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AN ETHNOGRAPHIC STUDY OF WOMEN UTILIZING HYPNOBIRTHING: THE MONGAN METHOD

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AN ETHNOGRAPHIC STUDY OF WOMEN UTILIZING HYPNOBIRTHING: THE MONGAN METHOD

by

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Dedication

This research is dedicated to the women that participated in the study and shared their birth stories. Additionally, it is dedicated to my family: Allan who is the love of my life and my best friend; my children and grandchildren who give life meaning to see they have futures in this changing world around us. As you read and hear this research information, I hope you understand why this research was so important and why I missed soccer games, Halloween nights, school performances, and birthday parties.

My children and grandchildren who I love so much are: Shane, Michelle, Charlotte, and Zachary; Joshua, Michelle, Payton, and Presley: Brad, Allison, Sydney, and Eliana. Thank you, Allison and Allan for driving me to Galveston multiple times, while I was recovering from chemotherapy, radiation, and multiple surgeries. Thank you, Allison, Brad, Sydney, and Eliana for sharing your birth pictures and encouraging me to finish in the face of multiple health problems.

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AN ETHNOGRAPHIC STUDY OF WOMEN UTILIZING HYPNOBIRTHING: THE MONGAN METHOD

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The purpose of this ethnography was to explore the values, beliefs and perinatal practices of women, who utilized HypnoBirthing. The aim was to explain the culture of HypnoBirthing through women's perceptions of their experiences of choosing, attending, and using HypnoBirthing. HypnoBirthing is a philosophy and childbirth education method used internationally that fosters a natural birth, combining childbirth information, self-hypnosis, and positive affirmations. Expanding research points to HypnoBirthing efficacy and safety reflected in more positive maternal/infant outcomes versus dominant childbirth methods including fewer preterm births and higher infant birth weights as well as less medical and surgical interventions ie: 17 % cesarean rate versus 32 % (Dolce, 2010). However, research is limited which examines women's reasons for choosing this unique method and perceptions of the actual HypnoBirthing experience.

This research drew on Spradley's concept of culture as a system of shared values, beliefs, behaviors, language, social interactions, and environment (1979, 1980). Additionally, Lederman's (1996) theory of *Psychosocial Adaptation in Pregnancy* was

used as a guide in explaining how values, beliefs, and practices inherent in HypnoBirthing influenced maternal responses to pregnancy and birth. Spradley's methodology (1979) guided the data collection (demographics, interviews, and participant observations) and analysis. The purposeful sample included 11 Caucasian women in the U.S who utilized HypnoBirthing. Study rigor and trustworthiness criteria included *credibility, transferability, dependability,* and *confirmability* (Lincoln & Guba, 1985).

Results of this ethnographic study strongly reflect all participants who used HypnoBirthing shared core cultural values and beliefs that influenced their choice to initially adopt this unique method and use it throughout their pregnancy, birth, and postpartum. These shared values and beliefs were categorized into three distinct themes: 1. "*Having it Mommie Driven"*- the need to have choices, sense of control, and being empowered 2. "*Overcoming Difficult Times"*- the ability to transcend challenges in the environment and method and shape their own meaningful experiences 3. "*Feeling Connected"*- the strongly expressed desire for women to bond with their babies and partners, while transitioning into motherhood. Findings may potentially help healthcare professionals provide more individualized and culturally-sensitive health care for women who select HypnoBirthing: The Mongan Method for childbirth.

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List of Abbreviations

AAP	American Academy of Pediatrics
ACOG	American College of Obstetrics & Gynecology
CBE	Childbirth Education
CDC	Centers for Disease Control
DRS	Developmental Research Sequence
EBP	Evidenced-based Practice
GSBS	Graduate School of Biomedical Science
HP	Healthy People
IOM	Institute of Medicine
IRB	Institutional Review Board
NIH	National Institutes of Health
NHS	National Health Service
USPHS	United States Public Health Service
U.S.	United States
UTMB	University of Texas Medical Branch
RQ	Research Question
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

INTRODUCTION

Chapter One identifies the study problem, purpose, and research questions. The background and significance of the study are presented. The justifications for the research design using Spradley's Ethnographic conceptual framework are explained. Lederman's Psychosocial Adaptation in Pregnancy: Seven Dimensions of Maternal Role Development (Lederman, 1996; Lederman & Weis, 2009) is introduced as the sensitizing framework. The plan for the presentation of the remaining chapters is provided.

STUDY PROBLEM

Childbirth is a sentinel cultural event (Davis-Floyd, 1994; Nichols & Humenick, 2000; Spector, 2004) with significant psychological importance in a woman's life (Lederman, 1984, 1996; Lederman & Weis, 2009; Mercer, 1981; Nichols & Humenick, 2000; Rubin, 1984). Childbirth practices are influenced by a society's cultural values and beliefs, which affect how women interpret their childbirth experience and women's self-esteem (Lederman & Weis, 2009; Nichols & Humenick, 2000). Meeting the cultural needs of women for childbirth is extremely important for the psychological well-being of women.

Childbirth education is a standard of U.S. health care (Enkin et al, 2000; Nichols & Humenick, 2000) and has been associated with better health outcomes in numerous research studies including: use of less labor pain medication (Charles et al., 1978; Dolce, 2010; Scott & Rose, 1976; VandeVusse et al., 2007), higher frequencies of spontaneous vaginal births (Cyna et al., 2006; Dolce, 2010; Martin et al., 2001; Scott & Rose, 1976), and shorter stage one labors (Dolce, 2010; Harmon et al., 1990; Lederman & Weis, 2009). Additionally, childbirth education has been associated with psychological health benefits such as: having greater confidence for childbirth and breastfeeding (Beck, 2004; Enkin et al., 2000; Nichols & Humenick, 2000, increased breastfeeding duration with increased maternal confidence (Lu et al., 2003), improved family connections, feelings of

empowerment, and greater childbirth satisfaction (Beebe, 2014; Dolce, 2010; Goodman et al., 2004; Ketterhagen, et al., 2002).

Although U.S. research studies noted above have demonstrated beneficial outcomes for the use of childbirth education, a recent large scale study of 2400 women post-delivery, funded by the Kellogg Foundation, found the number of first time mothers attending childbirth classes has decreased from 70% in 2002 to 59% in 2012 (Declercq et al., 2013). It is important to note from the results of the above study the highest proportion of women not utilizing childbirth education classes were Hispanic and African American women who reported substantial socioeconomic difficulties which potentially could cause problems attending private childbirth education classes. African American women had more complications with pre-term labor, low infant birth weights, a lack of partners for support, and were least likely to attend childbirth classes (Declercq et al., 2013).

Clearly there is a need for more targeted research which examines the multiple factors that prevents or enhances women's abilities to participate in childbirth education classes including socio-economic issues, accessibility, perceived benefits, cultural values and beliefs about specific childbirth methods including those with a focus on less medical interventions. There has been limited research which explores women's decisions to select HypnoBirthing: The Mongan Method childbirth education and yet there appears to be a growing interest and use of this method both in the U.S. and internationally. HypnoBirthing is both a philosophy and method of childbirth education used that fosters a natural birth, combining childbirth information, self-hypnosis, and positive affirmations. Better understanding of the cultural beliefs influencing women's childbirth choices and experiences may assist the providers of healthcare to more effectively provide culturally sensitive healthcare and improve maternal/infant health outcomes.

STUDY PURPOSE AND RESEARCH QUESTIONS

The purpose of this ethnographic study was to explore the values, beliefs and perinatal practices of women, who utilized HypnoBirthing: The Mongan Method. The study aim was to gain an understanding of the culture of HypnoBirthing as perceived by postpartum women through their experiences of choosing, attending, and using

HypnoBirthing: The Mongan Method of childbirth education for their birthing experience. The study addressed the following research questions:

Central research question: How do women who utilized HypnoBirthing childbirth education describe and explain their experiences with this method?

Sub-question 1: What expressed values and beliefs influenced these women's decisions to use HypnoBirthing childbirth education and mode of childbirth?

Sub-question 2: How did women describe their actual experiences, outcomes, and level of involvement using the HypnoBirthing method?

Sub-question 3: What facilitated or inhibited women's use of HypnoBirthing during their experience?

BACKGROUND AND STUDY SIGNIFICANCE

Approximately 4 million women give birth annually in the United States (U.S.) with 99% of births occurring in healthcare facilities (Martin et al., 2010) making it the most common reason for hospital admission in the U.S. (Merrill & Steiner, 2006; Weir & Andrews, 2011). The national hospital bill for birthing related care in 2008 exceeded other health conditions at $97.4 billion dollars (Weir & Andrews, 2011).Great emphasis is placed on the safety of the mother and baby (Miltner, 2002) and in an attempt to ensure their safety perinatal care during the past several decades has become very "high tech" even for many women who are considered to have low risks for complications and who may prefer a natural birth (Davis-Floyd, 1994; Henley-Einion, 2003; Martin et al., 2012).

In 2007 approximately 85% of pregnant women in the U.S. were considered low risk for birthing problems (Martin et al., 2009) but the high tech dominant model of care was used. Statistics indicate when using the high tech model of care there are a large number of births that occur with medical interventions including: a 32.8% cesarean section (CS) birth rate in 2010 (Martin et al., 2012),which is more than twice the 15% CS rate recommended by the World Health Organization (WHO) (2010). There is a 76% epidural rate for labor management (Declercq et al., 2006), a 78% labor induction rate (Martin, et al., 2007), and a 90% continuous fetal monitoring rate (Declercq et al., 2006).

In spite of extensive use of interventional modalities in childbirth, the U.S. lags behind many other countries in important maternal/ infant outcomes. For example, there were 33 countries with lower maternal mortality rates than the U.S., as well as 37 countries with lower neonatal mortality rates, 65 countries with lower rates of low birth weight newborns, and 32 countries with higher rates of exclusive breastfeeding the baby the first 6 months (WHO, 2010). Additional research studies that examine the efficacy of interventional obstetrical care used routinely in the U.S. are needed to improve U.S. childbirth outcomes (Beebe, 2014).

Improving maternal and infant health is a public health concern in Texas, where this research is being conducted (Center for Health Statistics, 2015). For example, it is striking to note that only 50% of African American women in Texas sought prenatal care in the first trimester and these women had a significantly higher number of preterm births, low birth weight infants, and infant deaths (Center for Health Statistics, 2015). The Healthy People 2020 National goal is for 70% of all women receive prenatal care in the first trimester. White women of non-Hispanic ethnicity were the only ethnic group of women to meet the 70% goal of having prenatal care in the first trimester (Center for Health Statistics, 2015).

Similar disparities are reported with attendance at childbirth education classes. White non-Hispanic women attend childbirth education classes more often than African American women (Lu et al., 2003) and other culturally diverse women (Berman, 2006; Risica & Phipps, 2006), contributing to a cultural disparity in not only who attends childbirth classes but also who benefits from the classes. Women are 75% more likely to breastfeed if they have attended childbirth education classes (Lu et al., 2003). Timing with receiving prenatal care, attendance at a childbirth education class series, and breastfeeding can influence outcomes affecting pregnancy, birth, the infant, and family.

The aims of prenatal care are to reduce perinatal risk factors and adverse outcomes. Prenatal care can be narrowly or broadly defined or conceptualized and has three major components: risk assessment, treatment or risk reduction, and prenatal education (Kotch, 2013). Health care interventions and the promotion of healthy behaviors during pregnancy have a lasting impact on mothers and their families (Huntington & Connell, 1994; Kogan et al., 1998; Kotch, 2013; Lederman & Weis, 2009;

Rogowski, 1998). Healthcare dollars can be saved, perinatal outcomes improved, and health problems prevented through use of evidence-based care. However, there is little current evidence in the U.S. about how childbirth education can affect prenatal and longer-term health outcomes.

The Institute of Medicine (IOM) has proposed that appropriate evidence-based prenatal, intrapartum, and postpartum care should be determined and made available for families in all population groups (2001). Evidence-based practice is defined as the best research evidence, as well as clinical expertise, taking into consideration the patient's values (Sackett, et al., 2000). Caregivers have a duty to identify evidence-based information and implement it in childbirth education (Philipsen, 2004; Lothian & DeVries, 2005) in their role within the interdisciplinary team (Institute of Medicine, 2010).

Women's perceptions of their childbirth experience can affect their feelings towards their infant, adaptation to motherhood, self-esteem, and vulnerability to postpartum depression (Beck, 2004; Lederman, 1996; Lederman & Weis, 2009). When women have prepared for the maternal role it has a positive impact on women's postpartum adaptation and satisfaction with their new role (Lederman & Lederman 1987). Additionally, positive pregnancy and birth experiences have been associated with positive maternal role development (Fowles, 1996; Lederman & Weis, 2009; Stainton et al., 1992).

Meeting women's expectations increases positive childbirth experiences (Tumblin & Simkin, 2001) and this includes shared decision making with caregivers (VandeVusse, 1999). Women want caregivers to know what they have learned in their childbirth classes and assist them with their childbirth practices and not take the control from them (Tumblin & Simkin, 2001; VandeVusse, 1999). Anger, dissatisfaction, and maladjustments can occur when expectations for the childbirth experience are not met (Beck, 2004; Mozingo et al., 2002). Activities that decrease anxiety and promote maternal role development should be identified and used during the perinatal period (Lederman, 1996; Lederman & Weis, 2009). Further study is needed to identify and evaluate the effects of childbirth education and especially HypnoBirthing on women's perceptions of their birth experiences, as well as longer-term results.

The use of high tech care may be inconsistent with the care women desire for a natural birth experience, creating a cultural conflict between those "who believe birth is a normal part of life in most instances and those who take a more mechanistic, technological approach toward birth" (Moore, 2005, p. 8). However, little is known about the current experiences of women desiring a more natural birth using HypnoBirthing yet birthing in a traditional U.S. healthcare facility.

JUSTIFICATION FOR THE STUDY DESIGN

Spradley's (1979) Ethnographic Developmental Research Sequence (DRS) design was used as the qualitative method to answer the research questions. Ethnographic approaches are used to learn from people, explore the meaning of people's actions and words, determine their behavioral patterns, and portray the culture (Spradley, 1979). According to Spradley (1979), ethnographic approaches may be used to understand human behavior and culture from the viewpoint of being a member of the culture.

The advanced technological approach to childbirth dominant in U.S. culture may create conflict for women who desire a more natural birth using a method such as HypnoBirthing. Using an ethnographic approach in the current study has provided an understanding of the worldview of women who believe childbirth is a natural process but gives birth in an environment that is more technologically sophisticated.

OVERVIEW OF THE STUDY DESIGN

Spradley's conceptual framework of ethnography guided this study and included the premise that the researcher functions as the instrument, performs fieldwork, collects and analyzes data, with a primary focus on exploring culture, immersion in the culture, and demonstrating researcher reflexivity (Spradley, 1979, 1980).

Spradley (1979) indicated that ethnographic researchers often use interviews to discover parts of a culture learned through the voice of an informant. Informants speak in their own language, using common words understood by members of the same culture. Consistent with ethnographic design, the researcher interviewed informants to obtain descriptions that could not be obtained from surveys or other quantitative methods as a

means of determining informants' values, beliefs, behaviors, understandings, and practices (Munhall, 201; Spradley, 1979).

Several sampling strategies were used in this study. Initially a non-probability convenience, or volunteer, sampling strategy was used, which was intended to include available persons who met study criteria (Polit & Beck, 2010). As the study progressed, snowball or network sampling was used, which recruited new potential informants referred by earlier informants (Polit & Beck, 2010). Finally purposive sampling was used, which involved deliberate selection of persons and which was aimed at promoting maximum variation in the sampling process (Polit & Beck, 2010).

Two principles guided the sample size used in the study. First, data saturation, or informational redundancy, is typically used as an indicator of sample adequacy in qualitative research (Polit & Beck, 2010). Data saturation or informational redundancy is considered achieved when interviews cease to provide new information or themes (Polit & Beck, 2010). Second, Spradley (1979) explained that the number of informants needed for an ethnographic research study is dependent on the information ethnographers have received; thus, an acceptable sample size could be as few as one. The sample should be adequate to develop interpretations, to search for alternative explanations, and to focus on the quality of information using Spradley's interviewing techniques (Spradley, 1979). Thus, ongoing data analysis determines when data saturation occurs. For the study, data saturation was achieved with five informant interviews. Nonetheless, six additional informant interviews were conducted to increase informant variability, to confirm that no new information was obtained and no further themes had emerged, and to achieve sufficient and high-quality information for development of interpretations and creation of alternative explanations.

Data included interviews, participant observations, casual conversations, and other materials. Each participant was interviewed by the researcher in a private, convenient location selected by the informant. Interviews were face to face in the informant's home or over the telephone at the informants' home. All interviews were tape recorded. Each informant was interviewed one to three times, with each interview lasting an average of between 60 to 90 minutes. There were no adverse effects during the interviews and all informants completed the study. Observations were collected via

attendance at childbirth education classes; informal conversations with labor and delivery nurses, midwives, and childbirth educators; and the researcher's personal reflections. Informant observations were written in field notes. There was a vast amount of data collected.

Spradley's (1979) DRS process was used with the first five interviews to create a domain analysis of key words spoken during the interviews. There were no new domains discovered after the first five interviews. An initial taxonomy was created to identify parts of HypnoBirthing childbirth education classes as a starting point in the research. The researcher completed a contact summary form for the expanded notes section of the journal. This helped the researcher expand on every question and answer from the interview guide in the same manner to avoid losing any information. As the interviews were coded a contact summary of salient points was developed. Informants' interview data were organized into one document listing emerging themes and several categories and components. There are examples of a contact summary form (Appendix F) and a contact summary form of salient points (Appendix I), providing an auditable trail of the investigator's pathway through data analysis.

Domain, taxonomic, componential, and thematic data analyses were completed using Spradley's content analysis strategies. Similar meanings were identified in and across all informants' interview transcripts and other data. Data were coded to organize and track the sorting of instances of data that represented common meanings about informants' perceptions of their HypnoBirthing childbirth education and childbirth experience.

Valid research employs systematic rigor throughout study design and implementation (Polit & Beck, 2010). The researcher used Lincoln and Guba's (1985) four criteria to determine rigor: *credibility, transferability, dependability,* and *confirmability*. How the criteria were met is explained in chapter three.

OVERVIEW OF LEDERMAN THEORY AS THE SENSITIZING FRAMEWORK

The sensitizing framework used for this ethnography was Psychosocial Adaptation in Pregnancy as developed by Lederman and originally presented in her book, *Psychosocial Adaptation in Pregnancy: The Assessment of Seven Dimensions of*

Maternal Development (1984, 1996) and updated in Lederman and Weis (2009). This framework was selected because of the prior experiences of the researcher with childbirth education classes (CBE) and how women's responses included in Lederman's book resonated with the researcher after thirty years of women's health practice. The seven dimensions of maternal development are supported with content usually taught in CBE classes. It would seem reasonable the content and practices taught in HypnoBirthing childbirth education classes would be beneficial for women sense women are taught to increase relaxation and reduce fear and anxiety in pregnancy, childbirth, and postpartum.

According to Lederman (1996), normal physiological and psychological changes that accompany pregnancy cause women to experience anxiety and conflict (Lederman, 1984, 1996; Lederman & Weis, 2009). Anxiety causes increased levels of stress, biochemical changes in the body, and adverse pregnancy outcomes (Lederman, 1984, 1996; Lederman & Weis, 2009). Thus it is beneficial for women to learn childbirth information and mind body techniques to help them decrease stress and anxiety during pregnancy.

According to Lederman & Weis (2009), seven prenatal developmental dimensions are assessed to evaluate women's psychosocial adaptation during pregnancy and postpartum. When these dimensions are evaluated as a set, the gravid woman's health state is "predictive of progress in labor, complications in labor, birth outcomes, and postpartum adjustment to parenthood" (Lederman & Weis, 2009, p. 2). A Prenatal Self-Evaluation Questionnaire and scale (PSEQ) developed by Lederman can be used during the prenatal timeframe to assess prenatal psychosocial adaptation to pregnancy. Each of the dimensions can be measured using the PSEQ which has met Cronbach alpha reliability coefficients of 0.75- to 0.92. Internal consistency for the scales measuring the dimensions has also been done. The seven dimensions are listed in Table 1.1 Seven Dimensions of Maternal Role Development.

Table 1.1 Seven Dimensions of Maternal Role Development

- "The gravida's acceptance and adaptation to pregnancy;
- The gravida's development in formulating a parental role and relationship with the coming child;
- The gravida's past and present relationship with her mother;
- The impact of the gravida's relationship with her husband or partner to her adaptation of the pregnancy;
- Knowledge of and reasonable (prenatal) preparation by the gravida for the events of labor;
- The gravida's prenatal anticipation of mechanisms for coping with fears involving pain, helplessness, and loss of control in the labor;
- The way(s) the gravida copes with (prenatal) fears involving loss of self-esteem in labor" (Lederman & Weis, 2009, p. 2).

The following three dimensions provided the framework for exploring and understanding the values, beliefs and perinatal practices of women choosing HypnoBirthing childbirth education to help women have a natural birth.

- "the impact of the gravida's relationship with the husband or partner to her adaptation to pregnancy" (Lederman & Weis, 2009, p. 2).
- "knowledge of and reasonable (prenatal) preparation by the gravida for the events of labor" (Lederman & Weis, 2009, p. 2).
- "the gravida's (prenatal) anticipation of mechanisms for coping with fears involving pain, helplessness, and loss of control in labor" (Lederman & Weis, 2009, p. 2).

According to Lederman (1996) it is important to meet the psychosocial adaptation in pregnancy dimensions to promote prenatal maternal adaptation of pregnancy and maternal role development. Thus, the three dimensions of Lederman's theory, as previously listed above, appeared as an appropriate framework for examining women's choices and utilization of HypnoBirthing childbirth preparation since little is known about this method. Additional information about Lederman's

theory will be included in the Chapters Two and Three.

SUMMARY

Chapter One presented the study problem, purpose, aim, research questions, background and significance. The study significance and the justification for a qualitative ethnographic study design using Spradley's Developmental Research Sequence (DRS) were provided. The chapter introduced Lederman's *Psychosocial Adaptation to Pregnancy: Seven Dimensions of Maternal Role Development* (Lederman & Weis, 2009) as the sensitizing framework.

PLAN OF REMAINING CHAPTERS

Chapter Two provides a focused literature review. Chapter Three presents Spradley's DRS research design and how the methodology was used for data analysis. Chapter Four presents the findings of the study and describes the sample demographics. Chapter Five provides the results of the study, compares findings to Spradley's concepts of a culture, Lederman's sensitizing framework, and the extant literature; discusses study limitations and strengths, study implications, and makes recommendations for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

INTRODUCTION

Chapter Two presents a review of literature relevant to the present ethnographic study of the cultural beliefs, childbirth education, and perinatal practices of women using HypnoBirthing childbirth education. The chapter describes Spradley's (1979, 1980) concepts for exploring culture. The review of literature provides a scholarly analysis and synthesis of the seminal and current research performed in the U.S. that addresses contemporary childbirth practices and cultural norms. Lederman's (1996; Lederman & Weis, 2009) Psychosocial Adaptation to Pregnancy Theory is presented as the sensitizing framework used in this study. Additionally**,** Chapter Two identifies gaps in knowledge integrated in each section of the review and a plan for the remaining chapters.

OVERVIEW OF CULTURE, CHILDBIRTH, AND CHILDBIRTH EDUCATION

It is important to have a conceptual understanding of how culture derives decisions or practices. Women had reasons for choosing HypnoBirthing that were based on their values and beliefs that were shaped from their life experiences and social encounters. Healthcare providers need to understand the culture of women using HypnoBirthing childbirth education so they can be supportive and sensitive to women's needs when providing care. There is an interface between cultural practices and norms and how they affect one another. The women's partners shared the Hypnobirthing preparation and practiced the specific behaviors required to assist during the childbirth experience.

Culture

There are numerous definitions of culture and the researcher selected Spradley's definition which is consistent with ethnography. Spradley (1979) defines culture as the "acquired knowledge that people use to interpret experience and generate social behavior" (p. 5). When using ethnography the researcher learns about the culture of an individual or group through examining what is said, done, or used and making a cultural

inference of what these symbols mean (Spradley, 1979). According to Spradley (1979), "Culture, as a shared system of meanings, is learned, revised, maintained and defined in the context of people interacting" (p. 6). Interaction occurs in a person's environment which is a part of the shared culture (Spradley, 1979). Understanding the culture facilitates recognition of important behaviors and assists in meeting the needs of members of that culture (Spradley, 1979). Little is known about the culture of HypnoBirthing and the women and partners using it for birth.

Spradley explains two people can interpret and respond to the same event but experience it differently based on the interpretation of what the experience means for the individual due to their cultural beliefs (1979). Women in all societies have an expectation of pain in labor and childbirth but pain is interpreted, perceived, and responded to with behaviors based on the cultural context or meaning it has for the women (Callister et al., 2003, Kay, 1982).

Healthcare providers are also influenced by their cultural beliefs regarding childbirth and pain in childbirth. The healthcare provider, with a technocratic view of childbirth, will interpret childbirth behaviors differently than midwives or women that view childbirth as a natural physiological process (Davis-Floyd, 1994). When there are differences between two or more cultural groups cultural conflicts may occur and cause the differences to intensify (Hunter, 1994). To prevent cultural conflicts in childbirth care, it is important for healthcare providers to learn more about women's preferences for birth and be supportive.

Women should be assessed by their healthcare providers to identify women's expectations for healthcare (Bonder et al., 2002). The healthcare providers can only provide patient-centered care, as recommended by the IOM, when the patient is at the center of the care (IOM, 2001, 2010). In patient-centered care the healthcare providers must show cultural sensitivity or respect for the cultures of other population groups besides the dominant culture (Bonder et al., 2002).When the caregivers have knowledge about other cultural groups the caregivers are more likely to provide culture-specific expertise care which would be most desirable (Sue, 2000). There is a gap in knowledge regarding the culture of women utilizing HypnoBirthing: The Mongan Method since it is almost nonexistent in the literature.

Childbirth Culture

Women place great importance on their childbirth experience. Birth rituals are often associated with religious beliefs and family practices which are shared within the culture and have evolved over time (Spector, 2004). Childbirth is a cultural event with social behaviors, rituals, and practices reflecting the values and beliefs of pregnant women and the culture in which women live (Bonder et al., 2002; Davis-Floyd, 1994; Lederman & Weis, 2009). In some cultures childbirth is considered to be a rite of passage for the new mother (Bonder et al., 2002; Davis-Floyd, 1994) or the first act of motherhood making birth one of the most important events in women's lives (Callister et al., 2003).

Women and their families are vulnerable when seeking healthcare (Bonder et al., 2002). Dominance of the healthcare system or providers may prevent women from making their desired choices based upon their values and beliefs (Bonder et al., 2002). Lothian (2008a) notes that many women are unaware of other options and think high-tech interventions are necessary safety measures to protect women and babies. There are limited research studies regarding women being allowed to make choices based upon their values and beliefs about childbirth. Women experience a sense of control when they have the opportunity to be involved in their labor by making decisions about care, using techniques learned in their childbirth classes, and feeling supported by their environment and caregivers (Hodnett, et al., 2002). There is almost nothing in the research literature regarding women using HypnoBirthing: The Mongan Method, their values, beliefs, practices, and the women's perceptions of their experiences.

Childbirth Education Culture

The areas of culture to examine and determine if the perception of health are affected would be the values, beliefs, language, environment, time orientation, social interaction, and behaviors when performing ethnography (Spradley, 1979, 1980). In ethnography by Morton & Hsu, (2007) childbirth education was identified as a cultural phenomenon that helps prepare women for the childbirth experience.

Childbirth education is believed to be of extreme importance for women's psychosocial adaptation and maternal role development (Lederman, 1996; Lederman & Weis, 2009). Childbirth education is a standard for prenatal care in the U.S. (American Academy of Pediatrics [AAP] & American College of Obstetrics & Gynecology [ACOG], 2002).

However, childbirth education is a dynamic and relative concept that is poorly defined and used inconsistently. Childbirth education may include one-on-one smoking cessation sessions with a physician, nurse, or childbirth educator (Davis, et al., 2000), group centering pregnancy classes (Massey et al., 2006; Risisky et al., 2013; Walker & Worrell, 2008), which do not replace childbirth education labor preparation classes (Walker et al., 2009). There are also eclectic hospital childbirth education classes with a hospital curriculum to prepare the woman to birth at the hospital (Monto, 1996; Morton & Hsu, 2007) which often creates cultural conflicts for certified childbirth educators with a natural birth philosophy of childbirth (Monto, 1996; Morton & Hsu, 2007). The hospital based childbirth education classes are informative but are not focused to prepare women for a natural physiological birth (Simkin & Bolding, 2004). Private childbirth classes to facilitate a natural physiological childbirth are available through HypnoBirthing, Bradley, or other Mind and Body Methods (Beebe, 2014) but they are expensive creating lack of access for women with a small budget.

The lack of a consistent definition of childbirth education contributes to the difficulty of evaluating the value of childbirth education (Lothian, 2008b). Lothian (2008b) acknowledges that childbirth education is at a "crossroads" dependent upon research and future birthing care models. Clearly, there is a need to study the effects and outcomes of various forms of childbirth education. Bradley, Lamaze, Kitzinger, and HypnoBirthing are considered major childbirth educational programs in the U.S. (Davidson et al., 2008). This review will introduce the philosophical roots and brief history of these programs.

CHILDBIRTH EDUCATION HISTORY AND PHILOSOPHICAL ROOTS

Dr. Grantly Dick-Reed

Before formal childbirth education programs were developed childbirth information was passed on from women caring for women (Davis-Floyd, 1994). Later midwives contributed to further the development of childbirth education programs (Davis-Floyd, 1994). In addition, one physician, Dr. Grantly Dick-Read, made significant contributions about women's childbirth experiences in the 1930's and 40's that serves as the basis in multiple childbirth educational programs (Ondeck, 2000) including HypnoBirthing (Mongan, 2005).

Dr. Grantly Dick-Read is labeled as the spiritual father of natural childbirth due to the early published works, *Natural Childbirth* in1933 and *Childbirth without Fear* in 1944 (Mongan, 2005). Dick-Read developed a theory of childbirth that integrated the body, mind, individual, and culture (Mongan, 2005). The books on natural childbirth introduced women to the idea that childbirth did not have to be painful and that women could stay awake during birth to hear the first cry of their newborns (Dick-Read, 1944). Dick-Read explained women experienced pain based on their cultural attitudes of childbirth versus the actual physical event (1944). Dick-Read recommended that childbirth education start with the first prenatal visit (Ondeck, 2000). Dick-Read expressed that fear triggered the flight or fight response, causing tension in the cervix, with corresponding perceived pain as the uterus contracted (1944). Education regarding childbirth was used to break the fear tension pain cycle, shorten the labor, and reduce the need for surgical interventions (Moscucci, 2003).

The Bradley Method

Dr. Robert Bradley, an obstetrician, wrote the book *Husband-Coached Childbirth: The Bradley Method* in 1965 and this method has become the second most popular form of childbirth education in the United States (Monto, 1996). Bradley (1965) was influenced by Dick-Read and felt women should be awake and aware of their labor and birth but also share the experience with their husband. Women should avoid the use of medication and anesthesia, and use breath control, abdominal breathing, and relaxation in harmony with women's bodies (Bradley, 1965). The American Academy of Husband-Coached Childbirth: The Bradley Method provides education and certification for

childbirth educators, who usually teach private classes with no connections to a hospital (Ondeck, 2000).

The Lamaze Method

Another major contributor to childbirth education was Dr. Fernand Lamaze, a French obstetrician, who observed laboring women in Russia in 1951 and took his ideas to France where he wrote the book, *Painless Childbirth: The Lamaze Method* (1958). Lamaze (1958) used conditioning and the gate control theory in preparation for childbirth. Prevention of pain by using psychological strategies instead of medications led to the name of psychoprophylaxis in childbirth (Ondeck, 2000) but this method as taught in the U. S. was never claimed to be painless (Wideman & Singer, 1984). Instead women were taught correct information, conditioned to respond to the labor contractions using coping techniques such as: controlled breathing and relaxation (Ondeck, 2000). Involvement of the baby's father as a support person during the Lamaze classes and in childbirth brought about an important change in hospital healthcare (Walker et al., 2009).

The Lamaze and Bradley Methods evolved at a time when mass communication increased the demand for self-help health information (Lothian & DeVries, 2005). This coincided with the women's movement, a time when the roles of women were being re-examined (Hole & Levine, 1971). Women lost control of their childbirth when birthing moved from home to the hospital (Hole & Levine, 1971). Women with the support of their partners were able to use what was learned in their small private classes to birth naturally without giving up control to medications (Lothian, 1997). This consumer movement demanding childbirth education classes and partner support and participation in childbirth brought about a social change in childbirth in the U.S. (Lothian & DeVries, 2005).

Hospitals became family centered for maternity care in appearance and offered free childbirth classes to meet the demands of consumers but the hospital classes were not small group classes taught by Lamaze certified childbirth educators (LCCE) over six weeks using a Lamaze curriculum (Ondeck, 2000). The hospital classes became a time for the hospital to focus on their curriculum often promoting their services (Henley-Einion, 2003).

Although childbirth educator certification programs prepare educators to deliver high quality classes (HypnoBirthing Institute, 2014; Lamaze International, 2014) there are no unified standards required in the U.S. for training or certification of childbirth educators (Nichols, 1993; Phillips, 1985). Therefore, hospital childbirth classes are taught by certified and non-certified childbirth educators. Often there are cultural conflicts between the certified childbirth educator's philosophical beliefs about a normal physiological birth and the content the childbirth educator has to teach using a hospital-based childbirth curriculum (Monto, 1996; Moore, 2005). Childbirth educators teaching private classes can avoid this cultural conflict. Hospitals currently provide childbirth classes for the majority of people seeking classes and therefore can have the greatest impact on women and whether women's needs are being met (Lamaze Int., 2004). Some feel women's needs for a normal physiological birth are not met through hospital based childbirth education classes (Simkin & Bolding, 2004).

The Lamaze philosophy to build confidence in support of a natural birth has become the central focus for Lamaze classes (Lothian & DeVries, 2005). Small interactive classes are recommended with ten couples or less (Lothian & DeVries, 2005). In addition, Lamaze International made a commitment to change the curriculum to include six evidenced-based care practices (Lothian & DeVries, 2005).
Lamaze International Inc. (2004) is aware that the majority of childbirth classes are taught in hospital environments where the six care practices are often not taught or practiced in childbirth.

The high value placed on the opinion of the medical profession caused a paradigm shift from a social childbirth philosophy to a medical-illness model (Becker & Nachtignall, 1992). The birthing experience, a human experience, was redefined as a medical problem, a medical event rather than a social event (Becker & Nachtignall, 1992). A source of tension exists between the medical community and certified childbirth educators and women who believe philosophically that childbirth is a normal, natural physiological process, needing little intervention (Lothian, 1997; Mongon, 2005; Monto, 1996; Nichols & Humenick, 2000). There is hope for another consumer driven movement to demand evidenced-based childbirth using the six evidenced-based care practices. Lamaze International Inc. Six Evidenced-Based Care Practices are listed below.

Table 2.1 Lamaze International Inc. Six Evidenced-Based Care Practices.

- Labor should begin on its own;
- Laboring women should be free to move though out labor;
- Laboring women should have continuous support from others throughout labor;
- There should be no routine interventions during labor and birth;
- Women should not give birth on their backs;
- Mothers and babies should not be separated after birth and should have unlimited opportunity for breastfeeding (Lothian & DeVries, 2005, 4).

The Sheila Kitzinger Method

Another top childbirth education method is the Sheila Kitzinger's psychosocial approach to childbirth education based on the work of Dick-Reed and Lamaze however, psychoanalytic theory and social anthropology were the most influential (Kitzinger, 1981). Kitzinger viewed pain with childbirth as pain with a purpose and not the most important aspect of the childbirth experience (Kitzinger, 1981). Women need communication skills and assertiveness to negotiate the desired birth experiences and the Kitzinger approach assists women with their relationships to make their desired experiences possible (Kitzinger, 1981).

The HypnoBirthing Method

HypnoBirthing: The Mongan Method is a philosophy of natural birth based on the work of Dr. Grantly Dick-Read. Women and their partners learn about their bodies' innate ability to labor and birth through releasing all their fears and anxieties, and building trust and confidence to have a calm, safe, and comfortable birth (Mongan, 2005). Mothers, fathers, and siblings participate in pre-birth bonding and building family relationships during pregnancy through using techniques learned in HypnoBirthing classes including self-hypnosis and positive affirmations (Mongan, 2005).

The HypnoBirthing program is designed to meet quality standards with a structured curriculum, designated 12 ½ hours of class time, and yearly renewal of certification for childbirth educators (Mongan, 2005). Class and educator evaluation forms are completed online and sent directly to the HypnoBirthing Institute (Allison

Bulycz, MS, HBCE, 2014 Personal Communication). HypnoBirthing: The Mongan Method has instituted measures to maintain the quality of the program.

How women feel about their experience of childbirth is based upon their cultural beliefs and practices. Women choose childbirth education to prepare for the desired childbirth experience. The Bradley, Lamaze, HypnoBirthing, and Kitzinger methods are popular childbirth education programs women choose to prepare for the childbirth experience. These four programs share philosophical beliefs from the initial research performed by Dr. Grantly Dick-Read. Each program has unique qualities. The Bradley method is known for preparing mothers and fathers for home births. The Lamaze method has experienced numerous changes but is committed to following evidenced-based practice research and support normal physiological birth. HypnoBirthing prepares women for a natural and gentle birth using a combination of childbirth preparation information, self- hypnosis, positive affirmations, and techniques to meet the desires of women wanting a birth without medical interventions. The Kitzinger method views personal and social experiences of labor as important as the physiological and psychological events and women must be able to negotiate to caregivers what is important for their birth experience.

To meet the consumer's needs childbirth educators and nurses need to know what women value and believe in the U.S. culture of childbirth. To work effectively as part of the healthcare team, childbirth educators and nurses need to know what the medical community values and practices in childbirth. Nurses need to know about the different types of childbirth education programs and how to provide support for women during labor. Childbirth educators need to know if women, who birth in the hospital, benefit from natural childbirth education such as HypnoBirthing. Healthcare providers need to know how they can assist women choosing to have a natural birth using HypnoBirthing regardless of the environment.

INTEGRATIVE REVIEW OF RELEVANT RESEARCH LITERATURE

The purpose of this focused integrated review of the literature was done to identify and describe empirical studies on HypnoBirthing/childbirth education, to provide insight that may help to answer or explain the central research question and sub-questions

and identify gaps in the literature. The review focused on studies conducted in the U.S., some of which are seminal studies older than ten years. Research studies conducted throughout the world may not be applicable to women and families of this culture, the type of obstetric care and high technology practices in the U.S. thus research conducted out of the U.S. will not be included in the review. Systematic reviews will include studies from the world's literature and may be helpful in understanding information regarding labor pain or coping measures that affect women.

Childbirth Education Research

Nichols and Humenick compiled the scientific knowledge from 1983 to 1986 and published the first researched base book for childbirth educators: *Childbirth Education: Practice, Research and Theory* (1988) and updated it in 2000. Childbirth educators were recognized as having a wealth of experiential knowledge about childbirth, parenting, and effective teaching strategies but the knowledge needed to be documented and verified in a systematic manner through research (Nichols & Humenick, 2000). Although childbirth education classes have been considered beneficial (Enkin et al., 2000; Hodnett, 2002; Nichols & Humenick, 2000) quality outcomes research is necessary to determine relevance for today's consumer.

The success of childbirth education in the future will depend on whether educators are meeting the consumer's needs in content, teaching and learning methodologies, class and educator relationships, eliminating the fear factor, and building confidence as women recognize they are prepared and ready for the childbirth and parenting experiences (Beebe, 2014; Moos, 2006; Nichols & Humenick, 2000).

Search Strategies

Since the research on HypnoBirthing: The Mongan Method is limited to non-existent, a review of the literature discussing childbirth education in the U.S. was conducted regarding research studies about the major childbirth education programs in the U.S. The literature review was conducted using electronic and manual search methods. The search period was from 1998 through 2014, restricted to primary research conducted in the United States and reported in peer reviewed journals written in English. Initially, CINAHL and Ovid and were searched, using HypnoBirthing as the key search

word, but results were very limited to non-research articles, then the search was expanded to include CINAHL, ERIC, Alt Health Watch, PsycInfo, and Medline OVID, using the above time frame, criteria and the following keywords: HypnoBirthing, childbirth education, antenatal classes, prenatal classes, Lamaze classes, Bradley classes, natural childbirth, patient education, and prepared childbirth. Additionally, a manual search was done of journals that would most likely have research articles on the topic, including the *Journal of Perinatal Education, Journal of Obstetric and Gynecological and Neonatal Nursing,* and *Midwifery*. Seminal studies were also identified from reading various research articles and books on childbirth education.

Research Synthesis

Studies examined were both quantitative and qualitative. It is difficult to randomly assign prenatal women to a control or other group when childbirth education is considered a standard of care in the U.S. There were methodological issues with most of the studies.

Findings Across Studies

Three categories emerged from the expanded integrative review conducted by the researcher: physiological and psychological benefits of childbirth education, childbirth educational programs, and women's beliefs and perceptions. Each of these three categories is discussed. In addition an analysis and synthesis of the reviewed research studies are presented. The research studies used for the integrative review are located in Appendix K, where more information is provided about each study.

Physiological and Psychological Benefits of Childbirth Education

In seminal and recent research studies reviewed on childbirth education many benefits for women and their partners were identified. Seminal studies focused on the physiological benefits and obstetrical outcome benefits of childbirth education (Charles et al., 1978; Scott & Rose, 1976,) and psychological benefits (Leventhal et al., 1989; Harmon et al., 1990; Zacharias, 1981). Women, who attended childbirth classes experienced less pain and used less medications (Charles et al., 1978; Dolce, 2010; Leventhal et al., 1989; Martin et. al, 2001; Scott & Rose, 1976) and had higher frequencies of spontaneous vaginal deliveries (Dolce, 2010; Harmon, et. al, 1990; Martin

et. al, 2001; Scott & Rose, 1976). In many of these studies childbirth education was not the focus of the study but it was noted the women had taken childbirth education.

A seminal study by Scott and Rose (1976) compared women using Lamaze with women in a control group not using childbirth education and determined women in the Lamaze group used fewer narcotics during labor, less anesthesia for birth, and had a higher frequency of vaginal births. Scott and Rose (1976) did not find any differences in the length of labor, number or type of maternal complications, frequency of fetal distress, mean Apgar scores, and neonatal problems.

In research studies combining hypnosis and childbirth education classes mothers had shorter stage one labors and their infants had higher Apgar scores (Harmon, et al 1990). In addition, women used less pitocin, anesthesia, postpartum medications, had fewer complications, and there were fewer NICU admissions (Martin et al., 2001). In a retrospective study comparing women that attended an antenatal hypnosis preparation class to women unprepared in the same manner, the hypnosis group used less sedatives, analgesia, and anesthesia, and their newborns had higher Apgar scores at one minute (VandeVusse et al., 2007). Several physiological benefits were identified with the use of hypnosis. As the reader can note from the research studies presented childbirth education is being compared to medical outcomes happening at birth.

Additionally, the benefits of HypnoBirthing were presented in an evaluation survey comparing results to the Listening to Mother's II survey funded by the Kellogg Foundation (Dolce, 2010). Dolce's (2010) research survey shows the cesarean rate as 17% with HypnoBirthing but women reported in the Listening to Mothers II and III surveys a 32% cesarean rate for women using other methods or no childbirth education (Declercq et al., 2006, Declercq et al., 2013). About 20% of the HypnoBirthing mothers received an epidural versus 80% of women in the Listening to Mothers II survey (Declercq et al., 2006; Dolce, 2010). HypnoBirthing mothers used significantly fewer interventions than the women in the Listening to Mothers II survey and had larger babies (Dolce, 2010).

In addition, there were psychological benefits for women taking childbirth education classes. Women had a more positive birth experience, felt ready for childbirth, worked well with and bonded with the baby's father (Hardin & Buckner, 2004; Koehn,

2008; Zacharias, 1981), expressed more satisfaction and enjoyment with the birth (Charles et al., 1978; Dolce, 2010; Leventhal et al., 1989), and felt less fear and sadness in the birth experience (Beck, 2004; Leventhal et al., 1989) than women not taking childbirth education classes.

Fisher et al., (2009) compared women using Hypnobirthing to women using information from a standard childbirth education class. Women in the Hypnobirthing group reported less pain in labor but could recall fewer coping mechanisms used after the childbirth than the women in the standard childbirth classes (Fisher et al., 2009). All other measurements were reported as not significantly different but very little information could be obtained about this study. The poster session has very little information published in the journal. This study did not sound like HypnoBirthing: The Marie Mongan Method was the HypnoBirthing method used.

Beebe et al., (2007) conducted a study with a convenience sample of 35 women that had attended childbirth education classes and reported women with higher prenatal anxiety experienced greater pain in labor and the higher their anxiety scores were in labor the less confidence the women had in their abilities to perform coping techniques thus decreasing technique efficacy. However, women who used more behavioral coping strategies stayed home longer in early labor and women that used more cognitive coping strategies had lower pain scores during pre-hospitalization (Beebe, et al., 2007).

Various coping techniques were taught in the childbirth classes including: relaxation, breathing, positioning, massage, hydrotherapy, hot/cold therapy, music, guided imagery, acupressure, and aromatherapy (Brown et al., 2001). Many of these techniques are also used in HypnoBirthing classes with the addition of self-hypnosis (Mongan, 2005).

Benefits when hypnosis and childbirth education were combined included improved outcomes for women such as: shorter stage one labors, higher infant Apgar scores (Harmon et al., 1990); less labor pain, medications, complications, surgical interventions, and admissions to the neonatal intensive care unit [NICU] (Martin et al., 2001). Furthermore, women highly susceptible to hypnosis experienced less postpartum depression (Harmon et al., 1990). The use of self-hypnosis for labor promoted women's

comfort and facilitated women's maintenance of control in labor and birth (Brown et al., 2001; Harmon et al., 1990; Martin et al., 2001; VandeVusse et al., 2007).

In the research studies reviewed the uses of self-hypnosis to relieve labor pain were consistent with systematic reviews in which; self-hypnosis was shown to be beneficial for labor pain management (Cyna et al., 2004; Smith, et al., 2006). Women used less medication for labor and birth and women were more satisfied with their pain management during labor than the control groups (Smith et al., 2006). The systematic reviews included women from countries outside of the U.S. and HypnoBirthing: The Mongan Method was not mentioned in any of the studies reviewed. Research is needed to understand the outcomes for women using HypnoBirthing: The Mongan Method.

Professor Dr. Soo Downe, a midwifery specialist at Central Lancashire University, United Kingdom conducted a National Health Service (NHS) clinical trial using some hypnobirthing methods (www.uclan.ac.uk, May 11, 2015). The NHS supported the study to decrease the costs of medications and epidurals used in labor and birth and to help women have an easier birth (www. hypnobirthinginbath.co.uk). Women were taught a couple hours on the use of self-hypnosis for use during labor and birth and provided a CD for home use (www.uclan.ac.uk, May 11, 2015). The use of epidurals was about the same as other childbirth methods but women did have significantly less postnatal anxiety and fear (www.uclan.ac.uk, May 11, 2015). The childbirth education and self-hypnosis presented for the study were not equivalent to HypnoBirthing: The Mongan Method with 12.5 hours of class with HypnoBirthing certified childbirth educators using a designated curriculum. There is a lack of research on HypnoBirthing: The Mongan Method and further research investigation is needed.

Childbirth Education Programs

Childbirth education programs is a second category that emerged from the author's integrative review of literature listed in Appendix K. The researchers were consistent in recommending curriculum changes to add more parenting content and choices to use for labor management as well as greater accessibility for classes in the community (Berman, 2006; Brown et al., 2001; Bryan, 2000; Corwin, 1999; Risica & Phipps, 2006; Schachman et al., 2004).

The majority of the research studies did not describe labor management interventions, class or course curriculums, class settings, or length of the classes (Beebe et al., 2007; Charles et al., 1978; Corwin, 1999; Hardin & Buckner, 2004; Harmon et al., 1990; Koehn, 2008; Leventhal, et al., 1989; McKinney, 2006; Monto, 1996; Scott, & Rose, 1976; VandeVusse et al., 2007; .Zacharias, 1981). Some studies had certified childbirth educators (Brown et al., 2001; Nichols, 1992; Maestas, 2003) but the other studies did not address certification of the childbirth educators. There is a long standing recommendation made by the United States Public Health Service (1989) that all women attend childbirth education classes taught by certified childbirth educators. However, there are no requirements for childbirth educator to be certified in the U.S. (Nichols, 1993; Phillips, 1985).

Findings from multiple studies reinforced the need to increase the time and content of childbirth classes to prepare new mothers for self-care during the postpartum and early parenting period (Bryan, 2000; Corwin, 1999; Schachman et al., 2004) and to build confidence for the birthing experience (Schachman et al., 2004). Interactive or comprehensive teaching strategies and ways to teach coping techniques were identified as needs in several research studies (Brown et al., 2001; Schachman et al., 2004). One study identified additional resources were needed in classes to help promote satisfaction and maternal adaptation (Schachman et al., 2004). It is not known if HypnoBirthing: The Mongan Method childbirth education classes have the curriculum to meet the needs of women to fulfil content needs to prepare them for pregnancy, labor and birth, and postpartum. One need of great importance is whether women attending HypnoBirthing classes feel prepared and have self-confidence to advocate for themselves and their babies. In addition, it is unknown if HypnoBirthing classes decrease women's anxiety in pregnancy and promote maternal role development. Lederman's psychosocial adaptation to pregnancy theory was used in the current study to address the above identified gaps in the literature review.

Women's Perceptions and Beliefs

The third category that emerged from the integrative review of research literature was women's perceptions and beliefs about childbirth. Women, taking the Lamaze

classes perceived the Lamaze techniques to be helpful when used during early labor at home but the hospital environment, including nurses, failed to provide the supportive care expected by the women (Beebe et al., 2007; Brown et al., 2001; Nichols, 1992). High anxiety caused women to have less confidence to use relaxation and other coping techniques which resulted in higher levels of pain during labor and birth (Beebe, et al, 2007). Self-help techniques or coping techniques were listed in category two. Several researchers discussed the need for more research on pain management techniques in labor (Beebe et al., 2007; Brown et al., 2001; Callister et al., 2003).

Eighty percent of women living in the U.S but from a different culture perceived it would be better to have childbirth educators from their ethnic culture to teach the classes and not just someone fluent in their language (Berman, 2006). They also wanted relevant cultural practices included in the class content (Berman, 2006). Only approximately 19% of women with English as a second language preferred a group childbirth class (Risica & Phipps, 2006). These women preferred to receive information from individual meetings with a nurse or doctor (72%) compared to receiving printed materials (54%), watching videos (54%), using the internet (28%), or listening to a CD (10%) (Risica & Phipps, 2006). The majority of women in other classes read books and magazines in addition to attending the Lamaze classes (Brown et al, 2001; Koehn, 2008). HypnoBirthing is taught internationally as group or private sessions.

Theoretical and Conceptual Issues

This section of the review will critique the research studies for various elements of the research methods. Eight of the quantitative studies utilized a theoretical framework and 2 qualitative studies used a theoretical framework which is ten of the twenty-three studies. These frameworks used in the quantitative research studies were: Knowles Adult Learning Theory (Berman, 2006), Transition Theory (Bryan, 2000), Parent-Infant Relationship Theory (Corwin, 1999), Neodissociation Theory (Harmon et al., 1990); Physiological and psychological responses to noxious stimuli (Leventhal et al, 1989); Conceptual Model Psychological Effects of Prepared Childbirth (Nichols, 1992); Resilience and Lederman's Maternal Adaptation theory, (Schachman et al., 2004); and the Biopsychosocial Model (Beebe et al., 2007).

The qualitative studies utilized the following theoretical frameworks: Social

Support (Hardin & Buckner, 2004); Rubin's Maternal Tasks of Pregnancy, Lederman's Psychosocial Adaptation to Pregnancy, Mercer's Maternal Tasks of Pregnancy, Experiencing Transitions, Emergent Theory of Negotiating the Journey of Motherhood, (Koehn, 2008). Lederman's Psychosocial Adaptation to Pregnancy theory was used in both qualitative and quantitative research studies (Koehn, 2008; Schachman et al., 2004). Findings from the studies support using Lederman's *Psychosocial Adaptation to Pregnancy Theory* as a framework for childbirth education which prepares the woman for pregnancy, labor and birth, postpartum and the transition to motherhood (Koehn, 2008; Schachman et al., 2004). Other studies provided links between childbirth education and maternal adaptation (Corwin, 1999; Bryan, 2000; Hardin & Buckner, 2004; Nichols, 1992).

Operational Definitions and Instruments

None of the studies provided an operational definition for childbirth education. The majority of the studies did not report on the reliability and validity of the instruments or if the instrument, interview guide, or survey was developed or adapted by the researcher. Four out of 23 research studies used measurement instruments and provided the reliability (Beebe et al., 2007; Bryan, 2000; Nichols, 1992; Schachman et al., 2004). Validity was rarely mentioned. Lederman's Prenatal Self Evaluation Questionnaire (PSEQ) was used in two studies and Lederman's Postpartum Self Evaluation Questionnaire was used in one study. Appendix K has the 23 studies included in the integrated review with additional information for further referencing.

Researchers counted outcomes and determined frequencies and statistical significance in several studies (Harmon et al., 1990; Martin et al., 2001; Scott & Rose, 1976). The durations of stage 1 and stage 2 labors were measured by time changes with women using hypnosis or other coping measures (Harmon, et al., 1990). The frequency of the use of pitocin in labor, anesthetics for birth, and postpartum medications, as well as, labor complications, surgical interventions, length of hospital stays for mothers, and admissions of the babies to NICU were measured (Martin et al., 2001). There are needs for additional studies on childbirth education methods.

Samples and Settings

All the studies used convenience or purposive samples. Some studies used a convenience sample with random assignment to groups. The majority of women were between the ages of 18-40 years old. Two studies exclusively had teenagers younger than 18 years old (Nichols, 1992; Martin et al., 2001) and two other studies included teenagers (Risica & Phipps, 2006; Zacharias, 1981). Some studies did not list the ages of the sample. The majority of the studies had white, middle class married women for the sample (Beebe et al., 2007; Brown et al., 2001; Bryan, 2000; Charles et al., 1978; Corwin, 1999; Harmon et al., 1990; Koehn, 2008; Maestas, 2003; Monto, 1996). The most culturally diverse group participated in a study to identify barriers to obtaining childbirth education (Berman, 2006). The sample had 59 women, 55 foreign-born with 45 from Latin American Countries, Spanish was the primary language for 70% of the women, the majority was married, and the average age was 27.1 years (Berman, 2006). One study had exclusively all participants from a military base (Schachman et al., 2004), three studies used one hospital (Charles et al., 1978; Leventhal et al., 1989; Scott & Rose, 1976), and one study used one clinic (Risica & Phipps, 2006). The Fisher (2009) study was reported from a poster presentation which did not provide information about the sample and methodologies. It was only included in this study to demonstrate that researchers are starting to research HypnoBirthing.

Literature Review Summary

Although benefits were reported the research studies had many methodological issues. All of the quantitative studies used convenience samples, the childbirth education classes were treated as a single intervention, and only four studies used instruments that were reported with good reliability and validity. Other studies did not address the instruments. Common instruments used in childbirth education research were Lederman's Prenatal and Postpartum Self Evaluation Questionnaires, Speilberger's Trait Anxiety Scale, McGill's Pain Questionnaire, and self-developed surveys. Findings from the studies support using Lederman's Psychosocial Adaptation to Pregnancy Theory as a theoretical framework for childbirth education which prepares the woman for pregnancy,

labor and birth, postpartum and the transition to motherhood.

Childbirth education was not operationally defined in any of the studies. Very little information was included about the childbirth education classes and whether the educators were certified. Childbirth education programs provide broad interventions with multiple variables making it difficult to evaluate as a whole for the impact on pregnancy, parenting, self-help abilities, and maternal confidence (Dumas, 2002). Each study has to be evaluated individually and the decision made if it meets enough rigor to accept the findings for practice.

A common practice in childbirth education classes is to recommend that women in labor stay home as long as possible to avoid unnecessary hospital restrictions and interventions. This is a childbirth education practice still taught that needs to be reconsidered based on the evidence. The research study by Beebe et al., (2007) explained how arriving at the hospital later when labor is more intense caused women to have more anxiety and women had difficulties regaining and maintaining their state of relaxation. Preregistration at the hospital or arriving earlier before labor becomes too intense may be a better option based on the Beebe's et al., (2007) research study.

Implications for Future Research

The Institute of Medicine provided a blue print for a healthcare system change in the book *Crossing the Quality Chasm: A New Health System for the 21st Century (2001)*. Included in that blue print are core competencies for all health disciplines to use in the delivery of quality health care. One of the competencies is to employ evidence-based practice in the delivery of healthcare services. Evidence-based practice is defined as the integration of the best research evidence with clinical expertise and patient values (Sackett, Straus, & Richardson, 2000). Prenatal and intrapartum care are listed as one of the top twenty priority areas for action to improve quality services by the Institute of Medicine in the book, *Priority Areas for National Action: Translating Health Care Quality,* (2003). Other studies and systematic reviews indicate there is a lack of high-quality evidence from randomized controlled trials, without bias, to demonstrate all the benefits of childbirth education techniques and methods (Enkin et al., 2000; Gagnon & Sandoval, 2007). Childbirth education does not have a well-established evidence base.

In this researcher's integrative review, eight of the quantitative studies and two qualitative studies utilized a theoretical framework, but multiple theories were used without consistency or building upon one another in other studies. Lederman's *Psychosocial Adaptation to Pregnancy: Seven Dimensions of Maternal Role Development Theory* was the only theory used in both qualitative and quantitative research studies and in more than one study (Koehn, 2008; Schachman et al., 2004). Lederman's (1996) theory fit well with childbirth education research since one of the seven dimensions of maternal role development is labor preparation. Additionally, other dimensions of Lederman's theory were found in the childbirth education research studies including: the women's relationship with their partners and mothers, women's readiness for labor, women's fear, pain, control and self-esteem in childbirth. There are gaps in childbirth education research and the culture of women choosing and using HypnoBirthing.

LEDERMAN'S PSYCHOSOCIAL ADAPTATION TO PREGNANCY THEORY

The sensitizing framework used for this ethnography was developed by Regina Lederman, PhD as described in her first two editions of her books on *Psychosocial Adaption in Pregnancy* (1984, 1996) and updated in *Psychosocial Adaptation to Pregnancy: Seven Dimensions of Maternal Role Development* (Lederman & Weis, 2009). All women experience conflict in pregnancy and childbearing and will respond in an adaptive or maladaptive manner (Lederman, 1996). When women respond in an adaptive manner, it promotes maternal role development but when women respond in a maladaptive manner, maternal role development is more difficult to achieve (Lederman, 1996).

According to Lederman (1996) there are seven dimensions of maternal role development that cause conflict and anxiety during pregnancy. Lederman (1996) developed prenatal and postpartum scales that can be used to measure these dimensions. Lederman's seven dimensions (Lederman & Weis, 2009) are listed in Table 2.2 Seven Dimensions of Maternal Role Development. Taken together as a set, these seven dimensions of maternal development are predictors for labor progression and postpartum adaptation (Lederman, 1996).

Table 2.2 Seven Dimensions of Maternal Role Development

- "The gravida's acceptance and adaptation to pregnancy;
- The gravida's development in formulating a parental role and relationship with the coming child;
- The gravida's past and present relationship with her mother;
- The impact of the gravida's relationship with her husband or partner to her adaptation of the pregnancy;
- Knowledge of and reasonable (prenatal) preparation by the gravida for the events of labor;
- The gravida's prenatal anticipation of mechanisms for coping with fears involving pain, helplessness, and loss of control in the labor;
- The way(s) the gravida copes with (prenatal) fears involving loss of self-esteem in labor" (Lederman & Weis, 2009, p. 2).

Lederman (Lederman et al., 1979) in a pioneer study identified a correlation between levels of anxiety and labor progression. The greater the anxiety, the more detrimental the anxiety can be to labor progression because of the effects on uterine contractility (Lederman et al., 1979). When anxiety is present during labor it can slow labor progression in the first stage of cervical dilatation from zero to ten centimeters (Lederman et al., 1979). It is undesirable to have anxiety during the labor and birth to prevent labor problems and have a manageable labor and positive childbirth experience (Lederman, 1984, 1996; Lederman & Weis, 2009).

There are also inter-correlated patterns between the seven dimensions (Lederman, 1996). Women's relationships with their husbands and mothers correlated positively with preparation for labor (Lederman, 1996). A poor relationship with the husband was correlated with poor labor preparation and was predictive of an early admission to the hospital for labor and more reliance on medication during labor (Lederman, 1996).

Relationships with the husband and the woman's mother are major factors that influence the woman's childbirth preparation (Lederman, 1996).

Labor preparation had a moderate correlation with fear of pain, helplessness and loss of control but low correlations with other types of fears (Lederman, 1996). If the woman is not informed and prepared for labor then her feelings of fear of pain, helplessness and loss of control increases. Labor preparation decreases the fear of labor pain (Lederman, 1996).

Childbirth education used to prepare women for their childbirth experience helps to decrease women's anxiety (Lederman, 1996). When maternal anxiety is reduced there is a positive correlation with progress in labor and postpartum adjustment (Lederman, 1996). How women perceive their childbirth experience affects women's self-esteem, feelings toward their infant, adaptation to motherhood, and vulnerability to postpartum depression (Lederman, 1996). Lederman's theory provided a sensitizing framework to explore HypnoBirthing Childbirth Education, as perceived by postpartum women, who attended HypnoBirthing childbirth education classes.

Nurses caring for women in labor need to understand the diverse cultures of childbirth, the meaning of pain, and the culturally derived behaviors women exhibit to deal with the pain (Callister et al., 2003). This research provided an understanding of the culture of HypnoBirthing, the rationale behind the choices made by women attending childbirth education classes, and women's values, beliefs, and practices as expressed in their language, rituals, and behavior during pregnancy, childbirth, and postpartum.

SUMMARY

This chapter presented a literature review relevant to HypnoBirthing: The Mongan Method and Childbirth Education. This chapter explained the relationship between culture, childbirth, and childbirth education. Childbirth education research is lacking in methodology and consistency of theory building. However, it does show women are interested in childbirth education and it is a part of the U.S culture. Lederman's theory of Psychosocial Adaptation to Pregnancy provided a sensitizing framework for quantitative and qualitative studies and was used for this study.

PLAN OF REMAINING CHAPTERS

Chapter Three presents Spradley's DRS research design and methodology for data analysis. Chapter Four presents the findings of the study and describes the sample demographics. Chapter Five provides a summary of the major findings; compares findings to Spradley's conceptual framework on culture, Lederman's theory for the sensitizing framework, and the extant research literature. In Chapter Five the researcher discusses study limitations and strengths; indicates study implications; and makes recommendations for future research.

CHAPTER THREE: METHODS

RESEARCH DESIGN

Chapter Three describes the research design used to explore the values, beliefs and perinatal practices of women, who utilized HypnoBirthing: The Mongan Method. The chapter briefly describes Lederman's (1996, Lederman & Weis, 2009) Psychosocial Adaptation to Pregnancy theoretical model, which was used as the sensitizing framework for the study. Chapter Three also details the study design and justification, methods, ethical considerations, provisions for rigor, limitations and strengths.

Lederman's (1996; Lederman & Weis, 2009) Psychosocial Adaptation to Pregnancy theory asserts that women will have conflict in pregnancy and childbearing, which prompts either an adaptive or maladaptive response. An adaptive response promotes maternal role development, whereas a maladaptive response creates challenges for women (Lederman, 1996). According to Lederman (1996; Lederman & Weis, 2009), there are seven prenatal developmental dimensions that cause anxiety in pregnancy and childbearing.

For the purpose of the study, three of Lederman's (1996; Lederman & Weis, 2009) dimensions were chosen as a guide to write grand tour, structure, and contrast questions. These were:

1) "the impact of the gravida's relationship with the husband or partner to her adaptation to pregnancy" (Lederman & Weis, 2009, p. 2);

2) "knowledge of and reasonable (prenatal) preparation by the gravida for the events of labor" (Lederman & Weis, 2009, p. 2); and

3) "the gravida's (prenatal) anticipation of mechanisms for coping with fears involving pain, helplessness, and loss of control in labor" (Lederman & Weis, 2009, p. 2).

STUDY DESIGN AND JUSTIFICATION

This study used a qualitative, ethnographic design. According to Mason (2002), qualitative research is used to understand the social world. A qualitative research design

may be used when little is known about a topic, and there is a need to explore, explain or describe to increase understanding (Marshall & Rossman, 1995; Polit & Beck, 2010). Because HypnoBirthing is used throughout the world to prepare for childbirth, studies to enhance healthcare providers' understanding of the experience were deemed necessary. Although there were studies on the use of hypnosis for labor in the literature, no studies of HypnoBirthing: The Mongan Method was identified.

Ethnography is a type of qualitative research used to study people, to examine meanings of what has been said and done, to identify and describe patterns of behaviors, and to provide cultural understanding (Speziale & Carpenter, 2003). There are six characteristics of ethnographic research: ethnographer as instrument, fieldwork, method of data collection and analysis, cultural focus, immersion, and ethnographic reflexivity (Speziale & Carpenter, 2003).

Culture refers to the "acquired knowledge that people use to interpret experience and generate social behavior" (Spradley, 1979, p. 5). Childbirth is a cultural event in which social behaviors, rituals, and practices reflect the values and beliefs of the pregnant woman, her culture, and the culture in which she lives. Childbirth education is a cultural phenomenon that helps women prepare for the birth experience and which is of extreme importance for the woman's psychosocial adaptation and maternal development (Lederman, 1996). Ethnography is used in cultural studies to describe alternative realities in the language of study subjects, to discover grounded theories, and to provide better understanding of complex societies and human behavior (Spradley, 1979). An ethnographic design was deemed appropriate because the present study explored the values, beliefs and practices of postpartum women who attended HypnoBirthing childbirth education classes.

Naturalistic ontology supports the existence of multiple realities (Lincoln & Guba, 1985). These realities are based on individual perceptions and can only be studied holistically, since they vary from person-to-person and change according to situations, contexts, and time (Lincoln & Guba, 1985). Because individuals have various perspectives, different meanings for these realities are often observed (Munhall & Oiler, 1986). In this study, the researcher described and interpreted women's experiences of attending and using HypnoBirthing Childbirth Education.

METHODS

This study used Spradley's (1979) Ethnographic Developmental Research Sequence (DRS) to explore the cultural context of childbirth education in U.S. women who attended HypnoBirthing: The Mongan Method Childbirth Education Classes and used HypnoBirthing for their birth experience. The researcher chose Spradley (1979, 1980) for the ethnography because of the structured process, the focus on describing the culture through the use of the informant's language, and the associated rituals and behaviors. The researcher felt using Spradley's methodology would facilitate the process to better understand the HypnoBirthing culture. Spradley's Ethnographic DRS includes 12 steps. Although Spradley's steps may appear linear, many of the steps occur simultaneously.

SPRADLEY'S ETHNOGRAPHIC DRS

Step 1: Locating an Informant

Ethnographers often explore cultures via informant interviews and subsequent examination of interview content (Spradley, 1979). Interviews provide descriptions of informants' values, beliefs, and practices as expressed through language and behavior (Spradley, 1979).

Step 2: Interviewing an Informant

Spradley (1979) stressed that informants should be encouraged to share their stories in their own words. Ethnographers examine informants' knowledge of individual topics by analyzing language used in their descriptions (Spradley, 1979). Ethnographers determine cultural inferences through observations, interviews, and notations of observed or mentioned artifact usage.

Step 3: Making an Ethnographic Record

An ethnographic record "builds a bridge between observation and analysis (Spradley, 1980, p. 33). Ethnographers act as *the instrument* through data collection and

cultural immersion. The overall purpose is to learn culture from the informants' perception (Spradley, 1979).

Step 4: Asking Descriptive Questions

Spradley (1979) emphasized that informants should be prompted to share their stories via descriptive questions. Spradley (1979) recommended that interviews begin with a "grand tour" question in order to reveal informants' perceptions without imposition of the ethnographers' view. When informants respond to a grand tour question, they are free to share information in their own words and manner. In ethnography, it is important to listen for answers to questions not asked (Spradley, 1979).

Step 5: Analyzing Ethnographic Interviews

"Ethnographic analysis is the search for the parts of a culture and their relationships as conceptualized by the informants" (Spradley, 1979, p. 93). In ethnography, it is important to analyze data before performing follow-up observations or informant interviews (Spradley, 1980). In step 5, Spradley (1979) suggested that ethnographers should perform preliminary searches for domains by exploring data for cover terms (e.g., things, people, places) and identifying semantic relationships between these terms. Spradley (1979, 1980) described four types of ethnographic analysis: domain, taxonomic, componential, and thematic. These analyses are described in the steps below.

Step 6: Making a Domain Analysis

Cultural domains are categories that indicate cultural meaning (Spradley, 1980). Domain analysis is defined as the search for words or phrases that fit into larger categories or domains based on identified semantic relationships (Spradley, 1979). The ethnographer has two aims when performing domain analysis: "to identify native categories of thought and to gain a preliminary overview of the cultural scene" (Spradley, 1979, p. 117) of that which is being studied. Domain analysis is dynamic because ethnographers are constantly reviewing new data and analyzing domains (Spradley, 1979).

Step 7: Asking Structural Questions

Structural questions help ethnographers find and confirm domains, cover terms, and semantic relationships (Spradley, 1979). Spradley (1979) described five kinds of structural questions that may be used, depending upon informants' responses.

Step 8: Making a Taxonomic Analysis

Taxonomic analysis is performed to examine "the internal structure of domains" (Spradley, 1979, p. 144). Ethnographers determine the "subsets within a domain and the relationships between these subsets" (Spradley, 1979, 144).

Step 9: Asking Contrast Questions

The purpose of asking contrast questions is to explore the cultural meaning of words or symbols (Spradley, 1979). The meaning of words or symbols can be discerned by comparisons to other words or symbols (Spradley, 1979). When observing differences in symbols or words, ethnographers can also identify when these terms are not parts of a domain or relationship (Spradley, 1979).

Step 10: Making a Componential Analysis

"Componential analysis is the systematic search for the attributes (components of meaning) associated with cultural symbols [words]" (Spradley, 1979, p. 174). Componential analysis is a process of searching, sorting, grouping, verifying, and adding information to identify a cultural worldview or paradigm (Spradley, 1979, 1980).

Step 11: Discovering Cultural Themes

Spradley defined a cultural theme as "any cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning" (1979, p. 186). Spradley (1979) provided multiple strategies to be used by ethnographers in identification of cultural themes. Spradley (1979) described strategies as guides and not sequential steps.

Step 12: Writing the Ethnography

Spradley (1979) described ethnographic writing as a translation process. The ethnographer's purpose is to discover cultural meanings and communicate those meanings to persons unfamiliar with the culture (Spradley, 1979).

SAMPLING STRATEGY AND SAMPLE

Several sampling strategies were used in this study. Initially a non-probability convenience, or volunteer, sampling strategy was used, which was intended to include available persons who met study criteria (Polit & Beck, 2010). As the study progressed, snowball or network sampling was used, which recruited new potential informants referred by earlier informants (Polit & Beck, 2010). Finally purposive sampling was used, which involved deliberate selection of persons and which was aimed at promoting maximum variation in the sampling process (Polit & Beck, 2010).

Two principles guided the sample size used in the study. First, data saturation, or informational redundancy, is typically used as an indicator of sample adequacy in qualitative research (Polit & Beck, 2010). Data saturation or informational redundancy is considered achieved when interviews cease to provide new information or themes (Polit & Beck, 2010). Second, Spradley (1979) explained that the number of informants needed for an ethnographic research study is dependent on the information ethnographers have received; thus, an acceptable sample size could be as few as one. The sample should be adequate to develop interpretations, to search for alternative explanations, and to focus on the quality of information using Spradley's interviewing techniques (Spradley, 1979). Thus, ongoing data analysis determines when data saturation occurs. For the study, data saturation was achieved with five informant interviews. Nonetheless, six additional informant interviews were conducted to increase informant variability, to confirm that no new information was obtained and no further themes had emerged, and to achieve sufficient and high-quality information for development of interpretations and creation of alternative explanations.

Inclusion Criteria

Inclusion criteria were as follows: (a) postpartum women, (b) completion of HypnoBirthing: The Mongan Method Childbirth Education Class series, (c) English-speaking, (d) 21 – 45 years of age, (e) amenable to audio-recorded interviews, and (f) childbirth within the last six months.

Exclusion Criteria

Exclusion criteria were as follows: (a) nulliparous women, (b) women who never completed HypnoBirthing: The Mongan Method Childbirth Education Class series, (c) non-English speaking women, (d) women younger than 21 years or older than 45 years, and (e) women unwilling to participate in audio-recorded interviews.

The decision to select only English-speaking women was deliberate. Because the researcher was the instrument for collecting and interpreting data, it was essential to be familiar with informants' language and the cultural meaning of words spoken by informants. Because the researcher for this study speaks only English, the study was limited to English-speaking informants. However, as noted, the researcher strove to include informants of varied racial/ethnic backgrounds. It is doubtful that such a language limitation excluded potential informants due to national demographic trends in women that seek childbirth education classes (i.e., Caucasian, middle income) (Berman, 2006; Lu et al., 2003; Risica & Phipps, 2006).

Setting

The researcher anticipated that most or all informants would live in or near San Antonio, Texas. However, in order to expand and diversify the informant pool, the setting was broadened to include informants residing in Utah and Colorado. Narrative data were collected via audiotaped interviews conducted by the ethnographer in face-to-face settings (three informants) or via telephone (eight informants); these settings were chosen by informants to ensure maximal privacy, comfort, and confidentiality. Phone interviews are credited with most of the same advantages as face-to-face interviews (Polit & Beck,

2010). Observations took place mostly in the San Antonio area, although informal conversations included persons residing in other states.

Recruitment

Following study approval and yearly renewal from the Institutional Review Board (IRB) at the University of Texas Medical Branch (UTMB) (Appendix A), the researcher used a flyer (Appendix B) to recruit informants; the flyer summarized the study purpose and provided the researcher's contact information. The study flyer was provided to Allison Bulycz, a HypnoBirthing childbirth educator in private practice, who in turn distributed the materials to current and past HypnoBirthing class attendees. Ms. Bulycz has been teaching HypnoBirthing for 12 years and is certified through HypnoBirthing: The Mongan Method Childbirth Education. Initially the flyer was used to recruit informants in the San Antonio area.

As informants were identified, it was noted that only Caucasian middle class women were responding. This trend was not totally unexpected, as women attending childbirth classes and participating in childbirth education research have tended to be middle class Caucasian women (Berman, 2006; Lu et al., 2003; Risica & Phipps, 2006). But in addition, the number of potential informants responding was very low (n = 3). In an effort to increase the number and diversity of informants, the researcher contacted Marie Mongan, the founder of HypnoBirthing, and requested that the flyer be sent to other childbirth educators. Consequently, interested potential informants from Colorado and Utah contacted the researcher to learn more about the study. In total, eight additional informants met study criteria and were enrolled, for a total of 11 study participants.

Instruments

A demographic data sheet designed by the researcher was completed for each informant at the beginning of the first interview (Appendix B). The demographic questionnaire was used to capture such data as age, educational level, ethnicity, number of births and living children, prior childbirth classes, healthcare provider, when prenatal care began, presence of labor partners, breast or bottle feeding, socio-economic level, and employment status. Informants' collected demographic data are described in chapter four.

Interview data were collected using a semi-structured interview guide (Appendix E) designed by the researcher—the guide was based on the sensitizing framework, extant literature review, the researcher's personal knowledge of the topic, and discussions with committee members. Observation data were recorded using field notes that reflected the researcher's experiences, ideas, feelings, thoughts, and reactions during data collection and analysis (Spradley, 1979, 1980).

DATA COLLECTION

The researcher personally collected all study data. At the start of the first interview, the researcher completed a demographic data sheet for each informant after explaining study purpose, responding to informants' questions, and obtaining informed consent (Appendix C). All informants selected their homes as the interview location, though eight interviews were conducted by telephone. All interviews were audiotaped and transcribed verbatim by the researcher. Eleven informants were interviewed once, one individual was interviewed twice, and three individuals were interviewed three times. Follow-up interviews were performed to collect further information and to validate findings based on the quality of the informants' metadata from the first interview. Informants were selected for re-interview based on demographic characteristics such as age and gravidity to gather diverse perspectives. Most interviews lasted 45 – 90 minutes. To prevent informant and researcher fatigue, interview time did not exceed 90 minutes.

Consistent with Spradley (1979), the researcher's interview guide started with a grand tour question: "Please tell me about your HypnoBirthing Childbirth Education Classes. I am interested in learning anything you would like to share about the classes or your experience." The grand tour question was followed with "mini-tour questions" that explored "smaller aspects of experience" (Spradley, 1979, p. 88). Examples of mini tour questions on the semi-structured interview guide (Appendix E) were:

- Please tell me about making your choice for HypnoBirthing childbirth education classes.
- Please tell me how you used information received in childbirth education classes during your birthing experience.
- What was it like using HypnoBirthing?

Some mini-tour questions explored three dimensions of Lederman's model of Psychosocial Adaptation in Pregnancy (1996). Examples of these questions in the interview guide were:

- How did your experience using HypnoBirthing childbirth education prepare you for labor?
- How did HypnoBirthing affect your readiness for labor?

Two mini-tour questions addressed whether healthcare providers were or were not supportive of the HypnoBirthing labor and birth experience. These could also be considered contrast questions as informants voiced differences between what they considered supportive or not supportive (Spradley, 1979). An example from the interview guide (Appendix E) was:

- Tell me how your physician/midwife/other healthcare provider was supportive during your labor and birth experience.
- Tell me how your physician/midwife/other healthcare provider was not supportive during your labor and birth experience.

The researcher included contrast rating questions, which were used to discover the values placed on a set of symbols in the semi-structured interview guide. Examples of contrast rating questions in the interview guide (Appendix E) were:

- What did you like about your classes? What did you dislike about your classes?
- What did you find helpful from the classes? What did you find unhelpful from the classes?

Structural questions, using the language of the informants, were asked throughout the interviews to verify and clarify data (Spradley, 1979). Some examples of structural questions were:

- What does natural mean to you?
- When you said it helps you relax, in what ways did it help you relax?
- You mentioned communication several times. In what ways could you describe how you communicated?

Spradley (1979) delineated four types of field notes: condensed, expanded, journal, and analytic and interpretative field notes. The researcher kept four types of field notes; these reflected the researcher's experiences, ideas, feelings, thoughts, and reactions

during data collection and analysis, and were believed to augment data richness. Condensed interview notes included setting, date and time, informants' nonverbal behavior, and any distractions noted during the interview. Condensed notes were recorded when time was insufficient to notate everything in detail.

Expanded notes were recorded systematically after each interview using a "Contact Summary Form" that summarized data from specific questions about main themes or issues, salient points, new questions, and necessary follow up items (Miles & Huberman, 1994). Appendix F provides an example of a contact summary form.

Journal notes provided an introspective record of the researcher's thoughts, experiences, ideas, and feelings during the research (Spradley, 1979). The journal notes enabled the researcher to examine her biases or opinions that may have influenced the research.

Analytic and interpretative field notes reflected study considerations, interpretations, and insights (Spradley, 1979). These field notes provided opportunities for the researcher "to think on paper about the culture" (Spradley, 1979, p. 76).

An ethnographer describes all knowledge of the culture including tacit knowledge, or information that informants may not openly discuss because it is so embedded that members may be unaware of its existence (Spradley, 1979, 1980). Tacit knowledge may become evident in informants' conversations, behaviors, and artifacts (Spradley, 1979). The researcher employed informant observations to gather tacit knowledge about childbirth culture. Informant observations were collected at hospital and HypnoBirthing childbirth education classes; through informal conversations with labor and delivery nurses, midwives, and childbirth educators; and via the researcher's personal reflections about her own pregnancy experiences with Lamaze, clinicians, childbirth educators, and HypnoBirthing labor coaches for family members. Informant observations were written in field notes.

DATA MANAGEMENT

All transcribed interviews were coded and not linked directly to informants. Interview transcripts were saved on a password-protected hard drive and USB drive for

backup. All informant interviews were labeled with alphanumeric code to ensure confidentiality; no names or other identifying data were used.

Informant observations were documented in field notes. The researcher ensured confidentiality of field notes through use of alphanumeric code to identify informants; no names or other identifying data were used that could link data to an event or person. Field notes were secured in a locked file in the researcher's office.

DATA ANALYSIS

The researcher used descriptive statistics to analyze informant characteristics. These descriptive statistics included: means, medians, ranges, frequencies, and percentages. Spradley's DSR guided data analysis of narrative data, and the six interrelated steps were as follows:

1. Selecting a single semantic relationship;
2. Preparing a domain analysis worksheet;
3. Selecting a sample of informant statements;
4. Searching for possible cover terms and included terms that appropriately fit the semantic relationship;
5. Formulating structural questions for each domain; and
6. Making a list of all hypothesized domains (Spradley, 1979, p. 118).

Data analysis in qualitative studies is not a linear process (Spradley, 1979). Data analysis began with the first interview and continued as subsequent interviews were conducted. The researcher also listened to interviews repeatedly and transcribed the interviews verbatim, which further immersed the researcher in the data. Following transcription of the first interview, the researcher read the interview line-by-line, underlining words or phrases that appeared significant to the study purpose. The researcher began to develop a preliminary code list that organized and categorized words and phrases as domains. The researcher then read the second transcript line-by-line, again underlining pertinent words and phrases, which were coded according to the initial list. New codes were also developed to organize and categorize new words and phrases that had not been observed in the first interview. The same process was followed for the third

Table 3.1 Summary of Data Analysis Process

Activity	Outcome
Underlining of informants' words/phrases	Preliminary codes for domains
Completion of domain analysis worksheets	Preliminary identification of domains and relationships
Completion of Contact Summary forms	Additions to/clustering of preliminary domains
Completion of taxonomic analysis	Identification of internal structure within domains: Further refining of domains
Completion of componential analysis	Identifications of attributes and differences within a domain: Further refining of domains
Completion of Summary Forms	Summarization of data within a domain across informants
Completion of schematic diagrams	Summarization of themes, sub-themes, and relationships
Completion of artifact worksheets	Identification of artifacts mentioned or used by informant
Reviewing all study materials	Identification of cultural themes: Categories, themes, sub-themes, and attributes; Alignment of themes under time frames; Development of overarching cultural theme

interview transcript and all transcripts thereafter. This process helped the researcher identify 40 potential domains. Table 3.2 provides an example from the first code list and words or phrases from the first three interviews that were clustered to develop the first preliminary domains. Excerpts are identified as belonging to a particular individual and interview, through labeling each informant alphabetically and each interview numerically. For example, in the phrase, "HBA1, 14," the "A" indicates the first informant, the "1" indicates the first interview, and "14" indicates the line of the transcript.

Table 3.2 Example of Early Coding and Domain Cover Terms

Words or Phrases	Domain Cover Terms
"I wanted a natural birth" (HBA1, 14)	
"This other girl had told me how HypnoBirthing had helped, too, with the fear, and I wanted that too" (HBB1, 31-32)	HypnoBirthing Choice (Informants reasons for choosing HypnoBirthing)
"I wanted something different to help me focus on relaxation during labor" (HBC1, 16-17)	
"Telling me positive things" (HBA1, 58)	
"Relaxation was most important" (HBB1, 65-66)	Helpful (What informants found helpful about HypnoBirthing)
"Fear releasing things" (HBC1, 174)	

Following the preliminary coding of potential domain cover terms in the first three transcripts, the researcher began domain analysis, which Spradley (1979) deemed the most important analytic unit. Identification of domain cover terms and their semantic

relationships continued as the study progressed. Spradley (1979) identified nine universal semantic relationships for ethnographic use, but also suggested that ethnographers may choose to examine data for informant-expressed relationships. A semantic relationship indicated how included terms (excerpts from informants) connected to the domain cover term. The researcher chose to identify semantic relationships expressed by the informants and prepared domain analysis worksheets for the first three transcripts. Figure 3.1 illustrates an example of a semantic relationship from this study.

Figure 3.1 Example of a Semantic Relationship from the Study

Included Terms	Semantic Relationship	Domain Cover Term
Feeling prepared	is part of being	ready for labor

As the researcher continued to analyze additional informant data, transcript excerpts were added to the domain analysis worksheet for which the semantic relationship applied. An example of a complete domain analysis worksheet for one domain is included in Appendix G. As domain analysis continued, the researcher added and clustered domain cover terms. The researcher completed 18 domain analysis worksheets for domain cover terms that were most relevant to the study purpose.

After the researcher transcribed the first three interviews and prepared the domain analysis worksheets, the researcher began development of contact summary forms as a way to review and summarize every interview in a standardized manner. The contact summary forms reduced data without losing pertinent information (Miles & Huberman, 1996). Contact summary forms included a synopsis of data from interview questions, summarized main issues or themes, and identified follow-up information or questions and other salient points (Miles & Huberman, 1996). Each completed contact summary data form was easily comparable. An example of a contact summary form without identifying information is included in Appendix F. Contact summary notes functioned as expanded journal notes and were recorded after each interview subsequent to the first.

Following domain analysis of the first three interviews, the researcher began taxonomic (in-depth) analysis of domains (Spradley, 1979). Taxonomic analysis occurred

concurrently with the remainder of the interviews. The process of taxonomic analysis helped the researcher identify "subsets within a domain and the relationships between these subsets" (Spradley, 1979, p. 144). Taxonomic analysis included examination of the domain cover terms, clustering of like terms, and construction of higher level domain cover term classifications. For example, three preliminary domain cover terms (most helpful, supportive persons and HypnoBirthing choice) were relabeled as the domain cover term *Mommy Driven Birth*. An example of the taxonomic analysis of the domain cover term, *Fear Factor*, is located in Appendix H.

The researcher also implemented componential analysis, which was defined as the "systematic search for the attributes (components of meaning) associated with cultural symbols" (Spradley, 1979, p. 174). The researcher examined data for differences (contrast sets), which involved sorting and clustering data to fully explain the domain and its contrast dimension (Spradley (1979). Table 3.3 provides the contrast set identified for the domain *Readiness for Labor*.

Table 3.3 Examples of Contrasting Subsets in the Domain Cover Term, Ready for Labor

Ready for Labor when Fear Eliminated	Not Ready for Labor when Difficulties Encountered
Felt prepared	Had difficult time using HypnoBirthing language (others did not understand)
Felt ready; confident	Wanted a recipe telling her what to do
Had eliminated fear through Fear Releasing Exercise	Found videos not helpful for hospital birth
Trusted in HypnoBirthing Childbirth Education Method	Found some coping techniques not helpful in labor
Practiced with someone	Felt less prepared for hospital birthing environment

The researcher used several strategies to identify cultural themes (Spradley, 1979). Initially, the researcher reviewed transcripts, data analysis worksheets, and journal notes to ensure inclusion of significant data. In the second phase, the researcher also

completed summary forms that were organized by themes and that identified salient points from each informant (Miles & Huberman, 1994). An example of a summary form for one informant is found in Appendix I. The researcher defined themes to aid clustering of similar data. Table 3.4 provides an example of salient points from informants, the theme in which points were clustered, and the organizing definition of the themes enclosed within parentheses.

Table 3.4 Example of Salient Points Organized by Preliminary Themes

Salient Points	Organizing Theme with Definition
"The breathing. . . Relaxing at night. . . Just being calm, relaxed. . . Just the relaxation that was the most important piece of it" (HBB1, 63-65). "Every night I would play the rainbow relaxation and do the affirmations" (HBA1, 31).	Perinatal Practices (Rituals a woman may have during the childbirth experience)
"I wouldn't say my birth was pain free, but I really felt the entire time that it wasn't something that I couldn't handle. It was something I could breathe through, and I took each contraction one step at a time. . . . I knew it was something that I could conquer" (HBD1, 127-130). "I felt like over all I had a much calmer experience and I felt much more relaxed and much more calm, and I had a long labor that started intensely right from the get go" (HBC1, 27).	HypnoBirthing Experience (A woman's perception of childbirth using HypnoBirthing.)

In the third phase of cultural theme identification, the researcher used schematic diagrams of domain cover terms—another strategy for theme analysis—to visualize

relationships, attributes, themes, and categories (Spradley, 1979). An example of a schematic diagram for the domain cover term "relaxation" is illustrated in Appendix J. The schematic diagrams were useful to the researcher in organizing equivalent themes into ordered categories.

In the fourth phase of theme identification, the researcher identified artifacts or things informants used during observations or mentioned in interviews. The researcher developed an artifact summary form, similar to the document summary form recommended by Miles and Huberman (1994), to organize this data.

Cultural themes provide a holistic perspective of a culture. Ethnographers must move beyond an "inventory approach" to have a better understanding of culture (Spradley, 1980, p. 140). To discover cultural themes, ethnographers must wade through vast amounts of data, relationships, and differences to identify larger relationships within cultures (Spradley, 1979, 1980). Table 3.5 demonstrates movement from narrative data to one of the cultural themes *Having it Mommy Driven*. As data analysis continued, the researcher further revealed that data fell into three time frames: *Prenatal-Choosing the Experience*, *Intrapartum-During the Experience*, and *Postpartum-After the Experience*. Study findings are presented in Chapter Four.

Table 3.5 Example of Moving from Narrative to the Cultural Theme, Having it Mommy Driven

Narrative Data	Preliminary Codes	Domains	Higher Level Domains	Category	Theme
"I felt so knowledgeable going in when I was ready to actually give birth" (HBE1, 11).	PFL: Prepared for labor	Ready for Labor	Becoming ready for childbirth experience	Having control of the experience	Having it Mommy Driven
"It took away any fear that I had to have a child and I knew that I was ready" (HBH1, 188).	RFL: Readiness for labor	Eliminate Fear Factor			
"I liked the idea of a very calm and relaxed atmosphere for birth" (HBE1, 34).	CH: HypnoBirthing Choice	HypnoBirthing Class and Information Natural Birth	Choosing HypnoBirthing		
"I wanted a natural birth" (HBA1, 1).					

SCIENTIFIC RIGOR OR TRUSTWORTHINESS

Valid research requires evidence of systematic rigor in all phases of study design and implementation (Polit & Beck, 2010). Lincoln and Guba (1985) identified four criteria used to determine rigor of qualitative research or the study's "truth value": *credibility*, *transferability*, *dependability*, and *confirmability*; for quantitative research studies, reliability, objectivity, and internal and external validity are the equivalent criteria used to determine study rigor (Fossey et al., 2002).

To establish credibility, Lincoln and Guba (1985) proposed the use of multiple strategies to ensure accuracy between study findings and informants' perceptions. The ethnographer used *member checking*, a procedure in which the researcher discussed data and interpretations of data with the informants to verify accuracy and confirm perceptual congruency (Lincoln & Guba, 1985). Member checking was accomplished via initial verification of data at first interviews; clarification and verification of data at second interviews with two informants; and discussion of final themes and resulting relationships as well as verification of theme repetition across timeframes at third interviews. Informants for the third interviews were selected based upon the quality of the data collected during their interviews and individuals' age, parity, and availability. *Data triangulation* was achieved through usage of multiple data sources, including interviews, journal notes, observations, informal discussions, and literature. The researcher achieved *prolonged engagement* through multiple interviews with informants and observations over an approximate two-year timeframe.

A qualitative study that meets methodological and interpretative rigor will exhibit *transferability* to other groups and settings with similar contexts (Lincoln & Guba, 1985). To facilitate transferability in the study, the researcher provided detailed descriptions from narratives and observations.

Dependability is defined as consistency and accuracy of the researcher in the research process and decision-making (Lincoln & Guba, 1985). *Confirmability* ensures that findings are internally consistent and sustained by data (Lincoln & Guba, 1985). Consistent with qualitative research methods, the researcher used reflexivity or "critical self-reflection about one's own biases, preferences, and preconceptions" (Polit & Beck,

2010, p. 566). The researcher also demonstrated dependability and confirmability through use of an audit trail of the research process and findings, spanning inception to conclusion. Examples included in the audit trail were procedures for informant selection, data collection, and data analysis. Committee members reviewed findings to determine other possible explanations for findings that may have been overlooked by the researcher.

ETHICAL CONSIDERATIONS

It is important that research studies possess ethical rigor. The researcher explained the study using simple language and obtained informed consent for informants' participation; this consent included any threats or possible harm that could result from participation in the study and informants' rights to participate or withdraw from the study at any time. Informants' confidentiality was protected at all times, data were de-identified and secured on password protected devices and locked file cabinets in the researcher's home, and findings could not be linked to any individual. It was not anticipated that harm could come to any informants, and no participant appeared to have been harmed by the study. The researcher sought to diversify the race and ethnicity of informants, and no individual who met inclusion criteria was excluded from the study. Researcher contact information was provided upon initial contact with informants, as well as two methods to contact the researcher. Informants were assured they could discontinue their participation in the study at any time, but no one chose to discontinue. All study materials will be destroyed at the conclusion of the study. Only de-identified data will be shared with others.

OPERATIONAL DEFINITIONS

For purposes of this study the following operational definitions of concepts were utilized.

1. Adaptation: "change that occurs as a response to particular environmental circumstances" (Bonder et al., 2002, p. 179).
2. Bonding: a feeling of a sense of connectedness between two or more persons.
3. Culture: the "acquired knowledge that people use to interpret experience and generate social behavior" (Spradley, 1979, p. 5).

4. Culture sensitivity: "having respect for and sensitivity to other cultures" (Bonder et al., 2002, p. 179).
5. Culture-specific expertise: the knowledge of the generally accepted values, beliefs, and behaviors of particular cultural groups (Sue, 2000).
6. Childbirth educator: a person trained specifically to provide information and coping strategies regarding pregnancy, labor, birth, and the newborn (Nichols & Humenick, 2000).
7. Childbirth education: the information and coping strategies provided by the childbirth educator to prepare pregnant woman for the pregnancy and childbirth process specific to the type of method chosen by the woman (Nichols & Humenick, 2000).
8. Cultural conflict: an event occurring when there are differences between two or more cultural groups that cause the differences to intensify (Hunter, 1994).
9. During the Experience: the time from when women entered the facility for labor and birth until they returned home after the birth experience.
10. Emergent culture: "a perspective on culture that emphasizes the dynamic, nuanced, and contextual nature of culture" (Bonder et al., 2002, p. 180).
11. Ethnography is a type of qualitative research used to study people, to examine meanings of what has been said and done, to identify and describe patterns of behaviors, and to provide cultural understanding (Speziale & Carpenter, 2003).
12. Feeling Connected: the strongly expressed desire for women to bond with their babies and partners, while transitioning into motherhood.
13. Feeling Empowered to Advocate for Self and Baby: trust women felt to advocate for themselves and their babies.
14. Feeling Unsupported: women meeting challenges did not have the emotional or physical assistance needed
15. Having Control of the Experience: women's desires to make choices for themselves and their babies.
16. Having it Mommy Driven: the need to have choices, sense of control, and being empowered.

17. Hypnosis: “a procedure wherein alterations in sensations, perceptions, feelings or behavior may be suggested” (Hammond, et al., 1994, p. 3).
18. HypnoBirthing: The Mongan Method: a philosophy and method for women preferring a natural childbirth that is designed to use mind-body techniques including self-hypnosis for a quiet, calm, and gentle birth (Mongan, 2005).
19. HypnoBirthing classes**:** twelve and a half hours of designated content that is taught to the pregnant woman and support persons for a calm and peaceful birth (Mongan, 2005).
20. HypnoBirthing childbirth practitioner: a person educated and certified by Marie Mongan and The HypnoBirthing Institute to teach HypnoBirthing: The Mongan Method childbirth education classes (Mongan, 2005).
21. HypnoBirthing experience: a woman’s perception of her childbirth using mind-body techniques taught in HypnoBirthing childbirth classes (Mongan, 2005).
22. Maternal Adaptive Response: a woman’s positive reaction to the physiological and psychological changes in pregnancy that promotes maternal role development (Lederman, 1996).
23. Maternal Maladaptive Response: a woman’s negative reaction to the physiological and psychological changes in pregnancy that results in anxiety and conflict (Lederman, 1996).
24. Multigravida: a woman who is pregnant the second or more times (Olds et al., 2004).
25. Overcoming Difficult Times: the ability to transcend challenges in the environment and method and shape their own meaningful experiences.
26. Postpartum-After the Experience: the time after women left their birthplace facilities and returned home in motherhood roles.
27. Primigravida: a woman who is pregnant with her first baby (Olds et al., 2004).
28. Prenatal-Choosing the Experience: the time from when women first learned they were pregnant until they entered a facility for labor and birth.
29. Rite of passage: a “ritual associated with the life cycle of a single individual” (Bonder et al., 2002, p. 181).

30. Ritual: “a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is alignment of the belief system of the individual with that of society” (Davis-Floyd, 1994, p. 324).
31. Self-Hypnosis: “learning to reach that level of mind where suggestions that you give yourself effectively influence your physiological experience” (Mongan, 2005, p. 78).
32. Symbol: “an object, idea, or action that is loaded with cultural meaning” (Davis-Floyd, 1994, p. 325).
33. Values: the concepts of what people consider worth-while or desirable and are reflective of their belief system (Bonder et al., 2002).

SUMMARY

Chapter Three described Spradley’s Ethnographic DRS as the design and methodology for the study. The study’s sensitizing framework, Lederman’s Psychosocial Adaptation in Pregnancy, was briefly introduced. The methodological strategies for recruitment of the sample, data gathering, data management, data analysis, and establishing trustworthiness were presented. The limitations and strengths of the study also were presented.

PLAN OF REMAINING CHAPTERS

The findings from this study will be presented in Chapter Four. Chapter Five will present a summary of the study, discussion of the study findings, comparison with the extant literature, implications of the findings, recommendations for future research, and conclusions.

CHAPTER FOUR: FINDINGS

INTRODUCTION

Chapter Four presents findings from an ethnographic study that used Spradley's Developmental Research Sequence (DRS) to explore the values, beliefs and perinatal practices of women, who utilized HypnoBirthing: The Mongan Method. The study aim was to gain an understanding of the culture of HypnoBirthing as perceived by postpartum women through their experiences of choosing, attending, and using HypnoBirthing: The Mongan Method of childbirth education for their birthing experience. The study answered the following **Central Research Question:** How do women who utilized HypnoBirthing childbirth education describe and explain their experiences with this method? **Sub-question 1:** What expressed values and beliefs influenced these women's decisions to use HypnoBirthing childbirth education and mode of childbirth?
Sub-question 2: How did women describe their actual experiences, outcomes, and level of involvement using the HypnoBirthing method?
Sub-question 3: What facilitated or inhibited women's use of HypnoBirthing during their experience?

INTERPRETATION OF THE DATA

Ethnographic studies require the accumulation of an enormous amount of data, which then must be systematically analyzed and logically presented (Spradley, 1979, 1980). For the current study, interview, journal, and observation data were analyzed using Spradley's (1979, 1980) DRS for conducting ethnographic research. The researcher followed Spradley's method to organize the data through identification of cultural themes, categories, and components. All of the data presented helped to answer the primary research question and the three sub-questions.

Demographic Profile

A description of participants is provided in Table 4.1. The sample consisted of 11

Table 4.1 Demographics of the Informants

Variable	n	Percentage
Age: mean 29.4 years		
21-25 years	4	36.36
26-30 years	2	18.18
31-35 years	3	27.27
36-40 years	2	18.18
Parity		
Primiparas	7	63.64
Multiparas	4	36.36
Marital Status		
Married	9	81.81
Living with partner	2	18.18
Ethnicity		
Caucasian	11	100
Education		
Technical Training	1	9.09
Associate Degree	1	9.09
Bachelor Degree	5	45.45
Master Degree	3	27.27
Doctorate Degree	1	9.09
Work		
Full time	3	27.27
Part time	2	18.18
No work	6	54.54
Household Income		
$0-15,000	1	9.09
$46,000-60,000	4	36.36
Above $60,000	6	54.54
Healthcare Provider		
Physician Only	3	27.27
Physician and Midwife	2	18.18
Physician and Doula	2	18.18
Physician, Midwife, and Doula	1	9.09
Professional Midwife	3	27.27
Month Started Prenatal Care		
First Month	3	27.27
Second Month	5	45.45
Third Month	3	27.27
Childbirth Classes Recommended		
Recommended	8	72.72
Not Recommended	3	27.27

Caucasian women between the ages of 21 through 40 (mean age 29.4).

The women were highly educated, with degrees ranging from technical or associate level to doctorate level. Women with a bachelor's degree or greater were more likely to report higher household incomes. Six women had a yearly household income greater than $60,000, four women's incomes were within $46,000 to $60,000, and one woman had an income within $0-$15,000. More than half of the women did not work outside the home, and only three women worked full-time. Women with higher incomes or with two or more children were less likely to work outside the home or to work at all. Interestingly, the woman who was married and had the lowest income did not work outside the home, and the woman who had the highest level of education and was married worked full-time. Three women lived in San Antonio, Texas, four lived in Colorado, and four lived in Utah at the time of the interviews. There were no significant differences found due to where women resided during the interview. All women chose to breastfeed.

For ten of the participants the HypnoBirthing: The Mongan Method Childbirth Education series was their first childbirth education course. One woman had previously attended another type of childbirth class called "Birth from Within" during her first pregnancy and then attended the HypnoBirthing: The Mongan Method Childbirth series for the second pregnancy. One woman previously attended a HypnoBirthing: The Mongan Method Childbirth series with her first pregnancy and again with a second pregnancy.

All informants sought prenatal care in their first trimester of pregnancy. Seven women were primiparas, and four women were multiparas. All the women gave birth to full term infants—10 women had singletons and one woman had twins. Ten of the women had a vaginal birth and one woman had a repeat cesarean birth. Nine women were married and two lived with partners.

All of the women reported having a physician or a professional nurse midwife to provide prenatal care. Additionally, three women used a doula to provide comfort during labor. According to the informants, five of the eight physician caregivers and all of the professional nurse midwives recommended childbirth education classes. Women reported that health professionals were slightly more likely to recommend childbirth education classes for the first pregnancy.

PRESENTATION OF FINDINGS

The major findings of this study are organized and presented according to each of the sub-questions and in-depth descriptions of the themes, categories, and components during all phases/timeframes of prenatal, intrapartum, and postpartum. A central finding in the study was how these women self-selected to get into this HypnoBirthing cultural group. The women did not attend the same HypnoBirthing classes. The women birthed at different times using multiple facilities for birth and lived in various geographical areas in Texas, Utah, and Colorado. In addition, data consistently appeared to fall into three timeframes: *Prenatal-Choosing the Experience*, *Intrapartum-During the Experience*, and *Postpartum-After the Experience* with the same three themes.

Following Spradley's method, the cultural scene is represented by a schematic/matrix that identifies the timeframes, themes, categories, and components. Study findings were presented in a matrix that explains how the three themes *Having it Mommie Driven, Overcoming Difficult Times, and Feeling Connected* persisted across the three timeframes and in some ways were manifested differently. Categories and components are also presented along with supporting data for the timeframes and themes.

Sub-question 1 was answered in the first timeframe Prenatal- Choosing the Experience. **Sub-question 2** was answered in all three timeframes since it is about the entire HypnoBirthing experience. **Sub-question 3** was answered with an in-depth discussion in Having it Mommy Driven and Overcoming Difficult times of the various factors that impact or impedes having the HypnoBirthing experience. Table 4.2 presents timeframes, themes, categories, and components.

Key sentences are like a roadmap that shows how the researcher derived the themes. Excerpts from interviews were linked to an informant and her interview through alphanumeric labeling. For example, the label "HBA1, 14" indicated the first informant ("A"), the first interview ("1"), and the fourteenth line of the transcript ("14").

Table 4.2. Overview of Timeframes, Themes, Categories, and Components

Timeframes	Themes, Categories, and Components
Prenatal: Choosing the Experience	**Theme: "Having it Mommie Driven"** **Category: Having control of the experience** • Choosing HypnoBirthing • Choosing the environment • Choosing breastfeeding **Category: Feeling empowered to advocate for self and baby** • Becoming ready for the experience • Having confidence in self and method • Feeling supported by environment **Theme: "Overcoming Difficult Times"** **Category: Feeling unsupported** • Environment • Method **Theme: "Feeling Connected"** **Category: Bonding** • Enhancing relationships • Increasing communication
Intrapartum: During the Experience	**Theme: "Having it Mommie Driven"** **Category: Having control of the experience** • Sustaining motivation and values • Making decisions for self and baby • Having a supportive environment **Category: Feeling empowered to advocate for self and baby** • Having confidence in self • Having confidence in method **Theme: "Overcoming Difficult Times"** **Category: Feeling Unsupported** • Environment o Not having a conducive physical environment o Not having knowledgeable healthcare providers o Not having supportive partner • Method **Theme: "Feeling Connected"** **Category: Bonding** • Enhancing relationships • Increasing communication
Postpartum: After the Experience	**Theme: "Having it Mommie Driven"** **Category: Having control of the experience** • Renewing motivation for natural birth **Category: Feeling empowered to advocate for self and baby** • Feeling changed as women and mothers o Feeling others' positive regard for their accomplishment o Having confidence in self, baby, and natural methods o Advocating for natural methods **Theme: "Overcoming Difficult Times"** **Category: Feeling Unsupported** • Wanting more control of the environment **Theme: "Feeling Connected"** **Category: Bonding** • Enhancing relationships • Increasing communication

First Timeframe Prenatal-Choosing the Experience

Central Research Question: How do women who utilized HypnoBirthing childbirth education describe and explain their experiences with this method? The entire matrix is about the experiences the women encountered with utilizing HypnoBirthing childbirth education for their birthing experience. The findings will be located under the headings for each of the themes and categories in each timeframe. Sub-question 1: What expressed values and beliefs influenced these women's decisions to use HypnoBirthing childbirth education and mode of childbirth? Findings related to decisions to use HypnoBirthing childbirth education discussed in this section help to answer sub-question 1.The first timeframe, *Prenatal-Choosing the Experience*, was the time from when women first learned they were pregnant until they entered a facility for labor and birth. There are three themes during the first time frame, *Having it Mommie Driven, Overcoming Difficult Times, and Feeling Connected*. The schematic for this timeframe is presented in Figure 4.1.

Figure 4.1 First Timeframe Prenatal-Choosing the Experience

Timeframe	Themes, Categories, and Components
Prenatal: Choosing the Experience	**Theme: "Having it Mommie Driven"** **Category: Having Control of the Experience** • Choosing HypnoBirthing • Choosing the environment • Choosing breastfeeding **Category: Feeling Empowered for Self and Baby** • Becoming ready for the experience • Having confidence in self and method • Feeling supported by environment **Theme: "Overcoming Difficult Times"** **Category: Feeling Unsupported** • Environment • Method **Theme: "Feeling Connected"** **Category: Bonding** • Enhancing relationships • Increasing communication

THEME-HAVING IT MOMMIE DRIVEN

In the first timeframe, the theme *Having it Mommie Driven* was defined as the need to have choices, sense of control, and being empowered. During this time, women expressed wanting to use HypnoBirthing techniques to be healthy and prepare for childbirth. Two categories were identified: *Having Control of the Experience* and *Feeling Empowered for Self and Baby*. These categories were essential to the mother feeling she was having the birth experience she desired.

HAVING CONTROL OF THE EXPERIENCE

The category *Having Control of the Experience* indicated women's desires to make choices for themselves and their babies. In the first timeframe, women had selected HypnoBirthing as their preferred childbirth education method because of their motivations and values about natural methods or prior exposures to the HypnoBirthing method. During this timeframe, women selected the environment for their birth, including the healthcare providers, setting for birth, and support persons. Women also selected breastfeeding as their preferred method of feeding their babies, as recommended in the HypnoBirthing classes and book.

Choosing HypnoBirthing

All 11 women selected HypnoBirthing because they perceived it to be "a natural birth" (HBA1, 4) experience. One participant described "having people there to support me while my body does just exactly what it is supposed to do" (HBF1, 38). Another woman said she felt, "like women's bodies were designed to give birth" (HBG1, 8).

As part of their choice for a natural experience, several women specifically mentioned avoiding medications and medical interventions for themselves or their babies. One woman commented, "I know that everyone says that birth is a natural thing no matter what, but, for me, it means un-medicated" (HBD1, 149). Another woman said, "I wanted to have her [baby] naturally and safely. . . . I didn't want to take medicine for anything unless I was in a lot of pain, so I didn't want that for my child either (HBH1, 139-152).

Additionally, some women mentioned their babies' fathers also desired a natural birth: "My husband and I both knew we wanted to do it naturally" (HBK1, 17). Another woman, who was having twins and was required by law to give birth in a hospital setting, commented that she knew from the first class that HypnoBirthing would support her needs for the type of birth experience she and her partner desired:

> Our original plan was to have a home birth. So, I knew I was really going to have to have a plan and a method to use so I wouldn't have to give into any drugs, since I was going to be in the hospital setting, and they were going to try and push it [medical intervention] on me. So, l looked on the Internet and found a HypnoBirthing class that was near, and my boyfriend and I started going to it, and the first session we absolutely loved it. I think our favorite part about HypnoBirthing class was our instructor took us step by step through the entire birthing process which we didn't know much about (HBD1, 7- 12).

Women also chose HypnoBirthing because they thought it was the best experience for the baby. One woman said,

> That is part of the reason why I chose HypnoBirthing. I liked the fact that the book talked about how it was his [baby's] birth experience, too, and not just mine, and that was part of the why this was so important to me, why I didn't want to use drugs (HBB1, 179-181).

Several women expressed choosing HypnoBirthing because they had prior positive exposure to the method themselves or through others. One woman noted,

> My sister-in-law also delivered via HypnoBirthing, and it was just an incredible experience versus my sister who had an epidural. . . . I could see a difference birthing naturally. . . . HypnoBirthing was a good way to do it naturally and manage the pressure and bring my baby into the world (HBH1, 17-19).

After using HypnoBirthing previously, another woman commented, "I do have positive feelings with all childbirth experiences, which I don't think many women have" (HBG1, 73-74). These experiences reinforced her desire to use the method three times in total.

Choosing the Environment

Several women chose HypnoBirthing because they wanted to control their childbirth environment. As one woman noted, "I didn't want a birthing experience where everyone, you know, [was] screaming and loud. . . . I really [liked] the idea of a very calm and relaxed atmosphere for birth" (HBE1, 32). Another woman said,

> It was really all about the environment which really helped going into delivery. . . . In the class, we talked about different types of sounds or music in general [to promote relaxation]. So I was able to take that idea and find out what worked for me. . . . I already knew going into it what I wanted my environment to be like. (HBK1, 38-43).

Women valued having the right healthcare providers and setting for their birth experience and were willing to make changes to ensure that such options were available to them. One woman said, "My insurance at first was at another hospital that I knew was not supportive, but my husband got a job, and we changed insurance" (HBH1, 127-128). Another woman changed her healthcare provider:

> I switched my physician early on in my pregnancy. I sought a midwife. There were four or five, and they all were knowledgeable about HypnoBirthing, and they knew what it was, and [a midwife] was going to be able to help (HBJ1, 88-90).

A third woman said:

> I actually started my pregnancy with an OB at [a hospital] and changed pretty quickly to midwives due to the policies at [the hospital], particularly in the aftercare in the nursery that I didn't want. I took their hospital tour and decided this is not what I want (HBC1, 99-101).

To ensure their care choices would be met, women made known their choices to health care providers (i.e., physicians, midwives, nurses, other hospital personnel) through use of a letter and birth preference plan. One informant described this process:

> In the classes, they [HypnoBirthing educators] talk about methods of coping with pain and also your birth plan, what you want your birth to be like, and have you write down, I think, things like "don't ask me about my pain level" and things like that (HBI1, 44-46).

The birth preference plans were especially helpful for when personnel changed or when multiple providers were on call for the delivery. One informant said,

> I wrote out birthing preferences that I talked about with my midwife prior to one of my previous appointments, and it went into my file so all the midwives, depending which one was on call, would have it" (HBK1, 118-120).

The women strongly valued support from their partner, which is an innate part of HypnoBirthing culture. HypnoBirthing educators encouraged women to choose a support person to be physically present and engaged during classes and the birth experience. All women chose their partner as their primary support person. Some women also chose to have their mother or a doula present. One woman said,

> The HypnoBirthing class curriculum does address specifically fathers and tell them, "You know, you are a part of this experience. It is not just mom and baby. It is mom and baby and dad." There is a handout that is specifically for fathers, and it tells them all the things they need to be doing during each stage of labor. They also have a handout for positive affirmations for the fathers they can use as well (HBG1, 145-149).

Another woman said, "I very much appreciate his [husband] willingness and full support of me through the whole process, through the whole pregnancy, trying to find providers, letting me be a VBAC [vaginal birth after cesarean section]" (HBC1, 144-145).

Even when partners could not be present physically during classes, some women tried to find ways to include their partner in the HypnoBirthing process. One woman said,

> I would copy parts of the book and mail it to [my partner] because we weren't together at the time; we were [geographically] apart. . . . I really wanted him to be included as much as possible, so I would copy the book and send him parts; he would read them, so he would kind of understand what I was doing, because it [HypnoBirthing] is so different than your traditional childbirth classes (HBB1, 168-171).

The woman added, "Having his [father of baby] support meant a lot to me" (HBB1, 230).

Choosing Breastfeeding

All the women had the desire to breastfeed their babies. HypnoBirthing education helped women learn, "a lot about after [childbirth], like breastfeeding, and it kind of went

along on the same thing [natural methods], how the body takes care of baby" (HBF1, 45-47). Another woman agreed, "I think most women who are looking to have a natural birth experience with HypnoBirthing also feel natural ways are the best and that includes the breast feeding" (HBG3, 53-54). The information taught in the HypnoBirthing classes reinforced women's desire to breastfeed—these classes described breastfeeding as a "gift with benefits that will last a lifetime" (Mongan, 2005, p. 281). HypnoBirthing materials view breastfeeding as a natural process bonding mother and baby, providing the best nutrition for the baby, and yielding life-long advantages for the baby (Mongan, 2005).

Women who chose HypnoBirthing were determined to find a method and environment that supported their choices and values about natural methods, even if such choices meant incurring financial or personal sacrifice. Women wanted to be heard and supported in their choices by all involved in their childbirth experience.

FEELING EMPOWERED TO ADVOCATE FOR SELF AND BABY

The second category, *Feeling Empowered to Advocate for Self and Baby,* refers to the trust women felt to advocate for themselves and their babies. In the first time period, women learned information and practiced skills to prepare their minds and bodies for childbirth, becoming psychologically and physically ready to give birth, gained confidence in their bodies' abilities to birth and to feed their babies naturally, and developed support systems to facilitate the experience they wanted.

Becoming Ready for the Experience

Women felt that becoming ready for the experience of natural birth required childbirth education. One woman said, "I knew I needed to educate myself to help me in that [preparation]. . . . I knew I wanted to take a class to help me (HBA1, 15). Another woman noted:

> This is my first baby, so I had heard of different kinds of methods of birthing. My mom had used Lamaze and had told me a lot about that. She used Lamaze for me and my sister, and I had learned about that, and I had a friend who had recommended HypnoBirthing. So I had actually started doing some research and

had chosen it, but, when I got to the classes, I was pretty uneducated about the whole birthing process, and just learned an incredible amount (HBE1, 4-8).

Women found HypnoBirthing class information to be comprehensive: "I learned about all different facets from breastfeeding to what my body is actually going to do throughout the actual labor" (HBE1, 8-10). HypnoBirthing classes reinforced women's beliefs that birth is a natural experience. As one woman commented:

> We talked about how the body is naturally created to birth. All the discussion we had in class about that made me appreciate more my role in the birthing process, and it made me, I think, appreciate the experience more because of how I was created for this and how my body would naturally take care of itself and the baby. . . . That idea made me more excited about the idea of giving birth, because of my role as a mother and what I was doing (HBK1, 198-203).

A second woman commented, "I like feeling like this [childbirth] has been going on for thousands of years, and I am going to be fine, and we can do this" (HBI1, 65-67).

Yet another woman described the HypnoBirthing classes as follows:

> I liked that I had a book to study. I had a video. I had CDs and lots of material that I could refer to. I could remember and practice on my own at home, and I liked that they showed women giving birth naturally, and it showed that it is a natural process and to just really relax yourself and you can do that (HBH1, 52- 54).

A fourth woman related she enjoyed, "How relaxing it [HypnoBirthing class] was. I liked the breathing exercises. It was very calm and peaceful" (HBB1, 102). Yet another woman said, "it [HypnoBirthing] made me feel less fearful and less anxious throughout the pregnancy" (HBI1, 17-18).

Women also had to dispel myths and learn new information and techniques that supported the natural experience they wanted. One woman said:

> The first part of the course was kind of, rather than learning, it was more about unlearning all the myths that come with childbirth and all the negative associations we have with childbirth. We kind of had to erase all of that from our brains and look at it from a new perspective, so we learned about the muscles in the uterus and how they work together to, you know, expel a baby and other parts

> of a woman's body that work together, you know, naturally in order to allow childbirth to happen (HBG1, 29-34).

Several mentioned "horror stories" they had heard about giving birth (e.g., HBA1, 140; HBC1, 210; HBE1, 13, 197). Every woman mentioned a desire to overcome fear related to giving birth. As one woman stated, "I was first interested [in HypnoBirthing] when I first learned about releasing fear because I thought nowadays everyone associates birth with fear . . . I liked that aspect of it" (HBA1, 8-9). A second woman said:

> Another co-worker had a baby without medication, and she and I had talked about the fear of the pain and not having that, and this other girl had told me how HypnoBirthing had helped with the fear, and I wanted that, too (HBB1, 30-32).

A third woman talked about dispelling "negative emotions and . . . certain things we were scared about, negative about, unsure about, and whether our provider was going to do what we wanted" (HBD1, 50-52). Yet another woman said,

> We talked about women having children, going back to how we were created to naturally give birth, but it's the fear of the experience that can make it un-pleasurable and the culture thing to be afraid of it. . . . The course taught you the original basics of labor and delivery so you can process it and know how it is supposed to be (HBK1, 232-237).

Women mentioned several methods they found helpful for overcoming the fear of the childbirth experience. One woman said, "We took all our fear and concerns, put them in a hot air balloon, we put them in a box, and then threw them over . . . to get rid of all our fears" (HBH1, 194-196). Another woman commented:

> Fear release is a big part of HypnoBirthing, where we go in, and in the hypnosis script, and we address any fears we have about childbirth and kind of erase those fears from our mind, and that prepared me really well because I did have issues that I was coming into it with (HBG1, 176-179).

Another woman expressed it another way:

> We tried to bring it out [negative emotions or fears] and talk about what we could do to change that and let it go. And, if we were worried about certain things, we tried to get them out in the open and talk about them and get to the core of why we felt negative about that (HBD1, 52-54).

All women found it helpful to learn and practice relaxation techniques. One woman noted, "The focus in class was definitely more on learning and practicing the techniques" (HBF1, 9). In HypnoBirthing classes, women were taught various mind-body techniques that promoted a trance-like state (Mongan, 2005). One woman commented, "I liked the mind aspect and the fear releasing aspect and relaxation" (HBA1, 150). Another woman summarized:

> We also learned a little bit about hypnosis, not a lot of detail, just kind of what it is and what it isn't, a way of relaxing your body and clearing your mind and relaxing your body to the point where it allows the muscles in the uterus to work the way it is supposed to. And we learned the reason why there is so much pain associated with childbirth: it's because women are afraid of it, and they tighten their body, and they are basically in a "flight or fight" mode, and that causes pain in the body during childbirth. . . . We talked a little bit in my class about music in childbirth, and how it works in childbirth, and some other comfort techniques as well, like light touch massage, and counter pressure. We learned about the power of positive affirmations, and we were actually given a list of affirmations for birth, and they were also on a CD that we got, and we could listen to it. And it just had positive statements about your birthing body and about childbirth in general, and it was a really neat thing, because I had never really practiced positive affirmations, and I know a lot of people do that, not for childbirth, but for life in general. So that was something that was really neat, having those positive things in my brain. And then we learned, just, different relaxation techniques with hypnosis. There were several scripts that we were given that we could listen to; we also learned the deepening techniques, such as progressive relaxation, eye tiring [a techniques used in hypnosis], and, just, quick ways to get yourself into a really relaxed state. That was about the general overview of it (HBG1, 34-51).

All women used progressive relaxation techniques. Several women described their use of progressive relaxation techniques: "Just starting at your head, relaxing your head, your facial muscles, and just going down through your body and just relaxing" (HBJ1, 159). Another woman described using deepening techniques with progressive

relaxation: “You can allow the relaxation; it is sort of a countdown back from 40. I can’t remember what it was called, but that one was awesome” (HBE1, 76-77).

All women reported listening to the Rainbow Relaxation and Positive Affirmation CD, which is used in all HypnoBirthing classes and which all women are instructed to use at home. One woman described the CD as, “Talking about handling everything over to your body and your baby and have a calm and peaceful birth, and I would close my eyes and listen to that, and that was really nice” (HBD1, 70-72). Another woman said, “Every night I would play the rainbow relaxation and do the affirmations. . . . Affirmations, relaxing, helped me stay calm and positive throughout my pregnancy” (HBA1, 30). Another woman concurred that the CD was effective: “I guess it did its job, because a lot of times I fell asleep” (HBB1, 26). This woman explained that the relaxation exercises she had learned in HypnoBirthing improved her overall sleep:

> I used to have to take medication to sleep, and I used to have to have the TV on to sleep, but, during my pregnancy, I didn’t have either of those two things ever since I took HypnoBirthing. I went to sleep, so that it was a huge benefit for me (HBB1, 124-126).

Having Confidence in Self and Method

As women learned information and practiced HypnoBirthing techniques, they began to gain confidence in the methods and their ability to use the methods and to feel ready for childbirth. All the women commented about feeling prepared and ready: “I was ready. I was prepared for whenever. I wasn’t afraid at all. I was excited” (HBB1, 208). A second woman commented:

> I felt so knowledgeable going in when I was ready to actually give birth and . . . comfortable and confident. . . . I felt like I really knew what to expect. . . . We talked about . . . using imagery and relaxation techniques. We practiced relaxation techniques. We were guided through a number of different types of relaxation, having our partners help us become relaxed and do these guided imageries [visualizations], and my husband learned how to work and how to do these with me, and we learned how to practice at home and did practice at home, and learned a lot about how the baby grows and moves and different ways to avoid medical

> interventions, if they weren't emergencies, which I really appreciated, and how to possibly avoid an induction if you were going post term and how to use natural techniques to maybe turn the baby if the baby was breach approaching the due date. We even talked about acupuncture, so really just talked about all kinds of natural methods to sort of avoid medical interventions if possible, and about all the, I don't know, about what to expect when we got to the hospital or birthing center or whatever we were using about conversations to have with our medical professionals that were going to be delivering us. Gosh [laughs], I just felt like I got some of everything. I felt very confident going into it [labor]. I felt like I really knew what to expect (HBE1, 10-51).

Several women mentioned trusting their HypnoBirthing childbirth educators. One woman commented, "I called my HypnoBirthing coach and she actually talked to us over the phone and kind of got my labor going so it was really nice to know she wasn't just a resource for class" (HBF1, 19).

HypnoBirthing gave women a sense of confidence and control over the pregnancy experience. As one woman noted:

> I think birthing in general is mind over body, and, if you don't have the confidence in what you are doing, then, I guess that is where the control comes in. If you don't have the confidence that your mind has the control over your body; I don't think you would be as successful if you didn't have that empowerment in what you are doing (HBK3, 53-56).

Feeling Supported by Environment

HypnoBirthing also gave women an understanding about what was controllable: "It [HypnoBirthing] emphasized that sometimes we can't control everything, and so we have to be willing to just accept what's going on and know that we can try as hard as we can to still have a calmer birth experience" (HBJ1, 125-127). Knowing what could or could not be controlled assisted the women in feeling they could still have the experience they wanted regardless of not having everything exactly as planned.

Women sought childbirth education classes to help them dispel fears of childbirth. As participants learned and practiced techniques, they released their fears and gained

confidence in themselves and their ability to birth naturally. HypnoBirthing gave women a sense of having control over the pregnancy experience. This sense of control promoted feelings of empowerment to advocate for themselves and their babies.

Theme-Overcoming Difficult Times

The second theme during the first timeframe Prenatal-Choosing the Experience was *Overcoming Difficult Times*. *Overcoming Difficult Times* was defined as the ability to transcend challenges in the environment and method and shape their own meaningful experiences. The theme Overcoming Difficult Times provides answers to the second part of **Sub-question 3** which is what inhibited the women's use of HypnoBirthing during the experience? This is true for each timeframe. The challenges or problems arose when the women were *Feeling Unsupported* by the environment (healthcare providers, setting, and support persons) or the HypnoBirthing method. Feeling Unsupported was an emotion women experienced when the women were encountering challenges with the environment or method in having the HypnoBirthing experience.

FEELING UNSUPPORTED ENVIRONMENT

Four women reported overcoming difficult times during the first time period. One woman experienced a unique challenge with healthcare providers because she had different physicians for every prenatal visit. She found that not all physicians understood how important she felt it was that labor start when both the body of the mother and baby were ready. She related her experience:

> I had an appointment at my due date, and they wanted to induce me right away and get it rolling. I would explain to them that it was only an estimated date and I wanted to give it some time and see how things go. They did not know why I wanted to wait. They are used to people wanting to be induced three weeks early, so they thought I was—they were not very supportive about that. (HBA1, 92-97).

FEELING UNSUPPORTED METHOD

Three women expressed difficulties with some aspect of HypnoBirthing techniques. One woman noted that more videos of "births using the hospital setting"

(HBA1, 76) would have been helpful because the HypnoBirthing video focused more on home and other settings for birth. A second woman said, "Not all the methods they used worked for me at home" (HBI1, 15). She added, "There were imagery techniques that did not work for me; the one where you release your worries in a balloon" (HBI1, 97). A third woman had doubts about the effectiveness of the method during labor:

> I also remember feeling somewhat unsure about the whole hypnosis part of it, and I didn't know if I would be able to hypnotize myself to the point that, I would be able to go through my birth without any pain. So, I was sort of second guessing myself about that part of the whole thing (HBG1, 11-14).

Only one woman, who reported having to take the classes without her partner, mentioned difficulties using the method due to the partner's geographical unavailability. "My difficulty was I was doing it [HypnoBirthing classes] alone. I didn't have anybody here with me, and we tried to enlist my sister to help and that didn't work out" (HBB1, 4-5). She added, "I think the hardest thing for me was practicing and not having someone to practice with me" (HBB1, 5-6). She further noted: "What would really have helped me is exercises in the book—if they had been recorded on CD so I could listen to those . . . since I didn't have a partner to give me the feedback" (HBB1, 14-15).

All women felt the HypnoBirthing education helped them prepare for labor. Women liked that HypnoBirthing stressed partner involvement and support, and having that support helped them felt more in control and confident. However, when women lacked partner involvement in class participation and for practicing, they felt this as a loss of an opportunity to share this important time.

Theme-Feeling Connected

In the first timeframe from pregnancy until entering a facility for labor and birth, the theme *Feeling Connected* was identified by this researcher as the strongly expressed desire for women to bond with their babies and partners, while transitioning into motherhood.

BONDING

Bonding is a feeling of a sense of connectedness between two or more persons. Women described verbal and nonverbal HypnoBirthing techniques they used during pregnancy that increased bonding. As one woman commented:

> I would always read that [baby script] or my husband would read it to me while I relaxed. . . . [The script was about] loving your baby. "I am taking care of myself for you, I am excited to meet you," and different things. . . . Sometimes it was just mentally, in my mind. I would just think of things to her. Whenever I would go for my appointment and stuff, I would tell her, "I am going to my appointment, you are doing great, I am healthy, you are healthy." . . . I would rub my belly. Pat my belly. Almost play games. Tap one side, tap the other, try one thing and she would usually kick back (HBA1, 102-137).

She added, "My husband would read me scripts and do light touch massage, and we would practice that a couple times a week. . . . My husband would kiss my belly (HBA1, 60-130). A second woman said, "I did the affirmations, talking to the baby, things like that, but I always talked to him [baby], I always rubbed my belly, and my co-workers were making fun of me because I was always touching myself [laughs]" (HBB1, 196-198).

The HypnoBirthing book and educators emphasize that babies can hear during the pregnancy and that mothers' emotions may affect their babies (Mongan, 2005), so some women attempted to communicate positive emotional states to their babies. One woman said,

> Oh, yeah, I understand when [I was] pregnant, they [her twins] were cognizant of everything going on. . . . It made me want to be happy all the time. Anything that was negative might cross over to them, so it really made me cognizant about being happy (HBD1, 148-150).

Some women felt HypnoBirthing classes increased communication and strengthened or enhanced relationships with their partners. One woman said:

> I feel like it connected us all. He [baby's father] would help with the scripts. He would be really involved with light touch and everything, and he would talk to her, my belly. Through all this, the script reading, it definitely brought us all together (HBA1, 117-119).

Another woman agreed:

> We felt it [HypnoBirthing] brought us closer. Doing these imageries together and doing the practicing that led up to the birth, we found it to be an awesome bonding experience between the two of us and the baby, too. She obviously wasn't born yet, but it really [was] kind of neat—a pre-family kind of bonding (HBE1, 171-174).

Through participating in HypnoBirthing classes, women felt their partners were more in tune with what women wanted for their HypnoBirthing experience. As one woman said:

> I think the best part about it [HypnoBirthing class], he [partner] knew what to expect about it [childbirth], just like I knew what to expect about it, and after the class we would go home and talk about everything we learned, and it just helped us to know the other person was thinking the same thing, and we both knew what was going on, and he wasn't clueless of everything (HBD1, 160-163).

Observations of women and their partners in HypnoBirthing classes revealed couples who were working together. They practiced HypnoBirthing techniques intently during classes and returned each week demonstrating progress. As the weeks progressed, couples increasingly commented to each other their preferences for scripts, massage, and other techniques. Observations further revealed emotional connectedness between couples and the baby. Couples were smiling and laughing with one another. Women lay back with a peaceful look on their faces as the fathers of their babies stroked (light touch massage) women's abdomens lovingly. Couples who knew their babies' gender sometimes talked to the baby by name.

HypnoBirthing methods encouraged parental attachment to their babies and strengthened bonds and communication between the couple. HypnoBirthing instruction promoted the recognition of the mind-body connection between women and their babies. Sharing the experience of class and practice brought the parents closer together and strengthened the family union. The parents focused on a common goal for the childbirth experience. Observations supported the notion that women responded more strongly to their partners than to the educator, emphasizing the importance of the bond between the mother and her partner.

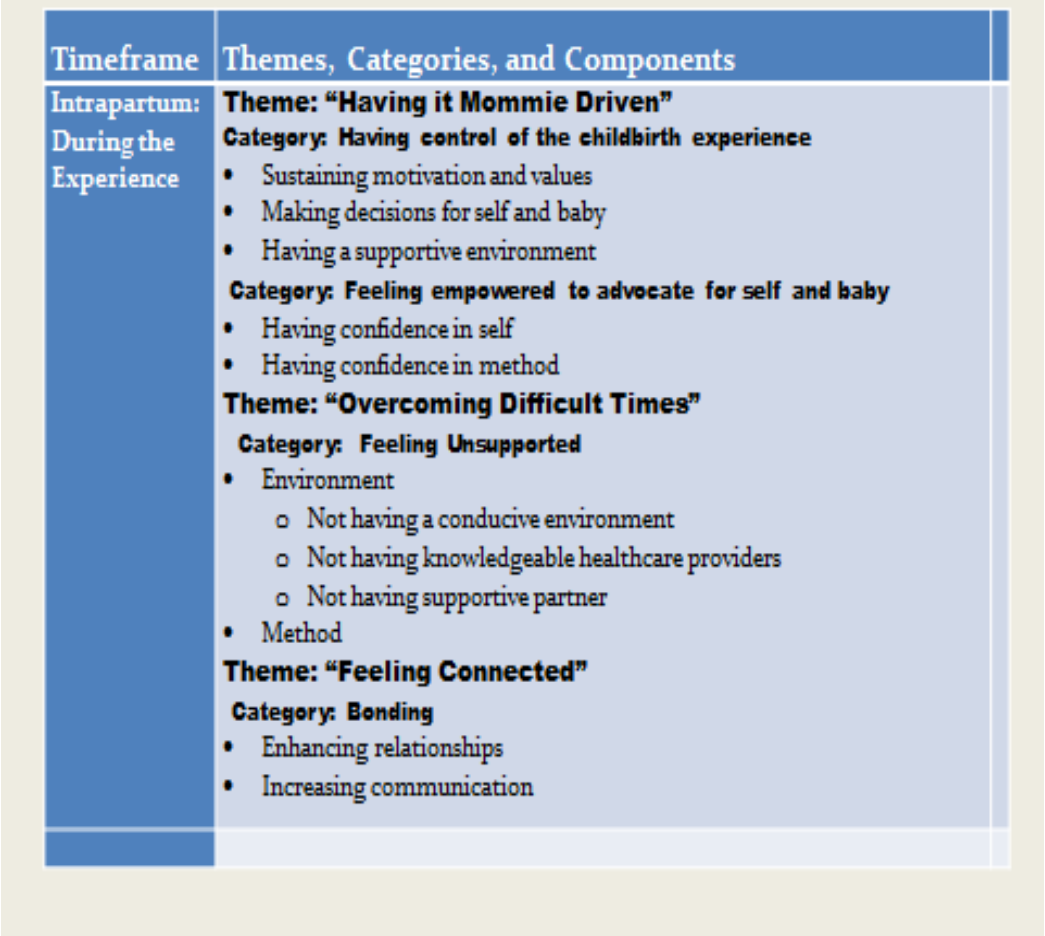
Women felt it necessary to prepare their mind and bodies for motherhood. They wanted to have the power to control their pregnancy and childbirth. In order to conquer the fear factor that was prevalent in all these women, they chose to use a childbirth education method that they believed would provide them with knowledge and skills to achieve this power and vanquish their fears. HypnoBirthing provided tools for the experience they wanted, but it was crucial they have a supportive environment in order to feel ready for motherhood.

In the first timeframe, *Choosing the Experience,* women described a conflict between the dominant cultural view of childbirth that associates childbirth with pain and risks and emphasizes medical interventions and their own view of childbirth as a natural experience. In order to have the natural birth experience they wanted, women had to gain confidence in themselves and HypnoBirthing, secure control of the environment, build a support system, and overcome obstacles. Through use of HypnoBirthing techniques, women and their partners developed a repertoire of behaviors to support a healthy pregnancy and advocate for the natural childbirth experience they desired. The primary challenge for women having a natural birth was an unsupportive environment. Through sharing experiences and goals using HypnoBirthing, women and their partners felt more closely connected to their babies and to each other.

The Second Timeframe-During the Experience

The second timeframe, *Intrapartum-During the Experience,* was defined as the time from when women entered the facility for labor and birth until they returned home after the birth experience. In this timeframe, women used what they learned in HypnoBirthing classes to cope with the stress of childbirth and to have the natural birth experience they desired. Three themes were identified: *Having it Mommie Driven, Overcoming Difficult Times, and Feeling Connected.* The schematic for this timeframe is presented in Figure 4.2.

Figure 4.2 Second Timeframe Intrapartum: During the Experience



Timeframe	Themes, Categories, and Components
Intrapartum: During the Experience	**Theme: "Having it Mommie Driven"** **Category: Having control of the childbirth experience** • Sustaining motivation and values • Making decisions for self and baby • Having a supportive environment **Category: Feeling empowered to advocate for self and baby** • Having confidence in self • Having confidence in method **Theme: "Overcoming Difficult Times"** **Category: Feeling Unsupported** • Environment o Not having a conducive environment o Not having knowledgeable healthcare providers o Not having supportive partner • Method **Theme: "Feeling Connected"** **Category: Bonding** • Enhancing relationships • Increasing communication

Theme-Having it Mommie Driven

For the second timeframe, the theme, *Having it Mommie Driven*, was defined as the need to have choices, sense of control, and being empowered. Women wanted to be given choices during the labor and birth experience and to feel they were involved in making decisions for themselves and their babies. This theme has two categories: *Having Control of the Childbirth Experience* and *Feeling Empowered to advocate for Self and Baby* that support the theme, *Having it Mommie Driven.*

HAVING CONTROL OF THE EXPERIENCE

The first category, *Having Control of the Experience*, indicates women's desires to make choices for themselves and their babies while in hospitals or birth centers. In this

timeframe, *Intrapartum-During the Experience*, women were involved in making decisions and directing their labor.

The ability to use learned HypnoBirthing practices sustained women's motivation to have a natural birth and to feel as if they were directing their birth experiences. As one woman said,

> It wasn't medically driven. It was mommie driven. . . . I was the one in control, and, I guess, determining how things were going to go. [It] was my own determination that helped me have that experience for him [the baby]" (HBB1, 183-190).

Women felt that a HypnoBirthing experience put them at the forefront of decision making. As one woman said, the HypnoBirthing approach provided a variety of options where she could make decisions:

> Follow the birth plan in the back of the [HypnoBirthing] book, almost did everything. I put the sign out on my door at the hospital, but a lot of that information I did get from the book: not wanting to be attached to a monitor, wanting the freedom to walk around. I did walk around and I did take a shower, and I did, you know, a lot of those things that I wanted to do. I guess that is part of the mommie driven thing, too. You are not restricted to being in your bed or being hooked up to a machine (HBB1, 201-206).

A second woman expressed, "It definitely put the power of birth back in my own hands. I didn't feel so dependent on them [healthcare providers]" (HBD1, 39).

Even women who were not making progress in their labor were nonetheless able to maintain control of their birth experiences. One woman was able to avoid medical intervention:

> Once I stopped and . . . sort of shut my brain off, and let my body focus on labor, that's when I really started to progress, and I did what she [HypnoBirthing instructor] said: "Get it quiet, and get it dark." And, we put on the Rainbow CD so what I was hearing and what I was actually listening to was stuff that was reinforcing labor and being relaxed in labor and getting ready for labor, and I felt like I was finally letting my body do what it was supposed to and we were [doing what we should be doing]" (HBF1, 89-93).

A second woman maintained a sense of control despite requiring medical assistance:

> I feel like I still had control over my birth, I was still in charge even though they did end up taking over at the end. I feel good about everything. Yes, I was the one who decided "Yes" or "No." Once I felt like, okay, I had done all I could do, now is the time for those interventions [pitocin, epidural and forceps], if they were necessary. I decided when those interventions were necessary (HBA1, 180-185).

Women also expressed feelings of control because of the existence of personal support systems in the environment. As one woman said, "I sort of felt empowered after taking the HypnoBirthing classes and having people with me [husband] and being able to take control. Having people [husband] with me who could take control of the situation" (HBG2, 25-27). Another woman said, "One of the most helpful things for me was actually the fact that the spouses, or, like, the birthing coaches, were there because I feel like when you are actually in the process yourself, it is kind of hard to think of all the things that you need to think of" (HBF1, 128). A third woman noted:

> I was very, very grateful that it [HypnoBirthing was so] we did it [labor] together. It really helped change what I did and in the moment, the actual labor we had gone through, what we practiced together. And he was very supportive, and he agrees wholeheartedly with all the principles that he reminded me each day—about practicing with the breathing and making sure I spent time during the pregnancy to relax. I had several contractions for a long time prior to labor, and had to, a couple times stop labor, and there were moments when I had contractions, he was there to help me (HBK1, 164-170).

Having a professional support system in place also helped women feel they had a sense of control over their desired birth experience. As one woman said about her midwives: "They were good about exploring options with me, but not pushing anything on me" (HBC1, 107). A second woman expressed that her nurses "really respected my wishes in regards to how I wanted to go about the labor and the delivery part" (HBK1, 104-105).

Several women indicated being more in control of their childbirth experience when their healthcare providers used the HypnoBirthing terms and techniques. One woman expressed:

> Both the student midwife and the midwife were very supportive, and I know that they are very pro-HypnoBirthing, and my student midwife even used some of the terminology from HypnoBirthing. While I was having a surge [contraction], she would say, "Use your hypnosis, use your hypno-anesthesia, depend on your body, relax your body," or whatever. So I really appreciated hearing that, you know, from her, because most care providers don't know that terminology, and that can be very distracting to a mother who has taken the class, has gotten used to these terms. . . . Also, she did a lot of counter pressure and light touch massage type stuff that we learned in HypnoBirthing, and that was nice as well (HBG1, 130-139).

Another woman commented:

> We actually had nurses who were helping with the counter pressure, and that was very helpful. I had great nurses: one was a HypnoBirthing instructor, and the other one was a Lamaze instructor, and they were really great to stay and help. . . . [One] would just check on me periodically and kept the lights dim. . . . [A second nurse] got more into it and helped me with the counter pressure helped me with my breathing, and, during the delivery, she helped me to be able to breathe the baby down, and she was really good. . . . They all kept the lights dim. . . . When the doctor came in, they turned on the lights, but my husband asked them to turn them back off, and my doctor was very obligating. . . . I wanted to just stay on my back and [have the doctor] deliver me just like I was, and I did (HBH1, 98-110).

Participants noted that health professionals helped them maintain control of the physical environment during childbirth. As one woman commented, "They got the bar out, the ball out. . . . She [the nurse] put up little Christmas lights, so I didn't have to, and rubbed my back, and gave me ice chips" (HBI1, 112-113). A second woman mentioned that health professionals helped her maintain the tranquil room atmosphere she needed:

> I really liked the dim lights, in that it kind of set the whole room for its calm. I mean, it helped with the midwives or any of the nurses that came in, because it

> automatically set the feeling of serenity and, especially with the waves, the sound of the ocean playing. . . . The dim lights helped me kind of escape mentally away from commotion. . . . just really made it more peaceful and calm (HBK1, 45-50).

Women felt supported when health professionals supported their plans to put the baby immediately to the breast. One woman commented, "Immediately after the baby was born, we went straight to the breast, which we had talked about in the class, which was a great idea, and I really like that" (HBK1, 180-182). A second woman said, "He breastfed right away and everything that I wanted, it went perfectly" (HBB1, 182-183). Another woman said, "My little boy was kind of breathing fast, and some of the nurses told me not to nurse him, but the midwife says, 'No, that's just what he needs.' That was very helpful" (HBJ1, 77-79).

HypnoBirthing education helped individuals orchestrate a birthing environment where women felt free to labor, birth, and initiate breastfeeding. Use of HypnoBirthing tools and a strong support system enabled women to direct their childbirth experience within the environment. Support from their partners and health professionals were essential to sustaining women's sense of control.

Feeling Empowered to Advocate for Self and Baby

For the second timeframe, the second category identified was *Feeling Empowered to Advocate for Self and Baby*. This was defined as the trust women felt in themselves to advocate for themselves and their babies while in the hospital or birth center. In this category, women described trusting themselves and the HypnoBirthing method.

HypnoBirthing education helped women trust their mind and bodies to labor naturally. One woman stated:

> I knew I could do most of my laboring at home. I was relaxed at home and used the hypnosis to calm myself, and, when I got to the hospital, I was dilated the right amount, and I was walking round the hospital, and I was fine. . . . I just wasn't even in much pain, until, like, I was an eight or nine. . . . So, I think that it really helps to just relax your body and let it do its thing (HBH1, 209-212).

Another woman commented, "HypnoBirthing is calming, relaxing; it gives your body confidence" (HBJ1, 121). Yet another woman expressed, "Just the way it

[HypnoBirthing] helped me stay calm; to apply everything in labor. . . . The mind stuff is what prepared me the most" (HBA1, 231-244). Yet another woman said:

> I think HypnoBirthing helped me have that confidence that I needed. . . .You do have this feeling after you give birth like, "Wow, that was really cool. I did that." It is really a confidence booster (HBG1, 169-172).

All women expressed confidence in using the HypnoBirthing method. Although a variety of techniques were used to decrease anxiety, all the women used a form of self-hypnosis for relaxation taught in their classes. One woman said:

> There were some imagery techniques, and the thing that really helped me the most was the Rainbow Relaxation, that CD, and then there were little short techniques like you would come up with a birth color. It was called a color for your birth, and you were supposed to count down, and went into different colors, and then into a relaxed state. That one worked for me (HBI1, 81-85).

Another woman said:

> The primary thing was to help me find what or how to get into my relaxing zone quickly. The thing we listened to, the Rainbow Relaxation [CD] and it was all about finding my spot. . . . I already knew what I wanted because I knew from the class the ocean already helped me relax (HBK1, 29-39).

All women also employed HypnoBirthing breathing techniques to promote relaxation. One woman said:

> We did . . . two or three breathing techniques from the HypnoBirthing book that I found most effective. . . . One of my favorite breathing techniques was this one where you kind of visualized the alphabet coming at you, and that is one of my favorites. I used that even before labor for other things to try and relax myself in other situations. Absolutely, that one was awesome [laughs] (HBE1 71-83).

In addition to helping women feel less anxious, HypnoBirthing education helped women's partners feel more confident and less anxious about labor and birth. One woman commented:

> It [labor] didn't make us as nervous going into it, because we knew what we wanted, and he knew how he could help me, because we had talked about it. I think it was a very good experience for the two of us (HBK1, 174-176).

A second woman remarked:

> I absolutely used the relaxation techniques that we learned, and my husband did them with me, and we used all the things that we learned and practiced at home and decided on what we thought would work the best for us. . . . It was extremely effective. And, just all the knowledge we had from the class meant that we got to the hospital, and we were laughing, and we were having fun through the whole process, and we were calm and relaxed. And all the medical professionals that were there were calm and relaxed, and it was just a fabulous experience all the way around. And I do think it was everything we learned, and we were just prepared, and we made it the experience we wanted it to be (HBE1, 58-65).

Women and their partners also felt confident in adapting the HypnoBirthing techniques to meet the individual needs of the woman. One woman described how she adapted the HypnoBirthing practice of using the birth ball to sway and move:

> We had talked about movement in the class, and . . . using the birth ball to sway with, so I think that is where I got the swaying idea. But, my husband had brought a ball to use, but I couldn't get out of bed. And not being able to use it, so I think I just came up with the same idea of swaying, and I found it very helpful. It helped a lot, so I just swayed my arms back and forth, and I did it along with my breathing going in and out and making that same motion (HBK1, 154-158).

A second woman described how her partner customized a self-hypnosis relaxation script:

> There was this one about walking through the woods imagery that [HypnoBirthing educator] gave us in the class. It was printed out, and that one I loved. My husband used that, and he added extra stuff of his own that he knew I would like and really did it as a guided imagery. Fantastic (HBE1, 78-80)!

Women believed that HypnoBirthing techniques learned and practiced would be sufficient to help them control the discomforts of labor. As one woman said, "I was confident with myself, in that I would be able to handle the birth, and I think I used different methods of coping with the pain with HypnoBirthing" (HBI1, 41-43). She added, "I really like it being in control of the pain" (HBI1, 89). Another woman said:

> I wouldn't say my birth was pain free, but I really felt the entire time that it wasn't something that I couldn't handle. It was something I could breathe through, and I

> took each contraction one step at a time. . . .I knew it (labor) was something that I could conquer (HBD1, 127-130).

A third woman remarked:

> We used the light touch massage we learned in class, and my husband did that. The breathing techniques are what I used a lot. Closing my eyes and listening to the music. I knew that was something important. . . . I was able to deliver without pain. I was a little uncomfortable but it wasn't painful (HBJ1, 149-163).

A fourth woman commented:

> Through the whole first half it was incredible. I used all the techniques that I had planned for and it was amazing at how effective all of these techniques were at managing or even completely hiding the pain, and just making all of my surges completely manageable. And [I had] a very calm experience (HBE1, 108-111).

Yet another woman expressed:

> I really used the relaxation and breathing techniques to relax my body during childbirth and just to breathe to ease a contraction and to just remember that I can withstand anything for just sixty to ninety seconds, which is how long your contraction or surge is (HBH1, 37-39).

Some women described how having their mothers, who were familiar with HypnoBirthing practices, helped the women maintain confidence in their ability to continue using HypnoBirthing methods. One woman said, "My mom was with me as well, and she had gone to a couple HypnoBirthing classes, and she was thinking the same things I was doing [in labor]" (HBD1, 108-109). A second woman, who had a short, three hour labor with very intense contractions, was encouraged to persist by her mother: "My mom even said to me, 'You know, they said in class that when you say, you are done, you are usually close' [laughs]" (HBF1, 216-217).

Because of what they had learned in HypnoBirthing classes, women felt empowered to ask for or to decline assistance during labor and delivery. One woman explained, "You have to kind of really advocate for yourself to get them do the things you really want" (HBF1, 243). A second woman said how her HypnoBirthing educator prepared her for the typical high technology approach that she may encounter in a hospital:

> She taught us hospital procedures. In particular, what nurses say and the different types of things they are going to push on you. What it is that we can say? We can say no to anything that we want to, that it is in our hands, that it is our birth. A lot of the nurses have this procedure they are used to following, and they have instructions from the doctor that they are supposed to do, and she told us that they are going to try and push it on us, but we are allowed to say no to anything, and it was pretty much everything she told us they were going to say, they did say. We definitely felt prepared when they dropped a line our instructor prepared us they were going to say. We knew exactly how to respond, which was really comforting to know (HBD1, 25-33).

Some husbands or partners had enough confidence in HypnoBirthing practices to advocate for the woman. One woman said:

> I think he [her partner] saw, too, how things went so well for us at home and how it didn't go that well once we got at the hospital. . . . Like, I asked the nurse not to ask me questions until after the next contraction, and she kept asking me questions. And my husband was like, "You know, she can't talk right now. You need to wait until she is done with the contraction." I think it was frustrating for him that he even had to tell her that. So, I think that for him, he really understood, and I think he really had faith in what they had been teaching us in the class (HBF1, 242-248).

Because of what the women had learned in HypnoBirthing education about the benefits of natural birth, they wanted to advocate for their babies to have that experience. As one explained: "It was his birth experience too, and not just mine, and that was part of the why this [natural birth] was so important to me, why I didn't want to use drugs" (HBB1, 180-181).

Women and their supporters felt confident about letting nature take its course during their labor unless medical interventions were necessary. They customized their experience through use and adaptation of HypnoBirthing practices to help them cope with the stress of labor. Women felt able to conquer the physical and emotional challenges of labor on their own without the use of medications. Women's confidence in their abilities

to birth naturally and their trust in what they had learned in HypnoBirthing classes helped them to advocate for themselves and their babies during the childbirth experience.

Theme-Overcoming Difficult Times

For the second timeframe, the category *Overcoming Difficult Times* was defined as the ability to transcend challenges in the environment and method and shape their own meaningful experiences. Challenges or problems arose when the women felt unsupported by the environment (setting, healthcare providers, and support persons) or the HypnoBirthing method. Challenges also occurred when women or their partners lost trust in using natural methods or HypnoBirthing during their experience.

FEELING UNSUPPORTED ENVIRONMENT

Sometimes the hospital's physical environment made it challenging for women to relax and practice their HypnoBirthing methods. As one woman explained, "Once we got to the hospital, it [was] very, very difficult to maintain the mental relaxation in the hospital" (HBF1, 100-101). A second woman agreed: "It was difficult to have the calm and peaceful environment at the hospital. It was the hospital that made me feel like, 'Come on, let's hurry up,' and that is where I got a little stressed" (HBA1, 155). Another woman commented about how the fetal monitor limited her mobility once she was admitted to labor room: "I felt like, once I got to the hospital, I lost a lot of the techniques and relaxation I had been using. So that was very unfortunate" (HBF1, 107). Yet another woman commented about the lights in her hospital room: "Lighting was important. I didn't want the bright lighting" (HBI1, 116-118).

Sometimes hospitals lacked the equipment women required during their labor to maintain relaxation using the self-hypnotic trance state recommended by HypnoBirthing. One woman who wanted to relax in water said: "I really wanted to labor in a tub, but the room [with the tub] wasn't available that night, and I was sad about that" (HBH1, 141). Another woman who had practiced relaxation using specific music commented: "The hospital didn't have a CD player. We didn't bring one. So we didn't have the relaxing music that we would have liked to have" (HBH1, 73-74). Although the woman and her husband tried to compensate by using other HypnoBirthing relaxation techniques, she

noted that she "would be relaxed until another surge or contraction would come, and then, it would kind of break the hypnosis for me, and I would have to start all over again" (HBH1, 75-76).

Sometimes hospital procedures, combined with a lack of understanding of the importance women placed on using their HypnoBirthing techniques, created difficulties for women to practice natural methods. One woman who required medication to start her labor expressed fear regarding the difficulty of the labor, and sought encouragement to use HypnoBirthing methods:

> I hear it [labor] is really hard if you are induced, and I still wanted to use some of these techniques as long as I can and avoid the epidural. I just didn't know what oxytocin would do to my body. So yeah, we even asked nurses if they saw that if women who are induced are able to avoid epidurals, and they kind of just gave us a look, and said, "No, that really just doesn't happen" (HBJ1, 136-140).

A second woman who wanted to wait to clamp the umbilical cord until it had stopped pulsing expressed displeasure with their healthcare provider: "I wanted to wait to cut the umbilical cord, and they didn't. They went ahead and clamped it" (HBK1, 121). A third woman explained:

> Once you get there, they check you, they want to put the baby monitor on, and they want to do all these things. And she [nurse] even said, "We want to check the baby once, right now, to see if the baby is okay." And I said, "Okay, that is fine with me." And she said, she would take the monitor off, and then she never did. So, I could never go and sit on chair, or go sit on the couch, or do something else. I had to be somewhat flat on my back in the bed (HBF1, 100-106).

She added, "If they [healthcare providers] would have known the values and the structure of what HypnoBirthing was, they would have been better at supporting me" (HBF1, 160).

Several women described how nursing actions failed to support their use of HypnoBirthing techniques during labor. One woman reported problems during two HypnoBirthing childbirth hospital experiences. In her first birthing experience, nursing actions interfered with the woman's ability to concentrate: "The first time, [the nurse was] talking about another patient that was in another room" (HBI1, 116). In the next

birthing experience, the nurse's action interfered with the woman's ability to use HypnoBirthing practices to promote comfort and relaxation: "The second time, [the nurse] wouldn't let me get in the position that I wanted, told me I had to lie down on my back, and shut the curtain" (HBI1, 117). Another woman was upset because her labor nurse acted before assessing the woman's progress in labor.

> I think if she had checked me, but she was, like, "I will give you something and then check in another 20 minutes." But I think if she had checked me, I would have realized that I was at about a nine, and I would have probably not ordered the epidural. But she didn't check me . . . but the nurses weren't quite ready for a first time mom to have a labor go that quick, because even afterwards they all went, "Wow! You have only been here 3 hours, and you had your baby already" (HBF1, 206-216).

One woman was able to have a calm and peaceful labor using HypnoBirthing techniques until she went into the delivery room, at which point she had insufficient support to continue the use of her relaxation and breathing techniques:

> In the delivery room, no one in there had gone through the training with me, so I didn't have anyone to tell me to breathe. I didn't have my IPOD on with the [relaxation] exercises. . . . There was one nurse in the room and the midwife. And the midwife was familiar with it, and she would probably help me more than anybody. But the girl who had actually recommended the classes in the first place was in training to be a doula, and she was in the delivery room with me. She didn't even help me, which was kind of her role that she was so supposed to take, and that didn't happen either. So, I don't know what happened, but I wasn't able to. . . I didn't really get the full benefit. I so badly wanted the experience those ladies had on the [HypnoBirthing] video—complete peace and calm—and I believed that it was possible, and, up until the last hour, it was. (HBB1, 39-52).

This woman was able to resume the breathing and relaxation and delivered immediately upon arrival of her partner.

FEELING UNSUPPORTED METHOD

Only two women found particular HypnoBirthing techniques to be unhelpful when used during labor. One woman said:

> Everybody [partner or mother] kept offering to read me a script, and I felt like that was the last thing that I wanted was for them to read me a story about a deer running through the meadow or something like that (HBD1, 96).

Two women and their partners lost confidence in natural methods of childbirth due either to medical complications or loss of trust in their abilities to continue using natural methods. One woman attempting labor after having a cesarean with a previous birth described her husband's concerns as the labor progressed: She said:

> He was traumatized during labor, and he had a much harder time than I did, because HypnoBirthing, calm and peaceful, it did not allow me to have a painless birth. I was in pain a lot and I think that was really hard for him to watch, and he would have made the decisions a lot differently if he had been making them on his own. I think, when we went in there at midnight, he would have been happy if we would have had the baby then. And that is what we did end up doing: we went to the C-Section. When we did, I looked up, and he was sobbing. And he said, "We have to have the baby." And I think I would have probably kept going [using natural methods], but he couldn't [Informant started sobbing] (HBC1, 144-156).

She added, "He was communicating with me strongly that he felt he wanted us to be done and get the baby here safely" (HBC1, 157). The second woman's confidence faltered when labor became very intense. She said:

> I looked at my mom and said, "This is too much". . . . In my head, I thought, "Oh my gosh, I am going to be here another six hours or more," since we had only been here for an hour, and I was, like, "There is no way that I can do this for another six hours." So we actually called in the nurse, and I asked her for an epidural. . . . I was actually at a 10. And, I hadn't used any kind of drugs all the way up to a 10, and I was, if I would have listened, if I would have practiced more, or was more relaxed, and was able to regain my relaxation, I would have been just fine [without the epidural]. I would have been able to have gotten through the labor, and, then, I think she [the baby] was out in less than 30 minutes [after the epidural] (HBF1, 182-202).

Although women and their partners had made great efforts to have a natural birth experience, nine women expressed difficulties using HypnoBirthing during labor in a healthcare environment. The primary difficulty occurred when women were unsupported by the environment. A secondary cause was when women or their partners waivered in their confidence in their ability to birth naturally.

Women who chose HypnoBirthing wanted the ability to choose and to be in control during their labor and birth in the healthcare setting. To achieve the natural childbirth experience they desired, women needed to trust themselves and the HypnoBirthing techniques, to have supportive birth partners, and to deliver in a healthcare environment that adhered to or gave preference to women's choices. At times women and their partners needed to advocate for what they wanted or needed. When these conditions were present, there was harmony between women's desires and the healthcare environment. When these conditions were absent, there was disharmony between what women desired and what the environment allowed.

Theme-Feeling Connected

For the second timeframe, the theme *Feeling Connected* was defined as the strongly expressed desire for women to bond with their babies and partners, while transitioning into motherhood. Women described various HypnoBirthing techniques they found to enhance bonding. Women who used these techniques described closer ties with their babies and improved relationships with partners.

BONDING

All women felt that HypnoBirthing affected their relationships with partners or babies. Several women commented that using HypnoBirthing during labor increased bonds between both parents and babies. Bonding is defined as a feeling of a sense of connectedness between two or more persons.

Women experienced bonding with their babies and partners and expressed it in various ways. One woman said, "It connected us all, I do think" (HBI1, 124). A second woman concurred:

> Doing these imageries together [in labor] and doing the practicing that led up to the birth, we found it to be an awesome bonding experience between the two of us and the baby (HBE1, 171-173).

One woman who previously had used a different childbirth education method commented, "I do feel more bonded this time [using HypnoBirthing]" (HBC1, 140).

Several women expressed that natural birthing practices used during labor facilitated bonding with their babies. One woman described how using relaxation rather than medication affected her ability to interact with the baby at birth:

> Having that initial bonding experience with your baby, where neither one of you have been drugged, so you are fully alert and fully aware, and you have incredible amounts of oxytocin going through your body, and you have just given birth. And, so, it's like you look at the baby, and there is no way that you cannot love and want to care for it. Yeah, an amazing feeling. I know other mothers who have had epidurals; I am sure that they have the same feeling, but I think it was much stronger because my mind hadn't been affected at all by any kind of drugs that were given. So, yeah, I think it makes the first few weeks easier, the recovery is faster, and, I don't know, I feel so much closer to my baby, I think from having that experience with HypnoBirthing and not having the drugs and everything (HBG1, 157-165).

A second woman agreed the nonmedical interventions of natural birth facilitated maternal-child interaction and responsiveness:

> When they put her on my chest, she was so aware, able to look right at me. . . . She started crying, and I started to soothe her like I did [in pregnancy] by singing. . . [and] she stopped crying. She actually lifted her head and looked at me . . . and I think that is because I had her un-medicated through HypnoBirthing . . . . If I hadn't heard and seen the way she reacted—she was my first baby—I would have been a little more skeptical about the pre-birth bonding. But now seeing how it has affected her from the moment she was born, and how she recognized us, I think the pre-birth bonding really did help (HBH1, 164-184).

Another woman described:

> I felt like I was communicating, mostly nonverbally, with my baby throughout pregnancy and delivery, and I really do think it helps, because I stayed calm [during labor]. And, although there were some stressful situations, the baby's heart rate was calm, because I just felt like I had that kind of communication going (HBA3, 96-99).

HypnoBirthing philosophy stresses total involvement of the birth companion, typically the woman's partner, during labor and birth. All women perceived the involvement of their partners in their childbirth as enhancing their relationships. One woman said, "Our relationship is definitely stronger because of, you know, the childbirth experience together and the HypnoBirthing Method. I really admire him [partner] and appreciate all the support he gave me during my birthing experience" (HBG1, 150-153). A second woman commented, "I respect him for being willing, and for finding time to read scripts to me" (HBA1, 189).

Two women expressed how the childbirth experience had affected their partners' feelings for them. One woman said, "He thought it was *amazing* that I could do so well during childbirth, because you know people tell stories, scary stories. But we had a really positive experience. He got to see how *strong* I was" (HBJ1, 96-98). A second woman concurred: "He [the partner] is really *thrilled* that I was able to do it. He couldn't believe it" (HBI1, 121-122).

Through use of HypnoBirthing methods, women and their partners were able to interact with one another and their babies during and after the birth, which promoted a sense of family connectedness. Women and their partners were able to focus on the love they felt for the baby and each other. Women and their partners had a new awareness of and a stronger appreciation for each other.

In the second timeframe, *During the Experience*, having a sense of choice and control afforded women opportunities to let birth happen naturally. Even women who experienced medical interventions yet maintained a sense of control and choice were able to feel strong and competent. Women who were prepared and felt ready for the natural birth experience were able to transcend their fears about childbirth. Most women who experienced a difficult time related it to an unsupportive healthcare environment (i.e., conflict between the environment and the use of HypnoBirthing), but other difficulties

occurred when women or partners lost trust in themselves and the method. Working together, women and their partners felt connected to each other and their babies and experienced a sense of great accomplishment.

The Third Timeframe: Postpartum-After the Experience

The third timeframe, *After the Experience*, was defined as the time after women left their birthplace facilities and returned home in motherhood roles. The third timeframe was when women were home and adapting to changes in the family, coping with the changes in their bodies postpartum, and interacting with their new babies. Three themes were identified: *Having it Mommie Driven, Overcoming Difficult Times,* and *Feeling Connected*. The schematic for this timeframe is presented in Figure 4.3.

Figure 4.3: Third Timeframe Postpartum-After the Experience

Timeframe	Themes, Categories, and Components

Postpartum After the Experience	**Theme: "Having it Mommie Driven"**
	Category: Having control of the experience
	• Renewing motivation for natural birth
	• Wanting more control of the environment
	
	Category: Feeling empowered to advocate for self and baby
	• Feeling changed as women and mothers
	  o Feeling others' positive regard for their accomplishment
	  o Having confidence in self, baby, and natural methods
	  o Advocating for natural methods
	
	Theme: "Overcoming Difficult Times"
	Category: Feeling Unsupported
	• Wanting more control of the environment
	
	Theme: "Feeling Connected"
	Category: Bonding
	• Enhancing relationships
	• Increasing communication

Theme Having it Mommie Driven

For the third timeframe, the theme *Having it Mommie Driven* was defined as the need to have choices, sense of control, and being empowered. Two categories were

identified: *Having Control of the Experience* and *Feeling Empowered to Advocate for Self and Baby.*

HAVING CONTROL OF THE EXPERIENCE

In the third time frame, the category, *Having Control of the Experience*, indicated the desires of women and their partners to control a future pregnancy. In this timeframe, women were consistently positive they would use HypnoBirthing again.

Women were satisfied with their HypnoBirthing childbirth experience. One woman commented, "If I ever have another child, I will have the same approach and use HypnoBirthing" (HBJ1, 119). A woman who had required an induction commented, "I look forward to future children because I will use the [HypnoBirthing] method again. And be able to take it [natural birth] all the way through to the end next time" (HBE1, 184-186).

FEELING EMPOWERED TO ADVOCATE FOR SELF AND BABY

In the third timeframe, the category, *Feeling Empowered to Advocate for Self and Baby* described how women trusted their bodies, their babies' bodies, and the use of natural methods to manage life after birth and coming home. It described how women and their partners felt transformed by their HypnoBirthing experience and felt compelled to champion natural methods.

All women expressed that the HypnoBirthing experience had changed their perceptions of themselves as women. Some women felt a greater sense of self-esteem. One woman said she felt, "completely empowered as a woman" (HBE1, 186). A second woman said: "I felt really good knowing that I was able to give birth naturally. . . .Yeah, I feel great about that." (HBJ1, 117-118). Another woman commented: "Just being able to feel your body doing this amazing thing, and, you know, because after that, the baby was born. 'Yes, I did this.' And it was so empowering and amazing to have that experience" (HBG1, 68-71). She added:

> Feeling that your body didn't do what it was supposed to do—that can make you feel like a failure. I just felt really good. My body had worked and did like it was supposed to do, and I had confidence in that. I felt really good about that. I felt

> happy. I didn't have postpartum depression, or trauma, or anything like that. I had been listened to, and I did accomplish something (HBG2, 115-118).

Women also expressed how the HypnoBirthing experience influenced them as mothers. One woman said: "I have more confidence in my own skills to deal with parenting and things like that" (HBF1, 274). A second woman concurred, "I feel like, it has shaped a lot of who I am, not just for childbirth, but as a mother and as a woman" (HBG1, 223-224). She later explained,

> When you are a new parent, there are those things that you don't know or you are not sure about. I had specific concerns about my baby's sleep habits. I was getting a lot of different advice from different people, my mother in law. My friends would say something else. I decided to start making decisions based on what I thought was right for myself and my baby. After I started doing that, everything was fine, and I trusted myself. When I think that, everything was fine. I think HypnoBirthing did that for me, my baby. . . . Yes, I am the mom. I have mothering instincts you know that tells me what to do. I learned I had to use that (HBG2, 31-44).

Some women's feelings of accomplishment related to their success in using HypnoBirthing were validated by significant people in their lives. One woman noted:

> It's very empowering [having a HypnoBirthing birth]. I just got a text message from my dad yesterday. . . . He wrote me back and said I had done a good job. . . . He wrote me back and said, "You're tough." That was good, coming from my dad. . . . For me, to be able to, do what I wanted to do, the way that I wanted it done, was very empowering to me, [tearing] and I guess proved to me to believe in yourself (HBB1, 213-223).

Some women expressed that the HypnoBirthing experience increased their trust in their own bodies. One woman said, "I kind of gained more confidence in my body's natural innate skills to get through life" (HBF1, 222). Another woman commented the HypnoBirthing affirmations also had an effect beyond childbirth: "I had confidence with breastfeeding. I always believed that it would work if I was calm and positive about it, and I breastfed for 18 months" (HBA3, 225-226).

Another woman emphasized how her HypnoBirthing experience increased her trust in the baby's body. She stated:

> She's actually gotten sick already. I feel like, if I hadn't gone through HypnoBirthing, I would have already been in urgent care with her, asking, "Oh, my gosh, she is sick. What do I do?" But, I think I kind of relaxed, and think she is, you know, if her fever is under a certain amount, she is still dealing with it fine. And, I have given her body more credit to deal with life, rather than panicking and freaking out. Every time something happens with her, I can sit back and wait a minute. "Is this something we are built to deal with?" So, I think I am. I've been able to be more relaxed with her and also let her body process things more naturally. And, which I think, it is going to be better for her in the long run, not to have medical stuff, you know, just turn to drugs, and all that stuff. I just don't go as quickly [to seek medical care], as what I would have, done before (HBF1, 222-231).

Women expressed trust in using HypnoBirthing techniques for themselves upon returning home. Several women continued to use relaxation techniques. One woman said she practices relaxation:

> With any situation that I feel a little stressed or anxious. Because of the time I had practicing, [I can] quickly get in the relaxing zone. Now, I can get in it a lot faster to calm myself down. . . .because of that time I had with all that practice of calming my body down (HBK1, 206-209).

One woman used positive affirmation to relax: "I just tell myself things are okay. If I am feeling uptight, I can relax. So, yeah, it can help any person pregnant or not" (HBA1, 200-201). Another woman used breathing techniques:

> If I found myself getting stressed out about something at work or outside of work or getting stressed out about something, I would a take a deep breath and just calm myself right down. I think I will use some of these techniques for the rest of my life (HBE1, 86-88).

Some women also used HypnoBirthing techniques for the baby. One woman said:

> I definitely look for ways to keep their [twins] environment peaceful. And, when I am holding them, I don't want negative thoughts carrying over to them. If I am

> having an argument, I don't want them to be around it. I like to keep the lights lower and not [have them] in an environment where there are loud people or music or over stimulating. It is really what I want for the babies, to be peaceful (HBD1, 150-154).

This same individual added:

> Our babies have a little bit of reflux. I visualize them eating peacefully and totally being able to finish eating, and not having that reflux and spitting up. And, I visualize them being very happy after they eat. I definitely use the visualization. Also, I play the rainbow relaxation tape for the babies, and I turn the lights down. I figure if they heard it [Rainbow Relaxation CD] in the womb, they may have some recollection of it, and it would help them calm down (HBD1, 172-176).

Yet another woman expressed how she used HypnoBirthing techniques as the child became older:

> I use the relaxation with her. I will hold her hands, have her take a deep breath and calm down. And, I have tried a few things to help her calm down, and I have seen a dramatic turnabout in her calming down a whole lot faster. (HBK3, 83-86).

Another woman described using HypnoBirthing techniques during breastfeeding. She explained, "Yes, I have [used] . . . progressive relaxation with nursing all the time" (HBC1, 188).

Using HypnoBirthing techniques during pregnancy and childbirth reinforced some partners to trust in other natural methods. One woman explained:

> He really understood, and I think he really had faith in what they had been teaching us in the class. And, after we went through the whole labor process, it was like, "Oh, my gosh they were right. It is a lot harder when you don't let your body do what it is supposed to do, and you are not relaxed." So, I think he is a little bit more supportive of me doing things more naturally now, even with food and general things like that now (HBF1, 247-251).

Most women using HypnoBirthing had sufficient trust in the HypnoBirthing method to recommend it to others. A woman who had used HypnoBirthing for all three of her births said, "I try and get, you know, my friends—I don't like pushing HypnoBirthing on anyone, but I always kind of put a plug in for it, because I think it can be so

beneficial" (HBG1, 224-226). Another woman commented: "Yeah, I thought it was a really cool method. I really enjoyed it, and I recommend it to a lot of people" (HBJ1, 167-168). A third woman said she had recommended HypnoBirthing to friends: "One signed up for classes, and one borrowed the book" (HBF1, 285).

The HypnoBirthing experience encouraged women to speak up for what they wanted for themselves and their babies. One woman said: "I learned that it is a good thing for me to advocate for things that I want [for myself or the baby]" (HBF1, 274-276). She added, "I have more confidence taking a stand on things like that with people, and being confident that it is a good choice" (HBF1, 279-280).

The benefits of using HypnoBirthing transcended childbirth education classes and childbirth. Women's sense of trust in themselves, their babies, and the use of natural methods provided greater confidence for their motherhood role. Women gained self-esteem and thought their partners had greater regard for them and the natural methods they valued. Women's trust in the method was so strong they incorporated HypnoBirthing techniques into daily life for themselves and their babies, planned to use HypnoBirthing for their next birth, and promoted using the HypnoBirthing method to other women.

Theme- Overcoming Difficult Times

In the third timeframe the theme, *Overcoming Difficult Times*, was defined as the ability to transcend challenges in the environment and method and shape their own meaningful experiences. Even though women and their partners were satisfied with HypnoBirthing and would choose it again, some women were making plans to seek a more supportive environment in future pregnancies. One woman expressed:

> I think after the whole thing, and we were home with the baby, he [husband] actually told me that he didn't want to go to the hospital for the next one—[he would prefer to stay] at home or a birthing center—and it shocked me. I would never have thought that he would ever say something like that (HBF1, 237-240).

Another woman said, "I think I am going to have to try a different route [birthing environment] because that was really my main issue: I needed support all around, and I wasn't fully getting that with my providers" (HBA3, 83-84). A third woman commented:

> If I was to give advice to other moms that were thinking about doing HypnoBirthing or something similar, I would say, "Number one, try as hard as you can not to give birth in a hospital." Because, everything that the HypnoBirthing class prepares you for that pertains to having birth in the hospital, it all happens. But, it still, it's just as hard as what they prepare you for, if not harder. Because, in HypnoBirthing classes, [the fact that the HypnoBirthing educator] teaches you what to say and that you have total control, doesn't mean that it's easy to say no. And, they [hospital providers] actually do ask you, and push things on you. If there is a way you can have a more peaceful environment than the hospital, then that is definitely the way to go (HBD1, 189-196).

The experience of HypnoBirthing reinforced the desires of women and their partners to have more control of their environment for the next childbirth experience. Although all women were satisfied with their birth experiences women and partners with less than optimal natural births would make greater efforts to control the environment in the future to overcome difficult times using the HypnoBirthing method.

Utilizing the HypnoBirthing method in their pregnancy affirmed women's beliefs in natural methods and the body's natural ability to take care of itself. HypnoBirthing gave them confidence in their roles as parents and in their abilities to make decisions and advocate for themselves and others.

Theme- Feeling Connected

In the third timeframe, the theme, *Feeling Connected,* described how women used HypnoBirthing techniques to bond with partners and babies during the labor and birth experience. During this timeframe, women continued to feel close to their partners and babies.

BONDING

Women felt HypnoBirthing had improved bonding as a family. One woman described HypnoBirthing as, "A really good bonding experience. . . . It connected us all, I do think" (HBI1, 121-124). Another woman said, "It was our experience together. . . . [Even with] the long distance relationship, it helped us [parents and baby] to bond

because of the HypnoBirthing" (HBB1, 229-232). A third woman agreed: "Yeah, I think it made me love him [the husband] more" (HBA1, 190).

Observations supported family bonding in the home of women who had birthed using the HypnoBirthing method. Parents held their babies closely and cuddled, called their babies by their names, looked into their babies' eyes when they spoke to them, and talked lovingly to and about the babies. All women had reported they continued to breastfeed upon returning home. Some women were observed breastfeeding and appeared very engaged with the baby. The women looked down at their babies' faces, talked softly and affectionately to them, and held them gently.

The family connectedness seen in the first two timeframes continued after the parents returned home. Women perceived they, their partners, and their babies had shared a special experience together through the use of HypnoBirthing that promoted stronger family bonding and which continued upon returning home.

Women experienced ongoing benefits from learning and using HypnoBirthing. Women's increased trust in their minds and their bodies, resulting from their HypnoBirthing experience, empowered them as women and parents and validated their beliefs in natural methods. The experience had forged strong and enduring bonds between parents and the baby.

SUMMARY OF THE FINDINGS

The current study explored the values, beliefs, and perinatal practices of women using HypnoBirthing: The Mongon Method Childbirth Education as expressed in their language, behaviors, and perinatal practices. Chapter Four described the informant demographics and study findings. Research findings revealed three natural timeframes: *Prenatal-Choosing the Experience* (the time from when the woman first learned she was pregnant until she entered a facility for labor and birth), *Intrapartum-During the Experience* (the time from when the woman entered the facility for labor and birth until she returned home after the birth experience), and *Postpartum-After the Experience* (the time after women left the facility where they gave birth and returned home in the motherhood role). Each of the three timeframes had three consistent themes: *Having it Mommie Driven, Overcoming Difficult Times,* and *Feeling Connected*. There were

several categories and components identified from the data that supported the three timeframes and themes.

In the first timeframe, *Prenatal-Choosing the Experience*, women deliberately chose HypnoBirthing as a "Mommie Driven" (HBB1, 184) childbirth alternative to the dominant medical model in the U.S. culture. HypnoBirthing childbirth education classes supported women's desire to have a natural birth experience. The knowledge and skills learned in HypnoBirthing education classes helped women learn to trust themselves and natural methods and to create a supportive environment for their HypnoBirthing birth. The fear women had about childbirth at the beginning of the classes was eliminated as the women became prepared and ready for the childbirth experience and empowered to speak up for themselves and their babies. As women and their partners mutually prepared for parenthood, they felt connected with each other and their babies. Most of the women experienced a difficult time in finding a healthcare environment where the culture was congruent with that of HypnoBirthing.

In the second time frame, *Intrapartum-During the Experience*, having choices and feeling in control helped women in "*Having a Mommie Driven*" childbirth. HypnoBirthing education provided the knowledge and tools women needed to feel prepared for and confident about labor. All the women said they felt prepared and ready for the childbirth experience. Every woman experienced some environmental challenges utilizing HypnoBirthing practices during childbirth. Thus, not every woman fully met her expectations for a HypnoBirthing birth. However, all women felt the HypnoBirthing experience increased their connectedness with their partners and their babies and were satisfied with their experience.

In the third timeframe, *Postpartum-After the Experience*, women felt changed by their HypnoBirthing birth experience. They felt more competent as women and mothers, confident in themselves and breastfeeding, strong, and good about their achievements in childbirth. The women and their partners had a greater trust in mind-body methods and were utilizing them for themselves and with their children. Women felt more in control of decision making for themselves and their children. The women were defiant they would choose HypnoBirthing for future births, but seek environments that were more supportive

and allowed more choice and control. In addition, women continued to feel strongly bonded as a family.

The women in this study had entered a quest for a natural birth experience, which they perceived to be a birth without the use of medical interventions unless absolutely necessary. To be successful in this quest, women had to become prepared in mind and body, gather tools and support, be committed to their cause, and persevere despite hardships. As an outcome of their preparation and experiences, they were transformed in ways they did not expect and that continued after the initial quest was over.

PLAN OF REMAINING CHAPTER

Chapter Five provides the results of the study, discussion of the findings in relationship to Spradley's cultural framework and Lederman's theory as the sensitizing framework, and the extant literature. In Chapter Five the researcher also presents implications for practice, strengths and limitations of the research, recommendations for future research, and conclusions.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

INTRODUCTION

Chapter Five reviews the study problem, purpose, method, findings and results. The study findings that answer the research questions are presented and compared to Spradley's cultural framework and Lederman's theory as the sensitizing framework, and relevant literature. The chapter discusses potential implications of the study for nursing practice, education, and research. In addition, there is an overview of the study's strengths and limitations, suggestions for future research, and conclusions.

Childbirth is an important cultural event (Davis-Floyd, 1994; Nichols & Humenick, 2000; Spector, 2004) with significant psychological importance in a woman's life (Lederman, 1984, 1996; Lederman & Weis, 2009; Mercer, 1981; Nichols & Humenick, 2000; Rubin, 1984). Childbirth practices are influenced by a society's cultural values and beliefs, which affects how women interpret their childbirth experience and women's self-esteem (Lederman & Weis, 2009; Nichols & Humenick, 2000). Meeting the cultural needs of women for childbirth is extremely important for the psychological well-being of women.

Little current research has been done in the U.S. to explore why women choose to participate in childbirth education classes, the method that is chosen, and whether the process supports women's values and beliefs about childbirth, and more importantly that the methods used support efficacy, safety, and good maternal/infant outcomes in today's high tech practice environment. Even less is known about women who choose HypnoBirthing: The Mongan Method childbirth education, that is both a philosophy and method of childbirth education used internationally that fosters a natural birth, combining childbirth information, self-hypnosis, and positive affirmations. Better understanding of the cultural beliefs influencing women's childbirth choices and experiences may assist the providers of healthcare to more effectively provide culturally sensitive healthcare and improve maternal/infant health outcomes.

The purpose of this ethnography was to explore the values, beliefs, and perinatal practices of women, who utilized HypnoBirthing: The Mongan Method. The study aim was to gain an understanding of the culture of HypnoBirthing as perceived by postpartum

women through their experiences of choosing, attending, and using HypnoBirthing: The Mongan Method of childbirth education for their birthing experience. The study addressed the following research questions:

Central research question: How do women who utilized HypnoBirthing childbirth education describe and explain their experiences with this method?

Sub-question 1: What expressed values and beliefs influenced these women's decisions to use HypnoBirthing childbirth education and mode of childbirth?

Sub-question 2: How did women describe their actual experiences, outcomes, and level of involvement using the HypnoBirthing method?

Sub-question 3: What facilitated or inhibited women's use of HypnoBirthing during their experience?

The study used an ethnographic approach consistent with Spradley's conceptual framework to study cultures and the Developmental Research Sequence (DRS) for the research process. Ethnographic approaches seek understanding of human behavior and culture from the perceptions of members in a culture (Spradley, 1979). The ethnographic approach was used to learn from postpartum women, by exploring the meaning of the women's practices and language describing their childbirth experiences, determining their social behavioral patterns, environments support, and culture (Spradley, 1979). Use of an ethnographic approach in the current study helped explain the HypnoBirthing culture as perceived by this population of women. The women expressed commonalities in their values, beliefs, and practices that helped to define them as a culture.

DEMOGRAPHICS

One of the unique findings of the study was the demographic profile of the participants. The purposive sample included 11 Caucasian, English speaking women who had taken and used HypnoBirthing: The Mongan Method for their birth in the last six months. Initially a non-probability convenience sample was used; as the study progressed, snowball sampling was used. The women were geographically located in three states: Texas, Utah, and Colorado and two of the women in Texas had physician husbands who were in the military and had lived in other locations so that the selection of HypnoBirthing was not limited by area of the country. Irrespective of location they

shared common beliefs and values about this birthing experience. Women's age ranged from 21 to 40 but most importantly these women tended to be well educated with college degrees, very computer savvy, and reflected a strong ability and desire to seek out information and were proactive critical consumers about childbirth education and methods.

There was a strong economic commonality among these participants. Ten of eleven women reported they were in middle to higher income range and six of those women were stay at home mothers at the time of the study and one was enrolled in college. This finding about income was important because it provided these women with the opportunity to seek out and use HypnoBirthing which is costly in time and money. These participants also reported that they had strong support from spouses, partners, and family in attending HypnoBirthing classes, practice sessions at home, as well as the birthing process. Nine of the eleven women were married.

The sample for this research study was consistent with samples found in many other childbirth education research studies which are middle class Caucasian women (Lu et al., 2003). Private natural birth classes are expensive, costing between $300 to $400, and this may be a barrier for some women. Additionally the women need a partner or support person to attend classes with them, practice what they learn, and be there for them during labor to assist.

DISCUSSION AND INTERPRETATION OF THE FINDINGS

As reflected in extensive discussion in Chapter Four, results of this ethnographic study strongly reflect all participants who used HypnoBirthing shared core cultural values and beliefs that influenced their choice to initially adopt this unique method and use it throughout their pregnancy, birth, and postpartum. These shared values and beliefs were categorized into three distinct themes: 1. "*Having it Mommie Driven"*- the need to have choices, sense of control, and being empowered 2. "*Overcoming Difficult Times"*- the ability to transcend challenges in the environment and method and shape their own meaningful experiences 3. "*Feeling Connected"*- the strongly expressed desire for women to bond with their babies and partners, while transitioning into motherhood.

Findings may potentially help healthcare professionals provide more individualized and culturally-sensitive health care for women who select this unique birthing experience.

The following discussion synthesizes and interprets the most salient findings in this study in response to the central research question as well as three specific sub-questions.

Sub-question 1: What expressed values and beliefs influenced these women's decisions to use HypnoBirthing childbirth education and mode of childbirth? The most dominant theme that emerged from the data to answer this question was the very strong desire and intent of the participants to have a substantial measure of control of their childbirth experiences and to feel empowered in the process/a theme characterized by this author as "Having it Mommie Driven."

The sense of choice and control grew out of their strong beliefs that birth should be a more natural occurring process than what is typically found with traditional hospital births. That belief is captured by comments that "women's bodies were made to birth a baby naturally" without medical interventions. Some of these women expressed they were birthing naturally for the baby- they wanted their babies to enter the world in a relaxed, calm, and gentle environment without bright lights, loud noises, or exposure to medications. This finding reflects that the participants' efforts to exert control over the birthing experience was not only about themselves but was seen as highly beneficial for the babies.

The participant's expressed desire for some control of the birthing process was also based on a belief that women *could* confront and manage fears about childbirth. HypnoBirthing classes and practice sessions with trusted partners provided them with a pathway for learning how to conquer the fear and pain of labor. When women felt prepared and ready for birth through HypnoBirthing, then they developed self-confidence and trust in the HypnoBirthing method. This also led to a profound sense of empowerment.

Sub-question 2: How did women describe their actual experiences, outcomes, and level of involvement using the HypnoBirthing method?

The themes of valuing and seeking control and empowerment were also apparent during the actual experiences of attending classes, practicing daily, and having a

HypnoBirthing labor and birth. These women expressed very strong beliefs about the energy and time they invested in seeking, choosing, not only the method of HypnoBirthing but also the right environment for the birth, including the healthcare providers, the setting for birth, and the support persons. It was women's sustaining motivation and values that helped them to have the *Mommie Driven* childbirth experience they desired. The confidence in self and the method helped them to feel empowered to advocate for self and baby. Moreover, women needed their partners to actively participate and advocate for them when they were unable to advocate for themselves.

A strong common purpose for a *Mommie Driven* natural birth with her partner being an advocate fortified the connections between women and their partners. Difficult times occurred if women felt unsupported by their partners or the method. This could cause them to lose trust in the method. Overall, the confidence women had gained through HypnoBirthing prepared them for the childbirth experience and aided their transcendence of the difficulties they encountered. All women reported satisfaction with their birthing experience using HypnoBirthing. The parental partnership and going through the experience of birth together intensified women's feelings for their babies and partners.

All of the women chose breastfeeding for the method to feed the baby reflecting the women's values of natural methods and following what women's bodies are made to do. Another expressed value was making the choice for breastfeeding because that was what was felt to be the best nutrition for the baby.

Sub-question 3: What facilitated or inhibited women's use of HypnoBirthing during their experience?

Facilitated: Women practiced listening to the Mongan CD Rainbow Relaxation and Positive Affirmations daily while preparing for labor. Some women used it in labor and others said the words were in their head that they had listened to it so many times. Relaxation with the Mongan CD, other scripts and mind body methods helped the women maintain their trance states and relaxation.

The role of healthcare providers, support persons, and setting are extremely crucial for women to meet their expectations for having a HypnoBirthing birth. In the current study the environment included the hospital or birth center setting, the women's

room and equipment, the healthcare providers, and the support persons or partner. The support person was extremely important in pregnancy, childbirth, and postpartum. Sometimes there were extra support persons such as mothers, doulas, and midwives. The women's partners attended classes, practiced with them, and served as advocates in the birthing environment. The women spoke of prenatal bonding occurring with their partners and babies.

HypnoBirthing is so much more than just coping with the contractions through the use of self-hypnosis. It is not expected of the women to do this alone without the support of their partner. Women with strong support from their partners had felt ready for labor, had confidence, trusted in the HypnoBirthing method, and reported having a good birthing experience. The true value lies in the growth of the family through this experience and if the women experiences a change in their birth plan it does not become a traumatic issue.

Relationships were enhanced and communication increased with women and their partners and babies while learning, practicing, and using HypnoBirthing. Women felt more connected with their partners and the babies through prenatal bonding which women felt helped to bond them as parents even before the birth.

Findings are consistent with Hypnobirthing literature, which asserts the importance of having a partner's involvement with the pregnancy and childbirth. It is important for the partner to attend the childbirth education classes, practice with the woman at home using the mind body techniques learned in class, and advocate for the woman to have the desired birth experience (Mongan, 2005).

Inhibited: Some women had to overcome difficult times finding a supportive environment for the HypnoBirthing experience. A couple women changed their healthcare provider or the hospital when they discovered conflict in having a supportive environment for natural birth. Women valued having their babies with them immediately after birth and to breastfeed their babies before they were taken from the birthing room. If women could not do this then it was a reason to change hospitals. It was not possible for some women to change hospitals due to their health insurance. One husband changed his job so his wife could have a different insurance permitting the couple to use a preferred birth site.

Most women experienced some cultural conflict when they entered institutional settings for childbirth. Women recognized the cultural conflict between the HypnoBirthing natural birth women desired and the dominant high-tech medical model of childbirth used in the U.S. These women entered the healthcare environment ready to advocate for themselves and their babies to have a natural birth without interventions. When women felt unsupported with either the environment or the method they experienced difficult times using the HypnoBirthing method. When encountering these challenges women could lose trust in self or the method. Sometimes the support partner helped them overcome and stay focused. Women needed encouragement to maintain their confidence in self and method.

Women felt the need to walk, sit in the shower, lean over the bed, get on their hands and knees, squat and move around but in the hospital they felt tethered to the fetal monitor. Being restricted to movement only in the bed was a major obstacle for the women. Women had to be creative to overcome this challenge. Rocking and swaying in the bed was one method used. Some items preferred with HypnoBirthing but were not available at various times in the hospital for the women in this study were showers, shower chairs, birthing balls, birthing bars, CD players, extra pillows, dim lighting, variations in lighting, and nourishment during labor.

COMPARISON OF THE FINDINGS TO SPRADLEY'S FRAMEWORK

The results of this study regarding women's use of HypnoBirthing strongly confirm and support Spradley's definition of a culture, the conceptual framework of the meaning and context of a culture. Spradley (1979) defines culture as the "acquired knowledge that people use to interpret experience and generate social behavior" (p. 5). When using ethnography the researcher learns about the culture of an individual or group through examining what is said, done, or used and making a cultural inference of what these symbols mean (Spradley, 1979). These women were drawn from very different geographic location yet the women used the same language in describing their experiences with HypnoBirthing and the women described vary similar values that guided their decisions to become involved in HypnoBirthing and going through it. For example, the women wanted autonomy, transparency, and total involvement in their

birthing process. Yet also they recognized there was power sharing that did occur with their physicians and midwives or partners. “Culture, as a shared system of meanings, is learned, revised, maintained and defined in the context of people interacting” (Spradley, 1979, p. 6). Interaction occurs in their environment which is a part of their shared culture (Spradley, 1979). Having a supporting environment to use HypnoBirthing for a natural birth was extremely important to the women. Understanding the culture facilitates recognition of important behaviors and assists in meeting the needs of members of that culture (Spradley, 1979).

Spradley explains two people can interpret and respond to the same event but experience it differently based on the interpretation of what the experience means for the individual due to their cultural beliefs (1979). Women in all societies have an expectation of pain in labor and childbirth but pain is interpreted, perceived, and responded to with behaviors based on the cultural context or meaning it has for the women (Kay, 1982).

Healthcare providers are also influenced by their cultural beliefs regarding childbirth and pain in childbirth. The healthcare provider, with a technocratic view of childbirth, will interpret childbirth behaviors differently than midwives or women that view childbirth as a natural process (Davis-Floyd, 1994). When there are differences between two or more cultural groups cultural conflicts may occur and cause the differences to intensify (Hunter, 1994). To prevent cultural conflicts in childbirth care, it is important for healthcare providers to learn more about women’s preferences for birth and be supportive.

The women in this study were a culture with shared values and beliefs .The major belief that natural methods are best for mother and baby included childbirth and breastfeeding. The women shared a common language, in describing their experiences but also some words used specifically for HypnoBirthing. All women shared the same beliefs about the needs for a supportive environment for HypnoBirthing during prenatal, intrapartum, and postpartum. The women supported relaxation in a trance state as helping the most to maintain control in labor and later to use as a parent. Women and their partner communicated with their babies, while in utero with pre-birth bonding prenatally and during the intrapartum timeframes.

In the current study it was evident women experienced difficult times when the healthcare providers and settings were not supportive of natural birth using HypnoBirthing. Unsupportive care included derogatory comments, lack of communication, unavailability of comfort devices and assistance for comfort measures, no positive reinforcement, loud noises in the room, turning bright lights on in the room, not waiting for the contraction to end before communicating, and the list goes on. Unfortunately many of these actions are care measures that should not happen with anyone in labor. Communication before or at the onset of labor is extremely important. Women birthing at the birthing center with midwives women expressed fewer difficulties.

Women's health and cultural expectations need to be discussed with their healthcare providers (Bonder et al., 2002). The healthcare providers can only provide patient-centered care, as recommended by the IOM, when the patient is at the center of the care (IOM, 2001, 2010). In patient-centered care the healthcare providers must show cultural sensitivity or respect for the cultures of other population groups besides the dominant culture (Bonder et al., 2002).Culture specific care is more likely to be provided when healthcare providers are informed of the patient's desires based on their culture (Sue, 2000).

COMPARISON OF THE FINDINGS TO LEDERMAN SENSITIZING FRAMEWORK

Lederman's theory of *Psychosocial Adaptation to Pregnancy* was used as the sensitizing framework for the study. The study findings were compared to three of six of Lederman's (1996) prenatal developmental dimensions, based on Lederman's extensive research that causes anxiety and conflict in pregnancy: maternal partner relationship, maternal preparation for labor, and maternal perception of being able to cope with her fears of labor (Lederman & Weis, 2009).

Lederman (1996; Lederman & Weis, 2009) proposes that women's relationships with their partners are the most important relationship in pregnancy and that women adapt to pregnancy better if their partners are supportive. Study results concur with Lederman's theory. In the current study, all women named and used their partner as their preferred labor companion. Women confirmed they wanted their partners to attend the

childbirth classes and practice HypnoBirthing techniques with them. Women wanted their partners present and actively supporting and being an advocate for them during labor and birth. The women and their partners were a birthing couple. The couple had completed birth preference sheets and discussed what they felt was important. Women felt the support of the partner throughout the pregnancy and believed this support had enhanced the couple's relationship, facilitated communication, and promoted bonding during pregnancy with the mother and partner and later as a family. The one woman with a partner working out of town strived in every way imaginable to keep him informed after each HypnoBirthing class, shared what she could over the phone, and the little time they had together when they saw each other before the birth. She definitely described having stress during the pregnancy, and had difficulty sleeping, until she started using the HypnoBirthing Rainbow Relaxation and Positive Affirmation CD. He made it in time for the birth but missed the labor and she felt a sense of loss not getting to share that with him. She held on to her values that she was having the natural birth not just for herself but also for her baby and she wanted it to happen for him (her baby).

Lederman (1996; Lederman & Weis, 2009) asserts preparation for childbirth decreases fear and prepares women physiologically and psychologically for the pregnancy and birth. This assertion is supported in the current study, in which all women expressed the need for childbirth education classes to help them decrease their fears and prepared their minds and bodies for a natural birth. Women felt their education and practice led to their success in having the *Mommie Driven* birth they desired. Mind and Body techniques were learned to decrease their fears and help them to feel confident and ready for the labor. Pain was not as much of an issue, when women felt prepared and in control of the labor and birth. The women wanted to learn the methods and be in control. They trusted the childbirth educator, the HypnoBirthing method, and understood the need to practice. They expected some pain but every woman expressed she felt prepared, ready, and confident to use the method, which they believed gave them power as a woman for birthing.

Lederman (Lederman, 1996; Lederman & Weis, 2009) proposes that pregnant women feel better prepared to cope with their "fears, feelings of helplessness, and pain" (p. 2) when women have childbirth preparation. When women have control over their

bodies during labor it helps to decrease the feelings of fear, pain and helplessness (Lederman & Weis, 2009). Study findings agree with Lederman's assertion. In the current study, all women expressed they felt fear and had the need for control in their labors and birth. Women also confirmed their HypnoBirthing childbirth education classes helped them to feel prepared and ready for labor. The women believed they were prepared and ready when the fear of childbirth had been eliminated and replaced with confidence in the method, their partner, and self. Lederman's assertion that preparation for childbirth decreases fear and prepares women physiologically and psychologically for pregnancy and birth (Lederman, 1996; Lederman & Weis, 2009) was supported by women in this study. All women transitioned into motherhood through their experiences using the HypnoBirthing methods. They were all satisfied with their birthing experiences. One woman had a repeat cesarean but said she felt so much at peace with the cesarean this time because she knew she had tried everything to have a natural birth and she accepted the outcome of the intervention.

COMPARISON OF THE FINDINGS TO RELEVANT LITERATURE

Childbirth is a cultural event with social behaviors, rituals, and practices reflecting the values and beliefs of pregnant women and the culture in which they live (Bonder et al., 2002; Davis-Floyd, 1994; Lederman & Weis, 2009). Childbirth practices are based on the meanings the practices have for the women which is enforced by Spradley that all behavior has meaning (1979).

Lothian (2008b) acknowledges that childbirth education is at a "crossroads" dependent upon research and future birthing care models. Clearly, there is a need to study the effects and outcomes of various forms of childbirth education. The women in this study were so committed to having the natural birth that was calm and peaceful with minimal intervention and only when necessary. They voiced how they wanted this not only for themselves but for their babies. For example, they did not want their babies' first impression of the world to be with bright lights shining in their faces and noise blaring in the room. It was about the importance of the entire childbirth experience from attending and practicing together throughout the pregnancy, through working together with their partners and feeling connected during pregnancy, labor, childbirth, and having positive

emotions during postpartum, and having a new set of coping skills to use in the motherhood role.

Although HypnoBirthing research is lacking, childbirth education research in general decreases fear and prepares women physiologically and psychologically for the pregnancy and birth (Nichols & Humenick, 2000). Fear of childbirth is a common problem in the U.S. but also a problem for fathers and mothers living in other countries (Eriksson et al., 2006). Results from the current study confirm women were able to conquer their fear of childbirth, through preparation that built their confidence for pregnancy, labor and birth, and the new motherhood role. The power of birth was put in their hands with the control they gained through self-hypnosis and knowledge. Relaxation while in the hypnotic state was the most helpful comfort measure for eliminating discomfort in labor. Relaxation was used in pregnancy and postpartum as well as labor and the women planned to continue what they had learned in HypnoBirthing throughout life.

Women are more likely to breastfeed and continue breastfeeding for a longer period of time if they attended childbirth education classes (Lu et al., 2003). The results of this study show all the women were confident in breastfeeding and implemented that method and were still breastfeeding in the first six months during first interviews. This meets one of the preferred outcomes recognized by the WHO (2010).

Results of this HypnoBirthing study show women felt in control, empowered as women and mothers, and prepared to advocate for themselves and their families. The women expressed they felt changed and validated as women and mothers. These results link closely with Goodman et al., 2004 study on childbirth education and how it helped the woman feel empowered and increased satisfaction with their childbirth experience (Goodman et al., 2004).

The maternal infant outcomes reported by the participants in this study were better than national averages according to current research. There were no preterm babies and all babies were healthy. There was one cesarean birth in the eleven women in the study which provides a 9% cesarean birth rate much closer to the desired WHO rate of 15% (2010), the 17% in HypnoBirthing statistics (Dolce, 2010), and definitely better than the 32% rate from National Vital Statistics and Listening to Mothers II Survey (2006).

In the current study all of the women reported they were able to use the self-hypnosis with limited difficulty. Hypnosis scripts provided by HypnoBirthing did not work well for all women but they had other choices to transition to that were effective for them. The research study by Dr. Mehl-Madrona suggests starting the hypnosis in the first and second trimester of pregnancy. That study was conducted over ten years at the University Of Arizona College Of Medicine. It supported the use of hypnosis to facilitate uncomplicated childbirth. There were 520 pregnant women in the first and second trimesters randomized into receiving hypnosis or attention only. The hypnosis group had significantly fewer complicated births, cesareans, oxytocin augmentation and inductions, epidurals, or other pain medications. The study recommended psychosocial care as a part of prenatal care and to start with hypnosis in the first or second trimester of pregnancy (Mehl-Madrona (2004).

Women reported the self-hypnosis was effective during labor. Several research studies found hypnosis was beneficial for labor. Continuous support was found to be beneficial and promoted an increase in birth satisfaction (Cyna et al., 2004). In the current study on HypnoBirthing the partner was the most important support person and the study confirmed the need for an advocate and continuous labor support. The systematic review (Cyna et al., 2004) emphasized the importance of the partner's support as well as support from the healthcare providers in using the hypnosis method. Smith et al. (2006) updated their systematic review and continued to support women seeking alternatives therapies for pain management in labor.

The evidence for Smith's (2006) review supported women using self-hypnosis in labor and found the women used less pain medications in labor and were satisfied with their labor outcomes. A study with larger sample sizes was recommended.

Numerous research studies indicate when healthcare providers demonstrate a caring and supportive relationship with women and their partners during childbirth; it helps the couple achieve an increased level of control and satisfaction of the childbirth experience (Goodman et al., 2004; Hodnett, 2002). Women expect nurses to understand the different childbirth education methods and to be able to provide women assistance in labor (Lothian, 2008a). In the current study most women indicated they were satisfied with their healthcare but two clear messages emerged: women expected their nurses to

know how to support them with HypnoBirthing and women can lose confidence in themselves and the method when they perceive to be in an environment that is un-supporting.

UNEXPECTED FINDINGS

There were several unexpected findings in the current study that occurred during all three time frames. During the first time frame of *Choosing the Experience* (prenatal) several women commented on how well they could relax and fall asleep using what they had learned in the HypnoBirthing classes. The women used the Rainbow Relaxation and positive affirmation CD to relax, feel positive, and sleep.

The women stressed how important the lighting was in the labor room. Some specifically focused on Christmas lights. It was as though Christmas lights brought more tranquility and peacefulness into their environment. This is something that is worthy of more investigation. Women did not specify if the lights were all white or multicolored lights. It was important for the room to be dimly lit so women could relax and stay in their state of trance. It was disturbing when a healthcare provider would walk into the room, flip on the bright lights, and break the women's state of trance. The healthcare provider was entering their personal space at that time and it was perceived as uncaring and unknowledgeable about HypnoBirthing.

The women sustained their motivation and trust in the method as they learned about progress in labor. Support from the healthcare providers was very important about their progress since it sustained their motivation and trust in the method. Women were surprised when they made progress in a short period of time and some women shared the nurses were surprised of the women's rapid progress in labor.

Another unexpected finding of the study was how women felt changed by their childbirth experience. When they started the Hypnobirthing classes, their goal had been to eliminate fear, prepare, and have a natural childbirth. However, in addition to becoming prepared, women gained much more: they felt validated as women and as mothers, and their confidence extended beyond labor and birth and on to their mothering or parenting role. The women expressed how they continued to use techniques learned in HypnoBirthing for themselves and their babies. Women used the relaxation techniques

when they felt stressed as a mother. They were planning to use HypnoBirthing again but in a manner where they would have even more control of the environment.

Women used the Marie Mongan HypnoBirthing Rainbow Relaxation CD to help their babies relax. Women knew the babies were used to hearing the familiar relaxing sounds while in utero. If the women wanted the baby to relax they would play the familiar Rainbow Relaxation CD for the baby.

Mothers referred to the powerful positive birth affirmations on the HypnoBirthing CD and how they still used the CD to maintain positive thoughts during postpartum. The positive birth affirmations on the CD helped them feel good about themselves improving their self-esteem.

After the Experience women and their partners were more interested in other natural ways to promote health for themselves and the family. The HypnoBirthing techniques had become integrated with their way of life. This was not found in the childbirth education literature review.

STUDY IMPLICATIONS

Nursing Practice

The findings of this research have potential implications that could affect the interdisciplinary team caring for pregnant women through postpartum. The findings may facilitate health care providers' awareness of how their practices affect women desiring a natural birth using HypnoBirthing. Findings may assist the physician, nurse midwife, certified midwife, doula, childbirth educator, nurse, and nurse educator when planning and providing care for women choosing HypnoBirthing or other natural methods of birth. Findings may also stimulate health care professionals to think about culturally sensitive care for all patients, including those who wish a less technological approach. Additionally, healthcare providers can only provide patient-centered care, as recommended by the IOM, when the patient is at the center of the care (IOM, 2001, 2010). In patient-centered care the healthcare providers must show cultural sensitivity or respect for the cultures of other population groups besides the dominant culture (Bonder

et al., 2002). The technocratic high technology labor and birth care and setting continue to make up the dominant culture (Davis-Floyd. 1994, Martin, 2012).

Nursing Education

Study findings support a need to teach cultural competencies that facilitate enhanced understanding of culture and any cross-culture differences. Teaching cultural competence for patient care integrated with the six IOM core competencies will improve and individualize patient care treatment plans. If this is not taught in nursing, nurse midwifery, or medical schools then perhaps the reason should be investigated. It needs to be understood that not all women want to birth in the high technology dominant culture. There are moral, professional, and legal responsibilities to meet the cultural needs of patients. In Title VI of the U.S. Civil Rights Act discrimination is prohibited and it mandates culturally sensitive care for all people and not just those receiving care that fits the dominant medical model of practice. It is problematic for a registered nurse, working in labor and delivery to say to another nurse or nursing student, "Oh, she is having a natural birth, so other than vitals you can leave her alone. We will see how long she lasts." This comment is disheartening coming from the nurse and disheartening for the women who will not receive support and care from their nurses. These women and their partners need to receive supportive care from their healthcare providers including at least: oral fluids as tolerated during labor, having the baby's heart auscultated intermittently, have freedom of movement, cervical exams kept to a minimum, and comfort levels assessed periodically (Romano & Lothian, 2008).

Nursing Research

Study findings support the value of qualitative studies that explore women's perceptions about labor and childbirth and the values, beliefs, and perinatal practices of women using HypnoBirthing Childbirth Education. Women identified what was important to them during pregnancy, birth, and postpartum. Nursing research findings need to be placed into practice to benefit the women needing assistance to have a natural childbirth experience. Additional research needs to be conducted to further explore the needs of women for best practices in childbirth education and childbirth. If women's

needs are not met for childbirth it could affect maternal adaptation and may cause postpartum depression, which is a major complication of childbirth. Suggestions for future research are listed later in the paper.

LIMITATIONS AND STRENGTHS OF THE STUDY

The study had several limitations. The sample was relatively small, non-random, and homogeneous. However, the criteria for sample size in ethnography do not rely on specifically large population but rather on data quality and achievement of data redundancy (Spradley, 1979, 1980). Qualitative research does not require random sampling, and informants were selected because they could describe the HypnoBirthing experience and culture. Although the researcher was unsuccessful in recruiting diverse informants, the homogeneous sample was reflective of the national profile of women attending private childbirth classes (Lu et al., 2003). Therefore, the study findings may well be applicable to similar groups of women choosing HypnoBirthing: The Mongan Childbirth Education Method.

A second study limitation was the requirement that informants speak English. Although the limitation was essential because the researcher speaks only English, it is possible that some non-English speaking women may have been excluded from the study. HypnoBirthing and other childbirth classes are taught worldwide and presumably in other languages. While it is possible that non-English speaking women in the United States choose HypnoBirthing, the national profile for women who chose private childbirth classes remains predominantly English speaking.

Strength of any ethnography is immersion in the culture (Spradley, 1979). Since the researcher had over 30 years of childbirth education experience, educated and taught multiple types of childbirth education programs in various settings, and involved in an evolving culture of childbirth educational programs over a long time period, the ethnographer had long history of immersion in the culture. The researcher's in-depth cultural knowledge and awareness of the underlying meanings of childbirth language, behaviors, rituals, and processes was viewed as study strength because it facilitated identification of cultural inferences.

Another major strength was the ethnographic design that provided broad and in-depth knowledge of the culture and encouraged women to express their stories. This approach allowed women to share their culture so healthcare professionals and others can better understand it.

POLICY IMPLICATIONS

The current study provides baseline data as a stepping stone to investigate this method further as well as other childbirth methods. It sets the stage for future studies on women's services and healthcare dollars to reach culturally diverse groups with disparities.

Policy makers at the state and federal levels are responsible for determining options to lower the costs of healthcare without lowering the quality of care with the Patient Protection and Affordable Care Act (PPACA) (Cosgrove et al., 2012). In the U.S. massive amounts of money are being spent for childbirth to occur in high-risk settings. Medical models of care for low-risk women desiring to have a natural birth, in a low-risk culturally sensitive environment seem to be a timely issue worth further investigation. Financing to offer classes to all women should be considered in an effort to decrease costs of maternity care while providing a needed psycho-educational program to women of ethnic diversity. This group of women has the poorest health outcomes and disparities in access to care.

Kitty Ernst RN (Honorary DNP), Board Member for Frontier Nursing University, and recognized for her work with the Maternity Center Association, Frontier Nursing Service, and as a Distance Education Nurse Midwifery Visionary said it best:

> We need to look at a different care model from what we have now. We need birth centers with certified nurse midwives, but combined with certified family nurse practitioners to provide care for the mother and the family. Mary Breckenridge set this up years ago before its time and wrote about it in *Wide Neighborhoods.* This is what nursing needs to do today. (Statement made on October 25, 2013 to Judy M. Staley RNC, MSN, WHNP, FNP-BC in a private conversation on break during the faculty meeting).

SUGGESTIONS FOR FUTURE RESEARCH

Based on the findings of this study future research needs to examine the choices and experiences of women using HypnoBirthing in a larger and more ethnically diverse population. There is also a need for more intensive studies of the specific outcomes of this method of childbirth. Future research may include an intervention study using Lederman's Prenatal Adaptation Scale before and after HypnoBirthing: The Mongan Method Childbirth Education classes.

CONCLUSION

There has been a striking lack of research and literature examining the cultural variables that influence women's choices of childbirth methods as well as practices and outcomes. This current ethnographic study was one of the first in the U.S. to examine the cultural values, beliefs, and practices of a sample of women who elected to use HypnoBirthing: The Mongan Method. The results of this study clearly reflect that these women shared core cultural values and beliefs about the need for choosing a childbirth method that not only fostered their sense of control, autonomy, and empowerment but that led to what they perceived as a safer and more naturalistic birthing process for themselves and their babies. They reported their overall satisfaction with the process/caregivers and outcomes. Findings from this study may potentially help inform healthcare providers about the preferences and needs of women who select this unique method of childbirth.

APPENDIX A: UTMB IRB APPROVAL

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Institutional Review Board
301 University Blvd.
Galveston, TX 77550-0158
409.266.9475

27-Feb-2015

MEMORANDUM

TO: Judy M. Staley, PhDc, RNC, WHNP, FNP-BC/Elnora P. Mendias, PhD, RN
School of Nursing 1029

FROM: Michael Loeffelholz, PhD
Institutional Review Board, Chairman

RE: Final Approval of Continuing Review

IRB #: IRB # 10-135

TITLE: Understanding the Values, Beliefs, and Practices of Women Using HypnoBirthing Childbirth Education

The UTMB Institutional Review Board (IRB) reviewed the above-referenced research protocol via an expedited review procedure on **24-Feb-2015** in accordance with 45 CFR 46.110(a)-(b)(1). Having met all applicable requirements, the research protocol; is approved for continuation for a period of 12 months. The approval period for this research protocol begins on **27-Feb-2015** and lasts until **24-Feb-2016**.

The research protocol cannot continue beyond the approval period without continuing review and approval by the IRB. In order to avoid a lapse in IRB approval, the Principal Investigator must apply for continuing review of the protocol and related documents before the expiration date. A reminder will be sent to you approximately 90 days prior to the expiration date.

If you have any questions related to this approval letter or about IRB policies and procedures, please telephone the IRB Office at 409-266-9475.

General Instructions

To maintain IRB approval in good standing, please observe the following requirements:

1. All subjects must sign the consent form before undergoing any research study procedures, including screening procedures. A photocopy of the signed consent form(s) should be given to each participant. The copy of the consent form(s) bearing original signature(s) should be kept with other records of this research for at least six years past the completion of the research study. The IRB considers a subject to be enrolled once s/he signs a Consent Form.
2. Obtain prior IRB approval for any modifications including addition of new recruiting materials, changes in research personnel or site location, sponsor amendments or other changes to the protocol or associated documents. Only those changes that are necessary to avoid an immediate apparent hazard to a subject may be implemented without prior IRB approval.
3. Report all adverse events, protocol violations, DSMB reports, external reports and study closures promptly to the IRB.
4. Make study records available for inspection. All research-related records and documentation may be inspected by the IRB for the purpose of ensuring compliance with UTMB policies and procedures and federal regulations governing the protection of human subjects. The IRB has authority to suspend or terminate its approval if applicable requirements are not strictly adhered to by all research study personnel.
5. When enrolling subjects who do not speak or read English, a bilingual translator must be available to facilitate communications between research personnel and a subject.

APPENDIX B: RECRUITMENT FLYER

ANNOUNCING A RESEARCH STUDY

Culture of HypnoBirthing Childbirth Education

Are you interested in learning more about a research study that is being conducted to learn about the values, beliefs and practices of postpartum women, who attended HypnoBirthing Childbirth Education Classes as expressed by language, rituals and behaviors? If so, please respond to this flyer. The person conducting this study is Ms. Judy Staley, a nurse who is studying for her doctoral degree in nursing at the University of Texas Medical Branch (UTMB) in Galveston, Texas. This research study is her dissertation study. The Institutional Review Board at UTMB has approved this study, and Ms. Staley is supervised by Dr. Elnora Mendias, PhD, RN and other committee members. All information you provide is confidential. The study involves no treatments, only conversation during scheduled interviews.

If you want to know more about this study, please e-mail Ms. Staley at justaley@utmb.edu and she will contact you to answer any questions and begin the study if you meet study criteria. If you would rather leave a telephone message, please call (830) 832-2982, leave a message, and your call will be returned as soon as possible. Thank you.

Judy M. Staley PhD, RNC

APPENDIX C: RESEARCH CONSENT FORM

RESEARCH CONSENT FORM

You are being asked to participate as a subject in the research project entitled, Understanding the Values, Beliefs and Practices of Women Using HypnoBirthing Childbirth Education, under the direction of Judy M. Staley, PhDc, RNC, WHNP, FNP-BC.

PURPOSE OF THE STUDY

The overall purpose of this study is to learn more about the culture of HypnoBirthing and the values, beliefs and birth practices of women, who attended HypnoBirthing childbirth education classes. This study fulfills a course requirement for Ms. Staley. Ms. Staley is a nurse who works as a Dean in a school of nursing, is certified in two types of childbirth education and has taught childbirth education for a number of years. You are being asked to participate in this study because of your attendance in HypnoBirthing: The Mongan Method childbirth education classes.

PROCEDURES RELATED ONLY TO THIS RESEARCH

This is an interview study. There are no interventions or experiments. During this study, Ms. Staley will interview you at least once but no more than three times about your experiences with HypnoBirthing Childbirth Education. The interviews will be conducted at a time and place that is convenient for you. Each interview will last no more than one and one-half hours and will be conducted over a period of time that lasts no longer than two months, counting from when the first interview begins until the third interview is completed. The interviews will be audio-taped and transcribed so that the ethnographer can find things in common among all the informants in the study. To protect your identity, the audiotapes and transcripts will be coded. Your name will never appear on

any study documents or recordings. Both the tapes and interview transcripts will be kept in a locked file cabinet in the ethnographer's office.

Following the completion of the first interview, Ms. Staley will contact you to set up additional interviews as needed. Need is determined on how much information was left to talk about when the first interview ended. The second and third interview meetings also provide time for Ms. Staley and you to clarify any questions you have, and for you to add any additional information you wish to share.

In addition to answering the interview questions, you will be asked to answer several questions about your age, gender, marital status, education, income, labor partner, childbirth education class attendance and socioeconomic status. This questionnaire will also be coded so that no identifying information can be associated with you. If, for any reason, you are unable to continue your participation in any of the interviews, they will be stopped without any penalty to you.

PROCEDURES NOT RELATED TO THIS RESEARCH

The only procedure in this research is the interviews listed in the above paragraph. There are no other procedures.

RISKS OF PARTICIPATION

The potential risks from participation in this study are few. You may become fatigued during the interview. There are no procedures or treatments associated with this research project; only conversation during the interview. Ms. Staley will take all possible steps to assure your confidentiality by coding study data and removing your name and other identifiers from study materials. However, there remains a minimal risk of the loss of confidentiality.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of subjects participating in this study is 5 and not more than 20 postpartum women. All the women will have given birth in the United States; most will be recruited from the population of women residing in the San Antonio area. All will have attended a HypnoBirthing childbirth education class series. This study will be conducted completely in the community rather than in a hospital. No one will ever learn of your participation unless you are the one to tell of your participation. The length of time of your participation will vary according to how many interviews you agree to have with Ms. Staley. As explained above under "Procedures Related Only to this Research", you will be asked to participate in at least one but not more than three interview sessions. No one-interview session will last longer than ninety minutes. The interviews will be conducted at a place and time that is convenient for you and a natural setting of your choice. Whether you will have one or more interviews will depend upon the progress that is made answering the questions Ms. Staley has. This study will begin in August 2010 and will be completed by April 2011. Your commitment of time will be only the interview sessions you agree to schedule and complete with Ms. Staley. Your last interview will be completed within two months' time from when you complete your first interview with Ms. Staley. While this study will go on for approximately 9 months, your participation as an individual will last over approximately 3 months.

BENEFITS TO THE SUBJECT

There are no direct benefits to you for your participation in this research project. By answering the ethnographer's interview questions, you may gain some insight into your experiences using HypnoBirthing Childbirth Education for your labor and birth.

OTHER CHOICES (ALTERNATIVE TREATMENT)

There are no treatments in this study. You will meet with the investigator only to discuss the interview questions and answers you wish to provide. The alternative to participating in this study is to choose not to participate. Participation in this study is voluntary and not required.

SAFE WITHDRAWAL FROM THE STUDY

If you decide to withdraw from the study you will need to inform Ms. Staley and the interviewing procedure will be stopped and no further requests for interviews will be made. There are no other procedures or steps that need to be taken.

REIMBURSEMENT FOR EXPENSES

You will receive a $20 Visa gift card after each interview as a token of appreciation or to cover any expenses incurred. This will be given to you in person after the interview or mailed within one week if you participate in a telephone interview.

COMPENSATION FOR RESEARCH RELATED INJURY

If you are physically injured because of any substance given to you or procedure performed on you under the plan for this study, UTMB will provide you with the appropriate medical treatment. Your insurance company will be billed and any charges not covered by your own insurance or health care program will be provided at no cost to you. You will be responsible for paying any costs related to illnesses and medical events not associated with being in this study. There are no plans to provide other forms of compensation. However, you are not waiving any of your legal rights by participating in this study. Questions about compensation may be directed to the study doctor.

COSTS OF PARTICIPATION

There will be no cost to you for your participation in this study.

REASONS FOR THE STUDY INVESTIGATOR TO STOP YOUR PARTICIPATION

You may be dropped from the study by the study investigator if the study is discontinued. If this is the case, Ms. Staley will contact you and explain the situation.

PROCEDURES FOR WITHDRAWAL

If at any time you wish to stop your participation in this study, simply contact the investigator at the numbers provided at the end of this consent form. Upon learning of your request, your participation will be ended.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Even though in this interview study no health information is accessed, collected, or used, you must know that all study records that identify you will be kept confidential as required by law. Federal privacy regulations, provided under the Health Insurance Portability and Accountability Act (HIPPA), provide safeguards for privacy, security, and authorized access to your records. These regulations require UTMB to obtain authorization from you if it or anyone employed there attempts to use and disclose your health information. By signing this consent form, you are agreeing to participate in this study. You are not authorizing the use and disclosure of your health information related to this research study.

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in this study's records. However, you do need to know that study records will be coded without your name and be kept confidential as required by law. You will not be identified by name in study records. A pseudonym will be assigned to you and only Ms. Staley will know that pseudonym. The key to the code will be kept in a locked file in Ms. Staley's office.

There are no sponsors for this research. Ms. Staley is acting alone, but under the supervision of her faculty, Dr. Elnora Mendias, to complete her requirements for a doctoral degree. The study data, meaning the contents of your interview(s), will not be linked to you as an individual. Instead, the data you provide will be put together with data from all other informants and reported that way. You may see or receive a copy of any research reports of findings from this study at its conclusion. Please request those from Ms. Staley.

If you sign this form, you are giving Ms. Staley permission to collect, use and share the information you provide during the interviews. Your health information is not part of this study and you will not be asked about it nor will it be assessed. You do not need to sign this form. If you decide not to sign this form, you cannot be in the research study. Whether or not you agree to participate in the research project or give us permission to collect, use or share your interview information will not affect the care you will be given at UTMB.

Your interview information, without your name on it, may be reviewed by Dr. Elnora Mendias, for purposes of assisting Ms. Staley with learning to understand the data analysis process. If for any reason you want to stop your participation in this study, you can at any time. However, you need to inform Ms. Staley at the contact numbers listed in this consent form. You need to say that you have changed your mind and do not wish to continue participating in this study. At that time and thereafter, Ms. Staley may not collect any additional interview information from you. However, she may use the information that she has already collected. It is important to learn everyone's experiences, not just those of persons who complete the research study. The results of this study may be published in scientific journals and presented as posters without identifying you by name.

ADDITIONAL INFORMATION

1. An offer has been made to answer any questions that you may have about these procedures. If you have any questions before, during or after the study, or if you need to report a research related injury, you should immediately contact Judy Staley, PhDc, RNC, WHNP, FNP-BC, at (830) 832-2982 or Dr. Elnora Mendias, PhD, RN, at (409) 772-8258.

2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty or loss of benefits and without jeopardizing your medical care at UTMB. If you decide to stop your participation in this project and revoke your authorization for the use and disclosure of your health information, UTMB may continue to use and disclose your health information in some instances. This would include any health information that was used or disclosed prior to your decision to stop participation and needed in order to maintain the integrity of the research study. If we get any information that might change your mind about participating, we will give you the information and allow you to reconsider whether or not to continue.

3. If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the Institutional Review Board Office, at (409) 266-9475.

The purpose of this study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent, including your authorization for the use and disclosure of your health information, at any time. You may withdraw your consent by notifying Judy Staley PhDc, RNC, WHNP, FNP-BC, at (830) 832-2982 or Dr. Elnora Mendias, PhD, RN, at (409) 772-8258. You will be given a copy of the consent form you have signed.

Informed consent is required of all persons in this project. Whether or not you provide a signed informed consent for this research study will have no effect on your current or future relationship with UTMB.

Signature of Subject	Date

Using language that is understandable and appropriate, I have discussed this project and the items listed above with the subject

Signature of Person Obtaining Consent	Date

APPENDIX D: INFORMANT DEMOGRAPHIC DATA

In order to describe the informants as a group, I need to ask you some questions about yourself. If there are any questions that you do not want to answer, just tell me, and we will move on to the next question. This information is only used to describe the informant in the study as a group.

1. How old are you? _____
2. What is your marital status?
   (1) Single___ (2) Married___ (3) Living with partner___ (4) Other ___
3. What is your ethnicity?
   (1) Caucasian___ (2) African-American___ (3) Asian-American___
   (4) Mexican-American or other Latino___ (5) Other_____
4. What is your highest grade level attended in school or college?
   (1) Grade school or lower___ (2) High school graduate___ (3) Technical Training___
   (4) Associate Degree___ (5) Bachelor's Degree___ (6) Master's Degree___
   (7) Doctorate Degree___
5. Do you work outside of the home?
   (1) Yes ___ (2) No___ (1) If yes, Full time___ (2) Part time ___
6. What is your total household income?
   (1) $0-15,000___ (2) $16,000-30,000___ (3) $31,000-45,000___
   (4) $46,000-60,000___(5) above $60,000___
   (1) Amount of your income_____
   (2) Amount of partner's income_____
7. What healthcare providers provided care during labor and birth?
   (1) Physician___ (2) Professional Midwife___ (3) Lay Midwife___ (4) Doula___
   (5) Other
8. In what month of your pregnancy did you have your first prenatal appointment?
   _____
9. Did your physician or other healthcare provider recommend or refer you for childbirth

classes? Yes___ No___

10. Did you ever attend any other childbirth classes before HypnoBirthing Classes? Yes___ No___

    If yes, what type of class did you attend? Lamaze___ Bradley ___ Other ___

    If yes, was it provided by the hospital? Yes ___ No___

11. Who was with you and provided the most support during this labor and birth? _____

    What is their relationship to you? _____

12. How close to your due date did you give birth to the baby? _____

13. Is this your first baby? Yes___ No___ Second?___ Third?___ or More?___

14. Are you breast- or bottle-feeding this baby? Breast___ Bottle___

APPENDIX E: POSTPARTUM INTERVIEW GUIDE FOR WOMEN WHO ATTENDED HYPNOBIRTHING CHILDBIRTH CLASSES

Introduction: I am interested in understanding how you feel about HypnoBirthing childbirth education or your experience with HypnoBirthing.

Grand Tour Question: Please tell me about your HypnoBirthing Childbirth Education Classes. I am interested in learning anything you would like to share about the classes or your experience.

Examples of Mini Tour Questions:

1. Please tell me about making your choice for HypnoBirthing childbirth education classes.
2. Mini Tour Question: Please tell me what you learned in the classes.
3. Mini Tour Question: Please tell me how you used information received in childbirth education classes during your birthing experience.
4. Mini Tour Question: What was it like using HypnoBirthing?
5. Mini Tour Question: What did you like about your classes?
6. Mini Tour Question: What did you dislike about your classes?
7. Mini Tour Question: What did you find helpful from the classes?
8. Mini Tour Question: What did you find unhelpful from the classes?
9. Selective Question: Tell me how your physician/midwife/other healthcare provider was supportive during your labor and birth experience.
10. Selective Question: Tell me how your physician/midwife/other healthcare provider was not supportive during your labor and birth experience.

Examples of Mini Tour Sensitizing Framework Questions that maybe asked:

11. Selective Question: Tell me about your experience of using HypnoBirthing.
12. Selective Question: Tell me how HypnoBirthing affected the relationship you have with the father of the baby.
13. Selective Question: How did your experience using HypnoBirthing childbirth education prepare you for labor?
14. Selective Question: How did HypnoBirthing affect your readiness for labor?
15. Selective Question: How did using HypnoBirthing techniques affect your labor?
16. Selective Question: Tell me how HypnoBirthing has affected how you feel about yourself. How you feel about your partner? How you feel about your baby?

Structural and Contrast questions may be posed upon the answers provided to the other questions.

APPENDIX F: CONTACT SUMMARY FORM

Contact type **Site: Home**

Visit: **Date: February 24, 2011**

Phone: X **Informant: HBF1**

What were the main issues or themes that struck you in this contact? She felt like she did not practice as much as she should have and didn't realize that until she was in labor.

Summarize the information you got (or failed to get) on each of the target questions. What would you like to share about the classes or your experience? The focus in class was definitely more on learning and practicing the techniques. They were definitely open to questions was really nice and everybody could ask any kind of question (12). It was very complementary to the book (14). It was nice to know that she (CBE) wasn't just a resource for class. She was fine with us calling her later for any questions she had and that was really neat (21).

How did you make the choice for HypnoBirthing childbirth education classes? I wanted to do a more natural birth and I didn't know what my options were and I actually was at Barnes and Noble and was going through the birthing books and had pulled off a few that were natural birthing and looked at few pages and didn't like what I had seen and then I looked at the HypnoBirthing book and thought this sounds a little extreme and opened it up and loved the first couple pages (28).

What did you learn in the classes? I learned a lot about how the body was supposed to do (42). I learned a lot about after like breastfeeding and it kind of went along on the same thing how body takes care of the baby the whole process that I learned (47).

How did you use the information learned in classes during your birthing experience? I felt like once I got to point where it was difficult to manage with the pain get myself calm and get myself relaxed and I feel like I almost didn't do that fast enough

I wasn't having to deal with labor right now so I wasn't using all the techniques and actually until I started to use them did my labor start to really move and progress even faster (56).

What was it like using HypnoBirthing? When I got to the hospital it was harder. In the car I felt like I lost it all with all the relaxation and all the concentration I just sort of lost everything (96). I was focused on life and not on labor (98). It was very very difficult to maintain the mental relaxation in the hospital (100).

What did you like about your classes? I really liked how opened the discussions were and how realistic they were (109). You know I think sometimes um people other tend to tell you the awful truth about birth or they tell you that you will be fine you'll get through it and I felt like it was kind of a balance right in the middle it was just really realistic I guess labor does hurt I'm not saying there is pain but we are giving you techniques to manage the pain to the point where a lot of women say it is totally comfortable (109-113). When you asked a question they would give you a very honest answer and a I felt like I built a lot of trust in the class and a lot of trust in the actual method (115).

What did you dislike about your classes? They (in the video) were in the tub completely naked and we weren't expecting to see that when we walked in. I don't know that I didn't like that but it three me for a loop (124).

What did you find helpful from the classes? They are not only teaching me but also the person who is not going to be in pain at the time they kind of teach you those things and for me that was probably the most helpful was that both my husband and my mom had gone through the classes with me so both were kind of thinking of things I133-136).

What did you find unhelpful from the classes? I was really excited to watch the movies because I thought they were going to reinforce the HypnoBirthing and I think there was only one class that the movies did that for me (143).

How was your physician/midwife/other healthcare provider supportive during your labor and birth experience? It was the nurses who were actually there for the whole thing and were supportive (157).

How was your physician/midwife/other healthcare provider not supportive during your labor and birth experience? Ah not supportive. I know the doctor was literally there to just catch the baby and stitch me up when I was done (154). She said she would take the monitor off and then she never did so I could never go and sit on chair or go sit on the couch. I don't know if they (nurses) were aware of what HypnoBirthing is and I feel like if they would have known the values and the structure of what HypnoBirthing was they would have been better at supporting me um they just asked if I wanted any pain medication and I said no I want to have a natural birth (162). Definitely didn't know that I needed to be quite and I needed to be relaxed and she would actually ask me questions when you know I was trying to breathe through the contraction so didn't understand that concept at all (165-167).

Sensitizing Framework Questions:

Did your experience using HypnoBirthing childbirth education prepare you for labor? They did everything they needed to do on their part. I just felt I didn't do everything I should have done on my part so I didn't do as well as I should have (256).

How did HypnoBirthing affect your readiness for labor? (Same as above**)**

How did using HypnoBirthing techniques affect your labor? When actually doing what the book had said and getting me calm and keeping me relaxed and not thinking about other things or concentrating on other things it was about 2 hours doing breathing and relaxing using techniques I started progressed very quickly (75).

How did HypnoBirthing affect how you feel about yourself? I have more confidence in my own skills to deal with parenting and things like that (274). I learned that it is a

good thing for me to advocate for things that I want (275). I have more confidence taking a stand on things like that (279).

How did HypnoBirthing affect how you feel about your partner? I think he is a little bit more supportive of me doing things more naturally now (251).

How did HypnoBirthing affect how you feel about your baby? I kind of gained more confidence in my body's natural innate skills to get through like I kind of put that off on my daughter (223). I have given her body more credit to deal with life rather than panicking and freaking out (227).

Is there anything else that struck you as salient, interesting, illuminating or important in this contact? She had only good things to say about HypnoBirthing. She felt she needed to practice more. She definitely equates HypnoBirthing with natural methods.

Is there other follow up from this interview? She answered the relationship questions based on her use of natural methods with the baby and the baby's father now approving of natural methods. I think a follow up question on bonding would be useful.

APPENDIX G: DOMAIN ANALYSIS WORKSHEET RELAXATION

Included Terms Semantic Relationship (ways to having; used to have a state of) Cover Term (relaxation)

Every night I would play the rainbow relaxation and do the affirmations (HBA1, 31); Rainbow relaxation worked (HBB1, 27); I did that with the rainbow relaxation a couple times a week (HBD1, 74); I had listened to the cd so much that I had it in my head (HBD1, 100); When actually doing what the book had said and getting me calm and keeping me relaxed and not thinking about other things or concentrating on other things it was about 2 hours doing breathing and relaxing using techniques I started progressed very quickly (HBF1, 75); I think mainly I just listened to the rainbow relaxation while I was expecting and just kind of remembered that visualized colors (HBJ1, 49); The primary thing was to help me find what or how to get into my relaxing zone quickly. The thing we listened to: the rainbow relaxation and it was all about finding my spot (HBK1, 27); I already knew what I wanted because I knew from the class the ocean already helped me relax (HBJ1, 39); Focus on what I was saying (HBA1, 37); focus on different parts of the body (HBC1, 31); Visualization (HBD1, 83); guided imageries (HBE1, 41) It eased my mind (HBA1, 37); Helped me think of good things (HBA1, 38); Good to come out of it (HBA1, 40) Reference to Rainbow relaxation and affirmations CD: I fell asleep (HBA1, 44), I fell asleep (HBB1), I fell asleep (HBC1, 43); It (cd) was the one talking about handling everything over to your body and your baby and have a calm and peaceful birth (HBD1,70); Classes (HBB1, 8), (HBC1, 28)

Breathing (HBB1, 123); Two or three breathing techniques from the HypnoBirthing book that I found most effective HBE1, 71); I really used the relaxation and breathing techniques to relax my body during childbirth and just to breathe to ease a contraction and to just remember that I can withstand anything for just 60 to 90 seconds which is how long your contraction or surge is (HBH1, 39);

Relaxing at night. Just being calm, relaxed (HBB1, 64); Just the relaxation that was the most important piece of it (HBB1, 65); Progressive relaxation (HBC1, 31); Relaxation techniques (HBE1, 40); I guess the progressive relaxation was probably my main one

(HBG1, 61); I knew I could do most of my laboring at home I was relaxed at home and used the hypnosis to calm myself and when I got to the hospital I was dilated the right amount and I was walking round the hospital and I was fine. I just wasn't even in much pain until like I was an eight or nine. So I think that it really helps to just relax your body and let it do its thing HBH1, 209-212); I liked the disappearing letters and imagine your body relaxing going from head to toe (HBJ1, 52); I focused more on relaxation through calming music and focusing more on my body (HBJ1, 69); Yeah just starting at your head, relaxing your head, your facial muscles and just going down through your body and just relaxing (HBJ1, 159);

My husband would read me scripts (HBA1, 60); Listened to one of the CDs (rainbow relaxation or affirmations) and then at night before we went to sleep we did a script (HBC1, 39); Conditioning (HBC1, 35); Hypnotic exercises (HBD1, 14); Husband learned how to work and do guided imageries with me (HBE1, 42); There was this one about walking through the woods imagery that one I loved (HBE1, 78); The depthometer, another one a tube going down through your body; and you can allow the relaxation it is sort of a countdown back from 40 that one was awesome (HBE1, 75); Rainbow relaxation is one of the scripts; um Birth Companion's Deepening exercise, the waterfall script (HBG1, 97); For me especially it was the deepening techniques that got me through each surge (HBG1, 62); You have to take off what your mind was going to do to help focus on something else and a safe place a place where you feel safe. And when you are faced with strangers you can keep yourself relaxed and at ease (HBH1, 34); There was some imagery techniques and the thing that really helped me the most was the rainbow relaxation that cd and then there was little short techniques like you would come up with a birth color, it was called a color for your birth and you were supposed to count down and went into different colors and then into a relaxed state that one worked for me um there was like a valve. HBI1, 81); My husband was able to use counter pressure on my legs pressing on them which was helpful. I had my eyes closed a lot. I found it helpful since I couldn't move around much. I was able to breathe I wasn't able to move around much so I swayed my arms I had not practiced that but since I couldn't move around it helped me. Each time I found it helpful because I couldn't move around much. The

whole labor only lasted four hours it didn't last as long as they expected. I think the music was helpful it helped me to relax it wasn't very loud and it probably wasn't supposed to be it helped me stay in myself.
139-141 We talked about movement in the class and we talked about need to sway. I couldn't get out of bed so I think I just came up with the idea of swaying and I found it very helpful so I just swayed backed and forth with my breathing using that same motion HBK1, 139-141);

Structural Question: Whenever you said it helps you relax and gave you positive affirmations in what ways did it help you relax? (HBA1)

APPENDIX H: TAXONOMY FEAR FACTOR

I. It (classes) took away the fear factor
   - A. Helped me stay calm and positive throughout my pregnancy
   - B. Affirmations positive birth
     1. Good positive things instead of anything negative associated with it, or risks, or anything like that
     2. Tried not to talk about horror stories
     3. Not talking about things that can go wrong
   - C. Best thing about HypnoBirthing is that I went through the whole labor process with a positive attitude and I knew it was something I could conquer
   - D. (Classes prepared them) step by step through entire birth process
     1. I knew what to expect talking about what body is going to do and what baby is going to do
     2. Being prepared from the moment we got in the car to go to the hospital to the moment we left the hospital for home and even before
   - E. Fear releasing exercise helped me
   - F. It (HypnoBirthing) helped me stay calm to apply everything in labor
   - G. I was ready, I was prepared for whenever, I wasn't afraid, I didn't think it was going to be painful
   - H. I knew they were going to get painful and tough but they (contractions) didn't have to be the struggle that a lot of people say they will be
   - I. Feeling prepared, feeling confident, feeling somewhat fearless, feeling completely fearless
   - J. I felt knowledgeable, comfortable and confident
   - K. What helped me the most was seeing other women delivering naturally without fear, without pain just to prove it can be done

APPENDIX I: CONTACT SUMMARY FORM: ILLUSTRATED WITH CODED THEMES

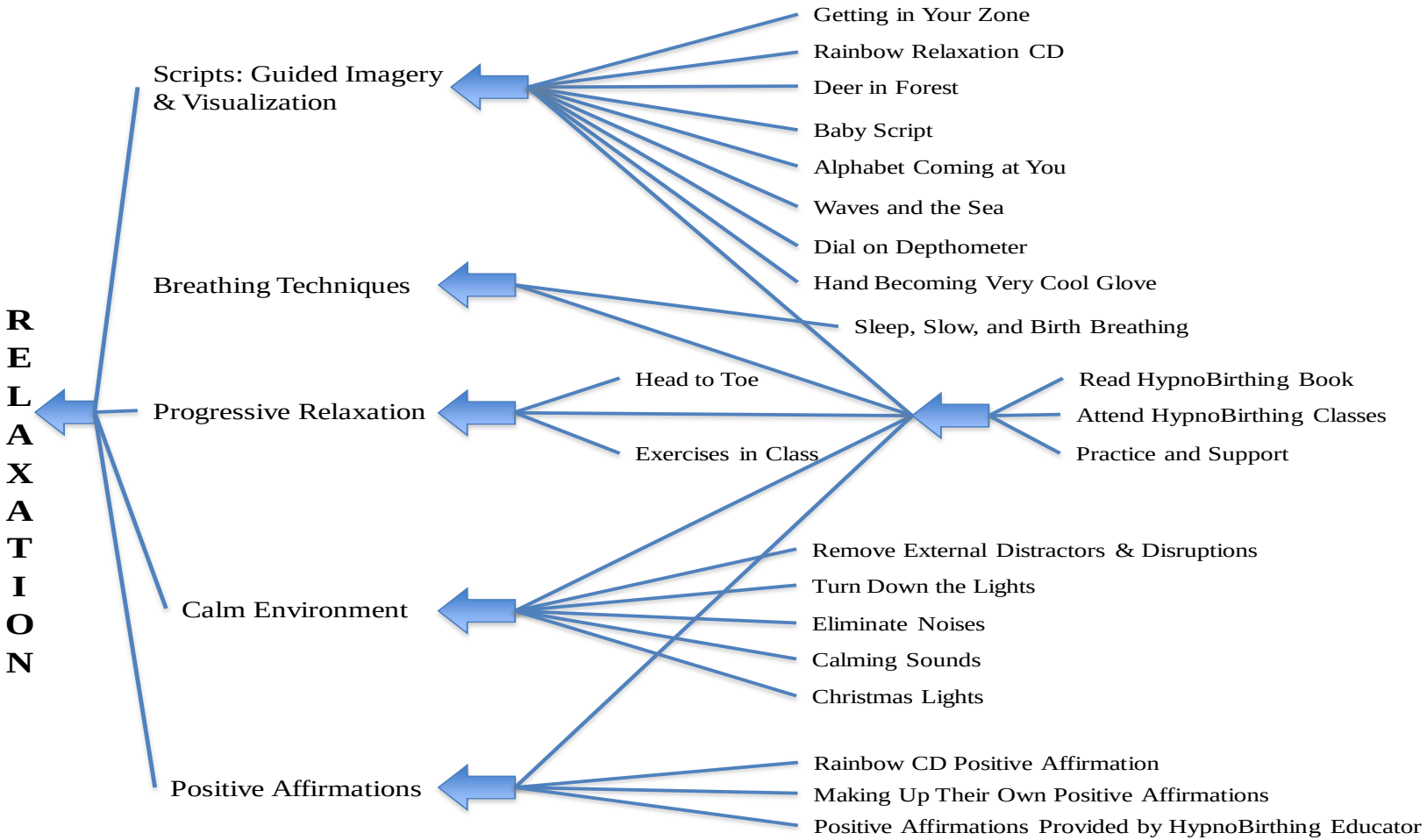
Type of Contact: Meeting: X Place: Her home Date: 10/17/2010 Coder: JMS Informant Interview: HBB1

Pick out the most salient points in the contact. Attach theme or aspect to each point.

LINE	SALIENT POINTS	THEME DOMAIN
39	The only thing that I regret was because I was doing the classes alone	Difficult Time
181	I didn't want to use drugs.	Natural Birth
32	This other girl had told me how HypnoBirthing had helped to with the fear and I wanted that too.	A Calm & Peaceful Birth
63 64 65 201	The breathing. Relaxing at night. Just being calm, relaxed. Just the relaxation that was the most important piece of it. I did follow the birth plan in the back of the book almost did everything. I did walk around, I did take a shower and I did you know a lot of those things that I wanted to do.	Perinatal Practices
37	I think that a lot of the prep work and the videos we watched and all of just seeing how natural of an experience it is and reading the book and all of that helped me to have the birth experience that I wanted to have.	HypnoBirthing Experience
157 230	They (health providers) were very supportive. Having his me (father of baby) support meant a lot to me. One thing I struggled with was a lot of negativity from my family, co-workers and my friends.	Support

197 I always talked to him (baby).	Communication
182 We (baby) connected right away. 226 I think it did in a good way I think he (father of baby) was really supportive with what I wanted to do.	Bonding
183 It wasn't medically driven. It was mommie driven. 190 I was the one in control and um I guess determining how things were going to go was my own determination that helped me have that experience for him. 205 I did you know a lot of those things that I wanted to do. I guess that is part of the mommie driven thing too.	Control
208 I was ready. I was prepared for whenever. I wasn't afraid at all. I was excited.	Eliminate Fear
213 It is very empowering.	Gained Coping Skills

APPENDIX J: PERINATAL PRACTICE ON HOW WOMEN RELAX



APPENDIX K
Informative Detail of Relevant Research

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
1. Beebe, K.R., Lee, K.A., Carrieri-Kohlman, V. & Humphreys, J. (2007). The effects of childbirth self-efficacy and anxiety during pregnancy on prehospitalization labor. *JOGNN 36*(5), 410-418.	Describe levels of trait anxiety, childbirth specific anxiety and self-efficacy for nulliparous women during the late third trimester. To describe levels of pain in nulliparous women in early labor prior to hospitalization. To describe labor management strategies used by nulliparous women before admission. To examine relationships among perinatal biopsychosocial factors, length of labor at home prior to admission and cervical dilation.	Convenience Sample 35 women with partners More than or equal to 38 weeks gestation Enrolled in a childbirth education class-no information on the childbirth classes, type, number of sessions, educator etc. English speaking Ages 18-40 years Would allow access to her medical records Anticipated spontaneous vaginal birth and was delivery in one of the two selected sites	Descriptive, Longitudinal, Correlational Quantitative Interview data analyzed using content analysis. Theoretical Framework Biopsychosocial Model	Speilberger State Trait Anxiety Inventory (STAI-T) .78 Prenatal Self-Evaluation Questionnaire II (PSEQII) 3 of the 7 scales, Labor preparation, Fear and Control, Care for Self and Baby. .73-.92 Childbirth Self Efficacy Inventory (CBSEI) .85-.95 SF-MPQ adapted MPQ Concurrent validity Interviews for demographic information face validity sought.	Higher the anxiety scores the less confident in her ability to perform relaxation and coping techniques. The greater the prenatal anxiety was the greater her pain was in labor. Women who used more cognitive coping strategies the lower the pain scores were during pre-hospitalization. Women who used more behavioral coping strategies stayed home longer in early labor. Need more labor comfort interventions, importance of psychosocial state of women, and the laboring environment.	Strengths: Explained the procedures used in the study. Cronbach Alphas were provided for all instruments and they had reliability established. Inter-item correlations. Pearson Product moment correlations T-tests and ANOVA to test for group differences Limitations: Women attended any childbirth education classes. No criteria or controls.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
2. Berman, R. O. (2006). Perceived learning needs of minority expectant women and barriers to prenatal education. *The Journal of Perinatal Education, 15* (2), 36-42.	To identify the perceived learning needs for pregnancy, childbirth, and the postpartum period and explore barriers to attending prenatal education classes	Convenience sample one clinic N=59 women, 55 foreign-born, 45 Latin American Countries, 70% Spanish primary language, majority married, average age 27.1 years. First pregnancy for one third of them	Descriptive Exploratory Quantitative Theoretical Framework Adult Learners Macolm Knowles	Perceived Barriers Survey No reliability information provided. Learning Needs Survey no reliability information provided. Content validity expert faculty member. Surveys were then translated to Spanish.	Needs of minority populations may not be met. 80% want teachers from their culture not just fluent in language. 76-81% wants fathers to attend. Incorporate relevant cultural practices. Barriers: childcare, transportation, costs, timing of classes. Preferred methods: lecture 54.2%, Video 50.8%, Demos 39%, Written materials 23.7%, Group classes 18.6%. Early topics: discomforts 57.6%, Nutrition 50.8%. Late topics: taking care of self after birth 55.9%, pain reduction 54.2%, normal labor & birth process 44.1%, breast feeding 39%, infant care 39%. 61% healthcare providers provide accurate information.	Strengths: Provided statistical information instead of vague terms. Research on minority groups was lacking in this topic area. Women from 45 countries were represented. Weaknesses: no reliability reported on the instruments used to collect data

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
3. Brown, S., Douglas, C., & Flood, L. (2001). Women's evaluation of intrapartum nonpharmacological pain relief methods used during labor. *Journal of Perinatal Education, 10(3),* 1-8.	Determine which non-pharmacologic pain-relief techniques laboring women used the most often in labor, were taught in their childbirth classes, and whether they were effective techniques. Everyone was taught relaxation, breathing, position changes, and massage. Aromatherapy was not taught.	Convenience sample 11 were in the pilot study, 90 surveys mailed with 46 returned. 37 primiparas, 9 multiparas. mostly Caucasians, 20 to 30 years old, 93.5% married. 10 randomly selected Lamaze certified childbirth educators for the childbirth classes selected from a list provided by Lamaze International. No information on the CB classes.	Retrospective descriptive design Quantitative No theoretical framework	Survey of 40 items. Survey developed by the researchers. Pilot used to test instrument. No reliability or validity information provided. Participants had to indicate if techniques were taught or not taught and then rank the effectiveness and indicate if they were used in labor.	Partner provided major support. Breathing listed most effective tool with relaxation, acupressure, and massage in that order. Majority read books and magazines in addition to the classes. Childbirth educators, nurses and healthcare providers need to provide comprehensive teaching and assistance with techniques for pain management. More research needed on pain management techniques and how to teach self-help measures. Half of the group did not have confidence and had fear going into the experience.	Strengths: Pilot study was done. Weaknesses: No reliability or validity information on the survey. Poor return rate on the survey leaving questions unanswered on the benefits of attending the classes..

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
4. Bryan, A. (2000). Enhancing parent-child interaction with a prenatal couple intervention. *MCN, 25(3),* 139-145.	To determine the effect of a prenatal couple group intervention on parent-child interaction post-birth. Hypothesis: Treatment group couples would have higher scores in post-birth parent-child interaction than control group couples.	Convenience sample with self-selection to the treatment group N=35 couples Control N=42 couples, Women mean age 25,Men mean age 28 96% Caucasian Treatment group had 23% unmarried couples vs control group had 3%, p=0.01 Power analysis needed 50 in each group Community CB classes 5 to 12 hours. No info on educators. Class content childbirth process, relaxation, breathing, pain management, complications, tour, medical care, 2 hours infant care class & Breastfeeding 3 more hours for treatment group	Quasi-experimental Quantitative Theoretical framework Transition-theory Transition to parenthood is a major developmental change for the couple and the individual parent.	NCATS scale 0.76 to 0.87 reliability established Cronbach alpha No validity information other than it has been established.	T-tests and NCATS scores Hypothesis was supported. Positive affect on parent-child interaction occurred in the treatment group over the first year or longer. Evidence for expansion of parenting in childbirth education programs. Nursing interventions should be directed to the couple not one individual parent because it can cause conflict when one is more informed or knowledgeable.	Strengths: Used a theoretical framework Confounding variables were analyzed using ANCOVA Nursing Child Assessment Teaching Scale (NCATS) had reliability. Weaknesses: Convenience sample, non-randomization, small sample did not meet power analysis numbers 23% couples in treatment group were not married vs 3% in control group

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
5. Charles, A., Norr, K., Block, C., Meyering, S., & Meyers, E. (1978). Obstetric and psychological effects of psychoprophylactic preparation for childbirth. *American Journal of Obstetrics and Gynecology 131(1)*, 44-52. Seminal Study	To examine the psychological and obstetric effects of women using the psychopro-phylactic method for childbirth.	Convenience sample 249 women from a large teaching hospital in a major metropolitan area. 95 women in the prepared group 154 women in the control group C-section births and women whose babies died or were in distress were excluded Unwed mothers were avoided. Women attended any Lamaze class. No specifics were provided.	Descriptive Study Correlation Quantitative Theoretical Framework none	Interviews 1 to 3 days postpartum Self-administered questionnaire on demographics, attitudes, pain and pleasure of labor and delivery. Robinson & Shaver Attitude Scales Medical records No reliability or validity on questionnaire or attitude scale.	Significantly lower levels of pain, greater effective control of pain, and higher levels of enjoyment were found in the prepared group. Parity, socioeconomic status and psychological attitudes did not have a significant effect. No significant obstetric differences in the two groups except for less use of analgesia and anesthesia in the prepared group. Substantial psychological benefits and no disadvantages for the prepared group were determined.	Strengths: Weaknesses: Convenience sample, no reliability or validity listed for scale. Prepared group attended any Lamaze classes. 96% of the prepared group was private patients and 4% were public, 72% of the control group was private patients and 28% were public. 23% failed to complete the questionnaire. Sample unequal

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
6. Corwin, A. (1999). Integrating preparation for early parenting into childbirth education: Part II- A study. *The Journal of Perinatal Education, 8*(1), 22-28.	To test the effectiveness of using a broad conceptual-ization of childbirth education that includes parenting preparation in pregnancy. Hypothesis; Parents participating in the expanded childbirth education program will show a significant increase in parenting knowledge as measured by a Prenatal Parenting Scale than did parents in a traditional childbirth education program.	Randomized couples Exclusion criteria established 48 total couples 66.7% Intervention group had expanded classes 54.2% Control group traditional class 70.8% Intervention group 4 yrs college 66.7% Control group 4 yrs college 41.7% Intervention group had > $60,000 income 20.8% Control group > $60,000 income Childbirth classes traditional full series at one hospital, no information on number, time, or certification of the educator	Quasi – Experimental Quantitative Theoretical Framework Theory of the Parent Infant Relationship.	Pre-postnatal administration of the Prenatal Parenting Scale which was by the researcher. Pilot study was done, reviewed by experts and revised. No reliability was provided.	Pre-test both groups 75% items were answered correctly. Post-tests in the intervention group were all higher than the pre-test. The control group had the same score or scored lower on the post-test. There was a significant difference between the two groups (p=.01) and the study hypothesis was supported. t-test for comparison of the two tests.	Strengths: Used a theoretical framework with assumptions. Pilot study done to develop the scale. Weaknesses: Homogenous groups, small sample, and findings are not generalizable. 70.8% of the intervention group and 66.7 % of control group had a 4 year college degree. Small group size of N=24 in each group. Bias from the test itself being a form of intervention. No reliability for scale.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
7. Fisher, B., Esplin, S., Stoddard, G., & Silver, R. (2009). Randomized controlled trial of hypnobirthing versus standard childbirth classes: Patient satisfaction and attitudes towards labor. *American Journal of Obstetrics & Gynecology, Supplement* doi: 10.1016/j.ajog.2009.10.140	To determine if hypnobirthing prepares women for the pain of childbirth compared to a standard childbirth education class series. To determine if attendance at a hypnobirthing course has positive satisfaction with: the childbirth experience and caregivers. To determine if attending a hypnobirthing course decreased the anxiety associated with labor.	38 women No information provided on the demographics but age, parity, and gestational age were stated to be similar at the time of course enrollment. 21 women completed a standardized childbirth class and at a minimum of one survey 17 women completed the hypnobirthing childbirth course and at a minimum one survey	Prospective randomized controlled trial	Information was not provided on the name of the survey used and the validity and reliability. Surveys were completed at the conclusion of the childbirth preparation courses and the childbirth. The surveys measured the attitudes that women had regarding the use of the coping mechanisms, roles of their partners and the nurses, and anxiety levels.	The hypnobirthing group perceived a greater ability to cope during childbirth after the completion of their childbirth course than the standard childbirth course. The hypnobirthing group had poorer recall of labor coping skills than the standard class group. Route of birth, birth weights, Apgar scores, epidural and analgesic uses were not significantly different. These were not described. Coping skills during labor were not perceived to be more effective than conventional childbirth classes.	Strengths Unable to determine strengths with the information provided in the report. Weaknesses The standardized childbirth class was not explained as to the type, number of classes, and whether the CBE was certified. The same is true for the hypnobirthing course. The demographics are not provided for either group. Information regarding the survey and completion not specific.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
8. Hardin, A. & Buckner, E. (2004). Characteristics of a positive experience for women who have un-medicated childbirth. *The Journal of Perinatal Education, 13(4),* 10-16.	Identify characteristics of a positive birth experience in women who have chosen to have an un-medicated birth.	Convenience sample of 17 postpartum women who did not use any medication for the labor and birth and volunteered to be in the study. Additional finding was they all attended non-hospital-based childbirth preparation classes to prepare them for an un-medicated childbirth. These included Lamaze, Bradley, and blended methods.	Descriptive study Qualitative Theoretical Framework Social Support	Interview questions asked by one interviewer over 30 minutes to one hour. Themes identified.	Some nurses did not provide physical or emotional support as anticipated from attending classes. Being able to move about in labor, have some influence on the environment, and maintaining control were all part of having a positive birth experience. Factors related to a positive birth experience were preparation, physical comfort, emotional support, and the ability to maintain control over the birth experience. Techniques utilized the most: walking, focusing inward, hip rocking, counter pressure on the sacral area of the back	Strengths: Patients perceptions of the nursing care to what they were taught in their classes Weaknesses: Convenience sample of women who delivered in the last 12 months. No control over the classes A qualitative study should have the rigor explained in depth and it was lacking. How was the data handled, analyzed, and the emergence themes etc. was not explained.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
9. Harmon, T.M., Hyman, M.T., & Tyre, T. (1990). Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education. *Journal of Consulting and Clinical Psychology, 58(5),* 525-530. Seminal study for use of hypnosis in birthing	To determine if there are beneficial affects using hypnosis as an adjunct to childbirth education. Hypothesis: 1. Women in the hypnosis group would have better outcomes than women in the control group. 2. Highly susceptible women in the hypnosis group would have the best outcomes relative to the other three groups.	Convenience sample referred by 5 personal physicians Random assignment of women, blind ratings 60 Nulliparous white women ages 18-35 Treatment group: had hypnosis that supplemented their regular 6 childbirth classes. Control Group traditional childbirth education classes and use of a relaxation tape made by Elizabeth Bing. Women attended 6 CBE classes plus the treatment or control exercises. Physicians provided the classes.	Quasi-experimental Factorial design – high and low susceptibility to hypnosis was crossed with hypnosis and control group. Quantitative Neodissociation Theory	1.Pain threshold IPT 2. MMPI pre and post birth 3. Apgar scores 4. Pain ratings of labor and delivery McGill Pain Questionnaire 5. Duration of Stage 1 and Stage 2 labor.	Hypnosis group had shorter stage 1 labors, used less medication, infants had higher Apgar scores, and the women had more frequent spontaneous vaginal births. High susceptible women to hypnosis had less postpartum depression. Hypnosis has some value in the preparation for labor.	Strengths: Factorial Design Use of theory Weaknesses: Self-motivated and self-selective group agreed to participate. Everyone received twice the amount of childbirth training than usual. McGill Pain scale reported as good reliability and validity. There was not any data reported on any of the measurement instruments.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
10. Koehn, M. (2008). Contemporary women's perception of childbirth education. *The Journal of Perinatal Education 17*(1), 11-18.	To explain and understand contemporary women's perceptions and experiences of childbirth education classes.	Purposive sample 9 married, pregnant, Caucasian, English speaking women mean age 26.3 years, all para 0, eight gravida 1, and one gravida 2. First time to attend childbirth classes. Eight attended 6 classes with childbirth information, variations in infant care, postpartum care, and breastfeeding. No mention if educators were certified or where the classes were held.	Grounded Theory Design Qualitative Theoretical Framework Maternal Task of Pregnancy and Psychological Adaptation Theories: Reva Rubin Regina Lederman Ramona Mercer Mid-range theory of Experiencing Transitions Proposed Emergent Theory of Negotiating the Journey to Motherhood	Interviews were taped. Data was analyzed using constant comparative analysis. Open coding, selective coding and theoretical coding used. Obtained data saturation.	Childbirth education classes contextually located within the larger process of transitioning to motherhood. Basic psychological process of Negotiating the Journey. Three themes identified within this: Exploring the unknown, Making it real, and Sensing the readiness. Completing classes had a positive effect on readiness for childbirth. Not attending classes had a negative effect on readiness for childbirth. Husband wife bonding occurred during the classes. All had read, questioned, listened, and sought information on birth before the classes.	Strengths: Experienced researcher in childbirth education. Trustworthy-ness was established using Lincoln & Guba's criteria. Weaknesses: Homogenous sample. All Caucasian women, middle to upper class and having their first baby. Limited information on the class series, educators, setting, and timeframe.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
11. Leventhal, E.A, Leventhal, H., Shacham, S., & Easterling, D.V. (1989). Active coping reduces reports of pain from childbirth. *Journal of Consulting and Clinical Psychology, 57(3),* 365-371. Seminal Study	To evaluate distress reduction as a function of two variables: participating in childbirth classes using the Lamaze method and instructions given to women to monitor the sensory features of their contractions upon admission to the labor unit. Report covers two studies with the same purpose and researchers.	Convenience Sample 89 normal pregnant women started the program. Random assignment to monitoring group. Lamaze group self-selected by attendance at classes. Data was analyzed for 48 subjects in first study and 29 in second studies. Loss of subjects due to procedural errors and use of paracervical blocks in labor. Treatment given to one group upon admission to the hospital The other group participated in local Lamaze classes. No Lamaze class information or certification of the educator provided.	Quasi-experimental Quantitative Theoretical Framework Physiological and psychological responses to noxious stimuli	Two residents taught the control group to monitor their contractions and to focus on them. Open ended questionnaire was used 8 to 18 hours postpartum to collect data about the births. 21 point scale was used to learn about fear, sadness, energy, tiredness, and pain.	Lamaze prepared group had less fear, sadness, pain, tiredness, and had more energy than the group taught to monitor their contractions upon admission to the labor unit. Lamaze group coped better with the labor event because of the accurate information given to prepare them for the event and they had expectations that matched this.	Strengths: Early study Weaknesses: Self-selection of the Lamaze class participants. Lack of accounting for other variables that may have impacted the groups. Lamaze classes were not assessed for quality or likeness. Not a true experimental study as labeled. No reliability or validity on the questionnaire listed in the report.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
12. Lu, M.C., Prentice, J., Yu, S. M., Inkelas, M., Lange, L., & Halfon, N. (2003). Childbirth education classes: Socio-demographic disparities in attendance and the association of attendance with breastfeeding initiation. *Maternal and Child Health Journal 7*(2), 87-93.	To examine whether socio-demographic disparities exist in attendance of childbirth education classes. To examine whether attendance of childbirth education classes is associated with increased likelihood for initiating breastfeeding.	National Survey of Early Childhood Health representative sample of children ages 4-35 had 1540 mothers demographic data extracted from that study who met the criteria for this study.	Descriptive Correlational Quantitative Theoretical Framework None	Telephone interviews asking if they attended childbirth classes. Co-variates included race-ethnicity, education, income, marital status, and maternal age.	75% of the college educated, Caucasian, middle class, and married attended classes. Women who attended childbirth classes had a 75% increase to breastfeed. Barriers to classes included: inadequate prenatal care utilization, transportation, , inconvenient hours, cultural or language barriers, ambivalence about the pregnancy, and lack of partner or family support.	Strengths: Large sample size. Research needed on minority populations. Weaknesses: Limitations due to the type of the design.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
13. Maestas, L. M. (2003). The effects of prenatal education on the beliefs and perceptions of childbearing women: 2000 Virginia Larsen Research Grant Winner. *International Journal of Childbirth Education, 18* (1), 17-21.	To explore the effect of prenatal education on women's beliefs and perceptions of childbearing.	Convenience sample 57 women from 10 different prenatal classes taught by 7 instructors certified by the International Childbirth Education Association (ICEA). Mean age 26 years, range 19-37. Most of the women were married, Caucasian, and primigravida. Mean of 15 years of education. 74% planned an un-medicated birth.	Descriptive Study Quantitative Data No Theoretical Framework	Utah Test for Childbearing Year, a 64 item survey using four different scales: Fear of the childbirth process, Childbearing Locus of Control: Reliance on Powerful Others, Passive Compliance vs Active Participation in Childbirth Care Decisions, Personal Values about Childbearing and Childrearing.	42 women completed the scales before prenatal classes and then after prenatal classes. In this group Fear of the childbirth process $p<.05$ and Passive compliance vs. Active participation in childbirth care decisions $p<.02$ decreased significantly from the pretest and the posttest.	Strengths: Provides some discussion on the use of the scale and scale development. Weaknesses: Article says the scale has reliability and validity but no data were presented from this study or others to confirm it. How participants were chosen for the study was not explained. Dropout rate was 15 women which was large.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
14. Martin, A., Schauble, P., Rai, S., & Curry, R. (2001). The effects of hypnosis on the labor processes and birth outcomes of pregnant adolescents. *The Journal of Family Practice 50*(5), 441-443.	Does childbirth preparation incorporating hypnotic techniques affect the labor processes and birth outcomes of pregnant adolescents? No hypothesis	Randomly assigned 42 pregnant teenagers under 18 years from county health department 22 in hypnosis childbirth treatment group had 4 sessions with childbirth information and hypnosis to build trust in the women's physicians and for the women to have greater self-confidence. Birth was viewed as a normal process. 20 in control group received supportive counseling and childbirth information only.	Quasi-experimental Random assignment Both groups received standard prenatal care.	Frequency statistics were identified for the two groups. Comparisons were made on the use of medications during childbirth including: Pitocin, anesthetics, and postpartum medications. Additionally the groups were assessed for complications and surgical interventions during birth, length of hospital stay for mother, and admission of infant to NICU.	No surgical intervention in hypnosis group, 12 in control group. Less medications used in hypnosis group for pitocin, 2 vs 6, anesthesia 10 vs 14 postpartum meds 7 vs 11, fewer NICU admissions 1 vs 5 Complications 12 vs 17 Hypnosis can be useful for promoting comfort, & control with a reduction of medical interventions during labor and birth and shorter hospital stays for mother and newborn.	Strengths: Results significant even with a small group. Weaknesses: Small number of participants. One of the researchers performed the intervention in the hypnosis treatment group-potential bias

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
15. McKinney, D. (2006). A qualitative study of the Bradley Method of Childbirth Education. *IJCE, 21* (3), 26-29.	Identify the experiences of women who have used the Bradley Method of childbirth education for their birth experience.	Criterion based sample Purposive 15 couples recruited from an online discussion broad email interview Inclusion criteria: Had attended Bradley childbirth education classes and used the Bradley Method for the birth of one or more children in the United States with a wide variety in experiences and ages. No information on the educators or the Bradley Childbirth classes.	Grounded theory Qualitative Theoretical Framework None Constant Comparison used for analysis, identified themes and categories	Email Interview	5 themes emerged 1. Role of spouses or partners dominant. 2. Concept of Natural Childbirth: control and freedom to choose comfort measures of choice. 3. Importance of relaxation and preparation: self-adequacy and empowerment. 4. Quality of materials: referred to outdated materials, teachers were liked. 5. Relationships formed with caregivers: mixed reactions regarding caregivers. Loss of empowerment when the women had no or limited choices. Empowerment: knowledge to make informed decisions has control over the experience, and the support person is included.	Strengths: Rigor in using member checks and colleagues for validation. Weaknesses: Bias with only people having positive exp. may respond. Refers to generalizing which is inappropriate for a. Uses vague terms such as most, etc. instead of exact qualitative study. Does not address transferability statistics.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
16. Monto, M. (1996). Lamaze and Bradley childbirth classes: Contrasting perspectives toward the medical model of birth. *Birth, 23*(4), 193-201.	Identify the contrasts between the perspectives of Lamaze and Bradley childbirth classes toward the medical model of birth.	Purposive sample of women enrolled and attending Lamaze and Bradley childbirth education classes. 31 primigravidas Lamaze mean class size 8 Bradley mean class size 6 Homogenous group of upper-middle class women with 2/3 having a college degree, and 25 of 31 women were white non-Hispanic.	Exploratory Descriptive study Qualitative Theoretical Framework none	Self as instrument Participant Observations Field notes during classes Qualitative Interviews 4 series of each method, Lamaze two are hospital based, one private business, Bradley two private homes, one doctor's office, one private hospital	Bradley Classes were alike in content, advocated drug free births, being non-supportive of the medical model, supportive of home births, and used lay midwifes. Lamaze classes promoted confidence and working within the medical and hospital system. Content on alternatives: varied in both classes according to the childbirth educator and their attitude. One instructor advocated cesarean births and 7 of her 8 participants had one. Bradley class participants had distrust of medical community. The educators affected the attitudes of the women.	Strengths: Provides insight into the contrasting perspectives that women receive based on the method of childbirth education class they attend and the educator that teaches the classes. Weaknesses: Self-selected sample to the type of childbirth education class. Homogenous group of upper-middle class women with 2/3 having a college degree, and 25 of 31 women were white non-Hispanic.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
17. Nichols, F. (1992).The psychological effects of prepared childbirth on single adolescent mothers. *The Journal of Perinatal Education 1*(1), 9-13. Seminal study	To determine the psychological effects with an adolescent who attended prepared childbirth classes: desire to participate in the experience, active participation in childbirth, childbirth satisfaction, and self-esteem after childbirth. 5 Hypotheses	Recruited 49 teens with 26 primiparous teens completing the study. Random assignment to groups. 16 women were in the experimental group 10 women were in the control group Experimental group mean age was 16.8 Control group mean age was 15.9. Attended at least 5 of 6 two hour weekly Lamaze classes with a certified Lamaze educator.	Experimental Pilot Study using pre-post-test control group design Quantitative Theoretical Framework Conceptual Model Psychological Effects of Prepared Childbirth Power analysis minimum sample size needed was 30.	Questionnaire pre and postnatal Rosenberg Global self-esteem scale .92, Prenatal Attitude Toward Childbirth Preparation Scale .62 & .73.8 Labor Agency Scale .86 Delivery Agency Scale .81 Labor Delivery Evaluation Scale .82.	Hypotheses were not supported. Post Ad Hoc analysis was done for explanation of the reasons. 87% experimental group: prepared childbirth techniques selected as most helpful for labor. 90% control group: indicated "other" which was the epidural block. Results from the attitudinal scales did not match the verbal descriptions from the interviews. Adolescents viewed what they learned in the classes was more helpful than the nurse caring for them in labor and delivery. Standard Lamaze classes did not meet the needs of adolescents.	Strengths: Design Much needed research on adolescents. Tools had good reliability and construct validity. Implications for future research that was presented. Weaknesses: Small sample size of 26 women. Lost participants when they decided to take the classes but were assigned to the control group.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
18. Regan, M., McElroy, K., & Moore, K. (2013). Choice? Factors that influence women's decision making for childbirth. *The Journal of Perinatal Education, 22*. 171-180. Retrieved from http://dx.doi.org/10.1891/1058-1243.22.3.171	To identify factors influencing the decision making process women used for birthing decisions.	Sample was self-selected from the recruitment fliers distributed in multiple places in one midwest city. 13 focus groups with 3 to 6 low risk primigravida women in each group that met for 1 ½ hours during a 12 month period. Women participated in only one focus group. Private setting was used for the meetings and the interviews were conducted by telephone. Women from the focus groups each had one postpartum interview within the first six weeks postpartum.	Mixed Methods Qualitative The quantitative information was not presented in this article except for the demographics.	Projective test women made up stories about a picture of a birth. Focus groups, postpartum interviews	45% of the women knew what kind of birth they desired before they became pregnant. 65% preferred to have natural birth. Four categories were identified to be influential for the choices women made for birth: birth stories or attending a birth, childbirth education classes, healthcare provider, and written sources. Bradley was the chosen method for natural childbirth. 71 % were influenced the most about birth stories or attending a birth.	Strengths: Triangulation Weaknesses: Women had a median income of $95,000 and 30 out of 52 women had master's degrees or higher, 30 women were Caucasian, 20 women did not attend any childbirth classes

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
19. Risica, P. M. & Phipps, M. G. (2006). Educational preferences in a prenatal clinic population. *International Journal Childbirth Education 21*(4), 4-7.	To assess the types of media access available and the preferences for delivery of educational materials in a low-income prenatal clinic population and identify topics of importance to women seeking prenatal care.	Convenience sample of women attending a prenatal clinic. 139 pregnant women, median age 23 years range 15 to 40 years, median gestational age 28 weeks with a range 4 to 41 weeks, 60% were primigravida	Exploratory Descriptive Pilot Study Quantitative No Theoretical Framework	Survey	Childbirth classes preferred by 19% of the population. 72% preferred to get information from a healthcare provider. Topics they wanted were eating well 64% staying fit 59% 47% wanted breastfeeding information, smoking cessation 9%, gestational diabetes 16%, genetic testing 22%, Newborn care 54%, symptoms of labor 52.5%, managing siblings, working as a mother, comfortable sleeping methods, depression during and after pregnancy, circumcision care, induction, medication use during pregnancy, and premature labor	Strengths: Research looking at disparities is needed. Weaknesses: Sample from one clinic, which serves a low income population group. No information on the survey development, testing, reliability or validity.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
20. Schachman, K., Lee, R., & Lederman, R. (2004). Baby Boot Camp: Facilitating Maternal Role Adaptation Among Military Wives. *Nursing Research 53(2),* 107-115.	To determine if an intervention class including strategies and content to help with maternal adaptation would be beneficial for the new military mother. Hypotheses: Military wives who participate in BBC will have greater prenatal and postpartum adaptation as well as greater perception of external and internal resources immediately after the intervention and at 6 weeks postpartum than those who participate in traditional childbirth education classes.	Convenience sample Randomized clinical trial with random assignment BBC classes or traditional CBE Primiparous women 32 to 37 weeks, 18-28 years old, married to active duty military men 44 in Baby Bootcamp (BBC) 4 weekly 3 hour CBE classes with 1 additional hour for BBC information 47 (CBE) group 4 weekly classes with 3 hours of additional classes. CBE met once a week, traditional childbirth breathing, relaxation, prenatal health, obstetric procedures, newborn appearance and care.	Intervention Study Quantitative Theoretical Framework Roy Resilience Model Lederman's Maternal Role Adaptation	Prenatal Self-Evaluation Questionnaire .83 to .94, Postpartum Self-Evaluation Questionnaire .87 to .93, Personal Resources Questionnaire. Resilience Scales .86	Hypotheses supported. Maternal Role Adaptation: greater in BBC group after class and at 6 weeks postpartum, Internal resources significant differences. Greater perceived social support in BBC group and sense of mastery and accomplishment in their labor and delivery. Additional time may be needed in childbirth education classes to include information to build confidence, implement interactive strategies, and identify resources to help promote satisfaction and maternal adaptation.	Strengths: Design, instruments have reliability and validity. Weaknesses: Strategies used for BBC may account for the benefits versus the information provided. Reliability not listed for the Resources Questionnaire.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
21. Scott, J. & Rose, N. (1976). Effect of psychoprophylaxis (Lamaze preparation) on labor and delivery in primiparas. *The New England Journal of Medicine, 294*(22), 1205-1207. Seminal Study	To determine if prepared childbirth classes have benefits and no adverse effects.	Convenience Sample from one hospital Treatment group: 129 primiparous women, who completed Lamaze Class preparation classes. Control group: 129 primiparous women with no Lamaze class preparation	Comparative descriptive study. Quantitative No Theoretical Framework	Numerical count was made of the outcomes, percentages calculated and statistical significance of the data was evaluated by the t-test and chi-square test. Use of narcotics, anesthesia, spontaneous vaginal deliveries, length of labor, number of maternal complications, and frequency of fetal distress, mean Apgar, and neonatal problems were measured.	The Lamaze group used fewer narcotics during labor ($P<0.001$), Received conduction anesthesia less often ($P<0.001$) and had a higher frequency of vaginal deliveries ($P<0.001$). No effect on length of labor, number or type of maternal complications, frequency of fetal distress, mean Apgar score or neonatal problems.	Strengths: Control group participants matched to the Lamaze participants. Weaknesses: Women self-selected to attend Lamaze classes. No standardized Lamaze class. Women could attend any Lamaze class series.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
22. VandeVusse, L., Irland, J., Healthcare, W., Bemer, M., Fuller, S., Adams, D. (2007). Hypnosis for childbirth: a retrospective comparative analysis of outcomes in one obstetrician's practice. *American Journal of Clinical Hypnosis 50* (2), 109-119.	To compare the outcomes of women using an antenatal hypnosis class series for preparation for labor with women that did not use an antenatal hypnosis class series for preparation for labor.	Convenience Sample 50 elected antenatal hypnosis class Control group of 51 women was randomly selected from a group of women that elected not to use hypnosis and had similar demographics of parity and delivery model	Exploratory Descriptive Retrospective Study	Information was collected from the women's medical records.	Hypnosis sample used less sedatives, analgesia, and regional anesthesia during labor. The newborns had higher 1 minute Apgar scores in the women using hypnosis.	**Strengths:** There was a control group with similar demographics. Weaknesses: The intervention of the antenatal hypnosis preparation class was not controlled. The hypnosis group was self-selected.

Study (APA Citation)	Purpose (Aims & Hypotheses)	Sample Description & Size	Design	Instruments	Findings	Strengths & Weaknesses
23. Zacharias. J. (1981). Childbirth education classes: Effects on attitudes toward childbirth in high-risk indigent women. *JOGN Nursing*, July/August. Seminal study	To determine the effect of childbirth education classes on high-risk medically indigent women's attitudes at city clinics in Georgia.	Convenience sample All patients high risk. Control group 30 women, 15 to 37 years old, mean age 24. Study group 20 women, 16 to 31 years old, mean age 22. No significance difference in education, income parity, or marital status. Nurse taught the classes certification in CBE not mentioned in report	Quasi-experimental Quantitative Theoretical Framework None	Questionnaire using Likert type scale Treatment variation with the focus on a positive childbirth experience shared with someone special	Data supported the hypothesis that women who attended the childbirth education classes, with the focus for a positive attitude, had a more positive attitude toward childbirth. Women in the treatment group viewed being in a partnership with the babies' father. Women in the control group viewed selves as being a part of the healthcare team.	Strengths: There was a control group with similar demographics. Weaknesses: Non-random assignment of the groups. The instrument was not scientifically tested. Measurement was not done after the labor and birth to see if they had a positive birth experience. No pretest was given.

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