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Full Length Research Paper

The being-in-the-world in the final trimester of a low-risk gestation reveals a being-with needing care

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Abstract

The goal of this study was to: understand the pregnant Being-in-the-world (Dasein) in the final trimester of a low risk pregnancy. The present article is the result of qualitative research based on Heidegger's phenomenology. Ten interviews were conducted with pregnant women in their third trimester of a low risk gestation. Results: due to their limitations, the pregnant Dasein becomes dependant of her partner and family. The pregnant Dasein longs for the moment that she will take care of her baby, be in its company, because she already fosters feelings for the baby. The pregnant Dasein in the final trimester of a low risk pregnancy requires care and support from her partner and family members during the pregnancy. It was noted that this being has doubts, fears and longings, and is more vulnerable. Therefore, a nurse that carries out low risk prenatal care during this period should be present, improving the quality of the approach to women and thus meet their needs.

Keywords: Pregnancy, Qualitative Research, Prenatal care, Nursing Care and Philosophy.

INTRODUCTION

The present article is part of a research under development, carried out by nursing academics as a compulsory activity for the conclusion of an undergraduate course in nursing. Following this line, the gestational period should be regarded as a completely unique phase that requires nursing assistance. Nursing, in the past few decades has established itself as a science, founded on praxis, based on evidence. The care with a patient is the essence of nursing practice, and understanding that this care isn't merely the fulfilment of requirements, but also includes interaction, contact, a helping and listening relationship, meeting the needs of the client, establishing a condition of independence and self-care.

Through this point of view, the process of nursing shouldn't be based on merely identification of signs and clinical symptoms or the execution of interventions, but on the changes that occur to the human structure that can affect its entirety, so that the one being taken care of is aware of the interest and respect towards her, conveying security and trust (Mutti et al., 2012).

Gestation can be discussed from several angles, from the psychic, completely unique, to the physiological process of reproduction of our species. From a physiological point of view, a woman's life cycle is marked by three moments of intense change, which are adolescence, gestation and climacteric (Maldonato and Dickstein, 2010). Just as the other aforementioned moments, pregnancy constitutes a transition with different aspects for each woman. Other than the biological process, there are social dimensions that involve the collectively, mobilize the family, and the surroundings in which the women live (Rezende, 2005).

In the third gestational trimester anxieties intensify upon approach of childbirth and the change in the daily routine after the baby´s arrival, manifesting itself greatly through childbirth fears, such as fear of pain and of death, physical discomforts; old memories and childhood conflicts of the mother-to-be with her own parents or siblings can also be more easily relived. The resurfacing

of these experiences can open up the possibility of interference in the mother-baby relationship as well as in the preparation for childbirth (Brazil, 2012).

Hence, the third trimester is a critical period for the woman, full of physical and psychic alterations, since the mother-to-be is not just a reproducing being, above all else she is an everyday Dasein that is going through a life-changing moment. This justifies and carries with it the relevance of this moment in the gestation as an object of research. The mother-to-be in the final trimester of a low-risk gestation is a thrown Dasein constantly relating with other beings, things and with herself. Therefore, she is a Being that is being-together in a dynamics of relationships; she is a Being-with. One never presents oneself to the world in an isolated manner, but is always thrown into relationships with others, things and with oneself (Heidegger, 2012). In human relational nature, every being is always with, even in loneliness and isolation. In this context, the need for nursing professionals to understand how the pregnant Dasein in the final trimester of a low risk pregnancy relates with other Beings can be observed.

In light of the above, the objective of this study is limited to: understanding the pregnant Dasein in the final trimester of a low risk pregnancy, to then get to know the world of this being that possesses an experience.

Literature review

With respect to the physiology of the woman-Being, gestation is a natural event, defined as the period between fecundation and the birth of the conceived. It is a multifaceted process marked by a sequence of complex facts, in practically all of the woman's organic systems, that follow paths that are completely unique in the formation of each new human being. During this period, many physiological changes occur to adapt the feminine organism to the growing demands of the conceived, such as changes to the anatomy and biochemistry which are reactions to the hormonal overload and to the mechanical actions set off by the impregnated womb (Costa et al., 2010).

Therefore, maternity is associated to transformations to the body, such as psychological and social ones, that can interfere in the intrapyschic and inter-relational scope of the mother-to-be (Piccinini et al, 2008). As from gestation, women experience maternity itself as space that is taken up little by little by the baby.

This fact can be observed in the organization of the physical space that her child will inhabit after the baby is born and by their belongings. Other observed behaviour of the experience of motherhood before the childbirth is the care that the woman takes with herself due to the baby's constant presence. Therefore it is not only through material aspects, or everyday facts, that the mother is revealed during gestation (Costa et al., 2010).

The many physical and emotional transformations undergone during pregnancy create an experience that is unique and sets off a series of surprises, joys and distress. These emotions are experienced by the mothers-to-be at every pregnancy, no matter how many times she has been pregnant before (Mota et al., 2011).

The emotional issues the mother-to-be experiences vary according to the gestational period in which she is in and this is divided into three trimesters (Brazil, 2012).

The following signs and characteristics are observed in the first trimester: ambivalence (to want and not want the pregnancy); moment of communication of the pregnancy to the partner, family and friends, which can have varying repercussions depending on the context of the pregnancy; anxiety and doubts about being or not being pregnant, since the foetus still cannot be undoubtedly felt and changes in the body are still discrete; fear of miscarriage; mood swings (increased irritability, vulnerability and sensibility), emotional instability; first changes in the body and some discomfort such as nausea,vomiting, drowsiness, excessive sleepiness, tender breasts and fatigue; food cravings and aversions and an increase in appetite (Brazil, 2012).

During the second trimester the mother-to-be experiences changes to her sex drive and performance and tend to appear with greater intensity. A decrease in the sex drive is commonly found. In some cases, an increase in sexual satisfaction, alterations in the body's structure; awareness of foetal movements and its impact (the child's presence is undoubtedly felt) which brings about relief and the interpretation of the foetal movements is a stage of the development of the mother-baby relationship. In the mother's imagination, the foetus starts to acquire peculiar characteristics and to communicate with her through its movements; the partner may wish to also feel the foetal movements and to communicate with the baby through the mother's belly, thus, the foetus is included in the familial relationship dynamics (Brazil, 2012).

Finally, in the third trimester, it can be said that anxieties are intensified with the proximity of the birth and changes in the routine after the baby's arrival; childbirth fears manifest themselves (fear of pain and death); physical complaints increase and old memories and childhood conflicts of the mother-to-be with her own parents or siblings can be more easily relived (Brazil, 2012).

Role and duties or the pre-natal nurse

The Humanization of Prenatal and Birth Program (HPBP) was created in the year 2000 in order to widen pregnant

women's access to pre-natal care, it created qualifying criteria for pre-natal care consultations, other than encouraging a link between ambulatory assistance and delivery and other objectives (Brazil, 2002).

Other than the HPBP, the Ministry of Health (Brazil, 2002) has a health care program for pre-natal and puerperium care, that focuses on receiving pregnant women and also on the accompaniment of the birth and on the woman's wellbeing.

The pregnant woman's knowledge of the importance of pre-natal care is generally limited, as well as that of breastfeeding, vaccination and preparation for the birth. Prenatal care consultations should constitute a space for exposing doubts and expressing anxieties, with a flow of necessary information in a personalized manner. Within this context, the nurse should direct her towards promoting her health and prevention of complications (Teixeira et al., 2010).

Pre-natal care for low risk pregnancies can be performed by a nurse, specialist or non-specialist, as foreseen in the Law of Professional Exercise of Nursing, decree nº 94.406/87 (Brazil, 1987), in that, it is the nurse that should, as foreseen in law number 7.498/86 carry out the nursing consultation, nursing prescription, prescribe medication, as long as established in public health programs and in routines approved by the health institution. It is also the nurse's responsibility to provide assistance to the parturient and to the puerperal, and to provide health education (Brazil, 1986).

In pre-natal care, the nurse provides guidance on general health care, the more common physiological and emotional alterations, baby care, breastfeeding and family planning (Brazil, 1986).

It is up to the nurse to provide guidance on the inevitable changes that will likely occur during the gestation. The point of the activity of health education is to prepare the woman for the natural birth experience, with a reduction of possible fears and anxieties (Costa et al., 2010).

Pre-natal care can be carried out in units of basic health care or in home visits. The scheduling of consultations or visits should respect the gestational period, classified in trimesters. The regularity of the appointments are more frequent in the third trimester, when obstetric complications become more common. The recommended minimum number of consultations is six, with a nurse and doctor, with the following distribution over a healthy gestation (Brazil, 2012):

- Up to the 28th week – monthly;
- From the 28th to the 36th week – fortnightly;
- From the 36th week to the 41st week – weekly;

After a survey of the scientific publication bibliographical databases from the Virtual Health Library (VHL), the year 2005 was used as a temporal fragment, the descriptors gestations, qualitative research and obstetrical nursing were used and 38 publications were found as a result, being that 07 are related to obstetrical nursing and only 04 are related to assistance of pregnant women.

In this sense, the research is justified, with the expectation of contributing to assistance implementing light technologies, with the hope of providing support to the practice of pre-natal and obstetrical services; to teaching through the production of implemented theory and to research incentivizing the development of new research innovating the set of nurse care tools.

METHOD

This is a qualitative research of a comprehensive approach with a reference of phenomenological analysis based on the ontology of Philosopher Martin Heidegger.The qualitative approach allows the focus of different experiences, as a result of the relationships and meanings of the context of the many natural cenarios (Lobiondo-wood and Haber, 2004).

Qualitative reaseach in nursing has contributed to the holistic understanding of man, other than making it possible to better explore each assistive situation. The adoption of caring models, founded on beliefs, values and experiences of the individual, suggests a humanized foundation of the health-illness process, for which the comprehensive approach has shown promise, because it studies the experience and meaning through the assisted client's point of view (Almeida, 2009).

With everyday experience, there is an approximation of the fundamental human problems from everyday life to show the phenomena experienced (Santos and Sá, 2014).

Phenomenology is used as a methodological proposition, in the area of health since it showed itself as a possibility for understanding the human being as a whole (Almeida, 2009).

The technique used in the fieldwork phase was a phenomenological interview. This is an open approach, which allows the subject to talk about her experiences, affected by the empathy between the interviewer and interviewee (Camurra and Bastistela, 2009).

The cenarios of this research were the municipalities of Rio de Janeiro and Nova Iguaçu, where the interviews reside, in order to ease the conduction of the interviews and to provide a picture of parte of the reality of our world.

The women were chosen by the researchers, while observing the criterias for inclusion and exclusion. The criteria for inclusion in the study was to be a low-risk pregnant woman between 26 and 41 weeks of gestation, under pre-natal care. And exclusion criteria were the non-fulfilment of the criterias of inclusion. To recruit these women we used the methodological technique snowball, known in Brazil as "Bola de neve" or "cadeia de informantes" ("chain of informants"). This sampling

technique results in a structure of reference chain. The initial pregnant women in the study refer other new pregnant women that they know and these in turn refer others, until the moment at which the essential structures become similar and the fieldwork stage is concluded. The sequence of new references carried on until the content obtained in the former interviews was repeated, without adding new and relevant information to the research (Baldin and Munhoz, 2011).

Meeting ethical requirements for research, authorization from the interviewees was conceded after signature of two copies of Free and Informed Consent (IC) Terms. One of the copies remains with the deposed and the other copy with the interviewers. The IC guarantees the deposed confidentiality and anonymity and the number of the approval and issuance of substantiated opinion was 655.326.

Following this line, the pregnant women were identified with a letter G and a roman numeral, numbered according to the order of the interviews.

The interviews were previously scheduled according to the availability of the deponents, and the statements were recorded with the use of a voice recorder and later transcribed for analysis.

The collected remarks were transcribed and separated into units of meaning, based on the theoretical fundamentals, to meet the objective of the study. Ten pregnant women participated and the interviews lasted 20 minutes on average.

As a method for carrying out the analysis, sections of their remarks that met with the objectives of the study were highlighted, using the universal traffic color code, green for essential structures, yellow for later revision and red for whatever was considered occasional/accidental. The green sections were used in the analysis, the yellow were revised and the red discarded.

Afterwards, the chromatic codification continued for all the essential sections, which then received a new free chromatic codification, where similar sections were given the same color and grouped in a square and identified with a caput, for presenting similar themes. Then, the meanings that were similar were added and detailed, and in doing so we constituted the units that were illustrated with the fragmenrs of the speeches of the deponents.

The units were named according to the fundamental sections that repeated themselves in the pregnant women's speeches, composing the conductive line of vague and median comprehension, always using the methodic rigor of Martin Heidegger's line of thinking.

RESULTS

Starting from the partial analysis of the speeches the pregnant Dasein in the final trimester of a low-risk-pregnancy was unveiled and reveled the Being with (Mitsein) through the following unit of meaning (UM):
U.M. The woman with the belly depends on the support of her partner and family and feels the baby's presence.

> *[...] I am the one carrying [...] both are pregnant only I have a belly and he doesn't [...] my mother was the happiest out of everyone, even more when she found out it was a girl [...] (G 1)*
>
> *[...] the good part was that I was already with my husband [...] living with him, [...] we like each other, and he is excited [...] and also anxious for the baby to be born. (G2)*
>
> *[...]my mother seems to love me more, my cousin even decided to visit me, it was something that my family wouldn't do because I live far away [...] My husband started to help me more [...] I think he (baby) already understands me. When I feel pain he stays still, he stays quiet. When I'm sad, home alone I talk to him, and he keeps moving around and it seems like he is answering me [...]* (G 3)
>
> *[...] now I am dependent of him (husband) [...] I can't clean the house anymore, I can't clean a bathroom [...] sometimes he arrives from work tired ... he helps me* (*G 4*)
>
> *[...]when it's there (the baby) you can't not love it , not have feelings [...] (G 5)*
>
> *[...] as a mother we think everything is important and tell the husband [...] He was really happy [...] If I were to feel unwell I have already given him a list of what to do, where to take me [...] That moment of the bath where it's just you and the belly, and you start to imagine that soon you will be giving your daughter a bath [...] (G 6)*
>
> *[...] my mother is loving her grandchild [...] the father is making himself present [...] he goes with me to the consultations [...] it is good to know that someone is with you taking care of you [...] and I am very restless [...] he (the baby) is already starting to get comfortable in his mother's belly (baby) [...] (G 7)*
>
> *[...] I like to have my husband 's support[...] when my little one comes to kiss my belly, he rubs affectionately and says " mommy how is the baby?" (G 8)*

The pregnant-Dasein-in-the-final-trimester-of-a-low risk-pregnancy in her everyday existence unveiled in her

vague and median comprehension that when both become pregnant and like living together and the father of the baby makes himself present and offers support, as well as the family being together, paying visits, offer attention and care. Which is important to the mother-to-be because it gives her security.

The mother-to-be in a low risk pregnancy looks forward to the moment she will take care of her baby. On the other hand, even before the birth, the baby that will be born seems to already understand its mother almost as if answering to the woman that already loves it.

The hermeneutics: pregnant-Being-in-the-final-trimester-of-a-low-risk-pregnancy announces herself as a Being-with (Mitsein), conducted by solicitude

The pregnant-Dasein-in-the-final-trimester-of-a-low-risk-pregnancy understands the need of being-together and pre-sense, acting and interacting in a continuous Being-with. The Being-with is a constitution of us, it is the manner that human beings relate with one another since the Being isn't an isolated I to others, the pre-sense is co-pre-sense, the world is shared, living is always coexistence (Mutti et al., 2012).

The pregnant-Being-in-the-final-trimester-of-a-low-risk-pregnancy shows the Dasein, essentially in the world in her fundamental relational characteristic and true human. The presence of the partner, family and baby are evidenced by the mutual relationship, because they are close to someone, relating, living and caring for each other. The facets of the existential movement of comprehension are revealed, in everyday coexistence, because it engages with other Daseins and with the context. Therefore the Being-with cannot be understood simply as man's behaviour or attitude, because it is a fundamental given of the human condition, Dasein.

The Being-with is in constant contact with other beings and care emerges from this relationship. Thus, care presents itself as a manner of proceeding with the world's involving entities, in this sense, care takes the form of solicitude. Care then becomes an existential possibility of Being, or, the essence of human existence (Almeida, 2009). The human mode of being involves the relationship with simply given entities (things) and with entities possessing pre-sense character (people) that are linked to the two modes of caring: occupation and pre-occupation.

Preocupation is related to the Being-with, because it is the way the way the Dasein relates with, involves with, cares and takes responsibility for another that carries the meaning of solicitude, which is to be available to take care of another (Almeida, 2009). Considering all this, we observe through the testimonies, that the mothers-to be are Being-with the baby that is about to arrive and their pre-occupations are linked to the birth, if the baby will be born healthy and how to take care of her child and to integrate it with the family. Furthermore, we realised that the pregnant-Dasein-in-the-final-trimester-of-a-low-risk-pregnancy also
receives help mostly from her partner, so that this final phase is easier and less physically demanding. This care is not limited only to the partner but every entity within her world.

CONCLUSION

This investigation allowed for the exploration of the comprehension on Being-with, experienced by mothers-to-be in their final gestational trimester of a low-risk pregnancy. Through a phenomenological focus is was possible to unveil a pregnant-Dasein-in-the-final-trimester-of-a-low-risk-pregnancy through knowing the everydayness from where it was possible to observe the world in which they live in, through their remarks we noticed that the pregnant-Dasein-in-the-final-trimester-of-a-low-risk-pregnancy is a Being-with with the baby even before she has held it in her arms, since care is taken from the moment of confirmation of the pregnancy and intensifies at each gestational period and most visible in the final stage of the pregnancy cycle.

This care doesn´t come only from the pregnant-Being-in-a low-risk-gestation with the Being-with that is the baby. Thus, the pregnant-Dasein receives care mostly from the partner and acknowledges that. We then realized how important the family's role is at this moment of the gestation.

In this sense, we understand the importance of the nursing professional in basic care, performing the prenatal care that can also be-with the woman and identify through empathy what bothers her, her doubts and fears improving the quality of the approach towards women with the aim of meeting the demands of this Being.

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