



# The Subjective Experience of Pregnancy and the Expectations of Childbirth on a Medicalized World: a Qualitative Study

Rute Brites<sup>1</sup>, Odete Nunes<sup>1</sup>, Mónica Pires<sup>1</sup>, João Hipólito<sup>1</sup>

<sup>1</sup> Centro de Investigação em Psicologia (CIP), Departamento de Psicologia, Universidade Autónoma de Lisboa, Portugal

Corresponding author: Rute Brites | [rbrites@autonoma.pt](mailto:rbrites@autonoma.pt)

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## Abstract

**Background:** To become a mother represents, for many women, a challenging existential process. Women have to deal with countless changes and adaptations, which can be experienced as sources of imbalance but also as moments of personal enrichment. Currently, this process is influenced by the medicalization of pregnancy and childbirth, which may have positive or negative consequences to the individual experiences of pregnancy and childbirth.

**Goals:** This study aimed to deepen the understanding of the experience of pregnancy and expectations regarding childbirth in a group of women, in a context where pregnancy and childbirth are increasingly medicalized processes.

**Methods:** In this qualitative study, we used semi-structured interviews to collect data regarding the experience of pregnancy and regarding expectations about childbirth in a sample of women (n = 37), recruited in health care centres or obstetric clinics by research assistants. The individual interviews took place at their homes. Data resulting from these interviews, focusing on the relationship with the health team, the partner and the unborn baby, and on the moment of childbirth, were analysed using ALCESTE software. Two senior researchers, psychologists, conducted the content analysis. Investigator triangulation was achieved through independent content analysis by each researcher and subsequent discussion and consensual interpretation.

**Results:** Thirty-seven pregnant women were interviewed. Four classes emerged from the analysis: "Expectations about childbirth and baby health", "Significant relational experiences of the past", "Mother-baby relationship process" and "Health care in pregnancy". Results emphasize the desire of future mothers to have a quick childbirth, without stress and with minimal suffering and anxiety. Despite these worries, women described a positive subjective experience of pregnancy and a feeling of security related to the knowledge they attribute to health professionals.

**Discussion:** "Medicalization" seems to be perceived as positive and securing, with no mention to a sense of disempowerment or loss of control. Therefore, the existence of spaces for sharing disturbing experiences and expectations of childbirth is prophylactic, contributing to the creation of conditions that foster positive expectations and mitigate fears related to childbirth.

**Keywords:** Pregnancy, Childbirth, Medicalization, Expectations, Qualitative research, ALCESTE software.

## Introduction

To become a mother represents, for many women, the possibility of being fulfilled, although pregnancy can be a period of existential challenges (Larsson, Wärna-Furu & Näsman, 2016).

In the process of pregnancy, women have to deal with various body-related, psychological, behavioural and

social changes and adaptations (Justo, 2005). These changes can be experienced as sources of imbalance (altered body image, feelings of anxiety and stress) and also as moments of reorganization and personal enrichment (Canavarro, 2001). According to Correia (1998, p. 356), the experience of motherhood can be felt as "dangerous, painful, satisfying, interesting, or even important", depending on the characteristics of the woman and her cultural background.

Although childbirth is part of the process of pregnancy, it can be sometimes experienced as a separate and individual phenomenon, with its own expectations. Several studies have focused on these. For instance, Moore (2016), based on different studies, identified several expectations regarding: (1) self-behaviour (personal control); (2) support from partner, others or family; (3) health care; (4) baby health; (5) labour pain. These expectations can be either positive or negative. According to the literature in general, expectations about childbirth are positive (Pedreira & Leal, 2015; Peñacoba-Puente, Carmona-Monge, Marín-Morales, & Gallardo, 2016), though may become slightly more negative at the end of gestation, specifically at the level of personal control (the fear of losing it) and circumstances of childbirth (mother and baby's health). The desire for a quick and easy delivery, although painful, with little medical intervention, emerges (Pedreira & Leal, 2015).

Fear of pain is common to many women, regardless of the type of delivery chosen (natural/medical) (Fenwick, Toohill, Creedy, Smith, & Gamble, 2015; Gibson, 2014). Studies on childbirth fear have increased and show disparate levels ranging from absence of fear to very high values (Eriksson, Westman, & Hamberg, 2005; Zar, Wima, & Wijma, 2001). Some authors argue that this distress affects between 6 to 15% of pregnant women (Salomonsson, Gullberg, Alehagen, & Wijma, 2013), being associated with an increasing of the duration of labour (Adams, Eberhard-Gran, & Eskild, 2012).

According to some studies, the experiences of pregnancy and childbirth may trigger anxiety and stress (Lydon, Dunkel-Schetter, Cohan, & Pierce, 1996). Simões (2016) refers that worldwide, there are two hundred thousand women traumatized by childbirth who developed symptoms of post-traumatic stress, despite the medical obstetric advances.

There is also significant evidence of perinatal mood disturbances, namely, postpartum depression and parenting distress (Epifanio, Genna, De Luca, Roccella, & La Grutta, 2015). Research shows that experiences of pregnancy and depression during this period are

predictors of postpartum depression (Lanes, Kuk, & Tamim, 2011; Nagy, Molnar, Pal, & Orvos, 2011).

Currently, in the occidental countries, pregnancy and childbirth are medicalized processes. The increase in physical and human resources (obstetricians/gynaecologists) (Rocha, 2012) in the public and private sectors has led to a growing medicalization, reflected on the routine prenatal screenings during pregnancy (Lou et al, 2017) and on the growth in the number of scheduled caesarean deliveries, worldwide (Betrán et al, 2016).

This process of medicalization has consequences both on the experience of pregnancy and on the expectations concerning childbirth. From the beginning, the experience of pregnancy is influenced by medicalizing technologies and expert knowledge (Lou et al, 2017), with women's authority over their bodies being institutionally removed (Evans, Walters, Liechty & LeFevour, 2016). On the other hand, while some women react positively to the medicalization of childbirth, valuing all medical means of reducing pain, other women choose the vaginal and "non-medical" delivery in an attempt to keep the process under women's maximum control. This non-medical delivery may include a natural childbirth without measures for pain reduction, choosing a home birthing or auxiliary methods as hypnotherapy, water birthing, meditation or other interventions (Malacrida & Boulton, 2014). Though these perspectives (medical and naturalistic/alternative) differ substantially, both argue, in theory, for the empowerment of women in relation to decisions about childbirth (Malacrida & Boulton, 2014).

Given the growing ambivalence between women's positive valuation of technological innovations and the feeling of losing the authority over their bodies (Rudolfsdottir, 2000), we sought to deepen the experience of pregnancy of a group of Portuguese pregnant women and to understand their expectations about childbirth. Essentially, we set out to ascertain what factors are considered most important in the course of the pregnancy and what expectations are developed about the childbirth event.

## Methods

### Design

In this qualitative study, textual data were collected through semi-structured individual interviews, recorded and transcribed for later analysis. These interviews were conducted by different psychology research assistants, all of them briefed about the study goals. Interviews were conducted until achieving data saturation, as described by Grady (1998, cited by Saunders et al, 2017) and Hill, Baird, and Walters (2014) (it occurs when no new information is heard from the ongoing interviews).

Data were first analysed using the ALCESTE lexical analysis software (Reinert, 1990). Afterwards, two senior researchers (psychologists) conducted the content analysis. Investigator triangulation (Biggerstaff, 2012) was achieved through independent content analysis by each researcher and subsequent consensual interpretation.

### Participants

Research assistants in health care centres or obstetric clinics recruited adult pregnant participants (aged between 18 and 40 years-old), regardless of their gestation week. Those whose pregnancy was considered clinically at risk or with previous pregnancy interruptions were excluded.

### Materials

A semi-structured interview script was prepared to ascertain the experience of pregnancy and expectations about childbirth. This script, with five open-questions, was developed based on a literature review, namely, the works about childbirth expectations (Moore, 2016) and fear of childbirth (Fenwick et al, 2015; Gibson, 2014); and the current medicalization of the birth event (Helman, 2007; Rudolfsdottir, 2000). The first question focused on the representations of the experience of pregnancy and the expectations of the birth (*"How do you see the birth to come? What are your desires for your birth? Can you tell me how you experienced your pregnancy to this day?"*); the second on the experience of remarkable events in the past (*"Have you lived some special events in the past that*

*have marked? Can you tell me about them?"*); the third focused on the relationship with health care providers (*"How do you perceive your relationship with the care staff during your pregnancy?"*); the fourth on the relationship with the future baby (*"Please talk me about your relationship with the baby to be born."*); the fifth addressed the couple's relationship during pregnancy (*"How has been your relationship with your partner since the beginning of your pregnancy?"*). To characterize the sample, we used a socio-demographic questionnaire focusing on general personal data and on pregnancy (first vs. previous pregnancy, weeks of gestation).

### Data Analysis

First, participants' complete set of responses to the semi-structured interview were established as the *corpus* for ALCESTE analysis. ALCESTE (version 2018) examines digital textual data and extracts the most significant structures, producing textual statistics (Image, 2012). ALCESTE defines the Context Units (sets of text) and Elementary Context Units (UCE) (segments of text, sentences); second, it searches for the reduced forms in the text (simple words or fragments of word); then, it counts and crosses UCE and reduced forms, producing tables that separates analysable forms (full-words) from illustrative forms (syntax elements like prepositions, pronouns, conjunctions). Then, ALCESTE develops a descending hierarchical classification (HDC) (Reinert, 1990), which allows the creation of classes of text segments with similar vocabulary but also with vocabulary different from the text segments of other classes (Camargo, 2005). After this, the software organizes the data in a dendrogram, which presents the relations between classes. Finally, based on the previous analysis, ALCESTE runs a Correspondence Factorial Analysis. Based on the chosen classes, it shows the most characteristic text segments of each class, allowing the contextualization of the typical vocabulary, in each one. It allowed also the stratification of participants, by age, marital status, level of education and pregnancy (first pregnancy or not).

Following the ALCESTE analysis, two senior researchers examined all data produced, in order to conduct and interpret the content analysis.

## Ethical issues

The research protocol was approved by the National Data Protection Commission and the Ethics Committee of the Regional Health Administration. All participants agreed to participate voluntarily in the study after having been explained its goals. A written informed consent was obtained from all women, both for the interview and its recording.

## Results

The participant group is a community sample consisting of 37 adult (older than 17 years old) pregnant women (regardless of gestational weeks) who agreed to voluntarily participate in the study after having been explained its goals. Women ages ranged between 19 and 40 ( $M = 30.05$ ,  $SD = 5.30$ ). Twenty-five (69.4%) were married and the remaining 12 (30.6%) were single (*de facto* relationships). Most have completed secondary or higher education ( $n = 16$ , 44.4% in both groups) and just 4 (11.1%) studied up to junior high school. The primiparous accounted for 59.5% ( $n = 22$ ), the gestation varying between 10 and 41 weeks ( $M = 28.81$ ,  $SD = 6.87$ ). The ALCESTE software was used for analysing the complete corpus, formed by 37 individual interviews (define as the initial context units [ICUs]), totalling 16741 occurrences, corresponding to 2091 different forms (with an average of 8 occurrences per word). In the reduction of the vocabulary to its roots (simple forms), 497 Elementary Context Units (ECUs) were determined. The DHC retained 73% of the ECUs, organizing them into four classes, each consisting of at least 25 words.

The dendrogram initially produced a division into two *subcorpora*. One of these *subcorpora* incorporates class 1, coded as "Expectations about childbirth and baby health". The second was divided into two new *subcorpora*, one corresponding to class 2, coded as "Significant relational experiences of the past" and another that brings together class 3 "Mother-baby relationship process" and class 4 "Health care in pregnancy".

The first division into two *subcorpora* may express differences in discourse between what is experienced in

childbirth and what refers to the pregnancy process (including the classes related to past significant experiences, specialized follow-up and inter-subjective mother-baby relationship).

### **Class 1: Expectations about childbirth and baby health**

#### Vocabulary analysis

This class accounts for 28% of the totality of the corpus and is formed by 103 textual units. The wish for a good delivery is expressed: it is hoped that childbirth is calm, as natural as possible, fast and without stress ("to be quick... without any complication", "to be quick and painless"). There is implicit and explicit reference to the fear of suffering and pain ("constant pain, seriously, I fear childbirth a lot"), with expressions of anxiety arising from the lack of knowledge about how it will work ("I am a little anxious"). In the discourse, the hypothesis of using caesarean delivery or epidural intervention and information about the process of pregnancy and childbirth appear as reassuring factors, reducing stress, anxiety and fear of pain ("in fact things may not go as I want and so the caesarean section is a strong probability at that time"). The presence of the partner increases the feeling of affection and support ("I wish to have my companion by my side").

Concern is expressed about the baby's health, the desire to have him/her by her side, referring to the bonding phenomenon ("anxiety in the sense of wanting to see her, I want to see her as she is"). There is also reference to apprehension about one's own health and its impact (positive or negative) on the baby ("I feel active and I am eating healthy food").

The variables-attributes that contributed the most to this class were women between 25 and 32 years of age, mostly married and with a higher qualification.

#### Most representative words

The most representative words of the class were, hierarchically, "childbirth" ( $\Phi = 0.50$ ), "be it" ( $\Phi = 0.36$ ) and "run" ( $\Phi = 0.32$ ). The similarity analysis provided by ALCESTE (it allows identifying the co-occurrences between words, giving indications about the connection between words) shows that the stronger word, "childbirth", is associated with terms

like "be it", "run", "desires", "natural" "caesarean", and "pain" (figure 2).

## **Class 2: Significant relational experiences of the past**

### **Vocabulary analysis**

This class accounts for 28% of the totality of the corpus, being formed by 103 textual units. It groups the terms that refer to the importance of others: those who have already experienced parenting (parents, friends) and who can provide relevant information ("many pieces of advice from friends and parents"). There are references to outstanding past experiences, positive or negative: strong attachment to the grandmother; the day the first child was born; trauma due to the parents' moving away during childhood; difficulties in adapting to school ("the birth of my first child was the happiest day of my life", "from an early stage my mother's absence since she worked abroad and my father because he was always absent").

Women aged between 21 and 40, most of them married and with the 12th grade of schooling or higher, were those who contributed the most to this class.

### **Most representative words**

The words that best represent this class are "mark" (Phi= 0.28) and "father" (Phi= 0.27). The term "mark" appears in the words "marking", "marked", "did mark", which are associated with "event", "birth", "parents" and "care". They reflect the impact of past relational experiences with relevant people.

## **Class 3: Mother-baby relationship process**

### **Vocabulary analysis**

This class, the most representative, registers 34% of the totality of the corpus and is formed by 120 textual units. It encompasses the aspects that relate to the sensory relationship with the baby, experienced positively in a binding way: touching, caressing, movements, conversations of the type mother/baby communication ("when she moves, I put my hand on my belly and it's very exciting! It is very good"). Expectations and doubts about the mother's role are

expressed: feelings of insecurity or expressions of fantasy and idealization. The desire to be a good mother and to create the best educational conditions is expressed ("I imagine a relationship based on respect and above all on friendship"). Expectations for the future related to the baby's appearance and way of being are equally expressed ("I think a lot how I'm going to be as a mother and how he's going to be like"). Partners are also mentioned in the discourse of women, mostly because they share with them the joyful moments in pregnancy ("it has been good, we have lived every moment together"; "whenever I feel the baby I look for him and he also puts the hand (in the belly)"). For these women, pregnancy didn't affect negatively their affective relationship; on the contrary, it was reported as is a dream shared by two.

The participants who contributed the most to this class were in their 20s, with degrees and married. For some it was their first pregnancy (not for all).

### **Most representative words**

The words with the highest association to this class are "good" (Phi = 0.30), "touch" (Phi = 0.25) and "thing" (Phi = 0.22), in addition to the pronoun "he" (Phi = 0.31). The first two terms refer to a pleasant sensation associated with the state of pregnancy, while the word "he" (the baby) may refer to a personification of the baby, felt as external to oneself, or to the partner. The word "good" is associated with terms that refer to the sensory level (feel, move, feeling, belly) and express the importance of this "physical" dimension for the establishment of the mother-baby relationship and for the positive experience of pregnancy. That word is also related with the reference to their affective relationship.

## **Class 4: Health Care in Pregnancy**

### **Vocabulary analysis**

This is the least bulky class, incorporating 10% of the totality of the corpus and 35 textual units. It is related to the experience of health care during pregnancy, with a very positive appreciation, with special emphasis on the relation with the professionals and their professionalism ("they were close and expressed their

concern... two different doctors, but I cannot tell which one looked after me better"). The reference to diagnostic tests is also positive, contributing to increased safety, since they allow evaluating the mother and baby health condition ("I just had an ultrasound and I think it's not sufficient ... we should have more"). There is also greater confidence when follow-up in pregnancy and childbirth is done by the same professional ("He was always there, and maybe because of that, because they are people we are used to, we have a different relationship and I have always been very well followed-up, I think it could not have been better").

The variables that contributed most to this class were age (19-30 years), first pregnancy, single marital status and 12th year of schooling.

#### **Most representative words:**

The words with the highest association to this class are "follow-up" (Phi= 0.44), followed by "doctor" (Phi= 0.38), "centre" (Phi= 0.32) and "nurse" (Phi= 0.32). The words refer very often to medical care (doctor, nurse, obstetrician), the context in which they occur (centre, hospital) or specific techniques (ultrasound).

## **Discussion**

This study aimed to deepen the understanding of the experience of pregnancy and expectations regarding childbirth in a group of women, in the current context in which pregnancy and childbirth are medically monitored.

The results emphasize the desire of future mothers for having childbirth short in time, without stress and with minimal suffering and anxiety. Despite these worries, these women described a positive subjective experience of pregnancy and a feeling of security related to the knowledge they attribute to health professionals. For these participants, "medicalization" seems to be positive and securing, with no mention to a sense of disempowerment or loss of control.

Pregnancy represents a unique experience in women's life, experienced positively and/or negatively. These

feelings nourish their memory, sometimes throughout their lives (Kitzinger, 1987; Simkin, 1991, 1992) and have impact on expectations of motherhood, pregnancy, maternal emotional well-being, and on the postpartum period (Staneva & Wittkowski, 2013).

In what refers to expectations about childbirth, the participants expressed they wished to have an experience with minimal pain. As in other studies, the prediction of pain caused by the expectation of the unknown triggers high levels of anxiety and fear (Fenwick et al., 2015; Gibson, 2014; Lydon, et al., 1996; Pedreira & Leal, 2015). However, the possibilities of a caesarian section and/or of measures for reducing pain were seen as helpful, not threatening.

Implicitly, expressions referring to adaptation to bodily transformations and recovery of the body as it was in early pregnancy were also present. Often, women have unrealistic expectations concerning the post-partum period, associated with body dissatisfaction, since pregnant women may perceive their bodies as very different from their ideal of beauty (Hodgkinson, Smith, & Wittkowski, 2014).

The importance of relational experiences of the past, namely the experience transmitted by people with affective value to the pregnant woman, appeared in the discourse. From the psychological point of view, these people help to integrate their present experiences (doubts and worries) and the expectations of the future (childbirth and their role as mothers after the birth) in a more comforted and safe way. Several authors point out the importance of social support in the course of gestation, contributing to decreasing anxiety and stress resulting from confrontation with the situations that occurred during this period (Bunting & McAuley, 2004; Clay & Seehusen, 2004; Figueiredo, Costa, & Pacheco, 2002; Glazier, Elgar, Goel, & Holzappel, 2004; Hung & Chung, 2001; McKee Cunningham, Jankowski, & Zayas, 2001).

Our results also highlighted the importance of partner's support during pregnancy, in accordance with previous studies (Bäckström et al., 2017; Cheng et al, 2016; Hildingsson, Tingvall, & Rubertsson, 2008),

showing the feeling of tranquillity due to the experience of a joint process.

In what concerns to mother-baby relationship, pregnancy is a particularly exciting time for the woman, during which responsibility for her role as mother emerges (Lee, 2000). Gestation is a path, especially trodden by two persons, in which the mother builds a relationship with the baby, mediated by the sensations that she experiences in her body as a reflection of the maturation process of foetal development (Ferrari, Piccinini, & Lopes, 2007). In this relational process, the mother constructs her own mental representation of the baby, based on her expectations and the interactions she establishes with him. After childbirth, this representation is replaced by the real baby. These women expressed the joy of seeing their baby, imagined during pregnancy, enabling them to experience and assume motherhood (Raphael-Leff, 1997).

The issue of health care in pregnancy, compared to other issues, had a lower volume of lexical units. However, the importance attributed to the relational aspect of technicians (doctors and nurses) throughout the pregnancy was emphasised. Despite the appreciation of careful medical follow-up, participants highlighted the importance of the affectionate relationship of these professionals as factors of human proximity, increasing their confidence in the resolution of the problems that occurred during pregnancy and in the forthcoming labour.

Obtaining information was also valued. According to several authors (Denis Parant, & Callahan, 2011; Figueiredo, 2001; McKenzie-McHarg Crockett, Olander, & Ayers, 2014), information obtained during pregnancy and childbirth represents an important contribution to the well-being of women and has a positive psychological impact in the postpartum period. This group of participants was less differentiated from an academic point of view, which may explain the greater need for clarification regarding the course of pregnancy (in relation to the mother and the baby) and the childbirth process. Although this is a routine procedure for technicians specialized in this area, for the woman who experiences pregnancy for the first time, the health care team is perceived as being very

important, either due to concern with what is happening to her or with the conditions of the birth of her baby (Fenwick et al, 2015; Lou et al, 2017).

### Limitations

During the research process, two limitations were identified. First, gestational weeks were not a factor considered both for the enrolment process and the analysis. In fact, pregnancy is a dynamic process that changes as the baby grows, becoming progressively more active in his mother's life. This could affect the discourse of the women. Second, the participants were interviewed at home, but it was not possible to assure that they were always alone. The presence of family members or others, even if elsewhere, may have influenced their answers.

### Clinical implications

This study brings essential clinical implications. First, women repeatedly expressed the desire of having a "brief" childbirth, without stress and anxiety, which can be connected to the "unknown" that the situation represents for them. Therefore, the existence of spaces for sharing disturbing experiences and expectations of childbirth is prophylactic, contributing for the creation of conditions that foster positive expectations, mitigate fears related to the birth event and may contribute (indirectly) to the decrease in the number of caesarian sections performed. This decreasing is recommended by the World Health Organization (WHO; 2015), given the association of the surgery with short and long term risks for both the mother and her child, and its potential implications for future pregnancies (Betrán et al, 2016; WHO, 2015).

These interventions should also address the body alterations during this period, contributing to create more realistic expectations about women's body in the post-partum period.

Second, these results allow us to identify the development of functional coping strategies in facing stressful experiences, based on the social support of emotionally relevant close figures and on the cognitive and

emotional control of disturbance-triggering factors. Since the emotional dimension also appears to be fundamental for women's health and well-being, both should be considered in childbirth preparation interventions.

Finally, the positive feelings expressed by women can be related to the perceived role of health professionals, given the comforting confidence obtained from the rigorous information, quality of care and the type of relationships established by the health technicians who accompany these women. Due to the current "medical status" of childbirth, although women's choices can empower them in their process, power is also placed in the hands of these professionals. The way they are treated and the care they feel in the services provided are especially relevant, in terms of their feelings of trust and security, in a stressful moment and where fear occupies a significant place.

## Declaration of conflicting interests

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## References

- Adams, S., Eberhard-Gran, & M., Eskild, A. (2012). Fear of childbirth and duration of labour: a study of 2206 women with intended vaginal delivery. *BJOG: An International Journal of Obstetrics and Gynaecology*, *119*. doi: 10.1111/j.1471-0528.2012.03433.x.
- Bäckström, C., Thorstensson, S., Mårtensson, L.B., Grimming, R., Nyblin, Y., & Golsäter, M. (2017). 'To be able to support her, I must feel calm and safe': Pregnant women's partners' perceptions of professional support during pregnancy. *BMC Pregnancy and Childbirth*, *17*, 234-245. doi: <https://doi.org/10.1186/s12884-017-1411-8>.
- Betrán, A.P., Ye, J., Moller, A-B., Zhang, J., Gülmezoglu, A. M. & Torloni, M. R. (2016). The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014. *PLoS ONE*, *11*(2). doi:10.1371/journal.pone.0148343
- Biggerstaff, D. (2012). Qualitative Research Methods in Psychology. In G. Rossi (Ed.). *Psychology - Selected papers. Croatia: InTech*. (pp. 175-206). <http://www.intechopen.com/books/psychology-selected-papers/qualitative-research-methods-in-psychology>
- Bunting, L., & McAuley, C. (2004). Research review: Teenage pregnancy and motherhood – The contribution of social support. *Child and Family Social Work*, *9*(2), 207-216. doi: 10.1111/jj.1365-2206.2004.00335.x.
- Camargo, B. V. (2005). Alceste: um programa informático de análise quantitativa de dados textuais. In M. A. S. Paredes, B. V. Camargo, J. C. Jesuíno, & S. M. Nóbrega (Eds.). *Perspetivas Teórico-Metodológicas em Representações Sociais* (pp. 511-539). João Pessoa, Paraíba: Editora Universitária – UFPB.
- Canavarro, M. C. (2001). *Psicologia da Gravidez e da Maternidade*. Coimbra: Quarteto.
- Cheng, E., Rifas-Shiman, S. L., Perkins, M. E., Rich-Edwards, J. W., M. W. Gillman, Wright, R., & Taveras, E. M. (2016). The Influence of Antenatal Partner Support on Pregnancy Outcomes. *Journal of Women's Health*, *25*(7). 672-679. doi: 10.1089/jwh.2015.5462
- Clay, E. C., & Seehusen, D. A. (2004). A review of postpartum depression for the primary care physician. *Southern Medical Journal*, *97*(2), 157-161. doi:10.1097/01.SMJ.0000091029.34773.33
- Correia, M. (1998). Sobre a maternidade. *Análise Psicológica*, *3*(XVI), 365 – 371.
- Denis, A., Parant, O., & Callahan, S. (2011). Post-traumatic stress disorder related to childbirth: a prospective longitudinal study in a French population. *Journal of Reproductive and Infant Psychology*, *29*. doi: 10.1080/02646838.2010.513048.
- Eriksson, C. Westman, G. R., & Hamberg, K. (2005). Experiential factors associated with childbirth-related fear in Swedish women and men: A population based study. *Journal of Psychosomatic Obstetrics and Gynecology*, *26*. doi: 10.1080/01674820400023275.
- Evans, K., Walters, K. A., Liechty, T., & LeFevour, K. M. (2016). Women's experiences of physically active leisure during pregnancy. *Annals of Leisure Research*, *19*(4), 386-404. doi: 10.1080/11745398.2015.1135068.
- Epifanio, M. S., Genna, V., De Luca, C., Roccella, M., & La Grutta, S. (2015). Paternal and Maternal Transition to Parenthood: The Risk of Postpartum Depression and Parenting Stress. *Pediatric reports*, *7*(2), 5872. doi:10.4081/pr.2015.5872.
- Fenwick, J., Toohill, J., Creedy, D. K., Smith, J., & Gamble, J. (2015). Sources, responses and moderators of childbirth fear in Australian women: A qualitative investigation. *Midwifery*, *31*. doi: 10.1016/j.midw.2014.09.003.
- Ferrari, A. G., Piccinini, C. A., & Lopes, R. S. (2007). O bebê imaginado na gestação: aspectos teóricos e empíricos. *Psicologia em Estudo*, *12*(2), 305- 313. doi: 10.1590/S1413-73722007000200011.
- Figueiredo, B., Costa, R., & Pacheco, A. (2002). Experiência de parto: Alguns factores e consequências associadas. *Análise Psicológica*, *2*(XX), 203-217.
- Figueiredo, B. (2001). Perturbações psicopatológicas da maternidade. In C. Canavarro (Ed.). *Psicologia da Gravidez e da Maternidade*. Coimbra: Quarteto: (pp. 161-188).
- Gibson, E. (2014). Women's expectations and experiences with labour pain in medical and midwifery models of birth in the United States. *Women and Birth*, *27*. doi: 10.1016/j.wombi.2014.05.002.
- Glazier, R. H., Elgar, F. J., Goel, V., & Holzappel, S. (2004). Stress, social support, and emotional distress in a community sample of pregnant women. *Journal of Psychosomatic Obstetrics and Gynecology*, *25*(3-4), 247-255. doi: 10.1080/01674820400024406.



- Helman, C. (2007). *Culture, Health and Illness (5<sup>th</sup> Ed.)*. Londres: Hodder-Arnold.
- Hildingsson, I., Tingvall, M., & Rubertsson, C. (2008). Partner support in the childbearing period – A follow up study. *Women & Birth, 21*(4), 141-149. doi: 10.1016/j.wombi.2008.07.003
- Hill, C. L., Baird, W. O., & Walters, S. J. (2014). Quality of life in children and adolescents with osteogenesis imperfecta: a qualitative interview based study. *Health Quality of Life Outcomes, 12*(54). doi: 10.1186/1477-7525-12-54.
- Hodgkinson, E. L., Smith, D. M., & Wittkowski, A. (2014). Women's experiences of their pregnancy and postpartum body image: a systematic review and meta-synthesis. *BMC Pregnancy and Childbirth, 14*(1), 330-340. doi: 10.1186/1471-2393-14-330.
- Hung, C., & Chung, H. (2001). The effects of postpartum stress and social support on postpartum women's health status. *Journal of Advanced Nursing, 36*(5), 676-684. doi: 10.1046/j.1365-2648.2001.02032.x
- Image (2018). *Alceste 2018 version Education: Un logiciel d'Analyse de Données Textuelles*. Retrieved from [www.imagezafar.com](http://www.imagezafar.com).
- Justo, J. (2005). Trabalho de Parto, parto e nascimento: a influência dos fatores psicológicos. *Arquivos de Psiquiatria, 2*(1/2), 17-143.
- Kitzinger, S. (1987). *A experiência de dar à luz*. São Paulo: Martins Fontes.
- Lanes, A., Kuk, J.L., & Tamin, H. (2011). Prevalence and characteristics of postpartum depression symptomatology among Canadian women: a cross-sectional study. *BMC Public Health, 11*, 302. doi: 10.1186/1471-2458-11-302.
- Larsson, A., Wärna-Furu, C., & Näsman, Y. (2016). Expecting a child: pregnancy in light of an ontological health model. *Scandinavian Journal of Caring Sciences, 30*, 757–765. doi: 10.1111/scs.12302.
- Lee, C. (2000). Psychology of women's health: A Critique. In J. M. Ussher (Ed.). *Women's health: Contemporary international perspectives*. London: The British Psychological Society (pp. 2640).
- Lou, S., Frumer, M., Schlütter, M. M., Petersen, O.B., Vogel, I., & Nielsen, C.P. (2017). Experiences and expectations in the first trimester of pregnancy: a qualitative study. *Health Expectations, 20*(6), 1320-1329. doi: 10.1111/hex.12572.
- Lydon, J., Dunkel-Schetter, C., Cohan, C. L., & Pierce, T. (1996). Pregnancy decision making as a significant life event: a commitment approach. *Journal of Personality and Social Psychology, 71*(1), 141-151. doi: 10.1037/0022-3514.71.1.141.
- Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health, 18*. doi: 10.1177/1363459313476964.
- McKee, M. D., Cunningham, M., Jankowski, K. B., & Zayas, L. (2001). Health-related functional status in pregnancy: Relationship to depression and social support in a multi-ethnic population. *Obstetrics and Gynecology, 97*(6), 988-993. doi: 10.1016/s0029-7844(01)01377-1.
- McKenzie-McHarg, K., Crockett, M., Olander, E., & Ayers, S. (2014). Think pink! A sticker alert system for psychological distress or vulnerability during pregnancy. *British Journal of Midwifery, 22*(8), 590-595. doi: 10.12968/bjom.2014.22.8.590.
- Moore, M. (2016). Multicultural Differences in women's expectations of birth. *ABNF Journal, 27*(2), 39-43
- Nagy, E., Molnar, P., Pal, A., & Orvos, H. (2011). Prevalence rates and socioeconomic characteristics of post-partum depression in Hungary. *Psychiatry Research, 185*, 113-20. doi: 10.1016/j.psychres.2010.05.005.
- Pedreira, M., & Leal, I. (2015). Terceiro trimestre de gravidez: expectativas e emoções sobre o parto. *Psicologia, Saúde & Doenças, 16*. doi: 10.15309/15psd160210
- Peñacoba-Puente, C., Carmona-Monge, F. J., Marín-Morales, D., & Gallardo, C. (2016). Evolution of childbirth expectations in Spanish pregnant women. *Applied Nursing Research, 29*. doi: 10.1016/j.apnr.2015.05.017 0897-1897
- Raphael-Leff, J. (1997). *Gravidez: A história interior*. Porto Alegre: Artes Médicas.
- Reinert, M. (1990). Alceste - une méthodologie d'analyse des données textuelles et une application: Aurelia de Gerard de Nerval. *Bulletin de Méthodologie Sociologique, 26*(24), 24-54. doi: 10.1177/075910639002600103.
- Rocha, T. S. G. (2012). *As Cesarianas em Portugal Continental – Fatores Explicativos*. Dissertação de Mestrado em Economia. Universidade de Aveiro.
- Rudolfsdottir, A. (2000). "I Am Not a Patient, and I Am Not a Child": The Institutionalization and Experience of Pregnancy. *Feminism & Psychology, 10*(3), 337–350. doi: 10.1177/0959353500010003004
- Salomonsson, B., Gullberg, M., Alehagen, S., & Wijma, K. (2013). Self-efficacy beliefs and fear of childbirth in nulliparous women. *Journal of Psychosomatics Obstetrics and Gynecology, 34*. doi: 10.3109/0167482X.2013.824418
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity, 52*(4), 1893–1907. doi: 10.1007/s11135-017-0574-8.
- Simkin, P. (1991). Just another day in a woman's life? Part I: Women's long-term perceptions of their first birth experience. *Birth, 18*, 203-210. doi: 10.1111/j.1523-536x.1991.tb00103.x.
- Simkin, P. (1992). 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*, 64- 81. doi: 10.1111/j.1523-536x.1992.tb00382.x.
- Simões, J. (2016). *Cesariana – um indicador de qualidade de cuidados obstétricos – mito ou realidade*. Dissertação de Mestrado. Instituto Ciências Biomédicas Abel Salazar.
- Staneva, A., & Wittkowski, A. (2013). Exploring beliefs and expectations about motherhood in Bulgarian mothers: A qualitative study. *Midwifery*. doi: 29, 10.1016/j.midw.2012.01.008.
- World Health Organization (2015). *WHO Statement on Caesarean Section Rates*. Retrieved from [https://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/cs-statement/en/](https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/)
- Zar, M., Wijma, K., & Wijma, B. (2001). Pre- and Postpartum Fear of Childbirth in Nulliparous and Parous Women. *Scandinavian Journal of Behaviour Therapy, 30*. doi: 10.1080/02845710152507418.