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RESEARCH ARTICLE

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Fear of childbirth from the perspective of midwives working in hospitals in Norway: A qualitative study

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Abstract

Aim: To illuminate the perceptions of hospital-based midwives who support women suffering from moderate to severe fear of childbirth during an expected vaginal birth.

Design: A qualitative descriptive and explorative study.

Methods: Focus group interviews were conducted with 18 midwives representing four different hospitals in Norway.

Results: Encountering fear of childbirth evoked the desire to protect and help, although the ability to provide optimal support was dependent on several circumstances, several of which were beyond the midwives' control. The main theme "Midwives finding their own strength when encountering the vulnerability of women with fear of childbirth" consisted of two themes: "Being present" and "Being alone." The midwives described being present as a prerequisite for continuity of care and affirmation. The emphasis on continuity of care could give rise to a sense of loneliness and guilt during and after demanding situations in the birthing room.

KEYWORDS
childbirth-support, fear of childbirth, hospital-based midwives' perspective, nurses, nursing, perceptions, qualitative method

1 | INTRODUCTION

The World Health Organization European political framework—Health 2020 (WHO, 2013) aims to develop and support health services offered on equal terms to improve health and well-being for all. Healthcare services should be evidence-based and person-centred, promoting influence, dignity and individuality to achieve sustainable use of healthcare resources (WHO, 2013). Maternity care in high-income countries is characterized by unnecessary use of resources and over-medicalization of normal births (Miller et al., 2016). The WHO (2015) considers the increase in Caesarean section (CS) for non-medical reasons a global challenge, stating that vaginal birth should be the primary mode of delivery in normal pregnancies. The predominant reason for requesting a CS for non-medical reasons is fear of childbirth (FOC); (Nieminen, Stephansson, & Ryding, 2009). Caesarean birth increases the risk of complications to mother and child compared with vaginal delivery (WHO, 2015). With sufficient resources to support their autonomy and enhance their working conditions, midwives can contribute to demedicalizing maternity care (Ten Hoope-Bender et al., 2014).

2 | BACKGROUND

Fear of childbirth is described as anxiety evoked by thoughts of a future birth, ranging from normal concerns and excitement to severe phobic fear (Zar, Wijma, & Wijma, 2001). FOC is clinically significant when it requires extraordinary attention in the

healthcare system and affects a woman's daily life or relationship (Wijma & Wijma, 2016). Severe or phobic FOC may be such a strain that it deters women from pregnancy or vaginal delivery (Ryding & Sundell, 2004).

In a 2014 cross-sectional study from Northern Europe, the prevalence of severe FOC was found to be 11%. There were non-significant variations between nations and only minor differences between primiparous and multiparous women (Lukasse, Schei, & Ryding, 2014). Various causes of FOC are reported: Fear of pain, concerns about the baby, fear of death or injuries, lack of control and influence, fear of being left alone or being unable to cope (Nilsson & Lundgren, 2009). A previous negative childbirth experience or operative delivery may induce FOC (Lukasse et al., 2014). Women who found their childbirth experience unsatisfactory have described FOC as a result of poor or insufficient support during labour (Nilsson, Bondas, & Lundgren, 2010). A connection between FOC and a history of sexual assault, abuse or violence (Lukasse, Vangen, Øian, & Schei, 2010) and mental illness (Rouhe, Salmela-Aro, Gissler, Halmesmaki, & Saisto, 2011) has been identified.

There are few general guidelines and no consensus on how to treat FOC (Larsson, Karlström, Rubertsson, & Hildingsson, 2015). Norwegian hospitals have established outpatient counselling for women with FOC, but their effectiveness is not documented (Norwegian Ministry of Children & Equality, 2015). In Sweden, one recent study came to the conclusion that major differences in midwives′skills, comprehensiveness and the organization of support implies that treatment for FOC is not offered on equal terms (Larsson, Karlström, Rubertsson, & Hildingsson, 2016). Norwegian health authorities suggests that 20% of elective CSs in the Osloregion in 2015 were performed due to FOC (Norwegian Ministry of Children & Equality, 2015). Previous investigations concluded that CS does not necessarily improve the childbirth experience in women with FOC (Halvorsen, Nerum, Øian, & Sørlie, 2013; Hildingsson, Nilsson, Karlström, & Lundgren, 2011). Healthcare services provided to vulnerable, pregnant women should be characterized by continuity of care. However, the organization of maternity care in most countries means that the woman is attended basically by an unfamiliar midwife during labour.

Existing research indicates that women with FOC are at higher risk of complications due to prolonged labour with a subsequent need for interventions or operative delivery. Furthermore, it is suggested that FOC might complicate the communication between the birthing woman and the maternity staff (Adams, Eberhard-Gran, & Eskild, 2012). Caring for women with FOC has been characterized as resource-demanding and emotionally challenging, as the fear might be channelled in a behaviour perceived as provocative. Midwives consider themselves as main caregivers to women with FOC, but some hospital-based midwives express concerns about their own capacity in figuring out the needs of the individual woman (Salomonsson, Wijma, & Alehagen, 2010). There is a lack of recent research on midwives′ perceptions of FOC.

2.1 | Aim

The aim of the present study was to illuminate the perceptions of hospital-based midwives who support women suffering from moderate to severe FOC during an expected vaginal birth.

3 | METHODS

3.1 | Design

This study employs a qualitative method with a descriptive and explorative design (Polit & Beck, 2012). Data were collected via focus group interviews, a method described as suitable for gaining knowledge of attitudes, opinions, feelings and perceptions. Participants are invited to collectively share and reflect on experiences and issues perceived as significant in relation to a given topic (Liamputtong, 2011). Focus group methodology was considered useful for obtaining broad descriptions of supporting women with FOC through the trial of childbirth.

3.2 | Participants and setting

An invitation to participate in the focus group study was addressed to the head midwives at seven hospitals in Norway. Four hospitals gave a positive response and received further information in an e-mail, which they were asked to forward to the midwives in their unit. Midwives with a minimum of 2 years of experience at a maternity ward who were willing to participate were asked to contact the authors by e-mail or telephone. All hospitals have outpatient counselling for women with FOC. Only one hospital facilitates the presence of a familiar midwife in exceptional circumstances and solely in connection with induced labour. Eighteen female midwives attended four different focus groups, with 3–6 participants in each group.

3.3 | Data collection

The focus group interviews were carried out between May–August 2016. Each group met once at the respective hospitals for an average of 75 min. At the start of each interview, the main focus on perceptions of moderate to severe FOC was emphasized and definitions of the phenomena of interest were agreed on. An interview guide focusing on perceptions of challenges and options in supporting women with FOC during an expected vaginal birth was prepared. The main question was: "Can you please describe your perceptions of supporting women suffering from FOC during vaginal birth?" Several examples from practice were given. The unique group dynamic and insights resulting from interaction between the participants demonstrated that their levels of engagement were high in all four focus groups. The conversations took new and unexpected directions for development of perceptions. The author (M.T.) conducted and moderated the groups. A focus group interview requires skills on the part of the moderator to prevent individuals from dominating the dialogue, as well as eliciting contributions from quieter members. Most

TABLE 1 Example of analysis from which the theme "Being alone" emerged

Meaning unit—statements	Condensed meaning unit	Sub-theme	Theme	Main theme
"I felt I was doing such a bad job, because I never managed to calm her down. And in a way, I expect to be able to achieve that. I am used to doing a good job"	Expressing disappointment with one's own effort, feeling powerlessness when expectations are not met	Guilt	Being alone	Midwives finding their own strength when encountering the vulnerability of women with fear of childbirth

of the times group synergy and consensus occurred, but this was not always the case. An observer took notes documenting the group processes, as group interactions are considered a part of the data (Liamputtong, 2011). Both the moderator and the observer contributed to a summary at the end of each interview to validate the data collection. The interviews were recorded and transcribed verbatim by the first author, who also noted silence, laughter, nodding or other forms of non-verbal communication.

3.4 | Data analysis

Data were interpreted using conventional content analysis, described as appropriate when evidence is scarce (Hsieh & Shannon, 2005). The interpretation process followed the qualitative content analysis steps described by Graneheim and Lundman (2004). The transcribed text was read repeatedly in an open-minded manner to gain a sense of its content, patterns, similarities and differences. Descriptions of experiences and perceptions of supporting women with FOC were reflected on in the search for unique statements. Meaning units in the text were condensed, marked and grouped in categories in accordance with their interrelated content, which constituted the manifest content of the text. Furthermore, the categories were linked to underlying themes and abstracted into the latent content (Graneheim & Lundman, 2004). During the whole analysis process, the authors reflected and discussed together on the tentative interpretations and underlying meaning of the data. The identified themes were adjusted on several occasions. The main theme emerged and was synthesized in the last phase. Finally, a shared understanding was reached that is intended to describe the participants' perceptions. According to Lincoln and Guba (1985), trustworthiness of the findings is related to the researchers pre-understanding and interpretation of the statements. One of the researchers is an experienced midwife and was aware that her pre-understanding could influence the interpretation. The other researcher has a background as a mental health nurse. Direct quotations from the interview text were included to acknowledge the credibility of the study (Table 1).

3.5 | Ethical considerations

Approval for the study was granted by the Norwegian Social Science Data Service (NSD; 48090/16) and assessed by the Regional Committee for Medical Research Ethics but considered to be outside the remit of the Act on Medical and Health Research (2016/514). Permission to conduct the interviews was granted by the head midwife and manager at each hospital. The study was carried out in line with the World Medical Association Declaration of Helsinki—Ethical Principles for Medical Research involving Human Subjects (WMA, 2013). The participants received written and oral information and signed an informed consent form to confirm their voluntary participation. The confidentiality of the midwives was assured and information that could lead to the identification of any participant was omitted from the data. The observer also signed a confidentiality agreement. The midwives in the respective groups were colleagues. There was no private or professional relationship between the moderator and the participants (Table 2).

4 | FINDINGS

The participants in the focus group interviews had many years of working experience as hospital-based midwives. Analysis of their perceptions of supporting women with moderate to severe FOC during an expected vaginal delivery resulted in a main theme: "Midwives finding their own strength when encountering the vulnerability of women with fear of childbirth," consisting of two themes: "Being present" and "Being alone." These themes comprised of several subthemes, presented in Table 3.

The main theme and sub-themes highlight contradictions in the midwives' perceptions. Encountering women with FOC was described as wide-ranging; from childbirth were simple measures led to positive outcomes, to demanding and complex challenges. The midwives felt a great responsibility to contribute to a positive childbirth experience. The participants were used to successfully employing their personal and professional qualities when supporting women in labour but experienced that FOC required a significant degree of commitment and empathy. Although the midwives appeared to be very dedicated, they nevertheless found it challenging to summon their own strength when encountering the vulnerability of women with FOC:

TABLE 2 Description of the participants (N = 18)

Age	Mean: 49 years Median: 50 years Range: 31–62 years	30–40 years: 5 midwives 40–50 years: 4 midwives 50–60 years 6 midwives >60 years: 3 midwives
Experience as midwife	Mean: 18 years Median: 15.5 years Range: 2–35 years	2–10 years: 4 midwives 10–20 years: 7 midwives 20–30 years 3 midwives >30 years: 4 midwives

TABLE 3 Overview of the main theme, themes and sub-themes of midwives' perceptions of supporting women with moderate to severe FOC during an expected vaginal birth

Main theme	Midwives finding their own strength when encountering the vulnerability of women with fear of childbirth	
Theme	Being present	Being alone
Sub-themes	Promoting continuity Affirmation	Feeling locked in the delivery room Lack of collegial support and influence Guilt

> Finding the resources in oneself. That I think, can be the greatest challenge as a midwife. Which side of myself should I bring out and use when encountering a woman with FOC? (FgB)

FgA,B,C,D = Focus group A,B,C,D.

4.1 | Being present

This theme consists of two sub-themes: "Promoting continuity" and "Affirmation." The midwives had to be close to the woman to be able to identify and respond to her needs and wishes. Time and space to be mentally present in the delivery room were highlighted in all focus groups through the midwives' descriptions of being touched by the labouring woman, her story and the expression of the labouring body. Forming a picture of her, required presence and empathy. Being present was expressed as a prerequisite for continuity and confirmation.

4.1.1 | Promoting continuity

The hospital-based midwives described the lack of prior knowledge about the woman as a major challenge. However, they had the impression that most women with FOC had been to outpatient counselling where writing a birth plan was included as part of their preparation for childbirth. Personal wishes were described as concrete and self-evident, perceived as an expression of basic insecurity. The participants in this study considered the birth plans binding. A birth plan could prevent misunderstandings and contribute to continuity and predictability during labour. The midwives perceived many women as open and trusting. However, the groups discussed how some could not express themselves in words or how they might have suppressed stressful experiences. Subtle nuances and expressions were difficult to capture without continuity and paying attention to each individual woman. Challenges associated with being undressed, regression, dissociation, bodily reactions during vaginal examinations or other physical contact were perceived as a need for protection and support:

> We might not even be aware of their history. They are unable to express themselves and just sign out.

> Sometimes I just put two and two together and suspect things from their past. You become sensitive to the woman's reactions. (FgB)

The midwives described an obligation to limit absence and communicate availability and responsibility. Several focus groups referred to the change between shifts as a disturbing moment, both for labouring women and midwives, especially if this occurred during the second stage of labour. Given the opportunity, many midwives found it natural to stay with the women even if the birth took place after their regular working hours:

> There are some births where you just don't leave, but stay. (FgD)

4.1.2 | Affirmation

All groups stated that they emphasized affirmation by taking care of the individual woman with dignity, seeing her resources and facilitating dialogue. The midwives encouraged the woman to express her needs in words. They also stressed the importance of pointing out the woman's resources to raise awareness of her own capacity. The midwives were therefore eager to confirm the normality of the woman's situation. Recognizing the woman's fear and taking her perspective seriously were also described as crucial. Affirming, showing respect and understanding were often essential for gaining the trust and acceptance of the woman and her partner. Professional self-esteem and experience gave them confidence in their role as a midwife. The participants expressed that they had to convey calmness, conviction and faith in the woman's ability to cope. Involving the woman was described as an important prerequisite for making the birth a common matter for mother and midwife. Being held accountable and allowed to take charge was also an expression of affirmation. The significance of the woman's cooperation was discussed by all groups. Sometimes situations occurred where it was not medically defensible to comply with a woman's wishes. Some midwives found it uncomfortable to assume leadership and challenge the woman:

> Sometimes you just have to be a bit determined as well. That is also a part of midwifery.

> Yes, but if they feel that they are not met, they will only become more panic-stricken. At the same time as you tell them what is required you have to confirm them. That balance is hard. (FgB)

4.2 | Being alone

This theme concerns how midwives' emphasis on continuous presence might lead to a feeling of being alone. Staying close to the

woman requires courage. Failure to create a dialogue, cooperation and a common goal in the delivery room was described as challenging. Being alone with the woman reinforced a sense of personal responsibility, which could lead to an impression of loneliness. The midwives missed a system of formal support after demanding births.

4.2.1 | Feeling locked in the delivery room

All groups discussed relational challenges and how insecurity and distrust could make it difficult to establish the contact and trust they were accustomed to. The midwives wished to ensure continuity, but also expressed the need for relief in demanding situations. Despite additional follow-up in pregnancy, the midwives experienced that some women and their partners expressed great insecurity and lack of motivation. The woman could appear closed or clearly indicated her reluctance to face the actual situation. Some participants had experienced that the refusal to perform a desired CS was a difficult starting point for a vaginal birth. They described situations where birth partners conveyed distrust on behalf of the labouring woman. The midwives expressed understanding for the partners' anxiety and need for care, stating that they attempted to include them in the cooperation during the birth. However, insecurity communicated through criticism and suspicion could be experienced as humiliating and uncomfortable:

> I think it can be difficult in cases where there might have been a traumatic birth previously, where the dad behaves as a strict lawyer, making sure everything goes well for her this time! He is having a hard time, feels great responsibility and ends up being a bit difficult.
>
> Slightly aggressive. (FgA)

4.2.2 | Lack of collegial support and influence

This sub-theme illustrates how the midwives described lack of collegial cooperation and circumstances beyond their own area of responsibility as an obstacle to accommodating the woman's needs and wishes. The composition of the colleague team, the workload in the ward and the extent to which other midwives accepted that a woman with FOC could require more resources influenced their opportunity to provide proper care. Several groups discussed how they negotiated with their midwife colleagues to be permitted to stay with a woman with FOC. Lack of collegial support made it difficult to stay in the delivery room, while at the same time they found it difficult to leave. One woman's increased need for continuous follow-up could mean that another woman had to manage for a longer period on her own:

> We are contributing to fear of childbirth with all our rushing. We often have several women in active labour to care for. I think that's why we get women with fear of childbirth too, when there really should have been more midwives on duty. (FgB)

Another recurring theme was the midwives' experiences of stress when an anaesthesiologist was not available to administer a desired epidural. Although birth complications meant leaving the overall responsibility to a physician, the midwives still considered the birthing atmosphere as their concern. As a result of their presence and relationship, the midwives perceived that they were in charge of knowledge about the woman, which was important to transmit to others to meet her needs. However, the midwives'perception of what was best for the woman was not always acknowledged:

> If she hadn't given birth within a certain number of hours, we should go for a Caesarean section. But then the physicians decide to stretch the agreed timeframe even further and you just have to make the best of it!
>
> And it feels like an assault in the delivery room. Where should one´s loyalty be then? You are dependent on the patient's trust in the physicians too. (FgA)

The participants expressed powerlessness and lack of influence when they had to maintain their loyalty to both the labouring woman and the physician. The midwives felt dependent on the labouring couple's trust, while at the same time they were subordinate to the physicians, a combination that could leave them with a feeling of having limited space for action:

> You lose your grip, bit by bit. She loses herself, bit by bit – and then there is no progress! You have exhausted yourself, thinking: "From where should I get the strength?"
>
> You really just want to leave the delivery room, feeling: "I have nothing more! I don't know what else to do now!". It is a traumatic experience! (FgB)

4.2.3 | Guilt

Guilt refers to the midwives' experiences of self-blame and frustration for being unable to anticipate or prevent difficult events during childbirth. Some participants expressed that their feeling of guilt could be perceived as irrational, as they had done their best within their area of responsibility. The feeling of failure was thus reinforced, which contrasted with the work satisfaction and confirmation the midwives usually experienced:

> I felt I was doing such a bad job, because I never managed to calm her down. And in a way, I expect to be able to achieve that. I am used to doing a good job. (FgB)

The participants in this study highlighted a particular responsibility in relation to women with a history of abuse. Several midwives had experienced how events during childbirth became a reminder of a previous trauma and described feeling guilty and concerned for being unprepared. Challenges related to vaginal examination and the second stage of labour were a recurring theme in all the focus groups, sometimes related to a feeling of having contributed to an assault:

> I would have liked to examine her because there had been an issue with the foetal heart rate, but I just had to give up. She crawled to the top of the bed in a complete panic! It was heartbreaking to see her. I have thought about it for years afterwards.
>
> Midwives shouldn't take the attitude of worshipping vaginal birth and promoting it at all costs. Some might be better off with something else. (FgC)

5 | DISCUSSION

The aim of the present study was to illuminate the perceptions of hospital-based midwives' who support women suffering from moderate to severe FOC during an expected vaginal birth. The overall theme "Midwives finding their own strength when encountering the vulnerability of women with FOC" reflects midwives' perceptions of having to mobilize an extraordinary level of personal and professional involvement. The two themes "Being present" and "Being alone" refer to contradictions in the midwives' experiences. The midwives described their job as meaningful and expressed a need to be present with the woman, while at the same time, continuous presence could lead to a feeling of being left alone in demanding situations. The findings highlight the complexity and contradictions in relation to the ideals of midwifery care, where the mother–midwife relationship is central (Berg, Olafsdottir, & Lundgren, 2012; Lundgren & Berg, 2007). The findings also show how organizational and collegial relationships influence the midwife's ability to support women with FOC.

Hospital-based midwives´description of encounters with FOC as wide-ranging might be because women with FOC are a vaguely defined group. Some midwives also argued that the complexity of FOC is primarily expressed when the woman is in labour. Few opportunities for comprehensive and continuous care by the same person(s) throughout pregnancy and childbirth caused the midwives in this study to consider birth plans as an important source of information. In the encounter with an unknown, vulnerable woman, the birth plan served as an aid to clarify important needs and wishes. This finding partly contradicts a Swedish study of midwives' perception of FOC (Salomonsson et al., 2010), where detailed birth plans were described as an obstacle to a natural approach to the woman. This result may be supported by the findings in the present study, as the participants found it difficult to deviate from the birth plan. The women's expectations were often closely linked to the contents of the birth plan. According to Lundgren, Berg, and Lindmark (2003), the birth plan does not improve the experience of birth for most labouring women, but has a positive significance for women with FOC. When the birth plan is perceived as an aid and a contribution to continuity between pregnancy care and birth, both midwives and labouring couples can experience it as a "breach of contract" in situations where the expectations cannot be met.

Salomonsson et al. (2010) found that midwives perceived supporting women with FOC as emotionally challenging, especially where fear was expressed in a provocative way. The participants in this study did not mention provocation, but on the other hand described distrust and demanding dialogue as uncomfortable, evoking a feeling of *being alone* with the responsibility. Midwives' experiences of difficult interactions with labouring women and their partners are sparsely elucidated in previous research. Lundgren and Dahlberg (2002) highlight the risk of emotional fatigue among midwives when the labouring woman does not exhibit participation and co-responsibility during childbirth. Midwives in this study considered that refusal to perform a desired CS could provide a challenging starting point for dialogue. One study describes how women with FOC who were refused a desired CS felt humiliated and ignored in the encounter with healthcare professionals. However, if their story was taken seriously and respected, it could contribute to a changed attitude towards childbirth (Ramvi & Tangerud, 2011). This might indicate that the woman's motivation for vaginal birth reflects the support and understanding she encountered during pregnancy, in addition to her experience of being in control. When the maternity care encounter became a refusal to perform the desired CS, it is reasonable to assume that the woman also feels insecure about whether she will have any influence during the birth. *Affirmation* in form of individual care and an invitation to participate in decision-making is prominent in studies where women with FOC described positive experiences. Furthermore, feeling ownership of the birth of their own baby seems to affect these women´s experience of self-worth (Lyberg & Severinsson, 2010a). A restrictive attitude towards CS may entail situations where women and healthcare professionals have different perceptions of what is best for mother and child. Women and couples with low motivation for vaginal birth are in great need of information and support. Offering women with FOC a familiar midwife can help them to feel safer and more motivated for vaginal birth (Lyberg & Severinsson, 2010a).

The midwives experienced a relationship between *continuous presence* and the quality of care they could provide. Continuous presence for women with FOC was described as a prerequisite for identifying individual needs as well as for establishing and maintaining the relationship with the woman. This perception is also in line with the findings of Salomonsson et al. (2010). The significance of the midwife's ability to be present is also confirmed by women (Lyberg & Severinsson, 2010b; Sydsjö et al., 2015). It is therefore worrying that several midwives described a lack of opportunity to be present as much as desired. Having to negotiate with other midwives to be permitted to stay with only one woman was perceived as an

ethical dilemma. Different ideologies and practices among midwives are described as a possible barrier to continuity in maternity care (Aune, Amundsen, & Skaget Aas, 2014). These findings are worrisome, as lack of care and support is a recurring issue in descriptions of negative childbirth experiences (Nilsson et al., 2010). A promise of induction, an epidural or the possibility to change from a planned vaginal birth to a CS might be a prerequisite for feeling safe enough to wish for a normal birth. It is a paradox that a promise of intervention can be agreed on, while the presence of sufficient personnel and resources for continuity of care cannot be guaranteed to the same degree. Findings in this study may indicate that the staffing and organization of maternity care does not cater for women with FOC, despite the desire of health authorities to limit unnecessary CS and visions of one-to-one support for all women in active labour (Norwegian Ministry of Health, 2009). The responsibility for a safe and positive childbirth is left to the midwife on duty, who is expected to handle the task within an ordinary framework. A childbirth service that guarantees interventions rather than continuity and interpersonal support can be seen as an example of how the biomedical paradigm has come to dominate modern maternity care (Blaaka, 2002).

The participants emphasized different expressions of *affirmation* as a central starting point for gaining trust. The core of high-quality maternity care has been described as midwives' genuine desire and ability to adapt to the needs of each individual woman while caring for her with dignity (Halldorsdottir & Karlsdottir, 2011). The present findings indicate that it is not a matter of course that hospital-based midwives always live up to the theoretical ideals of care. The participants in this study described the absence of support due to a heavy workload or disagreement with other personnel as unsatisfactory. The midwife's autonomy and influence are of great importance for the continuity of women-centred maternity care (Severinsson, Haruna, Rönnerhag, & Berggren, 2015). It is probably essential that the midwife herself feels independent and supported by collegial cooperation to convey confidence and support women with severe FOC. Poor interaction and inadequate communication between healthcare professionals poses a significant safety risk in maternity care (Lyberg, Dahl, Haruna, Takegata, & Severinsson, 2017).

A central finding in this study was the midwives' sense of *guilt* after difficult birth events. Several participants described perceptions of having contributed to violating the woman. Unintended violation in maternity care has been reported. Women in labour are considered particularly vulnerable because childbirth involves intimate body parts being touched (Lukasse et al., 2015). Several midwives described how the second stage of labour was perceived as challenging for women with a history of abuse. Halvorsen et al. (2013) found that nulliparous women who were exposed to rape as adults experienced reactivation of the violent trauma during birth. The maternity unit routines and procedures became reminders of the previous trauma for these women, regardless of whether the birth was vaginal or by means of CS (Halvorsen et al., 2013). This indicates how vulnerable some women may be when in labour and how challenging it can be for unprepared healthcare professionals to assist them. Strategies to uncover experiences of sexual violence are incorporated in Norwegian antenatal care guidelines (The Norwegian Directorate of Health, 2014). However, midwives in this study expressed concern that transparency about abuse is difficult for many women. The findings indicate a need for increased attention to maternity care for women with FOC, as well as to the consequences of violence and sexual abuse for reproductive health.

5.1 | Study limitations

The sample size is limited, and all participating midwives were native Norwegian women educated in Norway. Midwives with a special interest in FOC might have been more eager to participate. In focus groups, there is a risk of the participants adapting their statements to each other, or to their perception of the moderator's preferences. On the other hand, the participants in this study appeared to speak honestly and freely, exhibiting great enthusiasm in their discussions. The fact that the moderator is also a practicing midwife might have increased understanding and recognition of shared experiences, although there is also a risk of certain issues being taken for granted as common midwifery knowledge. Midwives representing different hospitals and units provided a wide range of experiences and perceptions that add to the trustworthiness of the study.

6 | CONCLUSION

Time and space to provide presence and individuality in maternity care are crucial for women with moderate to severe FOC. By conveying a midwifery perspective, this study adds relevant aspects that should be considered in the maternity care of women with FOC. In the absence of guidelines and practical arrangements at maternity wards, midwives have to develop their own strategies when supporting women with FOC. Encountering FOC implies facing vulnerability. The midwives felt great responsibility to facilitate positive birth experiences. Dealing with a woman's fear was experienced as professionally and personally demanding. The ability to offer optimal support depends on several circumstances, several of which are beyond the control of midwives. A personal sense of responsibility could give rise to loneliness and guilt. The midwives requested support and the results highlight the need for clinical supervision among hospital-based midwives. The results of this study reveal how midwives might lack the opportunity to be continuously present, even with women with FOC. Continuity and person-centred care are difficult to achieve if the ideology is not rooted within the entire staff, among managers and at organizational level.

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CONFLICT OF INTEREST

None declared.

AUTHOR CONTRIBUTIONS

Design: MT, AL. Manuscript preparation: MT. Conceptualization of the study: MT, AL. Analysis and interpretation of the data: MT, AL. AL supervised the study. The authors have agreed on the final version and meet at least one of the criteria recommended by the ICMJE (http://www.icmje.org/recommendations/).

ETHICAL APPROVAL

Approval for the study was granted by the Norwegian Social Science Data Service (NSD: 48,090/16). It was assessed by the Regional Committee for Medical Research Ethics, but considered to be outside the remit of the Act on Medial and Health Research (REC: 2016/514). The study was conducted in accordance with the WMA Declaration of Helsinki – Ethical Principles for Medical Research involving Human Subjects (WMA, 2013). Written informed consent to participate in the study was obtained from all study participants.

CLINICAL TRIAL REGISTRY AND REGISTRATION NUMBER

Not applicable.

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