation of this study is that all participants were Swedish; the findings might have been somewhat different if women from other cultures were included. Some women from other cultures were admitted to the labour ward in the latent phase during data collection. However, none of these women spoke Swedish and were consequently excluded.

It must be taken into consideration that a qualitative study implies interaction between researchers and participants and that the researcher's pre-understanding might influence interpretation of the material (Charmaz, 1995). This pre-understanding might be considered as a limitation but also as strength. The following facts are believed to vouch for the quality of the actual research process. Two of the authors (I-MC, KOP) are midwives with clinical experience, which might sensitise the processing of the data. The second author (LR-MH), a nurse and psychologist, asked critical questions to avoid simplified interpretation due to professional pre-understanding. The second author (LR-MH) is, moreover, a recognised grounded theory researcher and KOP has also published several grounded theory studies.

The conceptual model, grounded in data, suggests that women being admitted to hospital in the

latent phase of labour experienced a need to hand over responsibility. It further suggests that being admitted and thereby being given the opportunity to hand over responsibility gave women a sense of security and control. This finding is confirmed by Bluff and Holloway (1994), and by Halldorsdottir and Karlsdottir (1996). Searle (1996), and Sjögren (1997), argue that many women appear to be uncertain and convey a sense of being 'at risk', both personally and with regard to the unborn baby.

Further reason for seeking care in the early stage of labour might be women's need for control and making sure that nothing goes wrong. According to Walker et al. (1995), handing over responsibility, and thereby control over the situation to professionals might be a way to indirectly achieve control.

Bluff and Holloway (1994) reported that women left all decision making to the midwife as the perceived expert. This only partially corresponds to our findings, which indicated that handing over responsibility for the labour process ranged from total release of control to partial participation in the decision-making process. The observed discrepancy between the two studies might be due to the ten-year span separating them. Contemporary women are probably more prone to actively participate in childbirth, particularly in Sweden where women are encouraged to plan for and express their wishes related to how their birth should be managed. Strong wishes and expectations from women in labour might be hard to handle and succumbing to the temptation to intervene. Further reasons for the midwife to intervene might be organising problems, when there is not enough rooms and personal resources to handle this group of women. In some other countries women are offered assessment at their home in early labour, but this is a rare opportunity in Sweden and the most common and sometimes only way, to get some professional help during early labour is to seek admission to hospital. Several studies have shown how women being admitted to hospital during the latent phase of labour are subjected to more interventions (Hemminki and Simukka, 1986; McNiven et al., 1998; Holmes et al., 2001; Bailit et al., 2005). It is crucial, however, that no intervention be performed in the absence of obstetrical and medical indications, particularly when considering the fact that complications are more frequent among women being admitted in the latent phase of labour (Hemminki and Simukka, 1986; Malone et al., 1996; Jackson et al., 2003; Bailit et al., 2005).

Women in our study found it difficult to manage the uncertainty, the pain to no avail and the slow

progress. Midwives' information and confirmation emerged as important strategies to handle this, which is supported by other researchers (Halldorsdottir and Karlsdottir, 1996; Lavender et al., 1999; Gibbins and Thomson, 2001). Berg and Dahlberg (1998), argued that women whose feelings of pain were confirmed could then experience self-reliance, self-confidence and intrinsic power. It is possible that the validation of women's feelings of pain also increased their pain threshold. Similarly, women in the actual study reported coping better with the uncertainty and pain, when they were properly informed and their feelings were confirmed by the midwives.

Women in the current study stated that they oscillated between powerfulness and powerlessness and one way to regain strength was to get some rest. Night sedation, for example, was considered quite helpful as it enabled women to go through the labour. Lee and Gay (2004), argue that a sufficient amount of quality sleep 48 hours before labour significantly contributes to reducing the length of labour and improving the outcome of labour.

Another aspect found to empower women in this study was support from their partner and their own mother during childbirth, which is also supported by several researchers (Lavender et al., 1999; Waldenström, 1999; Gibbins and Thomson, 2001; Hodnett et al., 2003; Waldenström et al., 2004). Despite support, the latent phase of labour was still hard to cope with according to the participants of this study. The sense of being a victim of pain and even being captured by it rendered them helpless at times, indicating that the latent phase of labour might be experienced as traumatic. Soet et al. (2003), found that feelings of helplessness and having pain were significant factors predicting women's experiences of a traumatic labour. The concepts applied by women when referring to the latent phase in the actual study are similar to those used by participants in Nystedt when studying prolonged labour (Nystedt (2005)). She found that women said they were exhausted, powerless and captured. The experiences of women with complicated labour are thus remarkably close to those of women who experienced little or no progress in the latent phase of labour. The current study further indicates that the negative experiences of the latent phase of labour might negatively influence the total birth experience and consequently women's willingness to go through another pregnancy. This finding is supported by Gottvall and Waldenström (2002), who found that a traumatic childbirth might affect future reproduction.

## Conclusion and implications for practice

The findings of this study indicate that women being admitted to labour ward in the latent phase of labour experienced a need to hand over responsibility for the labour, for the well-being of the unborn babies and for themselves to professionals. The women conveyed that they longed to complete the pregnancy and regain their bodies physically as well as mentally, that they experienced difficulty in managing the uncertainty, the slow progress combined with pain to no avail and feelings of powerlessness. These experiences were strong and left women with the sense that the latent phase of labour was traumatic. In turn it influenced the total childbirth experience negatively, even to the extent that some women expressed doubts about having more children. Midwives have an important role in helping the women to cope with these experiences. Appropriate midwifery care needs to include confirmation of the women's pain, the normality of the process, information and support. This study hopefully contributes to the body of midwifery knowledge by offering new insights from the perspective of women who seek care at an early labour stage. Such knowledge might improve the caring and management of women who are being admitted to the labour ward when they are still in the latent phase of labour. To optimise the care of these women, future research should focus on both obstetric and caring perspectives.

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