

EXAMINING THE NEXUS OF LABOUR PAIN AND CULTURE USING AN APPLIED SOCIAL SCIENCE FRAMEWORK

EXAMINANDO EL NEXO DEL DOLOR DE PARTO Y LA CULTURA USANDO UN MARCO DE CIENCIA SOCIAL APLICADA

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ABSTRACT

Birthing women can convey a cultural response to pain. The greater the cultural distance between a woman and her midwife, the greater the chance of misinterpretation of her labour experience. This paper examines childbirth beliefs, influences and practices, which contribute to cross-cultural understandings of pain.

A literature search was conducted in April 2013. Studies were included if they had pain as the primary outcome and examined non-elicited pain language from the maternal perspective. Twelve articles were included. The language findings were reported in a companion paper. The present paper reported the cultural findings using an applied social science framework to reflect upon the nexus of pain and culture within pain communication and the development of culturally sensitive practice.

The studies depicted shared childbirth beliefs and practices across African, Asian, European, North American and South American cultures, which in part is attributed to common physiological factors of childbirth. Childbirth may be impacted upon by 'internal' factors: pain reactions and attitudes, religion and spirituality, pain definition and meaning, anxiety, pain acceptance and tolerance, conceptualisation of motherhood, psychology, and societal beliefs; external factors may include the environment (physical setting or context of childbirth) and the model of care. The interpretation of these beliefs may be influenced by the midwife's development of their cultural competence. Viewing cultural patterns provides a cultural lens for midwives across care models (e.g.

technocratic, humanistic, and holistic) to better understand women's experiences of pain, to reflect upon cross-cultural interpretation of pain and to develop cross-cultural competence.

Keywords: pain, parturition, culture, model of care

RESUMEN

Mujeres que dan a luz pueden transmitir una reacción cultural al dolor. Cuanto más distancia cultural hay entre una mujer y su matrona mayor es la posibilidad de una interpretación errónea de su experiencia del dolor de parto. Este artículo examina las creencias, influencias y prácticas del parto que contribuyen al entendimiento transcultural del dolor. Se realizó una búsqueda de la literatura en abril de 2013. Fueron incluidos doce estudios los cuales tuvieron el dolor como un resultado principal y examinaron el idioma del dolor no provocado (es decir, el idioma natural que no está obtenido por la evaluación estandarizada del dolor) de la perspectiva materna. Los resultados lingüísticos fueron presentados en otro artículo anterior. En cambio, este artículo presenta los resultados culturales usando un marco de ciencia social aplicada para reflexionar sobre el nexo del dolor y la cultura dentro de la comunicación del dolor y el desarrollo de una práctica culturalmente sensible.

Los estudios representaron creencias y prácticas del parto compartidos por la cultura africana, asiática, europea, norteamericana y sudamericana que está atribuido – en parte – a los factores fisiológicos comunes del parto. El parto puede estar impactado por los factores ‘internos’: las reacciones y actitudes del dolor, la religión y espiritualidad, las definiciones y significaciones del dolor, la ansiedad, la aceptación y tolerancia del dolor, la conceptualización de la maternidad, la psicología, y las creencias sociales; los factores externos pueden incluir el ambiente (entorno físico u contexto del parto) y el modelo de atención. La interpretación de estas creencias puede estar influenciada por el desarrollo de competencia cultural de la matrona. Observar los patrones culturales ofrece a las matronas unos lentes culturales, a través, de los modelos de atención (ej. tecnocrático, humanista, holístico) para entender mejor la experiencia del dolor de la mujer, para reflexionar sobre la interpretación transcultural del dolor y para desarrollar la competencia transcultural.

Palabras clave: dolor, parto, cultura, modelo de atención

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INTRODUCTION

A woman's childbirth experience may be shaped by previous childbirth experiences, previous pain experiences

including health events from her childhood, and other associations with acute pain. Her labour experience is also filtered through her ethno culture.

Culture cannot be separated from the context of childbirth, especially in multicultural societies, as Davis-Floyd¹ argues, the fundamental values of any society are most apparent in the cultural treatment of the birthing body, specifically how that society relates to “the natural world and to the natural reproductive forces upon which its continued existence depends” (1, p. 1125).

Culturally inspired behavioural patterns influence the individual’s pain experience.² A bio cultural model connects the biological, cultural and psychological aspects of the pain experience, and explains why there are similarities and differences between ethno cultural groups in how they process pain and respond to pain.²

The family is the primary influence on people’s attitudes, expectations, and how they create meaning, and where appropriate social and emotional responses and behaviours are learnt and developed:² for example, learning from a young age to react stoically to pain due to the cultural expectation that boys do not cry, illustrates what Bates et al. describe as the discouragement of an overt expression of pain.² These learned values impact on the individual awareness of pain, including the recall of previous pain events.³ Therefore, despite similarities in pain neurophysiology across ethnic groups, ethno culture may impact on the physiological processes that shape pain including pain threshold, pain tolerance, perception of pain, and psychological and behavioural responses to pain.³ Cultural patterns do not only dictate the

type of pain report or behaviours (appropriate or inappropriate), but they may also impact on pain perception² and thus the individual’s experience of pain.

Each individual uses their cultural patterns and internal models to form their assumptions and perspectives about how a particular phenomenon works and how to interact with others.⁴ These assumptions may be based on external influences from popular culture, media, overseas travel, or experiences with people that one perceives to be similar based on in-group generalisations.⁴ In this respect, both the birthing woman and the midwife bring ethno cultural perspectives to the childbirth experience. However, the way in which the midwife interprets maternal responses to childbirth pain may impact on pain communication between the midwife and the birthing woman, and this raises the question:

[...] a labouring woman in one part of the world may be silent during the pain of contractions, while an individual elsewhere may emote continuously throughout her labour. Is one person not feeling pain as much as the other, or are the two women reacting to the same physiologic process in very different manners? (5, p. 474)

A birthing woman may offer a cultural response to pain, captured in her birth narrative, which has its own linguistic and cultural framework. Research suggests that the greater the cultural distance between the birthing

woman and the midwife, the greater the chance of a misinterpretation of the woman's pain experience (6, p. S19). It is therefore important to be sensitive to the cultural cues of the birthing woman, to be aware of one's own biases and attitudes towards other cultures, and to develop cross-cultural communication skills in the provision of culturally sensitive birth care.

For the midwife, pain communication can be strengthened by the development of cross-cultural competence. Intercultural communication is a transaction between two individuals from distinct cultures who are aiming to find common ground through an interpretation and generation of shared meanings.⁷ When applying this communication process to labour, the midwife and the birthing woman are continually exchanging meanings to find a shared meaning of birth pain or to create an entirely new meaning of pain. Therefore, cultural competence is a non-technical skill in birth care and in some contexts is considered a model of care in itself. Campinha-Bacote explains that becoming culturally competent takes practice through a combination of cultural skill, awareness, knowledge, cultural encounters and a desire to learn more about other cultures (8, p. 183).

Three elements that are important to cross-cultural competence are cultural humility, cultural safety, and ethno cultural empathy. Cultural humility includes an understanding that the healthcare interaction are impacted upon by the cultural perspectives of both parties.⁹ There is an active, two-

way communication, which may include self-reflection on the part of the health professional and the acknowledgement that the individual in care knows which cultural factors from their background are significant to the interaction.⁹

Through becoming culturally competent, midwives are also able to provide a culturally safe environment, in which the birthing women's cultural beliefs, practices and values are respected and protected.¹⁰ Pain is a global phenomenon, which transcends cultures. Having an overall genuine connection to and understanding - as much as possible - of the phenomenon of birth and labour from the birthing women's sociocultural perspective assists in the development of ethno cultural empathy.

METHODS

Framework and objective

In this paper, we use an applied social science framework, which draws upon the aforementioned cross-cultural competence, pain, midwifery and applied linguistic to examine the cultural patterns of labour pain. Applied linguistics acknowledges the connection between culture and language and views cultural and linguistic data within a real world context¹¹ in this instance the context of pain and childbirth.

Our objective is to provide a cultural lens through which midwives regardless of birth care models can view multiple realities of a universal phenomenon. Davis-Floyd's¹² anthropological

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perspective is particularly pertinent to this investigation. Midwifery research has highlighted the ongoing relevance of the Davis-Floyd framework to midwifery practice.^{13, 14, 15, 16} In this instance we apply it to the context of labour pain. We recognise Davis-Floyd as part of the earlier movement in midwifery (e.g. transcultural nursing^{17,18} cultural safety^{19,20} to establishing

guidelines for non-technical skills in the provision of culturally sensitive care. Her technocratic, humanistic and holistic paradigm¹² provides a very general guide for midwives to understand which professional culture or model of care they work in (Tabla 1).

MODEL	Technocratic	Humanistic	Holistic
APPROACH	Mind/ body separation	Mind-body connection	Interconnection of body-mind-spirit
	Mind more important than body	Body as organism	Body as energy system interconnected to other systems
	Unimodal, left-brained, linear (closed system unique to medicine)	Patient as relational subject	'Whole-life' context taken into consideration when healing
	Medical knowledge is authoritative/ supervaluation of science & technology	Science & technology counterbalanced with humanism	Science & technology are tools used by the individual
	Active participation and control are good	Open-minded toward other modalities	Open-minded toward other modalities
	To be strong one must be in control	Balance & connection	Connection & intergration
	Patient as object	Bi-modal	Multi-modal; fluid; right-brained
	Supervaluation of science & technology		
	Intolerance of other modalities		

Table 1. Key approaches of technocratic, humanistic and holistic models of care (Davis-Floyd, 1994, 2001)

The technocratic model is marked by but not limited to the premises of medical knowledge as authorities, the person is treated and viewed as an

object, and the super valuation of science and technology.^{1,12} Furthermore, a technocratic model of care may view childbirth as

a mechanical process in which the woman's body is the machine which houses the foetus and as long as she is cognizant then she is considered an active participant during labour.¹

In a technocratic model of care the woman's pain is viewed as negative and her access to pain relief and a pain free labour is viewed as a fundamental

human right.¹

The technocratic model is in stark contrast to a humanistic model or holistic model of care, which views the person as a relational subject, where science and technology are counter balanced by humanism, and other modalities are considered or used.

Focus of literature review	Group 1. Non-elicited pain language	Group 2. Pain as study variable	Group 3. Publication
Question 1: <i>What type of language is used in women's labour pain narratives?</i>	- Pain narrative (captured during labour or retrospectively) as primary mode	- Pain is a primary outcome measure	- Peer reviewed scholarly articles
Take away: culture and language are intertwined in pain experience ↓	- Non-elicited pain language (language used and/ or behavior described in narrative)	- Captured from onset of active labour pain until arrival of baby (including back pain during labour)	- January 1950 to April 2013
Action: closer examination of language data to extract cultural patterns	- Language is captured by unstructured or semi-structured interviews	- Pre-intervention or no intervention	- English language only
Question 2: <i>What are the cultural beliefs, influences and practices regarding labour pain?</i>	- Maternal perspective		- Qualitative research design

Table 2. Inclusion criteria, objective of the original critical and interpretive literature review and resultant cultural examination

	AFRICA GHANA ¹	ETHIOPIAN, LIBERIAN, SOMALIAN & SUDANESE ²	ASIA INDONESIAN ³	IRANIAN ⁴	EUROPE DUTCH ⁵	FINNISH ⁶	SWEDISH ⁷	SWEDISH ⁸	ENGLAND ⁹	NORTH AMERICA THE UNITED STATES ¹⁰	THE UNITED STATES ¹¹	SOUTH AMERICA BRAZILIAN ¹²
Birth is viewed as form of 'rebirth'						•	•					
Birth pain is difficult to convey						•	•			•		
Birth is bittersweet				•		•					•	
Labour pain is expected		•				•						•
Pain is viewed as essential to labour process	•	•			•	•	•		•			
Use of prayer	•		•									
Pain is God's will/ force of God	•			•		•						
Impact of technocratic culture		•							•		•	•
Minimal or non-pharmacological intervention	•	•	•		•	•						
Cognizance of childbirth as woman and as mother							•				•	
Birth pain is bodily distress	•									•		•
Fatigue							•		•	•		

Table 3. Cross-cultural beliefs, influences or practices pertinent to labour and pain

We first discuss the findings from the literature review and then apply these findings to midwifery practice using the Davis-Floyd¹² framework. We undertook a critical and an interpretive review of the research literature to examine women's non-elicited pain language in qualitative birth research, which resulted in the inclusion of twelve qualitative studies (n = 12). The results of the language analysis are reported in a companion paper²¹. The original inclusion criteria and research questions are provided in Table 2. Our primary motivation for the literature review (Question 1, Table 2) was to investigate the type of language women use in their labour pain narrative.²¹ In the interpretive review we aimed to provide a holistic view of childbirth and pain, which reflected our

own disciplinary interests.²² Therefore, while reviewing the pain language, we also saw it timely to examine the cultural beliefs, influences and practices of labour (Question 2, Table 2), which contribute to cross-cultural understandings of childbirth and pain. The twelve qualitative studies focussed on African, Asian, European, North American or South American cultures and their broad collective aim was to examine the lived experience of childbirth according to maternal perspectives.

Women birthed in a variety of settings, including home, rural clinics, birth centres, medical centres, smaller community hospitals and larger metropolitan hospitals.²¹

Following the language analysis²¹, we then examined the raw language

data again to extract cultural patterns. This was an iterative, detailed and manual coding process. We first examined the language data as a whole and extracted first level themes related to pain behaviour. We then extracted second level/ sub-themes and continued this process until we had reached saturation point where no new themes emerged. We then revisited the data for a third time and linked the themes across cultures including beliefs, influences and practices (Table 3).

RESULTS

The reviewed studies display a diverse range of beliefs, influences and practices regarding childbirth and pain. We present the studies according to region and ethno culture in order to convey the cultural patterns across groups. It is important to note the studies which were conducted in countries different to the study participant's country of origin, as shown in Murray et al.'s²³ Australian based study of Ethiopian, Liberian, Somalian and Sudanese birthing women. Furthermore, some studies do not clearly define the culture or ethnicity of the study participants, such as Ogden et al.'s²⁴ study based in London, and DiMatteo et al.'s²⁵ study based in California with English-speaking birthing women. These studies are illustrative of the nature of multiculturalism and the challenge of defining culture in the research context. Therefore, in these instances, the countries where the studies were conducted, rather than their ethno culture, are listed in Table 3.

The beliefs/ influences relevant to labour and pain broadly included birth as a form of rebirth, pain as God's will, birth pain as difficult to convey, labour pain as expected, birth as bittersweet, pain as intrinsic to the labour process, the cognizance of childbirth as a female and as a mother, and birth pain as physical distress and fatigue. Practices included the use of prayer and minimal or non-pharmacological interventions. Key quotations are provided for each ethno cultural group, which exemplify an overarching characteristic or quality in the childbirth narrative are presented according to region (Africa, Asia, Europe, North America and South America) to allow comparison between groups.

Africa

The time that you deliver, the pain is so severe that if God has not intervened, you will die [...]. (26, p. 215)

African studies included women from Ghana,²⁶ Ethiopia, Liberia, Somalia and Sudan.²³ In Ghanaian women's experience religion and spirituality played an important role in childbirth.²⁶ Pain was viewed as a force of God and a form of punishment for defiance, reminiscent of Adam and Eve, which was based on the Christian-Islamic faith.²⁶ If a woman was able to endure her pain, then this was a form of deific intervention, whereas relentless pain signified no deific intervention and her pain became comparable to death.²⁶

There was maternal recognition of the sensations of labour as an acute temporary pain, which was viewed as part of the birth process and necessary

for the birth of the baby. Therefore, pain medication was often not used. Women demonstrated an inner strength or an endurance drawn from their religious beliefs, and conveyed in their attitude and in their expectations leading up to the birth, unless the pain was constant or there was maternal fear regarding the baby's wellbeing. Vocalisations such as crying out were believed to set off far-reaching financial or physical consequences, for example, a hospital transfer or a prolonged labour. However, vocal prayers to request and ensure a safe birth were considered appropriate behaviour during labour.

In Ghanaian culture, children are considered part of the thread of everyday life. Despite the pain, women withstand labour regardless of the type of experience, because of the societal expectation that they must have children to ensure the continuation of the family. Therefore birth is viewed as a natural event and part of the life/ death cycle.²⁶

When you give birth the pain will be relieved [...] so I just want the pain should (escalate), so that it comes out. (23, p. 467)

A similar view that pain medication hinders the process of labour and therefore is not often used is captured in Murray et al.'s²³ study, which examined four cultural backgrounds: Sudanese, Liberian, Ethiopian, Liberian, Somalian and Sudanese. These cultures also regarded labour as an expected and natural phenomenon, so there was maternal preference for longer labours over caesarean sections.

Women had an overpowering sense of anxiety, isolation and the unknown

during their birth experience as newly migrated mothers to Australia. They felt a sense of powerlessness in an unfamiliar birth context and in navigating a new health system. However, they were hesitant to ask for professional support, and their concerns were often misconstrued. Women felt they had a positive birth when they received good professional support and when they felt they were involved in the birth. Therefore, communication with midwives and doctors was considered an important part of the birth experience.

Women relied on self-knowledge of their own bodies and previous birth experiences, which was detailed through descriptions of natural childbirth; thus, maternal expectation was for a subsequent natural birth. However, women found it difficult to birth in a technocratic environment where pain medication or analgesics are often used.²³

Asia

The more you are in pain, the more you call God and God would help you more. God never leave his creatures alone. God helped me to endure the pain. (27, para. 29)

Asian studies included women from Indonesia²⁸ and Iran.²⁷ Religion also forms part of the birth experience in Iranian culture, where women's faith sustains them throughout labour.²⁷ Beigi et al.'s study focused on the severity and the type of pain and the emotional and mental states that accompany pain, the factors which escalate pain and reduce pain so it is bearable, and the results of pain. Women reacted to the

sensations of labour outwardly e.g. with a strong emotion, or they showed a quieter determination. Pain is often regarded as an enigma in childbirth, and some women in this study viewed labour as a positive experience while other women felt isolated during labour.

Regardless of how pain was expressed, there were financial and social reasons for women to endure the pain: for example, there was a belief that women who are from wealthier families experience a more comfortable labour due to having the financial means for pain relief. A further cultural belief was that birthing a baby boy equates to less pain and therefore an easier birth. This was tied to cultural expectations that the mother is required to produce a son, thus adding to maternal anxiety and familial concern.²⁷

I am screaming during pain, and then biting my clothes. Feeling anxious... I wanna seat and get down from bed! Firstly, screaming aloud. (28, p. 265)

An Indonesian study linked women's type of labour pain experience with education and information.²⁸ The study highlighted the role of prior knowledge to ameliorate pain, the role of anxiety, yet pain must be confronted, the need to be able to control the pain, the need to be accompanied, and general awareness regarding a birthing woman's care needs.

Prior to experiencing childbirth, women understood that contractions bring very intense pain, but during actual labour this was experienced differently in individual women due to the lack of information regarding the

childbirth process. This expectation and understanding of pain as unavoidable came from different sources: their own experiences, professional experience, other women's experiences, and books. Notably, women did not receive pain education from health care professionals and were not well informed regarding options for pain management. For example, some birthing women were equipped with information about water birth, hypnosis, or epidural anaesthesia despite the hospital not offering these options. Other women believed that pain cannot be controlled, and this often led to bewilderment and thus hampered women's abilities to make decisions during labour. For some women pain was viewed as a tool to track their progress during labour. Midwives in Indonesia reassured women that pain was a common phenomenon and they recommended prayer as a method of pain relief, in addition to a focus on breathing and massage. Women were acquiescent to pain when they felt they had lost control. In addition, women felt their support partners e.g. family and/or husband, assisted in minimising the pain they experienced, thus companionship was preferable and had a positive impact on birth; however, there was no guidance for support people, particularly husbands. Overall there was a lack of pain management. Despite voicing some of their expectations, women had trouble talking about satisfaction in their birth experience due to cultural expectations of compliance i.e. not complaining.²⁸

Europe

I wanted to make a noise and sort of groan [...] so I was wandering around the corridor trying to keep out of the way, because you need a bit of privacy when you want to make a noise. (24, p. 341)

European studies included women from the Netherlands,²⁹ Finland,³⁰ Sweden^{31,32} and England.²⁴ A study from England reported that, for some women, homebirth was not a viable birth option, thus clinical environments such as hospitals were often encouraged, or women themselves decided to have a hospital birth.²⁴ Several aspects were identified which may impact on the pain experience including memories of previous pain experiences (negative connotations), when pain was experienced as marginal (positive connotations), or when women acknowledged pain as being an essential component of labour because it physiologically signifies the arrival of the baby.

Some women tried to manage their pain, but they lamented their lack of control during labour. The significance of the impact of medical interventions, for example, and whether a woman had control over interventions, or if the interventions removed a woman's capacity to control her pain management. Other women were relieved to be with health professionals who could manage their pain, for example, the anaesthetist. Birthing women were also impacted upon by how others cared for them, particularly in less satisfying or negative birth

experiences. For example, sometimes support people were welcomed by birthing women, whereas in other instances unknown people were viewed as invasive.

There were also aspects connected to technocratic culture, which included the element of risk and the assurance of safety, which may have impacted on women's decision to have a hospital birth. Adversely, in this environment, the matter of privacy and the use of birth equipment also impacted on women's perception of their environment as impersonal (24, p. 344). In addition, the provision of clear and sufficient information and the manner in which it was conveyed impacted on how a woman felt she was being attended to by health professionals. Finally, there were contrasts in how women experienced childbirth as loneliness, when there were no people to support the birthing woman, or as a depersonalised experience when there were too many people.²⁴

[...] it's very hard to describe pain in words... it hurts so much that you rather want to get rid of it, but you will do anything to get a baby, what makes you stand the pain is that it is positive [...]. (31, p. 106)

In a Swedish context, pain was considered part of the natural phenomenon of childbirth.³¹ Pain was difficult to define and had a contradictory nature, and it was important that women trusted in themselves and their bodies during childbirth.

Labour became more painful when it was not progressing, thus safety,

support and reassurance were needed. Women intuitively listened to themselves. This inner strength was also viewed as part of a woman's journey to motherhood in which they learn about themselves and their bodies. Pain was used as a form of catharsis through which birthing women released undesirable emotions through strategies such as relaxation and creating a sense of refuge. However, this came down to how women trusted in their bodies. Their ability to endure the pain came through their own distinct and personal experience with labour. Ultimately, pain in childbirth was revered as part of a physiological process, and therefore was not regarded as concern.

Moreover, pain connected women with their unborn babies, and labour held profound meaning as it heralded the start of a new chapter, which brought women new cognizance regarding life and motherhood.³¹

Then I thought I was going to die, I was in so much pain. My labour pains were incredibly strong. (32, p. 60)

The opposite view, again from a Swedish perspective, was described in a prolonged labour context.³² In this study women were caught in labour; they were feeling fearful as they experienced a heavy, interminable pain process, which occupied their bodies. They felt shattered, impaired and therefore immobilized and without control, and they became reliant on pain medication. Birthing women were dependent on midwives for their care and the decision-making processes during childbirth and the outcome of this was being alleviated from the pain of labour.

Despite childbirth being compared to being gravely ill and women being horrified at the prospect of being consumed by the experience, they withstood the severity of their pain in order to uphold their dignity (32, p. 63).

There are hard situation[s] you have to go through, times that are hard for you to control. And it hurts, it hurts very much. You just keep on living. I think it is the same thing with giving birth. It hurts, and there are some things you cannot control like the pain. Giving birth represents both good and bad. It is like life. It is difficult but you also have happiness. (30, para. 20)

It is a very extreme experience. Of course, a very natural biological process and because you are so busy coping with the pain, it is a very introverted experience [...]. You listen to yourself and concentrate on the pain. (29, p. 174)

Two more Scandinavian studies in which mothers viewed childbirth pain as a positive experience included Finnish women in a tertiary care medical centre³⁰ and Dutch women in a homebirth context.²⁹ Both studies highlighted pain as an integral aspect of the childbirth experience. Pain was expected,³⁰ as demonstrated in the proverbs used by Finnish mothers: *Life is not a dance on a bed of roses* (30, para. 19). This approach encapsulated the worldview that childbirth is as poignant as it is challenging³⁰, the enigmatic nature of labour. In a similar vein, Dutch women found their inner strength in the intensity of the labour experience: "I really went down to my earth [...] The deep down feelings. You

have a lot of strength [...] I didn't know I had it" (29, p. 174). Pain was functional, vital, and thus valued in childbirth.²⁹

Both Dutch and Finnish women viewed childbirth within the context of a woman's overall wellbeing^{29,30} and the Dutch perspective indicated a focus on the promotion of wellness.²⁹ Self-efficacy meant power, a 'can do' attitude, and confidence, and these were qualities, which formed part of the maternal view and shaped women's birth experiences.³⁰ Further, there was a preference for non-pharmacological³⁰ or minimal pharmacological interventions,²⁹ for example, massage and acupressure.³⁰

Women felt supported and calm in a homebirth context: they were the experts of their bodies and they viewed labour as a straightforward, physiological experience that was manageable.²⁹ However, women were also calm in knowing that the hospital was an option. Mothers worked with the pain and reached a deeper level of self-understanding. They believed in themselves and their ability to birth.²⁹

Women recognised birth as an intense pain event. However, this pain was viewed as something practical and beneficial, which brought feelings of empowerment and was held by women as a valued moment in their lives.²⁹ At times women were able to convey their feelings about childbirth, but at other times it was difficult for them to articulate, possibly due to their emotional states when recollecting the experience of labour.³⁰ However, women acknowledged childbirth as

awesome and unequalled in its nature, yet they also acknowledged childbirth as a common phenomenon, which connected them to generations of women. In particular the first childbirth experience was viewed as a kind of rebirth for the woman on her journey to motherhood.³⁰

North America

People told me that contractions are like very severe menstrual cramping but these pains were like perforating the bowel, or [the] appendix rupturing. (33, p. 26)

There were two studies from the United States.^{25,33} Women who birthed in America felt there was a pervading mythology, which created idealistic beliefs about birth: for example, childbirth is a wonderful experience for the parents-to-be, when in reality some women felt that the baby was the focus regardless of the parents' experience, and the baby's wellbeing came first regardless of the birthing woman's wellbeing.²⁵ In addition, women felt their support people (health professionals/ educators, friends or family members) did not prepare them for the reality of labour.²⁵ Some women felt unprepared for the intensity of pain and the stamina required.^{25,33} Pain endurance and using non-pharmacological strategies such as walking or hydrotherapy were connected with women's overall attitudes in childbirth: for example, the ability to withstand pain for the maximum time possible before requesting an epidural.³³ Furthermore, women felt a range of emotions from elation to apprehension.³³ for some

women this was punctuated by a lack of support, a sense of isolation felt during labour,³³ or financial pressures such as no health insurance, or discovering that the health insurance did not cover maternity care.²⁵

There were psychological aspects of the childbirth experience such as external influences from the media: for example, one woman planned an epidural after viewing childbirth portrayed in the media.³³ There were also physical consequences, due to the technocratic culture of the birth environment such as women who wanted to move around during labour, but could not due to being attached to a monitor.³³

DiMatteo et al.²⁵ discovered women considered postpartum pain and the resultant pain from medical interventions to be worse than the pain associated with vaginal birth. Women felt disconnected from their birth experience, or the physicality of birth posed a risk, and they felt a general bodily distress.²⁵ When faced with the combination of pain and fatigue, women chose an epidural.³³ Furthermore, women felt a lack of autonomy²⁵ and control,^{25,33} which may have increased the element of trauma.³³

Birth was viewed as poignant with the arrival of the baby and this overrode any previous tribulation³³. Finally, the experience of birth was difficult to express, as one participant explains, “No matter how much they teach you in Lamaze, it never really gives you an idea of the real [pain]. And those contractions – it was beyond description” (32, p. 206).

South America

[...] I was tearing my hair, I was not creating a scandal but, inside, I was... Oh, my God! I couldn't stand it anymore... I did not feel any regret [...] I control myself. I don't make a fuss, but the pain is strong. (34, p. e846)

There was one study from South America which examined Brazilian women's experience of childbirth.³⁴ Brazilian women indicated that childbirth was a form of physical and emotional distress, a traumatic and horrible experience in which pain was expected and often perceived to be linked with infant death.³⁴ Childbirth was viewed as a cataclysmic event, which was marked by a common belief that high-intensity pain signalled not only the stage of labour progression, but also hospitalisation. One woman was astonished when her birth experience differed to her highly charged expectations of labour when she did not experience strong pain during labour.

The authors commented that the humanisation of care movement in Brazil attempts to overturn the more traditional technical and medicalised care of birth, which echoes technocratic culture. Ultimately, childbirth for Brazilian women was about keeping control, that is, not screaming or crying out, and surviving the experience.³⁴

DISCUSSION

Pain reactions and attitudes

The studies illustrated that women convey different reactions and attitudes to the sensations of labour. In the 1950s pain pioneer,

Mark Zborowski, discovered that cultural and social patterns on physiological activity may be in conflict with the biological needs of the individual in pain (35, p. 16). Zborowski³⁵ differentiated between reactions and attitudes to pain, explaining that one does not necessarily exemplify the other, particularly in “reactive patterns similar in terms of their manifestations may have different functions and serve different purposes in various cultures.” (35, p. 24). In the reviewed studies women have common reactions to labour pain across different ethnic groups which transcend ethnicity and culture, for example, the feeling of fatigue, which was felt at an emotional and physical level.^{25,33} Some women felt defeated by the entity of pain, they were at times in despair and with very little strength,³² and in extreme moments of labour they preferred death to continuing with the process of childbirth.³³ Zborowski’s premise highlighted attitudes such as pain apprehension in e.g. North American women, who wished to avoid the sensations of labour pain, regardless of how they felt the pain or whether they accepted the pain. Furthermore, pain anxiety arose when a woman was focused on the causes of her pain, the meaning of her pain, or its importance in terms of her overall wellbeing, or the wellbeing of her child. Zborowski concluded that anxiety was provoked by the pain experience (35, p. 18). In the

reviewed studies, women’s attitudes to pain also differed according to culture, caregivers, and birth setting, for example, and these factors influenced women’s perceptions and experience of birth pain.

Religion and spirituality

Across cultures, birth and death are often considered in the context of religion and/ or spirituality. Birth narratives, which are interwoven with religious faith, may show the significance of pain in daily life, which cannot be separated from the concept of being human.⁵ Pain, provides individuals with an opportunity to look closely at behaviours, which are connected to suffering, and, as a result, they may come to a deeper understanding about themselves and others. This was exemplified in the reviewed studies in Iranian culture, where women who were fearful of birth felt that God helped them to endure their pain by discerning how their labour would end and assisted and accompanied them throughout labour.²⁷ This maternal understanding was also present in Ghanaian culture²⁶ and Finnish culture³⁰ where some women felt it was God’s will that they went through the pain of labour. In addition, African and Brazilian women associated suffering with labour^{23,34}. Therefore, birthing women expected the pain.^{23,30,34} Through prayer, Indonesian and Ghanaian women felt Allah/ God provided for or assisted them in having a safe birth^{26,28}.

As has been documented in anthropological, midwifery and medical

research, religion plays an important part in the cultural rituals of childbirth. For example, Mayan religion views birth as a critical life event for the individual woman and her community;³⁶ this is in part due to, what is considered in the local Mayan context as, the precariousness nature of childbirth at a physical level for birthing woman and their babies, and at a spiritual level, the childbirth processes brings the birthing woman and her family closer into contact with the spiritual realm.³⁶ Rituals around labour can be quite complex, as viewed in Tibetan culture, where women and family undertake long journeys to make religious offerings or seek out particular materials or food, for example, eating fish from a certain region in Tibet, so the birthing woman will have a safe and less difficult labour³⁷.

In the reviewed studies, women also viewed childbirth as a form of rebirth in Swedish³¹ and Finnish³⁰ cultures. From an Anglo Caucasian Western perspective, we contend that this term is usually interpreted metaphorically and is representative of the great transition that occurs during pregnancy and labour. The pain experience is often part of this passage to motherhood. However, cross-culturally the rebirth concept may be interpreted differently; for example, Liamputtong's³⁸ examination of reproductive beliefs in Hmong culture revealed that a child could only be conceived once the 'spirit parents' give their approval to the appropriate soul. This soul will then be reborn as the future child to a woman who is privileged to become a mother.³⁸

This example illustrates that profound concepts such as rebirth are open to interpretation depending on ethno culture, adding to the potential complexity of interpreting the cultural nuances in childbirth.

Difficulty in defining pain

There are elaborate cognitive processes, which take place when the mind is submerged in pain (39, p. 26). Whose role is it to label the experience as 'unpleasant' or as 'pain'? Is it the woman or the midwife? There is no correct way of denoting pain. Furthermore, providing a standardised universal understanding of pain, one in which all perspectives agree, is an insurmountable mission.⁵ Therefore pain is often difficult to convey, and in the reviewed studies this was due to a number of factors. Swedish women found labour to be contradictory in nature³¹. Finnish women experienced highly emotional states³⁰, and North American women, although they reported feeling bodily distress, still described labour as beyond description²⁵. There may be a difference in the recall of pain according to the type of experience and its impact on the maternal perception of pain which is evident across the spectrum of birth experiences. For example, Caffrey⁴⁰ highlighted the difficulty of describing an orgasmic birth, which was deemed empowering and healing. The study participant had read about orgasmic birth prior to her labour, but felt her experience did not match what she had read. Further, her support people perceived her orgasmic moments as the

most painful moments of her labour⁴⁰. Childbirth also becomes difficult to define in the data of women who have a deep fear of childbirth⁴¹. For example, severe pain in addition to the maternal experience of not being present, and an indifference in midwifery attitudes towards the birthing woman, were associated with suffering during labour, and thus distressed women were fearful of subsequent birth experiences.⁴¹ Pain therefore carries an intimate and unique meaning for the individual and this can never be completely understood by another person⁴² regardless of the context of birth.

Role of anxiety on pain acceptance and tolerance

Minimal or non-pharmacological intervention during labour was another aspect shared cross-culturally; however, this carried different meanings in each culture. For example, in Finnish culture³⁰ and Dutch culture²⁹ the decision not to use pain medication was based on the worldview that childbirth is part of the wider scope of female health. In African culture the same decision was due to maternal expectations of a natural birth and birth as a natural phenomenon in daily life.^{23,26}

In contrast, women in Indonesian culture gave themselves over to pain in an acquiescent manner and believed that pain was a phenomenon that could not be controlled; consequently, these birthing women could not express their satisfaction easily regarding how their pain was managed during labour.²⁸

From this perspective, in the reviewed studies, women may have experienced higher levels of anxiety due to not having a clear understanding of pain management nor being provided with pain management options.²⁸ Their low intervention births were one of circumstance and not of choice. In addition, a feeling of isolation due to the birth environment e.g. technocratic hospital environment,²⁴ or as a recently arrived migrant to a new country,²³ may form part of maternal anxiety during labour.

Conversely, Finnish women³⁰ or Dutch women²⁹ felt more centred in themselves and in their wellbeing as birthing women and as females, due to being empowered. This is evidenced in the wider literature in studies such as Hardin's and Buckner's,⁴³ where women were able to have some control over their body, control over their decision making regarding the birth setting, control over how they move their body, and being supported in their decision to have no pain medication. These are nuances that are often hidden in cultural generalisations of birthing women.

Pain and conceptualisation of motherhood

Labour may be considered one of the most extreme pain events in a woman's life, and yet also one of the most fulfilling (44, p. 335), which makes pain communication an intimate and complex process. This is revealed in women's accounts of birth across Iranian²⁷, Finnish³⁰ and North

American³³ contexts in the reviewed studies. In addition, the cognizance of childbirth as a woman and as a mother is often mentioned in childbirth narratives, particularly in phenomenological research. In the reviewed studies this was prevalent in North American women, who recognised a range of emotions connected to their birth experience,³³ and Swedish women, who were finding the profound meaning of birth.³¹ Women in Finland,³⁰ the Netherlands,²⁹ Africa^{23,26} and England²⁴ considered pain as naturally connected to the labour process: for example, it brought them closer to their babies,³¹ brought a necessary process to a conclusion,²⁴ or it signified a function that was vital to the process of birth.²⁹ Rayner⁴⁵ argues that during pregnancy, with the feeling of the baby's first movements, maternal cognizance becomes ever-present, and a woman may become more excited about motherhood. We contend that women may also experience a healthy level of concern, which may be represented in feelings such as enthusiasm, desire, impatience, or a longing to meet her baby. Conversely, the perinatal period may also be experienced by some women as a reflective and intense experience impacted upon by anxiety and mood,⁴⁶ as exemplified in the reviewed studies by Ghanaian²⁶ and Brazilian³⁴ women, where mothers-to-be experienced anxiety about their baby's wellbeing and the process of childbirth.

Psychological impact

Birth as bodily distress was

identified in North American women who were debunking birth mythology²⁵, Ghanaian women who were acknowledging distress as part of the birth experience,²⁶ and Brazilian women who viewed childbirth as cataclysmic;³⁴ therefore in the reviewed studies, distress was understood according to not only how women experienced pain, but also how women perceived childbirth individually and cross-culturally.

The type of experience a birthing woman has can have psychological and physical implications on her postpartum health.⁴⁷ For example, women who had a forceps-assisted vaginal birth were most likely to have ongoing psychological concerns such as post-traumatic stress disorder.⁴⁷ This has the potential to impact on a woman's postpartum perceptions of labour and therefore her conceptualisation of childbirth as bodily distress, similar to how distress is viewed by the Brazilian mothers in Nakano et al.'s study.³⁴ In contrast, women may view bodily distress as common, and this understanding of physical change or bodily phenomena has been established during pregnancy e.g. where women are captivated by the evolving functionality of their body,⁴⁸ similar to women from Ghana²⁶ or the United States²⁵ in the reviewed studies.

Pain and meaning

Profound meaning is found in life stages such as childbirth and illness where pain is often present.⁴⁹ For example, pain was subsumed as part of the wider birth experience, which

was considered a rewarding and memorable life event in the homebirth context;²⁹ whereas in a clinical birth with a prolonged labour, the role of pain became quite prominent and connected to a life-threatening phenomenon, which ignited anxiety and fear in some birthing women.³² Therefore, gaining insight into the type of childbirth, in addition to ethno culture, can assist in building an understanding of childbirth practices and behaviours. In the wider literature, women who had experienced prolonged labour were consumed by an intense pain and accompanying emotions due to a negative birth experience, in which childbirth was comparable to death.⁵⁰ Therefore labour also equated to suffering and women felt damaged or frightened by the process.⁵⁰ Furthermore, other studies highlighted that prolonged labour was more commonly experienced by primiparous women, who also experienced worse labour outcomes (51, p. 6).

Societal beliefs

Some women's belief systems about childbirth are also based on underlying societal beliefs. For example, women's belief that boys are easier to birth than girls,²⁷ or that when a woman shouts out during labour that means she has been overly pampered,²⁶ or that birth is embodied by chaos.³⁴ From an anthropological perspective, the practices from Asian, African and South American cultures which are

tied to these beliefs may be viewed as rituals.⁵² Birth knowledge is retained through cultural rituals and practices.^{53,54} It is important to value the individual by showing respect for cultural norms thus enabling better communication, which in turn enables better outcomes for the individual's pain. However, this communication needs to be approached in a sensitive manner and may become a form of negotiation in order to ensure that the cultural norms do not hinder the best option of care according to evidence-based practice.⁵⁵ There may be a necessity to find a compromise between asking an individual to change their cultural behaviours towards their pain management and the health professional's role in guiding the individual to make an *informed* choice for their specific needs (55, p. 45).

Model of birth care

In a clinical context, midwifery practice may be influenced by one or a number of models of care depending on the midwife's education and work culture.²¹ For example, the midwife may practice within the biomedical model or technocratic model,¹² the social/ woman-centred model of birth;⁵⁶ the biopsychosocial model,⁵⁷ which contains elements of Davis-Floyd's humanistic model;¹² and finally the holistic model of care.¹²

The cultural context of the care model may impact on the experience of labour pain. In the reviewed studies, in a clinical birth setting, the predominant

culture was the technocratic model, which appeared across three continents: Africa,²³ the United Kingdom,²⁴ and the United States,³³ and which was alluded to in a Brazilian context.³⁴ The technocratic model has raised some of the most pressing questions, one of the most important being, “it’s view of the body as being endlessly malleable by science” (58, p. 3), which has brought into focus the social and ethical implications in the conceptualisation of the bodily self.⁵⁸ The technocratic model is echoed in the reviewed studies where there was a reliance on pain medication,²³ limited mobility due to monitoring during labour,³³ an onus on the medicalization of birth,³⁴ and the use of technological birth equipment and the element of risk.²⁴

The reviewed studies depict shared childbirth beliefs and practices across cultures, which in part can be attributed to common physiological factors of childbirth. We contend that, with the exception of when pain overrides or minimises potential cultural influences e.g. the anxiety or distress of a prolonged labour, the studies exemplify a type of chain reaction in birth. That is, the studies show how maternal perspectives may be influenced by a variety of internal and external factors, which are acted out through decision-making processes, which impact on or

lead to the type of birth experienced. For example, internal factors include the psychological, emotional, and the religious/ spiritual, and external factors include environmental (the physical birth setting or the context of childbirth) including the culture of the birth care environment e.g. technocratic culture.

APPLICATION AND IMPLICATIONS

Cultural awareness and sensitivity to potential intercultural communication issues in birth is a non-technical skill in midwifery, which can be cultivated formally through professional development courses, or informally through opportune moments in daily practice.⁵⁹ In Figure 1. we present a framework for the interpretation of cultural competence in communication between the midwife and the birthing woman during labour. In addition to becoming aware of the cultural patterns in labour, midwives may also consider the model of care in which they work in e.g. holistic, humanistic/ biopsychosocial and/ or technocratic/ biomedical.

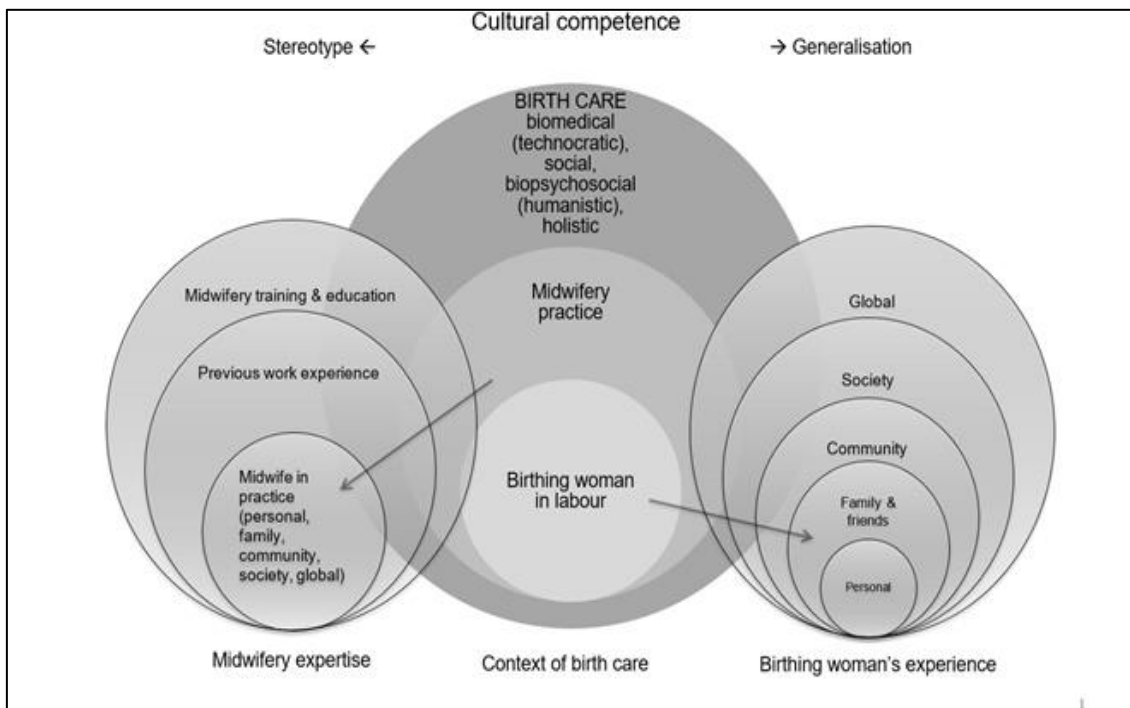


Figure 1. Nexus of culture in labour care. Overview of cultural competence taking into consideration example models of birth care and Davis-Floyd (1994, 2001) framework

As we have discussed, the birthing woman's non-elicited pain language is shaped by her culture and her beliefs about health, and this is shown through verbal and non-verbal behavioural cues/communication²¹. However, it is unhelpful to stereotype, assume or generalise the nature of an individual's pain, including their pain tolerance or pain reactions based on limited experience with a particular ethnocultural background².

According to Galanti⁶⁰, a cultural stereotype is an ending point in that the learner does not investigate further whether or not the stereotype is suitable (60, p. 335) for a particular person or group of people, which adds to the risk of cultural misinterpretation. In contrast, a generalisation is reporting a shared tendency within a group. Hence, a generalisation may be viewed as a

starting point to comprehend another's culture⁶⁰ or to provide a preliminary basis for understanding a wider ethnoculture. In this review, several generalisations have been made about birthing women across African, Asian, European, North American, and South American cultures. If these generalisations were perpetuated without/ outside their original research context they could then become stereotypes; for example, African women do not want or need pain medication; Scandinavian women always view childbirth as a natural phenomenon and as a positive experience; or North American women often choose to have epidurals.

Therefore health care professionals are advised to pay particular attention to intra-ethnic variation, rather than the variation across ethnic groups⁸. Green et

al.⁶¹ provide an example of this variation in their study, which focused on two socioeconomic stereotypes of birthing women in southern England. The results disproved myths regarding both stereotypes, and clarified that women from varying levels of education across socio-economic groups were equally likely to maintain the ideal of a drug-free labour where possible⁶¹; for example, the less educated mothers did not wish to relinquish control during labour, and they held the highest expectations regarding birth as a fulfilling life experience (61, p. 125). Such studies add to a growing body of qualitative birth research that sensitively refutes existing generalisations of birthing women that may be considered misrepresentative⁶¹.

Labels such as 'ethnic minority' minimise other contexts of health, such as personal, regional, generational or sometimes socioeconomic differences within one community (58, p. 3). If there is no acknowledgement, for example, of inter-ethnic variation of participants, this may inadvertently create harmful generalisations. Sometimes a stereotype is reinforced by the health literature, which (inadvertently) surmises fixed characteristics for a particular culture⁵⁸. However, sometimes a stereotype provides the only piece of information a midwife can access in the moment in a busy clinical context, particularly if they have not met the birthing woman beforehand (61, p. 126). An incorrect generalization or stereotype may be relied upon a little too easily⁶¹, which in the context of childbirth can cause a

misinterpretation of pain communication

CONCLUSION

Narratives capture rich information regarding individual and wider ethnocultural birth values and practices. It is clear that there are universal physiological and psychological phenomena of birth across African, Asian, European, North American and South American cultures such as fatigue, anxiety and distress, which manifest in different ways according to the individual woman e.g. as a recently arrived migrant to a new country or as a woman experiencing prolonged labour. There are also specific cultural practices and cultural interpretations of pain, which may impact on how women view their options for pain management. For example, practices which are internally driven by pain reactions and attitudes, religion and spirituality, pain definition and meaning, anxiety, and pain acceptance and tolerance. Practices may also be externally driven by environmental factors such as the physical setting or context of childbirth and the model of care. These internal and external factors may affect how much a birthing woman feels she is in control or without control, regarding how she manages her pain, how she views her pain options, or how others assess and manage her pain.

It is important for midwives to become aware of these cultural patterns and incorporate this awareness into their own professional practice. The midwifery non-technical skillset includes the development of cultural

competence, which is particularly pertinent to interpreting pain communication. Midwives can learn to differentiate between stereotypes and generalisations. Informed cultural generalisations are useful, but are only one aspect of providing a comprehensive understanding of pain.

Midwives can also consider how the individual birthing woman is viewed

within the model of birth care in which they work. A comprehensive pain assessment may also include the use of standardised pain assessment and the observation of the individual woman's verbal and non-verbal behaviour during labour.

Conflicto de Interés: Los autores declaran no tener conflicto de interés

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