PRIMIPARAS' EXPECTATIONS OF CHILDBIRTH:
THE IMPACT OF CONSCIOUSNESS

A Dissertation Submitted in Partial Fulfillment
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in Prenatal and Perinatal Psychology

by
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This is to certify that the proposal entitled:

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Abstract

Primiparas' Expectations of Childbirth: The Impact of Consciousness

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This study extends the research conducted among primiparas (women pregnant for the first time) by examining their expectations of childbirth in light of current scientific understandings of consciousness. The purpose of this study was to determine if primiparas' conscious *and* unconscious expectations influenced childbirth outcomes. Small qualitative studies generally indicate that pregnant women feel that their childbearing experiences differ from their conscious expectations (Gibbins & Thomson, 2001). However, quantitative research reveals that pregnant women tend to get what they expect (Green, Coupland, & Kitszinger, 1998). This qualitative research consisted of in-depth before-and-after-birth interviews with seven primiparas residing in Arizona. Their explicit expectations were compared with implicit expectations portrayed through their drawings of an ideal birth (a projective technique) together with statements made during their interviews. Although phenomenology served as the model for data collection, feminist theory, art interpretation, consciousness studies, and quantum physics each contributed to interpretation of the data. The participants in this study each experienced outcomes that differed from their conscious expectations. Indications of their unconscious expectations were evident in both their dialogues and drawings. It could be deduced that these women experienced what they *unconsciously* expected. This finding seemed to reconcile the apparent disparity between the results of smaller qualitative and larger quantitative studies. The implications for expanding the awareness of consciousness into the realms of pregnancy and childbirth are far-reaching, potentially enhancing the lives of mothers *and* babies while improving the quality of education and services designed to reach this vital and vulnerable population.

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Chapter I: Introduction

Pregnant women wait in anticipation for nine months, with a variety of thoughts and emotions, sometimes eagerly expecting the uncomplicated births of their healthy babies. Many times, however, pregnant women experience fear that the pain of giving birth will be unbearable or that something will go wrong. Gibbins and Thomson (2001) report that "all women seem to develop expectations of childbirth and the kinds of expectations vary among women, as does how realistic they are" (p. 302). Indeed, pregnant women express opposing feelings about giving birth (Gibbins & Thomson, 2001; Green, Coupland, & Kitzinger, 1998; Ip, Chien, & Chan, 2003; Raphael-Leff, 2001). In their psychosocial textbook *Development through Life*, Newman and Newman (2006) state, "In most normal pregnancies, women experience anxiety and depression as well as positive feelings of excitement and hopefulness" (p. 115).

For this dissertation I conducted a phenomenological study of a small sample of American women pregnant for the first time (primiparas) to address their expectations prior to giving birth and to assess their experiences after giving birth. Where small qualitative studies exploring the expectations of pregnant women have been conducted outside the United States (Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996), phenomenological research of American primiparas has been virtually absent from the literature (one notable exception was a longitudinal study conducted in 1991 by Simkin who included unstructured interviews). Instead of simply replicating other small qualitative studies like those performed by Gibbins and Thomson (2001) of England and Halldorsdottir and Karlsdottir (1996) of Iceland to determine if a similar study performed in the United States would yield the same or different results from those conducted in other countries, I went beyond other phenomenological research by bringing the current

understanding of consciousness to bear on my results. I chose to include a projective device as an additional source of information that had the potential to reveal both conscious and unconscious thoughts and feelings. In addition, I called upon my background in Women's Studies to approach the study as a feminist researcher. Therefore, my investigation adds to the body of knowledge in the field of prenatal and perinatal psychology expanding existing phenomenological research that examines the expectations of pregnant women by gathering data from first-time pregnant women in the United States and interpreting that data through the binocular lenses of the science of consciousness and feminist theory.

An Overview of Birth in the United States

In general, it appears that women in the United States expect to have babies in hospitals with doctors in attendance and with interventions, particularly drugs, that minimize pain and speed the delivery. This contention is substantiated by the fact that ninety nine percent of women have physician-assisted births in hospitals, a rate that has prevailed for decades (Center for Disease Control and Prevention [CDC], 2003). The cesarean section rate has reached 29.1 percent, "the highest rate ever reported in the United States" (Martin, Hamilton, Menacker, Sutton, & Mathews, 2005). It seems that the medicalization of birth has been virtually taken for granted and several generations of women have come to believe that giving birth is dangerous and, therefore, a medical procedure requiring technological intervention. A CDC National Center for Health Statistics (NCHS) News Release issued December 2, 1999 reviewed trends occurring in births from 1989 to 1997. It reported: "Electronic fetal monitoring, ultrasound, induction and stimulation all increased over the period with the most dramatic increase being the doubling of the use of induction of labor (from 9 percent in 1989 to 18 percent in 1997)"

(Key Findings, para. 4). Although the use of forceps declined, the use of vacuum extraction almost doubled. Interestingly, and perhaps contradictorily, the same report also stated that osteopathic doctors and midwives were attending more births. However, this proportion was still relatively small, under one half of one percent when the Center's 2003 report was issued.

In spite of the increasing use of medical technology the NCHS (2004) reported that the data for 2002 showed "a significant increase in the IMR [infant mortality rate] to 7.0 infant deaths per 1,000 live births [from 6.8 in 2001], the first rise in the U.S. IMR since 1958" (Supplemental Analyses of Recent Trends in Infant Mortality, Summary, para. 1). The NCHS had already reported in 1999 that the United States ranked twenty eighth internationally in infant mortality, behind other industrialized nations like Japan, Sweden, Norway, Canada, Australia, and even Cuba. A CDC/NCHS Fact Sheet released in November 2004 stated that "infant mortality rates are higher for infants of women who were *born* [italics added] in the United States, compared with women born outside the United States" (Patterns in Infant Mortality, para. 3). Referring to government statistics unheralded since their release in 2002, a 2005 *New York Times* editorial declared:

> Babies are less likely to survive in America, with a health care system that we think is the best in the world, than in impoverished and autocratic Cuba. According to the latest C. I. A. World Factbook, Cuba is one of the 41 countries that have better infant mortality rates than the United States. (Kristof, para. 2)

Some doctors are outspoken in their criticism of hospital births in the United States. For example, one naturopathic doctor reports that "home births are the best way to save money, bring the family together and save yours [sic] and your baby's life. More infections occur in the newborn and in women during postdelivery in the hospital than at

home!!" (Wallach & Lan, 1996, p. 75).

These are bold contentions. In fairness to the medical system that has come to predominate in the United States other facts need to be disclosed. In the early 1900s childbirth was extremely dangerous. According to Opdyke (2000) in *The Routledge Historical Atlas of Women in America*, "in 1915, for every 100,000 live births, more than 600 mothers died in childbirth. By 1996 the number had dropped to six" (p. 126). This can be explained by the improved health and nutrition of mothers; by the advent of antibiotics to stop infections; by better prenatal care; by the use of contraceptives to reduce the number of pregnancies and increase the space between children; and by the legalization of abortion to end unwanted pregnancies without risking the life of the mother. It was also during the early 1900s that American women discovered Twilight Sleep, a cocktail of drugs being used in Europe. Twilight Sleep was touted as a way to end the suffering of childbirth. It was women themselves who demanded that their reluctant doctors provide this anesthetic (Mitford, 1992). It is understandable, then, that women have come to rely on medical technology and pharmacology to make their deliveries safer and less painful. Nonetheless, the United States ranks behind many other countries in infant mortality. It is time to reevaluate attitudes and procedures that currently appear to be taken for granted. One way to begin would be to ask the child bearers themselves what they believe, want, and expect.

Pregnant women are bringers of new life. In a society inundated with messages of violence, disease, and death, and one that medicalizes birth because of its presumed inherent dangers, a woman might have a difficult time maintaining a positive, fearless attitude. Some spokeswomen in the fields of childbirth (Arms, 1994), cultural anthropology (Davis-Floyd, 1992), and women's studies (Mitford, 1992) have pointed to

the socialization of women as a major contributor to women's fears about giving birth. Dick-Read (1959), author of *Childbirth without Fear*, stated that "superstition, civilization and culture" (p. 39) have raised women's anxieties concerning labor. He described how fear produces muscle tension and resistance which lead to pain during labor. He proposed natural childbirth methods over sixty years ago to relieve pain while insuring the health and safety of mothers and their newborns.

Current books also address fears common among pregnant women. In a popular book (having sold over ten million copies) *What to Expect when You're Expecting* (Murkoff, Eisenberg, & Hathaway, 2002), Murkoff recounted numerous worries that she had experienced when pregnant. She reported that:

> When my symptoms, problems, or fears *were* discussed, it was usually in an alarming way which only compounded my concern. . . . I certainly couldn't find relief for my worries by opening a newspaper, flipping on the radio or television, or borrowing magazines. According to the media, threats to the pregnant lurked everywhere: in the air we breathed, in the food we ate, in the water we drank, at the dentist's office, in the drugstore, even at home. (p. xxv)

In *Fearless Pregnancy*, Clayton, Fischbein, and Weckl (2004) stated that "in an age of so much information (and misinformation), pregnant women can hardly help but be fearful . . . being bombarded with precautionary advice, admonishments, and warnings" (p. 13).

Birth has become medicalized to the degree that over 99 percent of women give birth in hospitals—institutions for treating the sick and dying. Dick-Read (1959) stated that "close investigation strongly suggests that the mind of woman is not cared for or the sensitive feelings of women in labor given due respect and attention in many hospitals and maternity institutions throughout this country" (p. 28). Decades after he identified

the lack of attention to birthing women's thoughts and feelings, laboring women are experiencing more interventions than ever. Interventions can disconnect them from their bodies, their minds, their feelings, and their newborns. In my study I listened to the thoughts and acknowledged the feelings of seven primiparas before and after they give birth. While the goals of other similar research has been to improve childbirth services, my objective has been to have my study contribute to a better understanding of childbearing women and to improve the quality of educational programs designed for this population.

Situating the Researcher

My personal experience having two children within the United States military medical system—my husband was in the Air Force—over forty years ago showed me how willingly women, in this case myself, accept common practices. I was only 17 when I had my first child. I was not encouraged to ask questions or request any different services from the ones I was offered. Indeed, I could not even entertain the idea that options were possible. I had a saddle block which not only blocks pain but paralyzes the body from the waist down for hours *after* the birth itself. I had not even met the doctor who delivered my baby because a change of shifts occurred while I was laboring. I did everything I was told including laboring *alone*. I was administered Demerol, given an enema, and shaved. An episiotomy was routinely performed without my consent. My baby was removed to a nursery for the first 24 hours after birth and brought to me only at four hour intervals once I recovered from the immobilizing effects of the saddle block. The five-day hospital stay was mandated. The same procedures were in place on a different military base two years later when I gave birth to my second child. Again, I acquiesced to "the way the things were done."

My own mother retells the story of my birth (her only child) forthrightly: she was terribly afraid; she was "prepped" (having pubic hair shaved and given an enema, customary procedures in the 1940s) and soiled the labor area, making the doctor angry; she was given Demerol, Scopolamine, and finally ether (or possibly morphine) to totally anesthetize her with the combination of drugs euphemistically called Twilight Sleep; the doctor used forceps to deliver me; my face was black and blue and my head misshapen; my father cried and asked the doctor if he had fathered a "Mongoloid Idiot"; I was placed in a nursery for nine days; Mother was unable to nurse me. She never questioned a procedure either – indeed, at 88, Mother still regrets the loss of her trusted old family doctor who delivered me.

My own birth and the births of my children seem to be somewhat representative of birth in America over the last several decades. My prenatal and perinatal studies have brought to light the lingering effects these experiences have had on me and pointed out that birth is still a relatively traumatic event for many mothers and their babies. It was my desire to understand not only why this was so, but also to join the ranks of those who sought to create birthing environments that were safe, harmonious, and a genuine expression of the peak experience giving birth has the potential to be.

My intention in conducting the research reported in this dissertation was also to combine several of my interests into one definitive project. I did not earn a Bachelor's Degree until I was 46. My earlier General Studies Associates Degree had included many courses in art. Even that interest played a role in this research (addressed in the art interpretation section of this paper). When I returned to college to complete the requirements for an undergraduate degree, I had no idea what curriculum to pursue. A counselor suggested I major in Women's Studies. That began a love for the study of the

issues that have faced women historically and those that face them today. I went on to earn a Master's Degree in Counseling and Guidance and, after an eight year career in private practice, returned to college to earn a Ph.D. In the meantime, I had been personally pursuing another fascinating field of study outside the academic arena to learn about relaxation, meditation, brain waves, and states of consciousness. I attended conferences like the "Science and Consciousness Fair" held annually in New Mexico and participated in seminars like "The Awakened Mind" presented by Anna Wise. Wise utilizes specially designed EEG equipment to help students learn to balance their brain wave states. In 1995, a trusted mentor, Dorothy Gates, Ph. D., addressing over 100 people at a seminar on stress reduction and relaxation achieved by accessing altered states of consciousness, stated, "Most of you are having difficulties because you were born in hospitals" (lecture, 1995). Several years later I discovered a new doctoral program in Prenatal and Perinatal Psychology at Santa Barbara Graduate Institute that could address Gates' statement that had generated so much curiosity in me. I wanted to know what kind of difficulties could arise from being born in a hospital and why? It is now that these areas of vital interest to me have synergistically aligned in the performance of this study. I have been able to combine consciousness studies, feminist studies, prenatal and perinatal psychology, and art as a medium for accessing the unconscious mind.

Justification for the Research

Many studies exploring the expectations of pregnant women have been conducted in other countries such as Finland, Australia, England, Iceland, Canada, China, and Sweden (Callister, Vehvilainen-Julkunen, & Lauri, 2001; Fenwick, Hauck, Downie, & Butt, 2005; Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir (1996), Hodnett,

2002; Ip et. al., 2003; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996). I found nine studies ranging from 1987 to 2004 conducted in the United States that related to my research, only one of which included transcribed interviews. I identified what I perceived as a gap in the literature with regard to studies of pregnant women's expectations: not many have been conducted in the United States; of those U. S. studies, most were quantitative in design; and the results of quantitative studies were substantively different from qualitative studies, a disparity that was not explained.

The findings of small qualitative studies have shown that pregnant women's experiences of childbirth were different from their expectations (Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996) while those of large quantitative studies have demonstrated that childbirth experiences coincided with expectations (Green, Coupland, & Kitzinger, 1990; Waldenstrom et al., 1996). When personally interviewed after giving birth, women have reported that labor was longer and harder than they hoped or expected (Gibbins & Thomson, 2001). Yet, when surveys of large numbers of childbearing women were analyzed, the results indicated that, in general, women "tended to get what they expected" (Green, 1993, p. 65). Green, Coupland, and Kitzinger (1998) found further that negative expectations were associated with poor psychological outcomes while positive expectations correlated with greater postnatal satisfaction.

Perplexed by what appeared to be contradictory findings, I wanted to explore *why* what pregnant women expected might *not* be what they experienced. I posed the research question: Were primipara's expectations of childbirth met or not? Further, I wondered: are pregnant women's expectations tied to implicitly held beliefs of which they might not be conscious? Applying a concept from the current understanding of consciousness, that is, that conscious and unconscious beliefs can differ, I was able to reconcile the

differences between these primiparas expectations and realities. I have also proposed an explanation for the contradictory findings of smaller qualitative and larger quantitative studies that each investigated the expectations of pregnant women.

In its essence, this research is synergistic, amalgamating precepts of qualitative phenomenological research design with feminism, consciousness studies, and psychological assessment by means of art interpretation. This unique combination of methods and theories could inaugurate new ways of perceiving childbearing. It may also contribute to an increased understanding of women's needs, desires, and expectations during pregnancy, labor, and delivery. New research and programs to educate this population could arise from data collected and interpreted in this innovative way.

Summary of Chapters

The introduction of this dissertation serves as Chapter I. Here I introduce the concept that all pregnant women have expectations, both positive and negative, related to giving birth. I present statistical data and situate myself in the research. I provide justification for the study and introduce subsequent chapters.

Chapter II is comprised of a comprehensive literature review. I initially define the term "expectation" and go on to present relevant research conducted in England, Finland, Sweden, China, Iceland, Canada, Australia, and the United States. In addition, each of the theoretical perspectives to be employed in analyzing the data is described and supported. These include perspectives on consciousness, art interpretation as a way to explore the unconscious mind, feminist theory, and prenatal and perinatal psychology.

In Chapter III I discuss in detail the study's methodology. I present a rationale for choosing the various methods I employed then describe the research design and associated protocols. I discuss the practice of epoche utilized throughout the research

process. I identify the population being studied along with the means I used to select participants. I state how I collected and analyzed the data and forecast the significance of the study.

Chapter IV contains a short description of the pilot study I conducted in 2004. I describe the methods I used, the participant, her responses, and what I learned that led to the methods selected for the final study. I identify which components were useful and which were not, so that certain omissions can be understood. For example, I explain why studying primiparas was significant, as opposed to studying multiparas, women who have given birth previously.

Chapter V contains case studies of the seven primiparas who participated in this study. Each woman, identified by a pseudonym, tells the story of her pregnancy, her expectations, her ideal (in the form of a drawing), her childbirth experience, and how that experience compared with her expectations. Her voice is heard through the liberal use of quotations excerpted from the transcripts. Throughout each case I identify themes that emerged from the data. I also provide a table showing the primiparas' expectations and realities and include a graphic representation of the emergent themes.

In Chapter VI I present the results of the study. It is here that I address each of the seven themes individually and collectively. I include a figure that visually represents the paradoxical nature of the themes. I interpret the drawings as expressions of the subconscious minds of each woman. I incorporate each primipara's own interpretation and add the views of two professionals who use art therapy in their practices.

In Chapter VII I discuss the results of the study. I describe the emergence of a holistic model that could enhance the understanding of primipara's lives. I identify elements of pictures that could predict successful births and suggest a way to employ drawings of

ideal births in prenatal classes. I offer an explanation for how women's expectations can differ from their realities citing research to support my conclusion. I present a variety of implications from my research, point out limitations of the study, and make a recommendation for change based on a successful model developed in the Netherlands.

Chapter II: Review of the Literature

Defining Expectations

A review of the literature relevant to pregnant women's expectations revealed that the word "expectation" is used explicitly by some researchers but is only implied by others. The word is used frequently but is rarely defined. To *expect* means to wait. It was first used as a euphemism for being pregnant in 1817. The word expectation means to anticipate, stemming from the Latin "ex" meaning thoroughly and "spectare" meaning to look (Barnhart, 1995). Considering its derivation, an expectation would be an act of looking at a prospect thoroughly. According to *The American Heritage Dictionary* (1975) expectation can suggest a quality of eager anticipation. In the studies reviewed in this chapter, expectations encompass both positive and negative elements. They can convey a sense of exhilaration and longing, or a sense of foreboding and dread. These dual expectations can be held simultaneously. It is this paradoxical blend of expectations that seems to affect most pregnant women cross-culturally. Looking at two opposing ways of expecting became a fascination and a motivation for me to conduct my research.

Within this body of literature terms used in place of, in conjunction with, or synonymously for "expectations" are preferences, perceptions, perspectives, desires, hopes, wants, needs, attitudes, beliefs, views, thoughts, and feelings. All these are important to a pregnant woman's well being and that of her unborn child.

> The course and pattern of prenatal development are guided by genetic information that unfolds in the context of the pregnant woman's biopsychosocial environment. A woman's health, her *attitudes* [italics added] toward pregnancy and childbirth, her lifestyle, the resources available to her during pregnancy, and the behavior demanded of her by her culture all influence her sense of well-being. Many of

these same factors may directly affect the health and growth of the fetus." (Newman & Newman, 2006, p. 113)

The following literature review focuses on studies dealing specifically with the various expectations of first-time pregnant women although words used in place of expectations will be noted from time to time if the studies using alternatives justify doing so. This review includes relevant research that addresses the material *and* immaterial things that pregnant women expect. An exploration of expectations seems especially appropriate in the context of childbirth—the realm in which women are indeed *expecting*.

In their book *Great Expectations*, Green et al. (1998) point out that women's expectations are formed from previous experience, from the media, from authority figures like doctors, from prenatal education programs, and from the culture in which they were socialized. The stories told by other women make particularly strong impressions. Newman and Newman (2006) note that:

> throughout the pregnancy, the expectant woman has recurring worries and fear about the childbirth experience, whether the baby will be healthy, her own well-being, and the health and well-being of her family. These fears may be accentuated if the woman has heard about problems with childbirth from friends and relatives. (p. 115)

A review of the literature from 1980 to 2002 found that most studies about women's expectations of childbirth have revolved around the researchers' particular interest such as the management of pain, various interventions, and support provided by midwives or significant others (Ip et al., 2003). The perspective of the researcher influences the focus of the study; for example, research on pain relief focuses on women's expectations that giving birth will be painful. My review, by and large,

includes those studies that focus on the women themselves and what they expect, both generally and specifically, at the time that they give birth. Although studies focusing directly on pregnant women and their expectations are essential to this review, phenomenological studies that address expectations more circumspectly are also included, as are a few larger quantitative studies that reveal significant results relevant to this research.

A Review of the Literature Exploring Pregnant Women's Expectations

Studies Conducted Outside the United States

England

While many of the studies investigating the expectations of pregnant women have been qualitative, the majority of that research has been conducted outside the United States. "Women's expectations and experiences of childbirth", published in *Midwifery* in 2001, recounts the findings of two English researchers who conducted interviews with eight pregnant women. They performed a qualitative, phenomenological study and found that the women in their study wanted to feel in control during their labor (Gibbins & Thomson, 2001). These researchers specifically explored the expectations of pregnant women, first as they prepared to give birth, and then again, after having given birth, to determine if the women's expectations had been met. The investigators' objective was "to explore, describe and understand the expectations during pregnancy and subsequent experiences of childbirth in primiparae [women pregnant with their first babies]" (p. 302). The authors contended that gaining this knowledge could enhance midwives' abilities to provide more effective prenatal and postnatal care for pregnant women.

Gibbins and Thomson (2001), researchers from Northern England, conducted two unstructured interviews, both tape recorded and transcribed, with each of their subjects.

Eight pregnant women were chosen for the study based on four specified criteria. The women were selected because of their unique knowledge of the phenomena which constituted a purposive sample congruent with the phenomenological approach.

Women's confidence, that is their self-empowering beliefs, as a predictor of a positive childbirth experience was emphasized by Gibbins and Thomson (2001). Educational programs, birth plans, readings, videos, and discussions with family and friends were mentioned as ways in which women prepared for childbirth. The absence of studies that investigated whether or not the expectations of pregnant women were met provided justification for the English study. That justification applied to this dissertation research as well; in-depth phenomenological studies addressing the expectations of pregnant women have not, to my knowledge, been done in the United States. My own research revealed that primiparas giving birth in United States have expectations *and* experiences that are much the same as those of pregnant women around the world. However, no studies have attempted to apply concepts that arise from what neuroscience is revealing: the capacity of the mind and its unconsciously held beliefs—which create expectations of which one may not be aware—to affect the outcome of events. My objective was to ask pregnant women in the United States what their expectations were prenatally, whether they were met or not postnatally, and, further, to propose an explanation for why or why not based on current understandings of the mind.

The data collected by Gibbins and Thomson (2001) were analyzed according to the tenets of traditional phenomenological inquiry; that is, to accurately assess and describe the phenomenon being studied as it is experienced by each individual. The findings were placed in three categories. First, the women in this study expected on a conscious level that labor would be long and painful, but hoped that labor would be short

and the pain manageable. They consciously feared complications that would impact the baby and/or themselves. Each of the eight women reported that their "labour was not as expected" (p. 306). Second, the women felt well informed about sources of pain relief and also anticipated support from their partners prior to giving birth. Postnatally, they reported feeling supported by their partners *and* by midwives. Each had chosen medication for pain relief in addition to a variety of non-pharmacological methods and felt they had coped well. Each woman had positive feelings about having given birth yet felt it was different from what was expected. Third, all of the participants had prepared for childbirth in various ways and felt that childbirth education, in its many forms, was important for making informed decisions and feeling in control throughout labor and delivery. The researchers stated that their most important finding was that these women valued feeling in control. Thus, enhancing pregnant women's feelings of being in control during childbirth was seen as the ultimate goal and the message imparted to midwives.

This study was a good prototype for the research undertaken for this dissertation. I proposed to augment this type of phenomenological research by adding a projective device (a drawing) to the interviews as a means of accessing pregnant women's unconscious beliefs. It was my intention to analyze data incorporating current understandings of the unconscious mind and how implicitly held fears could sabotage consciously held expectations. This approach was an attempt to answer the question: Why are some women's expectations of childbirth met while others are not? An answer, which caused me to reevaluate the question, is proposed in Chapter VII.

English research psychologist Josephine Green and her associates Vanessa Coupland and Jenny Kitzinger (1990) also conducted research which focused on women's expectations. In *Expectations, Experiences, and Psychological Outcomes of*

Childbirth: A Prospective Study of 825 Women, these researchers used questionnaires to determine women's childbirth expectations. This was a large quantitative study which differed from the type of research I conducted, but it generated results that specifically address women's expectations:

> Negative expectations may be associated with poor psychological outcomes: women who did not expect birth to be fulfilling were less likely to find that it was, and . . . women who were very anxious about pain were less satisfied and had lower EWB [postnatal emotional well-being]. . . . Women who expected labor to be very painful were likely to find that it was, whereas those who preferred to cope without drugs were more likely to do so and had higher satisfaction scores. Women who expected breathing and relaxation exercises to be useful were more likely to find that this was so and to be more satisfied than other women. We also found that expectations of being in control (both self-control and control of what was done to one) were positively associated both with achieving that aim and with higher satisfaction and EWB scores. This evidence therefore consistently contradicts the stereotype of the woman with high expectations who is bound to be disappointed. On the contrary, low expectations are associated with poorer psychological outcomes. (pp. 19-20)

In this large study, Green et al. (1990) found that the participants tended to experience what they expected. This contradicted the findings of Gibbins and Thomson (2001). The study undertaken for this dissertation was a small phenomenological study similar in design to the Gibbins and Thomas study, and sought to determine why a smaller qualitative study's results might have differed from those found in the larger quantitative study.

In 1993 Green published "Expectations and Experiences of Pain in Labor: Findings from a Large Prospective Study" (p. 65). This study, similar in design to her previous research, focused on the expectation of pain. Green reiterated her earlier findings. She was emphatic that positive expectations were associated with both producing the desired outcome and with providing a better psychological outcome as well. She stated, "In general, women tended to get what they expected" (p. 65). This again contradicted the findings of Gibbins and Thomson whose participants (eight) felt that their birth experiences differed from what they expected.

Green (1993) mailed questionnaires to over 700 women, the same method utilized in her previous research, to explore "women's attitudes, knowledge, and expectations of childbirth in a variety of contexts, such as pain relief, birth plans, obstetric interventions, and social-behavioral aspects of birth" (p. 66). The size of her study could be perceived to enhance the credibility of the data; however, the meaningfulness of the data could be diminished by the lack of personal contact with each woman. Nonetheless, Green's results were corroborated by a large Swedish study conducted in 1996. Specifically referring to Green's research, the Swedish investigators found in their study of 295 women who responded to questionnaires that there was a direct correlation between positive expectations and positive outcomes (Waldenstrom et al., 1996).

Expectations were assessed among 81 primiparas before delivery and compared to postnatal accounts of experiences by English researchers Slade, MacPherson, Hume, and Maresh (1993). These investigators found that expectations "in general were positively related to experience but the strength of the association was weak" (p. 469). Slade and associates found "that high levels of positive expectations may be helpful rather than harmful and that such expectations could coexist with a realistic appreciation of the

negative aspects of labour" (p. 478). The participants in this study gave birth in a large urban teaching hospital where many interventions were routinely used. Many of the women did not expect some of the interventions they received which implied that they had not been informed prior to delivery or, as first-time mothers, they were informed but did not comprehend the impact of the interventions prior to the actual experience. These researchers went further than simply encouraging health care professionals and educators to look for ways to promote positive expectations, stating:

> Psychological theories can make valuable contributions to the development of more effective preparations in antenatal care and there is a need for greater integration between psychological principles and midwifery practice. (p. 480)

It was my intention, while interpreting the data gathered for this dissertation, to utilize several theories in an effort to explain findings. The principles inherent in prenatal and perinatal psychology are presented as recommendations to be considered in Appendix K.

A commentary on *Changing Childbirth*, a report published in Great Britain in the early 1990s, suggested that "women should be provided with adequate information to enable decision-making regarding care" (Churchill, 1995, p. 32). Churchill contended that "the notion of consent to medical intervention in childbirth becomes a nonsense if women are not adequately informed" (p. 32). Indeed, what women expect can be significantly influenced by the education they receive prior to giving birth. This particular journal article debated whose responsibility it was, either midwives or medical professionals, "to impart information to women to empower them to participate in decision-making" (p. 33) and whether that information was accurate and comprehensible. Enhancing communication between health care providers and pregnant women so that those women could make informed choices in concert with achieving their positive

expectations was a point Churchill made well.

A new and related study from England examined 54 "women's expectations of their infant's characteristics during pregnancy, their perception of the infant after birth, and the bond between the mother and infant postpartum" (Pearce & Ayers, 2005, p. 91). Whether the women were primiparas or multiparas, their perceptions of their infant's characteristics did not coincide with, but exceeded, their expectations. For the most part, mothers in this study found that their babies were less fussy and more adaptable than they had expected. More importantly this study found that "mothers' perceptions of their infants, both in pregnancy and after birth, have a strong effect on the mother-baby bond" (p. 101). Unfortunately, but not surprisingly, "women who expected their infants to have a more difficult temperament and then evaluated them, similarly reported a poorer mother-baby bond postpartum" (p. 89).

This research considered a different aspect of expectations that I had only seen in one new psychosocial college textbook: "a woman's attitude toward her unborn child may be pride, acceptance, rejection, or—as is usually the case—ambivalence" (Newman & Newman, 2006, p. 115). I added this study because maternal-child bonding is a desirable occurrence from the perspective of pre- and perinatal psychology and demonstrates another facet of childbearing women's expectations.

Finland

Finnish women have been studied because the researchers felt that it was "important to study women living in Scandinavia who give birth within a health care delivery system demonstrating the lowest infant mortality rates in the world" (Callister et al., 2001, p. 29). Twenty Finnish women were interviewed within two weeks following giving birth. Three major themes emerged from this qualitative study:

1. The bittersweet paradox of participating in the creation of life.

2. Maternal confidence or self-efficacy, which influenced the women's perception of and management of childbirth pain.

3. The conceptualization of childbirth as a transcendent experience beyond the physical. (p. 30)

The nurse-researchers listened to the voices of Finnish women, hearing "the richness and diversity of the childbirth experience" (p. 31). They found that the women expressed deep feelings when recalling first seeing their newborns and seemed to appreciate being able to share their thoughts and feelings with an interested inquirer. This study indicated that women liked to be heard and were receptive to being interviewed, particularly post-partum. This set a good precedent for the design of my research project.

These Finnish researchers asked women how they felt about being pregnant, what they felt when they first saw their newborns, and generally what their personal perspectives were regarding their birth experiences. Expectations were specifically addressed and could be inferred from the use of similar terminology. Callister and her colleagues (2001) found that their participants dealt with pain—which they expected—in various ways, generally managing without the administration of drugs. They used breathing techniques, support from partners, walking, rocking in a rocking chair, alternative positions instead of lying on their backs, acupressure and massage, and soaking in water. These women also expressed the paradoxical nature of their feelings, referring to the contrast of pain and ecstasy that can accompany childbirth. This finding had been noted by other Swedish researchers in 1996 as well: "negative and positive feelings can coexist" (Waldenstrom et al., 1996, p. 144).

Callister and her associates (2001) were careful to quote their participants in their

own words. These words expressed the women's conscious thoughts, feelings, and expectations. The investigators were also attentive to nonverbal cues such as eye contact, gestures, and tearful expressions of emotion. An observer in these circumstances would look for continuity between what was said and what was being exhibited in the form of behaviors, facial expressions, and bodily movements. These researchers, open to receiving fuller communication than that conveyed by words alone, found consistency between cognitions and somatic traits. In my study, I sought to observe both facial expressions and body language. I also incorporated a projective device in the form of a drawing to gain further insights into the unconscious minds of the participants.

Finnish researchers Melender and Lauri (2001) explored the concept of security among pregnant women. They reported that their initial research into fears experienced by pregnant women could be linked to feeling a lack of security. They hypothesized that fears could be prevented and dispelled by helping women to feel more secure. They noted that it seemed a natural part of pregnancy to feel uncertain. These investigators interviewed 20 pregnant women using semi-structured interviewing techniques. Many of the participants found it difficult to answer a question that addressed feelings of security because they had not considered feelings of security as part of their experience of being pregnant. This was valuable information to consider in designing the proposed research. Since my research would involve semi-structured interviewing and would ask open-ended questions, it was important to carefully consider both the words used and the intention of the questions asked. I wanted to elicit information in ways that allowed themes to emerge rather than focusing the inquiry on a specific topic like fear or security.

Melender and Lauri (2001) analyzed transcripts and selected expressions that represented the participants' answers to each of the research questions. They found that

the elements that most contributed to a woman's security while pregnant and giving birth were "maternity health care, social support, a sense of control and one's own attitudes" (p. 233). It was the *attitudes*, implying beliefs and expectations, of the individuals that were most relevant to this dissertation. The researchers noted that positive attitudes related to their process created a sense of security. Among the elements that favored feeling secure were "*expectations* [italics added] that everything would go well" (p. 235).

Sweden

Investigators Olsson, Jansson, and Norberg (2000) sought to find out what childbirth meant to a small of group of Swedish women and men using a phenomenological hermeneutic approach. They noted that "*expectations* [italics added] are culturally coloured, individually created and influenced by family, organizations and institutions" (p. 123). Women in this study viewed childbirth as a goal which included the paradoxical elements of both longing and dread. Although childbirth was perceived by the participants as a natural process, they were ready to interfere with or control that process if they perceived that it was justified, for example, to electronically monitor the baby's heartbeat fearing that something was wrong with the baby.

For the women in this study, childbirth meant acknowledging their pain and fear while remaining as self-possessed and as in-control as possible (Olsson et al., 2000). Olsson and colleagues came to these conclusions by interpreting interviews with five Swedish pregnant women. The researchers were convinced that there was a difference between what one said and the meaning that the words themselves conveyed. These investigators sought to understand what was being implied or suggested beyond what the words actually said. This small qualitative study which considered women's words, and what the words implied as well, provided another good model for my research. It

suggested that relying on words alone might not be enough to provide a comprehensive understanding of what a woman truly expected when giving birth.

These investigators subsequently generated a metaphorical way of portraying their findings. They equated giving birth with descending a rapid—a perilous boat journey in which steerswoman (mother) and passenger (baby) were subject to the vicissitudes of the process and willing to yield to a helms woman (midwife) for safe passage when the journey became too painful or frightening. The researchers considered the implications hidden within the transcripts to determine major themes. The major theme, which was the women's willingness to interfere with what they had already identified as a natural process, was interpreted by these researchers as the women's acceptance of a "mechanistic and medicalised view of childbirth" (Olsson et al., 2000, p. 130). This finding could represent American women as well based on the statistics reported in Chapter I. My study, conducted in a manner similar to that of Olsson and colleagues, confirmed this contention. These researchers were aware that there was more to a woman's beliefs than those explicitly expressed and analyzed their data for themes that were suggested on a more implicit level. This was consistent with hermeneutic research practices and supported the direction taken by my study which added observations and the interpretation of a drawing to the analysis of transcripts.

The ambivalence demonstrated by the conflicting acknowledgment and acceptance of a natural process opposed to the lack of hesitation to interfere with that process was of particular interest to me since conflicting ideas and emotions seemed to prevail in the realm of childbirth. Green and her associates (1998) had noted that "positive and negative feelings can co-exist" (p. 241). Conflicting feelings could impact the outcome of events, and could certainly influence one as significant as giving birth. I

propose a rationale for how ambivalence can occur in the consciousness section of this chapter and describe in the discussion (Chapter VII) the impact it can have on one's expectations and subsequent outcomes.

The researchers in the Swedish study found that the bio-medical aspects of childbirth were emphasized during their consultations, while the ontological aspects of childbirth were absent. They observed that "childbirth has the potential to arouse ontological overtones not only because it represents the entry into life but also because there is an inherent threat to the physical survival of both mother and baby" (Olsson et al, 2000, p. 132). Referring to another Swedish study by Waldenstrom et al.(1996) (included in this literature review), Olsson and colleagues concluded that technology and pharmacology have not improved childbirth for women or their children. They saw this as an opportunity to consider ontological aspects inherent in the birthing process, that is, those aspects that consider what it means to exist—to be in this world. The wonder of bringing a new life into being can bring forth a longing and positive anticipation which could be disturbed by the medicalization of birth. If birth were considered pathology, needing to take place in hospitals where sick and diseased people go for treatment, it could generate fears, insecurities, and a host of negative expectations. I address both positive and negative perceptions of pregnancy and delivery in the analysis and interpretation of data gathered for this dissertation.

Waldenstrom et al. (1996) utilized a questionnaire to assess different aspects of 295 women's birth experiences. The researchers described the "halo effect" (p. 151) which is the phenomenon that occurs when women recall giving birth more positively immediately after delivery than they do months or years after the birth. Waldenstrom and her associates noted that "fixed-scale questionnaires also seem to elicit fewer negative

responses than do open-ended interviews" (p. 151), an observation that contributes to the understanding of the differences in findings between larger quantitative studies and smaller qualitative studies. They found that primiparas tend to report more positive expectations of their impending birth than do multiparas. Of most relevance to my study, they found that expectations were among the six major factors that "contributed to explaining women's overall birth experience" (p. 144). Their study showed that "negative and positive feelings can coexist, thus confirming the multidimensional character of the birth experience" (p. 144).

In a Swedish study of "women's perceptions of childbirth and childbirth education before and after education and birth" (Hallgren, Kihlgren, Norberg, & Forslin, 1995, p. 130), researchers who qualitatively interviewed eleven primiparas recommended that childbirth classes should, as a matter of course, assess the childbirth expectations of the students. In their study they looked for consistency between what a woman expected and what actually occurred. Nine of their participants had experiences better or worse than expected and two had experiences that coincided with their expectations. This study utilized childbirth education classes as a realm for research related to expectations and pointed out the importance of asking women during classes what they expected to have happen when they gave birth. With the objective of addressing women's expectations, more effective childbirth education programs could be designed.

A study of Swedish women that included 50 primiparas and 88 multiparas was based on the premise that "a woman's expectations of labor and childbirth can influence the degree of in-labor pain experienced" (Fridh & Gaston-Johansson, 1990, p. 103). Sweden is a country in which pregnant women receive extensive prenatal care and are attended by midwives during delivery. Even so, these researchers found that "pregnant

women at 32 weeks' gestation did not have realistic expectations of actual labor pain and discomfort and, as a rule, they experienced more pain than they had been given to expect" (p. 108). In Sweden, according to this study, pregnant women's expectations are considered important and are correlated with outcomes. What makes a difference in the severity of pain experienced is whether or not, in the opinion of these researchers, the women's expectations were realistic or not. I address realistic versus unrealistic expectations in Chapter VII.

China

A recent study conducted in China, where research of this type has been limited, studied Hong-Kong Chinese women pregnant with their first babies. Ip et al. (2003) noted that an earlier study revealed that "Chinese women expect to have safe and satisfying childbirth experiences" (p. 151). This research assessed the expectations of 200 primiparas by means of a 35-question *Childbirth Expectations Questionnaire* adapted from a Canadian model and translated into Chinese. One hundred eighty-six questionnaires were suitable for analysis. Most of the respondents had not attended any prenatal education classes. The pregnant women in this study expected to have support from partners and midwives while laboring and during delivery. However, they expected that the pain would exceed their own abilities to cope. In both the East and the West, women seem to have many of the same expectations about giving birth.

The Chinese women in this study, like Western women, had high expectations of social support, although more from partners and immediate family than from midwives or medical professionals. Most said they "wanted a normal vaginal delivery and favoured breathing exercises as the major method of pain relief during labour" (Ip et al., 2003, p. 152). Yet, they simultaneously "expressed a high level of expectation of the use of

medical intervention" (p.157). Even though these women wanted a more natural birth experience, they doubted their own abilities to cope with pain and expected to ultimately rely on medical interventions. This same attitude was reported by Olsson et al. (2000) in their Swedish study.

Ip and colleagues (2003), like Hallgren and associates (1995), concluded that their findings "illustrate the importance of comprehensive assessment of women's expectations about childbirth" (p. 157). They also recommended that their finding be incorporated "into childbirth education classes to help pregnant women develop realistic and positive expectations" (p. 151). Again, cross-cultural studies were revealing the ambivalence that women exhibit when they were expecting, particularly in countries where medical procedures were readily available. Women both happily look forward to a natural process and a healthy baby but fearfully anticipate intolerable pain or conditions that could require medical intervention—to which many willingly submit. This dissertation examines how dual attitudes can be held and how positive conscious expectations can be countermanded by stronger negative subconscious ones.

Another 2003 study of Chinese pregnant women from mainland China was conducted by qualitative researchers from the United States. Kartchner and Callister (2003) interviewed ten primiparas to enhance the cultural understanding of holistic nurses. They encouraged nurses to be aware of cultural beliefs and practices when providing care to laboring women. According to these cross-cultural researchers, "the childbirth experience is influenced by culture, politics, and family" (p. 102). In The People's Republic of China the culture values childbirth as "'the meaning of human existence'" (p. 102), but the government has a one-child policy. Families get involved with childbearing women because they appreciate this "'once-in-a-life-time event'" (p.

102) and honor their tradition and moral responsibility to care for the health of family members. Chinese childbirth practices are different from those of other cultures, according to these researchers, in that "most urban women give birth unmedicated in hospitals" (p. 103). Chinese women seem to view childbirth as a brief but necessary step in motherhood and are impacted by a community of interested people and policies. Giving birth is not seen as a particularly *personally* meaningful or individual experience.

Kartchner and Callister (2003) audiotaped their interviews "to capture inflection, emotion, and other verbal responses to incorporate in data analysis. Nonverbal cues were recorded at the time [as well]" (p. 105). This research provided a precedent that lent credence to my research approach for this dissertation in which conscious thoughts and feelings were corroborated or contradicted by means of nonverbal expressions video recorded as well as by drawings made by the participants. The transcripts from the ten Chinese women's interviews were analyzed by Kartchner and Callister and each woman verified the themes that the investigators identified. This protocol is one advocated by feminist researchers and involves the participants as co-researchers.

In this Chinese study "most women were excited and happy to learn they had become pregnant" (Kartchner & Callister, 2003, p. 106). Of note was the observation that Chinese women believe that their feelings influence their unborn children. "According to traditional and contemporary beliefs, the emotional state of the mother affects the fetus" (p. 106). The belief is that adverse emotions will have an adverse effect on the baby's character later in life. There is awareness in Chinese culture of principles being discussed from prenatal and perinatal psychological and quantum physical perspectives in the West. This belief does not extend into the arena of birth itself among mainland Chinese women, however. The actual birth appears to be an event that is

endured to produce the end product—a healthy baby. All the participants in this study gave birth without their husbands present although the researchers had stated that the women looked forward to the support of their partners. Childbirth is the realm of women in mainland China, therefore, husbands apparently do not often attend labor and delivery. Four women in this study had vaginal births with no medications but six had cesarean births. This ratio did not seem to reflect the earlier contention of the researchers that Chinese women prefer unmedicated births. It may be representative, however, of the medicalization of birth in China which could override a woman's preference on the grounds that intervention of this magnitude is necessary for the health and wellbeing of mother and/or child. More than half of their participants had cesarean sections, reflecting the influence of technology even in a culture steeped in tradition. Of the findings, the most relevant to this dissertation was the feeling of these women who "described childbirth as a bittersweet experience" (p. 109). Cross-culturally it appears that women feel both agony and ecstasy as they give birth.

Iceland

An Icelandic phenomenological study was conducted according to accepted guidelines (Halldorsdottir & Karlsdottir, 1996). Fourteen mothers who had given birth in hospitals in Iceland were interviewed. Again, it was noted that a "woman's expectations can . . . influence her perception of the birth experience. Some expected it to be easier than it is while others expected it to be worse" (p. 51). In this case the women had expectations that differed from the reality they experienced. This research revealed once more that a "woman's circumstances and expectations colour her perception of the journey" (p. 60) of giving birth. In addition, in this small sample, expectations were found to be inconsistent with experiences. Gibbins and Thomas (2001), whose study of

eight women was reviewed above, also found these results. Small populations personally interviewed, as opposed to larger populations responding to questionnaires, yield different results. How either consistencies or inconsistencies between expectations and experiences could occur is germane to this dissertation.

Canada

Canadian Ellen Hodnett, RN, PhD, (2002) performed a literature review which included 137 reports pertaining to those factors that influence a woman's evaluation of her childbirth experience. This review of "descriptive studies, randomized controlled trials, and systematic reviews of intrapartum interventions" (p. S160) is relevant because a large number of varied studies addressing childbirth satisfaction concurred that a pregnant woman's expectations were exceedingly important. In fact, Hodnett reported that personal expectations were one of the four factors that were most influential in women's high ratings of satisfaction with their birth experiences. Expectations were so important they overrode all demographic considerations including "the influences of age, socioeconomic status, ethnicity, childbirth preparation, the physical birth environment, pain, immobility, medical interventions, and continuity of care" (p. S160).

Hodnett (2002) distinguished between expectations and preferences which she noted other studies had not done. She asserted that preferences reflected a person's wishes while expectations were based on what choices were known to be available. I would contend that *conscious* expectations are based on what choices are known to be available *and* that unconscious—or denied—expectations could be at work as well, regardless of any choices perceived to be available. Most important in Hodnett's research was the strong support she found for the conclusion that, in general, pregnant women's expectations tended to be met. Although expectations were not exactly

fulfilled, there was a tendency for positive expectations to yield more satisfactory outcomes than negative ones, and for negative expectations to yield poorer outcomes.

Australia

A recent qualitative study has been conducted by Australian researchers (Fenwick et al., 2005). Performing research that consisted of 202 telephone interviews with pregnant women and women who had given birth within the previous twelve months, these investigators explored the labor and birth expectations of Western Australian women and sought to "identify the factors that influence these expectations" (Summary, Para. 1). These investigators noted the contribution that books, magazines, publicly held views, and stories told by mothers and sisters made in shaping a woman's childbirth expectations. The woman's personal history, her age and life-style, and the impact of the opinions of professionals could all influence how a woman perceived her experience. This study was perhaps one of only a few that considered why women have the expectations they do. The research conducted for this dissertation also investigated *why* women expect what they do *and* why outcomes did or did not match expectations. The science of consciousness and feminist concepts of social conditioning were relied upon to posit possible explanations.

These researchers professed that their findings "challenge the anecdotal evidence that many contemporary western women willingly and knowingly choose or expect birth to be a medicalised event" (Fenwick et al., 2005, Implications, para. 1). Identifying more positive expectations than negative among their middle class participants, the researchers suggested that

> as childbirth becomes an increasingly medicalised event, characterized by technology and spiraling intervention rates, it is important to explore current

> childbirth expectations in the hope that maternity systems and health-care professionals can better meet women's individual needs and preferences. . . . The findings of the study could be said to give 'hope' and 'heart' to those who continue to campaign for the return to a more humanistic approach to the childbirth process. (Conclusion, para. 1)

Prior to the study conducted by Fenwick and her colleagues, Brown, Lumley, Small, and Astbury (1994), four Australian researchers, published *Missing Voices: The Experience of Motherhood*. These investigators had conducted two research projects: 790 women initially were mailed lengthy questionnaires and 90 women were personally interviewed in a follow-up study. Brown and her colleagues performed women-centered research in which women were "acknowledged as active, conscious, intentional authors of their own lives" (p. 5). The researchers noted that, while appealing, this approach is an ideal which does not often match reality. Women, according to these authors, are frequently unable to exercise control in their lives because they are restricted from doing so by "social arrangements and structural inequalities not of their own making" (p. 5).

These researchers, like myself, were most interested in hearing women's voices. They stated, "The focus of our study was deliberately on women's own views of their childbearing experiences from pregnancy to the postpartum period" (Brown et al., 1994, p. 1). Looking at childbearing women's emotional wellbeing and emotional distress, Brown and associates conducted both qualitative and quantitative research that included the views of women which "have often been ignored in much existing research" (p. 8). Ultimately they found that more than half the women in their study experienced postnatal depression. "What women wanted most was the recognition that someone was listening" (p. 263). Brown and associates (1994) concluded their book with the statement:

> It is our hope that the 'motherhood statements' in this book, the powerful and moving accounts of what it is like to be a mother, will be heard and will make it easier for other mothers to find someone who 'listens' to them with eyes, ears, heart and undivided attention. (p. 263)

Studies Conducted in the United States

In October of 2002 the results of *Listening to Mothers: Report of the First National U. S. Survey of Women's Childbearing Experiences* were released. Developed by The Maternity Center Association (MCA), "*Listening to Mothers* is the first national U. S. survey of women's childbearing experiences. The survey explored women's attitudes, feelings and knowledge about many aspects of their maternity experiences." (Declercq, Sakala, Corry, Applebaum, & Risher, 2002, p. 8). Over 1500 women who had each given birth to a single baby within the two years prior to the survey participated. First time mothers were found to be more likely than experienced mothers to "attend childbirth education classes, use pain medications and various other labor interventions, report negative feelings during labor, have a physician as birth attendant, or give birth by cesarean" (p. 7). Labor was reported to be technology-intensive.

> While 20% of mothers indicated that they used no medications for pain relief, there were virtually no "natural childbirths" among the mothers we surveyed. Even mothers having a vaginal birth experienced a wide array of medical interventions including: being attached to an electronic fetal monitor continuously or nearly so throughout labor (93%); being connected to an IV line (85%); having their membranes artificially ruptured (67%); being given artificial oxytocin to start or stimulate labor (63%); having a gloved hand inserted into their uterus after birth (58%); using a catheter to remove urine (41%); getting an episiotomy (35%);

> and having pubic hair shaved (5%). Less than 1% of mothers gave birth without at least one of these interventions, and almost all of these came from the very small group (also less than 1%) of home births in our sample. (p. 4)

The authors of this poll undertook this first-of-its-kind survey to focus "the discussion of maternity care in the U. S. on the people who care about it most: mothers themselves" (Declercq et al., 2002, p. 1). My objective for writing this dissertation was in concert with the focus of this national survey. My intention was to conduct in-depth interviews with a small sample of pregnant women to determine the essence of their expectations, beliefs, and experiences—indeed, to focus on the mothers themselves. This feminist/phenomenological approach and the details of how the research was carried out are presented in Chapter III.

Heinze and Sleigh (2003) studied women in the United States, looking at relationships between beliefs about childbirth and pain control choices. They used the internet to survey 46 women within six months of having vaginal deliveries finding that there was, indeed, a relationship between the choices women made regarding pain control and their beliefs about childbirth. The researchers found that women's attitudes did not change as quickly as medical practices, observing that the women in this study seemed to exhibit attitudes that were noted in studies twenty years earlier. Heinze and Sleigh stated that their findings demonstrated "that women may make their choices about pain control based on their beliefs and preferences rather than on the physical or medical need for pain medication" (p. 330). Most of the women surveyed chose their method of pain control prior to the onset of labor. The researchers found, as they had predicted:

> women who chose to deliver with an epidural had high fear of childbirth, an external locus of control for childbirth, and a desire for passive compliance in the

childbirth process. Results also showed that women who laboured without an epidural had low fear of childbirth, an internal locus of control for childbirth, and a desire to actively participate in the childbirth process" (p. 323).

In this study it can be deduced that the experiences of childbirth were consistent with the expectations of the mothers.

Heinze and Sleigh (2003) gathered data by means of a survey which included three scales to determine levels of fear of childbirth, locus of control for childbirth, and the desire to participate actively in the birthing process. Questions included: "Most women are really frightened at the thought of going through labour and delivery. . . . [and] Childbirth without fear is an unrealistic idea" (p. 326). These were not open-ended questions and seemed to incorporate stereotypes and assumptions that I preferred not to introduce as I interviewed my participants. I wanted to allow women to convey their own beliefs, expectations, and feelings, rather than have them agree or disagree with prepared statements. Certainly the information gathered by survey is valuable. However, surveys can also shape responses by the specific questions they ask. A small qualitative study provides an opportunity to look in greater depth at an individual's experience, in this case, birthing women's expectations and experiences. I interviewed pregnant women to explore how their conscious and unconscious beliefs and expectations (favorable or fearful) contributed to the outcome of their births by allowing each woman to share her views through discourse and drawings.

As part of a larger quantitative study conducted in the Midwest, researchers asked 77 women one question: "Is there anything about your labor and delivery that is still bothering you?" (Fowles, 1998, p. 236). This was asked via a written questionnaire and responses were mailed back to the investigator who used qualitative analysis to identify

themes. No personal contact was made with participants and no verification or clarification was sought. The author noted that the wording of the question probably elicited negative responses and the results confirmed this. The intention of the study, which was "to determine if women experienced any discrepancies between the expectations and realities of their births" (p. 235), coincided with the purpose of my research; however, I thought that exploring expectations and realities could be done more effectively in the context phenomenological inquiry. Without the suggestion that something was *bothering* postpartum women, perhaps the participants would have shared different perceptions of satisfaction. Fowles' study identified significant frustrations due to pain, lack of control, lack of knowledge, and negative perceptions of caregivers. Gaining an awareness of these concerns might, as Fowles suggested, provide insights into ways that healthcare providers could help women have a more positive experience during labor and delivery.

A study published in 2001 was conducted relating self-efficacy expectations to labour pain. Larsen, O'Hara, Brewer, and Wenzel (2001) initially recruited 65 women from Lamaze classes to complete a battery of inventories regarding their expectations of labor and then evaluated their experience of pain while actively in labor. Only 37 of the women completed the entire study which the authors said did not result from demographic differences. I would suggest that the high attrition rate might be due to the volume and complexity of the inventories used and the fact that personal contact was limited to the birth itself. I would also contend that it is during labor that women most need subjective, caring support, and encouragement. The study's method appeared to be representative of procedures within the medical model which prevails in the United States. The process for gathering data was approved by an Institutional Review Board

and 37 women did agree to and complete the study. To assess the conscious and unconscious expectations and beliefs that I sought to investigate in my study I elected to conduct interviews pre- and postnatally, but not during the birth itself.

The 2001 study performed by Larsen and associates found that the women's expectations of their abilities to cope with the pain of labor varied throughout the process—as labor pain became more severe their assessment of their ability to cope diminished. The Lamaze classes did not appear to adequately prepare these women for the intensity of their actual experiences. Women appeared to find their experiences "incongruous with their expectations" (Larsen et al., 2001, p. 212). The investigators found that

> self-efficacy expectancies did not predict levels of transitional labour pain. After accounting for self-efficacy expectancies, importance and outcome ratings did not explain additional variance in pain levels for any phase of the first stage of labour. While higher self-efficacy ratings predicted lower levels of pain in early and active labour, it is unclear why women's beliefs in their ability to use coping strategies did not explain variance in transitional pain levels. (p. 203)

These inconsistencies—and consistencies—between expectations and outcomes were considered from several perspectives in my study and, to the degree possible, an explanation was offered. In the above study, the researchers applied "Bandura's self-efficacy theory (Bandura, 1977) [to] . . . provide a theoretical framework for relating women's beliefs regarding their ability to perform techniques taught in childbirth preparation classes to their reports of labour pain" (p. 204). I utilized other theories including feminist theory and current understandings of the conscious and unconscious mind in particular, to explain the findings of my study.

Another study focusing on labor pain compared maternal satisfaction and pain among 47 women who elected natural childbirth. Twenty-three were able to successfully follow through without medication while 24 requested and received epidural analgesia. The findings, distilled from three questionnaires and the reports of nursing staff who rated the intensity of pain throughout the three stages of labor, showed that women who received epidurals reported less pain than those who proceeded to give birth naturally, but were "less satisfied with their childbirth experience than those who did not" (Kannan, Jamison, & Datta, 2001, p. 468). These researchers stated "this study highlights the importance of experience and prelabor *expectations* [italics added] on maternal satisfaction with childbirth" (p. 468). Not all the women in this study were primiparas; those who were first-time mothers tended to perceive more pain and requested epidurals. Subsequently, they were less satisfied with their birthing experiences. The investigators recommended more studies to "evaluate the relationship of antepartum education, expectations of labor pain, spouse support, and duration of labor with maternal satisfaction" (p. 472).

Kannan and colleagues performed research much like that of Larsen and her associates (2001). Again, the tendency in the United States appeared to approach the study of pregnant and birthing women using quantitative measures. Giving birth is, perhaps, the most physically and emotionally sensitive act ever performed by a woman. To be in harmony with her seems to me to be essential to her feeling empowered, capable, secure, and appreciated as she brings a new life into the world. While information distilled from larger studies in extremely valuable, I was motivated to perform a small, personal study in a country where research of this type is virtually nonexistent.

One related study, an extensive review of English-language literature, evaluated various types of care provided to women during labor and concluded that "support by untrained lay women starting in early labor and continuing into the postpartum period demonstrates the most consistent beneficial effect on childbirth outcomes" (Rosen, 2004, p. 24). Although Rosen recommended more studies to validate this conclusion, it appeared that feeling supported and encouraged by other women, being heard, being respected, and even served during this vulnerable time most contributed to a woman's satisfaction and the realization of her positive expectations. Support was one of the themes that emerged from the data that I gathered.

One older study is worthy of mention because it was a bit more qualitative in its methodology. It involved a twenty minute interview with each of 70 women within 72 hours of giving birth. Nineteen questions were asked in order to rate the degree that expectations were met. For example, women were asked "in general, would you say your labor and delivery was about like what you expected, somewhat like what you expected, or not at all like what you expected?" (Stolte, 1987, p. 100). No pre-labor questions had been asked, so a limitation of this study was that expectations had to be recalled after the birth had occurred. The majority of primiparas reported that their experience was not what they had expected. This result paralleled those of small qualitative studies (cited above) but differed from the findings of later larger studies (also cited above). Stolte, whose study was conducted in Oklahoma, suggested that "some women may have unrealistic expectations about coping abilities in labor; positive reinforcement of efforts to cope may help women resolve inconsistencies between their expectations and coping during labor" (p. 103). Consciousness studies shed new light on how women's expectations could be unrealistic. This subject is illuminated in Chapters VII.

The results of a longitudinal study were published in 1991. Penny Simkin (1991) "explored and analyzed the long-term impact of the birth experience on a group of 20 women from the natural childbirth culture of the late 1960s and early 1970s" (p. 203). Simkin used questionnaires and unstructured interviews. She found that even after many years women still recalled their birth experience vividly and with deep emotion. "Those with highest long-term satisfaction ratings thought that they accomplished something important, that they were in control, and that the birth experience contributed to their self-confidence and self-esteem" (p. 203). In her conclusion Simkin advised caregivers to be aware of their influence as authority figures. She suggested, "Before labor, find out what the woman's expectations and hopes are in terms of clinical management, use of pain medications, presence of loved ones and support people. Also, if possible be aware of her fears and concerns" (p. 210). Simkin's and Stolte's research were the only U. S. studies I could identify in an exhaustive search of the literature that addressed women's expectations in a qualitative manner.

Although a departure from studies focusing on pregnant women's expectations, recent studies looking at the impact that a pregnant woman's stress has on her unborn child are noteworthy. Janet DiPietro (2004) of Johns Hopkins University has been researching the role of prenatal maternal stress on fetal development. She concludes that "too much or too little stress may impede development, but a moderate level may be formative or optimal" (p. 73). Verny and Weintraub (2000) say that "though some stress during pregnancy is normal, our studies show that mothers under extreme and constant stress are more likely to have babies who are premature, lower than average in weight, hyperactive, irritable, and colicky" (p. xxii). Nonetheless, DiPietro, Costigan, and Gurewitsch (2003) have focused on inducing *benign* psychological stress which is similar

to the periodic exposure to stressors that a pregnant woman would naturally encounter. Measuring fetal heart rate, heart rate variability, and motor activity in 137 low-risk pregnant women, these researchers observed that:

> the fetus is periodically exposed to threats to homeostasis promulgated by maternal emotional stress. . . . We propose that patterns in the maternal-fetal dyad may serve to entrain autonomic development in the fetus and that characteristic response patterns begin in utero. (p. 136)

Scientists are discovering what is going on in the womb. The significance of this first nine months is becoming evident to researchers, prenatal psychologists, and parents alike. It would appear that while mild stress contributes to the development of life-long response patterns, severe stress during pregnancy would negatively influence a pregnant mother's attitude and expectations and negatively impact her fetus as well. Expectations warrant more research as they impact a pregnant woman's stress levels and, therefore, her health and the health of her unborn child.

Having reviewed the literature, I continue the literature review by addressing current understandings of consciousness, projective techniques and art interpretation, feminist theory, and prenatal and perinatal psychology.

Theories Applicable to this Study

Perspectives from Brain/Mind/Consciousness Studies

Definitions of Brain, Mind, and Consciousness

Noted neurologist Richard Restak (1984) dodges a complex definition of the brain in his book *The Brain* by saying that it is "the part of the central nervous system that is contained within the skull" (p. 8). He defines mind as "nothing more than a term we employ to describe some of the functions of the brain" (p. 343). Not all scientists would

agree with Restak's simple definitions. The mind is also divided into interdependent conscious and subconscious components (Lipton, 2005) and extends beyond the brain into the entire body (Pert, 1997).

According to Ornstein (1991), "Being conscious is being aware of being aware" (pp. 225-226). He views the mind as "a collage of adaptations (the propensity to do the right thing) to different situations" (p. 2). Alluding to other research that follows in this review Ornstein states:

> Most of our interpretations take place unconsciously, automatically, and work by rules evolved over millennia. As the mind is divided into processes that make comparisons, ignore information, shift reactions into place and then out, so consciousness is divided, spread out on different levels. The trick in managing the mind is to bring the automatic reactions into consciousness. (p. 225)

Jenny Wade (1996) provides a broader definition of what it is to be conscious by identifying four essential components of consciousness itself:

> (1) Consciousness is the experience of being alive. . . . (2) Consciousness concerns the intersection between private, "interior," "subjective" experience and (3) the "objective" or "outside" world. . . . (4) Memory is an integral part of conscious experience, binding the moment-to-moment sense of awareness into a coherent pattern that provides the sense of personal continuity, the ongoing self. (pp. 4-5)

Richard Grossinger (2000) brings consciousness together with both mind and phenomenology. In his book *Embryogenesis* he states that:

> consciousness is the spark of knowing that can manifest in any form throughout the universe; it is collective, universal, and archetypal—a primary attribute of

> being. Mind is a particular form of consciousness that has evolved on Earth through atoms and cells, nervous systems and brains—an artifact of biological evolution. Phenomenology is the dynamic process linking them. (p. 828)

Beliefs and expectations

There is a growing awareness that a person's individual beliefs, expectations, attitudes, and thoughts not only have an impact on how they feel and behave (Amen, 1998; Ornstein, 1991; Szegedy-Maszak, 2005) but directly influence the reality they experience. Michael Talbot (1992), author of *The Holographic Universe*, states that:

> Studies have shown that the attitude an expectant mother has toward her baby, and the pregnancy in general, has a direct correlation with the complications she will experience during childbirth, as well as with the medical problems her newborn infant will have after it is born. (p. 102)

Bruce Lipton (2005), cellular biologist, corroborates this contention. In his book *The Biology of Belief* (2005) Lipton addresses the impact that a mother's perceptions have on her unborn child: "The responsiveness of individuals to the environmental conditions perceived by theirs [sic] mothers before birth allows them to optimize their genetic and physiologic development as they adapt to the environmental forecast" (p. 157). According to Lipton (lecture, 2001), if a mother perceives her environment to be threatening, her unborn child will develop enhanced musculature and a larger hind brain, preparing itself to survive in a hostile world. If a mother feels safe and cared for, her growing fetus will develop an enhanced forebrain, preparing it to be more creative and contemplative in a world that it already perceives as supportive.

The results of a British longitudinal study published in 2005 "suggest that the development of children is influenced by women's attitudes during the antenatal period

towards parenthood and the forthcoming child" (Deave, p. 73). Deave corroborated the link "between antenatal expectations and the risk of antenatal/postnatal depression, and between women at risk of depression and cognitive development" (p. 73). This study showed that a "woman's positive attitude to pregnancy and motherhood have been linked to higher cognitive development scores" (p. 73) of her child assessed at age two. A pregnant woman's attitude toward pregnancy and motherhood affect her own propensity for depression postnatally and also have an impact on the cognitive development of her child. As Lipton has proposed, studies are confirming that a mother who feels good provides an environment for the development of a smarter child.

Lipton (2005) points out that a person's beliefs shape her own biology. On the microscopic level of individual cells, beliefs directly impact the expression of one's genes. Lipton explains that beliefs and perceptions are virtually synonymous. He states that "our perceptions, whether they are accurate or inaccurate, equally impact our behavior and our bodies" (p. 137). Both a pregnant woman *and* her fetus are at the effect of the mother's perceptions. Indeed, all individuals are affected, down to the smallest cells in their bodies, by the beliefs and perceptions they hold.

Larry Dossey (1982) speaks of perceptions as "the models we make of the world [which] actually determine in some measure what we see" (p. 10). Dossey goes further: "We determine our own reality by mirroring our perceptions" (p. 50). "What we call physical reality, the external world, is shaped—to some extent—by human thought" (p. 116).

Wendy McCarty (2002), a prenatal and birth therapist as well as a proponent of consciousness studies, states that "our beliefs are the foundation of organization of our reality. . . . They are the raw materials from which our reality is created shaping our

expectations of the future" (p. 342). Through her extensive work providing therapy for babies and their families, McCarty emphasizes that "beliefs permeate, influence, and are part of the very core of being at all levels: they appear as ways of being in the world, revealed in states of being, embedded and expressed in body structures, postures, physiological processes, and movement on both micro and macro levels" (p. 346). These ways of being can be observed in babies—and in adults. Like Lipton, McCarty contends that early perceptions become "subconscious beliefs through which all later experience is filtered and organized" (p. 343).

Kenneth Pelletier (1992) states:

> In modern sciences, ranging from the neurophysiology of consciousness to quantum physics, it has been evident that the structure of personal belief systems concerning the nature of the self and the universe governs experience (Muses and Young, 1972). Inherent in any system of belief is a self-fulfilling prophecy: what is expected is observed, and what is observed confirms the expectations. (p. 33)

According to these doctors and scientists, *unconscious* beliefs, as well as the conscious expectations of pregnant women, will influence their experience of giving birth.

The conscious and unconscious minds

What people tell us does not always accurately reflect the totality of their thoughts and feelings. Some ideas and emotions are held beneath conscious awareness. In *Hidden Minds* author Frank Tallis (2002) points out that "parts of the mind (or processes operating within the mind) are either permanently or temporarily inaccessible to awareness" (p. ix). He notes that the "concept of the unconscious is surprisingly ubiquitous; scientists, philosophers and artists, neurologists and mystics have all explored or discussed the concept of the 'unconscious'" (p. ix).

In *The Discovery of the Unconscious* Ellenberger (1970) writes:

> The assumption that a part of psychic life escapes man's [or woman's] conscious knowledge has been held for many centuries. In the seventeenth and eighteenth centuries, it attracted more attention, in the nineteenth, as one of the most highly debated problems, it became finally one of the cornerstones of modern dynamic psychiatry. (p. 312)

The mind has been bisected into consciousness and unconsciousness. Damasio (1999) defines consciousness as "an organism's awareness of its own self and surroundings" (p. 4). According to Damasio, "the unconscious, in the narrow meaning in which the word has been etched in our culture, is only a part of the vast amount of processes and contents that remain nonconscious, not known in core or extended consciousness" (p. 228). Damasio's definition of unconsciousness includes an astounding array of not-knowns like images, neural patterns, hidden wisdom, and innate knowledge that never reaches conscious awareness. He also notes that emotions stem from the unconscious. Joseph (1992) elaborates on Damasio's neurological perspective by describing the unconscious more psychoanalytically, from the perspectives of both Freud and Jung, as a "psychic realm in which dreams, intuitive understanding, emotional conflicts, and embarrassing and unpleasant impulses have their source and origin" (p.16). Lipton (2005) views the conscious mind as creative while the subconscious mind is "a repository of stimulus-response tapes derived from instincts and learned experiences" (p. 127) and is "millions and millions of times more powerful than the conscious mind" (p. 128).

A history of the Western view of the unconscious mind

The Western perception of "mind" has been shaped by 17th century French

philosopher René Descartes whose ideas have spanned centuries. "Proposed as a temporary expedient to permit investigation of the human organism unencumbered by the dogma of the ruling Church, this [Decartes'] separation of mind and body has dominated medical practice and thought" (Ornstein & Sobel, 1987, p. 11). Neuroscientist Antonio Damasio (1994) points to this long-standing notion calling it "Descartes' Error: the abyssal separation between body and mind" (p. 249). Descartes envisioned "a universe perfectly assembled, moving in utter precision like a clock" (Dossey. 1982, p. 13). Sir Issac Newton later "mapped the workings of this clockwork universe" (p. 13). Within this paradigm the mind itself has been thought of as mechanical. Dossey asserts that "reductionism—the notion that all events in the human body, including complex mental events, can be explained by the elemental electrochemical processes inside us—has dominated the thinking of most modern physicians" (p. 12).

It was in the 1800s that German philosopher Johann Friedrich Herbart not only acknowledged the existence of the unconscious mind, he portrayed it as a receptacle of conflicting thoughts. Herbart is credited with introducing the concept of repression. In Herbart's rather Darwinian view, "animated cognitions and percepts compete with each other for a limited resource—consciousness—and only the 'fittest' survive in awareness" (Tallis, 2002, p. 13). Information may appear to be forgotten but is actually repressed by stronger thoughts and ideas which preclude its emergence into consciousness.

By the middle of the 19th century the unconscious was "established as a topic worthy of independent study" (Tallis, 2002, p. 14). By 1885 Pierre Janet had coined the term *subconscious*. He had, through his treatment of mental patients, uncovered and changed previously inaccessible memories. Tallis notes that "today, Janet's special term 'subconscious' is used in exactly the same way as the more commonly used

'unconscious'" (p. 45).

Throughout the early 20th century Freud and his colleagues popularized the notion of the unconscious mind. The mind could now influence behavior but was still perceived as separate from the body. Even though consciousness and unconsciousness are recognized, people with mental, physical, or emotional disorders are treated with "therapies that largely dominate Western medicine today—drugs, surgery, radiation, and so on" (Dossey, 1999, p. 18) which are still based on a mechanistic view. Ironically, the medical community approaches disorders of the mind in the same manner as those of the body; that is, by attempting to eliminate the symptom with medications that can be administered to and through the body. This begins to acknowledge that body and mind are united, but that unit is still perceived as a mechanical device.

In the 1930s and '40s neurosurgeon Wilder Penfield (1978) established the "relationship of mind to brain" (p. 67). Through his surgeries on conscious patients Penfield stimulated exposed brain tissue with electric probes. Patients experienced an array of thoughts, dreams, hallucinations, and moods. They could experience a memory as if it were happening in present time. Penfield identified the intimate connection between mind and body. His research quite literally united mind with brain tissue.

Memories housed in the unconscious are now understood by neuropsychologists to be either implicit or explicit. "Explicit memories are available for conscious recollections and can be verbally described, whereas implicit memories are not available for conscious manipulations and are very difficult to describe verbally" (Elias & Saucier, 2006, p. 225). Implicit memories remain in the realm of the unconscious. They are particularly respected by prenatal and perinatal psychologists who view the lingering effects of birth memories as problematic (Chamberlain, 1998; Janov, 1983).

Today brain scans allow neuroscientists to see the evidence of brain activity non-invasively. The mind, formerly viewed as separate from the body, is no longer separated from the body *nor* restricted to the purview of brain tissue. Damasio's efforts have re-embodied the mind and awakened an appreciation for emotions which have previously been excluded "from mainstream cognitive science" (Damasio, 1994, p. 159). Biophysics researcher Candace Pert (1997) corrects early assumptions about the venue of emotions as being within the brain stating, "we can no longer consider the emotional brain to be confined to the classical locations of the amygdala, hippocampus, and hypothalamus" (p. 141). Indeed, in an audiotaped lecture she declares that "your body *is* [italics added] your subconscious mind" (Pert, 2000). The marriage of mind to brain *and* body is accomplished in her one concise and elegant statement.

A theory of the evolution of consciousness

Jenny Wade (1996), a researcher in developmental psychology, has formulated "a noetic theory of human development, that is, a theory focusing on the unfolding of individual consciousness" (p. 1). To do so, Wade uses a post-Newtonian perspective calling her theory "holonomic" (p. 8). This theory is based on the physicist David Bohm's quantum physical concept that physical reality is part of an undivided whole (Bohm, 1990). Wade's theory is complex as it encompasses both quantum science and metaphysics. What she proposes is the existence of non-corporeal consciousness. She cites studies that "lend weight to theories that the fetal brain may give rise to a kind of consciousness capable of rudimentary cognition, learning, and some individuation" (p. 37). Even more, Wade has found evidence that:

> Two distinct sources of consciousness exist before birth and during the perinatal period. Fetal consciousness is more advanced than formerly believed. The

> transcendent source of consciousness is not a nondualistic form of awareness, but may be comparable to aspects of highly evolved noetic stages. It seems to operate outside the boundaries of materialism as currently understood. The chronology of the physical and transcendent accounts suggests that as more advanced neural structures become operational, the more likely it is that the transcendent source of consciousness is bound and limited by the brain. (p. 58)

Wade's theory acknowledges that the prenatal period is filled with consciousness. The consciousness of every adult would be influenced by the consciousness it had in the womb.

Emotions and the unconscious mind

At the turn of the 21st century dialogue about the mind, conscious and unconscious, includes the emotions. In fact, emotional intelligence, in the opinion of behavioral and brain science writer Daniel Goleman (1995), is more important than intellectual intelligence. Goleman states "our emotions have a mind of their own, one which can hold views quite independent of our rational mind" (p. 20). Professor of Science at New York University's Center for Neural Science Joseph Le Doux (1998) substantiates this saying, "it now seems undeniable that the emotional meanings of stimuli can be processed unconsciously" (p. 64). Le Doux even makes a distinction between the cognitive unconscious and the emotional unconscious. What one really feels can be hidden within the recesses of the unconscious mind. Conscious expectations, thoughts perceived by the conscious mind, then, may or may not be underpinned by comparable unconscious emotions. If these two minds agree, then the outcome one consciously expects tends to be realized—if they do not, realizations may be surprisingly different from conscious expectations.

A recent article in *U. S. News & World Report* (Szegedy-Maszak, 2005) emphasizes that most of what we do is unconscious.

> Burgeoning understanding of our unconscious has deeply personal and also fascinating medical implications. The realization that our actions may not be the pristine results of our high-level reasoning can shake our faith in the strength of such cherished values as free will, a capacity to choose, and a sense of responsibility over those choices. (p. 54)

This understanding, now reaching the general public, has great implications for conclusions drawn from my study.

The adaptive unconscious and dual attitudes

In *Strangers to Ourselves*, Wilson (2002) expands the understanding of unconscious which he defines as "*mental processes that are inaccessible to consciousness but that influence judgments, feelings, or behavior*" (p. 23). Wilson postulates the existence of an *adaptive* unconscious which "can have its own beliefs and feelings—not because these beliefs and feelings are so threatening that the forces of repression keep them hidden, but because the adaptive unconscious operates independently of consciousness" (p. 125). Wilson acknowledges that "emotions are states that inundate consciousness . . . accompanied by bodily changes . . . such as increased heart rate and shortness of breath" (p. 125). Nonetheless, people can have feelings "without knowing it" (p. 125).

Arising from one's adaptive unconscious, two opposing feelings toward the same topic can be experienced at the same time, according to Wilson (2002), "one more conscious than the other" (p. 132). He refers to these as "'dual attitudes'" (p. 132). Dual attitudes can explain how pregnant women feel a sense of positive expectation and

longing as they anticipate the birth of their babies, and simultaneously feel a sense of fear and dread. In *Psychological Processes of Childbearing* Raphael-Leff (2001) notes the influence of unconsciously held concerns on conscious processes. She points out that as a woman anticipates giving birth, "seemingly rational worries reflect underlying unconscious fantasies and anxieties which in turn colour her conscious ideas about birth" (p. 236).

Therefore, some of the emotions that a pregnant/birthing woman feels may be consciously perceived and some may not. Wilson (2002) states:

> There may be . . . times when it is more difficult to recognize the feeling generated by the adaptive unconscious, even when people introspect about their feelings. The conscious system is quite sensitive to personal and cultural prescriptions about how one is supposed to feel. . . . These "feeling rules" can make it difficult to perceive how one's adaptive unconscious feels about the matter. (p. 129)

Wilson (2002) proposes three circumstances by which feelings are prevented from emerging into one's awareness: repression, inattention, and obscuration. Repression is the manner in which a person buries, or simply does not acknowledge, feelings that are too threatening to face. Inattention is "the failure to notice that a feeling has changed" (p. 134); one continues to think and feel according to prescriptions learned in their cultural milieu. Obscuring feelings occurs when a person's conscious beliefs create a smoke screen behind which deeper more authentic feelings can hide. Any or all of these explanations could apply to a woman who finds that her conscious expectations differ from the reality of her experience—that deeply rooted feelings conflicting with her consciously perceived thoughts and emotions well to the surface when she is giving birth.

It is important to explore and seek to understand why conscious expectations are realized or not. It appears that unconscious processes hold the key.

> Virtually every aspect of mental life is connected in some way with mental events and processes that occur below the threshold of awareness. . . . the profound importance of unconscious procedures, memories, beliefs, perceptions, knowledge, and emotions is recognized universally. Moreover, for the first time in the history of psychology, scientists are equipped with technologies of sufficient power to undertake a thorough exploration of the unconscious: an exploration that will very probably transform the general conception of what it is to be human. Even basic assumptions about the nature of identity and our ability to make choices will be challenged. (Tallis, 2002, p. 182)

The Use of Drawings to Assess the Unconscious Mind

Sometimes words do not convey all of, or even accurately reflect, one's core beliefs about a topic being discussed. Many people do not verbalize their true feelings when questioned. Sometimes they are not aware of underlying attitudes or fears; sometimes they are in denial that certain attitudes or feelings exist within them; sometimes they may feel that disclosing how they really feel will cause them to look bad in the eyes of others. There are probably a multitude of reasons why people knowingly and unknowingly do not verbally express how they really feel.

Drawings as expressions of the right brain

One way to enhance communication and better understand a participant's world would be to engage her entire brain/mind. This could be done by actively stimulating *both* sides of her brain. Although both hemispheres of the brain work to compliment and support one another, there has been recognition, since the split-brain research of Sperry,

that the two hemispheres of the brain process information differently (Restak, 1984). "It is not doubted that LH [the left hemisphere] is superior at linguistic processing" (Elias & Saucier, 2006, p.116). "The RH [right hemisphere] is specialized for music, emotion, and spatial abilities" (p. 101). The right hemisphere does not express itself verbally, although neurologists are finding that it *is* involved in verbal communication. "The left hemisphere responds to the verbal content of emotional expression and the right to tone and gesture" (Ornstein, 1991, p. 81). The right brain can recognize and interpret nonverbal language and is the seat of intuition, insights, and feelings (Silver, 2001).

Drawing provides an opportunity for a participant to share her thoughts and feelings in a non-verbal way. Drawing accesses the right brain and subconsciously held images and feelings. In *Art as Language* (2001) Silver states that "the visual arts provide an alternative channel for articulating feelings that are difficult to verbalize" (p. 6). The visual representation will either corroborate the oral discourse or reveal other factors that may not have been processed by the cognitive language centers of the brain of the person speaking during an interview.

Drawings as projective techniques

To gain access to otherwise unconsciously held notions, I asked each woman draw a picture of her ideal birth. This elicited a broader spectrum of thoughts and feelings than words alone. "Drawing is viewed as a projective technique in which a client shares his [or her] perceptions and reactions to the world around him [or her]" (Drummond, 1988, p. 151). Among art therapists drawings are viewed as ways in which the individual projects—thus the term *projective technique*—her inner feelings and experiences. Drawings can help to gain information in a non-threatening manner; information that might reveal inner conflicts, hidden desires, or unspoken fears (Oster &

Gould, 1987). One's joy or apprehension can emerge in a drawing. Indeed, drawings are outward expressions of an individual's inner world.

Drawings are accepted as a means of assessing personality among helping professionals (Drummond, 1988). When minimal direction is provided it allows the individuals being assessed the freedom to construct their drawings in any manner. "Through these drawing instructions, individuals interject (project) personal meanings onto the task based on their unique histories and perceptions of their world" (Oster & Crone, 2004, p. 60). Since therapy was not the objective during this research, the drawings were not intended to be psychometrically accurate instruments for either diagnosis or treatment. The drawings were used as an adjunct to the recorded interviews—as "'supplementary interviewing aids'" (Oster & Gould, 1987, p. xvi).

Interpretation of drawings by the researcher

Interpretation of drawings like that done during the pilot study (described in Chapter IV) and those rendered during the actual study falls within the domain of art therapy. There are some basic guidelines for interpreting drawings. Placement of figures on the page, size, pressure used in the strokes, symmetry, erasures, detail, distortions, omissions, perspective, shading, and color can all be considered to represent the inner workings of the mind of the artist (Drummond, 1988). Nonetheless, most therapists are not specifically trained in art therapy, nor am I. Even those formally trained would not always agree on the meaning of a single drawing by a single client. Moreover, a study has shown that the best clinician-judges to evaluate drawings are those who use a feeling or "intuitive approach" (Hammer, 1981, p. 175) rather than those who rely on specific signs or a scientific approach.

The accuracy of any interpretation could be called into question. Therefore, I

determined that the participants themselves would be first asked what their drawings represented to them. My interpretation would be derived from my study of prenatal and perinatal psychology and influenced by current brain research, consciousness studies, art interpretation guidelines, and feminist views regarding deeply seated beliefs that arise from cultural conditioning. In addition, two therapists who use projective techniques in their practices were asked to interpret the drawings. This helped to enhance the reliability of the interpretations.

Ultimately I utilized my own intuition to look for indications in the drawings that appeared to provide clues to the inners worlds of these primiparas. In *Intuition: The Inside Story* Monsay (1997), a theoretical physicist in the area of relativistic quantum field theory and phenomenology, emphasizes the value of intuition in the development of scientific theory and practice. She describes the process of accessing and applying intuition saying, "true intuitions will only be expressed if an individual is open to new ideas and not subject to constraints of censorship" (p. 118). She promotes imagination, mental imagery, and intuition in science.

> We see that the common public picture, often promoted by scientists themselves, of the unemotional, rational scientist who mechanically pursues the Scientific Method as a sure highway to true knowledge is wrong. Instead, we see the emotionally involved thinker whose imagination is fueled with intuitive notions of realities yet to be developed into the reason of tomorrow. (p. 118)

Even though my interpretations of the drawings call on intuition and could be valuable, I did not rely solely on the drawings for meaning. "Projective material is most meaningful when looked at within the context of the other sources of information" (Klopfer, 1981, p. 242).

Interpretation of a drawing by a participant

It is accepted and even encouraged that those making assessments ask their subjects what their drawing means (Oster & Crone, 2004). I followed this guidance during each first interview at the time the drawing was rendered. It is most important to honor the symbolism that the artist intended rather than to superimpose concepts. Nonetheless, drawings can be revelatory and fresh insights can arise in both the artist and the observer when they behold a newly created image.

Not all therapists agree that asking a client to interpret her own art is advisable. Levy (1980) considers this folly! According to Levy the explanation offered would then need to be interpreted by the professional. She notes that "the veil of the hidden unconscious language" (p. 35) is difficult to pierce. Asking the client to interpret her own drawing would be valuable, in Levy's opinion, only if it did not impede therapy. Since no therapy was conducted during this research, Levy's admonition is unwarranted. Enhancing the understanding of each woman's point of view provided the justification for using art as well as dialogue.

Theory supporting the use of projective techniques

Generally art therapists are artists who have studied psychology or psychologists who have studied art (McNiff, 1988). There is no single theory underpinning the use of projective techniques in art therapy. However, Holzberg (1968) attempted to relate several psychological theories to the use of projective techniques. He identified at least seven theories to substantiate the use of projective devices. Psychoanalytic theory applies well to this study integrating with both feminist theory and prenatal and perinatal psychology. It also embraces the concept of an unconscious mind. The psychoanalyst seeks from a subject information of which the individual is not consciously aware.

Projective techniques like ink blots and drawings are tools employed to meet that objective. According to Holzberg, this theoretical stance, therefore, supports the use of drawings as mechanisms for gaining access to unconscious information. Oster and Crone (2004) point out that art therapist's base their methods of interpretation on "projective-analytic theory" (p. 61) which assumes that the careful examination of drawings can reveal "deep and often unconscious feelings" (p. 61). Other art therapists substantiate the application of art in the arena of "analytically oriented psychotherapy . . . [as] it permits direct expression of dreams, fantasies, and other inner experiences that occur as pictures rather than words" (Ulman & Dachinger, 1975, p. 4).

Feminist Fabre-Lewin (1997) questions the overuse of psychoanalytic theory in the realm of art therapy in her chapter of Hogan's book *Feminist Approaches to Art Therapy*. Fabre-Lewin is somatically oriented, appreciating the physical interaction of one's body with art materials. She views verbal therapies as secondary in value to art therapy in its many forms including movement and imagery which provide the primary channels for an individual's personal exploration, depiction of unconscious material, and ultimate liberation. Fabre-Lewin favors artistic expressions as the means to connect with both mind and body, doing so without the imposition of psychoanalytical approaches that, from her perspective, only reinforce cultural conditioning.

Cultural conditioning is one of the ways in which an individual learns. In the next section, I address feminist theory, expanding its application beyond art therapy into the realms of social conditioning and learning. It is important to note that projective techniques have been linked to learning theories. In essence, the conditioning that an individual receives while developing leads to the themes (motives, beliefs, expectations, and intense emotions) that can be detected in her drawing (Holzberg, 1981).

Feminist Theory

A definition and history of feminism

According to Judith Harlan (1998), "feminists identify themselves as people who support political, economic, and social equality for women" (p. 73). Even though equality may appear to be a worthy goal, feminists have been criticized for extreme points of view, as anti-establishment and man-hating. Within the ranks of ardent feminists there is great diversity and a number of groups who identify with particular branches of feminist thought. There are schools of liberal feminists; cultural feminists; radical feminists; Marxist and socialist feminists; ecofeminists; racial, ethnic, and gendered feminists; and even male feminists. Noted feminist bell hooks (2000a) states, "A central problem within feminist discourse has been our inability to either arrive at a consensus of opinion about what feminism is or accept definition(s) that could serve as points of unification" (p. 18).

In addition, there are eras of feminism: first, second, and third waves. The first wave includes foremothers who were suffragettes and first spoke out on behalf of women, particularly to gain voting rights, in the United States. The second wave, growing out of the efforts of women who had entered the workforce during World War II, started in the early 1960s by outspoken women who were seeking pay equity, and access to better jobs and education while attempting to find a better balance between the demands of both work and family. They founded huge organizations like the National Organization for Women (NOW), but this wave seems to have ebbed in the 1980s. A current third wave is surging to life in a more global way. Products of the second wave, these third wave feminists are more confident and point to the accomplishments of their predecessors. They promote the strengths of women, focusing less on women as victims,

and look to better integrate women into the major institutions of American society (Harlan, 1998).

Some feminists, however, view the third wave as one manipulated by corporations that see women as targets for marketing products and promote the fantasy that women can have it all (Gamble, 2001). Nonetheless, there are *new* voices within the ranks of these third wave women who represent women of color. One eloquent spokeswoman, bell hooks (2000b) articulates a position to which I subscribe:

> Unlike many feminist comrades, I believe women and men must share a common understanding—a basic knowledge of what feminism is—if it is ever to be a powerful mass-based political movement. In *Feminist Theory: from margin to center*, I suggest that defining feminism broadly as "a movement to end sexism and sexist oppression" would enable us to have a common political goal. We would then have a basis on which to build solidarity. Multiple and contradictory definitions of feminism create confusion and undermine the effort to construct feminist movement so that it addresses everyone. (p. 434)

A woman's voice

Feminists generally see women as being less valued than men (Gamble, 2001) and, therefore, receiving unequal treatment. They also tend to believe that women have the power to effect change and can best do so collectively. To bring about change they must have a voice. Harvard educator Carol Gilligan (1982) addressed "voice" when she focused attention on women's development and how it differs from men's. She wrote *In a Different Voice* in which she pointed out that women and men in American society are socialized differently; women for relationships and men for independence. She awakened awareness that women's voices *are* different and should be heard. Lugones,

an Hispanic, and Spelman (2000), a white/Anglo, call for women, particularly women of color, to tell their stories in their own voices. "The demand that the 'woman's voice' be heard, and the search for the 'woman's voice' as central to feminist methodology, reflects nascent feminist theory" (p. 19). According to these authors all women, not just white middle class or privileged women, need to be represented within the community of feminists.

Voice has been one of the most important concepts in feminist theory and also in a new field—feminist communication theory (Rakow & Wackwitz, 2004). Those who have been silenced must have their voices heard according to feminist theory, but Rakow and Wackwitz caution that researchers must take care not to let their own "privilege and interpretations shape the selection and presentation" (p. 97) of what other women have to say. To provide an opportunity for another to be heard, is, in my opinion, an opportunity to listen, to witness, to reflect, to reinforce, and to learn. It is also an opportunity for a researcher to interpret, offering insights that can, within the framework of feminist theory, precipitate positive change for individuals and the larger shared community.

Feminist perspectives of childbirth

"According to the medical model, birth is a medical problem. . . . Nature is a bad obstetrician; medical intervention is absolutely necessary" (Wagner, 2001, p. 30). This attitude prevails in the United States where women are inundated with this message, not only by medical personnel, but by the media which portrays birth as a life-threatening event filled with pain. In *Birth in Four Cultures*, Brigitte Jordan (1993) states that birth "is everywhere socially marked and shaped" (p. 3). She describes birth as both a physiological and social event saying: "To speak of birth as a biosocial event, then, suggests and recognizes at the same time this universal biological function and the

culture-specific social matrix within which human biology is embedded" (p. 3). Jordan (1997) is credited with coining the term *authoritative knowledge*, that is, knowledge that becomes so ingrained in society's thinking that it is not questioned. In the forward to *Childbirth and Authoritative Knowledge*, Rayna Rapp (1997) states that "authoritative knowledge isn't produced simply by access to complex technology, or an abstract will to hierarchy. It is a way of organizing power relations in a room that makes them seem literally unthinkable in any other way" (p. xii). In general, Americans no longer question the appropriateness or safety of giving birth in hospitals. At a deeply unconscious level most women appear to believe they do not have the ability to give birth naturally or easily. Having medical assistance at a birth is the norm; indeed, it is deemed irresponsible not to have it.

Scholar in women's studies, sociology, and the humanities, Robbie Pfeufer Kahn (1995) discusses the Western tradition of childbirth in terms of language used, texts published, and attitudes cultivated in her book *Bearing Meaning*. She points out that medical protocols are based on providing safety for mothers and their babies, both born and unborn. However, attitudes imply that "if the mother wants to gratify herself by staying home[to give birth], she may be putting her infant at risk" (p. 206). Indeed, I found this attitude assailed one of my research participants who chose to give birth at a Birth Center. Women in Western society, according to Kahn, are "taught to doubt their ability to give birth" (p. 12) and are demeaned by those who have adopted the attitude that birth in a hospital equates to a safe birth while birth in any other venue equates to elevated risk and diminished safety, especially for the baby.

Ellen Lazarus (1997) emphasizes, "Birth in the United States is a medical event controlled by the medical profession. . . . This medical view of birth as potential

pathology, in which something could go wrong at any time, is a powerful and dominant model" (p. 134). Lazarus continues: "Birth models are similar to models of sickness and health in that they are made up of beliefs and expectations that are part of a person's cultural experience and cognitive being" (p. 138). She "found women to have unequal access to knowledge and differing degrees of desire for such knowledge" (p. 139). The pregnant women in her studies wanted

> to believe that they had control over the process as a part of control over their lives. . . . In what they intended to be one of the most significant experiences of their lives, all of the women believed there was the possibility that something could go wrong, and therefore birth, in the last analysis, must be a medical event. (p. 146)

Lazarus found that even among those who had access to information and had prepared for childbirth,

> it was never enough. No matter what they knew, it could not empower them within the medical system. Knowledge itself could not give them authority, nor could they know all the contingencies of the birth process or of institutional care. Despite all their preparations, then, they were cognizant of and even willing to subordinate themselves to medical authority. (p. 147)

In her book *Birth as an American Rite of Passage*, Robbie Davis-Floyd (1992), a cultural anthropologist and frequent presenter at congresses of the Association for Prenatal & Perinatal Psychology & Health, contrasts two paradigms "along a spectrum of possible beliefs about birth in American society. One end of that spectrum is defined by the extreme form of the technocratic model of birth, the other by the extreme form of what . . . [she calls] the wholistic model of birth" (p. 6). She explains "how obstetrical

procedures work to map this technocratic model onto the woman's perceptions of her labor and birth experience, with the goal of aligning her individual belief system with that of society" (p. 6).

Social conditioning and social learning theory

Davis-Floyd (1992) points out that core values within a culture are instilled in its members by means of social conditioning. "Cultural influences begin at birth; from the very first day of life we begin to civilize the child" (Hilgard, Atkinson, & Atkinson, 1971, p. 67). Cultural values must be passed on within a society if it is to continue its existence.

> Because mothers are generally most responsible for socializing their children, their absorption of the "group-cognized environment" and its implicit behavioral dicta must be so thorough that they cannot help but teach those systems of behavior and cognition to their children simply by their patterns of daily living. Such *unconscious* [italics added] and thorough absorption can be very effectively achieved by the cultural treatment of the woman during the "opening" process of birth. (Davis-Floyd, 1992, pp. 38-39)

Mothers in this culture have been thoroughly socialized to accept what Davis-Floyd calls the technocratic model of birth.

One process by which women have been socialized throughout their lives, and a way in which they pass on their particular social conditioning, is through modeling. Social learning theory "highlights the relevance of models' behavior in guiding the behavior of others. These models may be parents, older siblings, peers, entertainment stars, or sports heroes" (Newman & Newman, 2006, p. 76). New models can be observed throughout life, thus social learning is an ongoing process. Learning is further reinforced

by receiving rewards or punishments.

When a woman has a baby she models certain behaviors. Her choices and her story can powerfully influence other pregnant women (Fenwick et al, 2005; Green et al., 1998; Newman & Newman, 2006). Beliefs are learned; often they are imperceptibly taken into the subconscious mind. A goal of brain and consciousness research is to help promote "conscious change" (Ornstein, 1991, p. xiii).

Women not only assimilate information about birth from the models they see within the cultures in which they reside. On some level a woman registers the imprints of her own birth (somatic) (Chamberlain, 1998; Janov, 1983; Janus, 2001), how she related to her own mother (emotional) (Raphael-Leff, 2001), and what she learned about her own ability to perform (cognitive) (Newman & Newman, 2006). All these factors contribute to the subconscious ideas a woman carries within her mind/body. They cannot be overridden by a conscious decision to behave in a way contrary to her unconsciously absorbed value system.

Feminism applied to research

Feminism has become complex and multifaceted. Yet, Lather (1991) has said, "Very simply, to do feminist research is to put the social construction of gender at the center of one's inquiry" (p. 71). It was my intention to conduct phenomenological research along guidelines suggested by Lather who argues that absolutes, rules, and boundaries no longer apply to research methodology. Her position fits perfectly into the world of uncertainties that has been revealed by quantum physics. Indeed, Lather declares, "quantum physics opened up another world, a world otherwise than Newtonian linearity, subject-object duality and universal covering laws" (p. 27). Feminism is well suited to this era of changing paradigms. She offers a new model for "those who

maximize the research process as a change-enhancing, reciprocally educative encounter" (p. 72). Lather points to research in which the women being interviewed insist on "interactive, reciprocal self-disclosure" (p. 73), and in which the participants have an opportunity to review data collected to insure its veracity. Included in Lather's feminist research design is self-reflexivity and the intention to accurately represent the lives of the participants but explain those lives "'without violating their reality'" (p. 74). According to Lather the way in which researchers approach the collection of data influences what data are gathered—a truly quantum physical perspective. Therefore, I engaged in extensive self-reflexivity during the course of gathering and analyzing data for this study.

Feminism applied to this study

I applied feminism to this study as Johnson (1997) defined it: "a way of thinking—observing the world, asking questions, and looking for answers—that may lead to particular opinions *but doesn't consist of the opinions themselves*" (p. 112). I considered the conditioning that influenced the expectations of the primiparas in my study. Social learning theory is linked to feminism and brain/mind science as well since it explains how human beings, not just women, learn. Every human has genetic potential which is shaped by the environment—that environment is primarily the society in which one is raised.

It seems especially appropriate that feminist theory be applied in a study of pregnant of women since it is in the performance of conceiving, carrying, and giving birth to a baby that women do the one thing only women can do. Some, myself included, view childbearing as a sacred act, one which should be appreciated, celebrated, and even revered. Not everyone feels that way. It has been said that "the heart of women's oppression is her child-bearing and child-rearing role" (Firestone, 1970, p. 73). Firestone

has advocated that women should be freed "from the tyranny of reproduction by every means possible" (p. 193) including using technology to create extra-uterine environments. Her views are extreme, seeing the act of creating a new life only as a burden. Science, through 4-D ultrasound and intrauterine photography, is revealing in no uncertain terms the wondrous process of life unfolding during these *first* nine months. Some mothers are attuned to the child they carry and interact with the life growing in their wombs physically, mentally, emotionally, and spiritually (Church, 1988; Verny, 2002a). The women in my study revealed their own individual attitudes toward childbearing. It was my responsibility to convey their stories honestly and with respect for the social conditioning that led each one to think and feel as she does.

Prenatal and Perinatal Psychology

I conclude this review of the literature with a brief overview of prenatal and perinatal psychology. It is my belief that this emerging field holds great promise for the future of primiparas, indeed, all mothers and babies, and therefore, humanity at large. Prenatal and perinatal psychology can be defined as follows:

> The field of Prenatal and Perinatal Psychology is dedicated to demonstrating, through research, education, and therapy, a reverence for human life that encompasses preconception, gestation, birth, and the early postnatal period. Prenatal and Perinatal Psychology is a multidisciplinary approach that explores in depth the biological, psychological, mental, emotional, and social development of babies as they grow into unique individuals through their relationships with caregivers. It honors the essence of life throughout the entire lifespan, and emphasizes the significance of the earliest formative relationships, which create the foundation for all subsequent interactions with others. (Highsmith, Landsberg,

& Vernallis, 2004, back cover)

The field of prenatal and perinatal psychology arose from the "growing realization by many experts that because their own professional disciplines would not accept their ideas, research, or therapeutic practices in the area of birth psychology they were blocked in their attempts to teach or to learn from like-minded individuals" (Verny, 1987, p. 13). Verny and his colleagues initiated the First International Congress on Pre- and Perinatal Psychology held in Toronto in July 1983. That Congress inspired the growth of the organization known as the Association for Prenatal & Perinatal Psychology & Health. Verny (1987) selected papers presented at the first congress and published them as *Pre- and Perinatal Psychology: An Introduction*. Although difficult to find it is a superb primer in this field that has virtually no texts.

Continuing his pioneering efforts Verny (2002a), together with Weintraub, has written *Pre-Parenting: Nurturing Your Child from Conception*. The premise of this revolutionary guidebook is that the nine months of life in the womb, starting at the moment of conception, constitute a sensitive period in which a child's brain organizes. Verny and Weintraub build on the neuro-scientific research (like the brain science mentioned previously in this review) of the past two decades to support their contention that "every biological process leaves a psychological imprint, and every psychological event changes the architecture of the brain. In short, early experience largely determines the architecture of the brain and the nature and extent of adult capacities" (p. 8). The environment, it turns out, "is paramount to development" (p. 10) particularly that provided by the mother in the *first* nine months. It is, therefore, incumbent upon mothers to recognize both the potential and the responsibility they have to care for themselves while pregnant and thus create the best possible environment for their unborn children.

The work of many pre- and perinatal pioneers cited by Verny in both of the aforementioned books is now legendary among students in this field. Instead of relating a lengthy history of those who have contributed to the emergence of prenatal and perinatal psychology, I believe that it is more relevant to this dissertation to focus on the principles that support the wellbeing of pregnant women and their babies. A distillation of those principles, which are stated from the baby's perspective, has been presented in a DVD produced by doctoral candidates at the Santa Barbara Graduate Institute:

1. Conception, pregnancy and birth are natural processes.
2. Pregnant mothers and babies share experiences.
3. Babies are conscious, aware, and expressive.
4. Babies need loving support for optimal development.
5. Babies' first relationships lay the foundation for all relationships.
6. Experience dramatically affects the development of babies' brains.
7. Imprints from early experiences can be enhanced—or transformed at any time. (Highsmith et al., 2004)

In this visual presentation Chamberlain, a respected psychologist and pioneer in pre- and perinatal psychology, states:

> Prenatal and perinatal psychology is a new science about the first stages of human development—the very first—from before conception to a little after the birth. . . . The influence, the love or the hostility, and the nourishment or the starvation that the mother and father provide to this baby growing in the womb affects how the body can grow and how the brain can develop. It's prenatal psychology as we see it because we think the psyche of the baby is very much alive. We have lots of evidence to show that. But people don't know it yet and we need to talk about it

> constantly to get people to open the womb and let them peek inside and be able to redefine in their own mind what a baby is. Then it's not something wooden; it's not inert; it's not passive; it's not a passenger in the womb. It is a participant in the womb. It's part of everything the mother is doing. (Highsmith et al., 2004)

Further, Chamberlain acknowledges that "the baby is never without awareness and consciousness" (Highsmith et al., 2004). It is the consciousness of the mother, the baby, and all those who support them to whom this dissertation is addressed.

Conclusion to Literature Review

This literature review has covered the background material that I felt was essential to proceed with the study of primiparas' expectations. The review has included relevant studies from the international community as well as those conducted in the United States. I described various theories that I planned to apply in the analysis and interpretation of data: the science of consciousness, feminist theory, art interpretation, and prenatal and perinatal psychology. In the next chapter I describe the methodology used in this study.

Chapter III: Methodology

Rationale for Research Methods

My intention in conducting this research was to listen to primiparas telling their stories and to retell those stories so their voices could be heard. Within American society there are researchers who contend that women's voices have been ignored and that women themselves have silenced for so long and so often that they have become unaware of the power and wisdom they hold within their bodies and minds (Brown et al., 1994; Davis-Floyd & Sargent, 1997; Wolf, 2003). It seemed relevant, indeed, important to conduct qualitative research in the realm of childbirth to find out what first-time pregnant women in the United States today believed about giving birth and to assess whether their conscious expectations were realized when they actually gave birth. To listen and report what primiparas thought, felt, believed, and expected required methods that could address the task thoroughly and respectfully. With those objectives in mind I approached the phenomenological research used for data-gathering by first examining my own beliefs.

Epoche, Bracketing, and Reflexivity

It was also my intention to be present for the women in my study—to hear them and to respect their perspectives. This approach was one that seemed natural to me and was encouraged by experts in the field of phenomenological research (Hertz, 1997; Levesque-Lopman, 1988; Moustakas, 1994; Patton, 2002). Listening to others with an open mind, aware of one's own biases but holding them in abeyance, was part of the phenomenological protocol I chose to follow. This attitude could be entered into either before commencing data collection or not later than beginning data analysis. Employing epoche or bracketing (further discussion of these terms follows), I sought to suspend my own opinions while interviewing women pregnant for the first time and to analyze and

present my findings as free of personal bias as possible.

Moustakas (1994) defines epoche as a process in which the researcher is engaged *throughout* the study. This includes the initial formation of questions, subsequent interaction with the participants (considered co-researchers), and analysis. Moustakas describes transcendental phenomenology, which he adapted from Husserl and other earlier theorists, as an approach to research in which the researchers seek to transcend their egos; to suspend any personal beliefs or institutional dogma; and, to intuit the essence of the phenomenon being studied. According to Moustakas, epoche is integral to the entire research process.

> The researcher following a transcendental phenomenological approach engages in disciplined and systematic efforts to set aside prejudgments regarding the phenomenon being investigated (known as the Epoche process) in order to launch the study as far as possible free of preconceptions, beliefs, and knowledge of the phenomenon from prior experience and professional studies—to be completely open, receptive, and naïve in listening to and hearing research participants describe their experience of the phenomenon being investigated (p. 22).

Patton (2002) considers epoche a process to be entered into as analysis of data begins. The intent of epoche, as defined by Patton, is to perform a mental cleansing—to identify and set aside any biases before commencing data analysis. Because researchers have preconceptions and judgments that could influence their interpretation of their data, phenomenologists look within utilizing the epoche process to become more aware of previously held views and, letting go of those views to the best of their abilities, examine their findings free of personal prejudice. Having accomplished a "'phenomenological attitude shift'" (p. 485), the researcher can present the opinions and experiences of the

participants in the most authentic manner possible.

It is after epoche, performing the second step of analysis called phenomenological reduction, that Patton (2002) incorporates the use of bracketing. This term also describes the suspension of preconceptions, thus examining "the data in pure form, uncontaminated by extraneous intrusions" (p. 485). Moustakas approaches all phases of transcendental phenomenological research employing epoche, while Patton delineates steps that distinguish epoche from bracketing, a similar process, and applies each in sequence after data has been gathered.

Bracketing is considered by Streubert and Carpenter (1995) to be "a methodological device of phenomenological inquiry that requires deliberate identification and suspension of all judgments or ideas about the phenomenon under investigation of what one already knows about the subject prior to and throughout the phenomenological investigation" (p. 313). In studies that I reviewed prior to engaging in this research, I found that bracketing was used by other phenomenological researchers performing similar studies but that epoche was not a term utilized to describe the process of suspending preconceptions.

Sociologist Levesque-Lopman (1988), author of *Claiming Reality: Phenomenology and Women's Experience*, uses the terms epoche (a term which she attributes to Husserl) and bracketing synonymously. She examines the phenomenology of Edmund Husserl and Alfred Schultz, building a case to support "how phenomenological sociology relates to a descriptive study of women's subjective experience" (p. 155). Husserl had presumed the existence of a natural attitude which masked a deeper essence of reality. This natural attitude would typically go unquestioned but could, with awareness, be suspended or bracketed "in order to be able to get to the

most basic aspects of consciousness" (p.17). Although the participants in any study would have acquired a natural attitude, it was the suspension of my own natural attitude that I wanted to accomplish.

As I approached my research phenomenologically, I was careful to frame questions in an open-ended manner, avoiding bias in the way in which I asked women about their expectations. In each interview I sought to set aside my own preconceptions and listen with an open mind. According to Zen Master Shunryu Suzuki (1983), "if your mind is empty, it is always ready for anything; it is open to everything. In the beginner's mind there are many possibilities; in the expert's mind there are few" (p. 21). Keeping an open mind is frequently referred to in texts on research methods as either epoche or bracketing (Levesque-Lopman, 1988; Moustakas, 1994; Patton, 2002). My intention was to create a safe container for the participants to reveal their thoughts, feelings, expectations, and experiences—to create a space for them to feel respected and accepted without the imposition by me of any personal bias. My attitude became one that supported each participant regardless of how she planned to or, in fact, experienced giving birth. I remained neutral and/or validated each woman's experience, honoring her thoughts and feelings as much as possible.

After conducting the interviews, I found I was ready to immerse myself in the data. This is standard phenomenological protocol. While transcribing each interview I listened to the audiotape as the first step in the immersion process and used transcribing as an opportunity to continue to wonder—to stay open to new insights while suspending any of my own biases.

I began this precursive period to the analysis by reviewing selections from qualitative research texts and studies in which researchers described using the processes

of bracketing or epoche while performing their own studies. I relied on Patton's (2002) *Qualitative Research and Evaluation Methods*, Moustakas' (1994) *Phenomenological Research Methods*, and Levesque-Lopman's (1988) *Claiming Reality: Phenomenology and Women's Experience* all quoted above. In addition, Gibbins & Thomson's (2001) study of eight pregnant women in England (reviewed in Chapter II) demonstrated how bracketing has been practiced in similar research. These researchers used bracketing "to retain an element of objectivity" (p. 305) by deliberately examining and suspending their own beliefs about the phenomenon under study. Gibbins and Thomson employed this process to defend "the validity and objectivity of interpretation against the self-interest of the researcher" (p. 305). They noted, however, that phenomenological researchers must routinely face the possibility that bias can influence the data.

> Indeed, it is questionable whether it is possible for researchers to be fully aware of their own biased attitudes and be able to lay those aside. . . . It is perhaps true to say that bracketing attempts to make the researcher's bias explicit, rather than eliminating it. It may be more realistic to recognise that researchers can only write about their bias as honestly as possible and clearly identify their presuppositions so that consumers of research can make their own judgement about how the research has been influenced by the bias. (p. 305)

Gibbins and Thomas point out that, although their chief researcher wrote down her thoughts and preconceptions about the phenomenon under study prior to collecting any data, the possibility of personal bias still existed.

In another earlier study of seven women with post-partum depression (Beck, 1992), the researcher used bracketing to peel away "the layers of interpretation" (p. 167) so preconceptions could be set aside and the phenomenon could be seen without

distortion. Prior to each interview Beck bracketed her own "experiential knowledge in order to capture the empirical reality outside herself . . . and to portray accurately the reality described by the mothers who participated in the study" (p. 167).

Both these studies described bracketing (the term applied rather than epoche) and employed the process prior to initiating data collection. I subscribed to this process as well, by approaching each first interview with a sense of curiosity, staying open to what each woman would reveal regarding her own expectations of giving birth. Anticipating the second interview (i.e., the postpartum interview), I was eager to find out how her experience had validated her expectations—or not. I stayed present to the actual thoughts, feelings, and experiences of the women, because it felt within me, ethical and honoring. To impose my ideal version of their births seemed to me to trespass on sacred ground—the sanctity of a mother and child meeting for the first time outside the womb.

In an effort to be as forthright as possible without precluding genuine sharing of other points of view, I disclosed to participants my feminist orientation and involvement in prenatal and perinatal studies with its philosophical underpinnings regarding reverence for life, particularly that of the unborn fetus. Discussions of right-to-life and abortion came up only once in the course of interviewing these women. One woman disclosed that years earlier she had had an abortion. It was a delicate and deeply private disclosure. I found that I could suspend my own personal preferences in light of the fact that this woman had made the best decision she could at the time. Although my own beliefs might have been challenged, I found that I could, indeed, adopt a transcendent attitude and easily accept this woman's choice. It also made me reconsider one of my criteria which, in this case, needed to be made more explicit—this was a first *full-term* pregnancy. No other woman reported that she had earlier miscarriages or abortions. I

accepted each response to my initial qualifying question, “Is this your first pregnancy?” as both affirmative and accurate.

Prior to conducting the interviews I had spent time engaging in extensive self examination. This process is known also as self-reflexivity, a pillar of feminist thought. While epoche and bracketing focus on the researcher letting go of preconceived ideas, reflexivity brings the elements of power and politics into awareness as well. Some feminist researchers, myself included, give serious consideration to “the interaction between the researchers and the researched in interview-based qualitative research designs” (Gergen, Chrisler, & LoCicero, 1999, p. 436), striving to reduce any power inequities that could occur while gathering the data. Reading discourses on feminist research made me acutely aware of issues in interviewing that included “concerns about question formation, [and] the amount of control the interviewer should have over the process” (p. 436). Therefore, I was attentive to each participant to insure that she felt respected and able to tell *her* story.

Hertz, editor of *Reflexivity & Voice* (1997), states that reflexivity “permeates every aspect of the research process, challenging us to be more fully conscious of the ideology, culture, and politics of those we study and those we select as our audience” (p. viii). Further, she explains the following:

> reflexivity implies a shift in our understanding of data and its collection—something that is accomplished through detachment, internal dialogue, and constant (and intensive) scrutiny of “what I know” and “how I know it.” To be reflexive is to have an ongoing conversation about experience while simultaneously living in the moment. (pp. vii-viii)

Researchers can use the processes of epoche, bracketing, and reflexivity to

contribute to the validity of their research. Becoming aware of, acknowledging, and disclosing one's biases regarding the phenomenon being studied, help researchers observe and report data more authentically. From a quantum physical perspective the observer always affects that which is observed. In terms of performing research from this point of view, "researchers are acknowledged as active participants in the research process" (Hertz, 1997, p. viii). In their chapter on interactive interviewing in *Reflexivity & Voice*, Ellis, Kiesinger, and Tillmann-Healy (1997) state that "interpretive scholars, particularly feminists, have debunked the myth of value-free scientific inquiry" (p. 121). By making my biases known, by having self-examined throughout the research process, and by staying intuitively open to the meanings, attitudes, feelings, beliefs, and expectations that the participants associated with their experiences, I trust that the validity of this research has been enhanced.

Research Design

The overall design of this study was qualitative. The strength of performing qualitative research is that it allows "human insight and experience to blossom into new understandings and ways of seeing the world" (Patton, 2002, p. 513). Its weakness stems from the same human element because "the researcher is the instrument of qualitative inquiry" (p. 513). The researcher is ideally expected to be an "empathic interviewer . . . astute observer … [and] an insightful analyst" (p. 513). To this prodigious mix of qualities the researcher should also be creative and even innovative. I have endeavored to be such a researcher.

My primary research method was phenomenological. Proposing explanations within the context of phenomenological research is not usually done. Presenting the data as authentically as possible and identifying themes is standard practice. I felt compelled

to consider the data in new ways. Louise Levesque-Lopman (1988), in her sociological book *Claiming Reality: Phenomenology and Women's Experience*, noted that "when sociologists study emotion they distinguish between the data received from the subject and their inferences from them" (p. 75). It has been a delicate balance to honor the thoughts and feelings shared by the participants and still remain open to the implied meanings, the suggested themes, and the not-so-obvious messages that were conveyed. This has been the concern of other researchers as well. Acker, Berry, and Essevold (1983) considered problems in feminist research and were faced with a quandary: "the question becomes how to produce an analysis which goes beyond the experience of the researched while still granting them full subjectivity. How do we explain the lives of others without violating their reality?" (p. 429). These questions occupied my mind during the course of this research.

I positioned myself as a feminist, as an advocate for the rights of women; that could have influenced the research. However, "feminism is a perspective, not a research method" (Rollins, 1996, p. 13). Consistent with the views of many postmodern feminists, I am particularly opposed to a positivist perspective which approaches research data as objectively quantifiable and views the world as one which exists independently from those who perceive it. Indeed, the study of consciousness has led me to the quantum physical notion that just the opposite is the case. The world according to quantum physics is one in which there is no fixed and certain reality—uncertainty is essential in a dynamic universe. In addition, it is now known that "it is not possible to observe reality without changing it" (Zukav, 1979, p. 56). Therefore, as a researcher, I was aware that I would have at least a modicum of influence on the participants that I interviewed, even with the best intention to simply observe their reality. While conducting interviews I was

also aware that the "researcher is co-creator of the narrative" (Rudestam & Newton, 2001, p. 39). Being aware of my influence, I asked each primipara the same open-ended questions and attempted to use prompts that encouraged each participant to share her ideas rather than to agree with me.

My phenomenological inquiry was based on the question: "What is the meaning, structure, and essence of the lived experience of this phenomenon for this person?" (Patton, 2002, p. 132). "Generally, phenomenologists reject scientific ***realism*** and the accompanying view that the empirical sciences have a privileged position in identifying and explaining features of a mind-independent world" (Schwandt, 2001, p. 191). Researchers of this school focus on elements of experience including "perception (hearing, seeing, etc.), believing, remembering, deciding, feeling, judging, evaluating, and all experiences of bodily action" (p. 191). The emphasis is on the meaning rather than the material. The authors of one of the studies reviewed in Chapter II of this dissertation, when reporting the results of their phenomenological study, explained that "phenomenology focuses on feelings about, perceptions of, meaning attached, attitudes about, and reactions to life experiences" (Callister et al., 2001, p. 29).

According to the authors of *Mindful Inquiry in Social Research,* "phenomenology is the study of experiences of consciousness" (Bentz & Shapiro, 1998, p. 172). That statement is particularly applicable to my study. Even more, "phenomenology attempts to get beneath how people describe their experiences to the structures that underlie consciousness, that is, to the essential nature of ideas" (Rudestam & Newton, 2001, p. 38). Based on my resonance with its orientation toward experiences of consciousness (Bentz & Shapiro, 1998), examples of its application in research relevant to my study (Gibbins & Thomson, 2001), and the manner in which it could be combined with

feminist, intuitive, and innovative approaches (Patton, 2002) made phenomenology my methodology of choice.

Research Protocols

Protocols suggest the application of rules and specific procedures. Interviewing was the primary procedure applied in the course of gathering data. Within the interviews I asked open-ended questions (listed below) allowing the participants to share their views as fully as possible. Patton (2002) states that "the *standardized open-ended interview* consists of a set of questions carefully worded and arranged with the intention of taking each respondent through the same sequence and asking each respondent the same questions with essentially the same words" (p. 342). Into this phenomenological methodology I integrated a feminist approach which emphasizes protocols such as collaboration and self-reflexivity. Calling the women participants as opposed to subjects, having them review transcripts as co-researchers, having them interpret their own drawings, continuously examining my own biases and setting them aside, and disclosing my feminist orientation helped build a sense of connectedness and equality between the primiparas and myself as the researcher.

Lather (1991) recommends interactive interviewing that can require self-disclosure on the part of the interviewer, serial interviewing, and more participation by the interviewees in the research process. These suggestions expand established protocols. It was my intention to utilize accepted protocols as a guide, but to use my own intuition in the moment. I was comfortable with self-disclosure, for example, and found that during each interview I would usually share something of a personal nature with the participant. These were often statements like, "I am a 62-year-old grandmother who has returned to school to study prenatal and perinatal psychology." This type of self-

disclosure seemed to be valuable in building rapport and facilitating reciprocal disclosures from each woman. I kept these personal statements to a minimum in an effort to keep from dominating the discourse, staying focused on the lives and experiences of the pregnant women themselves. I followed established guidelines while staying open to possibilities throughout the interviews and during interpretation of data.

Selection of Participants

The participants in the study were women selected on the basis of several criteria:

1) Being 18 years or older to meet the age requirement for legal consent (Although liberated minors have legal rights and could have been included, the pilot study, described in Chapter IV, confirmed that 18 years was the optimal minimum age.);

2) Being pregnant with their first child;

3) Having a low risk pregnancy so that negative circumstances would not unduly influence attitudes and decisions made during the pregnancy and at birth. This minimized the risk that an interview could precipitate any adverse physical, mental, or emotional consequences to the pregnant women or their babies. Since each woman was a volunteer and fully apprised ahead of time as to the purpose of the study and my orientation as a researcher, the risk seemed minimal.

4) Living in Southern Arizona so that two face-to-face interviews could be conducted conveniently and in a timely manner.

Because I wanted to focus on primiparas giving birth in the United States, I considered making citizenship a criterion. Discussing this possibility with my Director of Research, we concluded that it would be discriminatory to deny participation in the study to a woman who resided in the United States but maintained citizenship elsewhere. Indeed, this situation occurred when one woman disclosed during the first interview that

she had been raised outside the United States. Since I had not required U. S. citizenship as a criterion, because the literature review had revealed that women of many cultures appeared to experience the same attitudes regarding childbearing, and because this particular woman had spent the majority of her life exposed to Western cultural practices, I decided that her participation was appropriate.

Although I anticipated that most of the women in my study would represent the society in which they reside, that is, they would predominantly choose physicians and hospitals and take measures to reduce pain, I did not establish a parameter addressing the manner in which a woman chose to give birth. Later, the results showed that the way in which the women in this study gave birth became the predominant distinguishing feature.

Between five and ten women were sought to allow for attrition as I predicted that some women might not follow through with both planned interviews. In fact, all but one who were initially interviewed were interviewed a second time as well. One woman moved from the area prior to giving birth so was unavailable for a second personal face-to-face interview. I decided that a telephonic interview would not suffice. Ultimately, seven primiparas comprised a small purposeful sample for this qualitative research. Patton (2002) defines purposeful sampling as a design strategy. The participants "are selected because they are 'information rich' and illuminative, that is, they offer useful manifestations of the phenomenon of interest; sampling, then, is aimed at insight about the phenomenon" (p. 40).

A member of a local "Birth Circle" referred her pregnant daughter to me. This young woman became the first participant in my study. I met the second primipara at a salon where we spent an hour developing a rapport. I met the third primipara at a conference where we, too, established a friendly association. The fourth pregnant woman

was referred to me by a local midwife. That participant subsequently referred another candidate so that ultimately I was able to rely on a "snowball effect" (Patton, 2002). More specifically, this participant referred me to the fifth, who referred me to the sixth, and finally that participant referred me to the seventh. Members of the Birth Circle (a midwife, a birth educator, and a Hypnobirthing instructor) often knew the same individuals so I was able to be recommended to a prospective participant by more than one person.

I noted that establishing a personal rapport with a prospective participant or being personally referred by someone the candidate knew well was essential to gaining and conducting an interview. Several women declined to participate in the study. I was referred to one young woman who agreed to participate but who forgot our first appointment. When I called her home we agreed to reschedule our meeting but she did not return any of the subsequent messages I left with her parents. I met two young women casually in a department store. One seemed offended and defensive but said she would discuss participating with her husband and call me. She never did. The other initially agreed to be interviewed but did not come to her scheduled appointment. She explained later that her husband did not want her to participate in the study. These women may have been reluctant because they did not know me. Interestingly, each represented an ethnic minority whose voice I would love to have included in my study.

Each woman who agreed to participate was very cooperative and willing to share her expectations and experiences. The willingness to participate in two interviews, once prior to delivery and once following delivery, *and* the willingness to be observed, to reveal personal thoughts and feelings, and to complete a drawing depicting an ideal birth were all factors that determined a primipara's inclusion in the study.

Data Collection Procedures

This study was designed as a two-part process. The first stage was to identify the participants, make arrangements to meet with them, and interview them while they were pregnant. Interviews were conducted utilizing open-ended questions since "the major way in which qualitative researchers seek to understand the perceptions, feelings, and knowledge of people is through in-depth, intensive interviewing" (Patton, 2002, p. 21). Interviews were audio and video recorded and observations were recorded in field notes. One additional step was taken: each participant was asked to draw a picture of her ideal birth. Here, the intention was to see if subconscious beliefs could be accessed through a drawing that might not have been expressed verbally during the interview. Patton points out that "projective techniques are widely used in psychological assessment to gather information [and are] creative qualitative modes of inquiry" (p. 394). Ultimately, the three tools available to qualitative researchers were capitalized upon: observation, interviews, and, review of documentation, in this instance, drawings.

A Description of Study form (Appendix A) and an Informed Consent Form (Appendix B) were given to each participant at the outset of the first interview. I went over each document with the women, advising them of risks and benefits, giving each participant an opportunity to decline or formally agree to participate in the study. I obtained signatures and initials prior to asking any questions. Copies of the two forms were given to each participant. This procedure protected each primipara and also followed established guidelines provided by the Santa Barbara Graduate Institute Institutional Review Board.

The first interview consisted of open-ended questions that asked the participant to reflect on her expectations regarding her pregnancy and forthcoming labor and

delivery. Prompts were used judiciously to encourage the articulation of attitudes, perceptions, and feelings. The first inquiry addressed the pregnancy and the second focused on the impending birth: 1) How do you feel about being pregnant? 2) What do you expect giving birth to be like? These questions were intended to be neutral and non-censoring, inviting both positive and negative feelings and expectations. I avoided questions that could be answered with a yes or no because they would not provide the detail of information that I wanted to elicit. The questions I asked were intended to be user-friendly, to build rapport, to be non-threatening, and to focus on the women themselves. I was receptive to more verbal interaction, reciprocation, and mutuality, but at no time did I want the focus of the interview to shift substantively from the participant. These questions, asked of each of the participants, were directional in nature and were intended to avoid the imposition of any biases.

Following the verbal portion of the first interview each participant was asked to draw a picture of what she thought her ideal birth would be like. Drawings are projective techniques used in art therapies to reveal unconscious thoughts and feelings. "Drawing is viewed as a projective technique in which a client shares his [or her] perceptions and reactions to the world around him [or her]" (Drummond, 1988, p.151). Reliability and validity of projective techniques are controversial. In this instance the drawings were employed in conjunction with observations and interviews to gain a more comprehensive view of the participant's world but were not intended for diagnosis or treatment as they would be in a therapeutic setting. Other portals into the realm of the unconscious are dreams (Jung, 1989) and hypnosis (Boyne, 1989) but these required more time to explore and could be perceived as too invasive or therapeutic in their intent. Neither dream interpretation nor hypnosis were appropriate in this research.

General guidelines for interpretation of the drawings were derived from texts included in the literature review but my own intuition was relied upon to offer the most probable explanation for understanding the minds of those creating the images. To improve the reliability of my interpretations I asked two therapists who regularly use projective techniques in the course of their private practices to interpret the drawings. Those are included in Chapter VI. Since they knew nothing about the primiparas other than that the drawings were the "ideal birth" images of pregnant women, the interpretations sometimes include observations that are not relevant to this study. Those are pointed out. Also, as is usual, each reviewer offered a slightly different interpretation. In many cases the interpretations were similar enough to suggest that some symbols have universal meaning and that the drawings conveyed the same subconscious messages to each interpreter.

The suggestion to include a drawing in my study was first made by a colleague at Santa Barbara Graduate Institute. She referred me to the book *Birthing from Within* by Pam England and Rob Horowitz (1998). These authors use drawings "to help mothers learn more about how they have internalized our birth customs and routine practices" (p. 88). They believe that "the personal concerns of the mother-artist can be inferred from the content and mood" (p. 92) of her drawing. I chose to focus the subject of the drawing on a primipara's ideal rather than her sense of birth customs or practices. I asked each woman to imagine that her ideal birth was occurring in present time. The orienting question was: What would your ideal birth look like? I supplied paper and colored pencils and tried to be unobtrusive while the participant was drawing. I reviewed my notes or otherwise made an effort to create and maintain a safe space for each woman to express herself artistically. I answered questions and reassured the participants that they

could draw realistically, symbolically, or in any manner that represented their ideal. I made it clear that there was no intention to grade the quality of their artwork. I requested an interpretation of the drawing from each participant herself, asking: Tell me more about what your drawing represents to you. The drawings were duplicated and copies were returned at the same time that the transcripts were submitted to the participants for their review. A copy of each drawing is included in an Appendix.

The subject of the drawing had been carefully considered. The pilot study had helped me distinguish between asking the participant to draw what she thought would happen versus what she ideally wanted to have happen. I did not want to promote fears but wanted to contribute to the most positive outcome. Therefore, I decided that an ideal birth would help each woman envision the best birth she could and still provide the kind of information that depicts either positive expectations or reveals hidden concerns. I was willing to obtain limited data rather than risk re-imprinting deeply held fears.

Each participant was encouraged to share as many details of her experiences, hopes, desires, and expectations as possible. I wanted each woman to feel secure and supported to tell her story. Since each of the interviews took place in the participant's home, I simply needed to ask where she would be most comfortable during our time together. The simultaneous observations, interviews, and drawing exercise were intended to last at least an hour which turned out to be a realistic timeframe. During the first interview it took about 20 minutes to review the Description of Study and the Informed Consent Forms. The interview itself took approximately 25 minutes and the drawing took about 15 minutes. In all, one hour was typical for the first interview.

Interviews were both audio tape recorded and video taped, for which consent was obtained. I also received permission prior to each interview to have a cameraman (my

husband) set up the video camera, check lighting, and insure that I could keep my attention focused on the participant rather than be concerned about equipment. The videographer, a rather grandfatherly type, remained unobtrusive and did not take part in the interviews. I kept note-taking to a minimum since the videotape would be available for review at a later time. It was important to me to make eye contact and to be present during the interview.

Because I have rather limited technical skills I debated over having a videographer, with whom I had worked before filming the DVD *Babies Know*, take responsibility for handling the filming or attempting to set up and run the equipment myself. I felt that prioritizing my interaction with each participant without the distraction of operating equipment with which I was uncomfortable was the best way to keep us both at ease. With these particular primiparas it appeared to work successfully. If I were to conduct another study of this type, knowing that women like those who declined to participate might be sensitive to the presence of another person, I would either film myself or not videotape at all. I found that the audio recordings which can be easily transcribed, supplemented by the drawings, made the most valuable contributions to the study. The second audio recording, recorded on the video tape sound track, provided a backup in the event of an equipment failure and also helped in deciphering unintelligible words in the primary audio recording.

The second interview took place after the birth of each participant's baby at a time convenient for the new mother. This interview focused on the actual experience of giving birth. I asked: 1) Tell me about your experience of giving birth. 2) How did your experience compare with your expectations? 3) What else would you like to share? The questions constituted a gentle debriefing. A review of literature found that "women

reported that an opportunity to talk with someone about the birth was helpful in facilitating recovery" (Gamble, Creedy, Webster, & Moyle, 2002, p. 72). The second interview, which did not require forms to be signed or time for drawings to be completed, usually took only about 30 minutes each.

Data Analysis

I transcribed all the interviews personally. Patton (2002) suggests that "doing all or some of your own interview transcriptions (instead of having them done by a transcriber), for example, provides an opportunity to get immersed in the data, an experience that usually generates emergent insights" (p. 441). I found this to be the case and noted my insights as I continued to read each transcript several times to identify emerging themes. Copies of transcripts were returned to the participants for their verification of accuracy. This step involved the participants as co-researchers although none made any changes to the texts. I reviewed the videotapes to reconcile spoken dialogue with facial expressions and body language. Drawings were first simply described, using the participant's own words when possible, then intuitively analyzed along art interpretation guidelines and added to verbal information to corroborate or refute the conscious thoughts and feelings expressed by each participant.

I approached the analysis by first identifying key words and phrases in the transcripts, and highlighting them with colored markers. I defined essential features that recurred throughout the stories and eliminated irrelevant data by simply not highlighting those passages. These steps are customary in the phenomenological analysis of data (Patton, 2002). I read and reread the transcripts and found that, like ink rising to the surface between the lines of a page, themes began to reveal themselves. The themes both underpinned and overwrote the stories. They emerged from the substance of the data and

hung like fine lace over the face of each exquisite self-portrait.

The data that I had gathered seemed so rich and powerful that I wanted to share as much of the women's stories as possible—on their own words. I also wanted to identify the themes that were repeating throughout each primipara's story and defer my interpretation of the meaning of those themes, individually and collectively, until the final discussion. I deduced from reading Patton (2002) that a phenomenological researcher, reserving any final observations or conclusions until all the data has been fully examined, could present results in an illuminating manner and subsequently add interpretations. I present my interpretations in Chapter VI, comparing and contrasting my results with those of other researchers, citing their studies when applicable.

I decided to report the findings as case studies (Chapter V). Although Yin (1989) describes case studies as research strategies which include "design, data collection, analysis, and reporting" (p. 14), Patton (2002) explains that "case study analysis involves organizing the data by specific case for in-depth study and comparison. Well-constructed case studies are *holistic* and *context sensitive*, two of the primary strategic themes of qualitative inquiry" (p. 447).

> The case study may be based upon a synthesis of evidence attained from all available sources, including interviews, projective or objective tests, observations in the natural environment, longitudinal studies, personal documents, public archives, the testimony of others, experiments, or any other method capable of producing relevant information. (Runyan, 1982, p. 443)

I chose to present the data collected as case studies because I could include quotations from interviews, descriptions of observations, *and* interpretations of drawings in a logical, comprehensive, and comprehensible manner. I found Patton's definition of a

case study as “a form for organizing and presenting information about individuals and their circumstances which may draw upon a variety of techniques of data collection” (p. 445) to best describe and justify my use of this protocol. My intention was to make “accessible to the reader all the information necessary to understand the case in all its uniqueness” (Patton, 2002, p. 450). Consequently I used Patton’s guidelines for writing case study narratives, presenting them chronologically *and* thematically.

The volume of data presented a challenge. I was writing seven stories while constantly referring to long transcripts for evidence of the emergent themes. I was concerned that I was organizing the data in a consistent manner so that the same types of information could be found in each case. I created a check list (see Table 1) simply to handle all the data and found it to be a superb tool for insuring that I included all the various components in each case study.

Table 1

Check List

CATEGORY	1 Annette	2 Barbara	3 Carolyn	4 Dorothy	5 Eleanor	6 Felicia	7 Gwyneth
Question 1							
Question2							
Question3							
Question4							
Drawing							
Theme1: Joy							
Theme 2: Education							
Theme 3: Choices							
Theme 4: Support							
Theme 5: Doubts							
Theme 6: Unexpected							
Theme 7: Acceptance							
Theme 8/1: Return to Joy							
Demographics: Age Marital Status Education SES Ethnicity							
Meeting Circumstances 1st & 2nd							
Conclusion							

After actually presenting the results as case studies in Chapter V and showing how I ascertained themes emerging from the data, I started Chapter VI by examining each theme individually and collectively. The pattern that I saw revealed a dynamic process composed of paradoxical elements experienced by each pregnant woman. At this point I created two Figures to graphically picture what I thought of as a three-dimensional process. This occupied my mind for days as I retold the primipara's stories, this time as support for the emergent themes. I had identified a thematic sequence that was interesting and perhaps helpful in understanding the paradoxical nature of pregnant women's thoughts and feelings. That understanding might heighten the sensitivity of anyone serving this population but I had not yet explained to my own satisfaction *why* the primiparas' stated expectations were *not* being realized.

I began to consider how to incorporate the theoretical perspectives that I had introduced in the literature review as the means for answering why the women in my study, like those in other small qualitative studies, would say their experiences differed from their expectations. I was particularly intrigued by current understandings of the mind and consciousness. I was aware that phenomenology does not distinguish between the conscious and unconscious minds, a point reinforced by Bentz (personal communication, July 7, 2006) during a review of my draft. I felt that it would be essential to fully comprehending the data to make the distinction between the two minds. I looked at the primiparas' drawings to access unconscious notions that might not be readily extrapolated from the narrative together with statements made during the interviews to see if indications had been given to suggest that a woman's expectations were something other than those she consciously expressed. The literature on consciousness had indicated that this was not only possible, but likely.

I wanted to feel confident that using drawings in qualitative research was appropriate and revisited literature that supported my approach. I found a study describing innovative methods that are gaining acceptance in psychological research. Gergen and colleagues (1999) describe "The Visual as Data" (p. 438) as one of the innovative methods "congenial to research in feminist psychology" (p. 431):

> Using visual displays (iconic representation) along with text (symbolic representations), researchers can simultaneously present diverse points of view in new and interesting ways. Psychologists have used photographs, graphic models of theoretical relations, *drawings by participants* [italics added] and clients, films, cartoons, paintings, posters, and other artistic renderings to inscribe their research objects and findings. (p. 438)

To enhance the validity of my own interpretations I asked two qualified therapists who utilize artistic renderings with their clients to also interpret the drawings. I added those perspectives to expand on mine and to demonstrate that interpreters can find both similar and different meanings. Whether the interpretations agreed or not is not as pertinent as the fact that each reviewer recognizes that a drawing contains projections from the unconscious mind of its creator.

In addition, as I looked toward the implications of my study I began to consider the data from the viewpoint of feminist inquiry. Sociologist Levesque-Lopman (1988) states, "the phenomenological investigation concretizes and personalizes social phenomena, their fundamental meaning in and for social action" (p. 154). She further links phenomenology with feminism saying that "whereas phenomenological sociology interprets our consciousness of the world, feminism seeks to transform it" (p. 157). Feminist researchers are also concerned about "how to create interpretations of interview-

derived data that both value the interviewee's words and express the perspectives of the interviewer" (Gergen et al., 1999, p. 436). Therefore, initially, I based my interpretation on the traditional methods of phenomenological inquiry, then further considered them from other perspectives including feminism.

The triangulation of phenomenology, consciousness-revealed-through-art, and feminism is intended to contribute to an enhanced understanding of primiparas. The integration of several methods into one study is a manifestation of "the potential for creating new mixes of methodologies" (Gergen et al., 1999, p. 437). I discuss the themes in more detail in Chapter VI. I posit explanations for each theme offering insights and referencing literature in the field which relates the findings to those of other studies, current theories, and clinical applications.

Significance of the Study

This study was designed to fill a void in the existing literature that appears to exist because of the relative absence of qualitative studies that explore the expectations of pregnant women in the United States. It is ironic that women, particularly those served by midwives abroad, are being asked what they expect at the birth of their babies in countries where the infant mortality rates are significantly better than in this country. Because birth is an event that is only experienced by women, I felt it was appropriate to collect and analyze data through the eyes of feminist theory. "Central to the feminist and liberationist critique of political and scientific discourse is the absence of the actual voice of poor and disenfranchised persons from research studies and social analysis in general" (Braud & Anderson, 1998, p. 78). This research provides a voice for pregnant women virtually absent from qualitative research in the United States.

The design of this study also expands phenomenological methodology by adding

a projective device to the data collection process. This procedure could provide a more comprehensive assessment of the thoughts and feelings of participants in other studies that incorporate such innovative methods. In light of the growing scientific understanding of the mind and established psychological procedures, unconsciously held beliefs can be deduced from the words, phrases, and metaphors used by speakers; from the observation of facial expressions and body language; and from an interpretation of drawings/projective devices. Words, acknowledged as powerful in their own right, can convey deeper meanings especially when juxtaposed to artistic representations of the subject being discussed. Together words and pictures can reveal a holistic pattern, a comprehensive and rich portrayal of the complexity of an individual and how she relates to the world. The theoretical approach to analyzing the data collected in this study includes current understandings of the way in which the mind operates at both conscious and unconscious levels. This could aid in understanding why women have the expectations they do at this meaningful time in their lives.

As Gergen and her associates (1999) suggested, I was able to "integrate diverse methods into one project" (p. 437). New expanded approaches to research are "especially suited to research topics involving human experiences that are *personal*, *subjective*, *significant*, and *relevant*" (Braud & Anderson, 1998, p. 19). These authors state that "studying rich human experiences warrants comprehensive methods, that is, methods of inquiry that engage logic and analysis as well as our capacities for imagination, intuition, and alternative states of consciousness" (p. 82). Thus, I found that I could creatively combine phenomenology, the science of consciousness, feminist theory, art interpretation, and principles from prenatal and perinatal psychology into one cohesive study. I trust that this synergistic approach provides a model for the further

exploration of pregnant women's expectations as well as other qualitative research in related fields.

In summary, this research consisted of interviews with pregnant women to reveal what their conscious and unconscious expectations were regarding the process of giving birth. The findings could lead to improvements in the delivery of prenatal services, birth procedures, and educational programs. This dissertation incorporates references to related studies, cross-cultural perspectives, feminist interpretation, scientific understanding of the conscious and unconscious minds, phenomenological inquiry, and the practice of childbearing from medical and holistic/natural points of view. This study holds the promise of feminist phenomenological inquiry as emancipatory. From that perspective it could contribute to a reawakening of women's innate wisdom and a reevaluation of childbirth in the United States.

Chapter IV: Pilot Study

Background

In May 2004 I performed a pilot study as part of a graduate level course in Qualitative Methodologies at Santa Barbara Graduate Institute. This study helped prepare me for the actual conduct of the research for this dissertation. It was my intention to interview a pregnant woman asking her to share her thoughts and feelings about her pregnancy and impending birth. I wanted 1) to identify who the most appropriate candidates would be for similar interviews, 2) to sample the questions I would be asking during my dissertation research, 3) to experiment with having a participant draw a birth-related picture, and 4) to determine through phenomenological analysis of the transcript if substantive themes could be distilled from the raw data.

Gibbins and Thomson (2001) reported that "all women seem to develop expectations of childbirth and the kinds of expectations vary among women, as does how realistic they are" (p. 302). These investigators performed their small qualitative study in Great Britain. Their research served as a catalyst and model for the study I would be undertaking. This chapter describes my first effort to interview a primipara about her childbirth expectations.

This pilot study describes only one interview with a pregnant woman. I have interpreted her remarks in the light of phenomenological methods, feminist theory, art interpretation, and brain/mind/consciousness science. Initially, I chose the participant after two other women were eliminated as possibilities. I had contacted several associates to help me identify someone to interview for this pilot study. The first pregnant woman to agree to be interviewed was 17 years old. I had, during the course of developing my project, established two criteria. The first was that the participant be at

least 18 years of age. Although I did meet with this young woman, I did not ask her any research questions, nor did I audio or video record. I determined that her circumstances were stressful enough, due to being unmarried and a high school dropout, without my asking her to reflect deeply upon her expectations at that time.

Being faced with making a decision to reject a potential participant caused me to re-examine my criteria, and reinforced having a minimum age as one requirement. The second woman I planned to interview was hospitalized the day we were scheduled to meet. She was only five weeks pregnant but began to have cramps. In the emergency room she was told that she might have an ectopic pregnancy. There were mitigating circumstances in that her mother-in-law had been visiting and was a source of great stress. In deciding whether or not to proceed with a rescheduled interview, I considered my second criteria; that is, the pregnancy should be low risk. This emergency had unknown causes and consequences. Ethically I felt that proceeding could possibly contribute to—or be coincidental with—an undesirable outcome. Therefore, I decided not to interview this candidate. After two women were eliminated, one for each criterion I had established, I was eager to find a qualified candidate. A friend referred me to young woman conveniently residing nearby in Southern Arizona. A telephone conversation with Heather (not her real name) eliminated uncertainties and established enough rapport to schedule an interview.

The Interview

Heather and I met in her home for more than two hours. I spent some time introducing myself and describing the study, then furnished both a "Description of the Study" and a consent form for her to sign. Heather was raised in the south and spoke with a strong accent. She was quite cooperative and expressive. She indicated that she

was happily married to a military man and was pregnant with her second child. She had a successful first pregnancy and labor and intended to give birth in a hospital a second time. Heather and her husband planned this pregnancy and, when asked the first question, how she felt about being pregnant, Heather said they were both "thrilled". Her husband, after having some misgivings about seeing his wife actually deliver a baby, had attended the birth of their first child and planned to be present when their second baby arrived as well.

The interview, which I audio and video recorded, was based on four questions but included several prompts and some casual conversation. The tone was light-hearted. Both Heather and I laughed a lot. One unanticipated factor was the presence of her three and a half year old son. Like most preschoolers he was curious, wanted attention, and interrupted several times. Heather gently disciplined him occasionally, never raising her voice. Nonetheless, this experience provided the impetus for my adding a third criterion for inclusion in the study: *first pregnancy*. The care of a small child was distracting to the participant as well as the researcher.

A more important reason to make first pregnancy a requirement is that primiparas would not be influenced by their previous experiences. Heather compared her current condition with her first pregnancy several times. In answer to Question 2, "Is your experience the same or different from what you expected?" Heather replied, "It has pretty much followed the same route as my first pregnancy did." She added, "I felt the emotional attachment to the baby a lot quicker than I did with my first one." On reflection I decided, as other researchers like Gibbins and Thomson (2001) had, that primiparas facing the *unknowns* associated with giving birth for the first time would provide the richest data within the context of my small qualitative study.

This inclination to include only primiparas was ultimately supported when Heather anticipated the last question (# 4: What would you like your birth experience to be like?) in the series while responding to Question 3, "What do you expect to have happen at the birth?" She replied, "What do I *expect* to happen, or what do I *want* to happen?" She went on saying, "I feel like it will be the same because I don't know any difference," again referring to her previous experience. She also expressed some conflicting expectations:

> I expect that I'm a little older now. I have a little experience with it, so I feel like, that whatever happens, that I will be able to deal with it better than maybe I would have the first time because, um, 'cause I know that it may not be as easy as that first time, and I'm kind a preparing myself for that; but then there's that little part of me that's preparing myself for—well, this is my second child. It could be easier. It could just be a breeze, and I go in there and have him, and it be wonderful. And so I'm kind of expecting in between, you know, not too hard, not too easy, which is kind of what I had the first time.

Heather's prior experience obviously colored her current expectations, therefore, I concluded that future interviews and the study itself would be better served by including *first pregnancy* as a third criterion.

Heather appeared to feel the pull of two opposing emotions when, as she talked about her pregnancy, she told me about having a recent ultrasound report that erroneously indicated that her baby had an irregular heartbeat. She was very worried for a week until the report was refuted by a specialist. She remarked, "Even though one person tells me it's O.K., that's in the back of my mind now. You know, is it really O.K.?" She went on to tell me how prayer brought her "peace" during the crisis.

Heather expressed lingering doubts regarding the health of her unborn child, but her primary concern at the time of the interview was her three and a half year-old son:

> I'm worried about what am I gonna do with him—in the middle of the night, you know, if somethin' happens in the middle of the night, 'cause we've only been

> here like since December? So who do you trust to come into your home and stay with your child when you need to be at the hospital with your husband?

Heather itemized several possibilities (described in the analysis that follows), demonstrating her resourcefulness, and pointed out other factors that enhanced her feelings of security.

In addition to answering my questions, Heather drew a picture of what her impending birth would look like. Initially I asked her to draw a picture based on the directions included in *Birthing from Within* by England and Horowitz (1998). However, as we were considering what she would draw, it became apparent that the instructions needed to be modified. Heather, appropriately, made a distinction between what she might expect, which could be negative, and what she "wanted" to have happen. I suggested she draw a picture of her *ideal* birth, which would show in the most optimistic and joyful way she could imagine that the successful birth of her baby. In terms of the brain/mind/consciousness science reviewed in Chapter II, expectations tend to be realized (Dossey, 1982; Lipton, 2005; Pellitier, 1992; Talbot, 1991). If a person subscribed to this point of view, as I do, visualizing a positive outcome could contribute to that realization.

Analysis

I personally transcribed the interview because it "provides an opportunity to get immersed in the data" (Patton, 2002, p. 441). Insights emerged from that process. I read the transcript several times each day for a week, looking for patterns and themes. "The term *pattern* usually refers to a descriptive finding . . . while a theme takes a more categorical or topical form" (p. 453). I used colored markers to highlight key words and phrases. As patterns emerged from the text, I consolidated several and distilled them into four themes and a few sub-themes. In considering themes I debated between identifying

categories using Heather's own words or applying my own "sensitizing concepts" (p. 456). For example, at times Heather used the words "worry," "paranoia," "afraid," or "scared". These could be considered patterns of response that fall under a theme of "fear." She used "spirituality," "God," and "prayer" which could come under an overarching theme of "faith." She used phrases like "perfect timing" and "burst of energy" as she repeatedly referred to feeling "tired," "icky," or "great" during different phases of her pregnancy. Inspired by Heather's words, I decided to identify the major themes that emerged from the text as *Time*, *Energy*, *Fear*, and *Faith.*

Phenomenological Themes

Time

Heather's first response was that it was "perfect timing" for her pregnancy. She exclaimed that "my husband had been wanting me to get pregnant—so when we were moving here I said, 'This would be the time.'" However, for Heather, being pregnant was "not so thrilling." She considered pregnancy "one of those things." She wanted it to end saying, "O.K. Let's get this part over with. Get that baby here and, you know, be the mother part." This was, for me, the most astonishing statement Heather made during the interview. On an unconscious level, she did not seem to equate pregnancy with motherhood! In Heather's mind a woman became a mother *after* she delivered her baby. Even so, Heather acknowledged that "the whole idea of being pregnant and bringing a new child into this world is just, I mean, is amazing!" She also expressed an old belief: "I thought you would just carry the baby for nine months and have it, and [it would] not really have any affect on you." For Heather, the real joy of having a baby came after it was born. Envisioning her new baby, Heather cheerfully said, "I know that it's just gonna be so grand."

In comparing her expectations for this birth with her previous labor and delivery, Heather indicated that "it wasn't quick, but it was . . . painless." She wanted her subsequent labor "to be short and sweet." Her previous labor was, in her view, long: "It was a good 12 hours before I was fully dilated and ready to push—a good ten or 12 hours—and then I pushed for about an hour and a half." Time and timing were substantial issues for Heather. Her greatest concern was arranging for the care of her son (addressed again under the theme of *Fear*) because she expected her labor to begin in the middle of the night. She had a few new friends she could call but said "If it's two o'clock in the morning, do I call *them* [one group of new friends], or do I call *them* [other new friends], or do I call the neighbor over?" On the other hand, she remarked, "As far as actual getting to the hospital on time, this town is so small that I could be just about anywhere in the [five mile] radius, you know, and get there. So I'm not anticipating a problem with that or anything."

Time emerged as a theme in regard to the timing of the pregnancy, the duration of the pregnancy and labor, the time of night/day that labor might commence, the time it might take to get to the hospital, and, even acknowledging that she had not taken time to fully consider the child she was carrying: "You know, this is probably the first time that I just kind a sat down to reflect on, what's really goin' on here?"

Energy

The theme of "Energy," and a sub-theme "feeling," emerged early in the interview as Heather described what being pregnant was like for her: "The first trimester for me is tired, tiresome, sick feeling." Sometimes she "could barely get through the day" but noting that "After that I had a burst of energy and just felt great!" The second trimester "is like the best part, where I'm like, this isn't so bad." Entering the third

trimester, Heather said, “O.K. I’m ready for it to be over.” Her energy level seemed to be low for six of the nine months. “Now I’m fixin’ to enter my seventh month and I’m startin’ to feel the drag come out again. Bein’ tired and just overdoing it easily.” These fluctuations in energy produced physical sensations for Heather who then felt tired and sick, or, in bursts, energetic.

Heather also described the absence of feeling, specifically at the “painless” birth of her first child. “I never got any, had any contractions or anything. So then they had to kind a induce, start the contractions. Then I had an epidural. So I didn’t feel anything.” Heather emphasized that she wanted her labor to be short and painless. “If I had an identical labor again, I would be perfectly fine with that.” Although Heather did not want to feel any discomfort giving birth, she recognized that she had loving feelings and emotions for her unborn child:

> I felt the emotional attachment to the baby a lot quicker than I did with my first one. And I think it’s because I know that it is, you know, a human, that it is your child. Whereas with the first pregnancy you didn’t really, you didn’t know what they were gonna look like, how you were gonna feel as a mother. You didn’t realize the love that you had toward that child.

Having her first baby seemed to resolve a feeling of unreality about pregnancy for Heather. Yet she could not equate having a baby growing within her womb with the experience of seeing and holding her newborn child.

Fear

Fear, and the manner in which Heather dealt with being worried, paranoid, afraid, and scared, became a theme in itself. Her most significant concern at the time of the interview was her son. “What am I gonna do with him?” She worried about who would care for her child if labor started in the middle of the night. Although she did not worry about getting to the hospital on time, Heather had some underlying doubts that, should

something go wrong, she would have to leave the local hospital and be transported by helicopter to a larger hospital in Tucson. "The only reason I think that I won't have the baby at this hospital is if somethin' is wrong or like preterm labor. Then they'll Medivac me to UMC in Tucson. So, I don't anticipate that either, but *you never know*." Heather's fear of preterm labor was evident as she described a recent "scare":

> The only scare I have had was when I had my ultrasound on Post. They sent their report to Dr. Herbert's [not his real name] office stating that the baby had a mmmmm abnormal—not—no, an *irregular heartbeat*! So they called me on the phone to tell me about that and, of course, I'm home alone, and they're tellin' me, you know, there's nothin' to worry about. But I'm like "irregular heartbeat!" I just lost it! I was afraid I was gonna trigger something [preterm labor].

Heather's concern for the health of her unborn child was clear. Even though her husband had attempted to reassure her, she had rejected his assurances saying, "Hey, you're not a professional, you know. This baby's not in you. You didn't hear what the, how the nurse, the tone of her voice, and everything." She said the doctor has been "reassuring too in saying that that's very normal. But it scared me that my doctor didn't *do* anything." Despite her concern, but like other pregnant women who feel ambivalent (discussed in the literature review), Heather remarked,

> I feel confident that they know what they were talking about when they said I have nothing to worry about. But you still—you want that baby to be healthy and perfect and not a thing wrong with it. And I don't know that any of 'em come out, you know, 100 percent like that.

Faith

What sustained Heather through this crisis was her "spirituality." The fourth theme, *Faith*, encompassed her belief in God and the power of prayer, her confidence in her doctor and specialists, and her trust in her husband. Heather first described her spirituality when she worried for a week about her baby's suspected irregular heartbeat. "I sat around and prayed and prayed and prayed. That's all I did for a week." She

described her thought process in greater depth:

> As far as helping me get through it and helping me realize that if something is wrong with this baby, there's not a thing that I can do about it. I have to go through the spiritual route. I definitely got through it by prayer, and by just giving it up, and saying, "If God was to give me a child with a special need, then I will be able to take care of it." So, I mean, I truly believe.

Heather appreciated the support of her husband, but it was her faith in God that sustained her. "Even though he was supportive and calm and reassuring, I still needed that extra [help from God]." Heather's husband was present at her first birth although he had serious misgivings about being there. She said, "He did fine and he was glad he was there. At least this time I'll know that he's like excited about it." Heather had confidence in her doctor who had reassured her and in the specialist who said she should never have been told that her baby had an irregular heartbeat. She had been told by these considerate physicians that, "the only thing you need to worry about is that you're gonna have another boy, and you're gonna have two boys runnin' around drivin' you crazy!" Heather's comments demonstrated her faith in a number of ways: that prayer could sustain her when all else failed; that her husband supported her in being pregnant and would be there at the birth; and that doctors would care for and reassure her when she needed their professional assistance.

The Drawing

Heather's interpretation

Heather's faith in her doctor, her husband, and God became more evident when she drew a picture [Appendix C] of how she envisioned giving birth. She first drew a brilliant sun shining through a window and a vase of flowers sitting on a table. She then drew the doctor holding the new baby and her husband standing beside him. Finally she drew herself lying in a pink gown, saying "I'm gonna have makeup on!" The doctor

appeared to be presenting her with a child wrapped in blue. Upon completing her drawing, Heather said, “The sun’s out shinin’. I’ve got my flowers. Everybody’s happy. Baby’s born. Everybody’s clean.” For Heather, it seemed that pregnancy was the justifiable means to achieve a valued and cherished end—a healthy baby.

Art interpretation

Superficially, Heather’s drawing could be considered entirely positive. Upon closer examination, however, several omissions become conspicuous by their absence. Heather drew the sun, the window, and the fresh flowers first. This could represent her spiritual connection, her faith in God, and her love of Nature. Next, she drew the doctor holding a baby wrapped in blue. It looked as though the doctor had delivered a baby boy and was presenting him to the woman lying on the table (drawn last). The husband stood to the side, grinning. All the adults were smiling but the baby had no mouth. His cries might be unwelcome in this ideal view—or he may simply have nothing to contribute in this process as the artist could feel that a newborn has no awareness (a view held by many). No one in the picture has ears. Perhaps the sounds of a delivery room would be disturbing, or the sacredness of the event transcended words. Most interesting was that Heather, the woman lying on the table, had no arms to hold her child. She might feel that her job was done, at least in this setting. She might, however, feel helpless. Arms can represent strength and the woman in the drawing has no power. In addition, there appeared to be a pillow over the face of the woman. She could feel suffocated, invalidated, or unconscious. This could represent the effects of anesthesia or a desire to focus on the baby (the product) while avoiding the realities of giving birth (the process).

A Feminist Viewpoint

Adding to the phenomenological themes and art interpretation, I looked at this

interview and drawing through the eyes of feminist researcher. From this vantage point Heather may very well subscribe to *authoritative knowledge*, that is, assumptions made by the majority of society that are not questioned and that inculcate the minds of those considering pregnancy and birth in this country. Those assumptions include: babies are born in hospitals; doctors deliver babies; childbirth should be painless (medicated); and babies are neither conscious nor aware. Heather appeared to be a loving mother who probably represents, to a great degree, the 99 percent of American women who elect medicated, physician-assisted deliveries in hospitals. From a feminist perspective, Heather's drawing depicted the powerlessness of women in medical settings, specifically in the realm of childbirth. Her words expressed the ambivalence of fear and joy as she looked forward to giving birth. She found solace in her faith in God, doctors, and her husband. Although these were wise choices and essential support, she could not seem to find her own strength, depicted by an armless woman lying on her back.

The Brain/Mind/Consciousness Model

Heather used her faith, trusting in both God and the medical establishment to help her have an optimum birthing experience. From the perspective of brain/mind/consciousness science, her ability to surrender and let go of negative projections (not focus on her worries or doubts), to cognitively consider various alternatives (to think rationally), to intuitively envision a radiant outcome (to access her unconscious creativity) all suggested that her positive expectations of childbirth would be met. Although I did not conduct a second interview with Heather due to the time constraints of the Qualitative Methodologies course, I learned later that Heather had given birth to a healthy baby boy. Having had the experience during the pilot study of only doing an interview prior to birth, I decided that for the dissertation I would add a

second interview after the birth. This would allow the participants to describe in their own words whether or not their expectations had been met. Therefore, the research for this dissertation would have the added dimension of follow-up interviews.

Conclusion

I relished the experience of interviewing Heather. I was able to make changes in real time and modified my proposed study accordingly. For example, I established better criteria for the participants in the study, and included *first pregnancy*, being at least 18 years old, and having a low risk pregnancy. I learned that the way questions were worded mattered greatly and refined the questions for subsequent interviews. I found that, consistent with principles of art interpretation and consciousness science, having a participant draw a picture of an *ideal birth* could enrich the data and contribute to a better understanding of their worlds. The question of what specifically to have a participant draw was well answered in that expectations have been shown to impact outcomes. Focusing on the ideal could be beneficial, and, at least, not be harmful. This pilot study suggested that unconsciously held beliefs could emerge from both dialogues *and* pictures. Finally, the data yielded a wealth of information about this woman. I did not intend to generalize the themes of time, energy, fear, and faith to a larger population, nor even apply them in the interpretation of new data. However, the thoughts and feelings of this one woman were so provocative that I was motivated to pursue qualitative interviews as the primary method of gathering data for this study. I planned to interview women who were receptive to alternative venues for giving birth. Heather seemed to take for granted the idea that birth occurred in hospitals with a doctor in attendance. I did not challenge her assumptions; in fact, I truly appreciated her perspective. This point of view was essential if I wanted to tell the stories of childbearing

women in the United States, most of whom give birth in hospitals. Certainly, I gained valuable insights into the process of interviewing by conducting this pilot study and was able to make adjustments that would contribute greatly to the successful conduct of the research for this dissertation.

Chapter V: Case Studies

Introduction

After several months of conducting initial interviews with seven delightful pregnant women and following up with second interviews after six precious babies had been born, I had collected enough data to begin to report and analyze results. I could proceed with the analysis of the first interviews while I was waiting for the seventh baby to be born. I asked myself, "What did I find?" and began reviewing transcripts, audio and video recordings, and the drawings each woman had rendered. Distilling the volume of data was both a joyful and daunting task. As I discussed my progress with my Research Director, Dr. Jill Kern, she noticed that my own creative process seemed to parallel the process each primipara was experiencing. Although I began the research with great joy, as I approached analysis of data, I doubted that I had enough substantive information to produce a credible dissertation or that I would be able to do justice to the data that I had gathered. I was just beginning to identify a series of emerging themes: the thematic sequence began with the first blush of happiness the women were reporting as they absorbed the realization that they were pregnant, and seemed to culminate in a return to joy as they reconciled their previous expectations with the realities they had encountered. The path traversed between those two points was a circuitous one that paradoxically juxtaposed joy and fear, self-confidence and self-doubt, appreciation and apprehension. My own enthusiasm surged as I made connections between the women's individual experiences seen in microcosm and the collective experiences seen as a macrocosmic whole. I saw the paradoxes—the consistencies and the inconsistencies perhaps both unique and universal—in the process of becoming a mother for the first time. I felt my own joy ebb and flow as I gave birth to my dissertation as well.

A Brief Overview of Outcomes: Expectations Differ from Experiences

In this chapter I present case studies of the seven primiparas who participated in both interviews required for my research. Although I began the analysis before the birth of the last baby, he was born in time to complete the fourteen interviews I needed to include all seven women in my study. Each primipara had a plan for where and how she wanted to give birth. Three of the births occurred where they were planned. Two of those women described their births as better than expected. According to plan one gave birth in a hospital and the other had her baby in a birth center. The third woman gave birth at home but reported that it was harder than she had expected. Four births occurred quite differently than expected; two of those women required hospitalization (one was transported from her home and one from a birth center), received medications, and delivered vaginally; one of the women who had planned to give birth in a birth center went into labor early, checked into a hospital, and had an emergency cesarean section; one woman, already in a hospital, underwent an emergency cesarean section as well.

Table 2 shows the manner in which the women desired to give birth and the way in which each birth actually occurred. Six of the primiparas stated emphatically that their births were *not* what they expected. The seventh woman said her experience exceeded her expectations. One of the others expressed that her birth experience was not what she had expected it to be but, in retrospect, was better than she had expected. Five of the women reported that their experiences were harder or worse than expected. In essence my results were agreeing with those of other small qualitative studies which showed that pregnant women's birth experiences did not occur as expected.

Table 2

Expectations and Experiences

Primipara's Pseudonym	**Expectation**	**Experience**	**As Expected?**
Annette	Birth Center No Drugs	Birth Center No Drugs	Not as Expected Better
Barbara	Hospital Epidural	Hospital Cesarean Section	Not as Expected Different
Carolyn	Birth Center No Drugs	Hospital Cesarean Section	Not as Expected Different
Dorothy	Home No Drugs	Hospital Pitocin & Epidural	Not as Expected Different
Eleanor	Birth Center No Drugs	Hospital Pitocin & Fentanyl	Not as Expected Different
Felicia	Home No Drugs	Home No Drugs	Not as Expected Different
Gwyneth	Hospital No Drugs	Hospital No Drugs	Not as Expected Better

Emergent Themes

Figure 1 presents a distillation of the themes that emerged from the interviews. My graphic representation depicts them as electrons revolving around the nucleus of an atom. The themes are not static; they contribute to a dynamic interaction that appears throughout each primipara's pregnancy and birth experience. They create a design that, like a snowflake, is unique to each woman. Described in detail later the themes are:

1) *Discovering Joy and Returning to Joy* (8/1)
2) *Receiving an Education*
3) *Making Choices/Exercising Will*
4) *Identifying Resources and Gathering Support*
5) *Questioning/Doubting*
6) *Experiencing the Unexpected*
7) *Accepting What Is*
8/1) *Returning to Joy* (Returning the women to Theme1)

I introduce each of the participants with a pseudonym. I chose seven-letter names arranged in alphabetical order for several reasons: I had identified seven distinct themes—an eighth theme returned each woman to the positive emotions she felt at the beginning of her pregnancy; I liked the continuity of working with seven, a number that numerologically connotes "the emergence from Chaos into a higher and more perfect Order (Heline, 1997); I favored names that bore no resemblance to the actual names of the women themselves; and, I felt that each name should not be random. I wanted to choose names for the primiparas as carefully they had chosen names for their babies. Therefore, each case study begins with a name, together with the origin and meaning of that name which I obtained from an Internet website called "baby names!" If husbands, friends, or doctors were mentioned by name in the course of the interview, I selected pseudonyms for them as well.

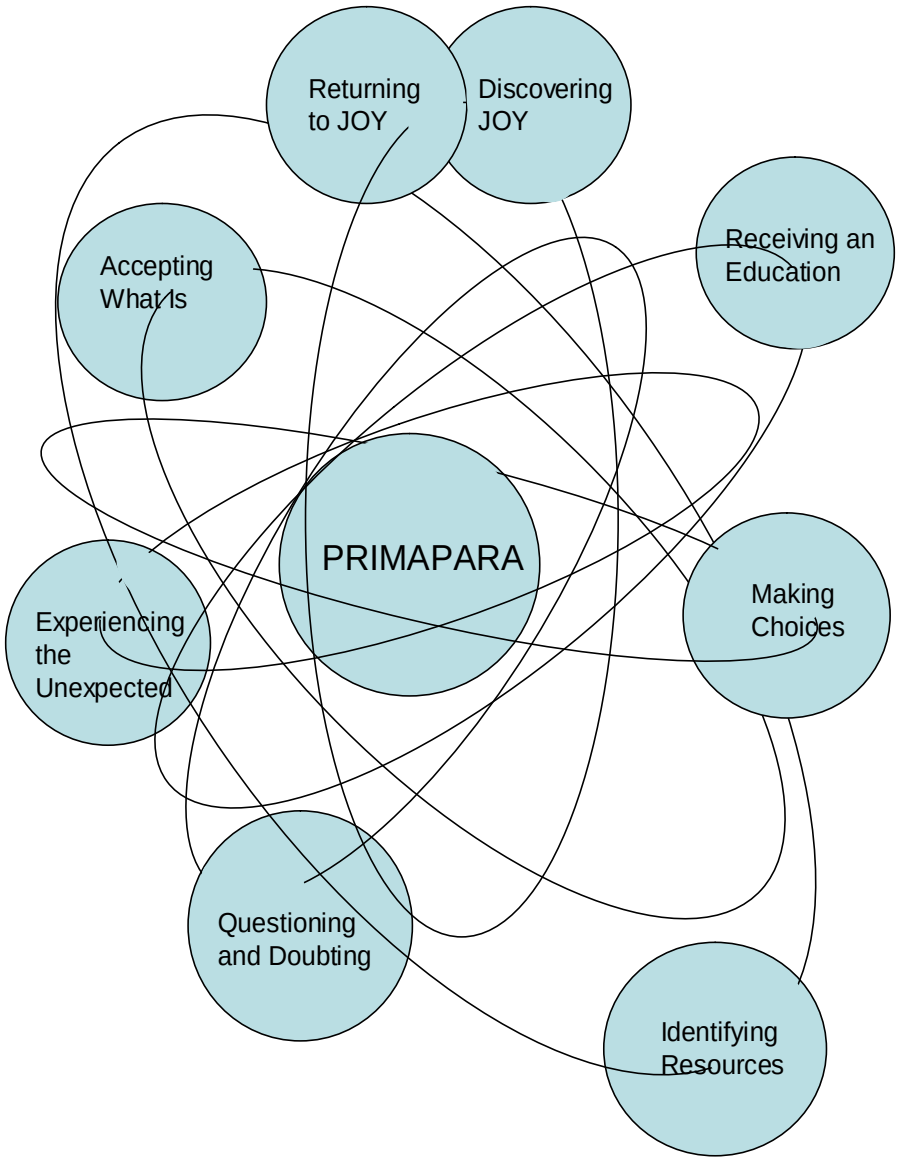


Figure 1

The Constellation of Themes

I proceed by presenting my initial impression of the primipara including demographic information and by describing the circumstances in which we met. This is followed by an in-depth elaboration of the content of both interviews. Quotations faithfully represent the women's stories and serve to demonstrate the emergent themes. My strategy at this point is to "organize participant responses in such a way that overall patterns . . . become clear. The emphasis throughout is on letting participants speak for themselves" (Patton, 2002, p. 525). The case studies include observations made at the time of the interviews, observations of demeanor or body language derived from review of the videotapes, quotations from each participant's dialogue recorded during the interviews, and descriptions of the drawings rendered by each participant.

Each case study is presented in the order in which I conducted the interviews and, within each interview, in the order that the questions were asked. I met with primipara "A" for Annette first and subsequently with each participant through "G" for Gwyneth. This procedure helped me keep track of the data and also provided a way for me to present the case studies. Within each case study I follow a chronological sequence that first describes how the primipara is feeling about being pregnant (*First Interview, Question 1*), followed by what she expects giving birth to be like (*First Interview, Question 2*). A description of the drawing (*Drawing*) rendered at the end of the interview and any final comments conclude the first half of the case study. How the birth was actually experienced (*Second Interview, Question 1*) and how the primipara's experiences agreed with or differed from her expectations (*Second Interview, Question 2*) are presented next. Last, I present how we came to closure (*Closure*) as the primipara shared any final comments. While the themes are described here, my analysis of the individual and collective case studies is presented in Chapter VI.

Annette

Origin of the name: French—Meaning: Gracious

First Interview

Annette and I met in her mother's and step-father's home in a small rural town in Southeastern Arizona. I was immediately struck by the beauty of this young woman. Her sky-blue eyes, pale clear skin, and up-swept blonde hair could all have belonged to someone too impressed with her own appearance. Instead, Annette spoke in a soft, shy manner. She told me she was 21 and single. She was due in only a week and had made some decisions about how she wanted to deliver her child. This was my first interview with a primipara and I was captivated.

Question 1

Annette answered my first question (How are you feeling about being pregnant?) by saying:

> It's been really interesting. Throughout the whole time I've been really happy. But, there's been mood swings. There's been so many different traumatic things I've had to deal with. But it's been great. I have a really supportive family and I've read a lot of books and so [pause] just the more information I get the more confident I feel. And I really enjoy being pregnant. I feel beautiful for the first time in my life, which is really cool and I'm excited about it.

I was impressed that Annette was so happy and excited (*Discovering Joy* – the first theme to emerge from the data), and that she had taken the initiative to educate herself (*Receiving an Education* – the second theme). Curious about what she had read, I used the opportunity to prompt her to say more. She replied:

> Well, when I got pregnant I didn't know a whole lot about babies or being pregnant, so right away I got vitamins, I set up a doctor's appointment, and I went to the library and looked up every pregnant book I could, rented them all, then read them all within a couple weeks. So, I just learned a lot about babies and how to take care of them; a lot about what to do when you're pregnant and different things that can happen to you; different options you have. I've learned about

> different procedures like cesareans or episiotomies, and just a lot of different medical aspects so that way I knew kinda what I wanted.

As Annette educated herself, her mother suggested that she investigate a birth center in a city two hours away.

> My mom brought up the birth center in Tucson so we went and checked it out. I really liked the atmosphere. I liked the midwives that I met and I was really interested in water birth so I decided that I wanted to go there. So I'd go there about every two weeks and meet with the group of women. I think there's about 12 of us that were all due around the same time. So instead of having individual appointments it was really neat because you heard all these different people going through the same things and it's just been really cool to see all these different people and they're all so different and yet they all have the same thing—they're having a baby. So it was more fun and they all have their babies except for me now. So I decided that I wanted to go with midwives and I wanted to have a natural birth. I don't want an epidural or any drugs, if I can deal with it. I read a lot about how to breathe and use different techniques and that way, hopefully, I'll be able to make it without being in too much pain, I guess. And then also the water birth is supposed to help with contractions.

A third theme began to emerge from this dialogue: that of *Making Choices and Exercising Will* based on the information she received. Annette chose the birth center and midwifes and rejected drugs. A fourth theme was suggested by this dialogue as well: that of *Identifying Resources and Gathering Support*. These were Annette's mother, the birth center, midwives, and a group of women who met regularly throughout their pregnancies.

Question 2

At this point in the interview I specifically asked my second question which addressed what she expected to have happen when she gave birth. Annette first expressed some concern about the length of the drive to the birth center and then questioned her own ability to know when her labor had begun:

> Well, it's a couple hour drive to get there. Hopefully, I'll actually realize when I'm in labor. My mom says she'll know. I think I won't know. But, we drive up there [Tucson] and then hopefully I'll be able to labor in the tub and if there's

> nothing wrong then I can stay there. If anything happens they'll take me to TMC [Tucson Medical Center] but the way I see it, I've been healthy and there hasn't been any problems so far. So I just see myself going there and having the baby in the water and my mom and my sister are going to be there, and then a midwife, well, a nurse midwife, and a nurse. So the rooms are really cozy. It's like a bedroom, kind of, and there's a big water tub in the corner. And, I don't know, it's really peaceful.

Two themes arose from her description of going to the birth center. One was her concern and questioning prior to giving birth intermingled with the hope that all would go well. I labeled *Questioning and Doubting* Theme 5. Annette also continued to gather support by choosing people to attend her delivery, in this case, her mother, sister, the midwife, and a nurse. I made these a part of theme 4: *Identifying Resources and Gathering Support* mentioned earlier. Here Annette elaborated on the birth center's cozy rooms and water tub, and the Medical Center as a possible venue in an emergency, all potential resources.

Drawing

The rest of the first interview was dedicated to drawing a picture of her ideal birth (Appendix D). When she had completed the drawing Annette described it:

> That's my mother. I think she'll be kind a scared so she'll be off in the corner. That's my sister and then somewhere there'll be the midwife and then the nurse but I'm not sure who's going to be there because there's four different ones. I put them over here outside the tub. It's a really fancy pool. A chair—a rocking chair up in the corner. Some people use it, I guess, for relaxation. We also have a birthing stool and it's shaped like a bean; and a ball. These are probably places where part of my labor will take place but, hopefully, I'll have the baby in the water.

Once again, the support and resources that Annette considered important and was choosing to have around her were portrayed in her drawing. Although she did not describe herself or her baby, their images appeared in the upper right hand corner of her picture just below her mother. Water was prominent in the drawing, and the more material resources were depicted on the opposite side of the room from the completed

birth. The center of picture was occupied by sister (at the top), nurse (center), and midwife (lower center).

Five themes emerged in this initial interview. I decided to call these themes: 1) *Discovering Joy*, 2) *Receiving an Education*, 3) *Making Choices and Exercising Will*, 4) *Identifying Resources and Gathering Support*, and 5) *Questioning and Doubting*. Two more themes would be suggested by the content of the second interview; some would repeat, and one would reappear culminating in a return to joy.

Second Interview

The second interview with Annette took place in the small sparsely furnished house that she and a girlfriend were renting. In the three weeks since I had seen her, she had given birth and moved away from her parent's home. She seemed relieved to have me hold the baby, and I was eager to comply. I held the baby for the duration of the interview. Annette remarked that she was "pretty tired." She said she would have to go back to work soon, and was looking for work that would allow her to keep her baby with her. Because I was not clear about her financial status although it seemed low and perhaps a bit tenuous, I asked if she would be self-supporting while bringing up her daughter. Her response was "Yeah. It's kind of an overwhelming thought!" I later saw this as a statement supporting the fifth theme, *Questioning and Doubting*. The spiraling nature of experiencing the themes seemed to continue even after giving birth.

Question 1

After a respectful pause, I asked Annette to tell me about her experience giving birth. She first said "Unbelievable!" She then related the story of a long labor lasting from a Saturday to the following Monday afternoon. She could not sleep most of that time because the contractions continued five to ten minutes apart.

> Then Sunday night at like 11:00 they started getting stronger, so I decided, OK, well, I'd better time these. I'd better wake up my mom. And then she's like, well, five minutes isn't that close together, you know. You probably don't need to worry about it. I was like, well, they're stronger than they were before. Something's happening.

Annette had doubted that she would know when to go to the birth center but she reported that she knew the contractions were becoming more insistent. Theme 5: *Questioning and Doubting* was surfacing again.

> So, we called the birth center and they said "We're swamped! There's people all over the place." So we'd better not go up together. 'So don't worry about it." I called them back later and said, "You know, they're still coming and I don't know what to do about it. I need to sleep." And they said, "Well, try a beer bath and Benadryl." And I was like—I don't have beer! And I don't have Benadryl. I can try the bath part. I tried that and they still kept coming, so about 5:00 Monday morning we decided to drive up there so they could give me something to sleep.

Annette was not sure what to do (Theme 5: *Questioning and Doubting*) but followed the guidance from the birth center's staff as best she could. With her mother's support she decided to drive to Tucson, hoping to get some rest.

> Well, before they did that [gave her something to sleep at the birth center] they decided to see how dilated I was, and they said, "You're six centimeters dilated! You're not leaving." So, I was just in shock! I was expecting there to be a lot more pain before you get to six centimeters. So I'm just waiting there. I was making jokes the whole time. It was so weird. And, you know, my mom was just amazed.

Annette began to experience things that she had not expected. This constituted the sixth theme: *Experiencing the Unexpected*.

> Well, I was still really tired and a couple hours later I was only . . . well, four hours later I was at eight. So that had taken quite a while to get there, so they decided to go ahead and break my water. So, as soon as that happened, I had a couple of really hard contractions and then after that I couldn't talk. I couldn't say my lips are really chapped and I want a Chapstick and I couldn't tell anyone. So it was kind of weird. I didn't realize that I wouldn't be able to say anything. Eventually, she [the midwife] was like "Do you have the urge to push?" I was like "Not really." She was like "Well, why don't we go ahead and try. Your baby's head is like *that far* [gesturing with her fingers one inch apart] from coming out. So, it's like, OK [dreamily]. First on the toilet, they had me push on

> the toilet, and then they moved me to a birth stool. I don't know if you know what that is?

I murmured, "um hum" and she continued:

> So I sat there for awhile. And then they moved me to the bed. I guess right before her head came out they were going to have me squat on the bed. Well, it didn't happen. I was in such an awkward position. My mom was on one side and my sister on the other and they were trying to support me and I just fell back. Then I pushed, I think one more time, and then all of a sudden I hear suctioning and her head was out! They're like one more push and her shoulders will come out. I'm like, "That's it?" It was so strange! 'Cause it didn't hurt. Like I was expecting a lot more pain and it was like—I was so tired that I couldn't feel anything. It was really strange.

Annette experienced an intervention (breaking her water), could not speak, and delivered her baby without as much pain as she had anticipated. All these were part of her *Experiencing the Unexpected* (Theme 6). I asked specifically, "There were no drugs?" Annette replied:

> No drugs. They laid her on my chest. My mom was on one side and Nicole was on the other and we were all crying and it was really amazing. There was no drugs. Like, in the beginning, I threw up a couple times, and so I hadn't eaten in probably a day. That was kind of hard. So I was just kind of weak and tired on top of that. But I didn't even have an IV or anything. It was really neat. Since it was Labor Day my family didn't have to work so everyone was there and we had called everyone before except for the father because I didn't want to stress out about that while I was dealing with labor. So we called them after and his mom was furious that I didn't call her before but I was just like, "I don't care." Everyone came in and brought flowers and balloons and it was great!

Annette had preferred to have a drug-free birth. She did. She was supported by her mother and sister as she had wanted. She was surrounded by family and friends (Theme 4: *Identifying Resources and Gathering Support*) and did not immediately call the father of her child (Theme 3: *Making a Choice and Exercising Will*). The birthing room became a place of celebration and Annette said she thought it was great. This suggested that a woman might come back to the feelings that she had initially, those she felt when she initially appreciated her pregnancy. I called this theme, (8/1) *Returning to Joy*.

The interview continued as Annette provided some details regarding the time she had delivered her baby and when she left the hospital. She went home just five hours after giving birth! Several of her comments were noteworthy. She recalled:

> Next door I heard the woman. I thought she was right there, like she was in birth, because she was screaming and then someone was like "That lady next door, she's five centimeters dilated." And I was just like, I guess it really is different for every person. It was just really amazing!

The other interviews that follow corroborate Annette's contention. Giving birth, although shared themes can be identified throughout the process, "really is different for every person."

Annette implied that she had been challenged since she returned home saying, "And since then it's been very interesting—a learning experience." She lamented, "The first couple of weeks have been really hard. I would go through a whole labor again if I didn't have to deal with the first couple [weeks] at all." Referring to her labor and delivery, she said, "That part was easy." I asked her to tell me more about why she thought those weeks had been so hard.

> Probably with the breastfeeding and she's [the baby] sleeping and it's really hard because, since I'm breastfeeding, there's no one else that can feed her. So I'm up with her all night. If she decides she doesn't want to sleep then I'm up with her. And she cries a lot and I don't know what to do. If other people hold her she's fine but I think she smells milk on me and so she'll act really hungry. But she's sweet. Every time I look at her I can't believe that that's a part of me. I did expect her to look a little bit more like me but she might change a little bit. But she's still very beautiful.

Even after giving birth the feeling of doubt surfaced for Annette, but, in her discourse, was almost immediately offset by a feeling of appreciation for her beautiful daughter. These virtually simultaneous feelings of doubt about not knowing what to do and appreciation for her baby's sweetness and beauty continued to be demonstrated in similar ways across the various themes throughout all of the interviews.

Question 2

I proceeded to ask Annette the second question: how had her experience compared with her expectations? She replied:

> I had wanted to have a water birth and that didn't happen because there was someone in that room when I got there. I got the last room. They were really packed. I labored in the tub for part of the time but it was just one of the regular tubs. And actually I don't think I would have been able to do the water birth anyway because I started sweating a whole lot when I was in the tub. I don't know if the water was too hot or my body just couldn't handle it. I'm not sure. Obviously it wasn't what I expected 'cause I expected a whole lot more pain and it wasn't there. I'm pretty proud that I didn't freak out and need any drugs or even an IV. My mom went and told them "My daughter's really squeamish. She probably will freak out. She won't be able to handle this." And, of course, after everything happened she was going around telling everyone that I'm the "Birth Goddess"! It's embarrassing.

Annette had begun to integrate her experience and demonstrated adaptability. She appeared accepting of the way her labor and delivery had occurred even though parts of it did not go as she had planned or expected. After reviewing all the interviews, I considered this attitude a theme and eventually labeled it *Accepting What Is* (Theme 7).

Annette observed that her experience had influenced another laboring woman: "After I had her [the baby], the woman that had been in labor, or that got there [to the birth center] before me, I inspired her to finally push out her baby. She was excited about that." I was struck by the impact women can have on other women and wondered if this aspect would appear again in other interviews. In a variety of ways, it would.

Closure

Annette concluded our interview saying: "So it wasn't what I expected, but it was worth it." I asked, "Was it better than you expected?" She responded, "Yes! It *was* better than I expected. It was really nice. I liked having the family around. They were all so supportive and loving." Indeed, it appeared that Annette had returned to joy.

Barbara

Origin of the Name: Latin—Meaning: Mysterious; Greek—Meaning: Exotic

First Interview

Barbara, a striking 30 year-old black woman, invited me to her house for both interviews. She was born in the Dominican Islands and had lived abroad in Korea and Canada. She married a man who has a job working for a government contractor in Southeast Arizona. He has a child from a previous marriage but this is Barbara's first baby. She has a Bachelor's Degree in Music and teaches piano lessons from her home. I was intrigued by her background, her understated manner, and her openness in disclosing her views about pregnancy and birth.

Question 1

When asked how she felt about being pregnant, Barbara initially said, "I feel good." However, she immediately added the qualification, "I felt more excited at the beginning than I do now." I asked her what she thought accounted for the change and she replied, "Partly because of the discomfort—the sleeping and getting up and stuff. And partly because it's getting near that end part." Barbara initially experienced joy at being pregnant (Theme 1: *Discovering Joy*), but her enthusiasm diminished over time as she felt discomfort. Displaying mild apprehension she explained, "I've looked at all the videos, and I've looked at a lot of the programs that are on TV, and attended prenatal classes, and I'm not exactly looking forward to the final moments." She was educating herself (Theme 2: *Receiving an Education*) but, unlike Annette who gained self-confidence from the books she read, Barbara's confidence diminished. I encouraged her to say more about her feelings which revealed a degree of doubt and apprehension (Theme 5: *Questioning and Doubting*).

> Well, I think it's the fact of the pain factor and the fact that I'm going to be having these people pulling and tugging at me; and I'm a little scared of what to do afterwards—after the baby's born, 'cause right now it just seems unreal—a little unreal that I'm going to have a baby.

Continuing to describe her pregnancy and the ways in which she was educating herself, Barbara explained:

> It's going fine, going fine. I can feel the movement, and you get this Internet little bit of information once a week. I can't remember, "Babies" or "American Babies" or something like that, and they give you a little bit of information about what's going on that week. So that's interesting, to keep up with the cute little pictures and stuff.

Smiling, she added how she had applied a strategy she had learned from the Internet source: "Just last night I was putting a flashlight on my tummy and there was movement once you turn the light on. It was cool."

In answer to my request to tell me how she was feeling about being pregnant, Barbara had disclosed her feelings of excitement (Theme 1) then her growing apprehension which demonstrated the paradoxes that seemed to emerge throughout the phases of each woman's experience. She also evidenced her desire to know more about pregnancy, educating herself (Theme 2) by viewing birth-related videotapes and television shows and accessing Internet sites that provided week-by-week pictorial descriptions of fetal development.

Question 2

In answer to my second question, "What do you expect giving birth to be like?" Barbara responded, "Scary! It seems from all the information I can gather, it's going to be very long, very tiring, very painful, [and with a sigh] and there's no vacation after that." She went on to tell me that she planned to give birth in the local hospital with a doctor in attendance. Her husband would also be with her. The two themes of *Making*

Choices (Theme 3) and *Identifying Resources* (Theme 4) could be distilled from her comments. I asked if she wanted to add anything before drawing a picture of her ideal birth, to which she replied,

> I have no concept of giving birth. I've just seen the videos and I haven't really talked to many women or anything like that even though I did take the prenatal class. I was very quiet, [laughing] just taking it all in.

Much of what Barbara took in seemed to increase her anxiety, rather than reduce it. Her apprehensive admission that she had "no concept of giving birth" appeared to qualify for the category I was identifying as Theme 5, *Questioning and Doubting*. As she drew her picture she commented,

> For my husband the most important thing is the safety of the kid; so definitely the hospital business and every instrument that they can use to help, and, I'm very cautious too, because I've never had a kid. I do have a—my sister-in-law lost her baby at seven months so we're a little bit kind of more concerned than we would have been, but, to me, I just want it to be a nice smelling room, and quiet music, and couple of pictures [of the birth], and to have a good memory.

Barbara and her husband were identifying those elements that would increase their sense of security (Theme 4: *Identifying Resources and Gathering Support*) and were also making choices (Theme 3) based on their belief that all precautions should be taken to insure the safe birth of their child.

Drawing

Barbara's drawing (Appendix E) shows two figures standing behind a baby in a bassinette all framed by yellow curtains. She seemed to need encouragement to describe her picture. When I remarked that "those look like bright yellow curtains." she replied, "Yeah. I don't think there are any windows in the hospital. To me the less work the better, and the quicker, the faster, and I don't want to feel any pain!" Her voice rose as she emphasized that she did not want to feel pain. Indicating she was finished she added,

"I think that's it." I asked, "This is your husband and yourself with the baby?" to which she nodded agreement.

I returned to her earlier comment by asking, "You don't want to experience any pain, so are you planning on having some medication?" Barbara said, "Yes, an epidural. I haven't really arranged for it but I've decided for myself what I'd like." This comment supported the third theme: *Making Choices and Exercising Will*. Further exploring her reference to videos, I asked where she acquired them. She willingly elaborated:

> At the library. I bought some at garage sales; the prenatal class; and also on TLC. The Learning Channel comes on at 9 o'clock and 2 o'clock. I try to catch pretty much every one so that I can see the whole experience of giving childbirth. They don't show the intense part or anything but the ones at the library and the ones I saw at the prenatal class have more details.

I prompted her to tell me more about the hospital room, which she had depicted with yellow curtains in her ideal birth drawing. Her response revealed some surprising information.

> It's pretty small but it's OK. I'm glad they have a shower. Actually there's one thing I'm debating 'cause I think I changed my mind after I saw one of the videos at the class, but initially I was thinking as soon as the baby's born I do not want to hold it. I'd like them to clean it off first. In my mind, it's like oooooooo. I know it's your baby and everything but just the whole, it's so dirty, and well, not dirty, but yucky, not clean. But then I saw a video of the reflex of the baby to actually climb up the mum's tummy to breast feed and I never heard of that. And they said it's the best thing as soon as you're born to put it on your tummy. I don't know. I hadn't really wanted that but I think I might change my mind for that one thing. I'm thinking about that.

Barbara had encountered a new idea that was very appealing to her, but her previous mind set had been to avoid handling a newborn that was "not clean." This attitude, one that many new mothers and even nurses exhibit, is addressed in the Discussion (Chapter VII). Here Barbara was considering making a new choice (Theme 3) based on having received new information (Theme 2).

Second Interview

Barbara greeted me with a smile as I entered her home for our second meeting. She showed me her newborn who was sleeping peacefully in the master bedroom. The baby looked angelic and remained quiet during the half hour interview.

Question 1

With good humor Barbara answered my request to tell me about her experience of giving birth.

> Well, I guess the week before the baby, I was a little nervous because I wasn't sure every little twinge or every little bump—I wasn't sure if that was the contractions. But when the contractions actually came, they were Sunday evening and we had just had visitors. My husband's sister had visited for a couple days and the day she left was the same day I started contractions. I was relieved that they had left 'cause it was really close. But when the contractions started they hurt a lot [laughing]. They started six minutes apart so the doctor said to come in when they were five minutes apart. So I had expected them to be a lot further apart to start with. So we pretty much went right away to the hospital. And I got very nervous because it was excruciatingly painful. And the thing I expected was, they were aware that I wanted an epidural which to me was the answer to any human person's prayers.

Barbara was describing going into labor and was already addressing the fact that her experiences were more painful and frightening than she expected (Theme 6: *Experiencing the Unexpected*). She continued:

> I arrived there [at the hospital], I guess, quarter to seven and they didn't give me an epidural until 2 a.m. To me, I thought it was mean, and I still don't quite understand why it took so long. My doctor wasn't at the hospital. It was somebody else at the time and they said they wouldn't give an epidural till you're five centimeters dilated. I was crying a lot. And they were saying they gave me, what's the name of that pain killer?

I answered with "Demerol?" to which she replied:

> Demerol. But it didn't do anything. It didn't lessen the pain. And then later on they gave me morphine, which to me didn't do anything either. I think my husband said I didn't seem quite as much in pain but I felt I was in just as much pain. I guess I was trying to breathe and all that, but, so I didn't get the epidural until two and I was really upset I guess. But, after that, I guess I slept for a bit

> and in the morning my doctor was in and I was at eight centimeters for about four hours. Anyway, I wouldn't dilate anymore. So they prepped me for a c-section. At that point I was so relieved, I was thanking God that I didn't have to push the baby out and I didn't have to go through anymore pain, because, right at the end before the c-section they let the epidural wear off. So that pain came back and I didn't enjoy it at all.

Barbara was questioning her treatment (Theme 5: *Questioning and Doubting*) and also was accepting of the final outcome (Theme 7: *Accepting What Is*). Indeed, she was greatly relieved saying,

> So by the time I was on the table I just closed my eyes for the whole thing and try not to remember any of it really. That's how I coped with that. So I actually had the baby at 12:44 the next day. So I think it was like 18 hours of labor. I was happy that it was over.

I asked about the baby and Barbara responded expressing more elements of the sixth theme, that of *Experiencing the Unexpected*:

> Well, she was fine. We were expecting a boy. So when they did take her out and they said it was a girl we both thought we were dreaming, or they got the wrong baby, or something went wrong. But we're happy. I was just in shock and I just wanted to close my eyes and not think about it really. And then they took her away and my husband went with her to get her footprints and stuff like that. I don't know. They went out for that but I was on the table.

The paradoxical feelings of doubt and disbelief countered by happiness and relief were both facets of Barbara's experience. Barbara described her disbelief further:

> She [the baby] cried after she came out, maybe a minute or two after she came out, but I couldn't see her so it's just like, it's just like, huh? Huh? You're looking and you're thinking "Oh, wow! Is that really mine?" Shocking, because we really weren't expecting a girl—or a c-section. And it happened so quick. It was like OK, we've been here for how long? Let's get ready and then 15 minutes later you're rolled into an operating room.

Shock and disbelief were significant following her delivery. Barbara was able to recover in the hospital for three days, taking pain medication that made her feel "great!" Returning home, she reduced her medication but felt worse. She concluded that she had stopped her medication too early because she had been feeling so good.

As the interview continued Barbara described her baby and a concern that had bothered her earlier in her pregnancy but which she had not mentioned previously.

> She was 8 pounds 3 ounces. They said her head was too big. My hips weren't as big as they could be. They look big but her head would not fit through my birth canal. That was what the doctor said. I was expecting the baby to be big and, actually, I had told the doctor or the assistant nurse or whatever maybe two months before the baby was born. I said that was one of my concerns that my husband has a big head. When he was born he had a really big head even though he was premature. And my concern was that the baby's head was going to be too big and she said "Naa." But she did do an ultrasound and looked at the head and said it was slightly bigger than where we were, but it looked fine. And I was surprised that they hadn't done at the hospital—done an ultrasound to check the size—or even after being in labor so long to have checked. They never did an ultrasound. They could have spared me a couple of hours [of labor pain] I think if they had just known, OK, the baby's head is too big. Then they could just move straight to a c-section. That was surprising. I never said anything but it's healed up well.

Question 2

When I asked specifically how her experience compared with her expectations (Question 2), Barbara questioned (Theme 5) parts of her process, noted that her experiences were not what she had expected (Theme 6), and had begun to peacefully accept what had occurred (Theme 7). Finally, she expressed joy (Theme 8/1).

> I think I was just anticipating going through the pain part, just scared, and I guess that it was worse than I thought it would be—the pain part. I don't think I've ever been in that much pain before. I've never really broken a leg or anything but that was the most pain I've been in. And I was disappointed that it took so long to get proper pain relief. But once I had the pain relief, I was fine. And the nurses and everybody were kind, and they were in and out. I thought, after the baby was born, I thought I'd either cry or laugh, but I was just like numb. I was just like—I guess, shocked. I thought I'd either—I mean you see all these shows on TV, the baby comes out, the mothers are sobbing, and they're so happy. I don't think I was happy or sad. I was just glad it was over. Once I saw the baby and she was breast feeding, that's where I felt the joy afterwards.

More details were disclosed as our conversation evolved. Barbara had been given pitocin but her cervix would not dilate beyond eight centimeters. She repeated how "scared" she had been, particularly since she anticipated that the baby's head would be

larger than she could accommodate. She described the bruise her baby had on the side of her face and her cone-shaped head, acknowledging that "she was trying to get through." As we were concluding the interview, I asked if there were any other things she would like to share. Barbara recalled that she could not breathe during the pain of labor.

> We did take the class in the hospital and they touched on the breathing technique and all of that. And I read a lot about it as well, but when that pain hits you, you just want to [big gasp!]. I kept holding onto the bed like this [laughing with arms extended and fists clenched] and lying on my back would hurt more, so I was more on the side during the contractions and everything. It's very painful.

Closure

Barbara then became philosophical and revealed another important fact that she had not disclosed during the first interview:

> I think in other places and other societies giving birth and raising families is more of a family event. The grandparents are near. As a kid you'd probably witness or know about the pregnancy, that it won't be such a closed event. Here they barely talk about birth, or, when you do go to the hospital it such a closed event. You only find out later. You don't witness anything. So young girls growing up here have no idea—absolutely no idea. Whereas somewhere else it would be—they give birth at home. Actually I was born in a house and I don't know who gave birth to me because I'm adopted, but from what I know, I was just born in the house. The family that I was born to was pretty poor. So everybody's around. Everybody's helping; Grandma, Mom, whatever. And here it's completely different. Grandma is in Pennsylvania, or Mom is over there. You only have doctors to take care of you and there's none of that discussion and help.

Barbara's adoption surely impacted her experience of giving birth. One's own birth experience, according to pre- and perinatal psychology, can contribute to the experience of giving birth, either positively or negatively. That is discussed in Chapter VII, as is Barbara's insight about the closed nature of birth in the United States.

Carolyn

Origin of the Name: German—Meaning: Carol/Song and Linda/Pretty One
Charles: Husband's Pseudonym—Origin: German—Meaning: Manly

First Interview

Carolyn and I met at a conference and forged a rapport immediately. She was eager to participate in my research and agreed to two interviews without hesitation. I planned to travel to the city in Arizona where she resided so that we could meet in her home. I had not realized that she was in a high socioeconomic bracket but her estate in a prestigious gated community demonstrated that unequivocally. Carolyn was a 42 year-old Caucasian who, with a Bachelor's Degree, taught kindergarten. She told me she was pregnant with her first child and deeply desired to have a spiritual connection with her unborn child as well as a natural birth. Her ideas were unique and, perhaps, New Age. I found her fascinating.

Question 1

Our first encounter began with my asking her how she felt about being pregnant. Her joy was evident.

> Ecstatic! Totally ecstatic! Like it's an answer—it's a blessing and an answer to a prayer. 'Cause I really thought it was going to pass by and I wasn't going to get the chance. And I had sorrow about that. So I feel happy to know I really am having the opportunity. It still feels often like—can I trust it? Is this real? More and more it's like, OK, this is real.

The first theme of *Discovering Joy* was readily apparent, as were the *Questioning and Doubting* of the fifth theme. Carolyn told me she was due in two months. She was communing with her prenate in ways that were distinctive.

> I keep so busy in my daily life that I don't get to tune into it enough, but I took a class the other day and they said "Have you felt hiccups yet?" I didn't think I had felt hiccups. Then the other night, "bump!" It was really rhythmic and I thought, that's hiccups! I'm starting to feel it more. I feel like he's very gentle with me.

> There's never elbows. It's more like swinging around. When I did get the ultrasound he had his toes up to his head and he was bending and flexing, and bending and flexing, so I feel like I have a little yogi in there. It's really just smooth and easy. I feel like he treats me gently.

Question 2

Carolyn had mentioned taking a class. Her methods of educating herself (Theme 2) became clearer as she answered my second question: What did she expect to have happen when she gave birth?

> I've put a lot of time actually towards envisioning that. Just the other night I was working with my doula. We were going through the specifics. I feel very fortunate to have aligned with this doula because there's been an education that I would not otherwise have received. One of the books she gave me is *Hypnobirthing*. We watched videos of really relaxing and then a birth. Then I also have been introduced to the Bethany Birthing Center and so I watched videos there of water births. And the other book she gave me is *The Thinking Woman's Guide to a Better Birth*. So there's been a lot of education to the various ways it can look and the way that I'm choosing to aim is to have the potential of a water birth—which is my hope, depending upon how it feels. But I really like the water. There's also the birthing ball and there's a lot of different things to hang from if you want to hang or different modes of support. But there is a firm anchor to hang from as part of the birth bathtub. There's four different rooms there and I'm hoping to get the one with the big tub so that my partner could be in the tub with me if he's comfortable with it and possibly behind me as a support person, and then I could hang from the wall to have a squatting position because in the class that I took she said you can get one to two extra centimeters. She says that counts a lot. And it is my first birth and so, of course, there's fear. The statistics of what I'm going into with the birth center are about ten percent go to the hospital. I'm hoping to be one of the ninety percent that are able to do it naturally. They do have drugs there--narcotics if you really want to do it, but I don't want to. You can't even choose an epidural. An epidural's not part of the options there unless you go to the hospital, and then it's into the emergency procedures and stuff. I went through a class called "Labor Day" and talked about what leads up to true labor. You don't rush right over there. You wait till it's getting down to more serious labor, so about five minutes apart. "So, what would you like to be doing?" she says. I thought, well, I'd like to eat a good meal and have relaxation at the house, maybe get into the pool or the Jacuzzi here, and do some stretches, and belly dancing, and just walking around enjoying my home environment before saying alright, this is getting ready—close enough to go to the birth center. And then I want to have time to drive over. Hopefully it's not during rush hour 'cause during traffic it would be an hour drive. Without traffic it's about a half hour. I want to be able to set up the room. I have some cloths to hang, and aromatherapy, and lighting, and some music. I have different kinds of

> music. I'd like to have some rhythmic kind of dancing music because I do like belly dancing and I feel like it's actually an ancient rite of birth, the birth process and celebration of sexuality that led to the birth process. So I want to be just doing some stretching and really getting in my pelvis and feeling comfortable enough to go into my own experience rather than have to be entertaining or performing or on for somebody else's idea of how it should be—and go into what my calling for it to be is. This dancing and moving are part of that. I've tried to do the meditation practices for part of the Hypnobirthing. I have a Hypnobirthing CD and so far it's just putting me to sleep. Maybe it's because I'm doing it too late at night which well could be. I think being connected to the dance is a really spiritual part of my own journey. I'm going to have to have movement in there for me as part of it. And *then* I can go into the relaxation and stuff, but to allow the dance and moving as part of the process to catch the relaxation. Those are the pieces that I have so far.

Woven into this detailed description of what Carolyn had learned about birth options were her identification of resources and gathering support (Theme 4), some insecurities and doubts (Theme 5), and many examples of making choices and exercising her will (Theme 3). Her resources and support were her doula, her husband, the birth center and all the equipment the center provided for laboring women, and her personal decorations and music. Her doubts were about being able to deliver her baby at the birth center rather than being transported to a hospital. Her choices centered around taking her time, moving, and, creating an atmosphere that suited her individuality using tapestries, scents, and sounds—incorporating all of her senses into her "own" experience.

Elaborating on her support system, Carolyn named her husband if he were not out of town on business, her midwife, doula, two girlfriends, and her mother. One of her concerns was that her husband might bring his cell phone into the delivery room.

> I have mixed feeling about his capacity to be fully present. He's maybe going to be into it and maybe not, and I have to be OK with it either way. But I really feel aligned with the women and so they're like my anchor of emotional stability and security and information and allowing me my process.

As the interview commenced Carolyn noted that she had spoken with her own mother about her birth experiences. Consideration of her mother's experiences, and those

of another friend, influenced the choices Carolyn was making.

> I have taken a lot of motivation just even talking with my own mother about her three births and how she really tried to go natural twice in the United States with my brother and my sister, and it just felt like the authority was taken away from her in which she was really trying to go with it and be natural and felt like the nurse had been supporting and working with her that way, and then the doctor came in and was like "You want to try this drug? I'm sure, probably, right?" [Mother] "Well. I guess so." Then the drug put her so out of touch with the process that by the time the baby was born she was just trying to stay awake, and she felt a loss in that one in terms of the connecting. The experience she had with me, because I was born in Africa, was very primitive in that particular setting. They had to set up the lights and get the bed out and everything. So that one happened to have been purely natural. She talked about how hot it was, and she sweated and sweated, and how much work it was and then afterwards just this rush of endorphins and giggling and laughing and being so happy. I see, at least in my family, I tend to have the happier disposition of the kids. So, I went, well, I'd like to at least give it a try to go natural. When I was talking to another woman friend, she was saying how, because she had overdosed on pitocin, they had induced labor, and then was given pitocin, but her cervix wasn't dilated enough and the nurse had given her a really, really strong drip. The doctor had said two to three, and the nurse heard 20 somehow. So the uterus was just contracting and the baby's head was up against that cervix, and she said it's colored her son's whole life. He was angry and had a stunted growth. After that experience she was like, well, I'm not gonna go through that again. [She] really educated herself, went into the Leboyer method and did a water birth and she says the nature of her two sons is just so, so different. You know, holding the baby down and allowing the blood to finish pulsating in before he's held up and cut. She said they figure babies can't smile. The baby's smiling and swimming right out of the womb! So that's all motivating enough that it makes me want to—like, I've been waiting a long time for this and I want to do it right.

After I acknowledged her wishes, Carolyn added:

> I admit I've still got the fears, some first-time mother fears. Maybe I'm too old and it hasn't formed correctly, or I've been too active, or squished the baby somehow; that I've done something wrong somewhere along the way and that's still scary. There's those fears but I am choosing not to empower those and [breathing out] let 'em go.

Paradoxical feelings surfaced for Carolyn as they had for the other two participants in this study. The fears comprise the *Questioning and Doubting* that I identified as Theme 5.

Carolyn continued by saying that she was "eating right" and taking good care of herself in many ways, but she was concerned about connecting with her unborn child.

> I know that there are women that talk about really making that psychic connection very strong and I feel like I've been still so caught up in the day to day busy-ness, plus it's like I don't do a lot of meditation. I know it's supposed to be very good and powerful. I do do journaling and prayer work sometimes, but I've been lagging behind in that whole realm. So I feel like I am going to have a month before my baby's born when I've stopped work, where I'm gonna be able to say "now is the time to start doing the art and tuning in and listening to more music and slowing down and prepping my own self" 'cause my concern has still been out there in the world doing physical stuff and so much. And feeling him move more is starting to tell me this is real, and be aware of the timing, and do the preparation for this personal aspect of my life right now as well. That's a shift that's wanting to take place but it's still hard because I've always had a pattern of being out in the world so much. But it's really a perfect time and a very inward time, and I'm looking forward to making that count rather than just traipsing through it.

Her words stated her intention, but the course of events would lead to a different outcome described later in the report of the second interview.

Drawing

Carolyn's drawing (Appendix F), completed at the end of the first interview, showed her vision of a loving Mother gazing into the eyes of her newborn. Swirls of energy in heart shapes drawn in rainbow colors surround the pair. Carolyn enjoyed drawing and called it an "invitation" to focus on her baby and her ideal birth. "I feel like I'm getting to communicate with the baby and say 'I do care. I do love you and want you.'"

Concluding this interview Carolyn related clearly the paradoxical emotions that were precipitated as she drew:

> It really can be a blessed birth. 'Cause there's all the anxieties that want to come in. Is it gonna break the relationship apart [with her husband] or any of that other stuff—fear factor type stuff? I just feel like, oh, just celebrate. Allow the feeling that it's an answer to a prayer, a blessing in your life. Thank you for coming [with tears].

Second Interview

When I called Carolyn to set up an appointment for the second interview, I was

surprised to learn that the baby had arrived early. I went to her home again, where Carolyn, beautifully groomed and happy, greeted me. She introduced me to her mother who had come to help with her new grandchild then looked for the best place for us to video tape the interview. She chose the back courtyard ramada next to the pool and settled herself, baby in arms, in a comfortable lawn chair.

Question 1

When I asked her to tell me about her experience of giving birth Carolyn was candid about her initial disappointment that things had not gone as she had planned or expected (Theme 6).

> Well, I had to fight the feeling of having been a failure at first because it didn't manifest quite the way I had envisioned. I had a doula who has not ever given birth yet, but is working with it and studying about it, and she had given me articles about birth as an orgasmic experience as an option and that it could be ecstatic. I was like, I can do that! So, in my head I had it kind of pictured at the birth center, and there's a family area that would be kind of like almost a party in terms of people coming and food offered, and I'd be off in the other room having an ecstatic experience. And it just didn't happen like that. So, on that level, I felt like a failure in some way.

Carolyn described her former self-confidence, followed by her self-doubt, paradoxical aspects of theme 5. Although she was feeling like a "failure" she was finding ways to accept (Theme 7) what had occurred and appreciate elements of her experience. She laughed, "But honestly, he was born October 17th which made him a Libra instead of a Scorpio. So I was glad for that." Carolyn's belief in astrology contributed to her reconciling the fact that the baby was born a month earlier than expected. In her mind the early birth changed the baby's astrological sign to a more favorable one. Again, demonstrating the paradoxical nature of a woman's birthing experience, she added, "It was scaring me but either way [whether the baby was born under the sign of Scorpio or Libra], I would have been happy. Just the main thing: I wanted a healthy birth."

It seemed that Carolyn's happiness was beginning to outweigh her sorrow (Theme 8/1: *Returning to Joy*). She described how she had been deterred from going to the birth center.

> Because I was in my 36th week, my midwife said, "That means the birth center is out." I was like "Oh, really? The birth center's out?" And so disappointed that I had to check myself into the hospital then because of that. She said, "It just needs to be the 37th week to be full term."

In retrospect, Carolyn was appreciating the circumstances that led her to be in the hospital (Theme 7: *Experiencing the Unexpected*).

> As it came down though, I was, I was glad to be in the hospital because it was really quite difficult. The whole experience is: my water broke; a full moon lunar eclipse; morning. I was still scheduled to go in to work. I went in and met my kindergarteners and told them my body was ready. It was telling me to have the baby. So my class got split up, and then I drove to the midwife and she said I hadn't dilated at all yet. So I would need to check myself into the hospital later that day.

Even in the midst of her disappointment Carolyn made the best of the situation.

> I met with my friends who were going to be with me for the birth and we had a big lunch, and then went to her [a friend's] house for castor oil and massage, and dancing, and Jacuzzi. So I did get all those elements in. And I really got to feel very sacred in that context. It was just one week after the 21 Praises of Tara Dance Ritual that we had here. In that sense I really had gotten to feel connected with women, connected with spiritual community, connected to the dancing the way I had wanted to. After I went to school, then we spent that afternoon having sacred time, and drove over to the hospital, checked myself in, and got all this stuff. It was really fun and laughing. I set up a beautiful altar and lights and ran the Jacuzzi. This was now about 4 o'clock and as the sun set the full moon came up, and there was a mountain right outside my window. I had a full moon and then lightning happening outside. So it was really neat weather-wise. The room was just beautiful. We had a CD with music playing and had the drone which is this low tone connected with Om-ing and the relationship between the jaw and the cervix. So I was doing very well with Ommmm, and just breathing through it and breathing through it. They would come and monitor the fetal heart rate by hand device.

Up to this point Carolyn was able to create her sacred space and enjoy the support of her friends. Then more unexpected events occurred.

> Then it [the baby's heart rate] was dropping and so they were saying, "Well, we're going to put a full term device on this or a constant device." So that was then strapped around my belly. And I had taken the Jacuzzi but then got out. So that [the electronic fetal monitor] was strapped around my belly and then it [the pain] was really getting into my lower back a lot. My friends were taking turns just really putting pressure on the lower back and that was helping and I was able to keep it under pretty good control even though it was like, "Whoa!" I hadn't bargained for that. And Ommmmm, Ommmmm. But then it started so intense I was like OOOOhhhhhmmmmmmm [painful sound]. You know, gosh, wow, I just didn't bargain for this. And it just felt like two screwdrivers in my lower back. I was: "What is causing so much pain?" I was shifting around trying to find the right position, so then that was knocking the belt fetal heart rate monitor off, so then they did an insertion where they did a head—onto his head. By that time then I was—by about 8 o'clock—I was about four centimeters and fully effaced. So at least I was making progress, 'cause I hadn't been dilated at all earlier. It seemed like we could go that way and I was being open to an epidural or what ever might help make this more manageable at that time. And so they were going to start to get set for the epidural.

Carolyn was ready to acquiesce, to let go of her determination to have a natural birth, and accept an epidural to relieve her excruciating pain. Then,

> the doctor came in 'cause I had only ever met my midwife earlier. So I met the doctor at that point. He came in and so by 9 o'clock, 9:15 that night, we were like, OK, this is too intense. They had given me medicine to slow down the contractions 'cause it was just like so intense and the pain so intense in my back that I wasn't ever being able to relax enough in the down moments. But then the heart rate was still dropping, even when it wasn't during the contractions and it dropped down to 20, and dropped down to 40, and then was dropping down to 20, so they said the baby is in distress. "*He's* telling us he doesn't want this—is not liking this." So then I said, "Alright. I'm open to cesarean." And at that point, then when it dropped down to 20, then it became an emergency cesarean so I had to sign the documents and it was just still so painful that I got carted into the other room separate from my friends and I had a thing in my arm, an IV, and they put medicine in that. It knocked me right out. Then an hour later, there was the baby.

When Carolyn awoke her response was disappointment and disbelief.

> I feel badly that I wasn't like witnessing the miracle and having him put right up on my tummy like that because there was a sense of distance. "Is that my baby?" You know, he just looked so peculiar, and not having gotten to witness and make that connection.

Some doctors and prenatal and perinatal psychologists have verified the sense of regret that Carolyn was feeling (Klaus, Kennell, & Klaus, 1996). Difficulty in bonding can

occur when a mother is anesthetized and separated from her newborn. Even so, Carolyn was already processing her regrets and making sense of her experience (Theme 7).

> But he was cute, right away. He did have his eyes open and looking around. So I thought, OK. So I got to hold him and be with him for a little bit, but then I just mostly passed out and slept and was glad for the sleep that night, and the nursery took care of him. But then I had a three-day process of bonding with him at the hospital and I was honestly *so* glad for that period because the lactation consultant that came in every morning was a really crucial help. I wouldn't have gotten that at the birth center. At the birth center you go home right away. When I think of that pain, if I was trying to transition to the hospital during that pain, or if I think about how, because the cord was wrapped twice around his neck and kind of around his shoulder—so I think part of the pain was he wasn't being able to descend properly. I'm not exactly—oh, he was facing the wrong way—the midwife would have had to have been tuned enough to, I don't know, maybe push him back in and unwrap the cord and then have the birth happen that way. But I was getting just so tense because of the intensity of the pain that it wasn't being fun for me anymore.

During the rest of the interview Carolyn debriefed by continuing to reflect on her experience and find peace in the manner in which her baby had been born.

> In a way, even though he's six weeks, he's almost really like two weeks. But his APGAR scores were high which meant he was good color and alert. That's good. I was glad for that and I was glad to just have kind of isolated time from the rest of the world. Some people came and visited but I needed like a before, well, first of all, part of that was just the healing, like just even being able to stand up because they did cut through the muscle. That takes a lot of healing. I was glad to just have my food all brought to me and all of the caretaking. If the baby was too much, have the nursery. And then I went and visited the nursery and they talked about swaddling, and here's how you swaddle him, and here's how you can burp him, and just getting to be around the other babies, and see how tiny they were too, and see the care and the confidence in which the people in the nursery handled him, and just adjust a little bit. It turned out alright. I feel good about it in the long run. I didn't have the episiotomy. I didn't have the epidural. I didn't have pitocin. So those were at least things I didn't want that I didn't have.

Laughing, Carolyn added, "You know, I did get knocked out and had my belly cut open." Again, the regrets and sorrows seemed to be countered by the relief and joy of delivering a healthy baby. Paradoxes were weaving throughout the themes that women presented during this research.

Carolyn pondered the alternative to her c-section birth, justifying her experience:

> If I would have lost the baby because of the birth center, because of my, like, I *have to have* the birth center experience, then it wouldn't have been worth it at all. It wouldn't have been worth it at all.

She continued to appreciate the support she was continuing to receive after giving birth.

> It's been great to have my mom here at the house. [She's] such a great helper. The father, Charles [not his real name] is really taking a really active role when he's here. He's gone a lot, but just being participatory, so that's helpful.

Then, in the next instant, she remembered:

> As soon as I came out of the anesthesia my doula was there, and I was like "I'm sorry. I'm sorry," just apologizing. It was at least very encouraging that from a variety of doula friends, they've said positive things about, you know, however it happened it was OK for it to happen. The fact that I was in labor at least that five or six hours, that, at least, it did a lot towards preparing him.

Carolyn was educated enough to realize that some prenatal and perinatal specialists suggested that laboring for awhile before having a cesarean section was better for the baby than not laboring. This knowledge relieved some of her concerns that the baby would have had a more positive birth experience had she been able to deliver him vaginally. Vacillating from feelings of appreciation to recollections of pain, she continued:

> I did have the whole environment of people that were involved and caring and wanting the best, so honestly, where I was at that point like, "Aaaah. It's over." It was so painful. I was glad to have it over like that! They wheeled me in and, it was five minutes later, had the baby out.

She considered the threat to the baby's health and safety and shared her concerns which led to her acceptance (Theme 7) of the unexpected cesarean section:

> What I'm trying to do is just surrender to it and say, "It's OK." And you know, I've heard about babies being born with it [the cord] wrapped with it once around the neck, but I think, twice, and then kind of around his shoulder too. It's like, it was tight! And 20 heart beats when you're normally way over a hundred, because I definitely would not want brain damage from prolonged birth.

Question 2

As Carolyn began to wind down from describing her birth experience, I asked her my second question: to briefly summarize and compare her experience with her expectations.

> In thinking about this interview, it was like, "How do they compare?" The key for me is that in drawing the picture the energy was still there—of the picture that I drew in terms of feeling the love and connection. It just didn't happen right after birth. But the baby is there. The connection is there between the baby and I.

The drawing of her ideal birth had been a positive experience and supported the resolution of her birth trauma. The ultimate vision she had created was, indeed, still realized. The timing and the means to achieve her goal were different, but her connection to her healthy baby had manifested (Theme 8/1: *Returning to Joy*).

Closure

> There were valuable lessons in Carolyn's process.
>
> I really choose the viewpoint that has been shared with me that believing that the energetic connection that I desired was established and that I did maintain that. And I think that a big part of the learning is nobody has all the right answers. It wasn't about the doula having all the right answers, or about the doctor having all the right answers, or about having the dance. And the baby has all the right answers. [To the baby whom she is cradling in her arms] You had the wisdom all along.

The innate wisdom of babies is a subject addressed in Chapter VII.

Dorothy

Origin of the Name: Greek—Meaning: A Gift of God
Dominic: Husband's Pseudonym: Celtic/Gaelic Origin—Meaning: Belonging to God
Darlene: Friend's Pseudonym: Latin Origin—Meaning: Little Darling

First Interview

Dorothy and I had only spoken on the phone to arrange our appointment prior to the first interview. She had been referred to me by a local midwife who knew about my study. I visited with Dorothy in her home in a small town in Southeastern Arizona. Her house was comfortable with two friendly cats lazing on couches in the living room while the dishwasher ran in the kitchen. Books about pregnancy, birth, and nursing were strewn over the coffee table.

Dorothy answered demographic questions by stating that she was a 28 year-old married woman. She had dark hair and eyes, and fine, regal features. She considered herself a middle-income Caucasian, "a European mutt." She proved to be articulate, a quality that was probably enhanced by her Bachelor's Degree in Accounting. I remarked that accounting was a career that she could consider doing from her home to which she responded:

> Family has always been a priority for me and even though I wasn't anywhere near marriage or anything. I knew that I didn't want to work once I had children and so I wanted a career that I could come and go in.

This was a forthright young woman who planned ahead and knew what she wanted.

Question 1

The interview began as usual by my asking how she felt about being pregnant. Dorothy replied immediately with "We're excited. We've been trying to get pregnant for awhile so this is a very welcome event." The first theme of *Discovering Joy* presented itself immediately and continued to be expressed as she used "we" instead of "I" while

she spoke about getting pregnant.

> We've been married, I guess, about a little over two years now, and we were both, when we met, we were both college graduates and established in our careers. So there wasn't like a lot of the financial inhibitions that a lot of people have. So it wasn't too long before we thought that it's probably about time to start our family. It took us a little while, over a year before we finally got pregnant, but it was very exciting, of course.

Dorothy described her early pregnancy in more detail:

> Compared to other ones I've heard of I think I've been very lucky. I had a little bit of nausea and uncomfortableness in the first trimester but nothing really bad. Since then it's been just fine really. I feel a little tired sometimes but nothing really miserable.

Question 2

> Although she felt that the later part of her pregnancy had "been getting awkward,"

Dorothy seemed to feel it was nothing to be concerned about. With that reassurance I

asked the second question regarding her expectations about giving birth:

> That's changed for me a lot in the last nine months. When we first wanted to get pregnant my concept of birth was probably the same as what you see in American media. You know, extreme pain, women in great distress, just trying to find the best way they can to get through this ordeal in life. So I had a lot of fears I think 'cause I've always been a real wimp for pain, and so just the idea of pain for me was very intimidating, and I had full intentions of walking into the hospital and numbing up and not feeling a thing.

I followed this explanation by asking "How has that changed?"

> Little bit by little bit. Actually we had a friend who we thought was a little extreme. She did a home birth, a water birth and she had Hypnobirthing and, you know, I've always considered myself kind of a skeptic and not really far out against the norm or anything, but talking with her, she explained to us about Hypnobirthing that she was doing, and it sounded like kind of a viable option, something we wanted to look into. My husband was--he wanted me to go without drugs. And, I guess, he probably instigated it because if he hadn't had that desire I never would have questioned it. So I kind a wanted to give it a try, but I was real intimidated because of the pain, so Hypnobirthing seemed like maybe an answer to that; maybe a way to eliminate some of the pain from natural childbirth. And so the more we looked into Hypnobirthing the more we came to realize that the way birth is portrayed just doesn't make sense. I guess we both consider ourselves educated people and the more and more we read about how birth is a

> natural process and there's no reason why there should be pain, and the reasons why, a lot of the time pain is just self-inflicted because of our fears and our own expectations. It just made sense to us and it really clicked for us. It felt like, you know, that's true. Why should using one muscle be painful and using another not? So, we subscribed more and more to the theory and hired a practitioner to help us learn how; to basically relax is all it is. I mean I was very skeptical about the hypnosis part because I've never believed in hypnosis, so we were kind of going out on a limb. I was really going out on a limb with the hypnosis thing but the more I realized it was just guided relaxation and helping yourself learn to relax, and, you know, control your expectations and your fears, that made a lot more sense to me.

The themes of *Receiving an Education* (Theme 2) and *Questioning and Doubting* (Theme 5) appeared in Dorothy's dialogue. These led to making choices (Theme 3) based on the new information, in Dorothy's case rather late in her pregnancy. She offered more about how she changed her mind:

> We were still planning on doing it in the hospital. We had the "*Just-in-case, What-if-something-happened?*" mentality. Darlene [not her real name] gave us a book to read regarding just hospitals and procedures and what to expect in a hospital and what your options are besides what they present to you. And the more and more I read, the more I picked up other books, and the more we realized the hospital was *not* what we wanted, and that we felt a lot safer just staying away from the doctors and the procedures. So we decided to do a home birth right at the last minute! [laughing] The ninth month is when we chose our midwife and ditched our doctors. For the longest time we were holding off thinking how I've been with my doctor for eight months, all these excuses, but in the end we were kind of like building our birth plan and our plan of attack—how we were going to fend off the doctors and we finally came down to it and we thought it was just like it's going to so much effort to fight to get what we want in the hospital. Why don't we just do it on our own and not have to fight and we can relax and have the birth the way we want to have it?

Dorothy would be employing a midwife and was even considering a water birth since she had "a real affinity for a warm bath." She had purchased an exercise ball which would serve as a birth ball. Her intention was to "just let the labor kind of dictate whatever works best." She expressed a concern that her husband would be out of town on business when her labor began but that was no longer worrying her since he had returned from his last trip and was not scheduled for any more travel. Her midwife, her

husband, and her home constituted her support system (Theme 4). In addition, like Carolyn, Dorothy had spoken with her mother about giving birth:

> I've been talking with my mother lately and actually surprised to learn her birthing experiences. I'd never really talked to her about them. She's never been one to like, you know, go off, "You took 24 hours," you know, your typical mother-guilt-trip. So I'd never really known what our births were like. And I guess her experience was—I was actually really surprised that she was a lot more, had a lot more affinity towards my choices than I thought she might, and I guess she kind of figured it out on her own. Her first birth she had an epidural and I guess she had a back ache for months afterwards and so she decided never again; not doing an epidural. And the next time she went in they gave her some sort of pain shot or something and it slowed down her labor and added two hours to it and she decided, forget it, from now on I'm doing it natural. And she had seven kids after that—all natural.

Dorothy was the sixth child and her own birth was natural. She wanted to emulate her mother saying, "I found out that she had fairly quick births and once it got started getting intense she was done in an hour [snapping her fingers]. I want to inherit that." I placed the influence of mothers on their daughters, and the influence of other women in general on those who are pregnant, under the theme of *Receiving and Education* (Theme 2). Dorothy mentioned that she was sharing information on Hypnobirthing and breast feeding with her sister who was due to have her first child within a few weeks. The impact of women sharing their knowledge and experience is discussed in Chapter VII.

Drawing

At this point I suggested that Dorothy draw a picture of her ideal birth. Her picture (Appendix G) showed a man behind a pregnant woman who is sitting on a birthing ball. Another woman stands beside a tub of water. The room looks like a bedroom, with a double bed and a large curtained window. Unlike the other women interviewed thus far, there was no baby in Dorothy's picture. She described her drawing:

> Well, it's in our own home, which is why I put the window in 'cause this is our curtains. It's actually our bedroom. There are different options just, I guess, the

> most important thing is—the main focus is me and my husband and there's, of course, our midwife support there to guide us and, you know, not tied down or restricted in any way in a bed with an IV or anything like that, but free to move about and find what works best whether it's water or birthing ball or relaxing. And then ideally it would be short because nothing will impede it. No fears and no bad expectations and relatively not—I expect it to be work. I expect it to be labor but with not so much pain per se. Just hard work, kind of what I'm expecting. So that would be ideal too. No pain, just work. I expect it to be happy and joyful. And I'm sure it's going to be very intense during most of it, but, in the end, I don't know, we've doing a lot of research and trying to find out what's not being told to most women. Just 'cause we attended the birth classes in the hospital and were kind of disappointed about—you get the whole medical aspect but there's so much more to it than just medically what's happening too. I kind of feel like we're warned and if something goes wrong then at least we'll have the information to make a decision then if we have to change our plans and, if not, we'll have our wonderful birth here at home.

Dorothy mentioned her relatively new choice to have a midwife-attended home birth (Theme 3: *Making Choices*) supported by her husband and a midwife (Theme 4: *Identifying Resources and Gathering Support*), the research she did to find out what was "not being told to most women" (Theme 2: *Receiving an Education*), and her belief that it would be "very intense but in the end, I don't' know" (Theme 5: *Questioning and Doubting*). All of these themes are discussed in depth in Chapter VI.

We were ready to conclude the interview and I had turned off the tape recorder when Dorothy made an astute observation. I asked her to repeat her comments and turned the recorder back on:

> I was just saying how grateful I am that I've met the right people and then was handed the right books to get the information that I just don't think is widely spread out there. It makes complete sense once you read it and once you open yourself up to it, but our culture, you know you talk to people, I've been speaking to women I know who are pregnant or have multiple births, and there's just such a fear of the "what if"—you know, versus look at it like a disaster waiting to happen, and it's just so sad because they don't realize that there's another way, that it doesn't have to be fear-ridden and relying solely on someone else to dictate what's going to happen. I think there's no trust in the process itself. That people are just—they're afraid that something awful is going to happen so they just subject themselves. Everything else is just worth it to have the interventions, to have the surgeries, to have the complications because I'm sure in some way or

> other, you must have to believe that. But, you know, I just realized—I remember one time really having an epiphany sitting in a group of ladies, all the pregnant women kind of gathered together and there were about six of us talking and several of them were on their, you know, a multiple child. It wasn't their first one. So they started talking about their past experiences and of those random six women every single one of them had had some huge complication. You know, it just struck me as being: that's not normal. This is a normal process. We shouldn't have that high percentage of problem births. The more they talked about it, they'd tell their experiences and I could pinpoint exactly where the avalanche per se had started with an epidural, or with some drug that the baby reacted to, or some other intervention like breaking their waters or something like that, and I guess having read some of the—just the information of what can happen when they do these things, you realize that it wasn't the birth that went wrong. It was the intervention that messed up who was going just fine. But these women, they just don't realize that they accept the fact that *he* saved us, *he* saved my baby, and, you know, we've got a child now and that's all that matters. It's just sad. I wish more women would have access to this information and it wasn't so entrenched in our society how, you know, birth is unnatural. It's not something to be afraid of.

Dorothy's perception of birth as a natural process came into her awareness when she was already in the last trimester of her pregnancy. She had previously held the view that birth was a painful, intense process requiring medical intervention. With that seed firmly implanted in her subconscious mind, it was not too surprising to learn that her birth experience varied from her more recent intention to have a natural birth at home.

Second Interview

When we met the second time, Dorothy greeted me cheerfully, holding her newborn. We sat in the living room again, with listening-music playing on the stereo. She appeared relaxed holding her infant and warmly accepted the two volumes of *Being with Babies* that I presented as gifts.

Question 1

Telling me her of her experience, she described her experience of the unexpected (Theme 6):

Well, we started out here at home like we planned. We had the water tub all set

> up and did—actually were here for a good 24 hours or so, but she was posterior so it was a little bit more painful than expected, and kind of slow going. My cervix wouldn't open really. So after 24 hours, when it actually started going backwards, I went from eight centimeters to six centimeters, we decided at that point that it was time to go to the hospital. So we transported to the hospital and got an epidural and, even with pitocin, it took another 10 hours of labor before she came.

Once in the hospital and receiving medication Dorothy could sense the contractions but was no longer in pain. She called the numb feeling "seductive." She and her husband had lost an entire night's sleep and were headed for another sleepless night. Her energy to give birth was exhausted. She was so tired that she "was shutting down." She admitted, "I had a little help, but it was so nice because we got there and I was able to sleep. Everyone got a good eight hours of sleep and then we finished up." She told me about finishing up which included some opportunities to exercise her will and make choices (Theme 3) that diverged from those the hospital staff recommended:

> It was actually pretty good 'cause once we got to a ten and were ready the nurse left us for a little awhile and I was able to do *my* kind of pushing, not forced pushing that she wanted me to do, you know. And so I kind of did my own thing for awhile 'cause I could feel the contractions and I did it my way while she was gone, and when she came back it took 15 minutes and she [the baby] was out. It was just super fast. Dominic [not his real name] got to deliver her once her head was out. We had great staff. We had nurses who were really sympathetic and nobody treated us badly because we tried to do a home birth, which we were really surprised about. And we got my old doctor, the one we had ditched. So she kind of knew us a little bit and she was very kind and let us do things our way. She let Dominic birth the shoulders and the rest of the body, and she coached him through it, and she let us wait to cut the cord until it stopped pulsating. She just was really, really accommodating for all the things that we wanted to do.

The staff at the hospital and her old doctor became her new support system (Theme 4). She was making sense (Theme 7) of her experience and returning to her initial joy (Theme 8/1). She observed, "I think we were real blessed, especially not to have a c-section." Because the midwife had delayed examining her at home, Dorothy's water broke when the pelvic exam occurred much later. To Dorothy this meant that she was

probably spared a diagnosis of failure-to-progress and a consequent cesarean section. Her labor could have been assessed to have started with the passage of some fluid hours earlier. At this point she was accepting (Theme 7) the necessity to go to the hospital saying:

> We weren't disappointed. I think Dominic was a little bit [disappointed] at first. He was disappointed at having to give up and go to the hospital. But I also don't think he knew—the midwives didn't tell us I'd regressed to a six until after we were in the hospital. They didn't want to disappoint us or discourage me. Especially after learning that, I have no regrets, and ten more hours in the hospital is like, I couldn't have done that at home. I was already exhausted. So it was a good experience. I got great nurses and a good doctor.

Ironically, just as Dorothy had observed among the pregnant women she had heard talking about their problematic births, she now reconciled the fact that having a slow and painful labor that resulted in the birth of a healthy baby justified the use of medical interventions.

Question 2

In response to being asked how her experience compared with her expectations, Dorothy stated:

> It was harder than I expected. I don't know if it was mostly because she was posterior and there was back labor the whole time. Yeah, it was. We actually spent a lot of time in the tub. That really helped. That's probably one of the reasons I did last as long as I did at home. But, oh, I don't know. It's a little disappointing to have to give up and go to the hospital, but at the same time we didn't. That's what the hospital's for. I believe it's there when things aren't going right. It's a backup, and that's what happened. I have no regrets going. And I think everything worked out well. And we made it all with fully knowing our decisions and what the consequences would be, you know, with the pitocin and the epidural. I kind of felt like we were informed, and it's nice our midwife came with us and she stayed with us the whole time. So we were able to get some second opinions and some things like the eye drops. The nurses put up a fuss when we tried to refuse the eye drops and the vitamin K.

Dorothy had experienced the unexpected (Theme 6) and was accepting with good grace the steps she took to have her baby (Theme 7). She noted that her midwife continued to

educate and support her (Theme 2), right in the delivery room. With that assistance she and her husband were able to successfully refuse eye drops and an injection of Vitamin K. She added, "We didn't get everything we wanted. We still got most everything we wanted for our baby." For example, the baby was placed on her belly immediately after delivery and the cord was not cut until it stopped pulsing. She smiled saying, "They let us do skin to skin right afterwards and, you know, I got to hold her for awhile until they cut the cord."

Closure

Our interview was concluding when Dorothy remarked: "We didn't tell a whole lot of people we were doing the home birth, 'cause we didn't want to have the pressure of performing, which we're kind of glad we didn't [tell a lot of people]." This was an interesting addendum. I would hear sentiments like this again during the next interview.

Eleanor

Origin of the Name: Greek—Meaning: Light or Mercy
Edwardo: Husband's pseudonym--Origin: Spanish—Meaning: Wealthy Guardian

First Interview

I was looking forward to interviewing Eleanor after our initial phone conversation. She had been referred to me by another participant who knew Eleanor was pregnant. She spoke rapidly and her voice exuded enthusiasm. We met in her home while her husband, an Army soldier, was on temporary duty elsewhere. Eleanor described herself as Hispanic—"a melting pot"—a mixture of ethnicities. She was 32 and had an Associates Degree in Arabic. I found this unusual and she explained that she herself had been in the Army where soldiers can be required to learn a foreign language like Arabic. She and her husband were in the midrange, socioeconomically. They were anticipating a transfer to a new duty station as soon as the baby was born; indeed, they had to make special arrangements to stay in Arizona so Eleanor could give birth at a birth center.

Question 1

When I asked Eleanor how she was feeling about being pregnant she responded without hesitation, "Oh, I love it!" (Theme 1: *Discovering Joy*). Like some of the other participants she added some qualifications:

> There's been some trials and tribulations but I think, just overall, the idea of bringing this child into being is so overriding. I mean I've had some back problems. I told you about the ear ache. But in spite of all those little things it's just amazing. I've just been amazed every day.

In spite of some challenges Eleanor's demeanor was happy, rather jolly. She laughed frequently as she answered questions and explained at length her circumstances. She had already mentioned her husband who had a child from a previous marriage, so I prompted

her to say more about his reaction to their pregnancy:

> Oh, he's been wonderful. He's gone now but it's really hard now because he was doing so much for me. He's really cute. He's really involved. He likes to feel the baby move. He likes to listen. He reads the baby stories at night. So, yeah, he gets real into it.

I found this to be a rather progressive attitude for a young couple in terms of the recent advent of prenatal education. They apparently had not heard about reading to a fetus; they just naturally found this activity gratifying. They were newly weds, having gotten pregnant on their honeymoon, and were anticipating a long separation. Edwardo [not his real name] was to be sent to Iraq in the near future and the couple's time together, especially with the new baby, was precious. Eleanor laughed as she told me that she talked to the baby a lot.

Question 2

In answer to my second question about her expectations of giving birth, Eleanor pronounced:

> Well, we're having the birth at the birth center [in Tucson] and I really like the idea of having midwives. I actually watched my mom have my youngest brother at home and so ever since that experience I never really wanted to have my baby in a hospital. And I want to really avoid any cesarean section 'cause I've never had a surgery and I don't want to start now. So the midwives and the birth center was a rule—a real important thing too, when I found it, and the way to avoid unnecessary surgery and to have the baby in a more home-like environment.

Eleanor felt it was very important to have her husband with her at the birth center (Theme 4: *Identifying Resources and Gathering Support*). Her education about birth (Theme 2: *Receiving an Education*) included a Centering Pregnancy Class at the birth center but was based on the model that had been provided for her when, at 16, she had witnessed the birth of her brother.

> Just from my mom, I would expect my labor to be about 12 to 15 hours, 'cause that's how long her labors were. And she was a really strong role model for me.

> The whole time she was in her early parts of labor she was walking around the neighborhood. She made dinner that night to keep herself kind a active. So I kind a hope I can be like her. I hope I can just find that inner strength.

Under her hope for inner strength was Eleanor's concern that the long drive to Tucson would impede her ability to walk around for over an hour; to move in ways that would be comfortable and contribute to an easy birth.

> The part I'm kind of nervous about is the drive. I'm a little nervous about driving in labor and having to go the hour, hour and a half, to the birth center from here. So I'm real nervous about that 'cause you just have to be there and be still and I won't get to move around if I'm not comfortable in the car. So I'm a little nervous about that.

As quickly as her nervousness was touched upon (Theme 5: *Questioning and Doubting*), thoughts of choices she could make (Theme 3: *Making Choices*) and the comfort she could receive in the birth center (Theme 4: *Identifying Resources*) emerged.

> And then when I get to the birth center—I really like the—I don't want to have a water birth, but I do like being in the water. It's something I've really liked while I've been pregnant. So I expect to find myself in the bathtub or in their, [laughing] or in their whirlpool.

Eleanor vacillated between her enthusiasm and her apprehension:

> We're writing our birth plan next week with the midwives and he [her husband] really wants to be a part of the delivery process instead of just watching. So they want to incorporate that into the birth plan for him. And, so I hope he can find that inner strength too 'cause I know he's never seen or done anything like that before. He's pretty excited about that part.

She began to think about the support she would get from the midwives and the recommended exercises she had been doing. She contrasted her positive outlook with the fears expressed by friends.

> I don't have too much of a vision 'cause it's just so new to me, obviously, since this is a first baby. But I love the midwives, so I expect them to be very supportive, and I've been practicing all the little exercises that I've been given. And so I'm really comfortable squatting. I'm really comfortable moving around and so I feel like that's going to help me a lot. As a matter of fact, some of my friends are scared. Like I'll get down on the ground to pick something up and

> like, “Oh, you’re gonna hurt yourself.” I’m like, “No, this is good for me.” It helps me practice and keep real mobile, so I’ve been trying to do that. So I hope all those things help, because I really don’t want to be at the hospital. That really scares me, going to the hospital.

Her worst fear was expressed. Eleanor continued with, “I expect it to hurt a lot.” Then we laughed together as we agreed that “they don’t call it labor for nothin’!” I then asked her if there any other things she would like to share.

> I’m a little nervous about kind of exposing myself. That’s something that I kind of got over a little bit in the Army. You kind of get over being modest. After watching some of the videos, I guess there’s a little bit of, part of me that’s maybe still a little bit embarrassed about some of the things that everybody around me might see, and two of the people being in the room that I might not know. ‘Cause they have the midwife in there and then they have the one nurse, and there’re lots of nurses I haven’t met at the birth center yet. And they have the one tech that takes care of the baby and I don’t know who the tech is. So, I guess I’m a little bit nervous about sort of being exposed like that to everybody. So I’m a little nervous. That’s the part I’m probably the most nervous about.

Exposure became an issue but not the bodily sort that she mentioned here. Eleanor made an incisive comment after drawing a picture that was totally consistent with current understandings of the unconscious mind—drawings can expose hidden ideas and attitudes.

Drawing

Eleanor seemed complete with sharing both her fears and her positive expectations. We were ready now to have her draw a picture of her ideal birth. She drew a smiling figure, like a Pillsbury Doughboy, in the center of the page. It had no arms or legs. It had a round hairless head, a large, round belly, and bright eyes. It was encircled by sunny yellow light but black streaks getting darker as they seemed to move further out, radiated from its core. To the right, at shoulder height, was a small figure lying on a purple cloud. A smiling blue stick figure with outstretched arms stood further to the right. On the bottom right were blue waves and on the bottom left, light brown earth.

From the ground bloomed three large flowers. They had pink and turquoise blossoms and green stems and leaves. When she was done I asked her to tell me about her drawing (Appendix H) and what it meant to her.

> That's me [in the center] and the stomach has got green and brown in it for fertility. And I've always really—and this is different from the kind of ancient fertility goddesses because they didn't have the heads on them, but whenever I started to get a little bit down about my body, I would remember what I was creating, and I would picture myself like the old fertility goddesses. So that's why I did the no arms and no legs. The flowers—the big one is the midwife, and then the two other ones are the other attendants. And I like flowers because of the rose. I like to think about the stem being support and the thorns kind of being the obstacles. And that stem is like women coming together to give you the strength to kind of overcome hurdles and obstacles that thorns represent. And then the flower is about blooming and becoming something different. So I thought the flowers would be good for the attendants because they're helping me get to that new place from being not-a-mom to becoming a Mother. And I drew the earth with the flowers because they're grounded and they're helping me stay grounded. But I drew the water as kind of the soothing aspect to counter the earth and, as I'm explaining this to you, some of it's actually starting to make sense because I don't know why I drew it when I first drew it. And the yellow's the light. I kind a envision myself, when I was in the Army, whenever we did something really painful or something I just didn't think I could make, I remember I used to just, if I could, I would close my eyes, but sometimes my eyes would be open and I would just find that role—kind a quiet spot inside—and really just focus my energy on just letting everything out and just doing that one little thing at a time. And I used to always picture there being a light that I was working towards and so the light is around me and I'm using that to help me focus. And the little black lines are the pain going away, outside of the light, and that's Daddy, and then the baby's on a little cloud because I just picture little babies like little angels.

Eleanor displayed a great deal of insight about her own drawing. Her next intuitive comment exemplified how drawing can access one's unconscious, concepts hidden from everyday observers.

> It feels kind of child-like but [laughing] it's really weird to like—it's that exposure thing, I think, to kind of pull all that out and put it where somebody else can see what's inside your head.

She quickly added:

> Oh, I forgot too. I did him [her husband] in blue because I thought I'm not really good at drawing. I knew I could only do a stick figure, but blue is a really strong color to me and I picture him being my strength.

The first interview was over, but as I went out the door, Eleanor shared that she and her husband had stopped telling people that they were going to have their baby at a birth center. She reported that many of their friends and family accused of them of not providing a safe environment for the baby's birth. Many were aghast at the couple's plans. This attitude, first mentioned in the Literature Review as "authoritative knowledge" is revisited in the Discussion.

Second Interview

When I returned for the second interview Eleanor was in the midst of preparing for her move. She was staying with her grandparents who had a house a few miles away. Edwardo was assisting the packers, while the new baby, only five days old, was resting in the arms of her tired mother.

Question 1

Eleanor held the baby as she launched into a long description of her birth experience. Her labor lasted almost 44 hours. After her water broke, she had traveled to the birth center, 75 miles away, only to be told that she needed to go home and rest. Her contractions were barely underway. Later in the evening, when the contractions increased in strength, she and her husband drove to the birth center again. This time they were welcomed and by the second morning Eleanor was encouraged to exercise, walk, take showers, and perform manual nipple stimulation to increase contractions and promote dilation. By the second evening she was experiencing hard contractions three minutes apart but had only dilated to seven and a half centimeters. The midwife suggested that she go to the Tucson Medical Center. This was not what she Eleanor had

expected (Theme 6: *Experiencing the Unexpected*), and was, indeed, what she had most feared.

> The midwife's suggestion was to go to the hospital, to TMC, so she could give me some pitocin, and, of course, I didn't want to be in a hospital. So I was just terrified, and we asked everybody to leave the room. I had a midwife and a doula, a student doula who was in training that came to attend our birth, and then I had my best friend there. And we asked everybody to leave the room and Edwardo and I just sat and cried, and, "Like, if that's what the midwife thinks is best and she's going to go with us. So we're going to go ahead and go," and 'cause, at this point, I mean my water had broken almost thirty-some hours before, so it had already been a really long labor. And I was getting so tired and they were really concerned that I would poop out basically before I got anywhere with the labor. 'Cause they [the contractions] were too strong to sleep but not strong enough to get me to any kind of pushing stage. We weren't even getting transitional labor and so [I was] a little bit concerned and scared to go to the hospital. We all packed up and went next door. And it was a hospital, so we were kind of not as comfortable there and, at first, well, my will just completely went. The whole time at the birthing center they said that everything they suggested I tried. I tried really hard to do everything they said. The second we got to the hospital I just was like, "I don't want to do anything!" I didn't want to try any positions. I didn't want to. It's just like I felt so deflated that I had to go from the birth center to the hospital.

Eleanor was making a new choice (Theme 3), but was reluctant to do so since she had feared going to the hospital. She had gathered support (Theme 4) from her husband, midwife, doula, and her best friend, all of whom could accompany her to the hospital. She was questioning (Theme 5) this change of venue and the procedures being applied.

At this point in the interview Eleanor began to cry. I asked her if she would like to stop for a minute and turned off both the tape recorder and the video camera. I soothed her with quiet words of sympathy while she held her baby. After a few minutes she said, "I really didn't expect that." Her experience was still so new, and she had gotten so tired, both during the birth and afterwards (she related more of this when we continued), that it seemed very natural for her to cry. After we had allowed the wave of emotion to pass, we resumed the interview.

Eleanor now shifted to feeling grateful for her husband's enduring support throughout her labor. In addition, the nurse that came to the hospital to attend her was one who also worked part-time at the birth center. Eleanor was comforted by the fact that this nurse had worked with her midwife before and was familiar with the birth center's philosophy. By now, however, the pitocin was being administered, and although it was in small doses, the contractions immediately increased in severity. She lamented, "Of course the whole idea of drugs is just really insane to me, but we went ahead with it and I was hooked up to all the IVs and the monitors and wasn't as comfortable, of course." The midwife was concerned about the position of the baby which seemed to be slowing the labor. Resisting an epidural, Eleanor was offered Fentanyl, a short-term painkiller. This was administered and Eleanor was actually able to sleep between contractions. She had not anticipated any of this (Theme 6).

> That gave me a little bit of rest that I desperately needed in order to push the baby out because I was so tired already. 'Cause now I think we're comin' on about 40 hours. And so I had the Fentanyl and that was nice, but it also wears off so that I could be totally present when we got to the next stage of labor. So I was still frustrated, not feeling like I was having the birth experience I wanted. I didn't like being in the hospital but the Fentanyl really helped, and then I just felt like I just *have* to get through this and, if we can get through this, I won't have to have a cesarean. So that was in the back of my head the whole time I was at the hospital. I just felt like I wasn't gonna get through it, just 'cause it's so painful. And I didn't have any energy left. I was so tired. I just felt like a hollow, limp little rag doll. I remember even saying out loud: "I just feel so hollow and there's nothing left. I feel so hollow and there's nothing left."

Eleanor continued to describe the choice she made (Theme 3: *Making Choices*) to finally lie on her side in the bed so that she could, with her best friend beside her and her doula helping hold her legs (Theme 4: *Identifying Resources and Gathering Support*), push her baby out. Her husband caught the baby and cut the cord, and Eleanor was able to hold her newborn at last. The family left the hospital earlier than the recommended 48 hours

so they could pack their household goods for their transfer to a new duty station. They arrived home to out-of-town visitors who wanted to see the new baby.

Eleanor was accepting the reality of her experience and expressing appreciation for the way things turned out (Theme 7: *Accepting What Is*).

> So we're just glad that we found the birth center because we know that our outcome would have been very different, and even though it didn't turn out exactly like we expected, it turned out exactly the way it needed to.

She was told that the umbilical cord had been short and wrapped around the baby's foot, delaying her descent through the birth canal. Eleanor was proud of the fact that she had not had an epidural, and particularly grateful to have avoided a cesarean section. In addition, she felt that her husband had grown from the experience of helping to deliver his child. She felt pleased that each person in attendance had served a unique purpose. Her fright and disappointment were transforming: "So it was just this really neat kind a transfer of energy between everybody and kind of experiences that were just really unique, I think. It was a really special birth."

Question 2

I asked my second question so Eleanor could compare her experience with her expectations. Her response ranged from experiencing the unexpected (Theme 6), through accepting what had happened (Theme 7), to re-experiencing joy (Theme 8/1).

> It happened in a different place and that's—and that was unexpected 'cause we were so adamant about not being at the hospital if at all possible. But, at the time, I didn't feel like it was the birth experience I wanted or needed or anything, [laughing] but almost within the first 24 hours it felt like I realized that it wasn't what I had expected on a like analytical level but, as far as like on a spiritual level, and on how she came into this world, I don't think that we missed anything. I think that everything was still very much present and I feel like the team that came together to make the difficult labor come out the way it did, even added to the birth experience. So I don't think I lost anything in the birth experience and amazing, I think I gained a lot from it.

Closure

I asked if there was anything else she wanted to share, Eleanor eagerly relayed her new-found philosophy:

> Yeah. I think I kind of went in there a little bit kind of thinking that a lot of this is on the Mom. You know, kind of like, not really like in a selfish way, but kind of just in a, like—a lot depends on the Mother and just, I don't know, like I really went in there thinking that it was all about the Mom. Like, no matter what happened, it was really just everything. Either the Mom made it or the Mom didn't make it. Or the Mom, I don't know how to explain it, not like it's her fault if anything went bad. I didn't have that impression. I kind a pictured it. Even though I have like little flowers in my picture, they're kind a off to the side, and kind a even my husband's off in the background. I think maybe in some ways in that drawing, I kind a had the Mom a little lonely with her baby. Like just the Mom and the baby kind a in the center by themselves and everything kind of in the background, and I feel like in my birth experience and this may or may not be true for everyone else, I don't know, but I really felt like that everything should have a little more. I still think the Mom and the baby are the central figures but I think I didn't anticipate the team part of it quite so much. Like it never occurred to me that having a baby would be a team event. I always kind of pictured it, yeah, like, you know, when you're looking at individual sports versus team sports? I always kind a pictured having a baby as like an individual sport. Like the Mom has to go through this labor and they're the ones that come across the finish line by themselves. And now that I look back at my experience, I think the one thing that really kind of keeps coming back up to me is, I keep using the word "team." And that's just really bizarre to me because I just never pictured it being a team event. It was always just about the individual, and she might have her coaches, and her, like in a pit, you know they have the pit crew but the car and the driver were kind of—but now I'm picturing more like a team event, like the actual team finishes together more so than I had anticipated before. And that doesn't take anything away from the Mother still being of central importance, but just of maybe central activity. I'm not really sure how to describe it. So I'm kind of surprised by that kind of notion. How integral everybody was. I mean, I think that's part of why I wanted the birth center experience versus the regular. I guess if it's regular but kind of the normal American OB/GYN hospital experience, 'cause in that sense I think there is no team. There's the Mom. Here's everybody else kind of telling her what to do and the Mom's largely left out. And I was picturing wanting a birth experience where the Mom was way over here, and then the rest of the team is kind of left out. And what I found out is it takes the whole group to kind of come together to do it. I think that's the better way to explain it.

Eleanor found her "team" of great value and made a case for gathering such support for any Mother giving birth. Her concluding remarks further demonstrated her gratitude and

her return to joy (Theme 8/1).

> I really think that I came away with much more than I anticipated with that kind of experience. And I learned a lot about my husband. I mean I'm just in awe of how great he did. I couldn't ask for anything more. I think there was a real bonding experience for the two of us—for the three of us.

Felicia

Origin: Latin—Meaning: Happiness
Farrell: Husband's Pseudonym—Origin: Celtic—Meaning: Proven Courage

First Interview

Felicia, a 26 year-old Caucasian woman, was also referred to me by one of the other participants as well as by a local birth educator. She invited me to her home on an Army Post in Southeastern Arizona where she resided with her husband. She greeted me with a smile, and, as I did with each primipara, I presented her with a small gift in appreciation for her willingness to participate in my study. When I asked her for demographic information she indicated that she had a bachelor's degree. She was married to an enlisted man, making them a mid-income family. It was apparent that Felicia was shy. Her speech flowed rapidly, almost nervously, but softly. Her dark eyes and hair both glistened as she sat in the sunshine that was streaming through her living room window.

Question 1

I asked how she was feeling about being pregnant and learned that she had married earlier in the year and gotten pregnant during the first month of marriage.

> I'm glad to be pregnant. I feel actually really grateful, but I kind of thought I wasn't sure if I'm going to be able to be pregnant ever. My mom had a lot a trouble being pregnant and they were already well into the adoption phase and then she eventually had four. And then my older sister still hasn't had any kids and they would really like one. So I just kind a assumed I was gonna be the same way. So we were very happy when we got pregnant. We just got married in March so—so, I mean basically one month after we got married we were pregnant. But we're thrilled. We've really enjoyed it. I think a lot of people today are against doing that, making sure that the marriage is gonna work or something, but we've really enjoyed our time together. But I do understand too women who don't enjoy pregnancy so much because there was—there's a lot of discomfort involved.

Hearing this, I asked Felicia to tell me more about how *her* pregnancy was, to which she

replied, “Easy. I mean it has all the discomforts that they talk about like heart burn and just, I don’t know, typical stuff. But I mean there haven’t been any complications.” She was already using words like “glad” and “thrilled,” which I thought fit into the first theme of *Discovering Joy*. However, as she thought about it, Felicia shared a concern:

> There was one small thing. When we came out here [moved to this duty station] we went and saw the doctor we chose. We’d heard really good things about her. But she, I don’t know, it probably has a lot to do just with liability type stuff. She became alarmed over, I think maybe I was like a centimeter dilated at one of my visits, and so then she wanted me to, for the next week, not do anything. Like no biking or walking or intercourse with my husband or anything like that. And we just thought that a little over reactive. And even though we both thought that, my husband and I, and we didn’t even follow through with her recommendations, and were fine the next week, we went back and she said, “OK. You’re fine. I’m not worried anymore.” But it still kind of made me a little up tight during that week and so that was, I guess, one of the small things we were really, that it would just be a lot easier not to have to do it [give birth] in the medical community because they have to be so careful, like extra careful. But that was the only, that was very minor, anyway a problem, but it’s the only thing that came up during the pregnancy.

Felicia had mentioned choosing a doctor and then implied that she was thinking of changing her plan to give birth in a hospital. Her statements about choice fit into Theme 3: *Making Choices* and the concern she had about the medical community exemplified Theme 5: *Questioning and Doubting*.

Question 2

After she exclaimed about being “thrilled” to be pregnant and declaring that she and her husband wanted “quite a few kids,” I asked her what she expected giving birth to be like.

> I guess I do think it’s going to be pretty hard. I am a little bit worried ‘cause frankly it’s like, say, just menstrual cramps? To me those are painful and not fun. And if this is going to be, you know, say ten times more intense than that, I do get sometimes—lately I haven’t been—but every once in awhile I do get a little anxious about it. And that was actually part of the reason of going with the home birth too. It’s ‘cause I was afraid if I was in a hospital and especially, they’re kind a almost pushing it on you to have narcotics or the epidural or anything like that.

> I was afraid I wouldn't be able to say no to it. Kind of like you're on a diet and they shove Twinkies in your face. So I thought I really was going to need it for this first baby. Since I don't know what it's going to be like, I really needed to have a lot of support and people encouraging me in what we're doing as opposed to say in the hospital where they're probably not gonna be supportive or encouraging. And I wasn't sure that I could make it through. I think it's going to be hard. I think I'll need all the support I can get basically.

Felicia's questioning of hospital policies led her to decide on a home birth. This process of questioning and choosing alternated, weaving themes 3 (*Questioning and Doubting*) and 5 (*Making Choices*) together. I was curious, at this point in the interview, about what constituted "support" for Felicia.

> Farrell [not his real name], I think. He's my husband. I think he's going to be excellent. And I think just having the midwives around to reassure us that this is normal, you know, whatever you're experiencing isn't putting you or the baby in danger. They've had plenty of experience and they're not going to be offering me epidurals or anything because obviously they don't have it with 'em. It's not even an option. And I think just being in my home. I can move around. I won't be hooked up to a fetal monitor which, no matter what your method, deliveries at [this town], at least 20 minutes out of every hour you have to be hooked up to 'em. So, just that type of support. Being in a comfortable place, having my husband there with me *and*, for him, I was worried too, that I was putting too much stress on him if we did it in a hospital 'cause he's going to be the one trying to ward off everybody from bothering me. And if I'm in a lot of pain and he's aware of that, it's gonna make it hard for him to know whether or not he's doing the right thing. So I thought if we do it at home the midwives will be there to reassure him as well as me. And so kind of just a big team as opposed to just Farrell and I against all the hospital staff.

Her husband, the midwives, and a comfortable home environment would all provide support (Theme 4) for Felicia. Her knowledge of the procedures of the hospital and the kind of reassurance she could receive from the midwives led me to comment that she sounded well-informed and ask, based on what five other primiparas had told me, if she had been educating herself.

> Well, we took classes with Trina [a local birth educator], and Farrell and I did that together. So that was probably about ten hours worth of birth classes where she came to our home and Farrell and I asked all the questions we wanted. You know, just a private setting. And then I've read quite a few books just from the

> library and lots of random ones. So I've gotten the whole spectrum of the Johnson's and Johnson's Child Care to Ina May Gaskin's child care. I got the whole spectrum there. . . . I would read books like *The Thinking Woman's Guide to Better Birth*. I'd just earmark stuff and then read it to Farrell, just certain portions that I thought were really interesting and probably a bit contrary to what we had thought about child birth. And so he didn't really read any books unless, as I say, a couple times I'd read a few pages. Mostly he did the classes with me and then he'd just listen to me tell him all that I was reading. I read lots of books and our class. But I've never been to a birth.

Receiving an Education, the second theme, was obvious in Felicia's report, as was her questioning (Theme 5) of her birth educator. I asked if she wanted to share anything else and she reiterated her concerns.

> I don't know that I really have too many expectations. I just think it's going to be hard, but I think as long as it's here [at home] it's going to be doable. I was very anxious when I knew that we were going to be going to the hospital. I was like Farrell and I were kind a preparing ourselves to have to be, how to say to all these things. And now I just feel like I can relax. So I don't really think about it much actually. I just pray about it every day and then don't think about it.

Drawing

Felicia's faith, in the form of prayer, appeared important to her. In fact, her drawing (Appendix I) had a spiritual quality to it. It pictured no birth scene at all. It was simply a night sky filled with stars and a crescent moon. She commented:

> This isn't the prettiest night sky, but it's just a night sky, and I like it when it's clear. And to me that's just peaceful and quiet. And that's how I want my birth to be. And I don't want lots of people. I don't want—our family won't be coming till January and March so it's going to be nice and spread out. I want it be peaceful and quiet and calm. And so, a night sky represents that to me.

I was curious to learn how her birth experience would compare with her desire for peace and quiet.

Second Interview

Felicia's husband was home during the second interview. He first sat with his arm around his wife and took turns with her holding the baby. Farrell was very quiet and

appeared to be devoted to his family. In fact, the baby seemed to calm noticeably in his arms. They spoke about this later in the interview.

Question 1

I asked Felicia to tell me about her experience of giving birth. She declared, "It was harder than I thought." This simple statement let me know that Felicia had *Experienced the Unexpected* (Theme 6). "It was hard?" I prompted, and she elaborated:

> I guess it wasn't necessarily longer than I thought it might be for the first time. I'd hoped it'd be shorter but it was kinda long. But it was really better we did it at home with the midwives. I think in the hospital it would have been much, probably would have been, I don't know, longer maybe. It just would have been harder emotionally. Here it got just painful and it was really hard and long, and I was tired, and I wanted it to be over. But I was really glad that Farrell was with me, and the midwives, and it was just nice to be here and not to be in the hospital. I could walk around and bounce on the ball.

In this description Felicia seemed to be saying that her experience of giving birth was different from her expectations (Theme 6: *Experiencing the Unexpected*), that she was accepting the fact that the home birth was long but might have been longer or "harder emotionally" had it taken place in the hospital (Theme 7: *Accepting What Is*), and that she was "glad" to have been supported by her husband and the midwives (Theme 4: *Identifying Resources and Gathering Support).*

Felicia began to provide more details: her contractions started in the middle of the night and were already five minutes apart. By mid-morning the midwife arrived and found that Felicia had dilated to seven centimeters. She used the birth ball and also got some rest. "I kind a dozed," she remarked. But later, when she had not made much progress, she and her husband went for a walk which "helped speed things up." Then labor slowed again. "Just part of me wasn't dilating and then I was really tired so we took a nap, and I woke up and my water broke." Felicia's perception was that the labor

was slow and painful. She thought the baby was caught in her descent so pushing "wasn't very productive." The birth itself was a relief.

> I think by the time she came out I was so tired and so wanting her out, I was just relieved that she was born. I wasn't necessarily looking forward to holding her, like I didn't have energy to pick her up. Farrell had her for the rest of the night and he's been excellent with her. He uses some baby tricks that are really good, that calm her even when I can't.

Farrell was now holding their newborn and the baby settled noticeably. He told me about a process he had learned to calm the baby. He recommended the work of Dr. Harvey Karp whose DVD *The Happiest Baby on the Block* had taught him the calming technique.

Felicia continued her story, saying that after she had passed the placenta, "it took a while for me to get enough energy even to walk to the bathroom. I was just really shaky. So that's how it was. So it was a very, very long day." I simply stated, "I can hear it was really tiring." "Yeah," she said, adding:

> So I'm hoping that if another kiddo comes along that it's going to be shorter. I was actually rethinking the whole bit about epidurals and their importance, and it wasn't sounding so bad [laughing]. I think we'll try it again the natural birth way if we could, shorter and easier the next time around since I've done it once. If it's just this difficult, I don't think I'd like doing it [naturally again].

These statements seemed to reflect Felicia's questioning of her old beliefs which, during analysis, I categorized in Theme 5: *Questioning and Doubting*.

During this part of the interview the baby began to fuss and I suggested that Felicia go ahead and nurse her baby. She was reluctant to do that until the interview was over. I recognized that the baby's desire to nurse needed to be heeded at once. As we considered alternatives, Farrell asked if we could put the lens cap on the video camera and let the audio recorder run, which was an excellent suggestion. We did this and continued the interview as the baby nursed contentedly. Farrell had said very little but at this point commented that, after delivery, Felicia "was pretty woozy. The midwives had

to hold her up a couple of minutes and they gave her a shot. I still don't know what it was. [She] was kind of a zombie for awhile."

The interview had focused primarily on Felicia but since the baby was now back in her arms, I shifted the focus to the newborn. Both parents related their perceptions of how the baby first appeared: Felicia said, "She was born forehead first." Her husband pointed to the baby's forehead, saying, "She came out—see the puff right here? She arched her neck back so her forehead rather than the crown of her head came out first." Felicia continued, "So she was in the right position, like she was anterior and all that, but her head was arched so that her forehead came out first instead of here." [pointing to the baby's head as well]. Farrell added, "So she had, right here [gesturing again], a big old cone head. Looked kind a like a Star Trek character." I remarked that the birth must have been hard on the baby to which Felicia added:

> Yeah, she crowned for a really long time like she was just kind a stuck there, which was very uncomfortable for me, not just for her. But it was just longer and more difficult than I had thought it would be. By the time she came I was pretty much out.

Question 2

I moved on to my second question: how Felicia's experiences compared to her expectations.

> Yeah, it was harder. It was more painful and longer than what I was hoping at least. You know, I had heard about birth like that but I was really hoping it wouldn't be for me. But as far as expectations of really being painful, that I was doing a home birth, that was very true. I did, over and over, thought even though it was hard, I thought, you know, maybe the epidural's not so bad. I was feeling so relieved that I was able to do it at home with [nodding at Farrell] and the midwife. So that side of it, there's like expectations of it being better, I guess emotionally on me, it was.

More painful and longer labor fit into the sixth theme, *Experiencing the Unexpected*. Hearing stories about birth from other sources in the culture is part of Theme 2 that I

called *Receiving an Education*. Reconsidering her opinion on epidural's fell into the fifth theme, questioning old beliefs. Feeling that ultimately the birth at home had been better "emotionally" appeared to be part of Felicia's process of Theme 7: *Accepting What Is.* Farrell emphasized that had they gone to the hospital "it probably would have been a cesarean." The baby reacted, seeming distressed. From the point of view of prenatal and perinatal psychology, the newborn was, perhaps, responding to the fears that her parents were conveying about how difficult the birth had been and how it could have been worse. With the focus now back on the baby, Felicia lamented:

> I didn't have energy to bond. [turning to her husband] You bonded with her. [then commenting to me] I would nurse her and then I would think, I was still apprehensive too, I was delivering the placenta then. I thought, man, I just want to be done having stuff come out of me. And it was uncomfortable with them prodding on me. Oh, My Gosh, [I thought] that can't be enjoyable at all. So I still had a lot of things that I was scared about and I didn't have, and I don't if it was because of the [low] energy response. I did want to nurse her and get started off and so the midwives helped me get started off on that.

Felicia had been able to hold the baby intermittently during the first hour after birth but was encumbered by the passage of the placenta. She reiterated how low her energy level had been and said that she had not really taken the initiative to hold her newborn. To nurse, "even then, they laid her next to me. I don't think I was choosing the moment." Felicia was still processing her experience, which had not gone as she expected (Theme 6), and seemed to be attempting to make sense of her feelings (Theme 7: Accepting What Is). She did not appear to be judging herself or expressing disappointment. She simply reflected on her experience, noting that although she got very tired, she had people around her—her husband and the midwives—to support her and the baby.

Closure

We seemed to be nearing the conclusion of the interview. I turned from recalling

the past to how Felicia was feeling in the present moment. She said she was feeling "good, really good." Then her eyes appeared to be seeing a distant image:

> Even that night I didn't really sleep. I just dreamed. Like my muscles had absolutely nothing left in them, so mentally I wasn't all that tired. But that night she kind a just stayed up and she just looked at me.

The peace that she had sought when she first envisioned giving birth, and depicted by drawing a star-filled night sky, seemed to show in her face. Felicia had just described the mother-infant gaze that can occur as mothers bond with their babies. From her expression, I deduced that she had returned to joy (Theme 8/1). The critical nature of the mother-infant gaze is addressed more fully in Chapter VII.

Gwyneth

Origin of the Name: Welsh—Meaning: Fortunate & Blessed
Gilbert: Husband's Pseudonym—Origin: English—Meaning: Trusted
Gabriel: Baby's Pseudonym—Origin: Hebrew—Meaning: God Is My Strength
Goodson: Doctor's Pseudonym—Origin: English—Meaning: Good/Dutiful Son

First Interview

Referred to me by Felicia, Gwyneth worked as a medical surgery nurse in the local hospital. On an afternoon when she was off duty, we met at her apartment. She had a freshly scrubbed look and a gracious manner. We sat next to each other on her couch where we reviewed the description of my study and informed consent forms. Gwyneth was 29, a mid-income Caucasian. She was married and a Registered Nurse with a Bachelor's Degree in Nutrition. She told me she was due in about six weeks. She would be the last primipara that I would interview.

Question 1

I warmed to this young woman as she told me how she felt about being pregnant. She said she was feeling "really good" now, but, she added, "Initially I wasn't sure what I got myself into." Curious about this change of heart, I asked her to tell me more.

> I had a lot, I had some pretty bad morning sickness for the first three months and I lost 17 pounds and was getting sick all the time [laughing with good humor]. So I wasn't sure if, I wasn't all too excited initially because I was feeling so yucky. But then after hearing the baby's heartbeat and then, of course, seeing the ultrasound, we were fortunate enough to have an ultrasound on one of our first appointments, so I got to see our baby pretty young; and then after that it was like my heart melted and I got excited about this baby. Now I'm feeling really good.

I asked her to elaborate on her feelings:

> I think that I get more excited every day. When I felt him move, it was a whole nother sensation of getting to know him, and now, and now I feel like I'm almost getting bits and pieces of his personality.

I wanted to know more about her perception of the baby's personality.

> Just the way he moves when I push on my belly, or at certain times of the day, he'll, I'll feel him more when I'm talking or when my husband's talking and he'll respond. It just feels like we're getting a piece of his personality.

This is a unique way of relating to an unborn child, taught by childbirth educators like Doctors Rene and Kristin Van de Carr at their Prenatal University. It surprised me that this young woman and her husband would connect with their baby, still in the womb, so spontaneously. Again, I encouraged Gwyneth to say more: "You know," she continued, "my husband will talk to my belly, or kiss my belly, and usually we'll get a kick or a flutter or something, and we'll feel like he heard. He recognizes Daddy's voice."

Gwyneth knew from the ultrasound images that she would have a boy. She related that she and her husband, a soldier in the Army, had moved from Texas and thought that when they got to Arizona they would actively attempt to get pregnant. She smiled, "We were able to conceive the first month of trying. So we were happy about that." Gwyneth's joy at being pregnant (Theme 1) was evident although its onset had been delayed by her morning sickness. I asked her if there were anything else about the pregnancy that she wanted to mention before we moved on to what she expected when she gave birth.

> It's just been a really neat experience. So I wasn't . . . I have had different fears about becoming a parent, you know, am I gonna do it right? How their child is going to turn out? But I feel that over the course of the pregnancy that I'm just more and more excited to venture on to the next phase for us.

Question 2

Having mentioned some of her longer-term concerns, I focused on the impending birth: "What do you expect giving birth to be like?"

> I think it'll be uncomfortable. But I feel like the benefits are gonna outweigh [the discomfort]; that even though it's gonna be difficult going through the labor, I'm anticipating it a little bit. You know, I haven't really gone through anything as far as like surgical or that has been extremely painful, so I don't feel like I have even

> anything at all to compare it too. So that makes me a little nervous; not really knowing how intense the pain is going to be or what it's going to feel like. But I think that it will be a special time especially between my husband and I. And I look forward to, I'm looking forward to just the bonding time that's gonna—that will take place between my husband and I as we birth our first baby.

In the midst of her concerns about a difficult labor (Theme 5: *Questioning and Doubting*), Gwyneth was able to look beyond any potential discomfort to a worthwhile and mutual goal shared by her husband. This positive attitude is discussed at length in Chapter VI.

Gwyneth noted that her husband would be with her at the birth (Theme 4: *Identifying Resources and Gathering Support*). Since I had been told by Felicia, who planned a home birth, that Gwyneth was planning to give birth in the hospital, I asked her what she anticipated.

> I don't think I'm opposed to home birth, but I know that there're a lot of good things that can happen with home birth. For me, I just feel like, especially with this being our first baby and not really knowing what to expect with labor and, you know, if there are complications, not knowing if I would be able to discern if there's something going on, I would rather be close, you know, in the hospital setting; that if something went wrong then everything would be there. I've talked with my husband, even early on in our pregnancy, that I want to labor at home as long a s possible because I know once I get to the hospital they're gonna want to start IVs and hook me up to a monitor, which we do want to talk to my doctor about that, and would prefer not to be hooked up to a fetal monitor, but I know that they'll probably still want to check, you know.

Gwyneth doubted (Theme 5) her ability to know if something were wrong and was looking for the best assurance of safety she could obtain, in this case, a hospital setting, for herself and her baby. She was making choices (Theme 3) and further exercising her will by informing her doctor of her preferences. She mentioned the education she was acquiring (Theme 2) as she talked about discussing options with her doctor.

> We've been reading a few books and my husband and I have been like, have really just been thinking there really is a lot we need to talk to Dr. Goodson [not his real name] about what our desires would be, you know, to see, we don't really

> know what his opinions are on certain things that we would prefer to happen. So my next appointment is this Friday and that's our plan, is to bring some of those things up.

She yearned, "We would love for him [the doctor] to be as honoring as we desire him to be." Her attitude was both cooperative and respectful. Nonetheless, Gwyneth still had some doubts (Theme 5) about her own ability to know when she was in labor and when she should go to the hospital since she wanted to labor at home as long as possible.

> I think the one concern I have with that is, since this is our first as well, not knowing when it's, oh, if I'll be able to identify, OK, it's time to go to the hospital, you know, or do we have more time at home because, you know, I'd hate to get to the hospital and only be at 4 cm. You know, I really would like to be closer to eight or so. But we're in the, my husband and I are in a birthing class so we're hoping to learn a little bit more information.

The birthing class was another way Gwyneth was educating herself (Theme 2). I was glad I did not assume she was attending the one presented at the hospital because, when I specifically asked, she indicated that the classes were a series provided by "a private gal that comes to our home. . . . We've only had one class with her but we're excited about the next five weeks and everything else we have to learn."

Laughing delightedly, Gwyneth said, "I do feel like I'm hoping to get the best of both worlds." She wanted to enroll the doctor in her plan to have a natural birth in the hospital. She articulated how her husband would support her (Theme 4) saying, "I really appreciate him being, I don't think that he'll be afraid to speak up to the doctor or the nurses, you know, what our desires are." Her attitude was not adversarial. She was willing to both voice her opinion and to negotiate for the cooperation she desired.

> One of the other things is with the, you know, most of the time in the hospitals women will deliver on their back always, and so I would like to have the freedom to, if I need to get on my side or squat or something, I would love to have the freedom to do that. I don't know how that's going to go over in the hospital. That's one of the things that we're going to talk to Dr. Goodson about, is to have

> a, you know, a squatting bar or birthing ball to sit on, you know, if I still need to labor a bit more at the hospital.

Concerns appeared to intermingle with positive planning. Gwyneth also seemed to vacillate between concern for her the accomplishment of own desires and concern that others would be adversely affected. She wanted to be considerate of others while maintaining a degree of privacy and self-determination. With regard to being a nurse herself, she did not want anyone assuming that she was knowledgeable about obstetrics when she was not trained in that discipline. She did not want to either intimidate others with her nursing background or miss some pertinent information she wanted to have.

> I'm sure they'll know. The nurses there will find out that I'm a nurse and I don't know how that's going to be. I would actually prefer if they didn't know or have any idea though. 'Cause I know sometimes that can be intimidating. I didn't even want Trina to know, our birthing gal, because I didn't want her to feel intimidated at all, or feel like I might know something that I don't know, because there's a lot about obstetrics that I don't know.

Gwyneth's modesty appeared genuine. She continued to talk about her expectations, juxtaposing positive anticipation with concerns about the unknown. To this point in the interview Gwyneth had not used the word "pain:" she referred rather euphemistically to being "uncomfortable." The power of the words—spoken and unspoken—is addressed in Chapter VII, as is the paradoxical nature of each primipara's expectations. Here, Gwyneth remarked:

> I think it'll a good experience. I mean I'm definitely looking forward to the experience, but I guess I'm just trying to be realistic with it being extremely uncomfortable. I mean I haven't met a woman that has birthed a baby that has said it was [pain free] unless they've had an epidural. In fact, all my friends that have had epidurals are like "Get the epidural!" you know, but that's something that I want to avoid and [I want to] do it as natural as possible and so all the ladies that have done it naturally have said it's uncomfortable but it's so worth it, and you forget about it after the baby's born. You're just so focused on this little one and just the miracle of life itself.

The messages that women impart to each other is shown in these comments. They

educate one another (Theme 2) as they share their experiences. Gwyneth was making choices in harmony with her own value system (Theme 3: *Making Choices*).

Drawing

I asked Gwyneth to draw a picture of her ideal birth (Appendix J). She drew an after-birth scene with a man standing beside a reclining woman who has an ankh-shaped baby on her lap. Radiating above them is a golden cross, musical notes, and an ivy garland bearing fruit and flowers. A lone blue figure stands to the side. A red cross on his cap seemed to indicate he was a doctor. Gwyneth shared what the picture represented to her:

> Well, this is my husband and I, and this me with a lot of sweat and that's tears of joy. And that's my husband with tears of joy. This is our baby. This is the Lord hanging his hand over both of us, and our family during this time. The ivy and the different kinds of fruit are food that's life and just it being a new phase of life that we're excited about growing together. And the music—the music notes represent just a time of worship and praise to the Lord for giving us our son and trusting us to raise him. And this is the doctor representing the hospital and the hospital setting. He's just kind of off to the side but the real picture is my husband and I and our son and our new family together under Christ's covering.

Gwyneth's faith had been understated until now. This disclosure made it abundantly clear that her relationship to a Higher Power provided a foundation for her life, not just during the process of giving birth. I asked no specific questions about her religious orientation, but I was quite interested to observe how such a strong faith might impact a birth. It did, indeed, seem to play a role.

Second Interview

Our second interview also took place in Gwyneth's apartment. This time she greeted me at the door holding her newborn in her arms. She indicated that her baby was ready to nap but she had wanted me to see him before she put him down. She looked radiant, her skin glowing and her eyes bright. The sleeping baby looked comfortably

cradled and, as I spoke in soft tones to welcome him, his eyes fluttered slightly. His mouth curled briefly into a sweet smile before he returned to blissful slumber.

Gwyneth introduced me to her mother who was sitting in the kitchenette. While she took the baby into the bedroom I told her mother what we were doing and what questions I would be asking her daughter. The exchange was warm and friendly. When Gwyneth returned we sat on the couch together. I gave her a gift, the two booklets by Wendy McCarty, *Being with Babies*. We checked the recorders and began.

Question 1

Obviously happy, Gwyneth told me about her experience of giving birth.

> Well, I went into early labor at 4:30 in the morning and I thought it was, I just needed to go to the bathroom, but at 5 o'clock in the morning I woke up again with more cramping and noticed that I had started spotting. So I thought, this is probably it [her voice rising].

Gwyneth questioned (Theme 5) whether she was actually in labor or not, then trusted her own judgment and relaxed into the process.

> And so I just went back to bed and laid down and just tried to sleep a little bit more. Um, we woke up about, well, actually I woke my husband up 'cause I kept getting up so much 'cause it was getting more uncomfortable [laughing], and so, um, we stayed home and – and labored. We didn't end up going to the hospital until 11 o'clock.

Gwyneth had wanted to labor at home as long as possible. She was exercising her will and making a choice (Theme 3). She and her husband played Scrabble most of the morning until calling the doctor about 10:30 to report contractions lasting a minute apiece and five minutes apart. At his suggestion they went to the hospital. Gwyneth was examined in the triage room and found to be only three centimeters dilated. Of more concern was the baby's heart rate which was between 90 and 115 beats per minute, lower than preferred by the medical staff. The baby's heart rate had been consistently low at

Gwyneth's last two doctor's appointments so the couple did not become worried or overwrought. They decided it was probably "positional" and went for a walk.

> They checked an hour later and I was still only dilated to three, but because of the heart rate, the doctor wanted to do a amniotic fluid check to make sure that the baby wasn't in any kind of distress or anything like that. So we were still in the triage room, and at that time my husband went out and got the birthing ball 'cause I told him that I didn't want to be in the bed anymore. I hadn't really been in the bed all that long because we had been walking around but every time they wanted to assess me, I had to get into the bed. The man doing the sonogram—it took about two hours for him to come and do the sonogram and then for them to get the results. . . . During those two hours I was on the birth ball and Gilbert [not his real name] was right there encouraging me and we were in the triage room or in the bathroom because the gal that did our childbirth education classes, she said, "You know, about every 30 minutes you're gonna want ta go to the bathroom. It'll just help move baby around and see if you go." So we did that and by the time the sonogram got done, I was dilated to 4 centimeters . . . and everything with the sonogram checked out fine. There was no problems with that. But the baby's heart rate was still running lower than they wanted it to. They went ahead and admitted me and that was about 5 o'clock in the evening.

Hours had passed and the couple remained calm, complying with the request to undergo tests to insure the baby's safety. They also were reassured by their birth educator's statement that frequent trips to the bathroom were normal and even helpful since Gwyneth felt that urge often. Once admitted Gwyneth had a discussion with the nurse on duty about pain medication. The nurse had her birth plan stating her preference to receive no drugs but said people often change their minds. Gwyneth was emphatic that she "did not want the epidural, but I would—was not opposed to Stadol which is just like Demerol or morphine." She asked more questions about the drug offered but ultimately told the nurse she "wasn't interested" because she was somewhat nauseated and did not want to be throwing up at the same time she was feeling contractions.

> So we, Gilbert and I, just continued to labor in the birthing room, and I thought I would want Gilbert, I mean Gilbert was really good with encouraging me, and I thought I would want him to be giving me words of encouragement during my contractions, but there came a point where I didn't want anyone talking to me. I wanted it quiet and no one talking to me 'cause I just wanted to focus on my

> breathing and my womb and, you know, just getting, um, you know just focusing through the contractions. So in between the contractions we got, he would help me go to the bathroom or get up to go to the bathroom, which I never was able to go but it was just good to move around. And so most of the time I sat on the birth ball and hung my arms over the side of the bed and they had me on the monitor and contraction thing, or monitoring my contractions during that time too. But it was right there so there was no problem for them with getting readings. So they were happy and we were happy and so that was good.

Again Gwyneth was making choices (Theme 3) and, at the same time, insuring that she was complying with hospital policies. She felt good and so did the staff.

The nurse suggested Gwyneth get into bed but lie on her side so they could change her from one side to the other, alternating to see if the baby's heart rate would speed up.

> So I got in the bed and laid on my side and I had one contraction that I can remember on my side, and then—and Dr. Goodson had come into the room at that point—and he said, "I'm going to check on someone else and then I'll be back in, in a minute." And then I had my second contraction on my side and felt the urge to push, and I think that's when my water broke 'cause I could feel Gabriel [not his real name] starting to descend. And um I told the nurse, "I need to push. I need to start pushing." And so she went and they got Dr. Goodson back in there, but before he got in there, she, the nurse went ahead and checked me and she could feel Gabriel's head right there. So Dr. Goodson came in and I um, he wanted to check me. They wanted me to get on my back for him to check me, so I said, "I want to make sure that you're ready to check me before I get on my back," so he did, and he said that, yeah, I was ready to start pushing, but I told him that I wanted to be on my side because the pressure. There's definitely a difference between that back pressure than being on my side. So, and, um, so the nurse looked at the doctor and Dr. Goodson just said "Why not! We'll let her deliver on her side." So I got ta. So it was, I was on my side and I pushed through. I had three more contractions and I pushed about three times per contraction. He [the baby] came out on the third contraction. So it was really, it was really fast 'cause at 5 o'clock I was only dilated to four and he was born at 7:55. So almost, you know, three hours later he was born. Yeah, it was really cool.

Gwyneth remained good humored while asking for what she wanted. Her doctor was cooperative, indeed, encouraging.

> And when Dr. Goodson came in, he said, 'cause I was having a contraction I wasn't sure if he was talking to the nurse or to my husband, but he had said, "You

> know, many women come in here with goals that she had and very few actually follow through." So it was good. I mean I just felt like that was a huge encouragement with that and the nurse that I had just thought, she was just amazed that I would want to get up to go to the bathroom, and I was doing fine sitting on the birthing ball. And she just thought it was great too, so I felt really, really good about everything.

The hospital staff remained congenial and cooperative.

> And so Gabriel was born and he stayed with us the entire time, even during the bathing time which they didn't bathe him for probably like two hours after he was born. They let us just hang out with him and I tried to breast feed but he just, he wouldn't latch on right away. But he was just wide awake and alert. That's the other thing the nurse kept commenting about how alert he was. Like probably at least five or six times she said, "He is just so alert. Wow!" You know, so that was really neat. But he never left our room that first night. They did everything from the assessment to the bath; everything they did in our room. So, yeah. Which, it was, it truly, as far as our expectations go, it was exactly, other than, because Gabriel's heart rate was lower than what they wanted, and the alarm, the heart monitor, the alarm kept going off. During my contractions that bothered me, but David learned where the silence button was, so David just kept pushing the silence button during it. So, but other than that, I mean we got to do everything that we wanted to as far as helping me get through the contractions the way I wanted it to. So, it was really good.

Gwyneth could have been alarmed herself by the sound of the equipment indicating that the baby's heart rate was lower than desired. Yet she and her husband not only remained relaxed, they literally turned off the alarm! Gwyneth was definitely exercising her will (Theme 3).

Question 2

Gwyneth's experience unfolded in a manner pleasing to her. I now asked specifically how it compared with her expectations.

> Well, I expected it to be *not* easy. I mean I knew that labor would be hard but it was, as far as like our, what we desired, as far as doing a natural childbirth at the hospital was like almost exactly—other than hearing that beeping monitor—was pretty much exactly to what we wanted. And we were very impressed with how the staff just worked with us and let us do what we wanted to do. So, um, that was great. And even after Gabriel was born, Gilbert and I were just amazed at how well everything went. We were really thrilled. . . . It was actually a little better [than we expected] because we thought we would be, we would be tied

> down. We weren't really sure what to expect with the hospital. We knew what we wanted to do. We didn't know how much freedom they were going to give us. And, um, they pretty much let us do what, whatever I wanted to do to get through my contractions. Yeah, and it was great that he [Dr. Goodson] was for us too. So, yeah, it was, it met my, probably *exceeded* my expectations, as far as how everything was gonna go.

The most unexpected (Theme 6) aspect of Gwyneth's labor was the baby's low heart rate but she and her husband did not over-react. In making sense of what had happened (Theme 7), she thought the delivery was better than expected. I calculated that she had started labor at 4:30 in the morning and had delivered before 8 that evening. This was a relatively short and manageable labor. She said loud enough for her mother in the kitchen to hear: "I think it might in the genes!"

Gwyneth's mother interjected:

> From the time I had my first pain till the time she [Gwyneth] was born, was four hours. I had only gone to the hospital. I went to the hospital at 7:00 and she was born at 9:01. But see, my mother has seven children and she never saw a medical rep until the seventh child and he was born breech.

Her mother then reminded her that the doctor had complimented her beautiful bone structure and Gwyneth agreed.

> Yeah, he did. He was like, "She has good hips for this." When I was actually, yeah, he said, "She has the good hips and pelvis for having these babies," so, yeah, I think, I know not very many women have it. I mean I know they have it a lot harder than probably what I experienced but I'm very thankful for the way went with us.

Closure

We were close to concluding our interview but I wanted to ask another question. I referred to our previous interview in which Gwyneth told me that she had wanted to bond more deeply with her husband, and in describing her drawing, she had felt she would be trusting in the Lord. Had those two elements manifested in her experience? Gwyneth responded:

> I can very clearly remember during when Gabriel was coming out, praying during that time that the Lord would help me endure, and at the same time, knowing that my closest girlfriends that have gone before me were praying—praying me through this time as well. So, yeah, I definitely feel like I know that the Lord was there with us and, um, you know, was sending Gabriel out just at the same time. You know, it was great. And Gilbert, actually when I was on my side, he was the one that was holding, got to hold my leg and was right there. So I felt like, with the bonding, I mean Gilbert, he wasn't nervous about anything. He was excited to just get right in there and he, it was, he said it was surreal watching his son be born and it really was a special time. So, yeah.

The power of prayer, including the power of distant prayer and nonlocal communication, has been researched, and been found to exert positive influences (Dossey, 1989). In terms of Gwyneth's experience, she truly appeared to have returned to joy (Theme 8/1).

Due to my prenatal and perinatal orientation, my curiosity was increasing with regard to Gwyneth's connection to her baby throughout her birthing process. I told her I had learned that the baby actually triggers the hormones that cause the birth sequence to begin, and wondered if she had been aware of her baby's contribution to their experience. Her reply was remarkable and an example of the consciousness that can occur when a mother—and father—are in tune with their unborn child.

> Well, I'll just say it is interesting that the night before my husband started talking to Gabriel in the womb saying, "OK, Buddy. You only have one more day to come out because Daddy has to work next week." 'Cause my husband really wanted him born at President's weekend because of his school schedule. It would be hard for him to take time off. So, that was kind of a big. We were talking about that too, how, you know, Gabriel was listening to his daddy and was--he knew that he only had that one more day left for his dad to be as much a part of the process as he wanted to be. So, yeah, that was really cool.

The case studies of the primiparas were fascinating to me and provided the forum in which to fully describe the emergence of the themes. I had created a check list (Table 1) to keep track of the themes, particularly to see if each theme appeared in each primipara's story. They did, in varying ways and times. The themes are discussed in depth in Chapter VI.

Chapter VI: Results

Phenomenological Themes

Introduction

Themes identified in Chapter V are now placed center stage. They are discussed from the point of view that, having emerged from the data, they can bear the light of examination as individual topics. Together they form a continuum that describes a holistic process—that of women giving birth for the first time.

I selected the title for each theme, employing a gerund. Gerunds imply an ongoing process, suggesting the passage of time. Grammatically, words ending in "-ing" are considered progressive, that is, they "express an action or condition in progress," (Morris, 1975, p. 1045). Whatever a primipara's experience, it is not static, nor comprised of a single element. It is both dynamic and multifaceted. *Discovering Joy* (Theme 1) implies that joy may emerge over time as a primipara adjusts to her pregnancy; it may vary in degrees, ebb and flow, and be countered by periodic feelings of fear. Ambivalent feelings are characteristic of pregnant women (Newman & Newman, 2006). Each theme, therefore, is a process in itself, containing paradoxical elements.

I present the themes in visual format (see Figure 1) that allows the dynamism of the themes, individually and collectively, to be perceived in a manner beyond what a verbal description can convey. These images are metaphoric and emerged from the data just as the themes themselves had. I considered various images: trees growing branches and roots, figure eights, concentric circles, and Mobius strips. I set those aside when the energetic images arose and linked the findings to the quantum physical paradigm that I was incorporating in this dissertation.

Figure 1, introduced in Chapter V, shows the constellation of themes that

pervades the thoughts, feelings, sensations, and actions—the mental, emotional, physical, and behavioral—aspects of a primipara's life. They revolve around her like electrons around the nucleus of an atom. The constellation is meant to suggest energy and movement. To more fully explain why I applied this image I rely on Dossey's (1982) description of how quantum physicists came to view the movement of electrons:

> Electrons exhibited curious behavior, appearing everywhere in their orbit at once, albeit more at one point than another, but everywhere present to some degree, ill fitting the earlier concept of discrete units. These characteristics forced an abandonment, thus, of Newton's earlier absolute distinctions between mass and empty space. (p. 233)

This behavior seemed to fit the manner in which I saw the themes revolving around a primipara. Most themes appeared randomly throughout the interviews, sometimes repeating as different subjects were addressed. Theme 5: *Questioning and Doubting*, for example, may have occurred after Theme 6: *Experiencing the Unexpected* as it did for many, and may also have occurred earlier when a primipara was questioning the intensity of pain she might experience or her ability to labor without medication, before Theme 2: *Receiving an Education*. The themes are elastic, and, although numbered in a logical, and even typical series, they do not necessarily adhere to a specific order.

The first theme, *Discovering Joy*, and the last theme, *Returning to Joy*, begin and end the dynamic pattern I identified. Where the eighth theme overlaps the first, the imagery depicts the holographic way in which interference patterns intermingle. Energies—themes—merge like ripples blending when two stones are thrown into a pond. At this intersection each woman has successfully completed her rite of passage and can embrace the shift from joyful anticipation to joyful realization.

In Chapter VI I first look at the themes through eyes of a phenomenologist. I examine the themes one at a time incorporating quotations derived from the transcript of each primipara's interview. The interviews yielded volumes of information that demonstrated how a woman's experience can be unique while still sharing common elements with others. I also include research that is related to the themes that I identified. Some of the studies had been included in the literature review. However, the themes emerged from the data. Since there was no way I could know ahead of time what the themes would be, I added relevant new studies here.

Individual Themes

Theme 1: Discovering Joy

The themes that emerged from seven primiparas' answers to open-ended questions began with *Discovering Joy*. Each of these particular women were happy to be pregnant, indeed, several had been consciously attempting to conceive. Nonetheless, each woman added one or more qualifications to her positive response. Annette said she was happy the whole time, in spite of mood swings and the necessity to face "traumatic things." Barbara said she felt good but was more excited when she first learned she was pregnant. As she neared her due date, her discomfort and apprehension grew. Carolyn was "ecstatic" viewing her situation as the "answer to a prayer" yet she doubted that she could "trust it" or really believe that, at 42, her pregnancy was "real." Dorothy's reaction appeared more cerebral and even subdued. She included her husband's response using "we" when she spoke of their reactions. They were both "excited" and saw the pregnancy as a "very welcome event." Even so, Dorothy was feeling increasingly "awkward." Eleanor loved being pregnant but, she too, had dealt with "trials and tribulations." Her joy appeared to outweigh any discomfort. Felicia was "glad" and

"grateful" to be pregnant because she had thought she might not be able to have children. She also identified with women who did not enjoy pregnancy because "there's a lot of discomfort involved." Gwyneth felt "really good" when I interviewed her but had been sick continuously during her first trimester. She said she "wasn't all too excited initially" because she was so ill but after hearing the baby's heartbeat and seeing his ultrasound image her "heart melted" and she "got excited" about her baby.

Although these primiparas indicated that they were happy to be pregnant, each added qualifications based on such considerations as her physical adjustment to being pregnant (Dorothy, Felicia, and Gwyneth), stressful life circumstances (Annette and Eleanor), or fears about the impending birth (Barbara and Carolyn). Some of these qualifications became more evident as other themes emerged. My findings were at once demonstrating the coexistence of joy and fear, of comfort and discomfort, that were indicative of the ambivalence that most women feel when pregnant (Callister et al., 2001; Green et al., 1998; Newman & Newman, 2006; Waldenstrom et al., 1996).

Theme 2: Receiving an Education

I included in the realm of education all of those vehicles that brought pregnancy and birthing information into the primiparas' awareness. The information may have precipitated a change of mind or not. This educational theme stood out because each woman, at some point during her interview, mentioned that she had read books (Annette, Carolyn, Dorothy, and Felicia), seen videos (Barbara and Carolyn), watched television programs about birth or accessed the internet as a source of information (Barbara), attended prenatal classes (Annette, Barbara, Carolyn, Eleanor, Felicia, and Gwyneth), talked with her own mother (Carolyn, Dorothy, and Eleanor), been influenced by the stories of other women (Carolyn, Dorothy, and Felicia), or heeded their partner's

outspoken desires (Barbara, Dorothy, and Eleanor). Because of her own limited financial resources and those of the small community in which she resided, Annette relied on books from the library and attended classes at the birth center. Barbara was very curious and apprehensive due to the fact that a sister-in-law had lost a baby during her pregnancy. She utilized a number of educational tools including videos, television programs, the internet, and prenatal classes. Her husband wanted her to take advantage of every medical "instrument" available. Carolyn noted that she had read *A Thinking Woman's Guide to a Better Birth* by Henci Goer (1999), as well as articles about orgasmic, ecstatic birth. She had watched videos about the relaxation attained through hypnosis, had attended a class called "Labor Day," had talked with her mother, and been motivated by the stories of friends who had shared their birth experiences. Dorothy was influenced by a friend who advocated water births and Hypnobirthing. She read books and had discussed birth options with her mother. Eleanor had witnessed her brother being born when she was 16. This provided an indelible role model for giving birth naturally. She also attended prenatal classes at the Birth Center where she intended to have her baby. Felicia and Gwyneth hired a private birth educator to come to their homes. Felicia's husband participated in the series of classes with her. She also noted that she had read the same book by Henci Goer that Carolyn had mentioned, although neither woman knew the other nor even lived in the same community. Felicia had also "heard about birth" being long and painful, which left an impression that had an impact on her labor. Gwyneth, a registered nurse, and her husband were reading books and also participating in private prenatal classes together. She made a point that she did not want her birth educator to know that she was a nurse because it might limit the education she could receive; that is, the birth educator might assume Gwyneth knew more about birth already.

Fenwick and colleagues (2005) noted many sources that contribute to a woman's childbirth expectations. In Australia they specifically include educational resources: books, magazines, publicly held views, and stories told by mothers and sisters. Lazarus (1997) "found women to have unequal access to knowledge and differing degrees of desire for such knowledge" (p. 139). Although some of the primiparas in my study had more or less educational information available than others, each of the seven women seemed eager to obtain information about the process of childbearing.

Spiby, Slade, Escott, Henderson, and Fraser (2003) state that "antenatal education aims to offer women information about labor and birth and ways of coping with pain and emotional distress" (p. 189). They found in their study of 121 women that breathing techniques, postural changes, and relaxation techniques were all discontinued during labor due to "common aspects of care, changes in environment, and the use of pharmacological pain relief" (p. 189). They recommend revising prenatal curricula to "include accurate information about coping strategies" (p. 193) and that those strategies be encouraged by care providers during a woman's labor. In my study Eleanor stopped using her coping strategies when she was transported from the birth center to the hospital, a change in her environment. She said, "The second we got to the hospital I just was like 'I don't want to do anything!' I didn't want to try any positions. I didn't want to—it's just like I felt so deflated that I had to go from the Birth Center to the hospital."

Better prenatal education is perhaps one factor that could contribute to women's positive labor experiences. In the United Kingdom a study by Madi and Crow (2003) has shown that:

> women planning a home birth were well informed about the options available to them, while the majority of those planning a hospital birth were less informed

about the availability of home birth and assumed that the hospital was the only option. (p. 328)

These researchers state that "there is still evidence of lack of information among pregnant women regarding services available to them" (p. 328). Much of the childbirth research continues to be done abroad but it would not be unreasonable to generalize these findings to the United States.

Theme 3: Making Choices and Exercising Will

Making choices was something each primipara had to do. She needed to choose a hospital (Barbara and Gwyneth), a Birth Center (Annette, Carolyn, Eleanor), or home environment (Dorothy and Felicia). She needed to select a doctor if delivery was to be in a hospital, or a midwife, if delivery was to be in a Birth Center or at home. Those choices followed logically from the choice of venue. The administration of pain relieving medication had to be considered. Felicia thought that being offered an anesthetic was like being on a diet and having "Twinkies" shoved in her face, something she wanted to avoid. Gwyneth also preferred to deliver with no drugs, even though she wanted to give birth in the hospital. Annette, Carolyn, Dorothy, and Eleanor all wanted drug-free births, although this was a new choice for Dorothy who reported that her views had changed during her pregnancy. She changed her initial intention "of walking into the hospital and numbing up and not feeling a thing" to intending to have a home birth without medication. Barbara was clear that she wanted an epidural. She was adamant that she did not want to feel any pain.

During labor each woman would need to exercise her will—to speak up so that her voice, in feminist terms, could be heard. Annette had asked for the resources and support that she wanted but found that she could not speak at all as her contractions

intensified. Barbara told the staff that the first medications were not working and that she wanted more effective drugs but she did not ask for the ultrasound she wanted that might have indicated a need for a cesarean section earlier. Carolyn, who had intended to use no drugs, felt such intense pain that she was ready to accept an epidural when she agreed to undergo a cesarean section instead. Dorothy, whose labor was progressing too slowly and painfully, chose to abandon her plan to give birth at home. She was transported to the hospital and agreed to the administration of both Pitocin and an epidural. Eleanor was transported to a hospital also. There, in spite of her desire to have no drugs, she accepted Fentanyl, a short-term pain reliever. Two women knew ahead of time that they might have difficulty finding their voices so they enrolled their husbands to speak for them. Felicia was worried that she "was putting too much stress" on her husband if they had the baby in the hospital because he would be the one "trying to ward off everyone." Subsequently she, together with her husband, decided on a home birth as the way to avoid what they perceived as interference from hospital staff. Of her husband, Gwyneth, a nurse herself, said, "I don't think that he'll be afraid to speak up to the doctor or the nurses, you know, what our desires are." Although these two women were expressing their preferences for natural births, they wanted the support—and the voices—of their partners.

All the women in my study had at least some difficulty in voicing their desires or exercising their wills. Green and her associates (1990) found that women's satisfaction with their birth experiences was enhanced by a sense of feeling in control, what I would call feeling empowered to exercise their will. Gwyneth asserted herself in the hospital by bringing and using her own birthing ball, by saying she was not interested in the offered pain medication, and by having her husband turn off the fetal heart rate monitor. She

reported the greatest postnatal satisfaction of all seven women.

Other research has suggested that feeling in control is desired by many birthing women (Gibbins & Thomson, 2001; Melender & Lauri, 2001) but statistics show that the vast majority of women in the United States give birth in hospitals (Center for Disease Control and Prevention [CDC], 2003) acquiescing to hospital policies. Four of the women in my study ultimately agreed to interventions that they had not anticipated. Three of those gave birth in hospitals despite their plans to deliver at home or in a birth center. Hodnett (1989) found that women who gave birth at home felt more in control than those who gave birth in hospitals.

Olsson et al. (2000) found that women who perceived birth as a natural process were ready to interfere with or control that process if they perceived that it was justified, for example, to electronically monitor the baby's heartbeat fearing that something was wrong with the baby. Carolyn did exactly this. Another study related to Carolyn's experience tied the themes of education (Theme 2) and making choices (Theme 3) together. Murphy, Pope, Frost, and Liebling (2003) reported that women who had undergone cesarean sections in the second stage of labor "felt unprepared for operative delivery and thought that their birth plan and antenatal classes had not catered adequately for this event" (p. 327). The study cites a 30 percent cesarean section rate in Britain, very close to the national rate in the United States. The authors state that "around 25%-33% of women report traumatic symptoms associated with childbirth, and this may be associated with obstetric intervention" (p. 1). They also say that "women consider postnatal debriefing and medical review important deficiencies in current care" (p. 1). I found that the second interviews I conducted seemed to constitute a gentle debriefing and, particularly in Carolyn's case, appeared to be beneficial.

Larsen et al. (2001) found that "self-efficacy expectations did not predict levels of transitional labour pain" (p. 203). Self-efficacy equates to being able to make choices and express one's will. In my study Dorothy and Eleanor were transported to hospitals even though they had exhibited self-efficacious attitudes prior to experiencing challenging labors. Carolyn had adopted an attitude of "I can do it" when she learned about ecstatic births but, when under great duress, like many women in this society, shifted to a posture of "I can't do it" and agreed to an epidural before becoming convinced that an operative delivery would save her baby's life.

In contrast Callister et al.(2001) found self-efficacy positively related to a woman's ability to manage pain. The Finnish women in their study exhibited "maternal confidence or self-efficacy, which influenced the women's perception of and management of childbirth pain" (p. 30). In my study Annette, Felicia, and Gwyneth were able to tolerate labor without medication. Three of the primiparas in my study could be seen to have experiences that supported a positive relationship between self-efficacy and pain management while three others could be perceived to support the opposite point of view. In the section of Chapter VII headed *The Emergence of an Explanation* I propose an explanation for these contradictory findings among studies and within my own research.

Theme 4: Identifying Resources and Gathering Support

Examples of resources in my study included both tangible, material things and intangible qualities. Support, for the purposes of this dissertation, was provided by people. Resources could be either internal or external. Gwyneth had a strong belief in God and a strong desire to endure any challenges to have a natural birth. Barbara had faith in the medical model and a desire to avoid pain at all costs. Beliefs are internal, but

they can shift the locus of control from an internal orientation to an external one.

All seven primiparas sought external resources. For Annette, a Birth Center, with its birthing stools, tubs for water births, rocking chairs, and cozy atmosphere qualified as a resource. Personal support would come from the group of pregnant women with whom she met weekly and, during the birth itself, from her mother, her sister, a midwife, and a nurse. For Barbara the primary resource was the hospital and its medical technology. She also wanted more ethereal qualities that she could sense: "a nice smelling room and quiet music." Her husband and the doctor would support her. Carolyn had identified a Birth Center as a resource and planned to use wall hangings, aromatherapy, candles, and music to create a reverent atmosphere. She had friends, women with whom she felt aligned, that would support her. She also had planned to have a midwife, a doula, and possibly her husband in attendance as she gave birth. In actuality, she was resourced by the hospital and the medical staff in addition to her friends. Dorothy identified her home as a resource late in her pregnancy. Her husband was part of her support team, along with a midwife and a Hypnobirthing practitioner. Her support transitioned from the midwives, one of whom remained with her at the hospital, to the doctor she had "ditched" earlier. She later said she had "great nurses" and a "good doctor" to support her. Eleanor too was transported to a hospital. Her plan had been to use the Birth Center as a resource. Her support would come from her husband, a midwife, a doula, and her best friend. Felicia felt her home would provide the comfort she needed to give birth. She wanted intangible qualities, and envisioned her home as being "peaceful and quiet and calm." She would be supported by midwives and, especially, by her husband. Gwyneth viewed the hospital as a resource but was realistic about its benefits and limitations. She enrolled her doctor in supporting her goals and had her husband to support her.

Support has been shown in the literature to be valuable to a woman at the time that she gives birth (Gibbins & Thomson, 2001; Kannan et al., 2001; Melender & Lauri, 2001; Waldenstrom et al., 1996). Support by other women, usually doulas or monitrices, has been shown to reduce the use of epidural anesthesia and forceps (Davis-Floyd, 1992). The presence of the birthing woman's partner has been shown to reduce fear, emotional stress, and anxiety and enhance self-confidence (Davis-Floyd, 1992).

Resources, which included choice of venue in my study, have been studied by researchers like Hodnett (1989) who investigated a woman's experience of control based on whether she gave birth in a hospital or at home. This study was mentioned above in the research related to Theme 3: *Making Choices and Exercising her Will*. I discovered that a particular theme could appear in the studies of other researchers who also identified it as a theme when they focused on an entirely different topic. Here Hodnett found that women who gave birth at home perceived themselves as well-resourced in that familiar environment. They had "a greater affiliation with caregivers and more freedom of exploration and self-expression, while those who gave birth in hospital experienced more aversive stimuli (intrusive procedures and unfamiliar people)" (p. 207). The primiparas in my study all had material resources and personal support from loved ones during labor.

Theme 5: Questioning and Doubting

In this study all the primiparas questioned and doubted at various points throughout their processes. *All* questioned institutional policies and procedures, either prior to or during their labors. Each had doubted her ability to persevere without medication or endure what she foresaw as hard work and/or potentially unendurable pain.

Annette began to exhibit questioning and doubting early in the first interview. She hoped that she would "know" when she was in labor, questioning her own innate

ability to recognize that labor had begun. She didn't "know what to do" when her contractions were increasing and the Birth Center was too crowded to accommodate her. After giving birth she was overwhelmed by the prospect of raising her daughter by herself, and didn't "know what to do" when her baby cried. She doubted herself in these new and foreign circumstances.

Barbara educated herself about childbirth but appeared to grow more anxious as she gathered more information. She admitted that she had "no concept of giving birth," questioning whether she could do so without suffering excruciating pain. During her labor she questioned the medications she received because they did not provide the relief she sought. She questioned why another ultrasound was not performed to determine whether the baby's head was too big to pass through her narrow pelvis. She doubted that the long wait to perform the cesarean section had been justified.

Questioning and doubting were evident in Carolyn's reaction to her pregnancy: "Can I trust it? Is it real?" She stated, "Of course, there's fear," referring to her doubts that she could successfully give birth at the Birth Center. She questioned her age (42) as being too old, the healthy formation of the fetus, her physically active life style, and whether she had "done something wrong" during her pregnancy. After her cesarean section she apologized to her doula, regretting that she had not witnessed "the miracle." This was part of her self-doubt. Had she done the best that she could?

Dorothy began to question birth practices within the medical model when she read "about how birth is a natural process and there's just no reason why there should be pain." She subsequently changed her birth plan, employed a Hypnobirthing practitioner and a midwife, and committed to a home birth. This process demonstrated the interaction of the themes: receiving an education (Theme 2) lead to questioning (Theme 5) which led

to making a new choice (Theme 3) and gathering support (Theme 4). Dorothy's plan was, of course, subverted when her labor did not progress.

Eleanor considered the long drive to the Birth Center and questioned whether she could remain inactive for an hour and a half in a car while in labor. During her labor she questioned the necessity to transfer to the hospital and so doubted the effectiveness of different procedures that she became non-compliant once in the hospital.

Early in her pregnancy Felecia began to question the recommendations of her doctor, whom she viewed as an alarmist. She thought drugs would be "pushed" at her in the hospital and questioned whether she would be able to say "no" when she really wanted to give birth naturally. She reported that she questioned this decision later when her pain became intense, thinking that epidurals might not be so bad after all.

Gwyneth questioned her ability to deal with the difficulty of labor because she had not experienced anything "extremely painful" before. She doubted that she would know when her labor actually began and, if there were complications, whether she would be able to "discern" that something was awry.

Robbie Pfeufer Kahn (1995) has pointed out that women in Western society are "taught to doubt their ability to give birth" (p. 12). Most of the participants in my study wanted to trust their own minds and bodies but as Kahn and others (Arms, 1996; Davis-Floyd, 1992; Jordan, 1993; Lazarus, 1997) have attested, they have been socialized to doubt themselves and to trust authority. Arms (1996) emphasized that:

> Because they are afraid and feel like they lack knowledge, they are often [ironically] reassured rather that anxious when they enter the hospital. At least at the conscious level, they believe that all will be will within those walls. They believe this because they trust that someone else will know what to do if

> something goes wrong. The authority has been transferred to someone outside. But the body doesn't lie, and that is why, despite a feeling of comfort in the hospital, many women still find that their labor slows or stops on admission to the maternity unit. It is also why so many women harbor nagging *doubts* [italics added] about the necessity of many of the procedures done—to them and to their babies—in the name of helping. (p. 27)

Nonetheless, some of the questioning by primiparas in my study was aimed at that authority. Women who question are among an elite group, the one half of one percent in this country, who are either resisting accepted practices or are searching for "the best of both worlds" as Gwyneth did.

Theme 6: Experiencing the Unexpected

Six of the seven primiparas in my study definitively stated that they had *not* experienced what they expected. Gwyneth, the last woman I interviewed, said her experience was "better than" she expected. I weighed whether "better" qualified as the unexpected because, so often, what-was-unexpected tended to be worse! I decided that a "better" experience constituted *Experiencing the Unexpected* as well as those that were worse.

Annette said she was in "shock" when she was told that she was six centimeters dilated upon arrival at the Birth Center. Clearly she did not expect this much progress having had so little pain. Other unexpected things occurred: her water was broken and the hard contractions that followed rendered her unable to speak. She had no urge to push, then delivered her baby relatively easily. She remarked that she had wanted a water birth but "that didn't happen." With pride she said, "Obviously it wasn't what I expected 'cause I expected a whole lot more pain and it wasn't there!" Like Gwyneth,

Annette's experience was better than she expected.

Barbara had expected her contractions to be further apart so she went to the hospital right away. She had expected a boy, so she was astonished that she had a girl. "When they did take her out and they said it was a girl, we both thought we were dreaming, or they got the wrong baby, or something went wrong!" She continued saying, "Shocking, because we really weren't expecting a girl or a c-section." She *was* expecting the baby to be big and to have a large head. She even had an ultrasound image analyzed for this contingency earlier in her pregnancy. During labor she expected that she would be reassessed, that she would receive an epidural sooner, that the pain medication would be more effective, and that the decision to perform a cesarean section would have been made sooner. Her experience was much longer and more painful than she anticipated.

Carolyn, too, had an emergency cesarean section. Her water had broken in her 36th week, making her ineligible to give birth at the Birth Center. Thirty seven weeks is considered full term, and, therefore, less risky from the institution's point of view. Carolyn had to check herself into the hospital where, as her labor progressed, the pain grew unbearable. She had not expected the intensity of discomfort, and had, in fact, envisioned an ecstatic birth. Her baby's heart rate dropped to a perilous level, so it was determined that she would undergo a surgical delivery. This was not what she had consciously expected at all!

Dorothy's experience was one full of unexpected events as well. She had intended to give birth at home with a midwife in attendance. She stated, "It was harder than I expected!" She found it "a little disappointing" to have given up and gone to the hospital. Even with Pitocin, she labored another ten hours. She had said during the first interview that she learned from her reading (Theme 2) that pain should not be part of

childbearing, yet her own experience prompted her to accept, indeed, welcome, an epidural. She made informed choices (Theme 3) and had no regrets (Theme 7), but her experience had differed markedly from her expectations (Theme 6).

Eleanor was transported as well. She had labored for more than 30 hours before the midwife suggested that she go to the hospital. Eleanor had, from her adolescence, wanted a natural birth, and this change of venue scared her as it threatened to lead to the use of medical interventions. She did not give birth in the Birth Center as she had expected even though she had been "so adamant about not being at the hospital if at all possible." She had also, unexpectedly, submitted to an injection of Fentanyl to temporarily relieve the pain and fatigue. Most unanticipated by Eleanor postnatally was her new perception that birth was a "team event," not an individual accomplishment.

Felicia remained at home for the duration of her labor and birth. Nonetheless, she admitted, "It was harder than I thought." She was reconsidering her stance against epidurals because giving birth "was more painful and longer than what I was hoping."

Gwyneth also faced an unexpected event during her labor: her baby's heart rate was lower than the hospital staff deemed acceptable. Nonetheless, Gwyneth did not become unduly concerned. She proceeded as if all were well and actually had her husband manually turn off the alarm each time it sounded. Gwyneth and her husband felt that, although they "weren't really sure what to expect with the hospital," they knew what they wanted to do. They felt supported in their intention to have a natural birth and, ultimately, Gwyneth declared, "It was—it met my—probably exceeded my expectations."

It is in the realm of expectations that research has produced the most contradictory results. Gibbins and Thomson (2001), like other researchers who

conducted small qualitative studies, found in their study of eight primiparas that women claimed after giving birth that their experiences differed from their expectations. Green (1993), on the other hand, found that in her study of over 700 women that, "In general, women tended to get what they expected" (p. 65). Hodnett (2002) conducted an extensive review of the literature and found that there was a correlation between expectations and perceptions of satisfaction. She noted that there was a tendency for positive expectations to yield more satisfactory outcomes than negative ones, and for negative expectations to yield poorer outcomes. The women in my study held positive expectations on a conscious level but found that they did not have the experiences that they expected.

It could be important to consider the research results of small qualitative studies that consistently diverge from the results of large quantitative studies (see Literature Review). I was perplexed that no other researchers seemed to address this blatant disparity. All seven women in my study had experiences that to one degree or another differed from their expectations. Approaching my own findings from the perspective of consciousness, I was able to discern how conscious and unconscious expectations could differ. I pose an explanation in *The Emergence of an Explanation* section of Chapter VII that could also resolve the discrepancy between the results of small qualitative and large quantitative studies.

Theme 7: Accepting What Is

This theme addresses each primipara's acceptance of her experience, regardless of whether or not it met her expectations. It is a process of reconciliation: making sense of her experience particularly when it differed from her stated intentions. Acceptance cultivates a state of mind that dwells in peace, rather than dwells on regrets. Dorothy

described women who say “we’ve got a child now and that’s all that matters.” This attitude could be called one in which the end justifies the means. Each primipara in this study found a way to accept her experience in her own way.

Annette had a better birth experience than she expected. Coming home with her new baby was particularly stressful as she realized the responsibility she would be facing alone. She countered feelings of being overwhelmed with thoughts of appreciation for her “sweet” little girl and how her family had supported her at the Birth Center and by recalling how she had inspired another woman to “finally push out her baby.” She acknowledged herself for the way in which she gave birth without drugs. Honoring herself for what she did well may have helped her appreciate her capacity to face and overcome future challenges. She was, to me, an inspiration.

Barbara reported that she began to experience relief the moment the doctor decided to perform the cesarean section. “I was so relieved, I was thanking God that I didn’t have to push the baby out, and I didn’t have to go through any more pain.” She said she “was disappointed that it took so long to get proper pain relief but once I had the pain relief, I was fine, and the nurses and everybody were kind.” She embraced the emergency cesarean section which ended her duress. She even acknowledged that the baby “was trying to get through.” Barbara was healing well and was grateful for the help she received. To her, medical interventions made sense.

Carolyn had more difficulty accepting the reality of her experience. She initially had to fight feelings of failure because she had undergone an emergency cesarean section. Coming to terms with the procedure, she said, “As it came down though, I was, I was glad to be in the hospital because it was really quite difficult.” She imagined that if she had insisted on a natural birth and the baby had been adversely affected, she would have

found that it had not been "worth it." She had needed help to deal with the pain and, in her mind, to save the baby's life. She justified her choices by appreciating the precious life with which she felt entrusted.

Dorothy's acceptance of her experience, different from her expectation, was more pragmatic. Having to be transported when her intention had been to have a home birth was somewhat disappointing, but, she shrugged, "that what hospital's for. I believe it's there when things aren't going right and it's a backup." Further, she said, "I kind of felt like we were informed." She was accountable for her choices and was looking forward, not back. She took the steps necessary to reduce her own extreme discomfort and insure her baby's safe delivery. She was at peace with her decisions and experiences.

Going through a more philosophical process to come to terms with her experience of being transported to a hospital, Eleanor said,

> I realized that it wasn't what I had expected on a like analytical level but, as far as like on a spiritual level, and on how she [the baby] came into this world, I don't think that we missed anything. I think that everything was still very much present and I feel like the team that came together to make the difficult labor come out the way it did, even added to the birth experience. So I don't think I lost anything in the birth experience and, amazing, I think I gained a lot from it.

She not only accepted her circumstances, she found greater meaning in the way events had unfolded.

Felicia decided that having a home birth, regardless of the fact that it was more painful and longer than she expected, was still the best way to have a baby. She felt that a hospital birth would have been harder on her emotionally. When we met for the second interview she was still processing her experience and bonding with her baby. She had felt so depleted after giving birth that she did not immediately want to hold her newborn. Felicia had been relieved when the birth was over and greatly appreciated how her

husband had supported her. Indeed, his continuing support of her and the baby appeared to be helping her find the peace and calm that she most valued.

Finding peace and coming to terms with her experience was easy for Gwyneth. First, she thought that her delivery was better than she expected. Her spiritual life seemed authentic as she reported that she prayed while giving birth. She had also emailed some friends just before going to the hospital so she knew they were praying for her too. She appeared calm as she said that she knew the Lord was with her and was sending her baby to her. Gwyneth radiated peace and grateful acceptance for her experience.

A woman's acceptance of her experience is probably best encompassed in the research on satisfaction with childbirth. A study of community-based maternity care in the United Kingdom by means of a database search distilled 40 papers from a total of 624 to find that "women expressed high levels of satisfaction with care" (Dowswell, Renfrew, Gregson & Hewison, 2001, p. 194) but the investigators acknowledged that there were serious gaps in the research. Green et al. (1990), looking at pain management, reported that women who preferred to cope with their labors without drugs and were successful in doing so had higher satisfaction scores than those who used pain medication. Kannan et al. (2001) found that women who sought natural childbirth but received epidurals reported less pain than those who proceeded to give birth naturally, but were "less satisfied with their childbirth experience" (p. 468) than those who did not receive pain medication. Some researchers seem to look for *dissatisfaction* which did not appear as a theme in my study but could be inferred as part of the paradoxical nature of a woman's childbirth experience.

The three women in my study who wanted natural births but who received pain

medication (one epidural, one general anesthetic, and one short-term pain relieving drug) all appeared satisfied with their childbirth experiences and the care they received. Most mentioned the caring staff, regardless of where they gave birth. I did not ask specifically if they were "satisfied" although they provided information from which I could deduce that they were (see individual case studies). During analysis I had looked for emerging themes rather than imposing satisfaction as a category. I identified a theme related to satisfaction as *Accepting What Is*: making sense of their experience, processing regrets, finding peace after experiencing unexpected events, and appreciating both the process (labor and delivery) and the end product (the baby).

Green and associates (1998) noted that it is difficult to measure satisfaction because of "the well know tendency of women to feel relieved, grateful and generally positive after the safe delivery of a healthy child" (p. 9). Davis-Floyd (1992) pointed out that women reinterpret even traumatizing events experienced during labor. This may have been what I observed among the primiparas in my study: what I called *Returning to Joy*.

Theme 8/1: Returning to Joy (Overlapping Theme 1)

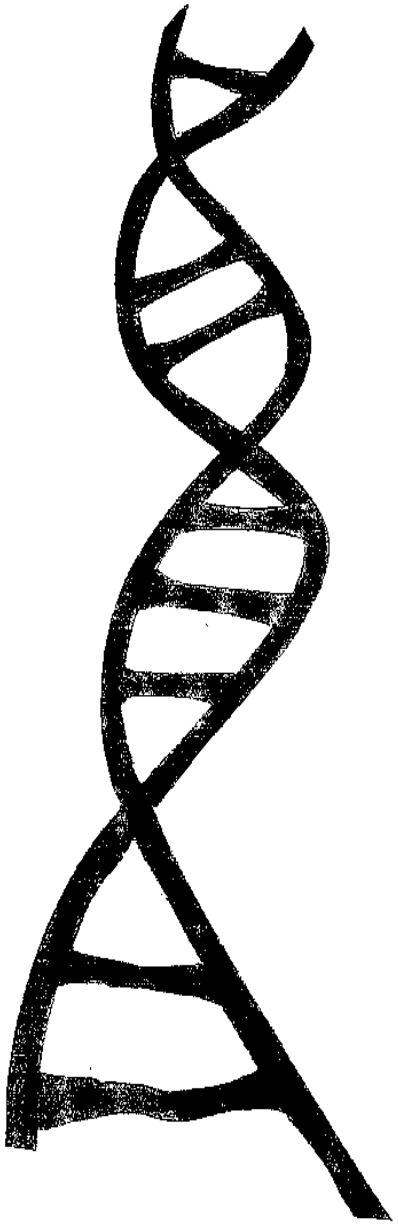
The final theme, in my assessment, returned the primiparas in this study to feelings of joy. The pattern appeared circular but, with the passage of time and the advent of the baby's presence *outside* the womb, new feelings of joy and happiness seemed to emerge. An image of a coiled spring comes to mind: from the end it looks like a circle, but when pulled out and extended, the rings separate and each coil loops forward repeating the pattern while having integrity of its own. Viewed from the side it looks like a wave. Interweaving waves—a double helix—is the image I chose to represent this pattern.

Love for each of their babies was obvious among the primiparas in my study. Each woman related to her child in her own way appearing to cherish and welcome her newborn just as she had welcomed her pregnancy. *Returning to Joy* was not a theme that stood alone—it is one that reappeared, phoenix-like, in a new form.

The Themes as a Collective of Paradoxes

Seven themes, plus an eighth one that reflected the first theme, emerged from the data. Because each of the themes was experienced to some degree by each of the primiparas, the themes could be viewed as an assembly—as a synergistic whole. Each theme made a contribution but together they created an interchange that revealed the complexity of a pregnant woman's entire experience.

Table 4 is meant to capture the fluidity of a woman's childbearing process in a three-dimensional image. A wave suggests the undulation of thoughts and feelings cycling throughout the nine months of pregnancy, during labor, and at the birth itself. It depicts frequency and amplitude, expansion and contraction, increasing and decreasing intensity. The double helix weaves one undulating wave into another. It depicts the paradoxical elements of each theme. Vacillating from love and joy to fear and apprehension, the most prevalent emotions expressed, the double helix shows the spiraling nature of the dance of opposites. The ambivalence felt by these primiparas, and known to be experienced by most pregnant women as well (Newman & Newman, 2006), is depicted as a natural flow of energy in which emotional highs and lows, positive thoughts and worrisome thoughts, comfortable and uncomfortable bodily sensations, weave in harmony or dissonance.



Theme 1:	*Discovering Joy*
Paradox:	Joy vs. Apprehension
	Love vs. Fear
	Comfort vs. Discomfort
Theme 2:	*Receiving an Education*
Paradox:	Open vs. Closed
Theme 3:	*Making Choices*
Paradox:	My Will vs. Their Will
	Control vs. Submit
Theme 4:	*Identifying Resources and Gathering Support*
Paradox:	Internal vs. External
Theme 5:	*Questioning and Doubting*
Paradox:	Self-confidence vs. Self-doubt
Theme 6:	*Experiencing the Unexpected*
Paradox:	Expected vs. Unexpected
	Ideal vs. Ordeal
	Life vs. Death
Theme 7:	*Accepting What Is*
Paradox:	Acceptance vs. Rejection
	Satisfaction vs. Dissatisfaction
Theme 8/1:	*Returning to Joy*
Paradox:	Joy vs. Apprehension
	Exhilaration vs. Depression
	Love vs. Fear

Figure 2

Double Helix of Themes

Joy and happiness were the dominant emotions of these primiparas' pregnancies, labors, and childbirths. It was prevalent as a theme at the discovery of the pregnancy (Theme 1) and again after the baby's delivery (Theme 8/1). It did not remain constant over the whole course as other thoughts (mental), feelings (emotional), and sensations (physical) interjected themselves. Nonetheless, the presence of joy helped to offset negativity when it occurred. It was perceived intermittently but frequently by each primipara. In the case of these particular women, joy far outweighed fear and apprehension, but the paradoxical juxtaposition of these emotions was evident.

Education (Theme 2) played a big role in the lives of the women in this study. Upon discovering she was pregnant each had gone to a library, spoken with other women or her own mother, viewed videotapes and television programs, taken prenatal classes, and in a variety of ways embraced new ideas that influenced her subsequent decisions. The assimilation of information was an on-going process. It could be identified as the second theme, and also be seen as a theme that recurred throughout the entire period. Acquiring new information had paradoxical elements as well. A woman could be encouraged or discouraged by what she learned. Annette, for example, gained self-confidence by what she read while Barbara's insecurities increased. Based on what they learned, Dorothy and Felicia changed their entire birth plans to avoid what they perceived as invasive hospital staff and procedures. A primipara could be either open to new ideas or closed to them. Interestingly, none of these women disdained educational materials or content. They stayed open to new ideas, even when those ideas contradicted existing beliefs. Barbara, for example, was considering having her baby placed on her belly following delivery even though she had previously abhorred this idea. Her subconscious mind, however, was already imprinted with strong negative feelings about this procedure.

This contradiction, identified by Wilson (2002) as a dual attitude, is addressed both in the Literature Review and in Chapter VII.

Each of the primiparas made decisions and exercised her will (Theme 3). In this study the primiparas sometimes asserted themselves and sometimes yielded to the will of others. The "others" were typically doctors, midwives, or husbands. The paradox of *my will versus their will,* feeling in control and able to give voice to her desires versus feeling out of control and needing to submit to the will others, flowed throughout the decision-making process. The theme of making choices led quite naturally to the next theme, deciding what constituted a resource and who would provide support.

Among the primiparas taking part in this research, each identified resources agreeable to her and gathered the support from those most important to her (Theme 4). The paradox of going within versus looking without emerged more when one woman's experience was contrasted with another. Seen as a collective the themes yielded new perspectives. A woman might look within to find strength, self-confidence, or faith or look without for more external resources. The tendency among these primiparas was to look for support from husbands, friends, mothers, sisters, doctors, midwives, and nursing staff. The range of desired resources extended from home environments (Dorothy and Felicia) to hospitals and the full compliment of technology available (Barbara). In the middle were birth centers (Annette, Carolyn, and Eleanor) or a blend of worlds--a natural birth in a hospital setting with support from a partner and the personal perception of spiritual assistance (Gwyneth).

All the primiparas in this study questioned and doubted (Theme 5). They questioned policies, procedures, medications, venues, and their own abilities. They doubted their condition, their fortitude, and their choices both before and after giving

birth. This seemed perfectly reasonable since, according to the *Social Readjustment Rating Scale* (Holmes & Rahe, 1967), pregnancy is the twelfth most stressful life event a person can experience. *Questioning and Doubting* had the component of fear running through it, counteracting the joy that the women were feeling at being pregnant and beholding their babies at birth. This ambivalence is well-recognized (Newman & Newman, 2006). The paradox within this theme seemed to be demonstrated by a woman's vacillation between self-doubt and self-confidence (internal) and between questioning procedures and acquiescing to them (external).

All the primiparas experienced something unexpected during their pregnancies, labors, and/or deliveries (Theme 6). Five found labor and delivery harder than expected while two found it easier or better than expected. For each woman, there were challenges to face and choices to be made that she had not anticipated. These challenges and choices provided opportunities for adaptation to the changed circumstances. Each met those challenges in her own way. The paradox of experiencing what is expected versus encountering what is unexpected while giving birth can be perceived quite literally as a life and death issue. The life of the unborn child and the life of the mother giving birth could both be at risk. None of these women feared for their own lives but some did fear intolerable pain or fear for the well-being of the baby. The unexpected can change the perception of labor from one of hard work and the realization of an ideal to one of travail and the manifestation of an ordeal.

In this study, when a mother came to terms with her experience of childbirth, she appeared to integrate all its thematic components including the emotions of joy and fear. She made sense of the actualities of her labor and delivery even when they did not agree with her envisioned ideal. This resolution could be observed in her composure, reflecting

an inner harmony. Each primipara accepted (Theme 7) her experience, and exhibited an attitude of appreciation. Even so, some encountered internal resistance to accepting what had occurred. The poles of acceptance and rejection, appreciation and resistance, are encompassed in the double helix.

The Results of Adding Art Interpretation and Consciousness Research

In addition to immersing myself in transcripts and videotapes, I also studied each woman's drawing. I described each of the drawings in Chapter V and included them as Appendices D - J. The women's own interpretations of the drawings were included, if possible, but my interpretations were deferred until I completed identifying themes from the texts. The drawings augmented the primiparas' words. From my point of view, the pictures reinforced much of the spoken dialogues and sometimes amplified thoughts and feelings only alluded to during the interview.

Drawings have the power to convey deeper meanings that may not be apparent in verbal dialogues. As Eleanor, who was particularly modest, said of her picture: "It's that exposure thing, I think, to kind of pull all that out and put it where somebody else can see what's inside your head." Eleanor intuitively knew what art therapists posit: a drawing allows one's "inner world" (Oster & Gould, 2004, p. 23) to be seen by others.

In Chapter II I presented an extensive review of literature supporting the use of drawings as a means to access unconscious attitudes and beliefs. I proposed the implementation of drawings as addenda to interviews in qualitative research on the basis that richer, more extensive, information could be obtained from the participants. Further, I tied drawing—as an expression of the subconscious mind—to the conclusions of experts in the field of brain/mind/consciousness (Dossey, 1982; Lipton, 2005; Ornstein, 1991; Pellitier, 1992; Talbot, 1991). I pointed out that expectations tend to realized

(Pellitier, 1992) and that expectations can be conscious or unconscious.

Since I did not rely on the drawings to contribute to the identification of the phenomenological themes, I now present my interpretation of each primipara's drawing, incorporating relevant quotations from her interview, her own interpretation of the picture, and applicable research from the fields of art interpretation and consciousness studies. In looking at the pictures I found that instead of allowing themes to emerge from the drawings I was attempting to impose themes on them. I, therefore, decided to identify in each picture one overall impression consistent with a theme identified in the transcripts. I include that thematic impression in each interpretation.

To enhance the reliability of my impressions I have added the interpretations of two professionals who reviewed the drawings. The instruction to each of the primiparas had been to draw a picture of her ideal birth. No other guidance was provided so the drawings are as unique as the women themselves. The direction to the reviewers was to assess each drawing which represented the ideal birth of a pregnant woman. Each interpreter's knowledge and experience made her comments unique as well. Like individuals who behold any particular event, they describe it from their point of view. Therefore, interpretations may or may not agree.

The drawings seem to me to enrich the qualitative data in order to more "holistically understand" (Patton, 2002, p. 69) primiparas' expectations and experiences of childbirth. I found that the process of analyzing the drawings caused me to examine the texts more closely. I had been looking for themes and, until I attempted to interpret the drawings, I overlooked some remarks by each woman that signaled either unconscious beliefs or beliefs of which they were consciously aware but were attempting to suppress. The drawings *and* the words worked together to expose underlying beliefs

that could interfere with accomplishing the ideal that each woman desired. A drawing does not have the strength by itself to be a reliable predictor of actual events. I see the potential for drawing in prenatal education classes prospectively and perhaps serving well during a postnatal debriefing in which the drawing is reviewed retrospectively. The memory of her drawing (Appendix F) had a healing effect on Carolyn whose emergency cesarean section had impeded bonding with her newborn. During the second interview she recalled the mother-infant gaze she had depicted and said, "The key for me is that, in drawing the picture, the energy was still there—of the picture that I drew in terms of feeling the love and connection. It just didn't happen right after birth."

The power of a drawing to enhance a mother's feelings of acceptance might be enough to recommend it but when I finished analyzing all seven pictures I found more. Two of the pictures had the potential to suggest what elements should appear in a drawing for a pregnant woman to clearly visualize her childbirth ideal and perhaps increase her level of postnatal satisfaction. Those elements are described in *Picturing a Better Birth* in Chapter VII.

Annette's Drawing

Annette's picture of her ideal birth (Appendix D) shows a nurse, nurse midwife, and her sister in the center of the picture. The Birth Center resources occupy the far left. Annette, her mother above her, and the baby are drawn in the upper right corner. Water seems to surround Annette and the baby suggesting a water birth. None of the figures, which are all labeled, have mouths or ears. If I had used the picture to predict what kind of birth experience Annette would have, I would have thought that the nurse, midwife, and sister would play major roles since they occupied the center of the page. It was the midwife, in fact, who encouraged Annette to push her baby out when she felt no urge to

do so. In reality her sister and mother stood on either side of her as she delivered her baby. Annette had placed her mother in the corner of her picture because she said she thought her mother would be afraid. Her mother's size and position above her suggests that her mother has more influence in her life than Annette might consciously recognize. Her mother turned out to be her greatest supporter and lauded her daughter's efforts calling her the "Birth Goddess."

Since no one in the picture has a mouth or ears it was not surprising to learn that Annette had not been able to speak during her most severe contractions. She literally lost her voice and could not make an audible sound. Subconsciously omitted features in a drawing can be significant, as these seem to be. That is, Annette was unable to speak during the actual event after she drew a picture of her ideal birth in which she appeared with no mouth.

The birth took place in a Birth Center but not in the water after all. Since the large bed in the lower left side of the picture occupied so much space, it could be deduced that it would play a prominent role. Annette utilized the birth ball and tub, both pictured, but did not mention using the rocking chair which is the only piece of equipment in the picture without a label. Ultimately she delivered her baby in a bed. There are no male figures in this picture, suggesting that Annette does not feel supported by men. In fact, the father of the baby was not welcome at the birth and was called only after the baby had been born.

Annette pictured a woman's world, containing all the resources (birth ball, tub, stool, and bed) and support (four different women) she thought she would need. Indeed, she had an "amazing" experience—better than she expected. The overarching thematic impression conveyed could be that of *Identifying Resources and Gathering Support*. The

drawing and her words demonstrated her confidence: “I just see myself going in there and having a baby in the water.” She used the word “hopefully” several times during the first interview which might signal that not all her desires would be met. “Hope” has a connotation of dread associated with it (Gates, 1995). According to Gates, people who use the words “hope” and “try” do not often succeed in their endeavors. Annette said, “Hopefully, I’ll be able to labor in the tub and, if there’s nothing wrong, then I can stay there.” As it turned out she could *not* stay in the tub because she adversely reacted to the heat.

A therapist who uses art interpretation in her practice but who knew nothing of any primipara’s situation noted that the sister’s neck is different from Annette’s and her mother’s. This suggested that the sister was “different” and probably disconnected from the rest of the family. The sister, Annette, and the attendants did not have feet making them seem ungrounded while the large image of her mother, who has feet, was probably powerful (I agreed with this perception). The nurse and nurse midwife were drawn differently than family members and were, therefore, probably not known by Annette (indeed, she did not know specifically who they would be). The absence of mouths indicated that Annette and the others might have difficulty communicating. Annette might be afraid to speak up. The baby’s lack of hair suggested that Annette did not know the gender of her child ahead of time (she did not, to my knowledge).

The second therapist to assess Annette’s drawing observed that the vertical arrangement of grandmother, new mother, and newborn indicated that Annette was influenced by her history and was getting energy from her past. Generational issues were evident. The sister, outside this hierarchy, was probably outside the relationship Annette had with her mother. Since therapy was not a goal in this study, I did not address filial

issues (mentioned by both reviewers) specifically with Annette or in my interpretation. The birth stool, ball, and rocker suggested that Annette clearly considered alternatives in the way she approached giving birth. The big bed, drawn in darker, heavier lines and dominating the lower left half of the picture suggested to this reviewer that it was more important than the other resources. It was more masculine and imposing than the other softer, wavy elements. Ultimately, Annette did give birth in bed.

There were features that the other reviewers pointed out that escaped my notice. Some, like the sister's role, did not seem particularly relevant to me. We all agreed that Annette's mother played a powerful role in her life and that the bed was a significant feature that could be more important at the time of the birth. Two of us remarked on the absence of mouths and thought that it indicated a reticence or inability to speak on the part of Annette and/or the women who supported her.

Barbara's Drawing

Barbara's drawing (Appendix E) was drawn lightly and quickly, and shows two figures behind a smaller one lying in a bassinette. Yellow curtains frame the three. Barbara said little about her picture, but did respond affirmatively when I asked if the couple represented her and her husband. I could see that she envisioned a successful outcome, but there *were* a few clues to foretell her dramatic birth experience.

The faces she drew had no features except for the baby's closed eye. The figures have no arms or legs. I would intuit from this representation that Barbara might feel helpless, at least with regard to giving birth. Barbara pictured herself with no senses to see, hear, speak, or even touch and might, therefore, have difficulty asserting herself. She said later that she was surprised that an ultrasound image had not been made during her labor to determine that the baby's head was too big. A decision to perform a cesarean

section earlier could have spared her hours of labor pain. She admitted, "I never said anything but it's healed up well." She did not speak up. Further, the baby's head in the drawing is noticeably large. Her verbal concern and the picture rendered before she gave birth suggested that this had been on her mind both consciously and unconsciously.

I had the feeling from her drawing that Barbara was observing rather than participating in the experience. She said she wanted "a nice smelling room and quiet music" but her drawing with her featureless face suggested that she might be unable to smell or hear. She had declared during her interview that she wanted to rely on all the medical interventions she could. She did so by undergoing a surgical delivery. Anesthesia would eliminate her pain *and* her ability to see, smell, hear, or even feel.

Barbara was physically separated from her baby after delivery. Prior to delivery, influenced by a video she had seen, she was considering having the baby placed on her abdomen immediately after birth. Her deeply instilled emotional reaction to this idea, however, had been revulsion. Ultimately, she did not have to make this choice because she had an operative delivery. Goleman (1995) might say that Barbara's unconscious fears emotionally high-jacked her conscious choice to deliver vaginally with the aid of an epidural. Her attitude, both implicit and explicit, that dreaded pain, "yucky" newborns, and a baby too large to pass through her narrow birth canal may have created the "complications" Talbot (1991) predicted. Nonetheless, Barbara's picture felt loving and looked like a precious family portrait. However, the idyllic picture was the result of events that her drawing indicated she did not want to *face* or to sense in any way.

To me the overall impression from the drawing was one of joy experienced *after* the baby had arrived. The first therapist to view this drawing said it looked like a nativity scene. It appeared that the family was unified, perhaps enmeshed. The lack of features

indicated that they probably did not usually say much about how they felt. The drapes framed the family unit but the attention given to them could signify that the environment or outside opinions were very important. The second art interpreter said the drawing was not concrete but airy. The artist appeared to have planned this event as if she had wanted to set the stage. Privacy would be important to this family whose members were close. There were some observations that I have no way to verify, but all of our interpretations agreed that the family members were close and either very private or not very expressive. Barbara said that she had not "really talked to many women" about giving birth and that during the prenatal class she "was very quiet, just taking it all in."

Carolyn's Drawing

Carolyn also had an emergency c-section. Her drawing (Appendix F) shows a glowing view of a mother holding a baby. The two make eye-contact while surrounded by swirls of energy and rainbow hearts that represent "love." It is a picture of how Carolyn wanted to feel as she bonded with her newborn. The drawing had an energetic quality symbolizing to me the very love and spiritual connection between mother and child that she wished to convey. The baby's adult features appeared to represent an old soul or mature child, at least in the mind of the artist/mother.

After she gave birth, Carolyn recalled her drawing saying, "The key for me is that, in drawing the picture, the energy was still there . . . in terms of feeling the love and connection. It just didn't happen right after birth." She reported that it took days to feel the "connection" after having an operative delivery. Her picture surely forecast her ultimate experience. It seemed to authentically represent her deep feelings of love for the baby but did not address *how* the baby would arrive, perhaps subconsciously masking deeper fears. It did graphically represent the mutual gaze that is known to be so

important for mother-infant bonding (Schore, 1994).

Carolyn's words better revealed her underlying concerns than her drawing. It was Carolyn's "hope" that she give birth in water; she was "hoping" to get the room with the tub at the Birth Center; she was "hoping to be one of the ninety percent" that could give birth naturally and not be transported to the hospital; she "hoped" her husband would be in town and not be distracted; she wanted to give it a "try to go natural." These were words that lacked conviction. As Gates (1995) interprets the use of the words *hope* and *try*, they would be harbingers of failure. Carolyn's success came from her flexibility, her willingness to let go of her birth plan, and her ability to reframe her perception that she had failed. She manifested her vision—the timing and method could have been the result of deeply held fears which she mentioned intermittently during the first interview.

In my assessment, Carolyn's picture conveyed an overall impression of joy. The first reviewer to assess her drawing saw it as dreamy and romantic. She noted that the baby and the mother looked just alike; the baby was part of her. This suggested that the baby was idealized and that the mother held high expectations for this child. Because the child was well developed and had adult features it was thought of as highly intelligent and gifted (Carolyn had called him a "little yogi"). Because the mother's breast and nipple were exposed this woman was open and comfortable with her sexuality. The other interpreter was struck by the spirituality conveyed by Carolyn's picture. She remarked about the movement and energy. Because the baby, a boy, was at his mother's breast, she appeared to be comfortable with her body. The prevailing feeling of the drawing through the eyes of this reviewer was one of strong feminine energy welcoming her baby. All three interpretations noted the positive energetic quality of Carolyn's drawing. The mother-infant bonding process stood out as the defining feature of this representation.

Dorothy's Drawing

Dorothy rendered a drawing (Appendix G) that depicted a pregnant woman sitting on a birth ball, her arms resting on a bed. She was supported by a man on bent knees. A woman stood to the left by a tub of water. A large draped window (her bedroom window, she said) occupied the top left half of the picture. This picture represented her laboring at home. I thought the standing woman might play a peripheral role because of her placement in the picture while the bed might play a large role in Dorothy's experience. The large window might suggest that subconsciously she wanted a way out.

The picture represented Dorothy's conscious desire and also became her experience--but only a part of it. Many unforeseen events occurred outside this one snapshot. Dorothy was able to convey an impression of her early labor in her drawing, but her labor did not culminate by giving birth in the pictured setting. Again, her words spoke volumes:

> When we first wanted to get pregnant my concept of birth was probably the same as what you see in American media. You know, extreme pain, women in great distress, just trying to find the best way they can to get through this ordeal in life. So I had a lot of fears, I think, 'cause I've always been a real wimp for pain and so just the idea of pain for me was very intimidating, and I had full intentions of walking into the hospital and numbing up and not feeling a thing.

Dorothy's beliefs about birth were well established long before she became pregnant. Social learning theory, introduced in the literature review, explains how beliefs about situations that have never been experienced by an individual can be formed. According to Newman and Newman (2006):

> People watch others, learn about the consequences of their actions, and remember what others have told or shown them and what they have read or learned about the situation. Over time, one forms a symbolic representation for the situation, the

required behaviors, and *the expected outcomes* [italics added]. (p. 76)

When Dorothy decided in her ninth month of pregnancy to have a home birth the decision was likely undermined by her long-held belief that giving birth was a painful ordeal. She labored at home, as she had consciously intended, then bowed to the conditioned expectations she held deeper within her mind and body.

Dorothy's drawing conveyed an impression of having identified resources and gathered support. The first reviewer noticed, however, that only the man in the picture had fingers. This implied that Dorothy believed on a subconscious level that men were more functional than women. According to this interpreter, the large window suggested that Dorothy might feel that something needed to be kept out. The window could depict a concern about how or what she would do in the world. The second reviewer observed that this woman wanted a specific room in which to give birth (this was, in fact, a picture of Dorothy's bedroom). Both the man and the woman were turned away from the water and toward the bed perhaps indicating that water would not be of particular importance. The hospital birth, of course, did not involve water. The window was more than half covered suggesting that something might be covered up (psychologically, fears, for example). The woman on the birth ball was "rolling toward birth" and the midwife appeared to be lending support from afar. Interestingly, Dorothy was driven to the hospital where the midwife acted as a consultant, continuing to be supportive but deferring to the obstetrician.

Eleanor's Drawing

Eleanor drew a picture (Appendix H) that she intended to be metaphorical. Her understanding of its meaning was enhanced as she described it to me. In the center of her drawing was an ancient fertility goddess, she explained, without arms or legs. The face

had a smiling mouth and open eyes. The belly was large and round. Eleanor said that while she was pregnant she envisioned this "goddess" image anytime she had negative thoughts about her body. The goddess was encircled by rings of yellow "light" that helped her focus and dark rays of "pain" emanated up and away. A baby rested supine on a cloud to the right—"a little angel"—with a larger blue stick figure beside it, Eleanor's husband, providing "strength." Three large flowers bloomed on the left which Eleanor described as her female attendants, the largest being her midwife. She saw the stems as support provided by "women coming together to give you strength," while the thorns (although none were drawn) were obstacles to be overcome. The earth on the lower left side of the picture "grounded" her while the water on the lower right soothed her.

In Eleanor's drawing I saw a pregnant being large in comparison to the two other figures. This being, without arms and legs, nose or ears, was separated from others. She was *perpetually* pregnant and full of life. She looked strong, yet disempowered by her lack of limbs and digits. The figure resting on a cloud could be a baby but it was asleep. I wondered how it could be the offspring of this being who was still pregnant. It seemed more dream-like. Perhaps to Eleanor being pregnant was desirable but the reality of giving birth was not. The blue androgynous stick figure, with limbs but without nose, ears, fingers or feet, stood smiling to the side. There was no real connection between the central figure and the others. Flowers dominated the left side of the page, and waves filled the bottom right. Nature was apparent here. Light abounded and dark rays appeared at the boundary of the paper. It was not clear if they were leaving or moving toward the central figure. There seemed to be a contradiction in the movement of the water, light, and blooming flowers opposed to the static, cartoon-like apparition in the center.

Knowing that this picture was drawn by a pregnant woman I would have anticipated that she would choose a natural birth. However, I would see her attempting to go it alone but feeling powerless due to the figure's lack of arms and legs. Since no birth is represented and a fertility goddess is forever pregnant, it could signify a long labor. The rather plastic figure's eyes appeared hollow, and later, Eleanor actually said, "I just felt like a hollow, limp, little rag doll. I remember even saying out loud: 'I just feel so hollow and there's nothing left.'" Indeed, her labor was the longest reported—44 hours.

Eleanor was astounded, after her long labor and delivery, to conclude that giving birth was *not* a solitary experience. She remembered her drawing and her former belief: "I really went in there thinking it was all about the Mom." The Mother Earth Fertility Goddess had dominated her picture. She recalled how she had placed the flowers "off to the side" and her husband "off in the background." She now appreciated "the team part" of giving birth, acknowledging the support she received from her best friend, the doula, the midwife, her husband, and even the baby whose heart rate remained "perfect" throughout her birth. The elements that both Eleanor and I saw in her drawing lent credence to the premise that subconscious beliefs contributed to her birth experience. There had been mixed messages: flowers symbolizing help but a solitary figure who could endure alone; a figure forever pregnant with only the dream of a child; a figure standing on both earth and water, perhaps off balance. Since a fertility goddess is usually carved in stone, this image might have suggested that Eleanor would have some difficulty delivering her baby. Although her labor was long and painful, ultimately, she shifted her attitude to one of genuine appreciation for the support she received and for the angelic baby whose heart rate had been "perfect" throughout the stages of her birth.

A joyful, symbolic, and even dream-like impression was conveyed by Eleanor's

drawing. One reviewer saw in the drawing the primipara's belief that being pregnant was a beautiful thing. The figure had its eyes wide open and was embracing the experience of being pregnant. The fertility figure (Eleanor) was more powerful than the other figure (her husband). Even though powerful, she had no arms and, therefore, could not help. The open-armed man appeared willing to help. The baby, not real yet on its cloud, was more of a concept than a real person that existed between them. The other reviewer said the figure appeared very happy. The stick figure probably represented the husband and support system. The baby on its cloud seemed separated from the woman represented by the figure without arms. She was clearly pregnant but there was no baby in her belly. Perhaps it was the ocean of consciousness that was pictured on the right. The interpreter wondered if this woman had lost a baby, as the floating baby was positioned as if leaving life rather than coming into it. To my knowledge, Eleanor had never lost a child.

Felicia's Drawing

Felicia's drawing (Appendix I) was unique in that it had no birth scene at all. She pictured a crescent moon in the upper right hand corner and ten yellow stars sprinkled in a dark blue night sky. This image represented her desire that it be "peaceful and quiet and calm" during her labor. The absence of people in her picture suggested to me that Felicia might feel isolated or alone; that she might not feel connected to her body or her baby.

Later, even though her labor had been relatively short, she described giving birth as "more painful and longer than what I was hoping. You know, I had heard about birth like that, but I was really hoping it wouldn't be for me." The use of the word "hoping" and the conscious recognition that she had "heard" about difficult births signaled underlying insecurities and the existence of negative socially conditioned messages. She

succeeded in having a home birth without medication and delivered a beautiful daughter. However, she was so tired she said she "didn't have energy to bond." The cosmic distances suggested by her drawing of the night sky could be a metaphor for her feeling of distance from her newborn. She felt no desire to hold her baby, but when she did, she made eye contact. She reported that throughout the night the baby "just looked at me." Schore (1994) notes that the infant's gaze evokes the gaze of the mother. This mutual gaze is a powerful inducer of the mother-infant bond. Quite naturally, Felicia was bonding with her baby after all.

To me the impression that Felicia's drawing conveyed was one that was spacious, vast, and eternal. It appeared peaceful (a quality of Theme 7), symbolizing, according to Felicia, the peace, quiet, and calm she wanted to prevail as she gave birth. The first reviewer called this picture metaphysical. It had a spiritual quality. Perhaps the artist felt like a part of the Cosmos, but had difficulty acknowledging the realities of physical existence. The other reviewer was astonished that there were no people in the picture. It could suggest romance, a starry, starry night, or apply to any topic. She could not relate this picture to an ideal birth.

Gwyneth's Drawing

The drawing rendered by Gwyneth (Appendix J) occupied only one quarter of the page. It looked nestled into the upper left hand corner conveying a sense that the figures were protected. She said the man and woman were her husband and herself. She had beads of sweat on her face and both were shedding "tears of joy." The small figure on the reclining woman's belly was their new baby. The cross and arc above them represented "the Lord having his hand over both of us." To Gwyneth the ivy and fruit represented life and the musical notes suggested a time of worship and praise. She also

included a figure that looked like a doctor with a red cross on his cap. This represented "the hospital and the hospital setting." Gwyneth noted that the doctor was "just kind of off to the side but the real picture is my husband and I and our son and our new family together under Christ's covering."

This picture seemed to have many positive elements: colorful fruit strung along a garland of ivy, musical notes floating above, and a Christian cross shining above the new family. The doctor was on the periphery, the baby was on the mother's belly, and the man and woman were both smiling and tearful. The interesting blend of spiritual and natural symbols drawn next to a medic suggested to me a balance I had not seen before. This picture seemed to relate "the best of both worlds" that Gwyneth had been seeking. The drops of sweat suggested there would be hard work, but the outcome would be a natural birth with the baby laid on the mother's abdomen. More than any of the others, this drawing seemed to integrate deeply held beliefs with practical realities. Ultimately, Gwyneth was one of only two primiparas who said her birth was better than expected.

Gwyneth's picture depicted a process, one that resulted in the birth of a baby placed on his mother's belly. The impression is one of joy. This image was clear to Gwyneth, perhaps helping the process play out in reality. Benson (1996), a proponent of guided imagery and the father of the relaxation response, has said that positive mental imagery can, indeed, contribute to a desired positive outcome.

The reviewer who first assessed this drawing said it looked like a nativity scene. The doctor was definitely an outside force as it was the couple and the baby—the new family—that mattered in this picture (just as Gwyneth herself had said). The other therapist noted the symbols of music and Christianity. The couple appeared happy and married or at least together as a family with the new baby. The red cross on the cap of

the offset figure suggested that this was a doctor or authority figure. Nonetheless, this interpreter thought the open space in the drawing seemed to indicate that this was a picture of appearances, of the way a birth *should* happen. In reality, the birth occurred much as depicted.

Gwyneth was the last woman in the study to give birth and thus, the last primipara I interviewed. I could now understand the value of asking women to interpret their own art: the primiparas had become active participants and co-researchers in the study just as feminist researchers advocated. In addition, when I placed all the drawings side by side I saw that the pictures of the two women who had the best childbirth experiences had drawn similar pictures. What this could mean is presented in Chapter VII.

Summation of Results and an Allusion to Interpretations of Findings

For this study I had chosen a purposive sample that included the requirement that each pregnancy be low risk. Indeed, all of the primiparas successfully gave birth to healthy babies. Not all the labors were easy, however. The more a woman expressed fears during her first interview, emphasized a desire to avoid pain, used words connoting dread or failure, and drew a picture that did not clearly delineate the birth process as she idealized it—with the baby included—the more likely she appeared to have difficulties.

In the Literature Review I reported that feelings of which an individual may be totally unaware can reside in the recesses of the unconscious mind. The primiparas in this study were surprisingly self-aware, but still most found many unexpected aspects in their birthing experiences. Hints concealed in their dialogues and pictured in oblique ways in their drawings could be interpreted after the fact to have foreshadowed actual events. Those women who had the most consistency between their conscious expectations and subconscious beliefs seemed to experience births closer to their ideals.

Chapter VII: Discussion

Phenomenological Themes

Overview of Results

I conducted interviews with seven primiparas and presented their stories as case studies in Chapter V. I saw the themes that emerged from the plethora of data as expressions of small processes occurring within the greater process of a primipara's experience of childbearing. Each theme contained paradoxical elements. Looking at the transcripts through the eyes of a phenomenologist I first observed, for example, a theme that I called *Discovering Joy*. Each primipara expressed happiness at being pregnant. Joy did not just arise instantaneously, however, and continue throughout the pregnancy. I could see that happiness might arise and then be submerged under feelings of discomfort or illness. It might be felt for awhile and then be challenged by life circumstances such as the absence of a partner or concerns about the responsibility of child rearing. It could be felt as longing to hold a beloved child and be countered by the fear that the pain of labor might be unbearable.

In all I identified seven themes, with one theme repeating in a new form: the first, just described, was *Discovering Joy*, followed by *Receiving an Education*, *Making Choices and Exercising her Will*, *Identifying Resources and Gathering Support*, *Questioning and Doubting*, *Experiencing the Unexpected*, *Accepting What Is*, and *Returning to Joy*, the first theme reappearing when pregnancy culminated in a successful birth. Each theme has been presented in Chapter VI with numerous examples of how it was demonstrated in the lives of these primiparas.

While thoroughly exploring each theme I found that patterns emerged as well. The themes seemed to arrange themselves, not in priority order, but like a cloud of

electrons revolving around the center of an atom. This constellation (see Figure 1) represented the ongoing, dynamic themes that permeated the life of each pregnant woman. Beyond this, they formed a holistic pattern in which the paradoxical facets of each theme could be easily perceived. I envisioned this as a double helix (see Figure 2) with two waves undulating around each other. Each theme's opposing qualities combined in a melodic counterpoint in which each element remained distinct while composing an extended harmonic relationship. This was meant to suggest both the intermittent joy *and* the fear that a pregnant woman might feel throughout her childbearing journey. As examples: primiparas remained open to new information, or closed to it; they exercised their will or submitted to the will of others; they found inner resources or identified external resources and support; they felt self-confident or doubted themselves; they experienced labor as an ideal or an ordeal, perhaps alternating between the two perceptions; they accepted their experiences or were dissatisfied; and finally they felt exhilarated or depressed. The dual natures of each theme appeared in a primipara's life and, when viewed holistically, appeared to comprehensively describe her overall process.

The Emergence of a Model

Having identified themes and examined them individually and collectively, I now suggest that considering them as a collective provides a model for comprehending the world of primiparas—a world comprised of expectations. The themes are not totally independent of one another. I suggest that the themes serve as a composite of processes that merits further consideration.

First, research has already been performed in several of the individual thematic areas: support (Callister et al., 2001; Gibbins & Thomson, 2001; Ip et al., 2003; Kannan

et al., 2001; Melender & Lauri, 2001), expectations (Callister et al., 2001; Fenwick, et al., 2005; Gibbins & Thomson, 2001; Green, 1993; Green et al., 1998; Hodnett, 2002; Ip et al., 2003; Larsen et al., 2001; Slade et al., 1993; Waldenstrom, 1999), and prenatal education (Gibbins & Thomson, 2001; Hallgren et al., 1995), for example. More research into individual themes could be done, for instance, regarding the women's attitudes upon discovering they are pregnant and how those attitudes might affect their unborn children. Studied from the perspective of consciousness, there is no doubt that there is an effect. This topic is one addressed by pre- and perinatal scholars but it is not universally accepted that a mother's initial feelings, or those she feels throughout her pregnancy, affect her unborn child.

The themes that I identified suggest the value of further research addressing the receptivity of pregnant women to prenatal education; their ability to assert themselves versus acquiesce to institutional polices and procedures; their access to internal, even spiritual resources; their self-confidence as opposed to self-doubt; their subconscious expectations and conscious manifestations; and their ability to find peace or satisfaction postpartum. It would be more valuable, in my estimation, to consider the interaction of themes because it is difficult to isolate a single facet of such a complex process. Again, using the metaphor of the atom, no one electron (theme) is more important than another. They work together holistically.

The themes I identified overlapped in a flexible interactive macro process of micro processes. When considered in the form of a double helix the paradoxical elements of each theme become apparent. When the themes are perceived as a cohesive unit they reveal a more comprehensive understanding of the complexity of an individual primipara's experience. The model itself emerged from the phenomenological data and

is the principle finding of this phase of my study. Researchers, care providers, supporters, and educators might be better able to understand the ambivalence, the natural flow of opposing feelings that a pregnant woman feels if they have a holistic model as a foundation. The picture provided by the in-depth study of seven primiparas seems to provide that model and a direction for many new studies and enhanced programs.

From the perspective of phenomenological inquiry I had wanted to hear the voices of primiparas. In answering my few open-ended questions they portrayed a multifaceted experience that I found remarkable. The assemblage of themes contains elements that are worthy of further study. Together they could provide a model for the enhanced understanding of primiparas, especially as a means for portraying the ambivalence that pregnant women can feel. More primiparas may need to know that in this dualistic world their conflicting feelings are usual. More need to appreciate the exquisite processes that make up the totality of their childbearing experiences.

Picturing a Better Birth

The drawings rendered by each primipara in this qualitative study are also enlightening. Phenomenological methods can include such innovative practices as the inclusion of projective devices (Patton, 2002). I found the pictures provided a bridge between what was said and what was subconsciously thought by the participants in my study. Further, the drawings may have provided another means for prenatal educators to support the positive pregnancies and deliveries—the positive expectations—of their students.

When I compared all of the drawings I found that two pictures contained common elements that could possibly be indicative of successful labor and birth. When considered with others, Barbara's drawing showed no process. The end result—the

baby—was evident, as well as support from her partner following the birth. She shared that her husband was very helpful when she returned from the hospital. There were no fearful elements in the picture but her interview revealed more about her intention to avail herself of all medical technology possible. Her surgical delivery was proof of that conscious intention. Carolyn's picture was one that did not show the birthing process either. Rather it depicted bonding taking place between mother and child after the birth. Dorothy's picture was of the labor process but it was also incomplete. No baby had been born. It could have been a photograph of one moment during her labor at home. In her case the ideal labor did not culminate in an ideal natural home birth. Eleanor's drawing contained no suggestion of a process. In fact, pregnancy and birth seem disconnected. The central figure of her drawing appeared inflexible and stood somewhat apart from others. One comment that Eleanor made when she interpreted her own drawing was, "I thought the flowers would be good for the attendants because they're helping me get to that new place from being not a Mom to becoming a Mother." Her words said that she anticipated receiving help. However, like Heather, whom I interviewed in my pilot study, Eleanor thought of being pregnant as "not being a Mom"—giving birth transformed a pregnant woman into a Mother. Later, I revisit this notion that being pregnant is *not* being a Mother by countering with the idea that motherhood begins at conception. Felicia's drawing not only showed no birth process, it contained no specific images of mothers, babies, or desired support.

Gwyneth and Annette, who both had better childbirth experiences than they had expected, drew pictures (Appendices J and D) depicting *both process and product*. Each drawing had three significant features:

1. a birth had occurred in a specific environment;

2. the woman herself was included in the picture with her newborn in close proximity; and

3. figures of people that the primipara wanted to support her were included.

Annette drew a picture of giving birth in a birth center with her mother, sister, nurse, and nurse midwife in attendance. She included water, a bed, a rocker, a birth ball, and birthing stool. She placed herself in the picture with her newborn baby nearby. Gwyneth portrayed giving birth in a medical setting with her husband and doctor in attendance. She showed the drops of tears and beads of sweat that were minute details of her labor. She drew herself with her newborn on her belly. She and her loved ones were sheltered by symbols of natural abundance and her faith in God. While some of these elements appeared in other primipara's drawings, only Annette and Gwyneth depicted *a completed process* with all the above mentioned elements.

I suggest that prenatal classes incorporate art, specifically drawing, into their curricula. Educators or care providers could ask a pregnant woman to draw a picture of her ideal birth which includes *all* of the above features. It would seem that the more detail, the better. The potential exists for this concrete visualization to contribute to a better birth experience. It will be up to other researchers, educators, and pregnant women to determine if this practice is effective.

Interpretation of the Data from the Perspective of Consciousness

Answering the Research Questions

One of the themes that emerged from the participants' responses specifically addressed the questions that guided this research. I asked primiparas what they expected when they gave birth. They were forthright in expressing their expectations, sometimes realistically anticipating hard work, for example. Some envisioned laboring without

medication or giving birth naturally. When asked if their experiences matched their expectations each woman reported that she *experienced something unexpected* (Theme 6). On a conscious level all described giving birth as different—either better or worse—than they expected. I wanted to know *why*.

My findings were corroborating the results of other small qualitative studies (Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996) and simultaneously contradicting the findings of larger quantitative studies (Green et al., 1990; Hodnett, 2002; Waldenstrom et al., 1996). This disparity was perplexing. I had just discovered a book that I intended to recommend at the conclusion of my study. I identified with the sentiments of the author, a sociologist. He said:

> I am a social scientist, and we social scientists cannot abide oddity. . . . We must find the pattern that lies under the peculiarity: We must discover how the exceptional case *follows* the rule. We welcome exceptions because they force us to rethink the patterns we have described, but we are not content to leave them as exceptions. (De Vries, 2004, p. 47)

As I searched for an answer to resolve the incongruous findings of small and large studies, I found that the way I asked my question could keep me looking for an either/or solution. Within a question about whether expectations are met or not is the assumption that the expectations are expressions of a united mind, both conscious and unconscious agreeing. I could see that I was identifying a paradoxical answer: two seemingly opposing points of view might be true at the same time. This suggested that I really needed to delve further into what constituted expectations in the mind of the person being questioned. Was this mind consistent in its beliefs or were conscious expectations being undermined by conflicting unconscious beliefs? The literature on consciousness

promised to provide an answer to these new questions and perhaps even resolve the inconsistency in the results of small and large studies.

Clark Moustakas' (1995) discovered a heuristic process that helped him "understand human experience" (p. 28). I realized in reviewing his book *Being-In, Being-For, Being-With* that I had been following the six steps in his heuristic process: 1) I had found an engaging topic that aroused my passion; 2) I had energetically immersed myself in the data; 3) I had let the information I gathered incubate: 4) I had begun to experience illuminating insights; 5) I was, at this point, beginning the "*explication process*" (p.30); and 6) I was looking for a "*creative synthesis*" (p. 30), a way to organize the major findings and integrate them into a cohesive whole. The data that I had accrued, "discovered" using Moustakas' term, seemed to be demanding that I go beyond strict adherence to phenomenological descriptive reporting to interpretation and explanation.

The Emergence of an Explanation

I sat for months examining transcripts, drawings, and relevant research. I studied texts written on brain science, quantum physics, the evolution of consciousness, and the understanding of mind/body interactions. I reviewed research that showed that in small qualitative studies pregnant women did not realize their expectations when they gave birth (Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996). The primiparas in my study had also said their experiences were better (two women) or worse (five women) than they had expected. I compared these responses to those of larger quantitative studies that said that pregnant women generally experienced what they expected (Green, 1993; Green et al., 1990; Hodnett, 2002; Slade et al., 1993; Waldenstrom et al., 1996).

I looked at the way in which the primiparas in my study had expected and subsequently experienced childbearing, then returned to consciousness studies to

reconcile the disparity between my findings and those of the larger studies.

> For the first time in the history of psychology, scientists are equipped with technologies of sufficient power to undertake a thorough exploration of the unconscious: an exploration that will very probably transform the general conception of what it is to be human. Even basic assumptions about the nature of identity and our ability to make choices will be challenged. (Tallis, 2002, p. 182)

In the spirit of exploration suggested by Tallis (2002) I brought the views of many consciousness researchers into a single focus. Like Moustakas (1995) I was experiencing "a birth process, an awakening" (p. 29) when I could understand what I had not understood before in my heuristic process. Thus, I applied quantum physical concepts and the current understanding of how the mind operates to my data beginning the explication and synthesis of my findings.

A woman's attitude toward her pregnancy is directly correlated with the complications that she experiences during childbirth (Talbot, 1992). If a primipara is feeling apprehensive based on her social and cultural conditioning (Davis-Floyd, 1992) or has deeply held fears based on her own birth-related experiences (B. R. Findeisen, personal communication, March 14, 2006) those fears could be processed unconsciously (Le Doux, 1998), leading to unforeseen consequences when she gives birth. Biologist Bruce Lipton (2005) contends that:

> When it comes to sheer neurological processing abilities, the subconscious mind is millions of times more powerful than the conscious mind. If the desires of the conscious mind conflict with the programs in the subconscious mind, which "mind" do you think will win out? . . . Messages programmed in your subconscious mind will undermine your best conscious efforts. (p. 128)

According to Goleman (1995), “unconscious opinions are emotional memories” (p. 20) or, more pointedly, emotional memories become unconscious opinions, programmed into the recesses of the subconscious mind (Lipton, 2005). The neocortical thinking centers of the brain “do not govern all of emotional life; in crucial matters of the heart—and most especially in emotional emergencies—they can be said to defer to the limbic system” (Goleman, 1995, p. 12). A laboring woman’s limbic or “emotional system can act independently of the neocortex” (p. 18), overriding her conscious intentions. When a laboring primipara’s conscious positive expectations are not met, the explanation could be that unconscious fears surface in this perceived “emotional emergency” (p. 12) and her fears prevail. Goleman calls this process “emotional hijacking” (p. 13).

Ornstein (1991) explains further that emotions “govern our choices, they determine our goals, and they guide our lives” (p. 96), usually unconsciously. When conscious positive expectations *are* met, a primipara’s limbic (emotional) and neocortical (mental) systems are aligned, producing the desired results.

Candace Pert (2000) pronounced that the body *is* the subconscious mind. A mind (conscious) and body (subconscious) work together to produce results. For example, a woman’s cervix could dilate or not, as a result of the *unconscious* direction it receives. Using Dorothy’s experience to illustrate: she decided in the ninth month to deliver her baby at home without drugs; however, her life-long belief had been that birth was painful and required medication; she labored at home but failed to progress and was transported to the hospital where she was administered pitocin and an epidural before giving birth. Her longer held apprehensions won out, in Lipton’s terms, over her conscious desires.

In teaching students about the conscious and subconscious minds, Gates (1995)

used the metaphor of an iceberg. Above the surface of the ocean is the small portion of the iceberg that can be observed. Below the surface is an unseen massive and powerful structure. In this image the visible tip of the iceberg correlates with the conscious mind thought to be contained within the brain and head. The large substructure depicts the unconscious mind, contained in every cell of the body according to Pert. The tip of the iceberg will follow the movement of the huge structure lying beneath it like a head attached to a body. The mind, like the iceberg, is a totality, but the unconscious mind has a far greater influence on outcomes than the conscious mind (Gates, 1995; Lipton, 2005).

When conscious desires merge with unconscious beliefs a consciously perceived expectation could be realized. However, conflicting expectations, denied by a woman but held in her subconscious mind and guided by equally unconscious emotions, would *always* be met according to this premise. Said another way: only unconscious expectations are met while conscious expectations are met only if they agree with those in the unconscious.

My explanation for why pregnant women realize their expectations—or not—demonstrated that my original question was limited. The perception of unmet expectations is the result of the conscious mind of an individual not recognizing or denying what is held in the unconscious. Wilson (2002) had called these mental processes repression, inattention, and obscuration. I amalgamated the conclusions of several consciousness researchers to resolve the discrepancy I observed between what seven primiparas expected and what they experienced. This also seemed to explain why individual childbearing women could describe their experiences as not meeting their expectations while large quantitative studies could report that pregnant women tend realize their expectations. I suggest that the quantitative studies could see a bigger

picture extrapolating from data from hundreds of women to uncover beliefs and expectations that were hidden beneath each individual woman's conscious perception of her experience. The richness of the qualitative data gathered in this study exposed the underlying *and* overriding attitudes to validate the findings of the larger studies: pregnant women do, indeed, get what they expect.

In a lecture given at the University of Arizona Medical Center June 1, 2006, Stuart Hameroff, Professor Emeritus and Director of the Center for Consciousness Studies, also used the iceberg as a visual image. He described the tip of the iceberg as the Classical World. This world operates according to familiar laws of physics and produces consistent and predictable results. The base of the iceberg, according to Hameroff, represents the Quantum World. It even extends into the vastness of the ocean itself. The Classical World—the tangible and observable world—emerges from the Quantum World. The Classical World, as an example, is one in which the light can be seen as radiating from the sun; illuminating, warming, and promoting life. The Quantum World reveals that light has an ambivalent nature. When scientists in the early 20th century tried to prove that light was a either a particle *or* a wave, they found that how they set up their experiment, that is, what they expected, influenced light's behavior.

Dossey (1982) has described this very phenomenon in *Space, Time & Medicine*. Quantum physicists discovered the paradoxical nature of electrons that could behave "as both particles and waves, depending on the experimental design" (p. 233). Paradoxes are fundamental to physical existence.

> Heisenberg showed, moreover, that there were built-in limits to our ability to extract knowledge at this [quantum] level. . . . The view arose through quantum theory, therefore, that there simply was no physics in the modern sense for the

> individual subatomic event. Physics had to content itself with knowledge of large numbers of happenings before it could speak accurately. The old, ironclad deterministic view, therefore, gave way to one of a statistical and probabilistic nature. When collections of events were considered, however, the predictive capacity again surfaced with great accuracy. (p. 233)

When qualitatively considering the primiparas' viewpoints I could see that they were sharing their expectations as they perceived them on a conscious level. They perceived that they did not get what they expected. The larger quantitative studies were showing statistically that pregnant women did, indeed, get what they expected. In my opinion, quantum physical principles, as Dossey (1982) points out, could apply to the interpretation of the data I had gathered and also explain the discrepancy in the research findings between the individual and amalgamated points of view. In larger studies more data is gathered and analyzed. Processing that data statistically could reveal the hidden inconsistencies that women have between their conscious and unconscious expectations. Questions may have been asked in different and multiple ways to reveal that overall pregnant women tended to get what they expected. This premise is used in the conduct and interpretation of mental status examinations that psychiatrists and psychologists use to reveal a patient's deeper issues that cannot be identified by simply asking straightforward questions. Thus, underlying pathology can be illuminated for diagnosis and treatment (Brannon, 2006).

There is more. From the quantum physical point of view there are no observers. We are all participants—co-creators in the realities we experience.

> In the modern view, however (according to the most widely held interpretation of quantum mechanics, the Copenhagen interpretation) human consciousness

> participates in the edition of reality that meets our eye. In fact, without an observer the concept of "reality" simply has no currency. For at the level of individual subatomic events, because of their inherent random, statistical, and probabilistic nature, several outcomes for each event are always theoretically possible. It is the act of actually observing that causes these possibilities to cohere into what we perceive as a single event in the world. Without the participation of an observer, what we refer to as reality simply does not unfold. Thus, the strictly objective status of the physical world has been transcended in the new view, and is replaced by a version of reality which attributes central importance to human consciousness. (Dossey, 1982, p. 234)

Not only is an individual observing and contributing to the creation of her own experiences, those around her are observing and co-creating with her as well. Just as scientists effect light's behavior by expecting it to behave in a certain way, people in the birth venue consciously supporting the same vision of birth as the laboring mother would contribute to her positive expectations being realized. If they have their own perception of childbirth, as a frightening event requiring medical intervention, for example, then the effects of their conscious expectations would amplify the laboring woman's fears and another possibility would occur.

Studies of consciousness from the quantum physical perspective have pointed the way to a clearer understanding of the role of each woman's mind, and the minds of all those around her, in the realization of childbirth expectations. I believe that prenatal and perinatal psychologists should embrace this view in the development of a cohesive theory that serves as a foundation for educating, caring for, and serving pregnant women and their families.

Implications

Realizing the "importance of human consciousness" (Dossey, 1982, p. 234) prompted me to extend the implications of this study to pregnant women, their babies, fathers, care providers, educators, researchers, and society at large. I, too, have been profoundly impacted by this research, by the women who participated in it, and by the realization that consciousness impacts all lives to a greater degree than I had suspected. Also, as a student of prenatal and perinatal psychology, I recognize the value of this awareness and incorporate principles from this field in pointing out implications and in making recommendations in this dissertation.

Personal Implications

In *The Brain Has a Mind of Its Own: Insights from a Practicing Neurologist*, Restak (1991) reported that experiments have been conducted which revealed that a subject's brain activates—decodes—to initiate an act about a third of a second before the decision actually takes place. Restak stated that

> at first glance this conclusion seems paradoxical, improbable, even absurd. We usually experience our decisions as freely emanating from an "I" or a "self," a center of command. But . . . [the] findings contradict that: the brain is actually in operation before our conscious act of will" (p. 46).

Essentially, even voluntary acts begin unconsciously. No one, it seems, is as conscious as she would like to think she is. My interaction with primiparas has led me to confirm, at least for myself, that what I think consciously may differ substantially from what I believe unconsciously.

For me, this insight has been revolutionary. I have begun to examine my own motivations, decisions, actions, interactions, and even deeply held beliefs. This study has

opened my mind to a far greater understanding about what I think I think. I have, from time to time during this study, experienced being totally present with another human being, a primipara who was willing to share her expectations and her experiences as she understood them. It has been with the deepest respect for each participant that I practiced setting aside my own judgments and listened with a whole heart to another. What I found was a way of perceiving that showed me the appearance of paradox is just that—an appearance. Depending upon one's vantage point, two seemingly contradictory points of view can both be true.

I feel better about myself for having practiced acceptance, for staying open to points of view that differed from mine. In this study it was necessary to set aside my image of how a birth ought to occur. In actuality, I supported each woman's ideal of how she could experience giving birth, and when events unfolded in a way that differed from that ideal, I supported her gracious acceptance of those differences. I have found that this is what it can mean to be *conscious.*

Implications for Pregnant Women

Pregnant women can approach their pregnancies with greater consciousness. This means being aware of what is in their minds and also what is happening in their bodies. If a woman agrees that it is important to be aware of what is held in her unconscious mind she can (by exploring recommendations that follow) gain access to more of herself: mind, body, emotions, and spirit. She can reflect on her own birth experience, consider intergenerational effects, and become aware of impacts that these might have on her giving birth. By awakening to who she really is, a woman can conceive and carry a child consciously, appreciating her role in the creation of this new life and honoring the precious life that is preparing for its earthly sojourn. She can be better attuned to the

consciousness of the child that is a part of everything she thinks, feels, and does for nine months. She can be aware of the importance of selecting others to support her who are the observers, employing Dossey's term, that help to create her reality. As this study has shown, women who intend to have natural unmedicated births can have their conscious intentions undermined by their own unconscious beliefs, and also can be dissuaded from their intention by people who subscribe to a different belief system. In an interview Michel Odent notes that a laboring woman can freely enter "an altered state of consciousness [helping her] ease into what her body is urging her to do" (Jones, 1987, p. 154). Women, informed by the current understanding of consciousness, can access the power and wisdom of their minds and bodies to create a new and better experience of giving birth for themselves and their babies.

Implications for Babies

Babies can be the joyful recipients of the unconditional positive regard that fully conscious parents and care providers can offer them. Babies, from the moment of conception, *are* conscious beings. As David Chamberlain has said of babies in utero, "The baby is never without awareness and consciousness. The baby is watching and listening all the time and learning from every experience," (Highsmith et al., 2004). Verny and Kelly (1981) pointed out in *The Secret Life of the Unborn Child* that "the unborn child is a *feeling, remembering, aware* being, and because he [or she] is, what happens to him [or her]—what happens to all of us—in the nine months between conception and birth molds and shapes personality, drive and ambitions in very important ways" (p. 15).

> The Western cultural assumption that human beings grow in consciousness as they mature is only half the truth. The opposite is also true. At the moment of

> conception, a child has a fully conscious spirit that is as sensitive, if not more so, than at any other time in life. (Linn, Emerson, Linn, & Linn, 1999, p. 4).

When the consciousness of babies, especially in utero, is acknowledged all babies will benefit.

Implications for Fathers

I have said little about fathers in this dissertation, but they have been included—and appreciated—in several of the primipara's stories. A father with enhanced consciousness can co-create with his partner a child that is welcomed even before conception. A father's role is beginning to be acknowledged, not just for the sperm he contributes to fertilize an egg, but for the essential qualities he can provide when he insures the safety and well being of his family throughout a pregnancy and during the childhood's of his offspring. According to Michael Odent, during labor a father should be "free of restraints and inhibitions" (Jones, 1987, p. 154). A conscious father *is* free, gaining the respect of his partner, his children, and all those who see the values he is modeling.

Implications for Care Providers

Those who provide services and care for pregnant women come from a variety of disciplines. They carry enormous responsibility in a litigious society. Many decisions are influenced by medical protocols and insurance company guidelines. Nonetheless, a conscious caregiver can contribute more than a commitment to do no harm. A conscious care provider can acknowledge the consciousness of both the mother and child, creating an atmosphere in which all are respected. In his birthing facilities in France, Odent states that "our first aim is not to disturb the natural process of labor. We medical professionals are really students. Babies and mothers are our teachers. We see our professional role as

always adapting to the needs of the birthing mother" (Jones, 1987, p. 152).

Biophysicist Beverly Rubik, in an interview with DiCarlo (1996), said:

> The role of the health care provider has been that of the technician administering the techniques for the patient to get well. It would be much more powerful if the consciousness of the practitioner and the patient were aligned in a kind of partnership. (p. 51)

Since most births take place in hospitals and laboring women have been defined as patients, medical professionals may benefit from the adoption of these student and partnership attitudes. These are models of conscious professionalism.

Implications for Educators

The field of education is rife with opportunities for introducing the concepts of consciousness and prenatal and perinatal psychology. Prenatal education is growing as young couples want to know more about bringing babies into the world. All of the primiparas in this study sought educational resources. Several participated in hospital, birth center, or private birthing classes. Often the chosen venue dictates the course curriculum but educators can create new models that explode old myths and raise the consciousness of new parents. Programs, both educational and therapeutic, are beginning to emerge from the "realization that prenatal and perinatal wounds have an important and lingering effect on us and that these experiences can have more power over us than experiences in later life" (Linn et al., 1999, pp. 2-4). It is the effects of these wounds that are stored in the unconscious mind/body. Educators have the potential, indeed the responsibility, to inform students of this vital realization.

Implications for Researchers

Research is needed to corroborate the findings of this study. Although the

principles of quantum physics, the recognition of the unconscious mind, and the awareness that childhood events can be of significance in a person's adult psychological life have been known for a century, they have been slow to encompass the period in the womb. This period of gestation can be a challenging time to study. There can be more subjectivity involved than many researchers find comfortable or credible. Nonetheless, the integration of consciousness and prenatal and perinatal psychology are creating a fertile field for new and exciting discoveries.

Implications for Society

Society is enriched, in my opinion, when its citizens realize that consciousness exists from the moment of conception. Everyone's thoughts and feelings matter! Each individual then consciously co-creates a society that promotes the well being of its members from the very beginning. In noting that everyone's ideas about birth count, Sheila Kitzinger (2005) asserts that what one thinks, including a pregnant woman, is important:

> This does not mean that all a woman need do is to have positive thoughts. Everything depends also on what is going on in the minds of those assisting the birth, the way it is conducted, and the relationships between all those involved. What we think and the connections made between ideas, everything we anticipate, what we hope for and fear—these are part of our birth culture. (p. 1)

Kitzinger advocates woman-centered birth but finds that precipitating change in a culture "is a painfully slow and frustrating struggle" (p. 64). Society may resist changing its established, familiar, and profitable policies. Even so, conscious members of a society have the potential to create a blueprint for transformation. Change could occur one mind at a time.

Limitations

This study was designed to provide data from only a limited number of cases. This meant that my small cohort did not represent *all* primiparas. The model that emerged was derived from a few cases examined microscopically. The attitudes and expectations of the pregnant women in this study were representative of seven women who have reached child bearing age in the early part of the twenty-first century. Historically attitudes, policies, and procedures change over time. These primiparas ranged in age from 21 to 42 and represented the socialization that took place in a particular era.

The women in this study were all happy to be pregnant. They approached their deliveries with some apprehension but generally seemed to feel positive and supported. As I acknowledge that there are many other women and viewpoints that were not represented here, I wish to emphasize that I intended to hear and relay the stories of a *few* primiparas and examine why they may or may not have had their expectations about birth met. I also wanted to perform qualitative research in a country and era when the pregnant women being served primarily by an established medical institution were not being *asked* what they thought or felt. I preferred to take a look at a purposeful sample of women.

As I considered each theme that emerged from the data I had collected, I could see that other primiparas might not share the same perspectives as those in my study. First, not all women are joyful at discovering they are pregnant. Among the myriad reasons might be: some women do not want children at all; some may have become pregnant due to an untoward circumstance such as rape; some may desire an abortion due to the fear of a painful delivery or an inability to provide the parenting required once a child is born; some may feel compelled to endure pregnancy but intend to place the child

up for adoption. If a woman discovers she is pregnant and is fear-full, as opposed to joy-full, then her subsequent experiences could not lead *back* to joy. She would probably not be "accepting" of what had happened or able to resolve internal tensions. Instead of returning to joy, should she deliver the child in a state of anxiety and depression, she would be a candidate for post-partum depression and/or post traumatic stress.

In terms of receiving an education, according to a midwife from a nearby community and researchers like Ellen Lazarus (1997), many primiparas do *not* desire to know more about pregnancy or birth. There appears to be a prevailing belief that giving birth is an ordeal. These women, described by Dorothy who initially had this attitude, have "full intentions of walking into the hospital and numbing up and not feeling a thing." Some women may not question or doubt policies and procedures. Many women simply may not be aware that alternatives exist or that there could be choices that would benefit them or their babies (Madi & Crow, 2003).

Many women do not wish to be in control, make decisions, or take an active part in the delivery of their babies. They may prefer to rely totally on medical interventions. This attitude has grown from the early 1900's quest by women in America to seek pain-free births. Over the last century, medicalized birth has become the accepted norm. Today it is the women who desire to labor outside of hospitals or without medication that are viewed as anomalies. Eleanor encountered criticism from friends and relatives when she chose to give birth in a Birth Center. To them her choice seemed risky and even irresponsible.

Some women may not want to have support while laboring. Some may be shy or ashamed or they may just want to be alone (De Vries, 2004). It was not that many years ago that it was customary to leave a woman alone during labor. I myself was left alone

by hospital staff during both my labors. Husbands were discouraged from attending births, even if they wanted to be supportive. Today husbands and families routinely attend births. There are now doulas to support women in labor, but they are not well known, nor popular. Indeed, doulas are sometimes regarded as adversaries by hospital staff.

Beyond the women who may not fit the profile of those that participated in this study, I also recognize that I, as a researcher, have had an effect on the primiparas I was interviewing. I was aware from reading about quantum physics that an observer affects the observed. The affect is, in fact, reciprocal. Observers are not isolated on the outside looking in, they are participants as well. Braud and Anderson (1998) say that "the purposes, intentions, and goals of all research personnel (researcher, participants, and audience) contribute to the design, conduct, and outcomes of research studies" (p. 17). Anderson and Olsen (2002) agree:

> It is known that face-to-face interviewing involves a substantial risk of producing interviewer effects—that is, responses that depend partly on how the interviewer looks, poses the questions, and expresses his or her attitude in body language and wording. (p. 95).

I am still considering how I influenced the responses of seven primiparas who were all happy to be pregnant. My positive attitude at least coincided with the positive attitudes of the women I interviewed. Quantum physics would suggest that this is the case.

> A new physics speaks of a potential brought into actuality by observation. The observer and that which is observed are participants in a reciprocal dynamic that makes a field neither existent nor able to be perceived—though its realized potential does exist and can be seen. (Pearce, 2002, p. 78)

The primiparas and I shared time and space—we were part of the fundamental interconnectedness and universal "interrelatedness" (Dossey, 1982, p. 233) that science has revealed. I acknowledge that we affected each others lives (as any researcher and participants would) because I rely on quantum physical principles to explain my findings—and because I was blessed by the lives of these seven women and their babies.

In addition, I knew as I began qualitative research that the findings of a study of only seven women could not be generalized to a larger population. My objective had been to tell the stories of these seven women as authentically as possible, to identify themes within their experiences, and to consider the ways in which the themes were expressed individually and collectively. I wanted to ask "why" pregnant women appeared to have their expectations met or not, and to find within existing research plausible explanations that could apply to my results. Not everyone may agree with the theories I employed or the explanation I posed. To me, particularly in the subjective world of pregnancy and birth, the theories and my explanation make sense.

Since generalizing my findings was not in order, I chose instead to extrapolate from the results information that could enhance the understanding of primiparas.

> Unlike the usual meaning of the term *generalization*, an *extrapolation* clearly connotes that one has gone beyond the narrow confines of the data to think about other applications of the findings. Extrapolations are modest speculations on the likely applicability of findings to other situations under similar, but not identical, conditions. Extrapolations are logical, thoughtful, case derived, and problem oriented rather than statistical and probabilistic. Extrapolations can be particularly useful when based on information-rich samples and designs, that is, studies that produce relevant information carefully targeted to specific concerns

about both the present and the future. (Patton, 2002, p. 584)

From this perspective, I inferred an explanation from the data and relevant research. I now offer some recommendations for interacting in the world of primiparas today.

Recommendations

As a recommendation I have focused my attention on one specific area: to encourage the consideration and adoption of a model proven to be successful. It is indeed a pleasure to recommend *A Pleasing Birth*. I first became aware of the need for a model when I read the works of Joseph Chilton Pearce. In *The Biology of Transcendence* Pearce (2002) defines the necessity for a model—from the very beginning:

> The mother is the model of the eventual child on every level and a new life must shape according to the general models life itself affords. For, as is true in all cases of nature's model imperative, the character, nature, and quality of the model determine to an indeterminable extent the character, nature, and quality of the new intelligence that manifests. (p. 116)

I deduced that models were needed at all levels, even in society at large. I was gratified to read about a model of care that resonated with my personal beliefs in De Vries' (2004) book *A Pleasing Birth: Midwives and Maternity Care in the Netherlands*. It seemed all encompassing, addressing the needs and wants of individual women while considering ramifications within society as a whole. It appeared to be a model that worked!

I had been dismayed by attitudes I found among respected international researchers who were calling for educational programs to simply cultivate more realistic expectations among pregnant women (Fridh & Gaston-Johansson, 1990; Ip et al., 2003). From the quantum physical perspective I could see that this meant further imbedding authoritative knowledge. In my mind it would focus pregnant women on the disaster

waiting to happen—the potential ordeal—rather than focusing on the ideal that was among the infinite possibilities. I looked for ways to in which to cultivate the support of ideals.

I was also dumbfounded by the comments of participants in my study, Heather (see Chapter IV) and Eleanor (see Chapter V), who implied that being pregnant was *not* being a mother! Then I found that renowned birth educators and researchers, whom I have chosen not to name, used expressions that described giving birth as the transformation to or the passage to motherhood. Apparently giving birth qualified a woman for the designation *Mother*. A principle of prenatal and perinatal psychology is that motherhood begins at conception. Until women realize that they *are* Mothers while they are pregnant, the consciousness of babies will be ignored and there will be little impetus to change birth practices. Thus, I was looking for a model that appeared to honor Mothers throughout the entire prenatal and perinatal periods as well as postnatally.

I searched for a model from a Western culture that was similar to this country's existing practices. Suggesting the adoption of a system from a primitive or a radically different culture, no matter how worthy, would be too far fetched for anyone to take seriously. De Vries (2004) a sociologist, notes that "all health policy rests on cultural foundations and that policy proposals that do not match cultural ideas are doomed to failure" (p. 245).

I checked the international infant mortality rates and found that in the year 2000 that many Asian, Scandinavian, and European countries including the Netherlands all had lower (that is, better) rates than the United States (Child Health USA, 2004). "Infant mortality rates have become a shorthand measure for the adequacy of a society's health system and its overall quality of life" (De Vries, 2004, p. 16).

DeVries' (2004) comprehensive study of the Dutch system of obstetric care received the endorsements of midwife Ina May Gaskin and cultural anthropologist Robbie Davis-Floyd, both authors of birth-related books. De Vries says that by "looking to maternity care in the Netherlands, we can find a way to live within our limits and to create a more just and effective health care system" (p. xv). He notes that it is surprising

> to find widely disparate conceptions of a pleasing birth in societies that are quite similar. Dutch society is not unlike other European or North American societies, and yet women there have an anomalous conception of a pleasing birth: More than 75 percent of pregnant women in the Netherlands choose midwife care at the beginning of their pregnancy; and more than 40 percent choose to have their babies at home. (p. 3)

De Vries (2004) sees the need to reform the health care system in the United States. He focuses on maternity care saying, "More than any other branch of medicine, maternity care is marked by the culture and society in which it is found" (p. 4).

> The relationship among caregivers and clients at birth is constantly being renegotiated; it is the product of changing social conditions (costs of health care, policy decisions, etc.) and cultural beliefs (faith in technology, religious ideas, ideas about gender, etc.)" (p. 16).

Further, he states that obstetrics "is the only discipline in medicine where something happens by itself, and, in most cases, everything ends well with no intervention" (p. 14).

De Vries (2004) chose the Netherlands for study, because it is small in size and has a language spoken almost exclusively within its borders. Also "birth in the Netherlands is accomplished much differently than it is elsewhere" (p. 9). Midwifery care, promoted in the Netherlands, yields lower infant and neonatal mortality rates and

higher birth weights (low birth weights are associated with low survival rates) even in the United States. Although these statistics have been available for years, they have had "almost no effect on health policy and the delivery of care in the United States" (p. 15).

De Vries (2004) points out that "for American women, hospital birth seems right and home birth seems frightening, but for many Dutch women home birth is the only appropriate option" (p. 19). This is due to the effects of the ambient culture. The choices that a woman "can imagine are constrained by what she knows, what she has experienced, what she has seen around her, and what she has heard" (p. 19).

In the Netherlands Dutch social policy directs women expecting a healthy birth into their primary care system. A midwife provides prenatal care and is present at the birth. Studies of continuity of care are showing that women have more positive birth experiences when they have developed a relationship with their midwife prior to delivery (Homer, Davis, Cooke, & Barclay, 2002; McCourt & Pearce, 2000). In the Netherlands a pregnant woman under the care of a midwife has the choice of a home or hospital birth. If complications arise a gynecological specialist is called upon to manage care throughout the pregnancy and hospital birth.

Postpartum care is normal in the Netherlands. It is provided by specialists who "come into the home of the new parents and perform a variety of tasks, including household chores, marketing, cooking, watching the condition of mom and baby, offering instruction in baby care, and feeding" (De Vries, 2004, p. 31). Not only is care provided by specialists, relatives and friends celebrate the postnatal period by decorating the house, eating pink and blue candy, and arranging parties and visits.

De Vries (2004) cites a long history of Dutch tradition that acknowledges the central place of the home and the important place of women in that home. Within her

nuclear family a woman is described as strong and independent yet feminine. She and her partner could be a model for those in a loving, friendly marriage. Because the Dutch seem to cherish their families they have, to a degree, resisted the industrialization of birth. This could paint a rather idyllic picture which would not be accurate. The appreciation of women as mothers and the tendency to trust in midwives are embedded in Dutch culture. Even so, a closer look at the statistics shows that almost twice as many births occur in hospitals as in homes and about the same proportion of births (almost twice as many) are attended by obstetricians as by midwives in the Netherlands.

The Dutch system demonstrates that appreciating women as mothers and offering them a choice can contribute to lower infant mortality rates. According to DeVries (2004) the Dutch practice of obstetrics which is to "be watchful and reactive rather than active and intervene has something to teach caregivers in a variety of fields" (p. 244). He states:

> Whether it be the search for a pleasing birth—a birth with a minimum of fear and pain, in the company of supportive family, friends, and caregivers, a birth that ends with a healthy mother and baby gazing into each other's eyes—or for a more just and loving system of health care, we must account for the role of culture in the form and reform of health systems. (p. 245)

The consideration of this model is suggested as a way to improve the care pregnant women receive in the United States while acknowledging the influence of the culturally instilled procedures that are already in place. Looking at a model that works provides a mental blueprint that can begin to precipitate desired changes.

As an addendum I would like to note that others would also like to institute changes in the American way of birth. Robbie Davis-Floyd and Christine Barbara

Johnson (2006) have recently published *Mainstreaming Midwives: The Politics of Change*. Davis-Floyd emphasizes that:

> Planned, midwife attended home and birth center births have been repeatedly shown to be as safe as hospital birth. Such births are far more woman-empowering, and far more baby- and family-friendly. They are also cheaper—a homebirth and home midwifery care cost an average of one-third that of a hospital birth. (p. 9)

Mainstreaming Midwives is dedicated to the midwives of America, in the belief and hope that one day they will realize their full potential to be the primary care providers for the majority of American birth-giving women, and that in doing so, they will continue to uphold their ideals and practices of woman-centered care.

Davis-Floyd supports midwifery by pointing out that:

> the United States and Canada are the only two industrialized nations in which professional midwives do not attend the majority of births. As the direct result of a campaign by physicians, nurses, and public health officials from the early 1900s on, by the 1960s midwives in North America had been almost completely eliminated. (p. 4)

Americans of stature including De Vries, Davis-Floyd, and Johnson are advocating for changes in birth practices in the United States. I am pleased to endorse their books and their positions that may indeed lead the way to mainstreaming midwives.

Conclusion

I have relied on the current understanding of consciousness to provide meaning, if not enlightenment, so that I, and those who read this dissertation, might better understand the world of women pregnant for the first time. I was surprised and delighted by a

number of my findings: several themes emerged consistently throughout all seven primipara's discourses; the themes appeared to merge into a single pattern that disclosed paradoxical elements making it possible for the pattern to be seen as a model of a primipara's mental, emotional, physical, and spiritual experience of childbearing; the primiparas' drawings, together with verbal expressions, provided clues to suggest that unconscious feelings influenced outcomes; specific drawings seemed to contain elements that might herald a successful outcome; current understandings of consciousness and how the mind operates on both conscious and unconscious levels might explain the difference between a pregnant woman's expectations and her unexpected experiences; the same science could resolve inconsistencies between the findings of small qualitative and large quantitative studies; and, the consciousness of every individual in the birthing environment contributes to the outcome experienced by a birthing woman.

I am still a feminist, a prenatal and perinatal scholar, and a student of consciousness studies. Feminist, prenatal and perinatal, and consciousness researchers all cited in this study promote changes in society. I am, thus, an advocate of change. Ultimately, I believe that women themselves will demand that they be given the opportunities to fully express their power and wisdom during childbearing.

> There are some women in the United States who supervalue nature and their natural bodies over science and technology, who regard the technological deconstruction of birth as harmful and dangerous, who desire to experience the whole of birth—its rhythms, its juiciness, its intense sexuality, fluidity, ecstasy, and pain. Those women who most deeply trust birth place themselves quite consciously as far out of the reach of the technocratic model as they can get, choosing to give birth in the sanctity of and safety of their own homes, and

> grounding themselves philosophically in a holistic model of birth. (Davis-Floyd & Davis, 1997, p. 147)

These women are models of a way of giving birth that has been scorned by advocates of the medical technological model.

Nonetheless, the childbearing women in America today are the products of their society. It is senseless to criticize them for thinking the way they have been taught to think about birth. Only with loving acceptance and the suspension of judgment regarding each woman's decisions can society make headway. Each person is accountable for her own consciousness. That consciousness can be directed at creating an ideal. Marilyn Ferguson, author of the *Brain Revolution*, in an interview with DiCarlo (1996), talks about grassroots efforts that precipitate desired change. She says, "You begin to make 'mini-revolutions,' people striving to improve things where they are. Out of that might emerge a shift that may eventually cause a change in authority" (p. 11). Like their foremothers who effectively influenced doctors to administer Twilight Sleep to birthing mothers almost a century ago, women can be the catalysts for their own liberation from technocratic birth. Some women are finding their voices; they are networking with other women; they are celebrating their ability to give birth. They will be the models for others and the roots of change.

I have been honored to share the voices of seven primiparas. I trust that this dissertation reaches the ears of others and perhaps catalyzes a change of mind about women at a time when they are giving the greatest gift endowed by nature—life itself.

Appendix A: Description of Study

Research is revealing that women have conscious expectations regarding giving birth. Most studies of pregnant women's expectations of the birth process have been conducted in other countries while only a few have been reported in the United States in the last two decades. I am currently conducting a research study to gain insight into the beliefs and expectations of first-time pregnant women (primiparas) in this country. This project is in partial fulfillment of the degree requirements for a Doctorate of Psychology in Prenatal and Perinatal Psychology at Santa Barbara Graduate Institute. I am interested in learning from you what you expect as you look forward to giving birth to your first child.

Some researchers abroad asked pregnant women what they expected to happen as they gave birth and, subsequently, asked if their expectations were met. I believe it is important to know what women in the United States expect. You may benefit from talking about giving birth by voicing what you envision. Others may also benefit from hearing about your experience: other pregnant women; women planning to have children; men who may not understand how women think and feel about giving birth; and even healthcare professionals who may not consider childbirth in the same light that you do. Your thoughts, feelings, beliefs, and expectations are important. It is valuable for me as a woman, mother, and grandmother, as well as a student and researcher, to understand the thoughts and feelings you have when you picture giving birth to your baby.

In order to conduct my research I would like to visit with you twice, once while you are pregnant and again about two weeks after you have given birth. It would probably be most comfortable for you to meet at your home, but we could consider another location if you prefer. We would need about two (2) hours for each interview. During that time we will get acquainted and I will ask you some questions. I will also ask you to draw a picture of "your ideal birth". I will provide drawing paper and colored pencils. I will be both audio and video recording with a camera our interviews as well as making some notes of my observations. These notes, audio recordings together with their transcripts, and video tapes are solely for my use. They will help me in writing my dissertation and will be kept in a locked file cabinet in my home office. They will be kept strictly confidential unless I obtain your written permission to use them for some other purpose. After our time together I will analyze and interpret the data. My findings will be included in my final dissertation. Although I will include the information you share with me in the dissertation, I will not use your real name in order to protect your privacy. You may request a copy of my dissertation when it is complete.

Your participation in this project is strictly voluntary. You can withdraw in part or in full at any time with no consequences to you. There are no known physical risks associated with participating in this research; however, due to the sensitivity of the subject matter being discussed (that is, pregnancy and birth) it is possible that you could experience mental or emotional discomfort, including fear, anxiety, anger, sadness, shame, guilt, embarrassment, concerns about being judged negatively, and so forth.

If mental or emotional discomfort arise during the course of your participation in this research and you would like to talk to a licensed therapist, please feel free to contact me and I will provide names of qualified counselors.

Thank you for your willingness to consider participating in this study. It is my intention to support the most positive outcome possible for both you and your baby.

Page two of two _____
(Please initial here)

Appendix B: Primiparas Expectations of Childbirth: The Impact of Consciousness

Informed Consent Form

I am a student at the Santa Barbara Graduate Institute and am conducting a study on the expectations that first-time mothers have about giving birth to their babies. Before any student at SBGI does a study, a panel of people review what the student plans to research and how they plan to conduct the study in order to insure that the project will be conducted ethically. The panel reviews the project in order to protect the interests, comfort, and safety of all participants.

I also want you to know that I aim, first and foremost, to conduct a study that benefits pregnant women and their unborn babies. I am giving you this form and the information it contains for your protection and so that you have a full understanding of the study's procedures before you decide whether or not you are interested in participating. If you choose to sign it, that will mean that you have (a) received this document describing what is involved in participating in this study and what the procedures and potential benefits and risks of participating in this research project are; that you have (b) been given enough time to consider the information in the document; and that you have (c) voluntarily agreed to participate in the project.

The names of the women who will be participating in this study will be kept confidential to the full extent permitted by law. Your identity will not be known to any staff member, faculty member, or student at SBGI other than myself. You will not be required to write your name or any other identifying information on the research materials unless you wish to do so. During the course of the research you will be assigned a pseudonym to maintain your anonymity. It is possible that, as a result of legal action, I, as the researcher, may be required to divulge information obtained in the course of this research to a court or other legal body.

All research materials will be kept in my home office in a locked file cabinet.

The observations and interviews will take place in your home or another location agreeable to you. Two interviews, one during your pregnancy and the other approximately two weeks following the birth of your baby, will be scheduled at times convenient for you. Each interview is estimated to take not more than two hours. As stated in the *Description of the Study*, both audio and video recordings will be made to assist me in writing my dissertation. I will also take written notes of observations that I make during our interviews.

The audio tapes will be transcribed personally and a copy returned to you for your verification of content. These recordings—written, auditory, and visual—are solely for my personal use to facilitate an accurate account of the data.

1 of 3 _____
(Please initial here)

They will be held strictly confidential unless your written permission is obtained to use them for some other purpose. You may choose not to answer any question I ask you and you may stop the interview at any time. The open-ended questions are intended to leave you in control of what you wish to share. You have the right to withdraw from this study partially or fully at any time without penalty.

There are no known physical risks associated with participating in this research. However, some women may experience mental or emotional discomfort such as fear, anxiety, depression, loss of self-esteem, shame, guilt, embarrassment, concern about being judged negatively, and so forth, when discussing pregnancy and birth. If this interview process elicits strong concerns or feelings and you would like to talk to a licensed therapist, please feel free to contact me (Susan Highsmith) and I will give you the names of qualified counselors in your area.

Agreement to Participate

Having been asked by Susan Highsmith of Santa Barbara Graduate Institute to participate in a research project, I _____have read the procedures specified in the document. (Please print your name)

I understand the procedures to be used in this project and that the results of this project may bring some benefits to childbearing women. I understand that some of the results may be published in journals and publications to serve other women and their unborn/newborn babies and I consent to that.

I understand that participation in this study does put me, and, therefore, my unborn child, at risk of experiencing mental or emotional discomfort.

I understand that I may withdraw my participation in part or in full from this study at any time.

I understand that any notes taken by the researcher, transcripts, audio recordings, and video tapes will be kept in a secure location.

I understand that I may request a copy of this dissertation when it is complete.

I understand that my identity will be kept confidential and that, in reporting the data, statements attributed to me will be identified by a pseudonym (a name made up to protect my identity).

2 of 3 _____
(Please initial here)

I also understand that I may contact Susan Highsmith, principal researcher, with questions or queries about the project at 520-458-6012. I may register any complaint I might have about the project with Jill Kern, Director of Research, by mail (Santa Barbara Graduate Institute, 525 East Micheltorena, Suite 205, Santa Barbara, CA. 93103), by phone (805-963-6896 ext. 106), or by email (jkern@sbgi.edu).

I agree to participate in this project, which consists of participating in two interviews, drawing a picture of "My Ideal Birth" at the conclusion of the first interview, and reviewing the transcripts of both interviews as described above.

Name (print) _____

Address_____

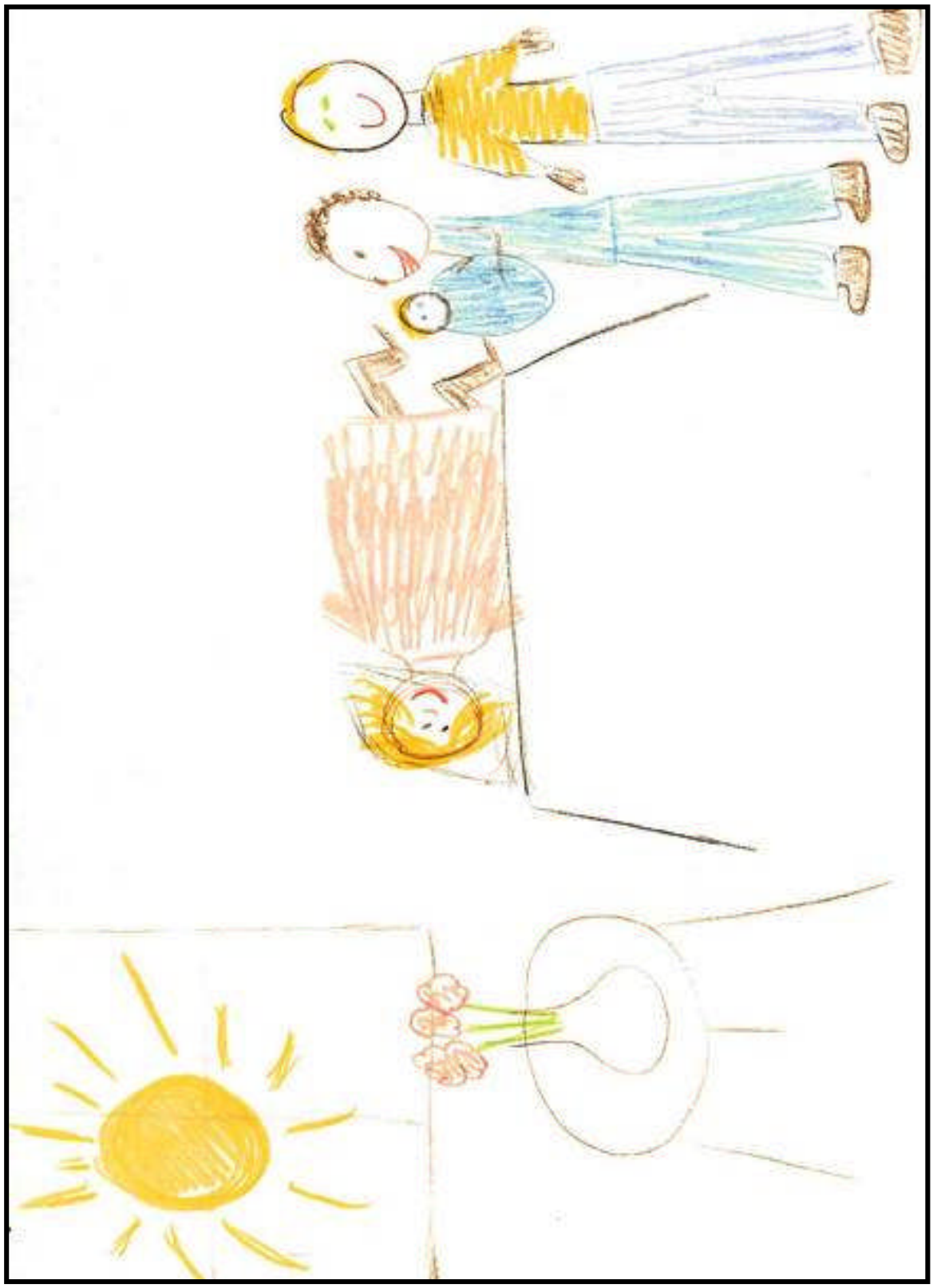
Phone Number_____

Signature_____Date_____

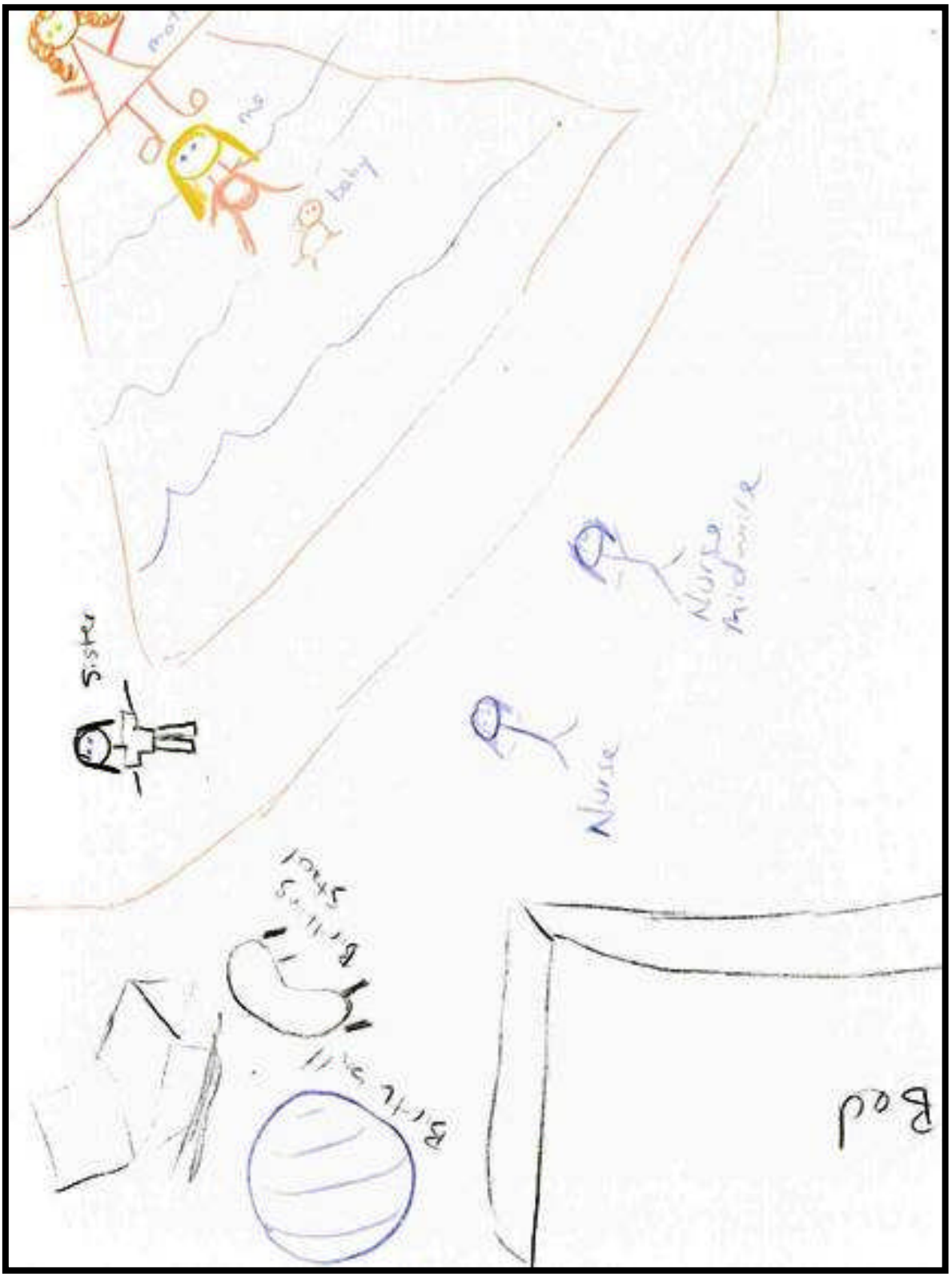
Signature of researcher_____Date_____

3 of 3 _____
(Please initial here)

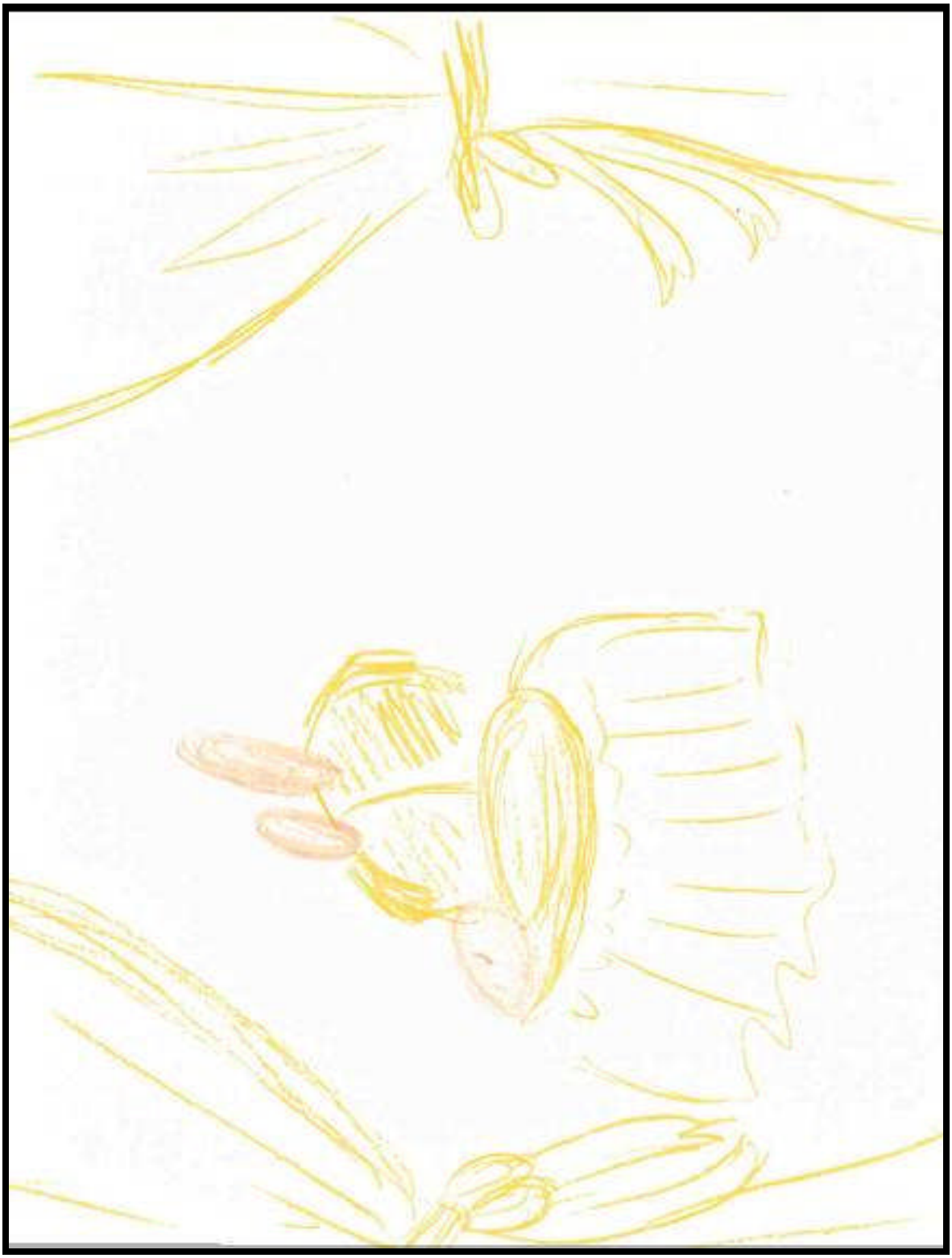
Appendix C: Heather's Drawing



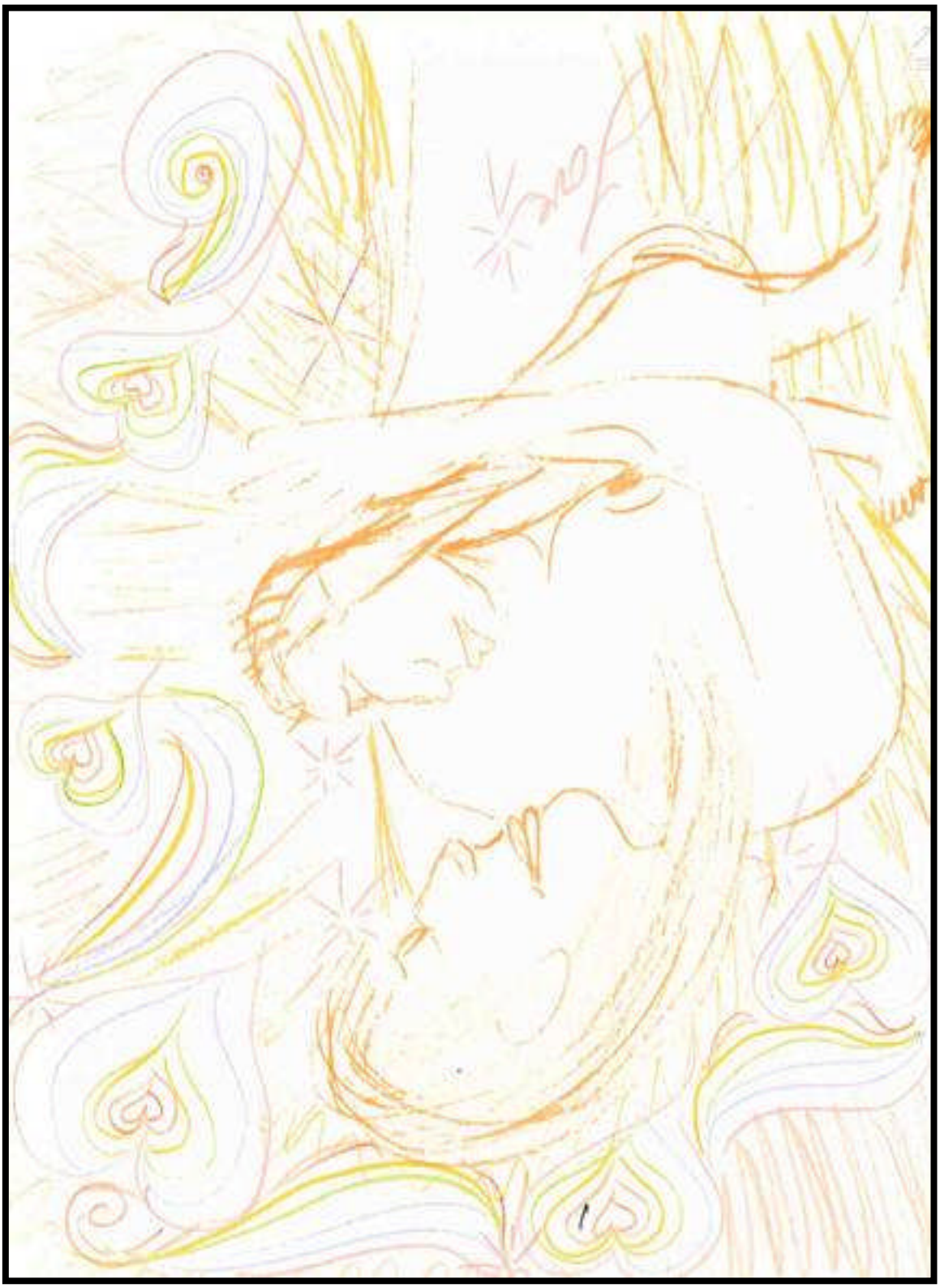
Appendix D: Annette's Drawing



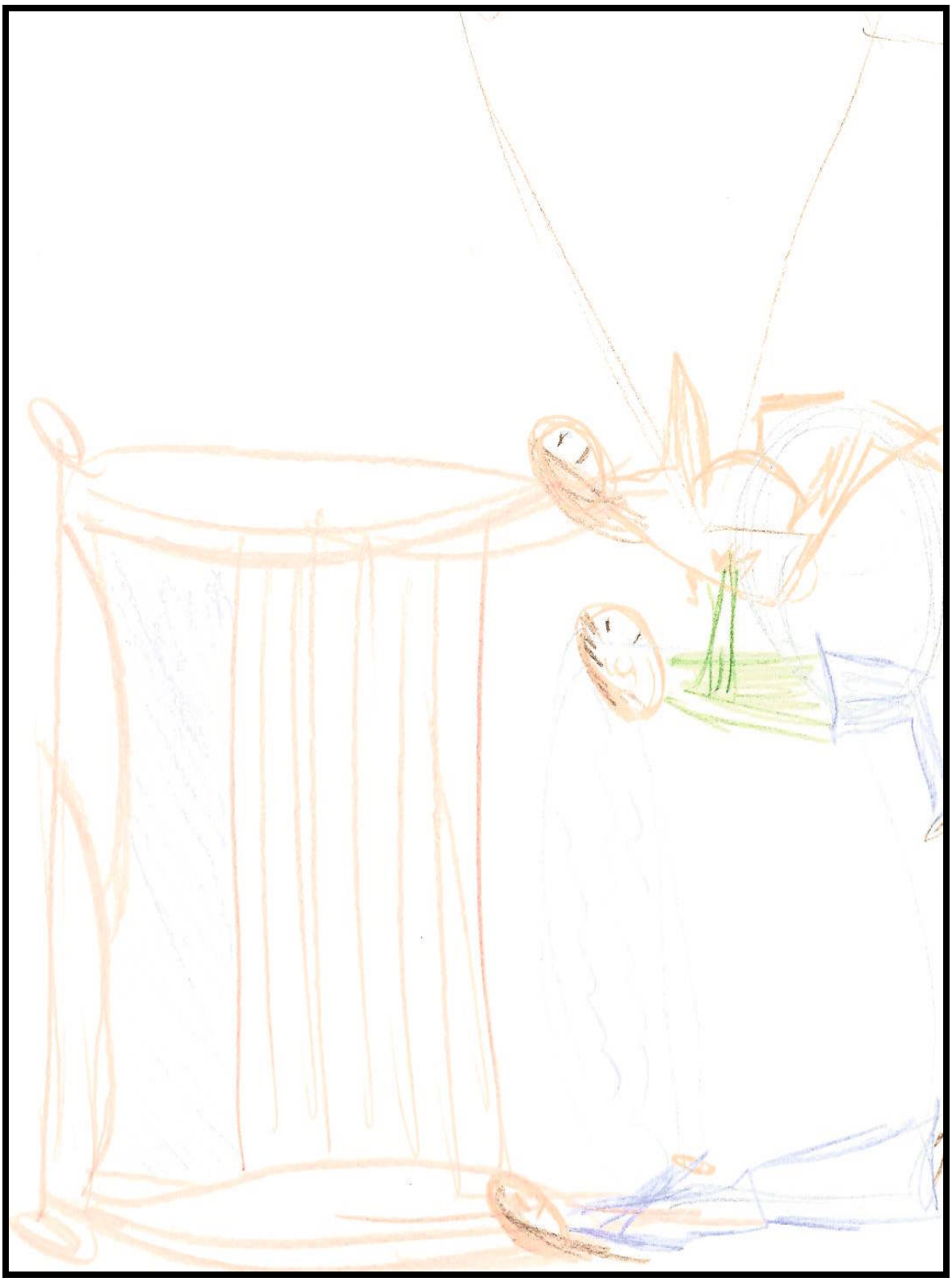
Appendix E: Barbara's Drawing



Appendix F: Carolyn's Drawing



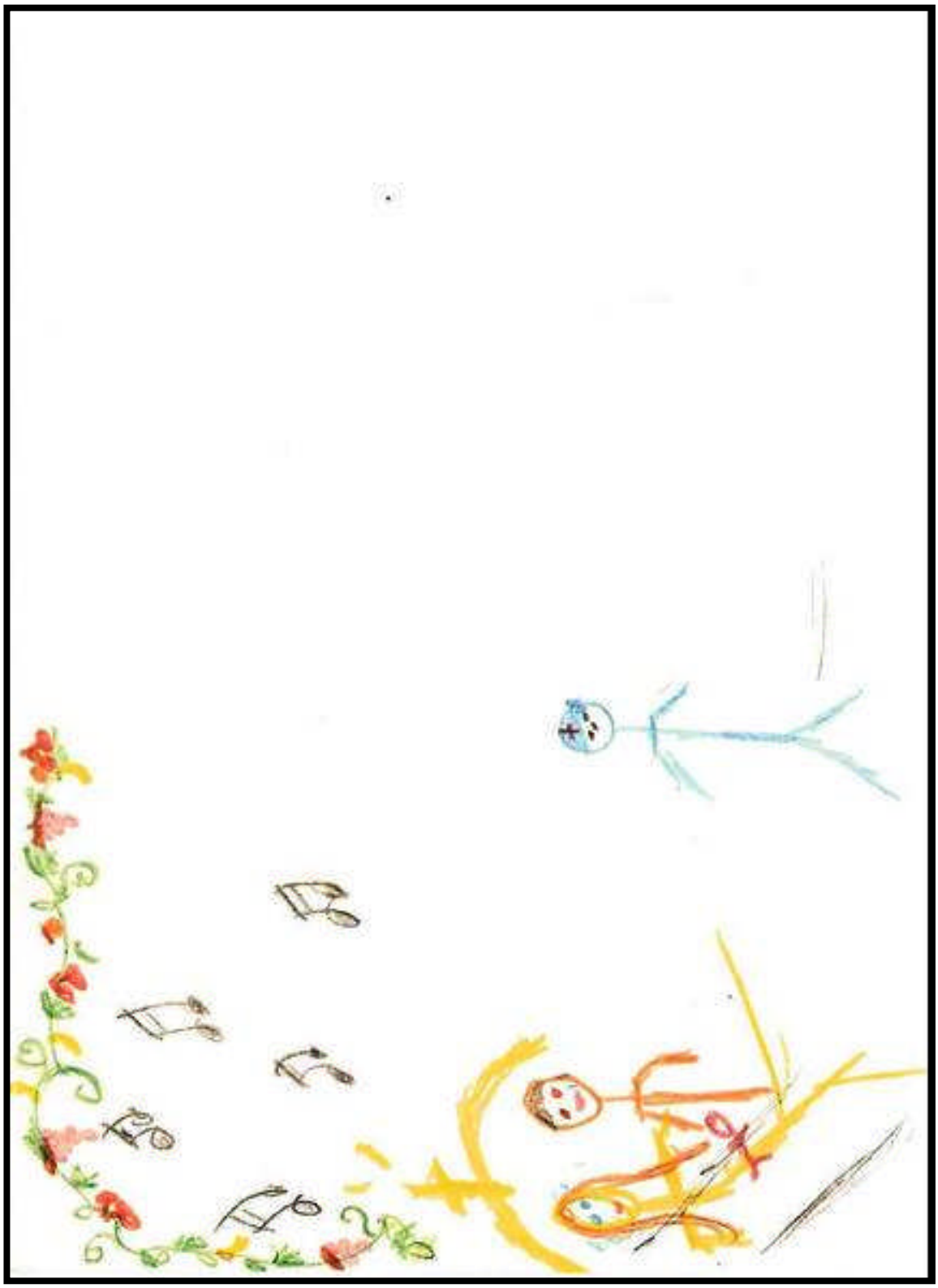
Appendix G: Dorothy's Drawing



Appendix H: Eleanor's Drawing

Appendix I: Felicia's Drawing

Appendix J: Gwyneth's Drawing



Appendix K: Recommendations of Prenatal and Perinatal Resources

In this appendix I have assembled some recommendations that constitute a list of prenatal and perinatal resources. This focuses attention on the many valuable materials and programs that already exist. They serve as models at every level so that anyone can begin to make a difference in her own life and the lives of others. Books, DVDs, audio and video tapes, prenatal education classes, graduate education programs in pre- and perinatal psychology, and organizations that promote the best interests of babies and pregnant women are all available. I focus on this one field as the forum for my suggestions because I have found it to be humane, progressive, multidisciplinary, and all encompassing as a discipline devoted to the well being of mothers and their babies, born and unborn.

Because so many prenatal and perinatal psychologists and their colleagues in other fields already embrace some or all of the concepts discussed in this dissertation, I call upon their work to continue to evolve and to inspire. Therefore, these recommendations could be seen as a resource directory. In addition, each of the primiparas in this study has contributed a particular pearl of wisdom that synchronistically provides an insight or a specific recommendation which I include here. They have been my teachers and I am privileged to express their voices.

Recommendations for Women

Choose Ways to Learn More About Yourself

Self-learning should include mental, emotional, physical, and spiritual elements. Women hold the key to their own liberation from unmet expectations. I would suggest: read, read, read. Surround yourself with people who share your ideals. Awaken your own consciousness to your underlying fears so that they can be healed. Consult a pre-

and perinatal psychologist or participate in a group seminar that addresses prenatal issues. STAR, founded by Barbara Findeisen, and Emerson Training Seminars led by William Emerson are two such groups that have the potential to be transformational in the lives of participants. Find other women with whom you can be mutually supportive. Like Davis-Floyd and Johnson (1997), I encourage the employment of midwives and the see the value of women intuitively supporting women giving birth:

> Their deep, connective, woman-to-woman webs, woven so lovingly in a society that grants those connections no authority of knowledge and precious little conceptual reality, hold rich potential for restoring the balance of intimacy to the multiple alienations of technocratic life. (p. 168).

Learn to do yoga, relax, think positively, meditate, or visualize. According to Dossey (1982) regular practice of positive mental imagery can cultivate a manner of being that is "less urgent, less hectic, and less anxiety-provoking" (p. 167).

I would say to pregnant women, begin to consider the consciousness of the child you are carrying. To women considering pregnancy, think about the soul that may be waiting for *you* to conceive. First read books like *Conscious Conception* (Pavarti-Baker & Baker, 1986), *Welcoming the Soul of a Child* (Hopkins, 1999), *Parenting Begins before Conception* (Luminare-Rosen, 2000), and *Remembering Our Home* (Linn, Emerson, Linn, & Linn, 1999). When pregnant read books like *While You Are Expecting* (Van de Carr & Lehrer, 1997), *Gentle Birth, Gentle Mothering* (Buckley, 2005), *Calm Birth* (Newman, 2005), and a book recommended by several of the women who participated in this study, *The Thinking Woman's Guide to a Better Birth* (Goer, 1999).

Annette's Wisdom

Annette provided a radiant model for how a woman can feel while she is

pregnant. She remarked enthusiastically, "I feel beautiful for the first time in my life." A recommendation to pregnant women: *appreciate how beautiful you are!*

Gwyneth's Wisdom

Gwyneth's experience encouraged me to add: consider cultivating a spiritual life. In *Reinventing Medicine* Dossey (1999) notes that "an extensive body of data—approximately 150 studies—supports the ability of thoughts, wishes, and prayers to affect distant biological systems" (p. 191). In this study Gwyneth actively prayed during her labor. On the day of her son's birth she emailed several of her friends to pray for her during her delivery, asking for what researchers call intercessory prayer. Gwyneth had the most positive experience, which she described as "the best of both worlds," of any of the primiparas. She elaborated:

> There was a song that was a worship song that was going through my head during the beginning part of the labor and one of the key phrases of the song is that "I'm trading my sorrows for the joy of the Lord." And I really, I mean, I really feel like the joy of the Lord is my strength. . . . I had sent an email to the four or five gals that are my closest friends that had gone before me, and said, this is a song, this is a worship song that is running through my head right now. So I don't know what that means but *be praying for us.*

Recommendations for Individuals

Take Care of Yourself

Both men and women can derive benefits from the recommendations that I addressed to women in particular. One point that I would like to make here has been said best by Jack Kornfield in the forward to *Welcoming the Soul of a Child*:

> We all want to give our children the best that we can give. But how can we expect to truly care for them if we are too busy, too distracted, and basically just too *unconscious* [italics added] to care for ourselves and our world in a nurturing and responsible way?" (Hopkins, 1999, p. xiii)

A great act of consciousness is to care for yourself which in turn models good self-care for your children. One way: experience massage or cranial sacral therapy. Touch is good for everyone, even vital to our well-being.

Carolyn's Wisdom

Carolyn provides an awareness of how busy a person can be, even while pregnant, and provides a worthwhile alternative:

> I've been still so caught up in the day to day busy-ness. . . . I do do journaling and prayer work. . . . *Now* is the time to start . . . tuning in and listening to more music and slowing down.

Recommendations for Parents

Welcome the Soul of Your Child and Nurture Her Spirit

In his foreword to Hopkins' (1999) book, Jack Kornfield said:

> Modern medicine and childbirth practices have frequently forgotten the soul. And how we raise the next generation, whether with soulless video and virtual daycare or loving community, will create the people of the world to be. This is a terribly urgent matter" (p. ix).

A great gift to your children is your Presence, indeed, your consciousness and awareness. Hopkins (1999) predicted that:

> If our children are nourished, guided, protected, and cared for with utmost tenderness and conscious awareness, we will witness their unfolding petal by

petal, blossoming into their most ravishing beauty. (p. 7)

Books about conscious parenting are growing in numbers. Several of significance are *Tomorrow's Baby* (Verny & Weintraub, 2002b), *Pre-Parenting* (Verny & Weintraub, 2002a), *The Prenatal Prescription* (Nathanielsz, 2001), *Prenatal Parenting* (Wirth, 2001), and *Parenting from the Inside Out* (Siegel & Hartzell, 2003). Read classics like Klaus, Kennell, and Klaus' (1996) *Bonding: Building the Foundations of Secure Attachment and Independence*. If you find that your baby has symptoms that could be related to a difficult birth, consult experts like Ray Castellino, director of BEBA (*Building and Enhancing Bonding and Attachment*), or Wendy Anne McCarty, author of *Being with Babies*, each of whom has excellent skills to assist little ones in resolving birth trauma.

Felicia's Wisdom

Felicia informed me that her husband supported her during her pregnancy and labor and that he immediately bonded with the baby at birth. This provides a role model for fathers and demonstrates the unity that a couple can share as they bring a child into the world. For Felicia, bonding with her newborn was difficult because of her fatigue. Nonetheless, she intuitively knew to return her baby's gaze, essential in forming a strong mother-infant bond. Telling the story of her process is a gift that Felicia shared.

> Even that night [after giving birth] I didn't really sleep. I just dreamed. Like my muscles had absolutely nothing left in them, so mentally I wasn't all that tired, but that night she [the baby] kind a just stayed up and she just looked at me.

Recommendations for Care Providers

Adopt an Attitude of Openness and Learning

Kitzinger (2005) has written:

> In all interaction between midwives, health visitors, doctors and others who care for pregnant women, those in labour and new mothers, it is vital to listen and learn, instead of telling and hoping that those at the receiving end are absorbing the teaching. (p. 214)

Attitudes and beliefs count! The beliefs of caregivers have been shown to be important to birthing women who evaluate the care they receive (Coyle, Hauck, Percival, & Kristjanson, 2001). The consciousness that each care provider brings as a quantum physical observer in the birthing environment contributes to the outcome that the laboring mother will experience. Halldorsdottir and Karldottir (1996) found that:

> A midwife perceived as uncaring seems to have the effect on the woman that she tends to lose a sense of control and the birth experience tends to leave her feeling helpless. Conversely, a midwife perceived as caring, who is competent and really cares for the woman giving birth, and who is involved in the woman's lived experience of giving birth, can help the woman retain or even regain control and can change even a terrible experience into an experience of hard work, where the woman, however, feels 'on top of the world' instead of being in the 'middle of a huge surge' which again our findings indicate increases the process of birth and increases the woman's satisfaction with the birth experience. Thus, a caring midwife who works with the woman, encouraging her, empowering her, as well as guiding her, seems to be a key element of a successful birth experience for a woman. (pp. 59-60)

Although the mother's conscious and unconscious expectations certainly contribute to the outcome of her experience, so do the conscious and unconscious expectations of every person who shows up to support her!

Eleanor's Wisdom

Eleanor first thought giving birth was all about the Mom. "What I found out is it takes the whole group to kind of come together to do it."

Recommendations for Educators

Seize Opportunities to Present Prenatal & Perinatal Principles

Programs exist that can be presented, modified, or enhanced. I was inspired to include drawings in my research based on the book *Birthing from Within* by England and Horowitz (1998). This book has a companion website and certification programs. Verny and Weintraub (2000) have written *Nurturing the Unborn Child: A Nine-Month Program for Soothing, Stimulating and Communicating With Your Baby*. Graduates of Santa Barbara Graduate Institute are offering prenatal parenting classes and coaching mothers to assist parents in having healthier, happier pregnancies and deliveries. Two colleagues and I produced a 20 minute DVD *Babies Know* that introduces the principles of prenatal and perinatal psychology to new audiences. It is being shown regularly in Birth Centers, in private birth education classes, charter schools, and in college classrooms.

The prenatal period is now being studied in college human development classes. "Theories of human development emerge and change within a cultural and historical context," (Newman & Newman, 2006, p. 41). In their text *Development through Life* Newman and Newman identify eleven psychosocial developmental stages beginning with a prenatal stage encompassing the period from conception to birth. This is not typical as students of development are more familiar with Erickson's model which has only eight stages that begin with birth. A chapter of Newman and Newman's text is dedicated to the earliest phase of development, "highlighting the bidirectional influences of the fetus and the pregnant woman within her social and cultural environments" (p. xiii).

I suggest learning about these programs and books and capitalizing on their creators' work. As pre- and perinatal psychologist David Chamberlain said in his interview in *Babies Know*: "We think the psyche of the baby is very much alive. We have lots of evidence to show that but people don't know it yet and we need to talk about it constantly to get people to open the womb and let them peek inside, and be able to redefine in their own mind what a baby is" (Highsmith et al., 2003).

Dorothy's Wisdom

There are women who want what you have to teach. As Dorothy indicated:

> I wish more women would have access to this information and it wasn't so entrenched in our society how you know . . . [birth is to be feared]? Birth is natural. It's not something to be afraid of. I was just saying how grateful I am that I've met the right people and then was handed the right books to get the information that I just don't think is widely spread out there. It makes complete sense once you read it and once you open yourself up to it. . . . I've been speaking to women I know who are pregnant or have multiple births and there's just such a fear of the "what if"—like a disaster waiting to happen and it's just so sad because they don't realize that there's another way; that it doesn't have to be fear-ridden and relying solely on someone else to dictate what's going to happen. I think there's no trust in the process itself.

Carolyn's Wisdom

In the realm of New Age thought, Carolyn offers this resource:

> There's one CD that's called *Welcome Baby* and I've listened to that. We have the privilege of bringing in a very special generation. In fact, we are the

caretakers of these old souls that have come here to show us many things. Every time I hear that message I get inspired.

Recommendations for Researchers

Conduct Studies That Link Consciousness With Pregnancy, Childbirth, and Babies

I found that conducting a phenomenological study which included both interviews and drawings worked well to gain rich data. In my study the drawings made a contribution to the enhanced understanding of how a woman's conscious and subconscious minds work together to produce a particular experience. There are other ways to investigate this link. I can envision productive studies utilizing biofeedback technology to determine brain wave states accessing the altered states of consciousness that have been noted by Odent (in Verney, 1987), Arms (1996), and Lipton (2005). The Heart Math Institute is a resource that promotes the awareness of the brain within the heart and the interaction of fields of energy that emanate from the heart. Their studies could be expanded to include pregnant women and babies, born and unborn. Studies are already being done to assess fetal responses to induced maternal stress by measuring maternal heart rate and skin conductance while simultaneously measuring fetal heart rates, heart rate variability, and motor activity (DiPietro et al., 2003). Both qualitative and quantitative studies could be designed that would yield important data to substantiate (or refute) the significance of consciousness and mind/body energies in the realm of pregnancy and childbirth.

Carolyn's Wisdom

Carolyn had a perspective that could awaken researchers to consider many new possibilities:

> I think that a big part of the learning is: nobody has all the right answers. It wasn't about the doula having all the right answers, or about the doctor having all the right answers, or about having the dance. . . . The *baby* has all the right answers. [Addressing the baby whose heart rate had dropped so low that the doctor said the baby himself was telling them that he was in distress and needed an operative delivery].

Recommendations for Society

Join a New Group

Many prenatal and perinatal psychologists (Chamberlain, 1998; McCarty, 2002; Verny, 1987), feminists (Kitzinger, 2005; Levesque-Lopman, 1988; Wolf, 2003), and researchers in the science of consciousness (Lipton, 2005; Ornstein and Sobel, 1987) are advocates for societal change in the realms of child birth and child rearing. Societies, cultures, and institutions are all aggregates of individuals. Once established they can be very difficult to change. Nonetheless, when individual members of a society are inspired to precipitate change, "the fire in our minds needs to be expressed in *action* at the level of the personal and the political. This action will change our birth culture" (Kitzinger, 2005, pp 215-216).

New groups are forming to support childbearing women, parents, and their babies. Joining one is an action that can combine the consciousnesses of like-minded people to bring into reality the vision that they hold dear. Naomi Wolf (2003), author *Misconceptions: Truth, Lies and the Unexpected on the Journey to Motherhood*, endorses "MOTHERS (for Mothers Ought to Have Equal Rights)" (p. 294). The Association for Prenatal and Perinatal Psychology and Health, The Alliance for Transforming the Lives

of Children, and Touch the Future are just a few of the wonderful organizations that already exist. Each of these has easily accessed and informative websites.

Barbara's Wisdom

Barbara was born in the Caribbean Islands. She offers a model of family-centered birth with a commentary on birth in the United States:

> I think in other places and other societies giving birth and raising families is more of a family event. The grandparents are near. As a kid you'd probably witness or know about the pregnancy, that it won't be such a closed event. Here they barely talk about birth or when you do go to the hospital it's such a closed event. You only find out later, you don't witness anything. So young girls growing up here have no idea; absolutely no idea. Whereas somewhere else it would be . . . they give birth at home . . . . So everybody's around. Everybody's helping. Grandma, mom, whatever. And here it's completely different. Grandma is in Pennsylvania, or mom is over there. You only have doctors to take care of you and there's none of that discussion and help.

Giving birth is not just the mother's responsibility; it is the responsibility of all, especially those who are conscious of the miracle of life that is coming into being. Change is also the responsibility of all of us. We can, together, create a world where each child is welcomed, each birthing mother is supported, and "everybody's helping."

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