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## NOTIONS OF YOUNG WOMEN WITHOUT CHILDREN ABOUT CHILDBIRTH

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*Aim:* The aim of the study was to find out what kind of imaginations and expectations of Hungarian young, childless women have about childbirth. In addition to mapping intentions and expectations, our questions focused on how they think about the circumstances, ways and types of childbirth and we asked them what they know about opportunities and procedures based on their previous experiences.

*Methods:* In our university research we conducted a qualitative examination using the method of depth interviewing young women about their birth plans (n. 154, 18–35 years old). The selection of interviewees was randomly recruited from the circle of acquaintances of university students. The data collection took place during 2016. The study used content analysis.

*Results:* In the case of randomly questioned women, the issue of the quality of birth is usually not part of either their primary or secondary socialisation. The source of imagination on childbirth is usually the media and negative family stories which describe birth as a dangerous and painful event and which mainly transform young women's attitudes to pregnancy and childbirth. Accordingly, the majority of interviewees do not consider themselves competent in their own childbirths, and intend to rely essentially on external authority.

*Conclusions:* On the basis of the examination it appears that the information obtained through formal and informal channels provide a rather distorted and unilateral image of the nature of childbirth, opportunities, and issues of competence, which do not facilitate real physical and psychological preparation for giving birth. This can influence the way and quality of birth-giving, the childbirth experience and, in the long run, the willingness to continue to have children.

**Keywords:** childbirth, planning birth, imaginations and expectations of birth, socialisation, competency of childbirth, way and quality of childbirth, depth interviewing, content analysis

### 1. Introduction

There are a lot of researches about whether women want a baby or not and, if so, how many, when, under what conditions, or if not, why. We also know that some of the

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desired children are not born – for economic, health, family or other social reasons. However, how young women think about giving birth and its connection to these data is less known. In fact, we do not even know how they think about the subject.

Theoretically, there are numerous pieces of accessible information available to parents-to-be on the nature of birth, fetal existence, pregnancy psychology, infant care, the importance of early attachment and imprinting. Both mainstream medicine and the alternative birth movement provide information, but it is mainly the latter one which puts increasing emphasis on psychology and perinatal science. It is also an important question whether information targeted at young women is reaching them and, if so, how they incorporate it into their thinking.

### **1.1. Theoretical background**

Our knowledge about birth and giving birth has extended not only in medicine, but also in social sciences and psychology. The researches of birth cultures in social sciences, both in the ‘traditional’ cultures (MEAD & NEWTON 1967; BLEDSOE 1990; VAN BOGAERT 2008) and in the modern societies (MARTIN 1987; OAKLEY 1984; GÉLIS 1991; DAVIS-FLOYD 2003) emphasise the significance of an emic approach and try to learn the experiences, the viewpoints and the interpretations of those involved and to compare them to the medical norms. Perinatal psychology, which – as a young interdisciplinary field – is part of perinatal science poses new questions about the issues of childbirth, giving birth (GOTTVALL & WALDENSTRÖM 2002; NILSSON 2012) or issues of the competence of the foetus (CHAMBERLEIN 1993; PIONTELLI 1996; ANDREK 2012), which question the procedures of modern birth culture fundamentally. The description of hormonal systems that are activated during childbirth raises countless new questions about today’s birth protocols (VARGA 2015; BUCKLEY 2015). Nowadays more and more attention is being paid to the emotional aspects of childbirth and the role of the professional and lay supporters of birth assistance (HODNETT et al. 2003; SZÉKELY 2016).

The new knowledge in the field of childbirth has been indicated in alternative birth movements from the middle of the 20<sup>th</sup> century, which clearly reflect the post-modern approach that emerges as part of the also criticised industrial and later consumer society. This movement shows its values not only in its ideas of birth, but also of alternative lifestyles (MATHEWS & ZADAK 1991; O’CONNOR 1993; COFFEY 2012). The image of the mother controlling her own body represents a new set of values and it has also become the subject of social studies (STANWORTH 1987; RAPP 1994).

Science is therefore keenly interested in the anomalies of the medicalised system of childbirth, attempting to redefine the birth culture, slowly (very slowly) incorporating the previously considered alternative methods (such as the use of warm water at labour, free movement and posture choice, continuous social support, tear prevention, responsive breastfeeding, complete rooming-in, etc.). However, these changes are known only by a small group of people – who are also looking for solutions that are less stressful for living organisms in other areas of their lives – since

the providing of information and access to it is highly privileged, haphazard and depends on certain professionals.

Since targeted researches suggest that there are correlations between ex ante expectations, preparation and certain preventive interventions (such as enema, shave, giving infusion, and episiotomy) (KISDI 2016) continuous social support – and the holistic approach commonly associated with it – walks hand in hand with less interference and better birth experience (KLAUS et al. 2002; CAMANN 2000; MEYER et al. 2001; SIMKIN & O'HARA 2002; SCOTT et al. 1999; GILLILAND 2002; STEIN et al. 2004; BASILE 2012; 14 studies are summarised by HODNETT 2002; furthermore CAUGHEY et al. 2014), and since the lifestyle and behaviour of the pregnant mother have an effect on the development of the foetus (WARD 1991, GAZZANIGA 1992, BLUM 1993, HUIZINK 2005), it is not irrelevant what presupposition, expectations and knowledge young adult women have.

There are relatively few researches available on how young women approach their prospective childbirth. These researches either studied their attitudes related to the fear of giving birth (CLEETON 2001; KISH 2003; NILSSON & LUNDGREN 2009; FENWICK et al. 2010; SAROLI-PALUMBO et al. 2012; STOLL & HALL 2013), or how they feel about certain interventions (LAMPMAN & PHELPS 1997; STOLL et al. 2009). In their study of 461 Canadian university female students Kathrin Stoll and Wendy A. Hall came to the conclusion that those who were afraid of giving birth considered it to be an unpredictable, risky and unnecessarily painful event, with a high chance of complications. However, women who were not afraid of giving birth were more critical of medical interventions and were more confident in their own competences (cited by SALLAY et al. 2015). In a previous study, STOLL and colleagues (2009) had questioned 3,680 female students about cesarean section and found that giving preference to a cesarean was also related to fear and how confident women were in vaginal delivery (cited by SALLAY et al. 2015). A Hungarian psychological study investigated non-pregnant and pregnant women as well with the method of an attitude-scale (SALLAY et al. 2015) and they found that the birthing-attitudes were closely linked to the specific aspirations and decisions about giving birth.

However, it is not fortunate to cite foreign researches in relation to specific expectations, because the Hungarian obstetrician system offers many possibilities and sets limits in other ways than elsewhere, and women's desire for autonomy is also shaped along other historical conditions.

## **2. Aim, method and sample**

In our university research we conducted a qualitative examination using the method of interviewing<sup>1</sup> young women about their birth plans (n. 154, 18–35 years old). In addition to mapping intentions and expectations, our questions focused on how they think about the circumstances, ways and types of childbirth and we asked them what

<sup>1</sup> Semi-structured deep interviews were made.

they know about opportunities and procedures based on their previous experiences. The survey was conducted in 2016 with the involvement of 18 well-trained university students.<sup>2</sup> The students were – starting with their own acquaintances – looking for additional interviewees based on snowball methods. Most of the respondents live in Budapest, the capital of Hungary, but many of them have moved to the capital from the countryside for reasons of study or work.<sup>3</sup>

In addition to the demographic and general questions, the questionnaire contained six research questions that were unfolded by interview questions. Our research questions were:

- 1.) What knowledge does the interviewee have about her own birth? (4 interview questions)
- 2.) What experiences about birth and giving birth did the respondents have during their childhood socialisation? (four interview questions)
- 3.) What experiences about birth and giving birth did the respondents have during their young adult socialisation? (five interview questions)
- 4.) What are the respondents' ideas, desires, expectations and plans about having a child? (six interview questions)
- 5.) What are the respondents' ideas, desires, expectations and plans about pregnancy and childbirth? (ten interview questions)
- 6.) What is the knowledge and opinion of the interviewed women about the procedures and opportunities related to pregnancy, childbirth and the post-partum period? (twenty-two interview questions)

All questions were expected to be answered, but neither the order of questions was bound nor the questions going further deep were excluded. The average length of an interview was 72 minutes. After transcribing the interviews we had half a year (in another semester) to generate meaningful data units, classify and order these units with the method of content analysis. This work is rather subjective just like the interview method itself, but as we continued to work together with the students, a wide range of research experiences and opinions prevailed in the content analysis.

In my paper I am going to reflect on those aspects of the research that focus on the effects of socialisation, early and present desires, plans, ideas, expectations and notions about childbirth, focusing on some of the top issues.

<sup>2</sup> The students of sociology and social studies (all female) were prepared in a university seminar for half a year by the research leader (Barbara Kisdi). The preparation included the introduction to the theoretical background, the methods of the research and the development of measurement tools.

<sup>3</sup> The place of origin and the circle of acquaintances of the students strongly influenced the circle of respondents, but since a qualitative research has no purpose of being representative, the criteria for sampling were only the age and the childlessness. In the sampling frame only the age was determined proportionally. The aim for every student was to make ten interviews during the summer holidays, but only the first three could be her personal acquaintance, the other respondents had to be recruited from the interviewees' acquaintances.

General characteristics of the sample: 74.6% of the respondents (115 people) are likely or definitely want to give birth to a child,<sup>4</sup> 18 are not, the others do not know. In the sample the ratio of highly qualified people is over-represented: 42 persons (27.3%) have a higher education degree and currently 43 persons (27.9%) are studying in higher education. Their lowest level of education is secondary level. In the sample there are 12 married persons, three divorced ones, 70 single ones and 69 live in partnerships. According to their own declarations, none of the respondents had had either abortion or miscarriage, so no one had had any negative experience in this area. They considered the state of their health predominantly 'excellent' (86 people) or 'rather good' (64), and only four respondents considered it 'rather bad'. No one considered it 'very bad'. In the future 85.2 percent of the interviewed people (98/115)<sup>5</sup> intend to give birth naturally (some people – 24 persons – mainly because of their concerns about a caesarean section and not because of a theoretical decision). Nine of them already know that for health reasons they will have to have a cesarean section, and eight of them – fearing the possible inconveniences of childbirth – would rather have a cesarean section.<sup>6</sup> According to the interviewees the concept of natural birth does not typically mean 'normal birth', that is birth without interventions,<sup>7</sup> but vaginal birth, so in most cases the category 'natural' may include drug-pain relief and artificial acceleration of the birth. What it means is that vaginal birth is still considered natural despite the fact that the procedure includes medicalised techniques that lead to pain reduction or elimination.

### 3. Results

As a qualitative study, the disclosure of results does not basically aim to evaluate numerical data but interprets the general tendencies of the randomly selected group of young women's thinking.

#### 3.1. Socialisational effects

When we want to learn about birth concepts, it is worth studying the relationship of the interviewees to their own births. Hungarian psychologists have found a clear correlation between the positive interpretation of one's own birth and their attitudes to childbirth:

<sup>4</sup> Desire for the child usually appears much earlier in women than the conscious intention and targeted information search (ANTOINE 2010).

<sup>5</sup> 115 are planning (likely) to give birth to a child, 98 of them plan 'natural birth'.

<sup>6</sup> STOLL and colleagues (2009) in their study of 3,680 persons have found that Canadian women who favour elective cesarean section would be opt for a cesarean section because vaginal delivery appears to them as dreadful, unpredictable and dangerous.

<sup>7</sup> About the issues of normal birth NOVÁK 2015 and *Making Childbirth a Positive Experience: New WHO Guideline on Intrapartum Care* (retrieved 27 April 2018 from <http://www.who.int/reproductivehealth/intrapartum-care/en/>).

The more positive birth experience [the respondents] had heard about from their mothers, the less anxious and the less avoidant as well as the more approaching attitudes they held towards their own future delivery. They were also more likely to regard delivery as a life event with a potential for [personal] growth.<sup>8</sup> (SALLAY et al. 2015, 305)

In the random sample we examined, the women knew little about the circumstances of their own birth and did not know what experience their mother had had of pregnancy and childbirth.

About half of the respondents knew nothing about their birth and the other half includes those who only knew about the events in general terms;<sup>9</sup> those whose complicated birth story survived in the family memory; and those who knew the story of their birth in detail. The last group had a more emotional report from their mother. The latter was the smallest group, with only five people. Experimenting with one's own birth story can give a girl or woman the opportunity to think about giving birth as a positive event, as a natural part of life, especially considering that other possibilities are less available (as the subject appears hidden, distorted or dramatised in media or in children's books).

Among the early experiences we also made inquiries about enlightening talks that took place at school, which, in principle, sought to supplement, clarify or complement the knowledge transmitted within the family. Although in Hungary family life education – also sex education – has been included in the curriculum since the 1990s, the content of the information to be provided and the expectation of the transferor are still not standardised and there is no positive feedback received from the students either (SEMSEY 2016). Within this framework, it would be possible to talk about giving birth in a way that does not cause fear, but awakens curiosity and a healthy expectation in the potential mothers of the future. Existing related professions, which intend to present the nature of birth and giving birth, still reach schools only on private initiatives. Although it would be important to present the positive emotional side of childbirth and to tinge the personality shaping potential of becoming a mother or a father, these topics have never been the focus of the enlightening lessons in the interviewees' reports.<sup>10</sup>

<sup>8</sup> Translated by the authors, Viola Sallay and Tamás Martos. Original text: 'Minél pozitívabbnak ismerték édesanyjukon keresztül saját születésük élményét, annál kevesebb félelem és távolítás, viszont annál több közelítés élt bennük a saját majdani szülésükkel kapcsolatban, és annál inkább tekintették növekedési lehetőségnek a szülést mint élethelyzetet.'

<sup>9</sup> 'As I know I was born healthy, naturally. Everything was right, there were no complications, my weight was fine. And that's all.' (VK1,22). Following the interview details the interviewer's monogram, the interview number and the interviewee's age are indicated.

<sup>10</sup> Today we know of civil initiatives which offer lectures and programmes for students of both lower and higher education, using the methods of drama pedagogy, which reveal the characteristics of sexuality, conception and birth in an age-group in a friendly way and emphasise the importance of a conscious relationship of the individual to his or her own body. These programmes are not compulsory, they are not included in the curriculum, and students can take part in the sessions at the request of the parents in charge. Availability is yet restricted and providing the opportunities is up to the school leaders.

In relation to childbirth, the interviewees were primarily concerned with maternity pain, mainly because the presentation of the pain of birth without interpretation is more likely to have a negative impact on the perception of the whole birth experience:

*I went to a sociology class and our teacher thought we should watch a birth movie [Silent Scream]. This was the point where we lost interest in this topic. [The birth of dogs and kittens] do not disturb me, I have no problem with that. The woman's screaming was more annoying in the movie. The cats did it silently. (TG 6,25)*

Most commonly, however, they did not attribute any significance to school-based enlightening lectures, they just took note of it, got over it or simply considered it awkward. Several people reported that human reproduction was simply left out of or skipped in the curriculum by the biology teacher.

Births in family or among friends left a deep impression in the respondents mainly when they encountered negative reports. In 33.7 percent of the cases (52 people) complications, an unexpected cesarean section and great pain were referred to as deterrent events. The positive effects did not derive from a good birth experience itself, but primarily from the fact that a woman gave birth and a child was born: in our case 20.7 percent of the respondents (32 people) suggested that they also felt after a birth report that they wanted to experience this great moment. It is typical that positive effects are much less based on concrete experiences than negative impacts. However, the majority of our interviewees felt that birth stories in their surroundings had no significance: they either did not know the story or did not care about it. Nevertheless, the effects of the narratives' motives which form young women's attitudes to pregnancy and birth and which describe the birth experience as dangerous and painful are not negligible.

### **3.2. Knowledge about labour and childbirth**

About one-third of our interviewees thought they had as much information about giving birth as their non-child-bearing peers, one third thought less and one third more. Few believed that their knowledge on the topic should be extended before pregnancy. Their own classification did not have a clear correlation with either their age or planned date of birth giving or the extent to which they were actually informed about giving birth. Although almost everybody thought it was important to prepare for pregnancy and childbirth, it only meant that the mother had to quit cigarettes and alcohol (if she was a user), eat healthy and limit her physical burden. That is, the preparation did not primarily concern child-bearing, welcoming the baby and building a relationship with it, but the project of having a child itself. The importance of psychological preparation has been emphasised by only a small number of people (18),<sup>11</sup> although the fear of body and lifestyle change and the probable difficulty of meeting maternal tasks make far more women uncertain (68 people). The lack of mentioning mental preparation is also a strange factor since in the

answers to our question about the conditions of having a child the importance of being ready to become a mother was emphasised. In other words the importance of mental readiness appears theoretically but there are no concrete ideas about its practical implementation.

There were many questions about how the interviewees imagined pregnancy, labour and birth. The ambivalence of pregnancy is a very strong motive: the coexistence of fear and joy, inconvenience and expectation characterises the narratives.

*I often wonder when I see a pregnant woman, oh, she is expecting a baby, how nice this whole process may be, but to be with a baby surely tires the body out very much and on top of that you also have to deliver that child. (BT 10,23)*

*I've always thought of this as a condition and that, so I don't know, a lot of people consider it as if it were a disease. She's got a backache, it's okay, so, of course, she can have a backache, but anyway this is a good thing because at least there's a little life. (MD 3,26)*

The image of pregnancy is typically a reflection of the narratives and interpretations of the circle of acquaintances and the media, which often give rise to internal debate and tension in young women. Among the most important criteria of a happy expectancy a safe relationship, a solid financial background, and a deliberate choice of parenthood were mentioned, in this order.<sup>12</sup> The women who want to have a baby basically imagine the expectancy as a delightful and extraordinary experience, but the terms 'burdensome', 'stressful', 'terrible', and 'awful' often appear when talking about the first and the last stages of pregnancy:

*I think it's a very burdensome thing, so it's very stressful for the human body. Although it can also be interesting, as my mother said, that a little alien is growing and moving in the belly of a woman and this is a completely different experience of life, if so . . . such a . . . raising and carrying a life for nine months . . . (OK 7, 30)*

Fear of labour is reflected on a large scale in our respondents' answers, where labour is described as a physically and mentally depressing process full of suffering and frustration – not even one positive feature was mentioned. According to most interviewees an ideal labour is painless and quick, which, in their view, is primarily due to drug-pain analgesics. Alternative pain relief options (free body positioning, warm water, walking, massage, belly-pack, sitting on a ball or holding on to a rope, clinging to the wall bars, etc.) were heard of by few, but in response to our specific targeted questions nearly half of our interviewees considered them as an option. The

<sup>11</sup> The majority of these 18 women belongs to the 'older' age group (over 30) and has a higher education qualification. They all live in partnership (two are married) and feel their state of health excellent, but because of the small size of the sample, far-reaching conclusions can not be deduced from the coexistence.

<sup>12</sup> Whereas when asking them about the deliberate choice of parenthood the first condition of the list was solid financial background.



other half of the interviewed women kept their distance from the question, but in 19 cases<sup>13</sup> they had a particularly negative attitude:

*I don't know, this wandering labour sounds pretty exotic, since I think, at least when you're in labour, I don't think such a complex movement as getting from A to B and back can easily be done. So, I don't know, the easiest and most practical way seems to be lying down.*<sup>15</sup> (MD 4,22).

The typical attitude of our interviewees was that it only depends on an individual preference of how to be in labour (that is, without saying it, they questioned labouring in a certain framework), and also emphasised that this is a non-predictable question and the use of options depends on the given situation.<sup>15</sup>

In terms of childbirth, the feeling of dichotomy is the most typical one, as one interviewee summed it up briefly: *'Fifty percent pleasure and fifty percent fear'* (OK 10,25). Talking about childbirth phrases like 'waiting', 'curiosity', 'beautiful', 'experience', 'makes sense' appear but the imagined birth is mostly described as a medicalised event where the woman is lying, following the instructions of the specialist and the doctors performing the necessary *surgeries* (this term was used by 36 persons to refer to episiotomy, caesarean section and post-natal 'recovery'). When describing the ideal birth, they usually emphasised the lack of any negatives and not the birth experience itself.

Concerning the parents' presence in the labour room, everyone knew that the father could accompany the mother at the moment of birth, but many were not sure whether this was the same in the case of the labouring process. Anyway they generally attributed much greater importance to giving birth than to labour. One third of our interviewees could not tell who the midwife is and the rest mostly regarded her as a physician assistant. A minor part of the latter thought she is a female obstetrician, and only 28 people referred to her as a labour and childbirth care provider who is a key figure in the process of childbirth.<sup>16</sup> The idea that during childbirth the woman

<sup>13</sup> Although the small sample also needs to beware of the general characterisation of respondents, this group has two exceptions for the 'younger' age group (under 30) and most of them finished their secondary studies. They did not know anything about their own birth or just that they were born in a hospital and everything went well. They considered their health status excellent or very good. Their attitude against alternative analgesia was explained by their much stronger confidence in 'normal', 'conventional' procedures.

<sup>14</sup> Since the foetus and the uterus weigh heavily on the abdominal veins and damage the blood vessels of the lower body (VARGA & SUHAI-HODÁSZ 2002; KITZINGER 2005), and the feeling of pain is smaller in a vertical position (DE JONGE et al. 1997), the lying backward position serves more the examinations and the assistance than the mother. That is why the horizontal labor and birth position is not a characteristic of any 'traditional culture' (KITZINGER 2005).

<sup>15</sup> In Hungary few hospitals are trying to satisfy this instinctive need; basically, the possibilities for the labouring woman depend on the midwife's and the doctor's own individual attitudes.

<sup>16</sup> The WHO made a proposal on obstetric interventions in 1985, and point 7 states that the training of midwives should be promoted. Managing the normal delivery is their job (World Health Organization 1985). These recommendations are regularly updated by the WHO. The last one has been displayed since February this year (WHO Recommendations. Intrapartum care for a positive childbirth experience. Retrieved 21 Feb 2008 from <http://apps.who.int/iris/bitstream/10665/260178/1/9789241550215-eng.pdf?ua=1>). However, it is important that the recommendations were published in 1985 and since then have become the reference basis for postmodern birth culture.

in labour is surrounded by a ‘complete medical team’, supported by assistants and nurses often (in 25 cases) came up. The latter were often mixed up with the midwife. Six people thought that there is a surgeon present at birth who is doing the episiotomy. A total of four people heard of doulas.

We asked questions about several methods of obstetrics which are at the centre of the discourse on childbirth both in professional and nonprofessional circles (such as shaving, enema, drug pain relief, EDA, artificial rupture of membranes, oxytocin infusion, episiotomy – as well as alternative procedures which are important points of debate between the representatives of alternative birth patterns and hospital practitioners) and we were wondering what the interviewees knew about these procedures and what their views were about them. To sum it up: our interviewees relied on uncontrolled information – mostly on hearsay and assumptions, which also appear in the way they put it:

*Well, enema . . . My mom told me she got it with my sister, but my sister was so low that it didn't help. But anyway, I think these are very important. It's a basic thing, so high-demanding, I think. But I think this is no longer a question in hospitals today. (LL 9,27)*

There was usually a great deal of consensus on shaving and enema, because ‘*I demande to be arranged and clean at giving birth, inside and outside as well. I don't want to become ridiculous on the birthtable*’ (KB 2,31). The unnecessary of these two procedures<sup>17</sup> were mentioned in only nine cases, and further 27 people expressed their ambivalent relation to one or both of these procedures – but without mentioning a specific reason.

Episiotomy was mentioned by our interviewees as the most feared intervention, but little is known about the fact that it is practically a routine with primiparas, but it is also very often used with multiparas.<sup>18</sup> The majority believes that this is certainly an intervention that the obstetricians perform only for a good reason because of its unnatural and long-term effects.

### 3.3. Competences of giving birth

According to the birth-experience researches, the mother's need to take charge of her own birth appears to be of great importance, but it does not mean some kind of cognitive control, but the subjection to the natural, spontaneous birthing process and also

<sup>17</sup> In the WHO's proposal shaving and enema are also among the processes to be avoided (1985).

<sup>18</sup> In Hungary the rate of episiotomy was 61.96 percent in 2012, where the estimated rate for primiparas is above 80 percent. There has been no official data since 2012. (Retrieved 21 Aug 2015 from <http://www.csaszarmetszesek.hu/gatmetszesek-aranya-korhazankent-2012-ben-2>). The WHO recommends that episiotomy should be avoided in the case of primiparas too and tear prevention should be used (1985). Also, in the WHO 1996 Handbook on Nursing, the acceptable rate of episiotomy was 10 percent (Maternal and Newborn Health/Safe Motherhood Unit (1996): *Care in Normal Birth: A Practical Guide*, retrieved 04 Nov 2014 from [http://www.who.int/maternal\\_child\\_adolescent/documents/who\\_frh\\_msm\\_9624/en/](http://www.who.int/maternal_child_adolescent/documents/who_frh_msm_9624/en/)).

decisiveness. When the woman has the information she needs, when she is not looking for external control and when she is provided with an intimate environment, her own – not conscious – control, which has a positive effect on both the delivery outcome and the childbirth experience (ARMSTRONG & FELDMAN 2007; ODENT 1999; STADELMANN 2013), is sufficient. This correlation raises the very complex problem of the place and mode of childbirth.

Except for the Netherlands, in Europe, as in Hungary, there is a small proportion of women giving birth outside the institutions. In Hungary the proportion of the pre-planned, professionally assisted homebirth ranges from 0.1 to 0.2 percent, although, a regulation of homebirth has been in force since 2011 (KISDI 2013; VARRÓ 2015). So it is not surprising that for the majority of our interviewees the place of birth was not an issue. The question is, however, if in their minds there is an alternative other than the hospital.

With five exceptions, all of our interviewees marked the hospital as *probably* the most ideal place for delivery. *Probably* because when talking about an unknown future event their opinion was that the safest place for delivery is the hospital.

These five interviewees raised the possibility of homebirth, although there was a great deal of uncertainty, no one had any specific knowledge about it. Our interviewees have come up with a number of contradictions, which are usually typical of their knowledge and preferences regarding childbirth:

*I really am thinking about homebirth, but since I said that the caesarean section is the most preferred by me, eventually I would consider which one. Furthermore, I really like this water birth idea, but then it means that I should give birth naturally, so . . . I do not know . . . Anyway if I have to give birth, I will be brave, I will find a psychologist with whom I can prepare, then I might choose birth in the water. And in a hospital, obviously. (MD 1,20)*

Those who prefer the hospitalised birth highlighted the importance of sterility, the resulting safety and the importance of experts: *'because there they know better what I need'* (VK 4,32), some of them even mentioned a private clinic or a clinic abroad where *'more attention and security'* can be expected for a big amount of money. A majority of those who prefer hospital birth, are afraid of delivery (94 people), primarily of pain, secondly of the whole process of birth and thirdly of the possible complications, episiotomy and caesarean section in particular. In the case of episiotomy the fear is about pain or the 'unnatural' mode of the procedure, and in the case of a cesarean the fear is about the fact that the baby comes into the world during a surgical procedure. The fear usually concerns the operation itself. Strangely enough, nobody mentioned the fear of defenselessness, although in our parallel guided questionnaire survey where the option categories included this option, a quarter of the respondents mentioned this type of fear among the possible categories in the first and second places.

Those who are not or less afraid of giving birth are more likely to look at the process as a natural event and less to rely on technical solutions. We wondered how

our interviewees wanted to release their tensions. Typically, we didn't have answers in which the way of overcoming their fear would be to deepen their own knowledge or gather information about the nature of childbirth, but rather to rely on the physician: the range of possible solutions was led by trust in the hospital's professional system and in the obstetricians, and in the case of believers, prayer. A typical answer was: *'I try not to stress about it, I try to relax, it can't be so horrible, others have survived it too'* (KB 5,28). Overcoming the fear of childbirth was largely imagined by trusting external authorities and by using the possibilities provided by medical science and medical technology.

Our questions included the following one: who should control the birth. The majority called the doctor as the leader or manager of birth: *'Well, I think the doctor, when – for example – I give birth for the first time, I don't even know what to do, and it's so good if he tells me what to do actually'* (TA 3,20). In one third of these cases, the doctor is considered as a key of the safety and success of childbirth, and two third did it in the absence of other alternatives: *'I do not know, maybe the doctors who are there at birth, I don't know, who else could it be'* (KB 5,31). Sometimes the doctor's preference was opposed by the presence of another helper: *'The doctor is there if everything is fine, if it is not, then comes the midwife'* (VK 4,32).

Twelve of the interviewees had no idea about the roles and the division of work during the delivery, therefore they expect someone to be there who is an expert in it. As for managing the birth 8 people considered the doctor and the midwife to be controllers of birth, 5 women said it is the common task of the mother and the doctor or the mother and the midwife, 24 people marked the midwife, 9 interviewees referred to the midwife or the doctor,<sup>19</sup> and only 4 thought that birth is not to be controlled, *'it runs by itself'*, or it is controlled by God. In relation to the significance of the question it was rarely mentioned (8 women) that the control of giving birth belongs to the mother or the mother's body, and only three responses considered it as the competence of the foetus.<sup>20</sup> The latter three did not exclude the possibility of homebirth. The preference of the midwife was usually explained by their being women or mothers themselves and by saying that *'the midwife is there all the time during the birthing process, so I would rely on her'* (KB 5,34). In this case the need for ongoing support is revealed by the researches (HODNETT et al. 2003), but it has not yet appeared in the public opinion.

It is common to attribute the tasks of a midwife to the obstetrician (constantly monitoring the position and heart tone of the foetus and the mother's pulse during labour), and the midwife is considered to be the obstetrician's assistant.<sup>21</sup> Few know

<sup>19</sup> In these cases the respondents did not know any the difference between the midwife's and the doctor's competences.

<sup>20</sup> In the nineties, Emma C. MOLNÁR (1996), a Hungarian psychologist and her colleagues, asked more than 100 pregnant Hungarian women about who they would rely on in the process of birthing, and then the researchers had similar results: firstly they would rely on the doctor, secondly on the midwife, thirdly on the relatives and fourthly on their own.

<sup>21</sup> In Hungary – with the exception of one hospital's attempt in the capital – midwives are not allowed to manage a delivery independently, although typically they assist the labour in the labour room. The doctor – who is mostly chosen and paid by parasolvency – takes over control at the beginning of the pushing stage.

what the midwife has to do, so no wonder that women consider the presence of a doctor as absolutely necessary. We also got a response that the midwife is a deputy of the obstetrician, but the tasks of the pushing stage (protecting the perineum during this period, counteracting the head of the foetus and receiving the baby at birth) were often attributed to midwifery competence.

As for the cesarean section, we asked them if they think mothers in Hungary are allowed to decide to deliver their baby by a cesarean section or not. The majority of our interviewees assumed that in Hungary mothers have the right to ask for a cesarean,<sup>22</sup> but most of them did not consider it a good solution because most of them preferred natural birth and considered cesarean section as ‘the final solution’ (though, as it has been said before, it is not uncommon that even though the cesarean section is considered a good solution because of the supposed painlessness and speed, they are afraid of it). Although we received the answer ‘*it should be a fundamental human right to ask for it*’ (HH 7,26), it is not typical that just for reasons of comfort a pro-cesarean section decision would be made. Nevertheless, lots of women emphasised (92 people, 69.7%) that, unfortunately, many women ask for it in Hungary to help their children to the world in this way – what they primarily consider to be the reason for the high number of cesarean sections. Fear of further health proceedings as a reason was only mentioned in two cases.

The most typical view about interventions (also preventive interventions) is that a labouring woman is not competent in deciding on childbirth issues because it is the doctors’ task, potential and duty:

*Basically, I think the doctor can judge whether an intervention is necessary or not, and no matter how well the woman gets the picture or how well she is informed about the subject, I think it is the job of the doctor to decide whether an intervention is needed or not. (MD 3,33)*

This viewpoint makes it difficult for women to look at themselves as an active and competent participant in their own childbirth and it – seemingly – does not require any preparation with information about opportunities and knowledge of the potential disadvantages and interconnections of preventive interventions. This is a problem because 42.8 percent of our interviewees (66 women) expressed their opinion that the process of childbirth as a whole is an essentially natural, satisfying and organic one, but self-subjection to medical competence leaves a little room for women to gain validity of this view:

<sup>22</sup> Which, of course, is not correct, as a caesarean section can only be performed with medical indication. What can be considered a medical indication is another question, because the extremely high proportion of cesarean sections can not quite be explained by the lack of maternal capacity of Hungarian women, and there is no official explanation for the large differences between the outcomes of hospitals. (In 2015, in Hungary, 39 percent of births, on average, ended with a cesarean section, which shows continuous increase. More recent data has not yet been published. Retrieved 21 Oct 2017 from [http://index.hu/belfold/2016/02/12/csaszarmetszes\\_szules\\_aranyok\\_infografika/](http://index.hu/belfold/2016/02/12/csaszarmetszes_szules_aranyok_infografika/)).

*Of course, it's not the same whether one lies on the birthing table for 16 hours or just one and a half, but I don't know, I think it's not practical to interfere with these things from outside, because nature has a very nice little law that usually works and I think it's a part of human foolishness that we want to interfere and we want to control from outside what otherwise goes by itself, just maybe a little slower. (MD 4,22)*

The accentuation of the importance of breastfeeding is rising nowadays, and we have more and more knowledge about the positive effects of mother's milk<sup>23</sup>, but breastfeeding indicators are still insufficient in Hungary.<sup>24</sup> 91 percent of the women we interviewed say that breastfeeding is important because of its naturalness, simplicity, and healthiness, but 73 percent of them say that '*not everyone is successful, not everyone has breast-milk*' (LA 2,24). This approach – that for some reason a woman does not have enough milk or the new-born baby can not or does not want to suck – can easily justify the introduction of supplemental or substitute food instead of asking for help from a lactation specialist – since this solution is not yet part of the operational mechanism of the Hungarian health care system. It is particularly problematic, because 96 percent of our interviewees say that the newborn needs supplemental food in the days following birth until the start of more abundant milk production. Only a total of three women knew that milk is initiated by the newborn's enduring breastfeeding, which, however, is made extremely difficult when offering supplemental food. Rooming-in was also introduced in Hungary in hospitals to support the mother and baby being together non-stop and this way help maternal breastfeeding,<sup>25</sup> but two-third of our respondents said that the mother's resting is important after birth and they are afraid that they will not be able to look after their baby expertly. So there is a remarkably high proportion of those who are afraid that they will not be able to handle their maternal duties in the first days without external help – as they also rely primarily on external authority when giving birth.

#### 4. Conclusion

Our research focused on the knowledge, expectations and attitudes of young, childless adult women in relation to childbirth. Of course, due to the method of sampling our results can not be generalised for all young Hungarian childless women, so its validity is high only among the respondents. However, it points out the context that was partly highlighted in previous studies, namely a strong correlation between socialisation impacts, concepts of childbirth and the interpretation of competence.

<sup>23</sup> American Academy of Pediatrics, 2012.

<sup>24</sup> Although according to the lactation experts 80 to 90 percent of mothers would be able to only breastfeed their children until the age of 6 months, this proportion was hardly above 37 percent in 2008, and it was only 34.8 percent in 2013 (big difference between the counties) (Központi Statisztikai Hivatal 2008, 2013).

<sup>25</sup> Instead of the outdated breastfeeding for the clock.

In parallel with previous researches (PIKÓ 2005; RAPHAEL-LEFF 2010; VARGA et al. 2011), we have found that facing the unknown and an internal uncertainty can easily lead to giving up the competences and shifting the responsibility, which fits the medical approach well. Women have little confidence in their own body – that the female body ‘can give birth’ (BÁLINT 1991). For women who have not yet had a birthing experience the physical process of birth is largely incomprehensible and uninterpretable, and because of its obscurity, they are afraid of it. This fear is reinforced by the lack of relevant knowledge about giving birth and the lack of a positive experience transfer. The confidence in medicalised birth largely responds to collective social fears that dramatise the death or the birth of a sick or disabled child (MOLNÁR C. 1996), as opposed to the introduction of the technology apparatus and medical expertise which are considered to be an adequate protection. Similarly to the results of STOLL and HALL (2013), we have found that in our sample the degree of fear of labour and childbirth is related to how much women want to rely on technical solutions. According to our study, those who are more afraid of giving birth are more likely to rely on medical knowledge and technology, while those who are not or are less afraid trust their own body’s functioning more.

On the basis of our quantitative research, it appears that the information obtained through formal and informal ways gives a fairly deformed and single-sided picture of the nature of childbirth, opportunities and questions of competence, which does not leave room for really preparing physically and psychologically for giving birth. If, during socialisation, girls met the issue of childbirth as a good and important opportunity of life earlier, and if they gradually gained access to differentiated knowledge about childbirth, they would probably have less fear and greater self-confidence when the time of giving birth really comes. This can influence the way, the quality and the experience of giving birth, and, in the long run, perhaps the willingness to continue to have children. Since the transfer of knowledge can not be influenced in the primary socialisation sphere, this is primarily on the task of the secondary socialisation environment, especially the educational institutions, where the involvement of experts in the subject can not be avoided.

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