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Women's experiences of the second stage of labour

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ABSTRACT

Background: The second stage of labour is generally considered as an intensive part of labour. Despite this, knowledge about women's experiences of the second stage of labour is scant.
Aim: To explore experiences of the second stage of labour in women with spontaneous vaginal birth.
Methods: This is a qualitative study where twenty-one women with a spontaneous birth at term, were interviewed four to ten weeks after birth. Data were analysed using qualitative thematic analysis based on descriptive phenomenology. The participating women had experienced a vaginal birth; some for the first time, having previously given birth by caesarean section and some with a previous vaginal birth.
Findings: Three themes emerged: "An experience of upheaval" which represents the women's experiences of intensity, power and pain during the second stage of labour. "The importance of trusting relationships" signifies the meaning of women's relationships during the second stage of labour. "Becoming a mother" which is characterised by feelings of accomplishment and the experience of the final moments of birth.
Conclusion: During the second stage of labour women experienced overwhelming sensations which made evident the importance of trusting relationships with those involved in the birth. The women were in a transformative state between pregnancy and motherhood where experiences of being involved and being provided with information and guidance were all considered crucial. Continuous support should be offered to women during the second stage of labour.

Statement of significance

Problem

Knowledge of women's experiences of the second stage of labour is scarce.

What is already known

The second stage of labour is an intensive part of labour. The birth experience has significant impact on women's health and wellbeing.

What this paper adds

This study contributes with knowledge about women's experiences of the second stage of labour. Sensations of extreme pain and intensity, fear and fascination imply a crucial need for trusting relationships during the second stage of labour.

1. Introduction

The experience of giving birth has been shown to be a significant experience in a woman's life which can have long-term consequences for her health and wellbeing [1]. A positive birth experience is related to an affirmative mother–child relationship and a positive start to motherhood which in turn has been connected to women's confidence and

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feelings of accomplishment [1,2]. On the contrary, a negative birth experience is a risk factor for developing postnatal depression, fear of childbirth and post-traumatic stress syndrome (PTSD) [3–7]. According to the World Health Organization (WHO), a positive birth experience is the primary outcome for all pregnant women [8].

The second stage of labour is generally considered to be an intensive part of labour for mother and baby. It is defined as the time from full cervical dilation until the birth of the baby and includes expulsive uterine contractions leading to an involuntary urge to bear down [8]. There is a lack of knowledge about women's experiences of the second stage of labour and which aspects of midwifery care can help or hinder women in the process of giving birth [9]. The overall birth experience has been in focus in previous research and research related to the second stage of labour has mostly focused on medical aspects and risk factors [10–14]. Yet, healthy childbearing women value psychological well-being and safety equally [15]. Knowledge about women's experiences of the second stage of labour can contribute to the understanding of factors influencing positive as well as negative birth experiences and factors related to subsequent fear of birth and PTSD.

Given the lack of research on women's experiences of the second stage of labour, it is of importance to listen to and consider women's experiences of the second stage of labour. The aim of this study was to explore women's experiences of the second stage of labour in spontaneous vaginal birth.

2. Methods

A qualitative interview study using thematic analysis based on descriptive phenomenology was chosen in order to gain a deep understanding of the phenomenon, women's experiences of the second stage of labour. Lived experiences refers to our experiences of the world and is in this study understood from a lifeworld approach [16]. The lifeworld approach is based on Husserls phenomenological philosophy and is well suited to understand and describe human experiences [16].

2.1. Setting

A purposive sampling was used for the study and in order to obtain a variation in participants and experiences, two strategies were used; recruitment of participants from two University hospitals in separate regions of Sweden and recruitment through a survey which is part of a clinical trial, which will be reported separately [17]. In the first phase, women who mastered the Swedish language and had a spontaneous vaginal birth at term were approached one to four days after the birth during their stay at the postnatal ward, either by the researchers or the midwives on the ward. If they wished to participate, they were contacted by one of the researchers four to six weeks later. Fourteen women were asked during their postnatal stay and all of them, except one, were willing to participate in the study. A further two women cancelled the interviews due to lack of time and four women did not answer the phone calls or text messages when contacted after a month. In the second recruitment phase, women participating in a clinical trial received a survey one month after birth. In this survey, women were asked if they would be interested in participating in a follow-up interview on their experiences of giving birth. Through the survey it was possible to identify women reporting both positive and negative birth experiences, thus increasing the variation in experiences. Eight participants who provided their phone numbers were contacted approximately five to six weeks after the birth and all women contacted this way consented to participation.

In Sweden, midwifery care during labour and birth takes place in hospitals where midwives are independently responsible for uncomplicated normal births with assistance from a nursing assistant. In case of complications or deviations from the normal, obstetricians assume responsibility, but the midwife remains involved in the woman's care. Midwives are often responsible for more than one woman in active labour. The care during pregnancy and birth is publicly funded and given free of charge.

2.2. Data collection

The interviews were conducted between four and ten weeks after the women had given birth, between March 2019 and January 2020. All women chose to be interviewed in their homes, except one who wanted to be interviewed at the maternity unit. Seventeen women were interviewed by the first author, three were interviewed by the last author and one was co-interviewed by the first and last author. The interviews ranged from 20−82 min.

The first three interviews were conducted as pilot interviews and started with an open-ended question: *"Can you tell me about your experience of the second stage of labour?"* During this process it became evident that in-depth descriptions and nuances of the experiences of the second stage of labour could only be attained when the women were allowed to relate their entire birth experience. Therefore, the following interviews started with the question *"Can you tell me about your experience of giving birth?"*. After the women had talked about their experience as a whole, the researchers conducting the interviews asked: *"Can you tell me more about your experience of the second stage of labour?"* Clarifying questions were asked when needed in order to obtain a deeper understanding of each woman's experience; "*Can you tell me more…"* or *"Could you explain that further?"* During the analysis, the pilot interviews turned out to contribute with variation and therefore were included in the results.

2.3. Description of participants

Data were based on interviews with 21 women. All the included women had a high school or university education and ranged in age between 24 and 37 years. According to the women's experiences, the duration of the second stage of labour varied from two contractions to seven hours. Two of the new-borns were separated from their mothers after birth as they required ventilation support and monitoring. None of these babies were admitted to a neonatal intensive care unit or had to be

Table 1
Obstetric details of included participants.

Pseudonym	Parity	Onset of labour	Epidural	Augmentation with synthetic oxytocin
Camilla	First birth	Induction	Yes	No
Mia	Birth after caesarean section	Spontaneous	No	No
Jenny	Third birth	Induction	No	No
Anne	First birth	Induction	Yes	Yes
Charlotte	First birth	Induction	No	Yes
Emma	First birth	Spontaneous	No	No
Lisa	First birth	Induction	No	No
Annika	First birth	Spontaneous	Yes	Yes
Linda	First birth	Spontaneous	Yes	Yes
Astrid	Birth after caesarean section	Spontaneous	No	Yes
Hanna	Sixth birth	Induction	No	No
Eva	Second birth	Induction	No	No
Andrea	First birth	Induction	Yes	Yes
Nora	Third birth	Spontaneous	No	No
Ina	Second birth	Spontaneous	No	Yes
Therese	First birth	Spontaneous	No	Yes
Isabella	First birth	Spontaneous	No	Yes
Louise	First birth	Induction	Yes	Yes
Diana	First birth	Spontaneous	Yes	Yes
Marie	First birth	Spontaneous	Yes	Yes
Erica	Birth after caesarean section	Spontaneous	Yes	Yes

separated from their mothers for more than 20−30 min (Table 1).

2.4. Data analysis

Data was analysed using qualitative thematic analysis based on descriptive phenomenology [18]. The interviews were audio recorded and transcribed verbatim. To achieve familiarity with the data, researchers first read the transcribed texts open-mindedly several times. Thereafter the analysis proceeded with the search for meanings of lived experiences in the text that were related to the aim of the study. Meanings related to each other were organised into patterns from which themes emerged and were formulated. These themes were initially tentative and were discussed thoroughly between all authors until consensus was reached. During this process, a deeper understanding was achieved by moving between the whole and the parts of the text. Openness to the lifeworld and the phenomenon was emphasised in the search for meanings. Reflexivity was sought during the entire process. The researchers continuously reflected on their pre-understanding in order to maintain a critical stance to the understanding of the data. The data was analysed using NVivo software. The writing of this paper was guided by the Standards for reporting on qualitative research (SRQR) [19].

2.5. Ethical approval and considerations

This research was approved by the Regional ethical committee in Lund (no: 2018/476). Giving birth, becoming a mother and forming a family is a sensitive period in a woman's life. To assure that women did not feel pressured to participate, when asked during their postnatal stay, they were contacted again after four to six weeks, which gave them time to consider their participation. The remaining women who were selected from their participation in the survey had already stated that they wished to participate by leaving their phone numbers. All women were given oral and written information about the study and the terms of confidentiality and reassured that they could withdraw their consent at any time. In order to confront the possibility that a woman with a traumatic birth experience might feel worse in connection with the interview, opportunity was given to talk to the researcher and ask questions after completing the interviews. If needed, the researchers could refer the woman to a childbirth counsellor or a psychologist.

3. Findings

The women's experiences of the second stage of labour are described in three themes. The first theme, *An experience of upheaval* describes the women's experiences of intensity, power and pain during the second stage of labour. *The importance of trusting relationships* points to the significance of the women's relationships during the second stage of labour. The final theme, *Becoming a mother*, refers to the sense of accomplishment felt by the women, their focus on the baby and experiences of the last moments of birth.

3.1. An experience of upheaval

The women described the experience of the second stage of labour as one of entering a powerful phase of birth. The start of the second stage of labour was experienced in different ways: some but not all women felt downwards pressure and an urge to bear down when the second stage of labour started. Most of the women knew that the second stage of labour had started as this was confirmed by the midwife after performing a vaginal examination. The first and second stages of labour were also experienced as a single entity and not as separate stages, which could be overwhelming.

> *"I was shocked, since I felt I took [only] a minute from the midwife saying I was 7 centimetres open to me feeling that I wanted to push."* (Mia)

An experience of upheaval was further described as a primordial power or a cleansing wave. The intense power of the birth process could neither be controlled nor be compared to anything previously experienced. A need to surrender to the process of birth and to a force that was hard to control was experienced with both wonder and fascination as well as fear.

> *"It's a very powerful experience and it's the coolest experience of the whole birth but it's also unpleasant and scary just because you don't have any control, you've just got to go with the flow, but at the same time, that's what's so cool."* (Charlotte)

The experience was also described as a strong pressure downwards and a sense of the baby pushing its way further down. The emergence of the baby's head was described as a burning sensation. Feelings of being ripped apart and torn were experienced, sometimes being referred to as frightening and as a pain difficult to contain. The women described unbearable pain and pressure taking over, making focus on anything else impossible.

> *"I don't think I've ever experienced that pain any other time. It's just dreadful. It feels like you're going to split in two. Both from the inside and the outside…oh! And it's kind of a pain that's both tension and just hurts."* (Jenny)

For some of the women, the experience came as a relief because their contractions became easier to cope with. The women expressed confidence in their bodies when the urge to push took over and it was possible to follow their bodily impulses. At the same time, women could describe an inability to find balance. Feelings of being overwhelmed by the intensity of the pain made it difficult to let go, even though they wanted to.

> *"I probably had a picture or a feeling that I would, in a better way, be able to ride the pain a bit more and work with it, but I was quite shocked about how painful it was so I felt at times that I fought it. That probably caused more pain"* (Anne)

The experience of upheaval could also mean an inner storm that was hard to navigate. Avoiding panic, balancing between loss of control and feelings of dying were sometimes experienced as so challenging that thoughts of not being able to manage the birth occurred. For the women it meant being in a vulnerable state where the body was experienced as splitting apart, and priority was given to survival. Even women who had given birth previously described how they were beyond themselves with pain and could not remember feeling such despair in earlier births. It was feelings of exhaustion, defeat and a wish for the birth to be over.

> *"I felt rather frustrated, I panicked. This is crazy difficult, and I had to constantly tell myself it's almost over and I am not going to die. I just had to tell myself that."* (Jenny)

Women who described feelings of panic and loss of control, meant they doubted in their ability to give birth, affecting how they viewed themselves as birthing women. Doubting in their own ability was further reinforced for those women who did not experience bodily impulses to bear down, as the second stage of labour was not proceeding as they had expected or hoped for. Thoughts of not being able to give birth could then arise and entail feelings of insufficiency, uncertainty, and disappointment in not being strong enough. Putting focus on achievement seemed to shape the women's view of themselves as they did not live up to their own expectations.

> *"It looks very simple and when you read about it, it seems simple and that it's a very natural process and that all women possess the ability, and that you just push a bit and the baby arrives. And when that wasn't the case, it was kind of a stone wall and "what's wrong?" and "what should I do? Is there something wrong with me?" and "why's it not working? Shouldn't it do that?"* (Andrea)

The women described that it was important for them to feel that the

birth progressed during the second stage of labour. Another dimension of the experience of upheaval was to gain control and find strategies to cope with pain and exhaustion. These strategies allowed the women to find strength and to trust in their own ability. They included screaming, focused breathing, taking command, being active, turning into oneself and focusing completely on giving birth.

"I remember thinking that I had to be focused. That I said to myself, that you must put all the pain aside and focus and push instead…. and so I did that for one contraction and it was much better. That I summoned strength and I felt the head move." (Nora)

3.2. The importance of trusting relationships

The women's relationships during the second stage of labour were described as a vital part of the experience. The partner was often described as being of utmost importance for the feeling of security and confidence.

"It was just security that I knew that he was there and that I knew that he knew what was going on and that he didn't freak out. So that made me calm too." (Jenny)

The women also described the importance of having trusting relationships with the midwives. The midwives were described as capable of understanding the women's particular needs which manifested in the creation of an atmosphere of security. The midwives' understanding, and guidance created feelings of confidence and of being in control.

"I probably felt calm anyway, because they were also calm. I felt secure all the time that the midwives know what's going on." (Annika)

A trusting relationship with the midwife could also be experienced when the midwives took on a leading role. This guidance was needed in situations when the women were about to panic and required the midwife to respond to their needs. Relief was experienced when the women let the midwives take command. Clear instructions were experienced as particularly helpful. However, feelings of security were not always dependent on what the midwife said but rather the feeling she transferred and her ability to manage the situation that made the women feel secure.

"One of those older "aunties", a little iron lady sort of, who barked and gave instructions and ordered everyone around. She was really wonderful, I think I needed that… She said "now you be quiet Nora, you won't give birth by screaming like that! Now do this and then do that." (Nora)

There were moments when the women did not rely on their own impulses but instead depended on the midwife; trusting and expecting her to know what to do. These occasions could entail feelings of assurance and security but could also create a sense of being exposed and out of control. For example, most of the women seemed to have a preconception that the start of the pushing phase should be determined by the midwife, and that pushing could not be initiated before permission was given. This idea was further reinforced by the midwives when they told the women how and when to push and when they needed to suppress their impulses to push. The women experienced that the instructions from the midwife stood in contrast with their own bodily impulses and the incongruousness was etched in their minds. Marie, a first-time mother described that she felt a strong desire to push but was told that she was only five centimetres dilated and had to stop bearing down.

"I wanted to push but I wasn't allowed, so I stop the feeling by tensing my legs, I was tense in my buttocks and legs and I tensed as much as I could, and that stopped the pain." (Marie)

Another examination shortly after having an epidural revealed that she was fully dilated. Being directed and not allowed to follow one's own needs caused disappointment in not being treated with respect or given the opportunity to give birth on their own terms. At times when the women did not understand or agree with actions taken, they were disappointed and expressed feelings of being controlled and mistreated by the midwives.

" It felt unnatural in a way, and it wasn't at all how I had pictured it when she arrived. That they had to hold me down." (Louise)

As a part of a trustful relationship with the staff, it was essential to be fully involved in all communication and decision making surrounding the birth, but relationships were not always experienced in this way. Some women described how the staff spoke to each other without involving them, which could induce feelings of being left alone despite staff being present, experiencing exclusion from participation and not being trusted.

"I think I felt that I would very much like to know what was going on, whatever it was. And I might have been calmer if I'd been given some kind of information. I think it would have been better than them talking about something that I didn't really understand." (Louise)

The women emphasised that in order for them to remain in control it was important that the midwife remained in the room with them. The experience of being left alone at this stage was almost unbearable, even when the partner was present. When recalling painful memories of loneliness, the women themselves did not use strong expressions. Rather, their feelings of being abandoned and losing control were understood by their crying and their body language. Lisa could not stop her tears when she explained the unease she experienced when the urge to bear down became stronger and the midwife had left her.

"It was just in that in-between phase, that I said to my husband: "go and get them" and "what should I do?" I felt I needed someone there to tell me what to do." (Lisa)

Yet another aspect of discomfort for the women, was a difficulty in establishing a relationship with new staff after shift change during the last moments of birth. Feelings of not being involved or informed were described by women expressing dissatisfaction of the care given. Sometimes the new staff outlined different instructions and plans before a relationship had been established. However, new staff could also reverse feelings of hopelessness and light a spark by bringing new energy, clear instructions, information and hope. Marie described how a physician finally entered the room and gave her just that.

"It was the first time that someone actually took hold of me and told me. Like this: "now this is what's going to happen". And it was so good, all of a sudden, I was like: "yes, thanks, now I know sort of where in the birth I am", because I didn't know." (Marie)

3.3. Becoming a mother

Becoming a mother included an understanding that the birth was imminent. For first-time mothers this meant entering an unknown sphere where feelings of happiness and excitement but also fear were described. The fear was related to not knowing if they were able to carry on, to the burning and stinging pain and also to worries about tearing.

"I think I was really frightened just before she came out, just when I felt that warm and yes, burning sensation. Yes, it was most frightening just before she came out" (Louise)

However, not all women experienced the pressure or the burning sensation but rather described the realisation of the birth as imminent when the midwife told them so. Women who experienced no bodily signals such as downwards pressure or an urge to push, could be unprepared for the moment of birth, which sometimes hindered them from experiencing the happiness they had expected. Moreover, when there was an absence of bodily signals, women reported this as causing doubts

about their own ability to achieve the last phase of birth. This in turn, made it more difficult to view themselves as birthing women and the baby seemed more absent. When finally realising birth was near, they were taken by surprise.

> *"I thought: it's going to end with a c-section, well, they have to do something, I was really surprised when I felt the head just being there…"* (Therese)

Another woman compared her second birth with her first experience when she had an epidural. When giving birth without epidural, she experienced a stronger connection between mind and body, being fully aware of the imminent separation of bodies.

> *"For me, pushing was really different this time, because now I did it myself and I was fully aware, I felt so clearly, how the head came out."* (Ina)

Women who were asked if they wanted to touch the baby's head while the baby was still inside of them, or those who actively embraced the emerging baby with their hands, experienced a strong sense of moving towards motherhood. These women described this as a fascinating feeling of being two in one body, that the baby was being born through them and that this made them realise that the birth was imminent and real. With the birth two new identities were born, the mother and the baby. Touching the baby during the last moments of birth helped them to overcome the enormous exhaustion that some of them felt. It allowed them an immediate connection to the baby and feelings of participation and presence. Erica who gave birth to her first child by caesarean section described that this moment still lingered one month after the birth.

> *"When I look at Sophia, that she has come out of me in a different way than my first child… and sometimes when I touch her head, I think about how I felt her head when she was inside me." (Erica)*

Becoming a mother could also entail an altered focus which meant putting the baby's need before one's own. Women who were told about signs of their baby being compromised during the birth, described that joyfulness turned into anxiety and that they shifted focus from themselves to the baby. It was experienced as leaving a state of inner focus and becoming more aware and alert in order to protect the baby. Even though they described the exhaustion and pain as overwhelming, it was set aside, and all their remaining power was focused towards pushing the baby out.

> *"There is in fact another person here, it's the baby who's being born. And I let go of the focus on all my feelings and all my experiences and just focused on him. That's maybe why I don't remember any pain from the pushing phase either, because I couldn't focus on that. You close down in some way at the same time as you keep your senses sharp, it's two-sided…"* (Emma)

Becoming a mother was further experienced in the immediate moments after birth. Feelings of relief and joy but also astonishment were described, since it was hard to believe that the baby was no longer inside but had come out. The very first meeting with the baby could be hard to grasp and was associated with overwhelming feelings for the baby. The women described a fascination over their capability and of possessing unexpected strength but also pride, amazement and a new-gained respect for their bodies.

> *"It feels cool, I've got a lot of respect for my body now, it feels sort of like this – cool, how cool is my body that can do this."* (Camilla)

Becoming a mother was also described as a completely natural event.

> *"I lay there with her on my chest and felt that this feels completely normal. It wasn't strange at all and I didn't cry and Eric and I looked at each other and kissed each other. But neither of us cried and it wasn't an over-whelming feeling, rather a quite pleasant feeling of – now this is where we are at, there's nothing strange."* (Marie)

4. Discussion

The result from this study about women's experiences of the second stage of labour was described in three themes: an experience of upheaval, the importance of trusting relationships, and becoming a mother. The women experienced the second stage of labour as entering a phase of culminating intensity, pressure downwards, unbearable pain, fear and at the same time a feeling of fascination. Women used a variety of strategies to take control and cope with this overwhelming experience and they emphasised the importance of trusting and safe relationships during this stage. The women put a lot of faith and trust in the midwives and expressed gratitude and great satisfaction with them and the care they provided. However, they also described experiences where they felt subjected to a lack of compassion, involvement and information.

The findings that the second stage of labour was about being in a transformative state between pregnancy and motherhood has previously been described as a vulnerable state of separation [9]. In this study it is described as a dynamic course of events where moments of fear and vulnerability, doubt and disappointment in the own ability, coexisted with feelings of power and of being in control. A strive for control was evident and the women described how they faltered between keeping and losing foothold. The women's vulnerability in the transformative state meant trusting relationships, and continuous support was crucial and helped them gaining control and trust in themselves. On the contrary, lacking presence and support could lead to remaining feelings of being insufficient.

The results show that the second stage of labour involved extreme physical pain which could lead to feelings of fear but also fascination and strength. Fear and pain are feelings usually interpreted negatively while feelings of power and fascination are positively charged and associated with a positive birth experience [20]. Extreme levels of fear and pain are common at the start of the second stage of labour [21]. Olza et al. explained the positive coexisting emotions by peaks in levels of endogenous oxytocin just before the pushing phase [21,22]. Endogenous oxytocin release during labour and birth not only induces pain relief and decreases fear and stress levels, but also stimulates social interactive behaviours which is why women often reach out for a person who can give mental reassurance to be close to them during birth [21]. In this study, the midwife, her knowledge and the care she provided was described as very important during this stage.

The women in this study described how they placed great trust in the midwife which meant that even if the midwife's instructions were at odds with their own bodily impulses, they presumed the midwife's knowledge to be superior. This perceived superiority was further exemplified as the women described a certification process, where permission to follow their urge to push was given after a vaginal examination. This process of being given permission to push has been described earlier [23] and might be understood in light of the dominating culture of birth. Birth culture encompasses how women perceive care, how they portray birth, how ideologies and belief systems regarding birth are conveyed and shape their expectations and experiences of childbirth [24]. The women in this study seemed content with the midwives' decisions and accepted their assessments as superior. However, other studies report that when women's own knowledge of the labour progress is disregarded in favour of the care provider's clinical assessments, this can lead to the woman experiencing birth as traumatic [25].

An important finding in this study was that not being informed or involved in decision making was experienced very negatively by the women. Withholding of information may create feelings of being unsupported [9]. The women's experiences of not being informed or involved, being forced to give birth in a position not of their own choice

or being left alone during the second stage of labour showed that a trusting relationship was sometimes not established. Midwives may have strong reasons for not meeting a woman's wishes. For example, de Jonge et al. reported that most midwives gave priority to women's choices about birth position but reported that they could also override when obstetric considerations took precedent [26]. In these situations, it is of importance to inform women why their wishes are not met, which was not always the case according to some of the women in the present study. Several studies have shown that women's feelings of control and a positive and empowering birth experience are enhanced by being informed and being active in decision making processes during birth [27–30]. The findings from this study show that loss of control was connected to feelings of disappointment, uncertainty and even panic. In those situations, it was described as important and highly valued that the midwife was observant of the women's needs and had the skills to firmly take charge and restore control.

In addition to the results from earlier studies [31,32], the findings from this study emphasises the need for continuous support during the second stage of labour and that changing staff during this time period should be avoided if possible. Midwives who care for birthing women are highly influenced by the workplace culture [33]. It has been reported that midwives in hospital-based settings strive to provide woman-centred care and to give continuous support during the second stage of labour [31] but that there are organisational barriers to this, since midwives are often responsible for more than one woman in active labour [32].

The experience of being neither one body nor a body encompassing two beings has been described as a liminal process [34]. Liminality has been defined as the "betwixt and between", neither the starting point, nor the destination [35]. In this study, liminality was experienced by the women who touched the baby's head during the second stage of labour. The women described that this experience caused them to become more present and aware of the imminence of the birth. Furthermore, this was important for gaining strength to give birth and led to feelings of confidence and accomplishment. This stands in contrast to the findings from the study by Lupton and Schmied who reported that touching the baby's head seemed alien and foreign [34]. This is an important aspect as the positive effects of touching the baby may not apply to all women.

Furthermore, liminality was experienced by women who's babies were being compromised during the second stage of labour as the focus altered from themselves to the baby. The experience of becoming more aware and conscious, has been explained by the need for women to leave their inner focus, earlier described by Reed et al. as "an altered state of consciousness", and reconnect to the external world before the birth of the baby [36] As an instinct to protect the baby, an ability to think and interact with the environment is required [37]. The openness and vulnerability characterizing the liminal phase, explains the importance of trustful relationship in leading women to have more positive experiences of the second stage of labour.

4.1. Methodological considerations

This study is strengthened by the design and the large amount of data. Using thematic analysis based on descriptive phenomenology enables a deep and nuanced understanding of the phenomenon. The pilot interviews drew attention to the fact that some women had difficulties in verbalising their experiences, when the researchers' starting point was the second stage of labour. This resulted in an alternative approach and the women were asked to tell their entire experience of giving birth, before asked to focus on the second stage of labour. This adjustment resulted in rich and nuanced data.

The findings must be understood in context, in this case Swedish women giving birth in obstetric units where midwives often provide care to more than one woman in active labour. Inclusion of women with other ethnicities might have contributed to a wider variation in experiences of participation and information from care providers. However, the bodily experience of giving birth is more likely to be generalizable to other cultures. This does not disqualify the application of the results to other contexts, but if this is done the findings must be related to the new context [16].

A limitation is that the interviews were conducted relatively shortly after the birth. The reason for choosing this time point was to capture detailed descriptions of the experience. Carrying out the interviews later on might have resulted in women being less satisfied with the care provided since it has been shown that the significance of negative events during birth seems to intensify over time, whereas positive aspects more often remain positive [38]. The authors used the WHO definition of the second stage of labour, which starts at full dilation of the cervix [8]. It can be argued that this is not always in accordance with women's perception of the start of the second stage [23,39]. However, most of the women in this study were aware of when full dilation occurred, since this was confirmed by a vaginal examination performed by the midwife.

5. Conclusion and implication

During the second stage of labour women experienced extreme pain, fear but also fascination. The women were in a transformative state between pregnancy and motherhood where experiences of being involved and being provided with information and guidance were all considered crucial. The women stressed the importance of trusting relationships with those involved in the birth. Being involved, being provided with information and guidance were considered crucial. Furthermore, it was important that the midwife took the lead when necessary. Women should be offered continuous support during the second stage of labour, and not be left alone. Encouraging women to touch the baby's head can help women to feel their own capacity for giving birth and to experience the liminality of being two in one body.

Conflict of interest

None declared.

Ethical statement

This research was approved by the Regional ethical committee in Lund on July 27th, 2018 (no 2018/476).

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CRediT authorship contribution statement

Cecilia Häggsgård: Conceptualization, Validation, Formal analysis, Investigation, Writing - original draft, Project administration. **Christina Nilsson:** Methodology, Validation, Formal analysis, Writing - review & editing, Supervision. **Pia Teleman:** Conceptualization, Resources, Writing - review & editing, Supervision. **Christine Rubertsson:** Conceptualization, Methodology, Validation, Formal analysis, Resources, Writing - review & editing, Supervision, Project administration, Funding acquisition. **Malin Edqvist:** Conceptualization, Methodology, Validation, Formal analysis, Investigation, Writing - original draft, Supervision, Project administration.

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References

[1] P. Simkin, Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I, Birth 18 (4) (1991) 203–210.
[2] J.M. Green, V.A. Coupland, J.V. Kitzinger, Expectations, experiences, and psychological outcomes of childbirth: a prospective study of 825 women, Birth 17 (1) (1990) 15–24.
[3] A.F. Bell, E. Andersson, The birth experience and women's postnatal depression: a systematic review, Midwifery 39 (2016) 112–123.
[4] S. Garthus-Niegel, C. Knoph, T. von Soest, C.S. Nielsen, M. Eberhard-Gran, The role of labor pain and overall birth experience in the development of posttraumatic stress symptoms: a longitudinal cohort study, Birth 41 (1) (2014) 108–115.
[5] H.T. Størksen, S. Garthus-Niegel, S. Vangen, M. Eberhard-Gran, The impact of previous birth experiences on maternal fear of childbirth, Acta Obstet. Gynecol. Scand. 92 (3) (2013) 318–324.
[6] C. Nilsson, I. Lundgren, A. Karlström, I. Hildingsson, Self reported fear of childbirth and its association with women's birth experience and mode of delivery: a longitudinal population-based study, Women Birth 25 (3) (2012) 114–121.
[7] C. Rubertsson, U. Waldenström, B. Wickberg, I. Rådestad, I. Hildingsson, Depressive mood in early pregnancy and postpartum: prevalence and women at risk in a national Swedish sample, J. Reprod. Infant Psychol. 23 (2) (2005) 155–166.
[8] WHO, WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience, 2018.
[9] T. Anderson, Feeling safe enough to let go: the relationship between a woman and her midwife during the second stage of labour, in: M. Kirkham (Ed.), The Midwife–Mother Relationship, Palgrave Macmillan, Basingstoke, 2010.
[10] M. Healy, V. Nyman, D. Spence, R.H.J. Otten, C.J. Verhoeven, How do midwives facilitate women to give birth during physiological second stage of labour? A systematic review, PLoS One 15 (7) (2020), e0226502.
[11] M. Edqvist, I. Hildingsson, M. Mollberg, I. Lundgren, H. Lindgren, Midwives' management during the second stage of labor in relation to second-degree tears—an experimental study, Birth 44 (1) (2017) 86–94.
[12] M.L. Kopas, A review of evidence-based practices for management of the second stage of labor, J. Midwifery Womens Health 59 (3) (2014) 264–276.
[13] A.H.F.D. Sultan, R. Thakar, Perineal and Anal Sphincter Trauma: Diagnosis and Critical Management, 2007.
[14] V. Aasheim, A.B.V. Nilsen, L.M. Reinar, M. Lukasse, Perineal techniques during the second stage of labour for reducing perineal trauma, Cochrane Database Syst. Rev. 6 (2017), Cd006672.
[15] S. Downe, K. Finlayson, O.T. Oladapo, M. Bonet, A.M. Gulmezoglu, What matters to women during childbirth: a systematic qualitative review, PLoS One 13 (4) (2018), e0194906.
[16] K. Dahlberg, H. Dahlberg, M. Nyström, Reflective Lifeworld Research, Studentlitteratur, Lund, 2008.
[17] M. Edqvist, H.G. Dahlen, C. Häggsgård, et al., One Plus one equals two—will that do? A trial protocol for a Swedish multicentre randomised controlled trial to evaluate a clinical practice to reduce severe perineal trauma {1}, Trials 21 (1) (2020) 945.
[18] A.J. Sundler, E. Lindberg, C. Nilsson, L. Palmer, Qualitative thematic analysis based on descriptive phenomenology, Nurs. Open 6 (3) (2019) 733–739.
[19] B.C. O'Brien, I.B. Harris, T.J. Beckman, D.A. Reed, D.A. Cook, Standards for reporting qualitative research: a synthesis of recommendations, Acad. Med. 89 (9) (2014) 1245–1251.
[20] A. Karlström, A. Nystedt, I. Hildingsson, The meaning of a very positive birth experience: focus groups discussions with women, BMC Pregnancy Childbirth 15 (2015) 251.
[21] I. Olza, K. Uvnas-Moberg, A. Ekström-Bergström, et al., Birth as a neuro-psycho-social event: an integrative model of maternal experiences and their relation to neurohormonal events during childbirth, PLoS One 15 (7) (2020), e0230992.
[22] I. Olza, P. Leahy-Warren, Y. Benyamini, et al., Women's psychological experiences of physiological childbirth: a meta-synthesis, BMJ Open 8 (10) (2018), e020347.
[23] L. Bergstrom, J. Seidel, L. Skillman-Hull, J. Roberts, "I gotta push. Please let me push!" Social interactions during the change from first to second stage labor, Birth 24 (3) (1997) 173–180.
[24] L. Kay, S. Downe, G. Thomson, K. Finlayson, Engaging with birth stories in pregnancy: a hermeneutic phenomenological study of women's experiences across two generations, BMC Pregnancy Childbirth 17 (1) (2017) 283.
[25] R. Reed, R. Sharman, C. Inglis, Women's descriptions of childbirth trauma relating to care provider actions and interactions, BMC Pregnancy Childbirth 17 (1) (2017) 21.
[26] A. de Jonge, D.A. Teunissen, M.T. van Diem, P.L. Scheepers, A.L. Lagro-Janssen, Women's positions during the second stage of labour: views of primary care midwives, J. Adv. Nurs. 63 (4) (2008) 347–356.
[27] R. Bluff, I. Holloway, 'They know best': women's perceptions of midwifery care during labour and childbirth, Midwifery 10 (3) (1994) 157–164.
[28] S. Meyer, Control in childbirth: a concept analysis and synthesis, J. Adv. Nurs. 69 (1) (2013) 218–228.
[29] J.M. Green, H.A. Baston, Feeling in control during labor: concepts, correlates, and consequences, Birth 30 (4) (2003) 235–247.
[30] L. Vandevusse, Decision making in analyses of women's birth stories, Birth 26 (1) (1999) 43–50.
[31] I. Lundgren, K. Dahlberg, Midwives' experience of the encounter with women and their pain during childbirth, Midwifery 18 (2) (2002) 155–164.
[32] M. Bjelke, L. Lendahls, M. Oscarsson, Management of the passive phase of the second stage of labour in nulliparous women-focus group discussions with Swedish midwives, Midwifery 75 (2019) 89–96.
[33] C. Nilsson, O.A. Olafsdottir, I. Lundgren, M. Berg, L. Dellenborg, Midwives' care on a labour ward prior to the introduction of a midwifery model of care: a field of tension, Int. J. Qual. Stud. Health Wellbeing 14 (1) (2019), 1593037.
[34] D. Lupton, V. Schmied, Splitting bodies/selves: women's concepts of embodiment at the moment of birth, Sociol. Health Illn. 35 (6) (2013) 828–841.
[35] G. Lahood, From' Bad' ritual to' Good' ritual: transmutations of childbearing trauma in holotropic ritual, J. Prenat. Perinat. Psychol. Health 22 (2007) 81.
[36] R. Reed, M. Barnes, J. Rowe, Women's experience of birth: childbirth as a rite of passage, Int. J. Childbirth (1) (2016) 46–56.
[37] R. Reed, Reclaiming Childbirth as a Rite of Passage: Weaving Ancient Wisdom With Modern Knowledge, Word Witch Press, Yandina, Queensland, 2021.
[38] P. Simkin, Just another day in a woman's life? Part II: nature and consistency of women's long-term memories of their first birth experiences, Birth 19 (2) (1992) 64–81.
[39] L. Dixon, J. Skinner, M. Foureur, Women's perspectives of the stages and phases of labour, Midwifery 29 (1) (2013) 10–17.