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Connecting Movement and Emotion for Childbirth Preparation: An Exploratory Study

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admission to the Degree of Master of Midwifery (Research)

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STATEMENT OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not been previously submitted for a degree nor has it been submitted as a part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help I have received in my research work and the preparation of this thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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GLOSSARY OF TERMS

Attunement: “attunement involves the alignment of states of mind in moments of engagement, during which affect is communicated with facial expression, vocalisations, body gesture, and eye contact” (Siegel 2015, p. 116).

Breath flow: “the phrasing pattern that resembles and is often directed by the rise and release of the breath” (Tortora 2006, p. 500).

Dance/movement therapy (DMT): “dance/movement therapy is the therapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual, based on the empirically supported premise that the body, mind and spirit are interconnected” (DTAA 2016).

The word *dance* in DMT: “is often used metaphorically to describe the give and take in social interactions and emotional expressions” (Tortora 2006, p. 7).

Embodiment: “embodiment is another way of describing the integration of parts-mind, body, feelings, internal and external worlds” (Bloom 2006, p. xvi).

Experience: “practical knowledge, skill, or practice derived from direct observation or participation in events or in particular activity” (Merriam-Webster 2016).

Experiencing in relation to DMT: “is the immersion into the rhythmic stream of movement, an emptying and opening, a focusing on bodily sensation through movement” (Shreeves 2006, p. 238).

Experiencing: “the feeling of emotions and sensations, as opposed to thinking; involvement in what is happening rather than abstract reflection on an event or interpersonal encounter” (Medical Dictionary 2017).

Feeling tone: “the tone of the emotions depicted in a group’s actions; refers to the overall mood of a group” (Tortora 2006, p. 502).

Inner speech: “the silent process of thought and production of unuttered words. This function is essential to thinking that is done with words” (Medical Dictionary 2009).

Mirroring: “is a process that involves a therapist literally embodying the exact shape, form, movement qualities, and feeling tone of another person’s actions as if the

therapist were creating an emotional and physical mirror image” (Tortora 2006, p. 506).

Movement: “is creative and improvisational, embodying the imagination whereby the body becomes the vehicle for self-expression and a bridge between emotion and motion for integration and healing” (Payne 2006, p. 3).

Movement repertoire: “the range of movement qualities and elements an individual uses to express him- or herself” (Tortora 2006, p. 505).

Movement signature: “the specific qualitative action used most frequently in an individual’s movement repertoire; that is, the actions that most characterise or define an individual’s style of moving” (Tortora 2006, p. 505).

Movement therapy: “consists of a variety of Eastern and Western movement approaches used to promote physical, mental, emotional and spiritual well-being” (Mosby’s Medical Dictionary 2009).

Movement metaphor: “a specific, personally stylized, nonverbal, qualitative element, posture, or sequence of movements that frequently recurs within an individual’s movement repertoire and may have personal meaning” (Tortora 2006, p. 505).

Mover: “the person whose movements are being observed to determine specific non-verbal movement qualities (Tortora 2006, p. 505).

Self-awareness: “the capacity to become the object of one’s own attention where the individual actively identifies, processes and stores information about the self. It includes the end result of this processing and storing – self-knowledge, the overall information one has about oneself” (Morin 2005, p. 117).

Woman’s birth signature™ : “A woman’s specific qualitative movement repertoire and posture; that is, the action that most characterises or defines the woman’s individual style of moving and positioning her body during labour and birth” (Handorf 2016 – trademark pending).

ABSTRACT

BACKGROUND

During pregnancy, many women desire to develop self-confidence in their physical abilities and emotional strength to give birth. In order to achieve this, women often attend childbirth education classes. A number of studies show that traditional classes neither support women's physical and emotional well-being, nor increase women's self-confidence or affect women's experience of childbirth. This led to a perceived need to develop a creative approach to exploring women's physical and emotional transformation in preparation for childbirth.

PURPOSE

To investigate women's perceptions of an innovative childbirth preparation programme that integrates the therapeutic strategies of movement therapy with midwifery. The study further explored women's experience of how connecting motion (movement) and emotions contributes to women's self-awareness, and might contribute to the woman's birth experience.

METHODS

An exploratory, pre-post, qualitative study investigated five women's participation in a specially designed, two-day, pre-birth workshop. Focus groups, before and after the workshop and one-to-one, semi-structured interviews were conducted six to eight weeks after birth. The interviews were digitally recorded and transcribed. Researcher memos and field notes recorded non-verbal communication and the language of movement in combination with the interview data. Data were analysed thematically.

FINDINGS

Three themes were identified where the therapeutic approach of movement therapy offered women 'strategies to find their own tools', supported 'women's dialogue' and 'connected the whole woman with her baby'. This innovative approach increased women's self-awareness and created positive expectations of giving birth. Paying

attention to themselves and learning through experiencing may raise women's confidence in their ability to actively give birth

OUTLINE OF THE THESIS

Chapter One introduces the research question and the aim and significance of the study. It further provides background information about current childbirth preparation.

Chapter Two presents a review of the literature examining conventional and alternative childbirth preparation classes from 2005-2016. The literature describes the effectiveness of standard antenatal/childbirth education; women's perceptions of childbirth education programmes; the integration of childbirth preparation with psycho-prophylaxis and with mindfulness practice, and pregnant women's self-confidence.

Chapter Three presents the curriculum content and the conceptual and empirical foundation of the 2-day preparation for childbirth workshop developed for this research project. The workshop is based on a number of concepts derived from several disciplines including midwifery, childbirth education, art therapy, dance/movement therapy (DMT), yoga, mindful-based meditation and social psychology.

Chapter Four provides an outline of the study design and methods of data collection and analysis. An exploratory, descriptive design was used in order to explore women's expectations and experiences of attending a newly developed childbirth preparation programme that focuses on connecting movement and emotion for childbirth. The chapter describes the careful choice of setting for the study, participant recruitment and considers the ethical issues relevant for this study. Methods of data collection included pre and post programme focus groups with the women and in-depth individual interview 6-8 weeks after the birth of their baby. The qualitative data analysis technique of thematic analysis was considered the most appropriate for this study.

Chapters Five to Six present the findings of the study. Chapter Five presents the findings of focus group one, which reveals the women's expectations of a childbirth preparation programme in general and in particular, their expectation of this programme. Chapter Six presents the findings of focus group two, describing the women's experience of participating in this childbirth preparation programme.

Chapter Seven presents the findings six to eight weeks after women have given birth, and explores the tools they gained from the programme and then used during labour and birth. The findings consisted of three major themes. These were: Women's Dialogue, Developing Tools, and Connection.

Chapter Eight discusses the findings in relation to the literature and encompasses the implications for practice and further research. In particular it explores the strengths as well as the limitations of this study and highlights the potential benefits of the integration of movement therapy into preparation for childbirth programmes.

CHAPTER ONE: BACKGROUND TO THE STUDY

Aim, scope and significance of the study

Traditional childbirth preparation classes aim to prepare parents-to-be for pregnancy, labour, childbirth and early parenthood. Such classes have widespread popularity amongst pregnant women and their partners. However the evidence of effectiveness of current structured childbirth preparation classes for pregnant women and their partners is lacking (Ferguson, Davis & Browne 2012; Gagnon & Sandall 2011; National Institute for Health and Clinical Excellence 2008; Svensson 2005). The purpose of this study is to build upon past knowledge and to explore a new, emerging approach to supporting women during pregnancy, and to prepare women for labour, childbirth and early parenthood.

Overall, research using a range of study designs including randomised controlled trials (Bergström, Kieler & Waldenström 2009; Bergström, Kieler & Waldenström 2011; Maimburg et al. 2010; Svensson 2005; Svensson, Barclay & Cooke 2008), cohort studies (Fabian, Rådestad & Waldenström 2005), quasi-experimental studies (Kish 2003), and systematic reviews (Gagnon & Sandall 2011) show that childbirth preparation classes do not equip women with confidence towards childbirth and parenthood and do not address women's individual, internal, emotional changes and mixed feelings that accompany pregnancy (Levett et al. 2016). As a consequence current childbirth education classes do not address the feeling of 'shock' women experience at their changed role as impending mothers (Svensson 2005) and fail to support women adequately with commonly expressed emotions such as fear of the unknown, as well as ambivalent expectations towards labour, birth and motherhood (Bergström, Kieler & Waldenström 2011; Koehn 2008; Steiner Celebi 2006). Encouragingly, in the last few years it has become apparent that care providers are moving away from rigidly structured models of childbirth preparation towards a more comprehensive and active participatory approach (Bergström, Kieler & Waldenström 2011; Consonni et al. 2010; Swenson; Barclay & Cooke 2008). Although different philosophies have led to different kinds of childbirth education as well as antenatal

education classes, the literature indicates that classes still continue to be structured from the perception of the educator rather than from the woman and her needs. Therefore, depending on the class outline and the teacher's emphasis, women may also learn a lot or a little about different pain coping techniques.

Being pregnant, going into labour and giving birth is a transformational journey in a woman's life and can be seen simultaneously as a physical, emotional, hormonal, and mind-driven process (Buckley 2005). It can be stated that, the emotional, neurological, endocrine and immune systems are deeply wired together (Douglas & Ludwig 2008), and whatever pregnant women think, feel as an emotion, or take action on, leads to an internal neurochemical reaction (a hormonal process and response) that makes the physical body respond (Hahn-Holbrook, Holbrook & Haselton 2011; Singer, Critchey & Preuschoff 2009). Therefore emotions, originating from different parts of the brain, are support messengers on a biological level and have an impact on mother's and babies' health (Buckley 2005; Dixon, Skinner & Foureur 2013, Foureur 2008). During childbirth, for example, whatever emotions and feelings a woman might have or develop, will support or inhibit the natural process of labour and childbirth (Buckley 2005; Dixon, Sinner & Foureur 2013). Human emotion, positive as well as negative, needs to be recognised as an opportunity for learning and growing (Alberts, Schneider & Martijn 2012) and I propose the role of emotion needs to be recognised in a new model of preparation for childbirth and parenthood.

In the early stage of pregnancy, mothers-to-be start building an image of their child, based on their own internal sensations and what they feel when their unborn babies move inside them (Tortara 2006). During pregnancy, physical movement plays a significant role in staying healthy and becomes an essential and helpful tool for labouring women (Domingues, Matijasevich & Barros 2009; Olson et al. 2009). During labour, for example, the quality of the woman's motion (or physical movement), as well as her emotions, enables midwives to discern the woman's emotional and physical state of well-being; provides clues about the stage of labour, and communicates non-verbally about how women are responding to and interacting with others (Fahy, Foureur & Hastie 2008).

Experiencing both motion and emotion can be seen as keys for learning and growing which emphasises the person's process of transformation; it creates changes that last and become embodied, and might empower women to birth their babies with confidence (Steiner Celebi 2006; Tortara 2006). A human's true being, feeling and meaning can only be discovered and supported by paying attention to their physical action (motion), their emotional feelings (emotion) and their mental thoughts (mind) (Tortara 2006). My proposal is that these important aspects of 'being', rather than simple information giving, need to be incorporated into a more comprehensive model of preparation for childbirth.

Most women have a vision of childbirth; they express their hopes of avoiding medical intervention and express their desire to birth their babies as naturally as possible (Kringeland, Daltveit & Møller 2009). Furthermore, most women want to be prepared, physically and mentally, for the birth of their babies (Steiner Celebi 2006; Svensson, Barclay & Cooke 2008). In working as an independent midwife, however, my colleagues and I observed that most women do not feel self-confident in their ability to give birth; they express anxiety that they might not cope well with labour pain and childbirth. To reduce women's fear of childbirth, to foster a sense of self-confidence and to build knowledge, midwives recommend participating in childbirth education classes with the hope that women will reach a state of certainty and feel confident in themselves and their abilities.

The National Institute for Clinical Excellence (NICE) has produced a guideline that supports midwives' recommendations and states that childbirth education classes should be offered to women (NICE 2008). The main reason women and their partners to participate in these programmes is to gain information about pregnancy and childbirth, decrease anxiety and gain confidence about childbirth, and learn about motherhood/fatherhood (Fabian, Radestad & Waldenström 2005).

After several years of observing women's mixed experiences with participation in childbirth education classes I decided to attend a range of classes myself to gain some personal insight. I attended three different courses. One childbirth preparation course was taught privately, one was a community sponsored childbirth education course

(provided by the Plunket Society in New Zealand), and one was a hospital based childbirth education course.

My observations were that despite the fact that women and their partners received valuable factual knowledge about pregnancy, and pain-coping strategies for labour and childbirth, women still expressed concerns about what options (like a shopping list) were available to help them to get through the labour pain, rather than 'going' naturally. Women focused primarily on possible problems that might arise and appeared to have developed a conflict between their own vision of a natural birth, their desires or needs to achieve a natural birth, and the technocratic medical options revealed in the childbirth education classes. It was apparent that women wanted to be prepared to birth their babies with confidence and were searching for ways to grow into motherhood. My understanding suggested that not knowing what to expect during childbirth and motherhood, and not having a good connection to their changing bodies and growing babies inside them raised emotions such as anxiety, fear and uncertainty. It was apparent to me that the information-sharing focus in the childbirth education classes I observed was inadequate.

There is an underlying assumption that the transfer of knowledge and skills training has major influences on behaviour changes that will in turn affect psychological and physiological outcomes (Gagnon & Sandall 2007; Jaddoe 2009). This assumption would incorrectly minimise other significant key variables such as women's own values, their own beliefs around labour and birth, or their available support people. A Cochrane review showed that the translation of skills from antenatal education into practise has no consistent effect (Gagnon & Sandall 2007). A recent study by Levett and colleagues (2016) asserts "the reorientation of antenatal education and the promotion of birth as a normal physiological event are critical if we are to reduce interventions in birth. This shift requires education and support to help women manage challenges faced during labour and birth" (p. 8). This assertion is in alignment with the underpinning philosophical approach that led to the study described in this thesis. There is a need for a very different kind of approach to the design and delivery of preparation for

childbirth if we are to truly prepare women for the uncertainty of labour and birth and becoming a mother, with confidence.

Positioning myself in the research

I am a qualified, registered midwife as well as dance/movement therapist and the novel childbirth preparation workshop developed and tested in this study is underpinned by knowledge from both professional fields of study. I have a professional qualification in dance/movement therapy gained in Germany in 1996. I am not a currently practicing member of DTAA. I am an associate member as I no longer actively practice in this area. I am a practising clinical midwife and my work is informed by my training and experience of dance/movement therapy.

Summary

This chapter has provided the background to the thesis. After observation and research I found the current childbirth preparation courses are somewhat inadequate in that they do not address childbirth from a holistic perspective. They do not adequately address the interconnectedness of physical and emotional aspects of childbirth. The next chapter gives an overview of the current literature about childbirth education classes.

CHAPTER TWO: A REVIEW OF THE LITERATURE

Introduction

Childbirth education classes have evolved over the past sixty years and moved away from childbirth education to a more broad centred approach to antenatal/ parenting education (Svennson, Barclay & Cooke 2008). Similar to what is found in the literature, both terms, 'childbirth education classes' and 'antenatal education classes' will be used interchangeably here. A qualitative study in Ireland by Murphy Tighe (2010), explored the attitudes of sixteen first time mothers towards antenatal education from the perspective of attenders and non-attenders. The focus group interviews revealed, that the majority of women attending classes in this study, in both the public health care system and the private sector, were almost invariably white, well-educated, middle-class women; a finding that has been confirmed in several other studies (Dwyer 2009; Gagnon & Sandall 2011; Koehn 2008). Murphy Tighe's study also revealed, even in this group of women, there are many barriers to attending antenatal education classes including class sizes, didactic teaching methods, timing of the classes, and the reluctance of the woman's partner to attend.

Over time and due to increasing demands from government and women themselves, many variations in antenatal education classes have developed. Today, classes may vary in number of hours, aim and focus, content and format, philosophy, educator training and sponsorship (Dwyer 2009). A lack of widely adopted standards or guidelines (Jaddoe 2009) as well as methodological issues makes the evaluation of antenatal education challenging (Dwyer 2009; Koehn 2008). Therefore there is little research that has established the value of antenatal education classes and any impact on maternity outcomes is questionable (Gagnon & Sandall 2007).

The majority of published studies have evaluated the effectiveness and the impact of women attending standard antenatal education classes on the outcomes of pain relief, the course of labour (Bergström, Kieler & Waldenström 2009; Ferguson, Davis & Browne 2012) and birth outcomes (Hajian et al. 2012; Levett et al. 2016). Other studies have considered whether classes raise women's self-confidence and self-

esteem in relation to their ability to cope with labour and childbirth (Consonni et al. 2010; Dunn et al. 2012; Fabian, Rådestad & Waldenström 2005; Gangnon & Sandall 2011; Hajian et al. 2012).

More recently, researchers have investigated whether antenatal education classes meet the women's perception of childbirth education in general (Bergström, Kieler & Waldenström 2011; Fabian, Rådestad & Waldenström 2005; Fisher et al. 2012; Koehn 2008). Researchers repeatedly state that the effect of standard antenatal education classes on various outcomes, in particular normal childbirth or parenthood, or both, remains unknown (Deave, Johnson & Ingram 2008; Gangnon & Sandall 2017; Gagnon & Sandall 2011; Jaddoe 2009).

Searching the literature

A literature search was undertaken using the search terms "antenatal education", "childbirth education", "childbirth preparation", "childbirth education and consciousness", "antenatal education and psycho-prophylaxis", "antenatal education and mindfulness". The review was conducted via an electronic search through the databases of Medline, CINAHL, PubMed, Proquest and the Cochrane database with the search period restricted to the years 2003 to 2016. Twelve articles were located for review. A manual search of the reference lists of relevant articles and a random search in Google scholar produced an additional 15 articles, which are also reviewed here. The review of the literature is divided into five sections; effectiveness of standard antenatal education; women's perception of antenatal education, antenatal education with integration of psycho-prophylaxis, antenatal education with integration of mindfulness practice, and pregnant women and self-confidence.

Effectiveness of standard antenatal education

Standard antenatal education classes offer women and their support partner the chance to build up an extensive knowledge base over a certain period of time. Typically, standard antenatal education classes are characterised by transferring information through a rational, logical approach surrounding pregnancy, labour and childbirth, and early parenthood. A large national cohort study of 1197 women

conducted in Sweden by Fabian, Rådestad and Waldenström (2005) revealed that the majority of women (74%) found childbirth education classes helpful in preparing for childbirth, however, provided no evidence that participation in standard childbirth and parenthood education affected first-time mothers' experience of childbirth and parenthood. Furthermore, the study indicated that women who attended antenatal education had a higher rate of epidural analgesia (50% of attendees versus 41% of non-attendees) which suggested that classes made women more aware of the available pain relief techniques rather than paid attention to women's own pain coping strategies. A subsequent randomised controlled trial, which involved 1087 Swedish women, did not confirm this finding (Bergström, Kieler & Waldenström 2009). This study compared childbirth education classes integrating interventions of breathing and relaxation techniques with standard childbirth preparation. The main finding was an epidural rate of 52% in each group (Bergström, Kieler & Waldenström 2009). This is in stark contrast to the most recent study located, published by Levett et al. (2016), who conducted a randomised controlled trial of an antenatal education programme that aimed to reduce the epidural rates in low-risk first, first time mothers. The programme was based on a range of evidence-based complementary therapies such as acupuncture, visualisation and relaxation, yoga, breathing techniques, massage and facilitated partner support. The results show that the epidural rate from the study group was significantly lower (23.9%) in comparison to the control group (68.7%), women were significantly less likely to require augmentation (28.4% compared to 57.8%) and the caesarean rate was almost halved (32.5% compared to 68.2%).

An earlier structured review of six randomised controlled trials and four observational studies carried out in Spain, Sweden, Canada, Australia, Iran, UK, Thailand and the USA (Ferguson, Davis & Browne 2012) identified that women who participated in antenatal education classes were more likely to have less false labour admissions, were more likely to arrive at the hospital in established labour and to experience less anxiety. However the study also found that the women were more likely to experience increased labour and birth interventions such as induction of labour and the use of epidural analgesia. This study therefore confirmed the findings of the 2005 study by Fabian and colleagues (2005). Arguably, overloading women with factual information

based on a biomedical model, promotes dependency and pressure to comply with hospital procedures, which removes women's freedom of choice and confidence (Murphy Tighe 2010). Walker, Visger and Rossie (2009) claim that antenatal and childbirth education classes place the emphasis on institutional policies instead of inspiring women's confidence towards labour, birth and early parenthood. These studies suggest that there might be certain increased risks for women attending fact based antenatal education classes.

The studies in this area were all well designed and had sufficient power to provide reliable data. Therefore it appears that standard childbirth preparation classes that consist of information giving over a period of time, which aims to reduce childbirth interventions, may actually increase the use of some interventions. The mechanism by which this occurs is unknown but it is reasonable to suggest that it could be a result of decreasing rather than increasing women's self confidence in their own ability to labour and give birth. The study by Levett and colleagues (2016) that used a range of alternative or complementary therapeutic approaches stands as an example of what could be achieved with approaches that integrate mind and body.

Women's perceptions of antenatal education

Women attend antenatal education classes to become informed about pregnancy, to reduce their uncertainty, to reduce fear or anxiety around labour and childbirth, to increase confidence, to have their questions answered, and especially to meet other expectant parents (Dywer 2009; Fabian, Radestad & Waldenström 2005; National Institute for Clinical Excellence 2008; Steiner Celebi 2006). A grounded theory study by Koehn (2008) was performed to explain how nine women interpreted a programme of standard childbirth education in the process of preparing for childbirth. The study findings indicated that the value of childbirth education might not lie in an effect on childbirth itself; however, it rather supports women to be ready for childbirth.

Svensson (2005) performed a large Australian doctoral study and looked into the effectiveness of current antenatal education classes. A needs assessment was performed to explore the concerns and interests of first time expectant parents and to

determine the learning process that best suited parents. The research provided rich data, based on expectant parents' surveys, interviews, focus groups and participant observation of antenatal classes. It showed that women favour and benefit most from participating in small homogenous groups, which meet regularly over a period of four to eight weeks, where the education is based on the principles of adult learning.

Adult learning builds on the richness of the already gained life experience of every adult and acknowledges the adults' right to determine what they need to know. Women want the opportunity to share, support and learn from other women's experiences and ideas. Being actively involved in learning through communication, discussions, and learning by experiencing was another request. Several studies in countries other than Australia have supported Svensson's (2005) findings (Murphy Tighe 2010; Schrader McMillan, Barlow & Redsham 2009; Steiner Celebi 2006).

Men and women's expectations and their needs of antenatal education classes differ from each other, but each gender preferred small participant-led groups which provided space to address their individual needs and concerns (Schrader McMillan, Barlow & Redsham 2009). Both women and men appeared frustrated and anxious when their information needs were not met (Svensson 2005). Men appear to be more interested in factual information such as child development whereas somewhat unsurprisingly, women expressed a need to gain self-confidence and the ability to cope with labour and childbirth (Maloney 1985). Nineteen years later, a study by Jaddoe (2009) confirmed that the lack of inclusion of fathers from antenatal education and inadequate preparation remains a concern to both women and their partners.

Antenatal education with integration of psycho-prophylaxis

A growing body of literature has emerged comparing standard antenatal education classes which are characterized by transferring information through a rational, logical approach, with antenatal education programmes where body-mind interventions such as training in psycho-prophylaxis (breathing and relaxation techniques), or physiotherapeutic and interaction activities are incorporated. Psycho-prophylaxis is

based on relaxation as a trained response to labour contractions and is coupled with various patterned breathing techniques. This literature is explored in detail below.

A non-randomised controlled trial by Cosonni et al. (2010) examined a “Multidisciplinary programme of Preparation for Childbirth and Motherhood” (MPCM) to determine its impact on maternal anxiety and perinatal outcomes in pregnancy. The trial included 67 nulliparous pregnant women, divided into two groups (MPCM group; n=38) and (control group: n=29). The MPCM interventional programme consisted of ten meetings, with each meeting lasting three hours, and comprising three interventions: educational, physiotherapeutic and interactive sessions. The educational component provided information on pregnancy, birth and the postnatal period. The physiotherapeutic activities included respiratory training, postural orientation for daily activities, muscle stretching and relaxation techniques and the interactive sessions offered the option for women to discuss their emotional experience involved in the journey of becoming a mother. The control group, with no participation in MPCM or any other childbirth preparation programme, was defined by maternal age, marital status, schooling, current activities such as study and working, and social support in regards to any emotional financial and/or practical support. The results of this study showed that the MPCM intervention was associated with lower State-Anxiety levels measured in the third trimester (31.1 % MPCM group versus 44.2% control group). The occurrence of vaginal childbirth predominated in the MPCM interventional group (81.6% versus 56.6 % in the control group) and the incidence of caesarean section predominated in the control group (41.4 % versus 18.4% MPCM group). Both findings were statistically significant. However this was a non-randomised controlled trial and insufficient information was provided as to how women were allocated to each group so it was not possible to assess the potential for biased assignment to intervention or control groups. However, these results do confirm the validity of the multidisciplinary programme.

A cohort study from Sweden showed contradictory results. Bergström, Kieler and Waldenström (2010) investigated whether the use of psycho-prophylaxis during labour affects the course of labour and experience of childbirth in 857 nulliparous women.

This non-randomised cohort study compared the course of labour and the experience of childbirth between women who used psycho-prophylaxis during labour and those who did not. No significant differences were found in the length of labour (adjusted odds ratio (OR) 1.32; 95% confidence interval (CI) 0.95-1.83), the fear of childbirth (users 15.7 % versus 18 % non-users), and the fearful childbirth experience (users 8.9 % versus 9.6% non-users). The women who used psycho-prophylaxis had a lower risk of emergency caesarean section (adjusted OR 0.64; C I 0.43-0.94) compared with women who did not use the method and users had a higher increased risk of labour augmentation (OR 1.67; CI 1.26-2.21), a longer mean duration of labour (users 11.9 versus 10.4 hours non-users) ($p = 0.05$). However the study is limited by the non-randomised study design, as each cohort may possess different, uncontrolled-for characteristics that influenced the differences in outcomes.

An earlier randomised controlled trial by Bergström, Kieler and Waldenström (2009), found that the integration of psycho-prophylaxis in antenatal education had no effect on subsequent use of epidural analgesia and labour outcome and no effect on the fear of childbirth experience. Both studies reveal that the use of psycho-prophylaxis during pregnancy is not effective in reducing women's fear of childbirth, women did not associate the use of psycho-prophylaxis with a more positive birth experience and psycho-prophylaxis did not reduce the women's need of pharmacological pain relief (Bergström, Kieler & Waldenström 2009; Bergström, Kieler & Waldenström 2010). Other body-mind integrative interventions have also been examined as described in the next section.

Antenatal education with integration of mindfulness practices

Mindfulness is an emotional non-reactive state, which involves purposeful and conscious direction of the participant's awareness of the present moment of experience with a non-judgmental attitude (Byrne et al. 2014; Kabat-Zinn 2012).

A small randomised controlled trial pilot study in Australia explored the effect of an eight-week Mindfulness-Based Cognitive Therapy (MBCT) class on eleven pregnant women. The results revealed that 75% of the women who participated in the MBCE

programme experienced a decline in stress symptoms and anxiety, and a positive change in their level of self-compassion (65%), whereas little change was noticed within the control group (Dunn et al. 2012). This was confirmed by a small pilot study by Bryne and colleagues who investigated a mindfulness-based childbirth education programme in 2014. The data provides results from 12 pregnant women revealing that mindfulness and skill-based childbirth education was associated with women feeling an increased sense of control and confidence in giving birth, were less fearful of birth, and their expectations of achieving a positive birth were increased.

Duncan and Bardacke (2010) conducted a mixed-method observational study with 27 women attending a Mindfulness-based Childbirth and Parenting programme (MBCP) during their third trimester of pregnancy. The MBCP programme was intended to help the participants' to practise being connected to the present moment to foster the development of greater confidence and a deeper sense of well being during the journey of becoming a mother. Participants completed self-reported, pre-intervention, questionnaires in late second/early third trimester and post-intervention questionnaires in late third trimester. They also provided a qualitative description of their experience of pregnancy, childbirth and early parenthood and their use of the course skills. Findings indicated a statistically significant increase in mindfulness ($p < .0001$), and nonreactive subscale of mindfulness ($p < .0001$) coupled with a decrease in pregnancy anxiety ($p < .0001$) and depression ($p < 0.016$).

Similar changes were described in a qualitative study conducted in Australia by Fisher et al. (2012) who used focus groups that included eighteen women and their birth support partners. The study identified that mindfulness-based childbirth education programmes (MBCE) empowered women to be more confident during their actual labour and birth and to become active participants in their own birth process. It is important to note that mindfulness-based interventions do not target symptom reduction but rather their primary aim is to increase participants' psychological flexibility (Dunn et al. 2012). Mindfulness can therefore induce a state of relaxation but is not designated in and of itself as a relaxation technique that fosters thinking; it is a state of being, a state of awareness as well as a state of feeling (Kabat-Zinn 2013).

Antenatal education classes increasingly integrate body-mind modalities as non-pharmacological approaches for women to minimize symptoms related to stress or reduce women's anxiety or fear towards labour and childbirth. Beddoe and Lee (2008) conducted a systematic review that examined published and unpublished evidence of body-mind interventions during pregnancy on perceived stress, mood, and perinatal outcome. Twelve out of 64 published studies between 1980 and 2007 met their inclusion criteria. The findings revealed that women experience health benefits from the integration of body-mind interventions in conjunction with conventional maternity care. However, the reviewed studies exhibited multiple methodological limitations.

It is noticeable that the literature in this area has gradually shifted from studies investigating the impact of standard antenatal education to a new focus on antenatal education that integrates body-mind interventions. Current studies focus on maternal stress reduction, and maximising healthy birth outcomes (Beddoe & Lee 2008). Common body-mind strategies are, for example, psycho-prophylaxis (relaxation and breathing techniques), meditation, yoga or mindfulness. Despite multiple methodological issues, research shows that most authors' focus on the transferred factual knowledge and methods that women can be taught to use as a buffer against their stress, or women's fear or anxiety toward labour and birth.

When knowledge based on 'information transfer' or 'stress coping techniques' is the centre of the teaching rather than the pregnant woman with her own unique needs, then the question must be asked about the impact on women's emotional and physical wellbeing.

Pregnant women and self-confidence

Self-confidence can be defined as a belief in oneself and in one's own abilities (Merriam Webster 2017). If self-confidence is the focus of consideration, Barbalet (1993, p. 230) states 'self-confidence is predicated less on knowledge as factual information and more on a form of self-understanding which generally operates below the threshold of awareness.' The knowledge of self-confidence is essential to engage the person with the feeling about his or her own capacities to what has been set out to

achieve in the future. The development of self-confidence in their ability to cope with labour and childbirth is arguably a strong motivating factor for women to attend antenatal education courses. However, only one study have been found on how and when women's self-confidence in their ability to cope with labour and childbirth might develop (Kish 2003).

When and how women's self-confidence develops was the focus of a quasi-experimental, multi-time series study conducted in the United States of America by Kish (2003). The data were collected through convenience sampling of 46 nulliparous women who completed three mailed questionnaires (at 8-12 weeks gestation, 28 weeks, and 37 weeks) and a postpartum interview. Kish identified that a relationship might exist between maternal confidence and self-perception of childbirth; however, no connection exists between fulfilment of childbirth expectations and women's confidence toward labour and childbirth. Furthermore, when women were asked postpartum about what they would change in regard to their experience of childbirth, improved self-knowledge was a common answer. When women develop self-confidence in their ability to cope with labour and childbirth, and what contributes to women's perception of self-knowledge is not yet fully understood and further studies are recommended (Kish 2003). This is the area that my study has addressed.

Summary

The review of the literature leaves the impression that, to date, childbirth education classes miss the point of what women really need and what they really want. The effect and success of these approaches is measured by the birth outcome only, that is by the extent or lack of intervention that was necessary, by the amount of medication that had to be administered, and the health of the newborn baby. However, how women perceived their own childbirth and how satisfied and fulfilled they were has not been taken into account.

Furthermore, it is evident that the emphasis of mainstream childbirth education classes is on the delivery of knowledge. This is not a woman-centred approach – on the contrary – it creates a subtle dependence on the medical system as all the information

given to the woman is directly or indirectly derived from what the medical model of childbirth has to offer. Supplying women with their own independence and establishing their self-confidence and faith in their natural birth instinct is clearly not on the agenda of those courses. As midwives commonly experience however, it is these very qualities that can determine how well and satisfactorily a woman births her baby.

This research project proposes a new woman centred childbirth/antenatal programme that is based on the hypothesis that the degree of a women's self-confidence and her connection to her physical (motion), emotional and spiritual body are the paramount conditions for a fulfilling and successful childbirth. The next chapter describes the study design in detail.

CHAPTER THREE: THE WORKSHOP

Introduction

This chapter presents the curriculum content and the conceptual and empirical foundation of the 2-day preparation for childbirth workshop developed for this research project. The workshop is based on a number of concepts derived from several disciplines including midwifery (Cioffi et al. 2010; Hauck et al. 2016), childbirth education (Varner 2015), art therapy (Uppal et al. 2014), dance/movement therapy (De Tord 2015), Kundalini yoga (Remer 2012), mindfulness-based meditation (Duncan & Bardacke 2010; Hauck et al. 2016) and social cognitive neuroscience (Rock 2008). An underpinning concept is that human beings are fundamentally social beings who want to belong to a collective group (Rock 2008). We feel safest in a group and our anxiety is lowered therefore this is the ideal format for a workshop that aims to reduce women's anxiety and enable a positive and life-enhancing approach towards the birth experience they are about to undergo. The chapter provides a description of the activities undertaken on each of the 2-days of the workshop and provides the underpinning disciplinary justification for the inclusion of each of the components. The aim for the inclusion of each aspect of the workshop is clearly articulated so that the reader can follow the intent of each component as well as how these might be very different to traditional childbirth education or preparation for childbirth courses. The chapter begins with a description of the setting and then the framework for the workshop.

Workshop setting

One important distinction between the proposed childbirth preparation workshop and many other classes was the careful thought and attention given to the location and ambience. A place needed to be found which was very different to the classroom-like setting of many traditional childbirth education courses where participants may sit in rows to listen passively to a lecture – or in some less traditional settings where they may be invited to sit in a circle on cushions on the floor to help them relax and to use their body in a very different way from sitting in chairs. Conventional childbirth

preparation classes are often held in health facility ‘territories’ such as hospitals or community health care centers that emphasise the medical model of childbirth in the minds of some participants, a perception that may create anxiety (Varner 2015).

The location and the ambience

Planning for the environment where the workshop took place was therefore an important consideration. A non-threatening environment needed to be established so that the participants felt safe and comfortable in order to share their experiences without fear of judgment (Hennink 2007). The childbirth education literature suggests a calming and stress-reducing physical environment needs to be well considered by the facilitator (Hennink 2007).

The place chosen was the New Zealand College of Midwives’ community house located in suburban Auckland. This is a non-medical space. It consists of two small rooms with bathroom and kitchen facilities and one large, open meeting room. I furnished the large room with yoga mats, body pillows, exercise balls, a journal for each woman called ‘all about me and my baby’, flowers, candles, materials for creative work such as coloured pencils and paper for writing and drawing, and educational resources such as baby doll, model pelvis and placenta for active midwifery teaching (See Illustration 1 below). The room was painted a calming soft yellow and there was no advertising or other material on the walls (which is likely to be present in institutional settings). There was ample space for each woman to walk around or lie down or sit with others comfortably. This location aimed to create a safe, welcoming and homelike space to give women the reassurance that pregnancy/childbirth is a normal life event and not an illness. It was an environment that encouraged equal social status between facilitator and participants (Rock, 2008), and where there was no evidence of political, religious or institutional power. This place aimed to provide women with opportunities to express their diversity and different realities, lives and socio-economic roles and it invited women to move (walk, dance, lie down or stretch), feel a range of emotions, explore how their bodies could move, and explore their minds and their dreams. In short, it was a place where women could be themselves. It was also a place that

encouraged creativity and supported the journey of cognitive, emotional and physical self-discovery (Hennink 2007).



Illustration 1: The workshop room setup.

Framework for the 2-day workshop

The workshop was designed as a 2-day intensive or ‘immersion’ experience rather than 2 hours per week across a number of weeks, which is a more traditional timeframe for childbirth education courses. The rationale for the 2-day format was that women not only needed uninterrupted time, they also needed a continuum of time in order to ‘tune into’ or listen to themselves and understand how their body, mind and emotions are connected, are interdependent and influence each other. Feeling confident about childbirth is not a question of age or maturity. It depends on how the woman’s personal experiences have been integrated, and on reflection, how she sees herself, how closed or open she is to the given situation, and how she handles herself, emotionally and physically, during a potentially insecure or stressful situation such as childbirth. When women experience pregnancy and childbirth as fearful, simply offering good advice or providing science-based information might not be sufficient support for what lies ahead. Whereas when women feel emotionally and physically competent they can develop the ability to perceive, modify and constructively deal

with their emotions and physical ability in any challenging situation. Conventional classes are directed mostly towards intellectual activity concerned with learning as much as possible about childbirth (Varner 2015). The workshop is not about perfection or knowing everything. It's about women being reflective about handling their own personal limits, knowing their own strengths and their dreams around their own childbirth experience.

In this workshop women will be enabled to explore their own emotional and physical world to develop their own personal resources, named 'tools'. The process was underpinned by the belief that each woman would personally learn and grow best when the mind is addressed, when positive emotions are activated, and when the physical (pregnant) body is understood and integrated into the process (Steiner Celebi 2006). Conventional classes aim predominantly at filling the mind with facts while more modern classes might devote aspects of their teaching to the mind and to the emotional part of childbirth using techniques such as hypnotherapy (Cyna, McAuliffe & Andrew 2004). However few consider the way that physical movement integrates the body, mind and emotions. Therefore in this workshop learning was initiated on all three levels, the body (physical plane), mind and emotions connected in equilibrium (Steiner Celebi 2006). The workshop was designed to move beyond teaching evidence-based knowledge and performing exercises. Personal development on all three levels, mind-body-emotion, was integral to the workshop. And in order to achieve this an intensive two-day workshop was chosen.

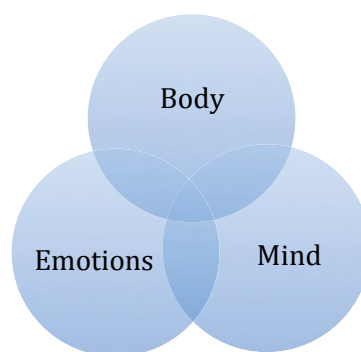


Figure 1: The three integrated components of the Workshop

The following Table 1 details the components of each of the two days as well as presenting the aim for each component and supporting evidence from its disciplinary source. While the programme suggests a linear progression with each element following the other in an orderly fashion, in practice the programme was much more dynamic as the group and facilitator responded to questions and the needs of the women. By the close of the 2-day workshop each component had been completed.

Table 1: Framework for the 2-day preparation for childbirth workshop

Day of workshop	Component	Aim	Supporting Evidence
Day 1	Introductions: Women getting to know each other	<ul style="list-style-type: none"> To provide a warm and respectful welcome and authentic engagement. To foster a sense of belonging 	Rock 2008
	Creating a safe space	<ul style="list-style-type: none"> To provide a physical and metaphysical environment conducive to effective communication 	Hunter 2008
	Storytelling from the women's perspective; Introduction to theme/topic	<ul style="list-style-type: none"> To model the process of active listening in order to learn from each other To develop empathic understanding and build trusting relationships. 	Black 2008; Grisham 2006; Hoppe 2007
	Meditation in motion (Breathwalk™)	<ul style="list-style-type: none"> Introduce body warm-up, body and breathing awareness and movement therapy 	Khalsa and Bhajan 2008
	Evidence-based knowledge regarding pregnancy, labour, birth and the postpartum period, and includes anatomy and physiology of pregnancy and childbirth, breastfeeding and early infant care	<ul style="list-style-type: none"> To provide factual information and evidence of effective labour and birth practices that may assist progress in labour and increase the likelihood of vaginal birth 	Evidence of effective practices from midwifery and obstetric research in Cochrane Library of perinatal randomised controlled trials
	Fostering realistic expectations through objective knowledge combined with storytelling from midwifery practice about women's experiences	<ul style="list-style-type: none"> To foster realistic expectations of childbirth and early parenting. To enable women to make informed choices from available options. 	Midwifery practice/experiential knowledge
Day 1	Exploring attitudes to challenges and change towards labour and birth through art and creativity Improving self-knowledge through movement interventions and	<ul style="list-style-type: none"> To increase women's receptiveness to change and for learning new ways of being and coping. To immerse women into a state of 'not-knowing' To raise women's determination and 	Hunt 1998; Steiner Celebi 2006

	repetition rituals	ability to 'see' more clearly – develop new perspectives and meanings	
Day 2	Practising mindful meditation	<ul style="list-style-type: none"> To create a sense of physical, emotional and spiritual presence and strength To increase moving and breathing awareness. To increase awareness of physical and emotional change 	Jain et al. 2007; Fisher et al. 2012; Hauck et al. 2016
	Immersion in personal movement repertoire, signatures and metaphors (using movement therapy and repetition rituals) Dance/movement therapy knowledge and experience Nurture mother and baby bonding	<ul style="list-style-type: none"> To foster taking responsibility for themselves To build an understanding of the connection between mind and body To prepare women, physically and emotionally for labour and birth To build confidence in their ability to give birth To build a strong bond between the mother and her unborn child 	ADMP UK 2003; Meekums 2003; Steiner Celebi 2006; Kish 2003; Kestenberg 1980; Kluny & Dillard 2014
	Increase knowledge of art based approaches	<ul style="list-style-type: none"> To foster creative thinking To understand personal meaning To develop imagination To explore and express emotion and feelings 	Dalley 1987; Goldie 2005; Hunt 1998; Naiman 2016; Railey 2001

In the following section I provide further details of each component

Creating a safe space

A safe space (physically and metaphorically) supports women's freedom to express their individual thoughts, hopes, fears and wishes around childbirth. It is a space where women feel welcomed and are relaxed; each woman feels safe despite her background (race/ethnicity, culture, religion), age, personal expression, physical or mental ability, and childbirth orientation (Hunter 2008).

Physical and metaphysical environment

In order to provide a physical space in which women would feel comfortable and safe there were several factors kept in mind. It is known that the immediate external environment, the physical surroundings, send influential messages to the subconscious mind and contribute to the behaviour of individuals within the space (Lepori, Foureur & Hastie 2008; Tortara 2006). Therefore, when choosing a space in which to hold the workshop several criteria needed to be met. For example, was there enough space for women to physically move around easily? This was important to consider because when women explore their individual physical movements and energy levels; when they move their body in space; when they gain awareness about body boundaries, they will discover how much physical space they need around their bodies to actually feel safe and protected. This deeper experience of self, largely through the body, aims to create insight for each woman of her personal space needs regarding physical movement within the birthplace. The room therefore contained a mix of closed/contained (corners, nooks) and open areas or non-removable physical objects (Tortara 2006).

Other elements contributing to creating a safe place included having a clear, structured session plan that was communicated to the women so they knew what to expect thereby reducing uncertainty (Rock 2008); having well prepared material and props; paying attention to room temperature; the creation of rest and comfort areas; and scheduling refreshment breaks. Creating a safe space takes time and trust. Therefore, it was important that the workshop was long enough to accommodate the diverse trust-needs of the women, especially for women who have difficulties in opening up sharing their thoughts, ideas and feelings with others or for women who need more time before they are able to speak within a group.

In addition to considering the physical space for the workshop and the length of time needed for some women to feel trusting enough to speak in a group, I also considered the potential impact of non-verbal messages, both positive and negative, such as the facilitator's clothing choice.

The non-verbal messages of the clothes we wear

Childbirth educators or facilitators work in a variety of different settings. Some work for institutions such as hospitals and have their attire proscribed by their employer, and some work in private practice where they are free to choose their own attire. The style of clothing and the wearer's general appearance are interlinked with a person's identity, self-confidence (Howlett et al. 2013; Martin M., Martin J. & Sangster 1986) and his or her trustworthiness (Howlett et al. 2013). Studies have revealed that wearing a uniform separates the facilitator from class participants; it implies that the childbirth educator has the knowledge, and thus power, and uniforms are identified with the negative impact of the medical culture of childbirth (Kalisch B. J. & Kalisch P. A. 1985; Kelly 1985; Waller-Wise 2007).

Being aware of these powerful non-verbal messages influenced the facilitator to dress in smart casual clothes in order to foster open and honest communication, and to represent the midwifery philosophy of 'being in equal partnership and being with women'. Increasing awareness of non-verbal messages had the benefit of emphasizing other non-verbal means of communication that might have an impact on the women including facial expression, body language and tone of voice.

Repetition rituals

The power of repetition rituals will be used in the workshop. Repetition rituals have three underlying processes: stabilisation, communication and transformation (Wollin & Bennett 1984). The rituals fostering stabilisation are rituals repeated time-after-time in a familiar fashion. For example, the workshop greetings and goodbyes, the planned meal and resting breaks as well as the consistent presence of known group members. The rituals fostering communication are the mere fact of women coming together for dialoguing at the same time, over two days, for the same purpose. The rituals fostering transformation are the rituals associated with the transitional period from one state of being to another which motivates women to seek this experience, again and again. The rules and the structure, which set in place, make a safe environment for women to share their thoughts, feelings and emotions (Wollin & Bennett 1984). In order to

provide sufficient time for repetition the best time to undertake the workshop would be between 24 and 32 weeks.

The workshop content

The content developed for the workshop draws mainly on the traditions of dance/movement therapy and the art and science of midwifery. Both professions share the same philosophy in that both disciplines believe that the body, mind and spirit are interconnected. Midwifery as well as dance/movement therapy uses a variety of techniques and styles to promote women's health, their well-being and to foster personal growth, especially when experiencing challenging circumstances such as childbirth. In the following pages I describe each component of the workshop with supporting evidence for the potential benefits of its inclusion.

Dance/movement therapy - An overview

According to the UK Association for Dance Movement Psychotherapy (ADMP), "Dance Movement (Psycho)therapy is the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration" (ADMP UK 2003, p. 1).

Dance/movement therapy (DMT) is a branch of creative arts therapy that is applied in a wide range of areas (Steiner Celebi 2006; Payne 2006). It is practised using different therapy styles and methods, dependent on the needs of the client, and can be offered to people of all ages, for group as well as for individual sessions. The session might be either structured or improvisatory, with or without music. Dance/movement therapy involves the therapeutic use of physical movement (motion). A core component 'body language', aims to help individuals reduce stress levels, improve body image, support emotional expression, and social interactions (Lumsen 2006). Moreover, DMT comprises techniques and strategies such as body action, kinesthetic empathy and rhythmic group activity to emphasise awareness, attention to inner sensations and target certain emotions and issues which foster verbal and non-verbal communication.

What made dance/movement therapy so unique for this workshop

The main principles of DMT are that there is a reciprocal body-mind relationship that means movement/motion and emotions are inseparable and interconnected (ADTA 2006). How we move influences our mind and vice versa and both are influenced by how we feel. The second principle is that the motion reflects aspects of our personality and unconscious processes. Thirdly, changes in movement facilitate changes in the state of mind. Lastly, the client-therapist or client-facilitator relationship is essential (Stanton-Jones 1992; Karkau & Sanderson 2006). In other words, the therapeutic use of movement supports the integration of the individual on all levels: emotional, cognitive and physical, social and spiritual (Payne 2008). DMT utilises an actively individualised, woman-centered approach, and offers a variety of techniques for self-exploration and expression, and emotional expression.

Introducing women in this workshop to the core body language aspect of Dance/movement therapy aimed to enable women to understand themselves in relation to their pregnant body/mind/emotions and how they could prepare for childbirth.

DMT describes the physical and emotional awareness and expressions and give and take of social interactions (Tortora 2006). The word 'dance' in dance/movement therapy can be used more or less metaphorically as there may be no 'dance' at all, an issue to which this thesis returns when discussing the findings of the study. Interestingly there are many terms used to describe DMT including "... dance therapy, movement therapy, dance-movement psychotherapy, movement psychotherapy, dance/movement therapy or dance-movement therapy" (Meekums 2012, p. 2).

Movement therapy uses the benefits of mild physical activity based on the belief that physical movement reflects an individual's pattern of thinking and feeling (Meekums 2012). Evidence reveals that dance/movement therapy reduces anxiety and postpartum depression (Dennis 2007; Cruz 1998). A Cochrane review by Mead (2010) also confirms that there is evidence of positive effects from using light physical activity

within a group, evidence that is so compelling that such activity is now recommended by the National Institute for Clinical excellence (NICE) in the UK in the NICE guidelines for depression (2010).

Within the workshop, light physical activity based on dance/movement therapy will be used in a number of different approaches. One approach is Authentic Movement, which is influenced by Jungian psychology (Whitehouse 1979), where the facilitator stands still and observes the woman's body movement (body signature / language). Another approach is a non-verbal technique between the facilitator and the women called 'mirroring'. The facilitator actively mirrors the characteristic movement of the woman as a way of achieving an empathic understanding and awareness about her own qualitative movements. As the workshop is not a one-to-one therapy session the mirroring technique will be slightly modified to not mirror the exact behavioral expression of the women's inner state (Berrol 2006). The third technique to be used is the activation of imagining being in labour and giving birth and experiencing this through the movement(s) women will have discovered about themselves. These three techniques will form an integral part of the workshop where women will be facilitated to discover their own body movement and position (women's birth signature) for labour and birth. As DMT asserts:

"Through acknowledging and supporting clients' (individual) movements, the therapist (facilitator) encourages development and integration of new adaptive movement patterns (movement flow) together with the emotional experiences that accompany such changes" (Association for Dance Movement Psychotherapy UK) (ADMP UK 2003, p. 1).

For women, being physically active and experiencing the psychological and physiological benefits for themselves and their unborn babies can be extremely motivating (Chasan-Taber et al. 2004; Derbyshire et al. 2008). Evidence from a number of researchers suggests that psychologically, women value the benefits of engaging with other pregnant women and value experiencing the relief of stress, tension and increased mental relaxation (Duncombe et al. 2009; Kolt & Nicoll 1999). Physical

movement also has a positive effect on women's state of mind during the postnatal period (Blum, Beaudoin & Caton-Lemons 2004).

Other therapeutic techniques

The workshop also included several other well researched techniques such as the use of mindfulness in relation to pregnancy and preparation for childbirth (Kabat-Zinn 2008; Fisher et al. 2012; Hauck et al. 2016); Kundalini yoga (Chuntharapat et al. 2008), conversational storytelling (Norrick 2000; Black 2008) and creative practices such as drawing and creative writing (Grisham 2006), applied as further expressive forms within the movement therapy technique. Each component is further discussed in the following pages.

Mindfulness meditation

Mindfulness meditation is integrated into the programme in order to enhance women's self-regulation mechanisms such as attention regulation, body awareness and emotion regulation. During mindfulness meditation it is the facilitators goal to assist women to maintain attention to their current internal or external experience in order to understand one's personal perception of self and environment. Evidence shows that mindfulness meditation is more effective on improving psychological well-being than relaxation; it reduces anxiety (Hofmann et al. 2010; Roemer, Orsillo & Salters-Pedneault 2008) and depression (Hofmann et al. 2007; Jean et al. 2007) and demonstrates significant pre-post decrease in both distractive and ruminating/behaviours (Jean et al. 2007). Therefore, integrating short sessions of mindfulness meditation during the workshop may help women's ability to shift and redirect their mind to the present moment, rather than thinking and worrying about the past or towards future events such as the impending childbirth (Fisher et al. 2012; Hauck et al. 2016). One study has suggested that in order to equip women with self-help tools, a brief training in this skill might decrease stress and also elevate women's positive mood states postnatally (Jean et al. 2007).

Breath-walking

Another technique accessed is 'meditation in motion' or 'BreathWalk™', which combines three simple activities, breathing, walking and attention. BreathWalk™ or meditation in motion is the practice of combining a specific pattern of conscious breathing synchronised with walking together in a systematic and meditative way to enhance physical, emotional and spiritual fitness (Khalsa & Bhajan 2008).

Cultivating breath awareness

Many childbirth educators, with origins within the yoga tradition, recommend certain breathing exercises to promote relaxation, emotional balance and self-regulation in women for labour and birth (Chuntharapat et al. 2008). However, cultivating breathing awareness and using simple slow and deep breaths is the approach to be taught during the workshop. Learning and practising breathing awareness during the workshop, which works at the prana-maya-kosha (bioenergetics body) through the ananda-maya-kosha (blissful body), aims to foster women's own breathing 'in and out' pattern/rhythm. A focus on the breath is recommended to use during labour and birth creating a state of altered consciousness and control (Chuntharapat et al. 2008). Women's own breathing pattern, used during contractions and rest periods between each contraction together with their own body movement pose, aims to foster calmness and relaxation, and supports the rhythm of contractions. Breathing in this way was used in synchronicity with women's physical moving in and out of their own positions (women's birth signature) during labour, facilitating an easier birth in two studies (Chuntharapat et al. 2008; Teasdill 2000). Women's own breathing rhythm combined with their own birth movement will allow women to be in control of themselves and therefore be more in control and active during their entire labour and birth experience. In order to increase women's capacity, 'to be with' the women's own breathing rhythm, regular practice of mindfully breathing in the available weeks before childbirth is strongly recommended (Duncan & Bardacke 2010).

Kundalini Yoga

Yoga practice is also incorporated into the workshop. Yoga aims to help women starting their journey of exploring and moving their bodies in different ways. Very simple yoga poses such as tailor-sitting, healthy sitting with spine straight, mountain pose or pelvis rocking will be silently incorporated into the workshop in order to increase awareness that labour and birth happens most profoundly through their bodies (Remer 2012). Yoga poses, body-scan meditation and movement therapy, are all disciplines that are in alignment with what Duncan and Bardacke (2010) state: “Noticing and moving into sensations during yoga practice, particularly sensations of stretching and contracting and noticing the times of ease and rest between poses, is mindfulness preparation for noticing the sensations of contractions and the moments of ease and rest between sensations during the labour process” (Duncan and Bardacke 2010, p. 194). Therefore, moving and using the body in a positive and familiar way may help women to develop trust and self-confidence that will support a healthy birth process (Remer 2012).

Creative practices

In order to embrace a holistic childbirth preparation model, where science and art become combined the workshop combines evidence based knowledge and intuitive knowledge. In the workshop women will explore their current ideas, visions, dreams and feelings in a creative way to support learning and expand knowledge about themselves. Integrating art into the workshop is mainly through creative thinking and writing and drawing. In the following section I provide examples of the creative practice included in the workshop. Their importance to the creative act of giving birth is echoed in the words of Uppal and colleagues who assert:

“Art is visceral and experiential and so is giving birth” (Uppal et. al. 2014, p. 312).

Creative thinking and writing

Engaging women in creative writing serves as a distraction from the worries and anxiety women express around labour and birth and offers new options through developing imaginary skills. Fostering imagination assists women to gain insight into the birth they desire for themselves and their babies. The particular creative writing activity is to write a letter to their unborn baby. This activity aims to nurture communication with their unborn babies and impact on pre-bonding. In order to maintain a holding environment, where women feel safe it was important to consider that creative writing encourages women to engage more closely with their inner life, and get in contact with their feelings and emotions. As Hunt states (1998), creative thinking and writing developed out of the desire to communicate and express one's self in all its complexity.

Conversational storytelling

The conversational storytelling component of the workshop concentrates on the beneficial interaction of the woman who tells the story (storyteller) and the other women (the listeners) of the group. Within the safe environment created for them women are enabled to engage and share parts of themselves through their personal stories. This interactive process of sharing stories, created by the storyteller (narrator), fulfils multiple simultaneous purposes (Norrick 2000). First, storytelling promotes women's dialogue and reveals aspects of the women's identity (Black 2008). Women's stories contain their personal experiences and events of pregnancy, and reveal their attitude, values and beliefs around pregnancy, birth and motherhood. It is important for the storyteller to make sure they have been understood, and to welcome interruptions such as being asked questions for clarification and receiving comments from the other women/ listeners. The joint participation in storytelling can lead to a response or redirection from one story to another as someone else becomes the co-storyteller. Such shared conversational storytelling helps the group to gain awareness and understanding of each other's journey, increasing connections as well as educating one another.

Evidence-based knowledge

As in the programme of mindfulness-based childbirth education designed by Duncan and Bardacke (2010) the teaching within the workshop is fully integrated with current knowledge of psychological and physiological pathways of labour/ birth and postpartum needs of mother and baby. The goal is to provide a programme that offers relevant evidence based knowledge, similar to conventional childbirth education courses, however in a more holistic and women-centred approach. The integration of evidence-based knowledge within the workshop will focus more specifically on women's individual needs and circumstances. This women-centred teaching and learning is understood as a transactional and transformative process. The facilitator aims to prompt conditions of integration such as fostering dialogue, story telling, or simply offering plenty of time for women to ask questions and receive answers (Mennin 2010).

Sharing “knowledge does not exist objectively ‘out there’; rather, it exists as a result of the exchange between participants” (Mennin 2010, p. 20). Therefore knowledge will be shared between the women and also between the women and the facilitator, rather than being contained in one (the facilitator) or the other (the women) (Mennin 2010).

Teaching/Learning Processes used throughout the workshop

Several educational processes will be used in the conduct of the workshop. The workshop embraces the concept of experiential learning, fosters social engagement and aims to influence self-awareness of the body and the emotions and to create a positive attitude towards childbirth. Overall the strategies combine in order to build self-confidence in each woman so that she has a trust in her own strength and ability to labour and give birth. In the following section each of these processes is explored.

Experiential learning

Experiential learning means exploring and creating a new experience that offers a new way of knowing, relating and making sense in the world we are living in. For the

women the experiential learning approach will involve stepping out of the familiar and gaining new awareness about themselves, physically and emotionally. The underlying concept of experiential learning is based on women experiencing themselves with creativity, spontaneity and play, gaining a new insight into the universality of emotional, physical and intellectual states of 'being'. Experiential learning through playing with different thoughts and visualization of different ideas or scenarios, triggers the mind to experience and learn. Through the playfulness of movement using either familiar movements or previously unexplored movements and postures, the body is triggered to experience and learn. Both visualization and movement affects feelings and emotions through 'reflection on personal reactions' leading to a greater personal awareness.

Fostering Social Engagement

One of the main aims of the workshop is to facilitate engagement. Engagement can be defined as, "...a state of being involved, occupied, fully involved or engrossed in something" (Higgins & Scholer 2009, p. 7) and also as, sustained attention (Scholer & Higgins 2009). This experience is connected to the concept of flow, which contributes to happiness, joy and therefore well-being (Higgins 2006).

Women engage with each other through talking together, sharing stories and experiences, making eye contact, moving their bodies or listening to sounds. When women increase engagement with other women during pregnancy it appears the group contact also brings women psychologically together (Smith 1999). According to an authority in the area, "...increasing psychological engagement with significant others can facilitate psychological preparation for mothering" (Smith 1999, p. 417). Duncan and Bardacke (2010), who set up a mindfulness-based preparation for childbirth programme, highlighted the importance of women building relationships and engaging with each other in order "...to reduce the potential negative impact of social isolation on the mental health of [women] in the postpartum and early parenting period" (p. 193). Although the mindfulness programme had some elements in common with the proposed workshop, the available time the mindfulness programme offered for relationship building differs significantly from the workshop.

The mindfulness programme offered a 15-minute snack break in each class for building relationships, whereas relationship-building and women engaging with each other is an essential element of the workshop that will be actively nurtured throughout the two days.

Fostering women's engagement in their personal experience and its meaning was a core element of the workshop. The techniques offered, grounded in movement therapy, art and mindfulness, all support the concept of the flow experience. Higgins (2006) states that experiencing flow might involve active or mental effort, whereas the experience itself is regarded as positive and effortless. Experiencing movement-based interactions engages and connects women with their own individual movement, creating awareness of the resources their body offers (Pylvänäinen, Muotka & Lappalainen 2015). This active and mental effort aims to assist the women to access their personal flow state.

Self-awareness of the body

The workshop aims to increase women's physical awareness of their own body, firstly through a Body scan meditation followed by discovering their habitual own body language/ movements (movement signature) attained through movement therapy. The body scan meditation, as described by Duncan and Bardacke (2010), is an awareness practice where women learn how to move their inner attention systematically through the body, starting from the top of the head down to the feet. This awareness practice introduces the quality of being in the present moment, step by step moving through the body and gaining awareness of unpleasant as well as welcomed physical sensations in various parts of the body. Feeling inner body sensations, learning 'to be with' those sensations, recognising and accepting them without acting on them, enables women to experience "physical sensation[s] arising and passing, moment-by-moment" (Duncan & Bardacke 2010, p. 194; Fisher et al. 2012). This concept of 'being' moment-by-moment, which is a core aspect of mindfulness practice, is particularly beneficial during labour. When a woman experiences a challenging physical sensation, such as the sensory component of the contraction/labour pain, the sensation can be uncoupled from any disempowering

emotions such as fear or anxiety. Learning and practicing 'to be in the present moment' increases women's body and sensory awareness, and during the workshop women will be given opportunity to learn how mindfulness practice can be used to their advantage.

Cultivating self-awareness of the body also encourages women to bring mindful presence towards their individual physical movements. In order for women to discover their own familiar and habitual physical movements and body positions (called their individual 'body signature') movement therapy offers several tools. Once women have recognised they have established their own physical movement and posture for labour and birth they will be encouraged to practice mindfully moving in, being with and moving out of their own posture, again and again.

This repetitive practice, which is based on mindfulness and movement therapy, will assist women to relax knowing how to let unpleasant physical sensations such as labour pain arise and pass and how to comfort themselves in between contractions (Jain et al. 2007).

Self-awareness of emotions (feelings)

Coping with disempowering emotions such as fear of childbirth are often accompanied with the desire to learn control-based strategies aiming to decrease or suppress the intensity and the frequency of those unpleasant emotions (Alberts et al. 2012). Coping strategies or regulation strategies are often desired by women in order to deal with sensations of contractions during labour and birth. However, the workshop will teach another way of handling any kind of emotions, based on acceptance (Alberts et al. 2012). Applying acceptance rather than endeavouring to control emotions is more aligned with the midwifery, movement therapy and mindfulness philosophy of 'to be with' (Duncan & Bardacke 2010). Therefore, the acceptance approach of 'to be with emotions' is presented as a non-goal-oriented process where women can willingly be in contact with their positive and negative emotions, but without reacting to them. This process aims to cultivate women's non-judgmental attitude towards emotions

and support their ability to stay in the present emotional experience (Duncan & Bardacke 2010; Alberts et al. 2012).

Building Self-confidence

In movement therapy self-confidence can be considered as dependent upon self-trust or the ability to respond to and express internal experience. Self-confidence is likely to be connected with playfulness regarding being open to the process and to self-value and self-assertion. In order to foster self-confidence, movement therapy uses movement metaphors as a vehicle for playfulness leading to emotional balance and self-confidence (Hayes 2008; Duncan & Bardacke 2010). Play and the development of playfulness, developed through engagement with movement, is associated with fluidity and openness, freedom and exploration, and involves imaginary experience. Movement therapy offers techniques where moving imagination can be used as a central tool leading women to a growing self-awareness, leading to self-acceptance, self-nurturing and self-compassion (Hayes 2008). The workshop aims to provide opportunities for women to experience their own individual body movement, feeling and imagining themselves being in labour to help them to explore their personal meaning of childbirth.

Attitudes to childbirth

The attitude women have towards childbirth depends on many factors. “Women know that the experiences of pain in labour are variable and complex and the predominance of fear and anxiety surrounding childbirth is almost universal” (Cyna et al. 2006 p.464). Nevertheless, women who have a positive attitude to childbirth most often connect the concept of ‘natural’ to labour and giving birth, and they have faith in their own strength and trust in their bodies. Further, women with a positive attitude to childbirth claim that labour pain is not dangerous and therefore using pain relief is unnatural and not good for their bodies and their babies. In order to achieve a positive attitude towards childbirth women need a safe environment, connection with other women, use acquired coping strategies, and connect to their own emotional strength. Further, women highlight that coping strategies contribute to their emotional strength, foster

their self-confidence and in return contribute to a positive attitude towards childbirth (Aune et al. 2015).

The workshop offers a physically and emotionally safe and positive environment where women can focus their attention on the offered experiential learning and personal growth activities (Aune et al. 2012). The facilitator's attitude and the proposed techniques women experience play a pivotal role (Vallerand 2012). Common coping strategies such as breathing techniques, postural changes or relaxation have been proposed for women to use during labour and birth. However, it is known that women do not necessarily use those taught strategies such as relaxation in labour (Slade et al. 2000). Helping women to develop their own unique set of coping strategies for labour is recommended. The workshop provides information and experience of techniques such as non-directed breathing, as well as finding and practicing their own body movement and postures (women's birth signature) as a way to increase women's belief in their own abilities for managing labour/birth. Based on movement therapy, mindfulness and art therapy, the proposed techniques all represent aspects of conscious awareness and aim to help women bring attention back to themselves through focusing inwards to promote self-confidence into their own ability to give birth.

Summary

This chapter has provided a detailed description of the 2-day preparation for childbirth workshop specifically developed for this study. The workshop is based on the art and science of midwifery, movement therapy, art therapy and mindfulness practices. The four art-based elements foster the development of playfulness, self-confidence and relationships based on the process of experiencing and reflecting. The combination of these elements aims to assist the women to gain confidence that their own personal birthing strategies developed during the workshop will be effective during the real experience of childbirth. In the next chapter I present the design of a study that explores women's experience of the workshop.

CHAPTER FOUR: RESEARCH DESIGN AND METHODS

Introduction

This research aims to explore women's expectations and experiences of a newly developed childbirth preparation programme and its influence on women's labour and birth experience. In order to achieve this an exploratory qualitative approach was chosen as the study design. This chapter describes the study design and methods used in this study.

Qualitative methodology

When performing a research project I needed to consider the appropriate research methodology in order to answer the research question. A qualitative approach is considered to be well-suited for gaining insight into the meaning people place on an event, process or experience. Further, a qualitative approach is able to explore the structure of their lives containing their perception, presuppositions and assumptions (Miles & Huberman 1994). The most common qualitative research methods used in health science are phenomenology, ethnography and grounded theory (Creswell 2007, Andrews, Sullivan & Minichiello 2004). Other methods are case studies, action research, feminist research and historical and explorative descriptive designs.

Descriptive methodology

Descriptive methodology is one method used for research questions about people's experiences or responses to something (Sandeloski 2000). This study design was chosen as the most appropriate for this research, which aims to examine women's expectations and experiences about a newly developed childbirth preparation programme. In regards to analysis it imposes both limitations and advantages. Qualitative descriptive methodology has been criticised for the data are neither generated nor interpreted based on existing theories or knowledge on the given subject, and it is not underpinned by theory, which makes the process sensitive to subjectivity. Further, qualitative descriptive studies have been criticised for a lack of trustworthiness or rigour, and for faults in terms of credibility. However, Braun &

Clarke (2006) and Milne and Oberlee (2005) do not consider this a disadvantage. The authors argue that enhancing rigour in qualitative research approaches can be achieved through carefully following the proposed data analysis and management strategies. It is therefore important to apply those strategies in order to reduce any subjective elements. Sandelowski (2010, p. 82) suggests that, in a wider perspective “all methods become what they are in the hands of users”; that is, methods are re-invented every time they are used”, and furthermore, that this is entirely acceptable.

Research Design

This study therefore used a descriptive exploratory design with data collected via focus group interviews, before and after a new programme of preparation for childbirth. A ‘before and after study’, is a qualitative approach and a type of non-experimental design that usually measures the outcome variables of interest both before (pre-intervention) an intervention and after the intervention (post-intervention) (Gravetter & Forzano 2011). However in this case there was no ‘measurement’ of outcomes since the major purpose of the study was to determine the feasibility and acceptability of the new programme to women and to gain some insight into whether they perceived it as useful. The programme was however an ‘intervention’ in that its aim was to assist women to increase self-confidence in their ability to give birth. In a subsequent study it will be important to use measures of self-confidence before and after the programme to quantitatively assess the effectiveness of the programme using objective, well-validated measures of self-confidence.

Despite the fact that this chosen form of study design is particularly prone to bias and cannot approach the internal validity of a true trial, it was justified under the circumstances in order to find out behaviour, knowledge or attitude change that is unlikely to occur without the introduction of an experimental treatment. The experimental treatment or intervention of the proposed study was comprised of a newly designed programme of preparation for childbirth. The details of the programme are outlined in Appendix three and explained in detail in Chapter Three. Three data collection points enabled the development of a preliminary understanding of how women understand and experience the essential connection of motion and

emotion in relation to childbirth and preparation for childbirth. The three data collection points were focus groups conducted with the women before the intervention, immediately after the intervention and four to six weeks following the birth of their baby. The approach of this study was led by women's experiences and therefore the study needed to have an open focus.

During each focus group interview, a semi-structured technique was used with basic descriptive open-ended questions, asking for both existing knowledge and feelings. For the interview itself a funnelling technique was used. To begin with, the questions were general and broadly open questions, to engage the women in a relaxed conversation. This was followed by narrowing down the questions into the core of the research interest (Minichiello et al. 2003). The final questions allowed the women to add any comments that I may not have asked but that the women felt were important.

Setting for focus groups

Planning for the environment where the focus group took place was an important consideration for me. Liamputtong (2011) found that when focus groups talk about the quality of a health service, participants feel reluctant to speak out about any dissatisfaction with care when it is held in health care facilities such as hospitals or community health care centres that emphasise the medical model. The quality of the focus group discussion plays a vital role in the participants' ability to express their true thoughts and opinions freely (Hennink 2007). In order to achieve this a non-threatening environment needs to be established so that the participants feel safe and comfortable to share their experiences without fear of judgment (Hennink 2007). A calming and stress-reducing physical environment around the group (location) needs to be well considered by the facilitator (Hennink 2007; Kitzinger & Barbour 1999, Krueger & Casey 1994).

The intervention: Dance/movement therapy

The intervention used draws on the traditions of dance/movement therapy and midwifery knowledge and on a number of other concepts derived from several disciplines. Movement therapy combines elements such as physical movement

(motion), emotional expression and social interactions (Lumsen 2006). It also comprises techniques and strategies such as observation of body language, mirroring, empathy and attunement, which foster verbal and non-verbal communication.

The main principles of DMT are that there is a reciprocal body-mind relationship that means movement/motion and emotions are inseparable and interconnected (ADTA 2006). How we move influences our mind and vice versa and both are influenced by how we feel. The second principle is that the motion reflects aspects of our personality and unconscious processes. Thirdly, changes in movement facilitate changes in the state of mind. Lastly, the client- therapist or facilitator relationship is essential (Karkau & Sanderson 2006; Stanton-Jones 1992). In other words, the therapeutic use of movement supports the integration of the individual on all levels: emotional, cognitive and physical, social and spiritual (Payne 2008). DMT therapy utilises an actively individualised, woman-centred approach, and offers a variety of techniques for self-exploration and expression, and emotional expression. In addition to DMT, other techniques were applied, such as Kundalini yoga, which is “a process of controlling the waves of the mind. The mind is considered to be the connection between the body and the spirit, or consciousness” (2001, p. 9). Another technique is meditation in motion or ‘BreathWalk™’ which combines three simple activities, breath, walk and attention. Breath walking or meditation in motion is the practice of combining a specific pattern of conscious breathing synchronised with walking steps together in a systematic and meditative way to enhance physical, emotional and spiritual fitness (Khalsa & Bhajan 2008). The proposed woman-centred childbirth education programme consists of two intensive days where women participate in a group workshop. Additional details are provided in chapter three which contains a description of the proposed childbirth education programme.

The term dance/movement therapy versus movement therapy

Prior to the study the women revealed that the term ‘dance’ and movement therapy used in childbirth preparation were associated with formal and freestyle dancing, hearing music and learning instructional movement steps in order to balance the body.

The women expressed that using dancing was not a viable option for them to consider in preparing for childbirth. This was also the case for one particular woman who was a professional dancer.

After the workshop, women understood that the word 'dance' in dance/movement therapy was used metaphorically to describe the give and take of social interactions and physical and emotional expressions (Tortora 2006). They stated that the term 'dance' was misleading and did not resemble what the women had gained and experienced through movement therapy.

After the workshop, the women recommended changing the title from 'dance/movement therapy' to movement therapy as there was no dancing involved. They recommended changing the name from childbirth preparation course to a childbirth preparation workshop, as there was no formal lecturing involved. In order to stay true to the findings the terms, movement therapy and workshop, was used throughout the thesis.

The term movement versus motion

The two words 'movement' and 'motion' are used interchangeably throughout the thesis, as it was hard to find distinguishing definitions. However, in dance/movement therapy the term 'movement' often implies some kind of complex physical movements, which means someone is moving from one place to another involving motion expiration, whereas the term 'motion' usually implies simpler or unspecified physical movements. It means, motion is the opposite of stationary; some parts of the body are moving.

Participants

The study recruited and collected data from five pregnant women who attended the childbirth preparation workshop. The eligibility criteria included self-selecting, nulliparous women with a singleton pregnancy, women being in the mid, second early

third trimester, older than 18 years at enrolment and having the ability to speak and understand English.

Sample size

To determine the sample size Kitzinger & Barbour (1999) showed that a group of eight to ten participants are considered as an ideal number in order to provide a variety of experience. Initially I aimed for ten women, however, only five of the ten recruited women participated in the workshop. To place the low participation number in context a brief description of the recruitment strategy and experience will be provided in the next section.

Recruitment of participants

The first approach-recruiting participants

As the optimal recruiting method, I considered contacting lead maternity carers (LMC) such as midwives in the hope of building relationships, gaining their trust and finally their interest in the study. In New Zealand, lead maternity carers provide continuity of care for pregnant women who choose to book with them. I approached midwives working as LMC's via email and text messages whom I perceived to be open-minded, articulate practitioners, and practising in different areas of Auckland. Midwives showing interest were offered first a phone conversation and secondly a face-to-face meeting based on their preferred day, time and location. Specially developed envelopes were provided for the midwives containing participants information sheet (Appendix One), and several participation study flyers (Appendix Five) for them to hand out. As a part of their practice, midwives then would invite eligible women into the study and provide a brief overview of what the study involved. Those interested in participating were given the study information sheet and a flyer containing my contact details. At this time, no back up plan was set in place, as I anticipated no difficulties in recruiting women to the study.

The challenges of recruitment

Unfortunately, recruitment of participants was more difficult than expected. The issues included the intense pressure of the midwives' workload, the women's general busy lifestyle and, my unfamiliarity with the different regions in Auckland. Unfortunately, those three variables disrupted the timetable of the study tremendously. The recruiting experience showed that midwives as well as pregnant women live very complex and demanding lives that might affect their willingness and/or the opportunity, to promote or participate in the study.

The busy midwives

Midwives' willingness to promote the study was never an issue; however, the face-to-face meetings disclosed the personal stress and incredible time demands midwives were living and working under. Although burnout amongst midwives is little understood, a study by Young (2011) uncovered the reality of the weight of professional obligation impacting on autonomously practicing midwives' (LMC's) experience. It further shows the 'on-call practice' has a high potential for burnout, which interestingly has an ability to mask itself through the busyness of everyday practice.

The busy women

Although the feeling of stress varies from woman to woman, when talking with women, similar themes arose connecting women and their experience of lifestyle stress. Women consistently reported the feeling of stress – as the demands in the workforce and their role in society and the family seems to be constantly increasing. Women expressed their desire to work fulltime until two weeks prior to their due date in order to save money and to have as much time as possible off when the baby arrived. Further, several women decided not to make space to prepare themselves for labour and birth because they subverted their needs towards others.

The second approach to recruit participants

In order to enhance the recruitment process I selected yoga teachers following the same approach. Four out of five contacted yoga teachers invited me to their sessions

to approach women who were participating in yoga classes. It was clear that women who joined the yoga classes took an active role in preparing themselves for labour and birth. Altogether, I attended three yoga classes and followed the same procedure in seeking women for the study. Ten women who matched the recruitment criteria agreed to take part in the study. After gaining the women's details, the initial contact was made by text-message asking for an opportunity to call them. The second contact was then made by phone.

Ultimately, only five of the ten recruited women participated in the study. In order to provide a holistic picture of the recruitment process a short description will be provided about why the number of participants dropped down to five women.

To protect women's anonymity pseudonyms were given.

Annabel	Had a car accident where she injured her pelvis.
Kerry	Overlooked the date of a family birthday party
Evelyn	Felt overwhelmed with moving house
Diane	Husband was not happy about Diane being away the entire weekend
Paula	Went into labour the week before

Data Collection

Focus groups and one-on-one interviews

The study involved recording and transcribing interviews with women who participated in the newly developed childbirth preparation workshop. Prior to the interview a full and clear verbal explanation of the study was given to the women and informed consent forms signed. Minichiello et al. (2003) and Bhutta (2004) stated that information needs to be presented in ways that are comprehensible to each participant and the informed consent should be obtained in writing. Following informed consent, the women were invited to participate in three focus group interviews with each having a slightly different focus. Interview one (before birth) was performed close to the women's attendance at the childbirth preparation workshop.

Interview two (before birth) was performed straight after the workshop completion and one-to-one interviews (post-birth) occurred six to eight weeks post-partum. The shortest possible time lapse between the pre and post interviews was chosen to rule out alternative explanations for any observed differences. Secondly, the pre and post interviews took place at the same location where the workshop was held and the one-to-one interview (post-birth) was performed at the woman's home in order for the women to feel at home, comfortable and relaxed. All interviews occurred at a mutually convenient time.

Focus group pre-workshop

The purpose of focus group one (pre-intervention) was to get an overall sense of the women's ideas and expectations of a childbirth preparation workshop, as well as their expectations, hopes and confidence around childbirth. It also investigated what women knew about the relationship between motion and emotion in regards to childbirth. Finally, a question was asked about their knowledge of the process of movement therapy.

Questions to focus group interview one included, but were not limited to:

- Can you tell me what you expect from a childbirth preparation workshop?
- Can you tell me about your ideas, expectations and/or hopes in regards to the birth of your baby?
- What do you know and/or understand about the involvement of motion (movement) and emotion in childbirth?
- Can you tell me if you know anything about dance/movement therapy?

Focus group post workshop

Focus group two occurred immediately following the last session of the two-day workshop. It invited the women to comment on their experience of the workshop and explored whether they felt their initial ideas of the childbirth preparation programme had altered how they were now feeling about their confidence approaching childbirth.

A final question was asked inquiring about the women's thoughts and feelings toward movement therapy and any perceived benefits.

Questions to the focus group-post workshop interview included, but were not limited to:

- What did you like or dislike about the programme?
- Did you notice any difference within yourself, emotionally, mentally and/or physically?
- Can you tell me how you feel when you think about the upcoming labour and birth of your baby?
- Can you tell me your experiences of the dance/movement therapy?

Each interview commenced with open and casual questions to facilitate the women's social and psychological comfort (Svensson 2005). Answers to those questions were not analysed.

The focus group interview itself was based on a semi-structured interview technique with questions that were open-ended to facilitate discussion and to make the interview conversational. The sharing in the group discussion between the women generated very useful insights into what matters to the women the most (Steiner Celebi 2006). Barbour (2005) states that the researcher needs to be flexible in order to facilitate interaction amongst participants. Follow-up questions or so-called probing questions served the purpose of encouraging the participants to add more to the answer that they had provided. That could be done through direct questions. An example could include: "You said earlier that you prefer ...? Can you tell me more about this?" (Bryman 2012).

One-to-one interviews (6-8 weeks after birth)

One-to-one (post-birth) interviews were conducted 6-8 weeks after the birth of the babies for all women in the group and invited further comments on the women's experience of childbirth. It explored whether they thought the ideas and knowledge presented in the workshop had contributed in any way to their labour and birth

experience and/or contributed to their understanding of the relationship between emotion and motion.

Questions of the past experience included, but were not limited to:

- How was your birth experience?
- Did you practise, before or during childbirth, what you had learned or discovered in the workshop?
- Can you tell me what you learned or discovered?

The one-to-one interview with each woman was conducted at a convenient place. Options were given to meet at the woman's home, at the New Zealand College Of Midwives centre, at my home or any other place the woman recommended. Four women felt most comfortable in holding the interview at their homes and one woman felt comfortable to visit my home. The interviews were conducted at a place and time, which best suited the women and their newborn babies. The interviews lasted between 45 minutes to one hour. The face-to-face interviews facilitated each woman to share her emotionally charged experiences and allowed her to care for her baby's needs at any time. Stopping and pausing the interview due to nappy changes and breastfeeding needs occurred frequently.

Data Analysis

Thematic Analysis

Data from the focus groups and interviews were transcribed verbatim and subjected to thematic analysis. Thematic analysis is a common and foundational method for qualitative analysis that identifies, analyses and reports major themes (patterns) within the data. Joffe (2011) acknowledged thematic analysis as a method that can be underpinned by a number of theories. It can be used to address a wide range of research questions, which often explores people's experiences and perspectives collected through interviews, focus groups, diaries, or qualitative surveys (Braun & Clark 2006). Joffe (2011) argues that thematic analysis is "best suited to elucidating the specific nature of a given groups' conceptualisations of the phenomena under study"

(p. 212). Besides the explanation of what thematic analysis is there are many different approaches to thematic analysis.

Attride-Sterling (2001, p. 403) argued that qualitative research often lacks interpretative tools, for the ‘creation of methods, guidelines and techniques, and for the exchange of ideas, concepts and experiences’. The criticism ranges from there being a lack of clarity and transparency about the analytic procedure (Furber 2010) to the specific need for new techniques that improve the coding transparency (Dixon-Woods 2011). Braun and Clark (2006) do not agree with the above-mentioned critiques but they acknowledge that an absence of clear and concise guidelines around thematic analysis can be a disadvantage. On the other side the authors highlight that the use of rigid tools or guidelines limit the flexibility and constrain the analysis. In other words, the hallmark of thematic analysis is its theoretical flexibility. It is interesting to note that Braun and Clark outlined a 6-phase guide on how to conduct thematic analysis correctly. The guide not only outlines the advantage or disadvantage of thematic analysis it also highlights potential pitfalls to avoid when doing the analysis. The data analysis of this study consists of six phases (as shown below), which were based on the checklist of criteria described by Braun and Clark (2006).

Table 2: Data Analysis phases for this study

Step	Phases	Rationale
1	Becoming Familiar with the data	Listening and repeated reading of the data assisted me in becoming familiar with the whole narration
	Transcribing of verbal data (Focus interviews and on-to-one interviews)	Personally transcribing the interviews enabled me to become fully acquainted with the stories Checking the transcript against the tapes supports accuracy Adding the field notes to the narratives provided a better understanding of the phenomenon of the study.

2	Generating initial codes	Working systematically through the entire data. Review the report for a concise, coherent, logical, non-repetitive and interesting account of the story the data tells – within and across the themes.
3	Searching for themes	
4	Reviewing themes	
5	Defining and naming themes	
6	Producing the report	Involves the final analysis and production of the report

Memos

Memo notes were written from the time the study was conceptualised. These notes helped to engage with the research topic and provided an option for the articulation of my subjective perspective (Birks, Chapman & Francis 2008). During the data analysis I used recommended analysis strategies in order to extract the meaning from the data and memos facilitated this process. Birks, Chapman and Francis (2008) state that memos support the researcher to articulate, explore, contemplate and challenge their interpretation during data examination. Writing memos offered me a place for thinking, exploring, reflecting, and re-thinking. Memos are defined as an analytical technique, which can be used alongside other sources of data. Field notes, which contain a certain degree of analysis, were written during the data collection and have been incorporated into the memos.

Field Notes

During the workshop, field notes were made that contributed to the analysis of the data. Field notes in research can be used two ways, structured and unstructured (Mulhall 2003). Structured field notes are more common in positivistic research whereas unstructured field notes have been more commonly used in interpretative/naturalistic paradigms, which this study is concentrating on. The value of field notes depends on the value the research places on them. Field notes might be used for recoding observations or the event shortly afterwards in order to ensure the collection of detailed information. In this study, collecting field notes regarding participant behaviour and non-verbal communication such as physical movement played an important role, which will be described next.

Dance/movement therapy field notes

Collecting field notes in the discipline of dance/movement therapy fulfilled an additional purpose for this study. Dance/movement therapy provides an analytical framework based on Rudolph Laban’s work (Laban & Ullman 1971). I was qualified as a dance/movement therapist so I was able recognise and to record finely tuned observations and nonverbal behaviours exhibited by the participants. During this project, field notes were recorded during and directly after the observation period (see Table 3) where I moved to a discrete space for writing. These notes included detailed observational assessments about interactional and non-verbal communication. It further included descriptions of the general behaviour of the participants and assessments of their physical movement. In addition, I also used the field notes to record my emotional response to these observations about each woman so that I could maintain a professional distance while still maintaining empathy and support. Below is an example of field notes written from my observations of the woman.

Table 3: Field notes: First Impression of Women’s Behaviour and Voice

Andrea	Lisa	Tina	Bella	Sarah
Energetic	Quiet	Controlled	Outspoken	Holding back
Voice: Controlled Cheerful	Voice: Bubbly, Warm-hearted	Voice: Determined	Voice: Powerful	Voice: Soft- spoken
Voice when Nervous: Bubbly, being funny,	Voice when Nervous: Chesty, Fewer words	Voice when Nervous: Bubbly, higher pitched tone, cheerful	Voice when Nervous: Voice calmed down, slow speech	Voice when Nervous: Low voice to becoming silent

An example of field notes, based on movement therapy, is provided below. The observational notes were taken during an experiential intervention at the beginning of the workshop.

Field notes about:

General physical observation:

- Sarah doesn't seem to move a lot. She is not curious to explore the areas of the room. She is standing, close to the window and her arms are still by her side, moving her hips very gently from the right to the left, and her back is straight.

Behavioural description:

- Sarah seems to be in her own world with semi-closed eyes. Not looking out but not focusing on anything around her or inside herself either. I experienced a sense of separateness and avoidance of being in contact with others and the environment.

What does it communicate to me?

- I have seen this particular behaviour before. I am wondering what it means to her. Might mean 'I'm seeking out some support' or 'I need time/space for going deeper into myself'? I'm not really sure where her focus and need is at present.

Feasibility

When considering the research question for this study, I refer back to Higgs, Horsfall and Grace 2009. The authors explain that feasibility is a vital factor that shapes the research question. During the study, the focus of the research questions changed from focusing on women's confidence to women's experience. Initially I had wanted to undertake a randomised controlled trial comparing the new programme with an existing programme, but this was not feasible as the programme itself had not been established as attractive to women and something they would want to attend. The initial research question 'Does a woman-centred childbirth preparation programme

based on motion and emotion increase women's confidence towards childbirth' developed into a more feasible research focus; 'Connecting motion and emotion: A newly developed childbirth preparation programme'. As a young researcher, the process of redefining the research question was not only unexpected, it was also interesting to observe how the process of learning to be open and flexible is a necessary quality to have as a researcher. This process occurred by discussing and evaluating the research question, methodology and research design with my supervisor. My critical thinking process was stimulated by asking further questions, which are described by Higgs, Horsfall and Grace (2009). The authors state that the researcher needs to ask themselves whether the research question is researchable, and if so, which methods best lend themselves to answering the research question. Therefore, framing the research question is a vital aspect of the planning and building of the research design. In regards to this study, both research questions were researchable, however, the chosen method was suitable for a Master's project but not suitable to answer the first question. In order for the research question to be in alignment with the research goal and to be feasible, the practical research question was explored and changed within the given resources and context (Higgs, Horsfall & Grace 2009, p. 16).

Reflexivity and trustworthiness

Reflexivity and its role in the research process is an important element to consider. It has been described in many ways, however, it needs to be distinguished and separated from the term 'reflection'. 'Reflection' can be defined as a thinking process about something that has already occurred (Finley & Gough 2008). According to Woolgar (1988) reflection is more a general set of thoughts, a process which includes verification in order to guarantee that the taken measure represents the participants' inner truth. In other words, when a reflection process occurs, the aim is to achieve accuracy when stating participants' accounts of reality (Hammersley & Atkinson, 2007). In comparison, 'reflexivity' means looking again, reflecting on one's own thinking, referring back to oneself (Shaw 2010). Finley and Gough (2008) explain that the word 'reflexive' has its root in etymology and means 'to bend upon oneself', which involves a more dynamic self-awareness.

Reflexivity is an active and integral process that describes the researcher as the primary tool of inquiry, whereas self-reflection is essential in order to acknowledge how one's beliefs, assumptions, and preferences might influence or affect the data collection and the data analysis (Clancy 2013, Patton 2002, Shaw 2010). Malterud (2001) describes reflexivity as 'the knower's mirror' and it means that reflexivity should be demonstrated through every step of the research process. Wilkinson (1988), on the other hand, distinguishes between two aspects of reflexivity, which she termed as 'personal' and 'functional' reflexivity. Firstly, personal reflexivity refers to the researcher's identity: as an individual with its influence on the research process. And secondly, functional reflexivity refers to the role the research has within the research process.

In regards to personal reflexivity, being a homebirth midwife and researcher it was necessary to identify my own motivation behind undertaking this study. Reviewing my motivation included my personal interest in this particular topic as well as my own philosophical standpoint about my political beliefs, my view on gender, knowledge and culture. Reviewing my motivation also included reviewing my external motivation such as my career advancement. Therefore, reflexivity can be seen as an active and integral process of critical self-inspection (Finley & Gough 2008; Grove & Burns 2005). Self-inspection was an important aspect for me to consider, as it helped to clarify not only my personal motivation behind undertaking this study, but it was also used to identify any possible issues of subjectivity prior to data collection, during data analysis and writing of the subsequent report (Finlay 2003, Shaw 2010).

To begin with, as a researcher it was my goal to approach this research with an ethical commitment and to produce a thesis that is honest and truthful throughout every step, which I believe underpins trustworthiness. In order to create trustworthiness and achieve unbiased results within qualitative research an 'audit trail' process can be used. First, this includes a clear description of the research path containing research decisions and activities. It also includes the transparency of the research design, data

collection decisions, and the analytic steps taken including the rationale underpinning these decisions (Tracy 2010).

When I undertook the data collection and analysed the data, field notes and a reflective journal were used. Those entries helped me to become aware of any discrepancy that arose between the collected data and the collected field notes. I acknowledge that my personal interest to protect women's well-being and supporting women to achieve their desired birth may have influenced the findings and the conclusion. However, integrating reflexivity into the process allows the researcher to acknowledge the role and effect they have within the research process (Clancy 2013, Patton 2002, Shaw 2010). Therefore, throughout the process I used a variety of reflective tools in order to present the findings as truthfully as possible.

Data management and storage

The data were transformed from digital recorded interviews to typed transcribed word documents. I completed the transcriptions myself. During this process all identifying information was removed from the transcriptions. Data from each research participant was stored securely, concurrent with ethical guidelines, and assurance about this aspect of the research was given to the participants at the beginning of each interview in accordance with the NHMRC guidelines (National Health and Medical Research Council 2007). This included that:

- Data were stored in a locked filing cabinet at my home office
- Transcripts were kept separately from the audio data
- Transcripts were coded with pseudonyms
- Any identifying data such as names of participants or names of health facilities were removed from the transcript word documents
- Transcripts were only accessible to myself and my supervisor

Ethical considerations

Ethical approval was gained from the University of Technology Sydney Human Research Ethics Committee Health (UTS HREC) and from the Disability Ethics

Committee (HDECs) in Auckland, New Zealand. The University of Technology Sydney Human Research Ethics Committee granted ethical approval prior to data collection in 2016. During the conduct of the research no adverse events occurred that required reporting to the ethical committee.

The participants were assured that participation in the study was voluntary and they could revoke their participation at any time. Informed consent, non-identifiability data and confidentiality between the women and myself were assured. In the nature of the proposed study, the women shared personal and private information with each other, and confidentiality was difficult to guarantee. Although I had no control over the comments and behaviour of other group participants, confidentiality had been discussed with the interviewees. Within the study participants were identified with pseudonyms and this was used throughout the data collection and the transcription process.

Information sheets and consent

Information sheets containing the details of the study were given to the women and also to the midwives who supported the recruitment of participants. The participants were asked to read then sign the written consent form prior to participation in the study. The ability to withdraw from the research was discussed at that stage. Participants had the opportunity to ask questions and discuss any issues of consent. The consent form contained the contact details of myself as a researcher and from the principal supervisor of the study.

Summary

This chapter has provided the rationale and explanation of the use of a qualitative descriptive approach when exploring the expectations and experiences of the women participating in a newly developed childbirth preparation programme. The chapter also provided a description of the methods used for the data collection and analysis.

The next three Chapters (Four to Six) present the findings of the study. The findings in Chapter Four reveal women's expectations prior to the workshop. Chapter Five reveals

women’s experience of the workshop and the final findings in Chapter Six provides women’s reflections on their birth experience and the efficacy of the skills that they learned during the workshop. Within each chapter, the core themes and sub themes that emerged from the analysis of either the focus groups (pre and post workshop) or one-to-one interviews conducted after the birth of the baby are provided in detail with supporting quotes from the women. Table 4 presents an overview of the research findings.

Table 4: Overview of the Findings of the Study

<p>Pre Workshop – Expectations of the women</p> <ol style="list-style-type: none"> 1. Sense of belonging 2. Tools (skills and knowledge) needed 3. The whole me and the baby 4. The brain – body connection
<p>Post workshop – Learning experience they valued</p> <ol style="list-style-type: none"> 1. Dialogue through <ol style="list-style-type: none"> 1.1. Words and stories 1.2. Art 1.3. Movement 2. Developing own tools through <ol style="list-style-type: none"> 2.1. Space 2.2. Breathing rhythms 2.3. Women’s birth signature™ 3. Connection through <ol style="list-style-type: none"> 3.1. Relationships 3.2. Me with my baby
<p>After the Birth – Effectiveness of workshop reflections</p> <ol style="list-style-type: none"> 1. Inner Dialogue 2. Using inner tools

2.1. Breathing rhythms

2.2. Women's birth signature™

3. Feeling connected

CHAPTER FIVE: WOMEN'S EXPECTATIONS OF A NEWLY DEVELOPED CHILDBIRTH PREPARATION WORKSHOP

Introduction

This chapter presents the findings relating to the women's expectations of a childbirth preparation programme. Four core themes emerged.

The four core themes were; 'sense of belonging', 'tools needed', 'the whole me and the baby', and 'brain-body connection'. Each theme will be presented here together with supporting quotes from the women. Where relevant, field notes made during the focus group and drawings that provide a visual representation of the women's body language and movement add further insights into the themes.

The five participants were of different nationalities; two were New Zealanders, one was Russian, one was Asian and one was German. They ranged in age from 32 to 37 years and were all in their late third trimester. All women were middle-class; first time mothers and all were in stable relationships and had planned pregnancies.

In the first focus group interview, women were encouraged to talk about their needs, views and expectations of a childbirth preparation workshop. The questions invited women to explore themselves in a self-reflective way. In order for the women to find their individual and true answers they were invited to turn their awareness inwards and tune into their non-verbal responses.

Sense of Belonging

At the early stage of analysis of the focus group transcripts the theme 'sense of belonging' emerged, acknowledging the women's desire to connect with other pregnant women, sharing their individual experience of being pregnant. In order to understand what 'sense of belonging' meant to the women personally it is important to explain how this theme actually developed. In early pregnancy the women believed that the general 'need to belong' and the need to talk about their pregnancy was

fulfilled by their families, a network of friends or their church. It seemed that the women worked hard to incorporate their physical, psychological and emotional changes into their daily life in a way that preserved normality. In fact, the women spoke about how pregnancy as a normal life event was modelled around them, emphasising that pregnancy is not something women need extra time for and birth is nothing to be concerned about. Interestingly, this model stayed unquestioned and became adopted by the women until they experienced it differently. Cathy, for example, before she became pregnant, had a very satisfying and demanding job, worked long hours and enjoyed being physically active. Beside this she was not used to giving-in to tiredness and felt quite surprised how pregnancy changed her energy level and stopped her from doing things she usually loved doing. Similarly, Tina described her experience:

“I know it’s like the most normal thing in the world to have a baby but when you are pregnant and expect your first baby, it’s just so ... different. You’ve seen all your friends and seen the baby bumps and everything but when it hits you, it’s such a different thing” - Tina

Beside women’s individual expectations of pregnancy, an enormous effort had been made by the women to adjust themselves quietly to the physical and emotional changes while keeping up with the demands of their daily life. The women’s attempts to integrate the pregnancy experience into their busy daily life together with the conflicting messages around childbearing practices had an inevitable impact on their trust in their body and ability to birth.

Bella, who aspired to a physiologically normal birth, lost more and more of her self-confidence as pregnancy progressed. She expressed the need to share her thoughts, wishes and concerns with other pregnant women in order to re-establish her self-trust and to know that her concerns belonged to a normal pregnancy. Bella’s first step was logical, sharing her concerns with others in the hope of finding a way to deal with the discrepancy of how she feels and what she actually wants to feel and what she desires. She said:

"I actually almost burst into tears a couple of times, god I can't do this. I have changed my mind. So, I need to deal with it really, really quickly because labour is quickly approaching. I don't want to start panicking. As soon the pain starts I don't want to go, "okay I'm not going to birth camp, I'm going to the hospital and get an epidural, because. I'm just too scared" - Bella

Lisa, who aimed for a vaginal birth, expressed similar concerns. She said:

"I'm very scared to be the person to birth this baby" - Lisa

Since the women were experiencing mixed emotions and unfamiliar thoughts they wanted to talk and to share their stories with other pregnant women. Being together, sharing time and stories together was generally associated with positivity and offered hope and certainty for women to know that 'you are not alone'. The women described that there was comfort in that knowledge. In fact, the women's desire to share, connect and belong to a greater pregnancy community grew out of the isolated nature of pregnancy and this desire increased as pregnancy progressed. One by one, the women longed for their emotions and imperfections to become accepted rather than treated, as something needing to be fixed. One woman said:

"I mean to be in a round like this it is really nice because it gives me a sense of belonging. It's nice to be in a group where I feel we [can] get to know each other, where I feel we can be really open and talk about our fears and to get a little bit [of] reassurance ... that we can do this" – Tina

Like Tina, Bella described wanting to have:

"A chat through that and leave all the fears behind and hopefully I [will] feel more comfortable on Sunday and get excited about the birth no matter how it goes" - Bella

Sarah was planning a homebirth and she said:

“It’s my first one (baby) and I put a lot of thought into it. At the same time I’m not sure what I’m going into to have a baby but I don’t feel like I’m ready. And I’m not familiar with other pregnant women and raising a child” - Sarah

Being with other women, having a ‘sense of belonging’, entering a safe and encouraging space in order to explore, share and express their individual pregnancy experience seemed to be important to the women.

Tools Needed

When the women were asked about their expectations from a childbirth preparation workshop, ‘getting tools’ to work with during birth was one of most desirable requests women expressed. Despite the fact that the women felt excited about motherhood, thinking about their upcoming birth left the women feeling nervous, fearful and anxious. Contributing factors such as hearing traumatic birth stories from friends, the negative attitude of their families to childbirth and, the conflicting messages about labour and birth, diminished women’s self-confidence in giving birth. Therefore, with advancing gestation the women described an increased desire to prepare for labour and birth and ‘getting tools’, as an act of control, seemed to be their focus.

Andrea, for example, attended conventional antenatal classes in the hope to gain some tools and professional advice in order to build her self-confidence towards childbirth. Andrea described the classes ‘felt really very medical; she learned that most women used a combination of medical and non-medical pain relief and giving birth in a hospital was considered the best and safest option. She said:

“You know it [antenatal classes] was very fast and you are going through 119 really important topics. I felt it was very medical and there

were very few tools to help. For me it made that fear bigger which worked in the opposite way” - Andrea

Lisa, who had a very satisfying experience with antenatal classes, explained that they offered valuable knowledge about birth physiology helping her to gain confidence into the nature of childbirth. In fact, building knowledge about childbirth contributed to Lisa’s ability to foresee a physiological birth, however the answer and idea to the question of “how can I achieve the birth I wish for?” was still missing. Bella, Tina, Lisa, Andrea, and Sarah all described that getting tools to work with might be the answer to this question. Women’s way of expressing their need for ‘getting tools’ was expressed in the following ways:

“I tend to panic and I am a worrier so I want to give myself as many tools as possible in my tool belt to be able to ride the wave for as long as possible, or as long as it takes and no matter what happens. Today and tomorrow I’m a woman who is making a baby and preparing to have that baby and getting all the tools to be able to do that” - Lisa

“I wish I had tools, tools that you can take with you, tools to deal with more my emotions just to stay calm and feel in control” - Bella

“I wish for some tools. I don’t know whether it would help me but at least you know how to breathe and how everything works” - Tina

Andrea’s answer to the question was:

“To add more tools hopefully make the process [more controllable] but you never know, you can’t plan for it. To have tools to plan, put things in place should things happen, should it go this way or that way, tools to know you are in control of your body? You just need another big tool base and experienced people” - Andrea

The thought of having the combination of tools and experienced people available offered the women a sense of control when thinking about childbirth. Overall the women considered that giving birth might be a possibly enjoyable but unfamiliar experience that hopefully could be controlled no matter how it progressed. Sarah said:

“I’m just trying to add to that and hope that it sticks around the moment the contractions starts; it doesn’t fly out the window” - Sarah

Knowing what tools can be used actively to cope with the challenge of labour pain was the major goal for the women. Taking tools into the birthing room to function as an anchor or lifeline seemed to be an important concept for these women to face the challenge of birth.

The whole ‘Me and the Baby’

During pregnancy, claiming time for themselves did not come naturally to the women until the physical changes inevitably became obvious and a feeling of urgency that birth was coming closer developed. These unavoidable sensations caused each woman’s frame of mind to shift more toward her own needs, hopes and worries. The desire to take time out in order to focus on the whole me and prepare for labour and birth was described by the women as a gradually increasing process reaching its peak in the early third trimester. For that reason, four out of five women in the study attended formal antenatal classes. Despite the fact that some women felt satisfied with the educational content about childbirth in the formal classes, none of the women felt they were being seen and treated as a whole person or gained confidence in their own ability to give birth.

Gaining evidence-based knowledge certainly helped Jane to realise ‘the power and the research behind birth’ but visualising herself actually giving birth continued to be challenging and concerning. Jane, who appeared to be a lateral thinker, felt dissatisfied with attending regular antenatal classes. Learning from ‘words-only’ made her feel distant from the actual experience of being pregnant and growing a baby. When she

was asked to explain what ‘the whole me and my baby’, meant for her, Jane expressed the need to address three areas simultaneously. Firstly, learning about birth from health professionals seemed to be vital, then having the opportunity to ask and share questions, and thirdly the importance of learning ‘things that are going to help’ practically for the birth. When Andrea heard about the course offered in this study she said:

“I kind of hope it’s (this workshop) very different. I hope again that its going to help me with the (birth) process, and not learn the kind of things like statistics and this is the chance you’re going to have that. I do hope that this course is different” - Andrea

Lisa, who appeared to be more a linear thinker, explained that ‘the whole me’ meant building on what has gone before; for her this meant a logical step-by-step progression. Therefore, antenatal classes fulfilled Lisa’s need to nurture her desire to learn the theory about childbirth first before she was ready to move to the second step, the active or practical part. This active part was based on learning certain practical “techniques” (through the body) and paying more attention to her unborn baby.

This step-by-step approach, addressing the mind followed by addressing her body/baby, was also important for Marion to feel treated as a whole woman. It was interesting to note that she did not require an integrated approach. She appeared to be happy to have one and then the other. When Marion heard about the workshop she said:

“I don’t expect this (workshop) to be like that (conventional antenatal class). I expect this more to be about my body and what I can do with it and create a space for two days where I can dedicate my time to being with my baby and not being a woman who works, cleans and looks after her partner. I just wanted it to be about me and my baby. A course like this really excited me because now I’m going to get to include movement into this experience and this is something that makes me really, really happy” - Marion

Up to this point, Tina had been reading books, watching TV series such as “One born every minute” and had used the internet as a resource for building knowledge and connection to the foreseeable future of giving birth and becoming a mother. Andrea repeated several times that getting reassurance from health professionals that ‘she can do this’ and talking about her emotional difficulties were as important as learning the knowledge around childbirth. She said:

“I think here, let’s say I would believe that there is a little bit more focus on the individual, because we are such a small group and we are spending a whole weekend together. I think it is more about emotions, and like you said as well, it’s more spiritual I suppose and less medical” -

Tina

Sarah, who planned a homebirth, said:

“My antenatal class was very medical and filled with technical information and I was very overwhelmed by lots of reading at this class. I almost felt the antenatal class was wasting my time. Through this course I just hope that I’ll be focussed with my baby and I do expect it will be different from antenatal class” - Sarah

All the women expressed the desire to be seen and treated as whole women who might have to deal with strong and unknown emotions, which were currently conflicting with their hopes or ideas of giving birth.

“I think it is very different. I think it is more natural birth, which is what we focus on as opposed to just the basics on the process. It’s more practical I think, it’s like a workshop” - Bella

Addressing 'the whole me and my baby' was associated with learning "practical things or techniques" in order for women to deal with the challenge of labour pain and achieving a normal physiological birth.

The Brain – Body Connection

When birth itself was coming closer, a myriad of thoughts travelled through the women's minds. In order to allay some women's fear regarding their impending birth, women exchanged their thoughts, ideas, and worries with their lead maternity carers and other pregnant women, or searched for answers on the internet or read books. The women's own thoughts and curiosity about 'what is happening inside my body' linked with acquired knowledge of giving birth clearly shaped the women's understanding of the birth process. The theme of 'the thinking brain and the body connection' referred to the women's understanding that thinking might create specific feelings and specific feelings create specific emotions. And finally those emotions might have the power to influence the action of the hormones that govern the physiology of childbirth, positively or negatively. The women described this connection as:

"You just have to support your body with your thinking and your body will do what it wants to do" - Sarah

"If you tense up, I heard that people blocked the endorphins working on your body, so you have to be consciously mindful to stop having tension and let the endorphins work in your body and try to stay relaxed" - Andrea

"I mean research shows that even just forcing yourself to smile during labour produces endorphins and helps you with the pain. Physiological I mean your thoughts create responses in your brain and of course hormones" - Bella

Despite the fact that the women felt calm knowing about the hormonal interactions of the birth process, many of the women recognised they still felt overwhelmed by their own thoughts of 'its me who is giving birth'. One woman expressed her concerns as, "there is no easy way out, whether you choose a medical or physiologically normal birth". The women acknowledged that thinking and fantasising about the birth, and finally preparing for the birth in theory was an important part of this process. Realising that their thinking and their own feelings might interfere with their bodily responses during labour and birth was an important focus for each woman. This was reflected in comments like:

"I think you'll freeze when you are scared, it just freezes and it interferes with the whole process" - Bella

"I even don't like the word pushing and so that connects an emotion. The idea that pushing has an emotional effect on my brain ... [it has] like a negative connotation" - Lisa

"I have anxiety and fears and go into this panic mode and I know it can ...create ... complications. I think it's just so critical to just to have tools to control your thinking, to control your emotions, to stay in control and not to panic" - Andrea

Although Andrea spoke about her anxiety and fears and her bodily responses to certain emotions, she had no ideas of how she could reduce her fear or how she could find calmness in times of stress. After building theoretical knowledge around birth hormones and ways to reduce stress, being in control of your thoughts and emotions seemed to be an essential goal for the women in order to maximise their chance of having a normal physiological birth.

Summary

This chapter has presented the findings concerning women's expectations of a childbirth preparation workshop. The core themes arising from the analysis were 'sense of belonging', 'me and the baby', 'tools needed', and 'brain - body connection'. The analysis revealed that the women valued building real connections between themselves and their unborn baby, and also between themselves and the other women in the group in order to share their emotional and physical journeys into motherhood. It seemed to be important to the women to receive tools they could use to deal with disempowering emotions and feelings such as fear and anxiety, and tools they could use to deal with the challenges of labour and birth. The next chapter examines the women's experience of attending the childbirth preparation workshop. It further examines what tools the women found valuable and potentially beneficial to use during labour and childbirth.

CHAPTER SIX: WOMEN'S EXPERIENCE OF ATTENDING A CHILDBIRTH PREPARATION WORKSHOP BASED ON CONNECTING MOTION AND EMOTION

Introduction

This chapter presents findings about women's experiences of attending the workshop. It examines what women experienced during the workshop, what movement/motion and emotion changes or connections they experienced and what they thought might be helpful or beneficial to their upcoming birth. While all quotes are from the participants, field notes and illustrative drawings from the group leader are also included to broaden the analysis. Three core themes with their subthemes emerged from the data. The core themes are women's 'dialogue', 'developing own tools', and 'connection'.

The first core theme women's 'Dialogue' describes the different ways in which the women communicated and interacted with each other in order to build relationships. Dialogue between women developed through sharing words and stories, as well as through creating and experiencing art and movement. The first sub theme, 'women's words and stories dialogue' describes the ways in which the women interacted and communicated with each other and what was important to them. The second sub theme, 'women's dialogue through creative art', reveals the dialogue women were holding inside themselves as well as with their babies. This sub theme shows the way creative art explored their thoughts, emotions and feelings on a deeper level. The third sub theme, 'women's movement dialogue' (non-verbal), reveals what women expressed through the communicative power of movement.

The second core theme, 'Developing own Tools', reveals the women's experience of being engaged with movement therapy in order to find their own tools regarding physical movement (motion) and their desired emotion to gain self-confidence to give birth to their babies. 'Developing my own tools' encompasses three sub themes. The first sub theme, 'Space' explores the women's self-awareness process and their acknowledgement of the two existing spaces within. First, the comfortable and well-

known space, where women usually operate from, and then the newly discovered and untouched space the women felt since they became pregnant. This focuses on women's experience of not only exploring this untouched inner space but it further shows women's experience in discovering the value of it.

The third core theme 'Connection' reveals what these women needed as a pre-requisite in order to be willing to share, learn and grow into the journey of giving birth. This core theme 'connection' encompasses two sub themes, 'relationships', and 'connecting me with my baby'.

The sub theme 'Relationships' explores the development of relationships and how this contributed to the women's journey. The second sub theme, connecting 'me with my baby' explores how the women connected to their babies and what difference this made to their journey towards giving birth and motherhood.

Women's Dialogue

A dialogue through words and stories (verbal)

The women shared time together; they talked with each other, asked questions and appreciated answers and feedback. Together they exchanged thoughts and expressed their worries, dreams, hopes and concerns about childbirth. Having a dialogue with each other through words and stories was seen by the women as an important and powerful act in order to learn from each other.

The women's interest in each other's experiences combined with the non-directive nature of the discussions and the group leader's focus on the women's abundance of knowledge, not on the lack of it, motivated the women to talk freely about themselves. Therefore, the communication between the women cannot be understood as a linear process that moved from mind, talking about the theory, to body performing physical exercise, or vice versa. In order to support women's intuitive thinking, instead of fostering reflective thinking, a number of movement therapy techniques were chosen by the group leader for women to explore different ways of thinking and

talking/discussing, in order for women to find their own answers to their questions. The women appeared to enjoy the experience as one participant said:

“I really enjoyed the discussions. I think there was a lot of it and I think this was the perfect environment to have that much discussion. I think we could have another three days to continue these discussions” - Lisa

The women repeatedly talked about the value of our ‘discussions’. After listening for a while it became clear that the value of the ‘discussions’ was not the content the women discussed with each other but rather ‘how’ women talked with each other. Those ‘discussions or talks’ occurred between two or more women to share their own inner felt world of thoughts, beliefs, values, feelings or images around childbirth and motherhood. From a group leader perspective, women appeared to enjoy being engaged in an exchange of their inner-self (inner world) for the purpose of supporting each other along the shared journey. This is an example of what women shared with each other:

“I need to really deal with it really, really quickly because labour is approaching soon. I don’t want to start panicking. As soon as the pain starts I don’t want to go, okay, I’m not going to birth camp, I’m going to the hospital and get an epidural, because I’m so scared” - Bella

During the focus group the women revealed what they valued about their shared discussions:

“I think the discussions were very good as well as the content, from the content perspective. I feel very prepared because I know the real steps of labour and birth and how my body brings me to it, what happens with me. I feel I have more clarity” - Sarah

“I feel like this is giving me more information in terms of what is going to help me through labour and birthing and just our rights as mothers and that process as well, in such an overwhelming time” - Andrea

“We talked about to be sort of open to [whatever] potentially could come our way and to know what to talk about with our partners about stepping in with certain things” - Tina

The inner-self described by the women seemed to be a combination of different aspects. Their own inner worlds were described as something that mattered to them, something that was very important to them personally. It included what they did and decided, what they thought and felt, or what they despised, loved and feared, and all this was explained and expressed in the women’s own unique way. It seemed that the women felt safe to reveal how they viewed the world through their own eyes and filters. Further, they expressed how they experienced the world, what grabbed their attention, what pulled them away or towards something. Certainly, all women made a huge effort to share what was happening inside and did their best to convey this clearly to the other women as well as to the group leader. This was explained by one woman:

“It [discussion and dialogues] definitely helped me to understand better and through the discussions we [were] able to ask you questions and you answered using demonstration[s] and your answer[s] [were] very straight forward” - Andrea

The way women shared their inner selves with each other can be considered as a woman’s dialogue rather than a women’s ‘discussion’. It is important to note that the warm and supportive group atmosphere certainly supported women’s different ways of communicating with each other and that it furthered women’s self-disclosure, self-understanding as well as understanding of the birth-process itself. This was expressed by Lisa as:

“We talked about the baby and that first hour as well other things. That was really important to discuss those things with people with an open discussion group I thought that was really powerful” - Lisa

Throughout the course the women’s dialogue flowed constantly, slowly at first like water flowing in a small creek, developing into a wide and deep river over time. Women shared their inner world of comforting or uncomfortable thoughts, wishes, ideas and worries, with other women, with the group leader, and metaphorically also with their unborn babies. This kind of sharing was based on verbal and non-verbal communication. The women’s verbal communication was through the spoken word in stories or poems. Whereas, the intentional non-verbal communication was lived through women’s creative writing, projective drawing or physical motion, and unintentional non-verbal communication through facial expression (mimic), eye contact, through gestures, touch and through their movements as well as being still (body language). The verbal and intentional non-verbal communication women undertook ‘with themselves’ and ‘with their unborn babies’, and ‘with others’ seemed to be factors in the creation of an environment that the women reported to be safe, trusting and positive and which offered the opportunity to be seen, held and listened to, that they valued.

Dialogue through art (non-verbal)

Experiencing writing a letter to their unborn babies, creative writing or drawing pictures was a new way for women to explore their inner dialogue.

In order to enhance each woman’s ability to communicate authentically, creative writing was introduced as a silent element. This intervention, applied as a further expressive form within the movement therapy technique, was introduced when women greeted each other for the first time and it was repeated in different ways and several times during the course. Different styles of writing enabled the women to express thoughts and feelings in a manner that was different from verbal means. With different media such as writing and projective drawing, functioning as bridges between inside and outside, the women entered another world where everything seemed to be okay.

“I really like the fact that there was these gorgeous little exercises that we did throughout the day as well like, the meet and greet exercise in the beginning and the exercise where we wrote letters to the baby. Those things weren’t necessarily anything to do with the movement but they were so important and special. I think those sort of things you take away for afterwards which are really important too, and the breath walking and those things that aren’t necessarily going to help in your labour but help incredibly afterwards. So I think no, definitely the course is perfect” - Andrea

These media are used in combination with movement therapy, which is expanded on in more detail in chapter three. One woman expressed how she felt as:

“The (changing) point was when we [were] writing down freely. Yesterday when we did what the birth looks like for us and today when we did the left handed writing, I think it just was the moment when we got to be really subconsciously honest” - Lisa

Dialogue through movement (non-verbal)

The women revealed two messages when they communicated with each other. Women revealed themselves through their words as well as non-verbally through messages based on action or body movements. In order to understand the true meaning of what they said, and what they meant by what they said, it was important to pay attention to their spoken words, their meanings and to the quality of their non-verbal messages, consciously and unconsciously. It was noticeable that, when women talked about themselves sometimes the meaning of their words matched their nonverbal messages; however, sometimes the verbal expression did not match their non-verbal messages. It meant, women showed their inconsistency though telling their stories based on words. A woman’s words may say one thing, however, her body says another. Further it was interesting to note when women displayed a certain degree of awareness their words

and their non-verbal movement qualities were in alignment with each other, which meant the verbal message matched the entire body language.

Developing Own Tools

Women identified tools as something they could learn practically when taught the facts by a health professional. Therefore, the women anticipated some kind of breathing technique to help them to deal with the labour pain; positive thinking techniques to harness control of one's body; learning ideal birth positions to support the birthing process, all in the hope of ideally, achieving a normal vaginal birth. When the course outline was explained to the women in detail, it took the women by surprise that none of the tools or techniques they had expected, had been incorporated into the course. This is explained further in the following sub theme of 'Women's own space'.

Space

When the women stepped into the journey of self-awareness they became aware they were required to relinquish any preconceived expectations, and instead, be willing to enter and experience their comfortable space as well as an untouched space. Although they called this new space 'uncomfortable', or out of the zone, conversations revealed that this untouched space was an unknown space within themselves that they realised was wanting to be explored and filled with new knowing. When women became aware of both comfortable spaces and untouched spaces, they understood how the changes of pregnancy offered an opportunity to acknowledge the unknown and untouched parts of themselves.

Movement therapy and meditation, address the emotional, mental and physical aspects of the human being, helping women to explore both spaces within themselves to a much deeper level than they had ever done before. However, this kind of self-discovery seemed to be unfamiliar and there was a worry this might cause discomfort to those for whom working with body movement was new or different. One woman described how she felt when reflecting on one of the techniques used in the workshop.

“The movement things aren’t necessarily things that I do regularly so it’s good to be out of my comfort zone and learn to really connect with, with the baby and connect with my body as well and emotions and things like that. Those activities are sort of living and come across before so it’s really powerful to connect with that side of things” - Tina

As a warm up exercise the women were invited to physically move around the room in any way they liked to music. Each woman had a piece of paper and a pen and when the music stopped they were invited to take someone else’s paper and write an observation, such as colour of hair or clothes they were wearing, anonymously. At the end of the exercise the women ended up with a list of positive affirmation or observation. The aim of the exercise was to create trust, attunement to each other and break down barriers.

“We only just met yesterday, and we had a little piece of paper folded in half and we wrote our comments. So that was really uncomfortable but I came to miss this, because that was so special. I really like that you put us into our zone of discomfort and then put us in our zone of comfort”

Clara

When women had spent time together and felt familiar with the environment, an empathic energy and openness developed which in turn created an emotionally and physically safe place. Under these conditions women showed willingness and openness to leave all their expectations behind and let themselves take part in this unfamiliar workshop and use it as an opportunity for self-discovery and personal growth. The experiential intervention offered women knowledge and simple strategies for how to move out of their comfort space and move into the untouched space within. Entering into both spaces helped not only to extract the meaning of what women think, feel, hoped or believed about themselves regarding childbirth, it further helped women to discover new information about themselves. With guidance and practice women

mastered the moving out and moving into the spaces in a way they felt positive about and even enjoyed. This was expressed by two women:

“I love the fact I was probably out of my comfort zone. So, things (movement therapy) like that aren’t things I do regularly but its good to be out of my comfort zone and learn to really connect with me, with the baby through those things and connect with my body as well as emotions. Those activities are sort of living, so it’s really powerful” - Lisa

“All the things we have done, or even just the word birth and then writing about it, and oh, am I doing this right? Am I just those things I think it’s really powerful to be out of your comfort zone” - Andrea

All the information that women discovered about themselves through experience, reflection and contemplation clarified and also shifted some women’s beliefs and values in new directions. Being aware about both existing spaces within, both comfortable and untouched was seen as important and meaningful to them individually, and this helped them to know better what they wanted for themselves, for their babies and from a wider perspective for their families.

Breathing rhythms

Breathing in and breathing out can be seen as the most primal rhythm of human bodies, supporting all movement activities. As an on-going natural flow, breath is inhaled making the body grow and expand, and when the breath is exhaled the body releases, relaxes and shrinks.

One of the first fundamental steps women explored was the movement of rhythmic breathing while physically moving. This is a kind of walking meditation known as Breathwalking™ (Khalsa, Guruchanran Singh & Yogi Bhajan 2008). Taking a conscious breath in and breath out, tuning into a women’s own rhythm of breathing and walking, made women aware of how it felt to be in a body that moves and feels so much. Entering a place where elements of rhythmic, breathing, walking and meditation were

combined seamlessly turned out to be new experience for all participating women. This was appreciated as expressed by Andrea:

“I really liked from yesterday ... the fact we were able to practice breathing, the Breathwalking™ that we were able to start practising from that and then doing the roleplaying from yesterday” Andrea

Practising Breathwalking™ supported women to turn their focus into the internal and external elements of movement offering the opportunity to discover what happened on a physical and feeling level. Breathwalking™ influenced women’s state of mind and they discovered that it could be a great ‘pick me up’ exercise after the baby is born. Breathwalking™ contributed to women’s sense of well-being by elevating women’s physical and mental energy and changing their mood level to the positive. One woman described the benefits she felt:

“I just noticed myself; I was really calm even just doing breathing and Breathwalking™” - Sarah

Beside Breathwalking™ women explored, learned and practiced conscious breathing. With conscious breathing women focused on bringing their mind into the present moment and concentrated on their own rhythm of breathing in and breathing out. Women valued the experience of ‘being with’ each in-breath for its full duration, each out-breath for its full duration, the pausing in between, and finally allowing thoughts and feelings to come and go. Andrea for example said:

“I liked the fact that you talked about the breathing we practice is very simple and manageable. We practice it in all different ways. Breathing with the walking, and active during the labour [rehearsal]. I know now it’s something you don’t have to think about ‘huh how did we do that again?’” - Andrea

This kind of simple conscious breathing served as a basis for all the interventions and skill development and was practiced throughout the entire workshop. Women practiced in stillness as well as in action, alone and with others, until their rhythm of breathing felt internalised, independent of the surroundings. Learning through practising was like peeling an onion, peeling off layer after layer until women reached a calm state of breathing, a state of being the observer of their own thoughts rather than being the thinker of their thoughts. Women felt relieved knowing that practising their own way of conscious breathing might be a wonderful self-help-tool for their upcoming birth.

“Definitely the simple breathing set an anchor. That was for me like the big takeaway of the movement. In whatever position I am, if I’m walking, if I’m leaning on the floor, if I’m standing or whatever, if I’m like in active labour, this anchor is something that I want to plant really deep into my subconscious because I know it’s getting me in the zone. Yeah!” - Lisa

“Breathing was ‘it’ for me as well. It was the same breathing but in different experiences I guess. Yes, we can use this as a very powerful tool” - Tina

*“The breathing we do subconsciously all the time; we are more conscious and I know now how I can use that to get through the labour”
- Sarah*

“The breathing was the only thing that kept me going” - Bella

Creating an experience in which women felt connected to themselves, being consciously able to calm down their mind and body was expressed as an invaluable tool to have in this fast paced and over-stimulated world. Feeling connected to a calm and

relaxed state provided the right base for the women to enter the next step of experiential imagination.

Women's birth signature™

Women's movement for birth

Through connecting motion and emotion, the workshop used the therapeutic strategies of movement therapy for women to find their own movement signature for giving birth. Although motion in general was not equally important to everyone, the women emphasized that knowing how to use their body and emotions to their advantage during birth might be an essential tool to learn in giving birth. One woman said:

"Yeah I agree, the movement it's just everything - absolutely everything and it's going to make all of the difference during labour, I think" – Bella

At first, women expected to gain clear and structurally defined physical movements and skills in birthing positions in order to learn how to give birth. They talked about how antenatal classes, health professionals, family, friends and media promoted certain body positions and movements they should take or do during birth. For example, being physically active and upright, circling hips, going into squatting or kneeling positions and in particular 'going with the flow' and 'trusting your body' were the main recommendations they had received.

The movement that we practiced and that you have helped me find because I wouldn't have recognized it without you just acknowledging a bit. That and the breathing was definitely perhaps what created such a successful and positive birth for us" - Andrea

Women's verbal dialogue revealed that particular recommendations to 'go with the flow' and 'trust your body' had no deeper meaning except of 'wait and see' what's happening with yourself when labour unfolds. In order to understand and acknowledge

the physical and emotional diversity of participating women, movement therapy offered different strategies. These were appreciated:

“It was very good content and I feel very prepared because I feel like that I know the real steps of labour and birth and how my body brings me to it, what happens with me. I feel I have more clarity” - Sarah

Acknowledging women’s individuality and uniqueness as soon as each woman walked into the room was part of the non-verbal information gathered by the group facilitator. The group facilitator observed women’s facial expressions as well as their physical movement and its qualities as women offered the first nonverbal expression of themselves. It was revealed in ‘how’ the women opened the door, walked into the room, or how they used their facial muscles displaying emotions such as excitement.

Movement therapy calls those physical movements with their individual qualities, the ‘movement signature’ of an individual person. How people move and the quality of those movements not only enable us to recognise family members from afar but it is also what makes us unique and endearing. The strategies of movement therapy helped women to develop observational skills making them aware of their own movement signature, their movement repertoire and what movement they used when they felt in a positive/empowering emotional state or negative/disempowering emotional state. One woman described how she appreciated this:

“I think we can read all the books and we try our hardest but actually [to] find it (movement) for ourselves and know that we are doing the right thing, it’s really valuable” - Tina

For women learning about their own body movements and their relationship to their emotions emerged out of an on-going playful and semi-guided process rather than from a deliberate process. The time women needed to immerse themselves into the

experiential intervention as well as the refreshment breaks were continuously adjusted to the women's needs. One woman described this:

"It was a very good variety of things, lets say we had physical movement and while we all had to get up and had our breaks in between, always as the group needed it, not just to specific times" - Lisa

Out of this process and with time and guidance women found their own body movements and postures where they felt at home and powerful. This was expressed:

"We have been able to find things that work for us, our own way. You haven't told us to do this way, or do it that way. You have let us experiment and find things that are working for us and then we have been able to share it sort of inspire each other as well. So, I think this is really useful because obviously during birth it's going to be us and ourselves and then we don't have to find those things too" - Andrea

After participation in this playful and semi guided journey women's individual physical movement and posture for giving birth was born. One woman said with a smile in her face:

"I guess, before any learning could take place some un-learning must have been happening" - Sarah

Women's emotions for birth

During pregnancy women had many opportunities to think about their upcoming birth in detail, however, it was evident that an inner image or a vision of 'seeing themselves giving birth' either existed vaguely or not at all. The movement therapy strategies were used to activate women's mental ability to consciously imagine themselves being in labour and giving birth. To support this process the group of women were semi-guided through three stages: women's general imagination of labour and birth, women's experiential imagination of labour and birth, and lastly, women's experiential

imagination of labour and birth connected with their desired emotions. These stages were designed to build one upon the other and were connected with each other.

Stage one was a guided process using imagination for women to connect with the labour and birth journey, in general. It was all about what women individually might see through the lens of their inner eye, what they might hear, what they might feel when they consciously imagined women being in labour and giving birth to their baby. One woman described this:

“It’s visualising and because I’m a visual person as well and imagining what [it] is going to be like when I’m in labour [and] ... now through the practice that we made [the whole process feels] a lot more empowering” - Lisa

Women used words to explain their thoughts and feelings, they told stories and shared drawings about their inner imagining. Further, they shared the images which were either highly inspiring resulting in positive emotions in alignment with their desired birth or images where they felt discouraged and that resulted in negative emotions. It was interesting to note to which approach they felt more compelled, to achieve the birth they desired or to avoid the birth they didn’t want. This process invited women to imagine the upcoming labour and birth further so that their imagination offered a clear picture of their perceptions, thoughts and feelings around labour and birth. It also showed what kind of birth they desired and what barriers might be there to stop them from achieving it. This was described:

“Visualising myself in the birth and in those different stages of birth and I imagined where I was and who was with me and just walking through that helped me” - Sarah

Stage two, the experiential imagination was a journey for women to dive into their own birth movement signature, which meant repeating it again and again, while ‘sensing

and creating' an imagination of their own desired birth. This was explained by women as:

"I kept imagining that I have already done this so I knew that I could have done the next contraction. Every time I had a contraction I just remembered going into position, coping with it, and knowing that it would end soon and that I have already done it. I kept trying to do this" -

Sarah

"Connecting the two of them (emotion and movement) through things like breathing, visualisation has definitely changed me" - Andrea

While women experientially moved in and moved out of their birth motion an imaginative picture of themselves being in labour developed over time. It was not about seeing themselves in the ideal birthing process it was more about feeling of being in the labour process. The relaxation and feeling of control was described as:

"Definitely, the visualisation for me has been huge because its something I think about a lot, things that make me feel calm and less anxious about what could be. So, yeah, I definitely feel a lot more relaxed and in control of what my body is about to do" - Lisa

Women said that 'seeing and feeling' themselves being in labour activated their senses. It was interesting to note that suddenly women's images had light, showed colour and sound and women intuitively added things to their images that they loved. The images offered clear pictures about how, where and with whom the women wanted to give birth. This stage provided a transitional and playful journey of experiencing an imagined labour and birth that made this journey not only 'as real as it could be', but actually made women feel and see their own birth-play-imagination; it became alive. Women expressed this as:

“I enjoyed moving and practising, I think the roleplaying is really powerful. It put yourself into the real, as it could be for the birth and just knowing how long or how short something may be. Just knowing the different stages and what to look for in different stages” - Anna

Experiencing the imagined motion and emotion of their birth instantly personalised the women’s journey in a way that enabled women to feel deeply connected to themselves and to the journey which lay ahead. Andrea described this as:

“I really like from yesterday that the fact that we were able to start practising and doing the roleplaying. So just putting myself in labour and I think that really helped me to understand and like, prepare me for being in labour. I know I have a lot better sense and have more confidence and I’m really intuitive” - Andrea

The semi-guided experiential imagination process was not a linear process as the stages were intertwined and connected with each other. It is also important to reflect that the women could not have done this in a state of unawareness or if the imagining did not fit with their own desires, values or beliefs. Women’s experiential emotional and physical birth-play-imagination of their desired birth not only empowered women’s own mental picture of giving birth, it further offered the first sense of control in this uncontrolled situation of childbirth. This was described by Tina:

“I just can see what’s happening, so I have clarity, I feel more confident in the physical and emotional ability and I can do it without [an epidural]” - Tina

Rehearsing the imagined process of childbirth again and again was a dynamic ritual that meant women were actively engaged, physically and emotionally, into imagining the process of childbirth.

“I really liked the roleplaying contractions, [the] music stops and you get a feel[ing of] hav[ing] a contraction. I think that hopefully would be an anchor ... for me... when it actually starts” - Bella

The birth-play-imagination repeated as a ritual, helped women deliberately to imagine and practise their own movement signature for birth while creating and holding their desired emotions until this felt internalised. This gave a feeling of confidence as described here:

“Yeah, both physically and emotionally it definitely made a difference in me and in times of confidence. I feel like I’m really ready because I only have a few more weeks to go. Doing those movements for labour that’s really empowering and to be able to just [practise] doing it and [then] actually doing it, so that when you are in labour you know I can do this and I now can imagine that I have pain and cramps that whatever will come. Knowing that, that’s really reassuring and, yeah, it gave me more confidence” - Lisa

Moving into and moving out of the movement signature for birth while holding empowering emotions for giving birth, was practised as a ritual and was constantly rehearsed throughout the entire weekend. This not only helped women to reflect on what birth they might desire, it further created an experiential imagination of being in labour and giving birth, again and again. This process was described as helpful by all women:

“I think before this weekend, I never have given birth and I still haven’t given birth, but now I feel like I have simulated a lot of the scenario. Visualized the whole process now from start to finish thoroughly enough that I feel like [I] almost have given birth. So now [when] I’m having my baby [it] will almost feel like doing it again and knowing this experience has been positive. I have no fear to have this experience even though I

know it won't be easy or hard. Those words are not appropriate (laughter)" - Andrea

"I think the biggest thing for me with your course was that I kept feeling like I have already done this. So the practice labours that we did I kept coming back to this on-going 'I have done this'" - Sarah

"This has definitely made a difference in terms how I feel, what I'm feeling to go into childbirth, which is really good. I know now that it [giving birth] is possible and I know exactly what will happen and so my mind is now connected to my body so much better because I can now trust that my body can do this and I can trust that I have the tools in my mind to allow my body to do its job - Lisa

"Physically, I have a feeling I'm prepared because mentally I know what is going to happen" - Tina

"I think I feel the same way (as Tina). I feel like this is giving me more information in terms of what is going to help me through labour and birthing and just sort of our rights as mothers and the active process as well" - Andrea

"I can actually get through this. So its really practical and it's definitely helped me to understand better and through the discussions... Yeah, I'm really intuitive" - Sarah

Women's Connection

Connecting relationships

Nurturing connection were the core building blocks of the entire experiential workshop. These building blocks were not something which were achieved under the guise of setting and tracking goals, but as something that has developed and grown over time.

Living connection meant being with women together and placing each participating woman's wants and needs into the centre of our care. This was described by one woman as:

"By doing the role-play and really practising the breathing and the situation and the timing and also talking through [where] we are at [in] the stage of labour, and practising all the different stages I think has prepared me. I have made the connection" - Tina

Connection, with its complex values in our lives was one of the core building blocks of the workshop. Although women did not mention the word 'connection' specifically, the desire to build 'relationships' based on trust, honesty and empathy was for women as important as the need for food.

"I really appreciate your approach to the course because you are so open and you build relationships very quickly and build that trusting honest relationship. And you give a very honest portrayal so it's really important in childbirth where it's something so big" - Tina

Spending a whole weekend together filled with creativity such as painting and writing letters to their unborn babies, as well as experiencing themselves through movement and emotion seemed to be an appropriate foundation in order to build and establish connecting relationships. Connecting relationship, therefore, meant for women spending quality time together, discover their individual personalities and characters in order to create a new experience of knowing, relating and making sense of their new journey into motherhood. Over time women enjoyed creating a sense of group cohesion while acknowledging each other individually. A connecting relationship was not limited to relationships between the participating women, or with the facilitator, it also occurred with women in their journey from womanhood to motherhood, with their changing bodies through experiencing motion and emotion, with their conscious and subconscious mind and in particular, with their babies.

Summary

This chapter presented the findings of the women's experience and tools they gained from attending the childbirth preparation workshop focusing on connecting the women's motion and emotion. The women appreciated having conversations with the participating women, between themselves and their babies. The women developing their own tools based on breathing rhythm, their body in motion and their desired emotion was valued in order to have the right tools for labour and birth. The next chapter explores what tools the women gained from the workshop and which ones were used successfully during labour and birth.

CHAPTER SEVEN: THE WOMEN'S BIRTH EXPERIENCE AND THE EFFICACY OF THE TOOLS THEY USED DURING CHILDBIRTH

Introduction

The previous chapter offered an overview of the experiential childbirth preparation workshop itself, which was based on movement therapy, and what tools the women gained from participating in the workshop. This chapter explores how the tools were used during labour and birth. The core themes from these data are directly related to the themes identified in the previous chapter. The core themes were 'Inner Dialogue', 'Using Inner Tools', and 'Feeling Connected'.

"Yes. I think without doing that course I would have gone into the experience that I had much more naively and with probably not the same enthusiasm and optimism that I had gone into birth. I think it should be compulsory for women to have to do something like that to achieve maybe more natural positive birthing experiences. Because I would have only been in the hands of other's people expertise whereas I knew that I had it all within me and I had tools to hold onto. If I didn't have that, I would have had somebody else's idea of a birthing experience and not my own" – Lisa

The first core theme 'Inner Dialogue' explores how the women used their own thoughts and inner words in order to change their emotional state to feel more empowered.

"...By the role-play ... and all those things that prepared me mentally to get me ... ready and empowered to give birth. It really did, I really felt after the course and that's why I remember texting and thinking I need to be back [there] because I remember that feeling; so just thinking "Oh my gosh, I can do this now. I feel empowered" - Andrea

The second theme 'Using Inner Tools' explores what the women's perceptions of what tools they used successfully in order to deal with challenges for labour and birth. The themes consist of two sub themes, 'breathing rhythms' and 'women's birth signature™'.

"You didn't force us to believe anything but it was about finding (tools) for ourselves" - Andrea

The third theme 'Feeling Connected' explores how feeling connected to the group of women from the workshop helped the women during labour to feel encouraged and empowered.

"So I really think women need those kind of stories from other women who walked the way, in my opinion, to support [my labour]. I have to think about how we can really get this more...This is another story" - Andrea

"The two days together for a whole period of time, I think is enough to say "Okay, let's keep these connections or to make connections" - Lisa

Although the themes are presented in a linear order within the chapter, the women's use of those tools during labour and birth were intertwined. Similar to the previous chapter, the quotes are from the women but the added field notes and drawings are presented in support of the findings.

Using Inner Tools

Inner dialogue

After the workshop and before the birth

As discussed in the previous chapter during the workshop the women became familiar with holding an inner dialogue with themselves and with their babies. The mothers-to-be practised holding a dialogue with their babies through words, humming songs,

through writing and drawing a story, and through their physical touch from the outside in. Being in touch with their babies and creating a deep mother-baby pre-bonding experience was one of the goals of the workshop (Kluny & Dillard 2014). After the workshop and before the birth the women kept the dialogue with their babies alive. They all stated that they talked with their babies and some women even started writing a dairy, humming songs or using their own imagination. This was described by Lisa:

“I think we spent a lot [of] time with our babies, and we did a lot of meditation and concentrating on what we could feel and think about them. Yeah after that [meditation] I was like, ‘oh okay, I’m going to start thinking about what I want for you’. So, I started writing things down whenever something popped into my head, things that I want to say to her, metaphors, or quotes. The connection to my baby was very nice and was the reason the meditation was really helpful” - Lisa

The women created different ways of holding a dialogue with their babies, which they perceived as a useful tool during labour.

[During Labour and birth](#)

Besides holding a dialogue with their babies within, the women learned to be the observer of their own inner thoughts. For the women, building an inner dialogue with themselves, knowing how to turn an accumulation of negative thoughts into something positive, was one of the important tools of self-development gained from the workshop. During the workshop the women were invited to calmly watch what was going through their mind and became aware of their own thought patterns. Practising holding a positive dialogue with themselves to counteract disempowering and negative upcoming emotions, if needed, was one tool the women gained during the workshop.

The women talked about their inner dialogue during labour and birth where some of the women became suddenly anxious, started crying or became panicked. The women explained when they were in labour negative feelings and emotions suddenly

appeared, making them concerned and distracting their attention from what they were doing. Bella was at home when she went into labour and at some stage she started crying and panicking. She said:

“I started panicking and knowing that this (feeling) might stuff my endorphins and then I thought no person in the world can help me even if I go to the hospital. You know, so I just thought ...I have to regroup myself, then I washed my face and put my information head on. Information, I mean was just that my body is designed to birth and my body and my baby will be in tune and committed. Yeah, I trust my body to give birth. So then I really tried to calm down” - Bella

Bella talked to herself positively and forced herself to smile because she was really determined to erase all those (negative) emotions until she turned her panic attack into feeling positive and happy to get everything going as it's supposed to happen.

Bella described her experience of going to the hospital in established labour and arriving at the birthing house. Three midwives welcomed her at the door, and they said welcome to [the primary birth unit] and they smiled. Bella said:

“I could hear myself talking (inside); really, I don't need that sort of welcome. I just need to go to the room and birth. It was quite funny, almost that I was hallucinating” - Bella

When listening to Bella's story it was noticeable that her demanding self-talk had the purpose of restructuring her mind and her focus. Whereas her short-tempered self-talk was in order to be brave enough to stand up for her needs. Bella said:

“I went to the bathroom and I just said turn the lights off please, can you bring me a chair? I need a chair!” - Bella

When Sarah was in labour she started her inner dialogue with thinking about the workshop and what the group talked about. Sarah said:

“I thought about that you mentioned that it’s ok to make noise. You know then the assimilation thing we did and the role play came into my mind and I (internally) said to myself, well ‘I have done this before and I can do it, and it’s ok to talk to myself and...” - Sarah

During labour, Sarah held an inner dialogue to achieve a sense of encouragement and reassurance that it was okay to follow her urge to make noises. This self-compassion inner dialogue was important to Sarah because it gave her consent to follow her intuition and do what she needed to. Holding an inner dialogue from within gave Sarah enough power to keep going with the challenges of labour and birth.

When Bella was in labour she was not holding a dialogue with herself, however, during labour she was holding a moving dialogue with her baby. Feeling her baby move during contractions activated Bella’s desire to help her baby to move further and further down. Bella said:

“I had my eyes closed the whole time and felt my baby move. I was twisting my body and then she was twisting her body and I also felt that we both were twisting at the same time. It’s almost [in order] to fit through, yeah; we both were working to kind of fit the puzzle through”

The women described different ways of using the tool of ‘inner dialogue’ with themselves and with their babies. However, each dialogue seemed to be highly beneficial and supportive and appeared to enable the women to do what they felt they needed to do; connecting themselves to the labour contractions, embracing the intensity and giving birth to their babies.

Breathing rhythms

The women's own rhythm of breathing in and breathing out, was an essential tool the women took from the workshop and reported that they used successfully during labour and birth. As mentioned in the previous chapter the women experienced the technique of breath-walking and mindful breathing, which established the base for women to discover their own pace and depth of breathing. During the workshop the women continually practised relaxing, to purposely and with focus, breathe in and breath out. Eventually the woman's own rhythm of breathing was established. Even this kind of conscious breathing seemed to be simple but it was a powerful tool to help the women to relax and bring them back into the centre of what they ought to do. Examples include breathing through contractions and relaxing while 'being in labour'.

One woman said:

"Yeah, I just dealt with the pain with breathing. Between the contractions I really tried to relax and do everything I learned through your workshop. I also tried to relax during contractions and just go limp. I remember thinking that because I understood the process behind contractions and what they are and what they do, I actually appreciated it as they became stronger and heavier" - Bella

In regards to the breathing, a goal of the workshop was that women enjoyed finding their own breathing technique and embraced their own breathing rhythm that worked for them. Therefore, during the entire weekend women practised being in the moment in so many different ways, taking a conscious breath in and breathing out until it felt internalised. When listening to the women's birth stories it became clear that attention to breathing prevented them from feeling overwhelmed and out of control during labour and birth. When Bella was in labour she hid in the toilet and when her midwife came to find her, her husband said 'she is silent and in labour'. She said:

"I didn't try to be silent but I was, naturally and I found the breathing was really helping. I always kept breathing through my mouth but the

only way I could deal with pain was through breathing and every time I gasped (took a breath) it somehow made it better. I'm not sure why" -

Bella

Taking a deep abdominal breath in and blowing it out, rhythmically through the mouth and gasping like a fish was the kind of breathing Bella established during the workshop and used successfully during labour. Breathing in and out through the mouth or gasping like a fish is not something that seemed to be recommended by conventional wisdom but it worked well during labour for Bella. During the workshop the women learned about breathing techniques recommended by experts such as yoga teachers and were encouraged to consider those recommended techniques. However, they were also encouraged to stay open-minded and explore themselves in order to properly find a technique or a way that might work best for them. Over the weekend the women established their own breathing patterns and repeated their technique many times and in different ways so that the repetition embedded their new breathing skills. When Sarah was in labour she said:

"From the course I think the breathing technique helped greatly. I just remembered to breathe in and breathe out, although it was getting harder and harder towards the end" - Sarah

When Lisa was in advanced labour and focused on breathing she said:

So, I did the breathing the whole time and I visualised the baby being pushed out like a coffee plunger. My body was the plunger and the baby would be the coffee and that's all I kept imagining - Lisa

When listening to the women's birth stories they all expressed, in one way or another, that labour and birth was not easy and was getting harder and harder as it progressed. However, they also stated that using their own breathing rhythm of simply breathing

in and breathing out made it possible to cope with each contraction at the time. Tina said:

“Really the breathing really kept me going” - Tina

Because the workshop was for women-only it meant that it was up to them to discuss any coping strategies they set in place with their birthing partners. In order to achieve the best support, some women decided to practise the breathing before going into labour and some women did not practice before at all.

“I broke it (breathing pattern) a lot of times, and I tried to come back or Max kept on trying to bring me back” – Lisa

“I think the breath walking was really good, especially now when I’m tired I find that very useful... you know; that was really true, and breathing was definitely the key [during labour and birth] along with the movement” - Andrea

Sarah said:

“I definitely practised breathing in and breathing out when I was walking. Otherwise I wouldn’t have done it during labour because I wouldn’t have practised. I think that’s really important to practise. I mean the perception of pain and things like that is different for everyone. So I think it’s important to get your breathing under control and get your mind flowing” - Sarah

During labour the women said they sometimes ‘broke the flow’ of breathing but they remembered, sometimes with the support from their birth partner, how to get back to their own pace and depth of breathing in and breathing out.

“The breathing was really what got me through. I remember you saying if you don’t remember anything just breathe and you will get through. The breathing was the key along with the movement” - Andrea

“Yeah, so knowing exactly what was happening made it much easier for me and it wasn’t easy. It all became internalised. The movement and role-play and all those things were internalised. So it made sense when it was happening. I think this sort of puts you in control of it” - Lisa

Women’s Birth Signature™

When the women talked about their movement and emotional experience during labour and birth their stories were not only related to the birth experience itself they also referred back to what they had learned and experienced during the workshop. As explored in the previous chapter, during the workshop the women experienced different strategies; a collection of interactions chosen by me in order for the women to develop their own motion and emotion signature for labour and birth. Experiencing their own birth signature™ made it so real and meaningful to the women that they decided to use this combination during labour and birth. The women explained that having those tools from within and knowing they were accessible to them anytime increased their self-confidence about their own ability to give birth. Sarah said:

“I didn’t practise the movement stuff but the practise that I did in the course really ingrained it in my mind. It just went through my head instead, the thing (movement) that I could do. It (the movement) just came naturally and just knowing this is what I meant to do, that helped. That weekend helped to build my confidence” - Sarah

When the women left the workshop they felt empowered and had a positive outlook towards their upcoming birth. Some women explained that they continued to use different strategies or exercises such as Breathwalking™ and experiential play-imagination they had learned in the workshop in order to stay positive minded and physically well prepared for the birth.

Lisa said:

“It was the positivity as much as any specific tools that helped. People who have had babies all kept saying you are very optimistic. They thought I was being unrealistic whereas I knew that I was being optimistic” - Lisa

When the women went into labour they talked about how their birth signature™ kept coming back. This meant they remembered, and their bodies remembered, to breathe in and to breathe out. They also remembered the flow of moving in and moving out of relaxation and action and they remembered their own body motion and position they developed for labour and birth. Importantly, they remembered how to keep their desired positive emotions alive during the journey of labour and birth.

“The movement was definitely key. I remember during pushing you said this little hint just the position to lift your tailbone and that came to my head at that moment and that helped hugely. Just being aware of what can happen at different times and when those things happen during birth then you feel confident in doing it” - Andrea

When Andrea was finding her own motion for labour, the motion and position her body had chosen took her by surprise. This was a movement she never used on a regular basis but it still was a movement she felt comfortable with. Andrea said:

“I knew exactly what my body needed to do during them. So the position that we’ve found worked for me was exactly what I did during birth and during the contractions. I just knew what to do. So, it was really, really good....even in the water, that same position again and the same movement were what I continued. It was one movement, really but the whole way through it worked for me” - Andrea

It was different for Lisa as her body in motion revealed her physical movement was a combination of an exercise motion, which she used during her dancing career. Lisa said:

“I kept imagining that I have already done this so I knew that I could have done the next contraction. Every time I had a contraction I just remembered going into position, coping with it, and knowing that it would end soon and that I have already done it” - Lisa

Through the intervention, based in movement therapy, each participating woman developed her own way of moving her body, her own motion for labour and birth. The women knew this was something they had within themselves and it was something they could hold on to.

“I knew I had it all within me and I had tools to hold onto. If I didn’t have that I would have somebody else’s idea of the birthing experience and not my own. I definitely had anchors from the course that shaped me to cope. Definitely, the simulations were really...have attached the idea that I have already done it, so I can do it again. It was familiar” - Andrea

During the workshop achieving a positive and empowered state of mind and experiencing its effect was addressed in different ways. The women enjoyed learning about this themselves through sharing stories, through art and movement and through understanding what was actually happening on a biochemical level. Bella tried it for herself during labour and she said:

“Also knowing that smiling, we actually discussed that; even if you force a smile it releases endorphins. So I sat there in the darkness trying to smile, making myself smile, because I was really determined to kind of erase all those (negative) emotions and completely flip it and try to be

positive and happy to get everything going as they're supposed to happen" - Bella

Establishing a positive mental state and the constant flow from moving into the breath, motion, position (tension) and letting go or moving out of the breath, motion, position (release) was practised again and again until it felt internalised. Practising their own motion and emotion for labour and birth, again and again, made the birth experience for the women feel familiar.

"So the labour rehearsal was definitely worthwhile because it gave, I think, from being quite anxious about the rhythm; I really didn't quite understand just exactly what was involved in a contraction and how long that would be. So by walking through the different parts of the birth and timing and practising what you do in that time, it was really beneficial because we had made it real. Then when the contractions began, I felt more comfortable about what was happening and about the timing that was happening in that moment and also aware of what was to come" - Andrea.

After the workshop the women expressed that:

"The birth play took some of the anxiety of birth away" - Tina

Experiencing themselves, their own motion and emotion for labour and birth; seeing and feeling themselves doing it, and knowing that the tools they really need are themselves, helped the women to believe that they could do this. Sarah said:

"The assimilation, the role-playing came into my mind, I have done this before I can do it. Yeah, it made a huge difference" - Sarah

Having the opportunity to develop their own birth signature™ and also having the opportunity to practice and master their own birth signature™ made a difference in the women's birth experience

"I think the course was really great because you didn't introduce a whole lot of ideas and new things....about fundamental skills that were going to help during the labour and birthing process. We did that in different ways throughout the 2 days and all of your different activities and exercises, the same breathing, moving; all of those things were sort of building upon it becoming more, I guess, embedded, and what was I going to do. So, ...things like even the breath walking and the 4 second breathing and that lead to the movement. So all linked together to create something that was going to work for use. So I think it was really good. It was fantastic because I didn't feel like I need a notebook to write down a million different things that I wouldn't have remembered anyway, by you repeating a whole lot of exercises and practices and with us talking. It just allowed the simple things that we have found that works for us become embedded" - Andrea

Feeling Connected

During the workshop the women enjoyed and valued the connection they established with each other. For some women the connecting relationship they developed during the workshop developed further into a friendship after the workshop was finished.

"The two-days together for a whole period of time; I think it's enough to say let's keep these connections. Now some of my best friends are from that course. So I don't think it would have happened if it had been only a one-day course" - Lisa

When Bella went into labour she said that she felt deeply connected with the women of the universe whereas Sarah felt connected and empowered by thinking about the women of the group.

“I think I was empowered through the other women in the course and just knowing we are all going through this and knowing that other women have done it. Yeah, so I didn’t hold onto that fear, so I just let it go. If I didn’t go to the course I think it would have been a different experience” - Sarah

Tina described how the group of same-minded women encouraged her, and made it possible to feel strong during this time of challenge.

“Being in a group of like-minded women, I felt kind of stronger. I felt like we are a different type of women, and these women are exactly like me, they want exactly the same thing, it’s not just me” - Tina

Knowing that they were not alone, knowing that what they wanted for themselves and their babies was not unreasonable, equipped the women with inner strength and made the entire process for the women walk-able. Further, the women talked about how vital it was, to their own sense of trust, to feel connected to the person who facilitated the workshop. It seemed that the women not only focused and valued the experience of knowing how to use their body and emotions as tools for labour and birth, they equally valued feeling being seen, held and listened to by the facilitator’s approach. Seeing, feeling, hearing and knowing that the facilitator believes in women’s strength and ability to give birth to their babies helped the women to build self-trust and reinforced their own confidence in their ability to give birth. Andrea said:

“With you and the time you put into us, having someone who believes in you and to give me those tools to believe in myself that changed me within” - Andrea

On reflection, women felt that the combination of experiential learning and intellectual learning reinforced her self-trust and wisdom to an extent that her thinking and self-belief changed to the positive. They said:

“The movement that we practiced and that you have helped me find because I wouldn’t have recognized it without you... That [movement] and the breathing was definitely perhaps what created such a successful and positive birth for us” - Andrea

“The movement was definitely key. I remember during pushing you said this little hint just the position to lift your tailbone and that came to my head at that moment and that helped hugely. Just being aware of what can happen at different times and when those things happen during birth then you feel confident in doing it” - Sarah

“While I was at home it was just as if I was in your class walking around listening to music and then when my contraction happened I find my position, staying there and getting back up. It was basically like I was in the class it was happening for real” - Lisa

“The women felt connected to themselves and their babies within, to their journey and to the other women. This encouraged the women to experience their inner tools and transformed their belief in their ability to give birth from ‘I hope I can do this’ to ‘I know I can do it’” - Bella

Bella said:

“And of course, having you as a real person instead of just books I found it not only more enjoyable but it also gave me almost like the feeling of backing and strength. Even when I was in my early labour I always kept thinking about you, what you were saying and just your confidence that

we can do it. I always kept thinking, I actually said to my husband, I wonder if I shall call you. For some reason it helped. I had someone who understands, has my value[s], my views. Your confidence was so contagious, you know. I thought if you were so confident then I could be too, I can do it"

Andrea said:

"You are so passionate in research and everything so I think that really helps to change people's pathway and their thinking and self-belief. I really believe your words because you live and breathe it, which makes all the difference; it was the turning point of my self-belief"

"Yeah, absolutely and that was the same thing again as that you didn't force us to believe anything but it was about finding for ourselves. So you gave us tools to take on what we needed to be able to do it. That was exactly what happens by doing that; it all became internalized, and that's where the movement and the role-play and all those things were internalized. So it made sense when it was happening" - Lisa

Summary

This concludes the presentation of the findings of the research. Chapter Four revealed the women's expectations of the childbirth preparation workshop, which was based on connecting the women's motion and emotion for labour and birth. The findings showed that the women valued the small group and to be with women-only. When the women thought about their upcoming birth they experienced mixed feelings, ranging from excitement to deep-seated fear, however they hoped to gain some tools in order to feel in control and achieve the birth they desired. Although the women felt well informed about the childbirth process and were happy learning about how their baby developed, they missed a deeper connection to their changing self and their babies. Therefore, they hoped to gain some tools in order to feel more connected to themselves and their babies.

Chapter Five explored the women's experience as well as the tools the women gained from attending the experiential based childbirth preparation workshop. The findings showed that the workshop appeared to have an impact on the women's confidence in their own ability to handle the challenges of labour and birth. Finding their own tools from within played a significant role in the process.

Chapter Six explored the women's childbirth experience in regards to the tools they gained from the workshop and explored how they used those tools successfully during labour and birth. For the women discovering their own tools coming from within was a journey of experiencing, reflecting, adjusting and manifesting. Movement therapy helped women to develop their own tools from within which they used successfully during labour and birth. Holding an 'inner dialogue' with themselves comforted the women in the sense of allowing them to do what they felt they had to do. 'Breathing rhythms' enabled the women knew their own breathing rhythm and this helped them to stay calm and focused. Creating the women's own birth signature™ helped women to physically move their body and stabilise their emotions and use this combination to their advantage. The women in one way or another used all these tools. The tools appeared to have increased their ability to tolerate the uncertainty of childbirth, they also appeared to have increased their belief in their own ability to labour and give birth to their baby.

"I think without doing the course I would have gone into the (birth) experience more naively and probably with not the same enthusiasm and optimism" - Andrea

CHAPTER EIGHT: DISCUSSION

Introduction

This chapter discusses the findings of the study in relation to the extant literature in this area in order to reveal supporting evidence for the findings. It also aims to identify where this study adds new insights into programmes of preparation for childbirth. The chapter discusses each of the three key themes: Women's 'dialogue', 'developing own tools' and 'Connection'.

The first core theme was 'Women's Dialogue'. Before the workshop the women expressed a desire to have a sense of belonging with other women from the group. During the workshop, through discussion and sharing of experiences, a sense of trust developed and the women were able to dialogue comfortably. They were also able to use internal dialogue to positively help them through the birth experience.

The second core theme was 'Tools from within'. The women came into the workshop asking for tools that they could use that would enable them to confidently and capably deal with the birth experience. During the workshop the women explored their own familiar movements (motion) associated with empowerment, energy and positive emotions and were then able to use these during the birth process.

The third core theme was 'Connection'. Before the workshop some women stated that they did not feel a connection between their mind and body. Others felt a lack of connection with their baby and expressed their concern about the birth. During the workshop, time was given to developing self-awareness such as body movement, emotional awareness and their own desire for their forthcoming birth experience. After the workshop the women felt well connected to their movements, emotions and to their babies. They also had developed a deep connection with each other, which they greatly valued. The women reported that during their birth process they felt a connection with their baby's movements and were empowered by their bodies.

In this chapter, the answer to the research question will be discussed, and how the findings contributed to the literature in regards to childbirth preparation. The childbirth preparation programme was held as a weekend workshop and in this chapter will be referred to as the workshop.

Women's Dialogue

The term 'dialogue' is derived from the Greek word 'dia – logos'. It is rooted in exploring the nature of choice and its essence is based in learning, connecting and building meaning (Bohm et al. 1991). It is a way of thinking and reflecting that seeks new possibilities, options or alternatives (Isaacs 2008).

Being 'in dialogue', means being engaged in a conversation between two or more people to explore a particular subject. When a dialogue was established between the women in the workshop it created a comfortable environment for them to share their fears, concerns and questions as well as their values and beliefs around pregnancy and birth. Being engaged in this process of sharing and expressing their emotionally charged life stories was pivotal for the women. The women being in dialogue with each other, with themselves and their babies was not a linear process that could be achieved quickly as it was a step-by-step process that developed over time. The journey went from finding a sense of belonging within the group, to holding a conversation, and finally being in dialogue with each other through words, art and movement. Finally when the women went into labour they used this kind of dialoguing as a supporting tool. What this journey meant to the women, and how this journey is regarded in terms of the literature is explored in the following section.

Sense of belonging

When the women were asked about their expectations of a childbirth preparation workshop a 'sense of belonging' was expressed as important. The second expectation was, time to talk in order to share ideas, questions and experiences around their individual pregnancies. The women expressed the need to belong and talk together as being as important as their need for food and shelter. This vital human need to belong is also confirmed by Baumeister and Tice (1990). As early as 1943, Maslow identified

that a sense of belonging, including the need for friendship, intimacy, and love from groups, family, or friends was one of the first five basic human needs. As Anant (1966) explained, to belong, for example to a group, is an experience of personal involvement and creates the feeling of being an integral part of a group.

When the women heard about the proposed workshop, and the opportunity to participate actively with other pregnant women who had a similar approach to birth as themselves, they were enthusiastic as this was exactly what they were looking for. In setting up this workshop the intention was to create and provide an environment where the participants felt a deep sense of belonging so that they felt connected. In other words, it was recognised that nurturing a sense of belonging causes greater feelings of social connection (Rimé 2009), of closeness (Gable et al. 2004; Reis et al. 2010) and offers the potential to create intimacy (Laurenceau et al. 1998). This was a critical element in developing the workshop in order to establish the best possible outcome. In contrast, an absence of belonging is associated with negative feelings such as anxiety (Baumeister & Tice 1990; Leary 1990), sadness (Leary 1990), anger (Williams, Shore & Grahe 1998) and lower self-esteem (Zadro, Williams & Richardson 2004). Both the fulfilment of belonging or absence of belonging has significant positive or negative implications for psychosocial well-being (Sargent et al. 2002). Therefore the women's expectation and basic need 'to belong' required serious consideration as it established an atmosphere of safety, the foundation for what was further developed in the workshop.

When a 'sense of belonging' developed and deepened within the group, the women's desire to share their story and listen to others' stories also developed and deepened. In other words, a 'sense of belonging' seems to be an essential prerequisite before emotional disclosure between people can occur. These observations were confirmed in a study by Hackenbracht and Gasper (2013) who investigated why people have a desire to regularly disclose their emotions with friends, but not with strangers. They proposed five possible explanations: interest, belonging, mood, self-esteem and validation hypotheses. The findings showed that the need 'to belong' had to have been

fulfilled for people in order to be motivated to listen to their friend's disclosures of emotions (not to descriptive information). The author proposed that when people listened to an emotional disclosure with "all ears" it might also help them fulfil their own need to belong (Hackenbracht & Gasper 2013, p. 5). When the women who participated in this study nurtured their sense of belonging through sharing their emotional narratives it not only increased their feeling of closeness and social connectedness (Rimé 2009; Reis & Shaver 1988) it also generated the desire to keep the communication flowing.

Communication

The workshop provided an environment where the women could communicate with other women on the same journey. Women from the group valued having the opportunity to communicate with women-only because they could share their concerns and issues that they did not feel comfortable sharing with their partners. They also found that their questions or concerns were different from their partner's.

Although research has not provided clear findings regarding the way that women and men communicate (Canary & Hause 1993), one researcher has described major differences in communication as well as learning styles between men and women, which go far beyond mere socialisation (Tannen 1991). Males use communication to gather information in order to find solutions and to evaluate their status within the group. In contrast, women use communication to seek input from other women, to negotiate closeness and to create intimacy with others. The female way of communication is based predominately in democracy and looks for agreement, with the desire to feel the same (Tannen 1991). In this situation the women in the workshop were grateful for the opportunity to share their experiences and concerns from a woman's perspective.

The women felt nurtured and safe with this female way of communicating. They stated that experiencing the closeness and intimacy between each other and getting a sense of being understood, was something women hoped to gain from the workshop. Despite the findings about gender communication in general, it is important to focus

on what is known and not known about pregnant women's needs regarding communication and learning in particular.

Some techniques used by childbirth educators are unhelpful to women's learning. A systematic review involving nine trials of 2284 women examined how childbirth educators delivered content in group-based and individual childbirth preparation courses (Gagnon & Sandall 2007). This review showed that the expressed educational and communication needs of participants were not considered within these programmes, nor was the teaching delivered in a way that was of any benefit to the women (Gagnon & Sandall 2007). This resonated with women from my study. Four out of the five women from the group attended conventional childbirth preparation courses prior to the study in the hope of learning, connecting and communicating with other like-minded pregnant women. Two out of the four women were satisfied with the overall course content, however none of the women were satisfied with the way the content was taught nor were they satisfied with the way communication was fostered.

More beneficial ways of teaching childbirth education have been explored. The concept of 'connected teaching' described by Belenky et al. (1986) reveal what it means to bring the feminine principle into the educational relationship. These authors relate the feminine principle to the midwifery model of teaching where midwives help women to draw out women's stories and birth their own ideas. Belenky and colleagues (1986) describe how connected teachers are the 'believers', who trust and have faith in their students capability of thinking and how it is the teacher's task to encourage students to expand their ideas. In relation to the workshop the teaching was based on the midwifery partnership model (Guilliland & Pairman 1995). This partnership model is woman-centred which means it places the woman at the centre of care, celebrating the centrality and value of the woman's experience (Eisenstein 1984). In regards to the workshop the facilitator supported each woman to focus on herself and her baby whilst the facilitator's focus was on the whole group. Facilitating the childbirth

preparation workshop in partnership 'with the women' was the fundamental difference between this workshop and conventional childbirth preparation courses.

When the women-only group in my study shared what mattered to them it was not a discussion where they were forced into feeling they needed to reach a goal or to find solutions to specific problems (Isaacs 2008). It was more like a 'dialogue', an on-going process of exploration, reflection and reasoning together (Grönross 2000) and a suspension of solution-focussed thoughts, to which all the women could relate.

Participants tended to identify 'being in dialogue' as sharing and looking together down through layers of meaning to the mutual examination of their own values, beliefs, thoughts, hopes and assumptions about labour and birth. This became the central focus and driving force behind the women's dialogue. Being in dialogue was a desirable way for the women to uncover their un-discussed thinking and to create shared meaning so that the wisest learning and decision-making could emerge (Isaac 2008; Palus & Drath 2001).

Dialogue through art

There are many ways women can be in dialogue with one another and this was explored during the workshop attended by the women in my study. Besides the importance of verbal dialogue there is art-based creativity, such as spontaneous drawing, non-dominant handwriting and authentic motion, which can be used as a vehicle to be in dialogue with the self and with others. The language of art-based creativity holds not only a pleasurable aspect; it also uses a wider range of a person's emotional and mental capacity (Naiman 2016; Riley 2001). There might be times in a woman's life when dialogue based on verbalisation has its limitations. Casey and Dalley (1987) stated that art-based intervention could be supportive in times when words feel invasive and interfere with the process of recognition. Some pregnant women might find verbalisation challenging. They may be innately shy, or feel reluctant to talk about their issues, or they may come from a non-English speaking country and their linguistic skills are restricted (Lett 1993).

Being engaged in a dialogue through creating art not only offers new insights, such as newly-posed questions and answers, it also has the power to act as an antidote to information overload (VanGundy & Naiman 2003). These authors explain that the art-making process helps us to find our authentic voice and creates a bond between two existing worlds. These consist of the objective outer world, which is shared with others, and the subjective 'inner' world through which we experience our own existence and filter our perception of the world that surrounds us (Lett 1993).

During the workshop, integrating art-based methods into childbirth preparation initiated different ways for the women to tell and express their stories. The women explored their inner and outer world, around pregnancy, labour and childbirth through the mediums of motion (movement) and drawing along with group discussions and self-reflective writing. These art-based activities used in the workshop served as an instrument for the women to find deeper meaning. The tools helped women to develop new questions in order to find an emotional truth about their individual situation. The women from the workshop confirmed that the expressive art approach allowed them to move away from focusing on the issues (objective world), to channel and express their feelings in a different and unknown way, which helped them move into a new and solution-orientated direction.

In my study, the multiple ways the women were in dialogue with each other and with themselves fulfilled their desire and need for connection, exploration and learning. The time in between, attending the workshop and before moving into the journey of labour and birth, the women kept writing and drawing journals, continued talking with their babies and kept in touch with others in the group.

Inner dialogue

During labour and birth, women from the workshop used the techniques of maintaining positive dialogue with themselves that they had learnt during the workshop. This birth dialogue was based on holding non-verbal conversations internally. However, how the birth dialogue became activated, what purpose it fulfilled for the women, and what it meant to the women was quite different than during

pregnancy. In order to highlight the difference, it is important to discuss what it meant for the women during labour and birth.

There are a number of different terms used to describe inner dialogue. Equivalent terms, which vary in meaning, are found in literature. These are: inner dialogue, inner speech, egocentric speech, self-communication, self-speech or self-verbalisation (Hardy 2006; Morin 2005). Self-talk (inner dialogue) can be described as what we covertly tell ourselves (Ellis 1962) in order to use this as a self-influencing tool to improve personal effectiveness (Hardy 2006; Neck & Manz 1992). Additionally, self-talk is used in many different disciplines such as sports psychology, clinical psychology, counselling psychology, education and communication, and has been studied in relation to performance (Hardy 2006).

A systematic review of the literature examining the relationship of self-talk to performance included 47 studies in the area of sport related activities, sport psychology and behaviour (Tod, Hardly & Oliver 2011). The findings indicated that positive, instructional and motivational self-talk has a beneficial effect on performance. However, the results on self-talk with regards to the athletes' confidence were not given or were inconsistent.

In my study, in order to increase women's confidence and find coping strategies for labour and birth, the women received tools to develop and experience their own creative self-talk. This kind of inner talk fulfilled the purpose of self-exploration and self-reflection rather than setting expectations as athletes might do to motivate themselves to perform well. Despite the existence of many self-help websites encouraging women to listen to positive affirmation tapes, no evidence based literature was found on using positive affirmations or self-talk as a coping strategy for women to deal with labour and birth. In addition, contemporary childbirth education models such as Lamaze, the Bradley Method, Hypno-birthing after Morgan Method (Morgan 1996), Mindfulness Childbirth, Birthing from Within and International Childbirth Educators Association do not use self-talk, inner talk or positive affirmations

within their teaching (Walker, Visger & Rossle 2009). In this workshop, the tool of self-talk was created for women to explore and anchor their own ideas, pictures and positive emotions around labour and birth. This was a unique approach to support women's confidence towards childbirth and distinguishes it from what is commonly known as self-talk.

Self-awareness and self-talk, also called inner speech, has not been widely studied. Morin (2005) proposed a neurocognitive and social-ecological model of self-awareness investigating the connection between self-awareness and inner speech. This study proposed that a general state of consciousness, and in particular self-awareness, most certainly represents a prerequisite for inner speech. Morin refers to self-awareness as the capacity to become the centre of one's own attention, where the individual actively identifies, processes and stores information about the self. In my workshop, experiential interventions based on movement therapy were used in order for women to place themselves into the centre of their care and to gain awareness about themselves. This included women paying attention to their mental state such as their perceptions of positive and negative intentions or emotions. Further, women gained self-awareness about their bodies through proprioception and reflective thinking upon themselves, through experiential imagination and inner speech.

Inner speech serves many functions such as verbal self-regulation and self-guidance, problem solving and planning, and memory (Morin 2005). When the women in my study went into labour they used inner speech as a tool for self-regulation and guidance. The women talked about how they were able to create a distance within themselves and the present situation (severe labour pain) through their inner self-talk, which offered a new perspective they had not seen before. Holding an inner talk included seeing and feeling their own positive pictures and emotions, which helped women to overcome the hurdle of labour pain.

In summary, during the workshop, women communicated with each other through a variety of ways. After developing a sense of belonging through a sense of trust with

each other, women began using different forms of dialogue. Dialogue, as a special kind of discourse, enabled them to share their emotionally charged stories, their concerns, visions and desires, and their different perspectives of labour and giving birth. The power of dialogue lived through the women's spoken word, the shared stories and the non-verbal forms of art and physical movement. The purpose of dialogue was not only to create a climate of good faith; it focused on creating a supportive bond between the women. The workshop took the women-only group away from the usual way of exchanging information into the core building blocks of meaningful relationships where understanding and learning from one another was experienced. The women from the workshop enjoyed sharing with each other their ideas and hopes regarding labour and birth.

Women's Own Tools for Birth

Regardless of what type of birth the women were aiming for, they expressed their desire to gain tools that they could use to cope with the challenges of childbirth. Certain tools were recommended by family, friends or different health professionals in order to make labour and birth easier, more comfortable or more effective. The offered tools ranged from non-pharmacological to pharmacological support tools and tools which could be grouped into applying to the outside or the inside of the body. For example, hydrotherapy or warm water immersion in a shower or bath is an example of an external tool and a breathing technique is an internal tool. Participating in the study was based on the desire to gain self-confidence for birth by learning about recommended tools.

Although the aim of the workshop, such as women gaining self-confidence in their ability to give birth, was in alignment with conventional childbirth preparation courses, the tools gained and the execution of the workshop were very different to what is usually offered in the field of childbirth education and different to what the women expected. The interventions and experiential workshop were partly based on movement therapy, which can be defined as the therapeutic use of movement on the principle that motion and emotion are inextricably entwined. This alternative model of

childbirth preparation offered the women the opportunity to learn about their own movement in relation to their emotions in regards to giving birth in a creative and experiential way. Therefore, the workshop helped women to discover and anchor their own familiar motion associated with positive emotions for giving birth. This was called the 'Women's Birth Signature™' (as opposed to the birth plan). This journey cannot be understood as a linear process as it was a journey from discovering and embodying the motion (movement) for birth, to exploring emotions. The women's emotional journey went from discovering the relationship of pain, fear and confidence about childbirth to the women's desired (positive) emotion for birth.

Women's birth signature™

Although the benefits of maternal physical movement and positioning during labour have been discussed for decades, evidence of tangible benefit is variable in the literature (Spiby et al. 2003; Simkin & Bolding 2004). A study performed by Spiby et al. (2003) investigated 121 women's experiences of using, starting and discontinuing three coping strategies that were taught in antenatal education classes. The coping strategies included breathing, postural changes and the Laura Mitchell relaxation method used during the first stage of labour (the Laura Mitchell relaxation technique, known as the 'Simple Method of Relaxation' is a technique of relaxing the whole, or parts of the body). The researchers reported that changes of environment and the use of pharmacological pain relief resulted in the discontinuation of those strategies by the women. Whereas the study disclosed that women started using these techniques most frequently as a reaction to pain, a significant proportion of the women's responses showed that they discontinued the strategies as they had minimal or no effect at all, especially with respect to relaxation.

A review of randomised controlled trials of the use of non-pharmacological approaches to movement and positions for relief of labour pain during the first and second stages of labour found the use of the upright position, unrestricted movement and positioning, decreased women's pain and may shorten women's labour (Simkin & Bolding 2004). Women were assigned to use certain body positions or movements to relieve labour pain and only a small percentage were allowed to move freely. Various

upright positions were compared with horizontal positions. In several trials women were asked to use positions such as sitting, standing, walking versus supine, or hands and knees versus supine, and were asked to take specific body positions for 15-30 min in length and then alternate to another for the same length of time and do this again until full cervical dilatation. The studies failed to consider how the limitation of movement during labour might affect women's emotional well being and what effect this could have on labour pain (Yerby 2000).

Other studies have provided some insights into the cause and effect interaction of posture and emotion. A study by Winters (2008) investigated the emotional change when choosing a posture and performing it, or when watching a person modelling the posture. Interestingly, the findings from 41 participants showed that people do tend to have an emotional response depending on whether they embody the posture or they observe it. Further, embodying a posture, which means doing it and feeling it, might unconsciously trigger primal feelings such as fear or happiness (Ekman 1972). In regards to pregnant women, it means when a woman moves into a posture during labour and birth this physical act has an influence on the woman's feelings and emotional well-being.

The women of the workshop confirmed this. Throughout the workshop the women were exposed to different, semi-guided and authentic, posture and body movement experiences in order to discover their own posture and physical movement for childbirth. During this process the women gained awareness about different body movements and postures until a physical movement and posture was found where they felt at home and empowered. Through a ritual of repetition the women's own birthing movement was established and internalised.

Emotions and primal sounds people make also have a connection to the physical body. Empirical research by Chondorow (1995), a movement therapist, explored the relationship between primal emotions and their connection to the physical body and the psyche. The study showed that movement qualities come from the primordial

unconscious level, come out of great depth and are autonomous and involuntary. These movements might be accompanied by sounds like crying, sobbing, moaning, gasping, laughing or shouting and last a variable length of time (Chondorow 1995). Midwives supporting women in the physiological process of labour and birth are more likely to witness these autonomous and involuntarily movements and primal sounds.

During the workshop, the facilitator (myself), a movement therapist who is trained to observe these movements from a witness-mover perspective, used this information to support and communicate with the women. Therefore, the women in the group experienced a semi-guided intervention, which enabled them to learn about where they felt at home in their own movements. For the women, 'knowing' means doing and feeling. This information was the first step to knowing how to support themselves through the journey of labour and birth. In other words, the women were not taught a new skill nor were they given an exercise tool, instead, they were given strategies to discover their individual movement signature for giving birth. This movement tool came from within themselves.

Bringing this unconscious movement, the person's signature movement, into consciousness and using this for labour and birth certainly distinguished this unique childbirth preparation workshop from conventional childbirth preparation courses. This childbirth preparation workshop was not comparable in content and execution with conventional or alternative childbirth preparation courses of which I am aware, where it is more likely that the body with its movement and the mind with its emotions are treated as separate entities. Only recent research has begun to connect the two units, motion and emotion, or more exactly, to recognise the two areas as a couple that belong to the same system.

Embodiment of motion

In dance/movement therapy, 'embodying' is more closely directed towards the individual person rather than to a system. Therefore, embodying in dance/movement therapy pertains to the expression and sensation of emotional, physical and sensorial feelings through the body and body action (Tortora 2006).

When the women from the group discovered their own movement signature for labour and birth this felt-sense quality of movement turned into an embodied experience. In other words, the women's own embodied movement became suddenly their own embodied birth-knowledge. The notion of an "embodied knowledge" is grounded in the bodily state and in the brains' modality-specific system (Niedenthal et al. 2005, p. 186), which has gained interest in many fields, in particular psychology, sociology, linguistics and philosophy (Niedenthal et al. 2005; Walsh 2010). However, the women's embodied knowledge regarding childbirth in connection with the art and science of dance/movement therapy has a different meaning and therefore a different focus from the fields of science.

Research based in health science focuses and explores different theories of embodied cognition in regards to pregnant women. A study by Neiterman (2012) was an exception amongst the scientific studies as it examined the social context and interactions that facilitated the process of pregnancy embodiment. The study revealed what it meant for pregnant women to learn, adapt to and 'perform' their pregnancy. It demonstrated women's emotional struggle around the social regulations of pregnancy based on an analysis of pregnancy seen as a performance.

In the current study, this emotional struggle was confirmed by the women of the workshop as they expressed a fundamental need and desire 'to be seen as an integrated person' (physically, emotionally and intellectually) and understood for who they really were and what they experienced from the beginning of their pregnancy. In the workshop, 'being seen, heard and listened to' was a dynamic experiential approach derived from dance/movement therapy (Tortora 2006).

This current study was about the women and their experiences, and the focus was on the women's emotional and physical experience of embodiment using the tools learned during the workshop. It is understood by movement therapists that our bodies store and remember everything that ever happened to us (Tortora 2006). Therefore,

fostering the kinaesthetic self rather than the thinking-self during the workshop supported each woman to the discovery of herself.

Emotional competence

Although the women of the study group felt familiar with their individual motion signature and knew how to use it during childbirth, they had concerns about their emotional strength in handling the pain of labour. Emotional strength (or emotional competence) is defined as the functional capacity, wherein a human has the ability to detect their own emotional feelings (state) and if need be, is able to modify and constructively move towards the desired direction. The women from the study developed emotional competence and gained the ability to manage their own emotions. They emerged from the workshop with a sense of subjective well-being and an adaptive resilience to be used in the potentially, stressful journey of labour and birth. In order to accumulate emotional competency the women were exposed, mentally, physically and spiritually to different experiential interventions. Those interventional tools not only helped the women to explore their own perception of pain but they also to explored their positive and negative emotions related to childbirth pain in particular.

The workshop had a different way of dealing with negative emotions towards labour pain than conventional childbirth preparation classes. Conventional classes often offer women control-based strategies in order to cope with negative emotions around pain. In contrast, in this workshop the facilitator works with women's negative emotions towards pain through acceptance. The workshop offered tools for women to experience and accept those negative and positive emotions first, without attempting to avoid or alter them. Working with different emotions towards labour pain in an acceptance-based way enabled women to develop a non-judgmental attitude towards negative emotions in particular. A study by Albers et al. (2012) investigated the extent to which acceptance-based coping with negative emotions required fewer regulatory resources than suppression of the emotions. In other words, accepting negative emotions uses less energy than suppressing negative emotions. The findings showed that acceptance-based regulation is a non-goal-orientated process in which the person

is willing to experience the current state, the emotional experience, remaining untouched to a specific outcome. Although this kind of acceptance promotes similar behaviour as suppressing emotions, it is not about altering an internal state it is about changing one's relationship to this state. The women of the study group not only learned, theoretically and experientially, about their emotions regarding labour pain they also learned to accept their emotional experience with its override of the natural (hedonic) tendency to avoid negative emotions.

Leknes' and Tracey's (2008) investigation of pain showed that pain, in general, encompasses two factors; hedonic (suffering) and motivational (avoidance) aspects of a painful experience, such as that experienced during childbirth. The two factors, avoiding pain and seeking pleasure (hedonism), are in general important for survival but sometimes these factors are in competition with each other in our human brain. This competition has its own purpose as it deliberately searches for constant optimisation of our internal homeostatic balance. Even though this mechanism is built in us for survival, it is easy to envisage scenarios, such as a woman's concern about labour pain, where these two motivations are simultaneous.

Midwives and other health professionals are witnesses to women's distress from their inner conflict between these two phenomena. Women's desire to avoid (labour) pain is in conflict with their need to gain pleasure, through having the baby/becoming a mother. The motivational decision model describes that this inbuilt pain-pleasure dilemma, in which large reward is gained at the price of the smallest pain, is a desired goal underlying an unconscious decision process (Lenknes & Tracey 2008).

In the current study, bringing this subconsciously driven survival (hedonic-motivational) mechanism into the women's awareness was the first step for the women to understand where the primary concern of experiencing pain might be coming from. Therefore one of the aims of this workshop was to explore the women's relationship with pain in general and in particular, to childbirth. The interventional

tools of movement therapy were used in order to support the women's exploratory journey.

Few childbirth education programmes aim to build bodily and emotional awareness in pregnant women. This was confirmed by a study of the educational content and aims of contemporary childbirth education models (Walker, Visher & Rossie 2009). The authors compared six different childbirth education models/ organisations but only one model included 'building awareness' as one of the main teaching points. None of the models offered women the option to explore human behaviour and physiology, outside of the physiological process of labour and birth, in order to gain deeper and empathic understanding of themselves. Nor was there an intention to consider that women's concerns, accompanied by emotional feelings such as fear, might be healthy behaviours, which could be offered as a tool for the facilitator to work with.

The women in the workshop verbally expressed their fearful emotions about labour and birth with different intensities. While the majority of women felt concerned thinking about labour pain, two women even experienced anxiety attacks and/or fear episodes when thinking about the pain that might be experienced in labour. In the workshop women's feelings and emotions were taken seriously, not only because they caused concerns and worries to the women, but also because emotions have a great impact on the unborn baby (Carolan et al. 2012). In order to support women's self-confidence toward childbirth the workshop evolved to have a strong focus on the women's strengths without avoiding the discomfort of negative emotions.

Women's self-efficacy or self-confidence, besides other variables such as the birth environment, has consistently emerged as the most significant influence on women's ability to cope with childbirth. Self-confidence has been shown to be strongly correlated with a decrease of pain perception and medication used during labour and birth (Lowe 2002). It is interesting to note that one of the major aims of childbirth education classes is to increase maternal confidence and lower the fear of labour pain (Walker, Visker & Rossie 2009). However, women participating in classes found it did

not make a difference to their self-confidence nor did it make a difference in decreasing their fear of childbirth. When questioning the women in my study, they agreed that their experience with traditional classes had been similar.

As stated previously, gaining tools for emotional competency in the ability to positively deal with labour pain and the acceptance of the idea of giving birth seemed to be equally as important as receiving physical tools to gain physical competence. Movement therapy, as used in the workshop, offered experiential strategies and intervention for the women to deliberately immerse themselves in a process that activated their own experiential imagination of being in labour and giving birth. In relation to this, a study by Goldie (2005) explored the role of real life emotional experiences, and the difficulties of imagining such experiences 'from the inside' as well as from the external experience. Goldie described experiential imagining 'from the inside' was where you imagined yourself in some situation undergoing a particular experience.

In the current study, when the women from the workshop participated in a role-play of 'me being in labour and giving birth', the connection of the desired (positive) emotion and familiar motion was established, rehearsed and anchored to be used later for giving birth. The women stated that connecting motion and emotion not only expanded their perspective of labour and birth by incorporating rational and non-rational forms of knowing, it further enhanced their capacity to feel intrinsically empowered. Further, rehearsing the women's birth signature™ provided the women a feeling of confidence as women stated it kept coming back during labour and birth.

In summary, the childbirth preparation workshop explored in this study aimed to help women understand how their body, mind and emotions were closely interlinked and influenced each other. The evidence presented in the preceding chapters revealed that the interventional tools of movement therapy helped the women to develop their own empowering motions and emotions and recognise their own birth signature™, in order to gain confidence in their own ability to give birth.

Connection

Another important aspect of this study was connection of self and with others. Humans need to be connected in order to thrive emotionally, physically, spiritually and intellectually, particularly when experiencing a life-changing event. Brenè Brown (2010), a researcher focusing on connection, states that the need for connection is in our biology from the time we are born. She states: “the more strongly we are connected with someone emotionally, the greater the mutual force” (p. 20).

Building connecting relationships based on trust, honesty and empathy was expressed as essential to women in the childbirth preparation workshop. Through cultivating a connection between people, through sharing stories and sometimes feeling the pain of others was pivotal (Brown 2010). This workshop catered well in building connection. How this was achieved will be described in the next section. It is also important to mention that the women have all remained friends after their babies were born.

Any group of people is unique; groups have their own dynamics containing the opportunity to develop in different directions. In this study, centralising the connectedness and the affiliation into the centre of the group was critical. In order for the women to achieve this, a felt sense of safety (belonging) needed to be established before a state of connectedness could occur (Berzoff 1989). How the women in the group developed their connectedness was best described through the ‘The Relational Model’ (Schiller 1997). This model describes five stages a group of women must move through in order to incorporate a connection, development and growth. The stages are: pre-affiliation, establishing a relational base, mutuality and interpersonal empathy, challenges and change, and final termination.

Stage one and five remain discrete whereas stages three to five flow into each other. In stage two, women come together to form a bond of affiliation and connection in order to establish a sense of safety within the group (Schiller 1997). For example, when the women came together in the workshop it did not take long before they established flowing conversations, which were far away from superficiality. They shared and

compared their pregnancy stories and experiences, and they listened to each other's thoughts and decisions they made around birth, and they reached out to find similarities. The third stage of the model, mutuality and interpersonal empathy, was the most interesting stage regarding connection. This stage "incorporated elements of both intimacy and differentiation, moving beyond simple connection and recognition and sameness to a stage of mutuality that allows for both empathic connection and for difference" (Schiller 1997, p. 5). In the workshop the same applied. For example, during the warm-up phase, the women spent time sharing the issues, concerns and struggles they experienced being pregnant. As time went on and the group moved into the third stage (mutuality), differences in where and how women planned to give birth became quite obvious. In this stage the women were able to continue to hold the connection while discovering the differences between each other. During this time the evidence-based knowledge about labour and birth, as discussed in conventional childbirth preparation classes, was interwoven in a flowing process. The last stage (challenges and changes), proposed a challenge 'at the heart of growth' for women. This was a stage where women learnt how to be engaged, accept differences and integrate new information without losing the connection and empathy. The different realities of each woman's journey, from how they became pregnant, their experience of pregnancy, and desires regarding childbirth were shared in the group.

Connecting me with my baby

During pregnancy the women connected with their unborn babies mainly through their thoughts, touch and bodily sensations. However, the women from the group expressed a deep desire to connect the 'whole me' with their babies; they wanted their connection between themselves and their babies to be established on all three levels, emotional, physical and spiritual. Women's connection with their babies was studied by Verny and Weintraub (2002) who found that women make these connections using three different forms of communication. Firstly, there is molecular communication; meaning maternal molecules of emotion reach the unborn baby through the placenta and umbilical cord. Secondly, sensory communication such as mothers stroking their belly (touch), walking (movement) and talking (voice). Thirdly,

there is intuitive communication where women connect with their babies through their thoughts, intentions, feelings and emotions (Verny & Weintraub 2002).

In the workshop the women were exposed to interventional tools supporting sensory communication between women and their unborn babies through dance, semi-guided movement exercises and meditation. Further, intuitive communication was fostered through intuitive drawing, writing a letter to the unborn baby with the non-dominant hand and through semi-guided relaxation techniques. After the workshop the women expressed their gratitude as they experienced a deep connection and attachment to their babies.

In regards to the maternal-foetal relationship the term 'attachment' has not been used in this study as a result of current conflict in the literature. There is an unclear definition of the word 'attachment' as referenced by John Bowlby when discussing the maternal-foetal relationship (Bowlby 2008). Bowlby's concept of attachment was limited to 'behaviours' that supported closeness to an attachment figure, typically the mother. Therefore, the term connection was chosen instead as this term was used by the women.

Although all the women expressed being in love with their unborn baby, only one woman out of the five stated that she felt deeply connected to her baby. When the women expressed their unexpected difficulties to create a bond and imagine their baby on a deeper level the women referred to their baby as 'the little moving thing', 'the baby' or 'this baby', or as 'it'. This workshop gave women the opportunity to build a deeper connection with their baby.

This connection has been previously studied. Interventional strategies of movement therapy have allowed women to move deeper into their bodies, creating awareness of their bodily sensations in order to establish the intimate connection between themselves and their baby (Kerstenberg 1980; Schroth 2010). In this study, the women were in the last trimester of pregnancy where the unborn baby begins to show

repeated movement phases and patterns from rest to activity (Fuller 1990; Kerstenberg 1980). The women experienced the Kerstenberg (1980) 'foetal movement notation', which is designed for mother's to connect to the rhythm of their baby's muscle contraction and its release. Learning about this notation helped women to explore their baby's movement repertoire and attributes, and they learned how to trace those notations on paper by hand (see appendix five). These simple line drawings helped the mother to have awareness on a deeper level about their baby's well-being.

The workshop interventions supported women's ability to attune to the baby's movement, felt through body sensation and touch, which was the first step to establishing the basis of the mother-baby bonding process. The women reported that taking this time to engage in this internal work, helped them to visualise and connect with their baby from within and made them aware that their babies were real human beings who can perceive pain, react to touch, smell, and hear sounds (Chamberlain 2014; Eichhorn 2012).

After birth the women stated that during labour and birth they considered their baby as a supportive partner (Kerstenberg 1980; Schroth 2010). Three out of the five women reported having an acute awareness of their baby's body and movements during birth, offering the mother an idea about how the labour was progressing.

These interventions differ quite significantly from other pregnancy classes in that they support the affective involvement with the unborn baby during the third trimester of pregnancy. There is evidence that those women who experience greater affection during pregnancy and fantasise more about their unborn babies in the last trimester experience a more sensitive interaction with the baby after birth (Fuller 1990; Müller 1996; Siddiqui & Hägglöf 2000).

A strengths-based approach to childbirth

The workshop focused on motivation as opposed to a focus on avoidance (e.g. fear) or controlled-based strategies. This approach emphasised women's strengths, activated

positive emotions and their willingness and openness to discover their actual self and develop their ideal self (as defined by the women). It was a strengths-based and motivational process that was complex to initiate, as it required intentional focus and effort (Fredrickson 2001). However, the strengths-based approach has been argued as more likely to show long lasting and positive effects compared with an avoidance approach (Boyatzis & Akrivou 2006). Attention was given to the women's actual self (real self) which was associated with women's present moment of well-being containing their concerns, their vision, and hopes, and in particular their purpose and inner calling around birth.

The workshop focused on the discrepancy as well as the steps in between, women discovering their actual self and developing their ideal self. When the women left the workshop they reported that they felt well connected to themselves and that their expectation about the upcoming labour and birth had changed from being anxious and scared to feeling positive and confident in their own ability to birth.

Women's expectations of their birth are important. This was explored by Ayers and Pickering (2005) who confirmed that women in general hold both positive and negative expectations of birth. The authors found that when women expect positive emotions in labour this is correlated with experiencing positive emotions, and when expecting a high level of pain this is correlated with experiencing a high level of pain and so on. Further, negative expectations were associated with the birth being less fulfilling, feeling less satisfied and experiencing less emotional wellbeing after the birth. The authors highlight that there was a link between expectations of control and experience of positive emotion during birth (Ayers & Pickering 2005).

Although the women in the workshop knew that they could not control their length of labour or other people's behaviour, they knew they could control their own perceptions and emotional wellbeing during labour and birth. This was the part the women from the group focussed on during the workshop.

In summary, fulfilling the basic human need of belonging and building a meaningful connection and intimacy was important for women in this study to establish in order for them to willingly engage in a new and uncertain experience. When the women's innate need for connection was fulfilled they felt, saw, heard, and were valued just as they were. The connectedness of the group had a positive wellness orientation that emphasised the women's dreams and visions as well as their worries, concerns and questions as opportunities to implement a new experience impacting the journey from woman-hood into motherhood. As Brown (2010) asserts:

“Connection begets connection” (p. 19)

This chapter has discussed the findings of the study in relation to the extant literature on aspects of childbirth preparation courses. The next and final chapter of the thesis reflects on why this programme is unique, examines the strengths and limitations of the study and provides recommendations for further research.

CHAPTER NINE: BRINGING IT ALL TOGETHER

This thesis has explored five women's expectations and experiences of participating in a childbirth preparation workshop focusing on connecting motion and emotion. The thesis also explored whether any of the tools gained during the workshop contributed to the women's birth experience. Although the qualitative nature of this study design and the very small sample size prevent any causal relationships between the workshop and the women's birth outcomes to be claimed, the women participants felt that the workshop had increased their self-confidence and their ability to give birth. This concluding chapter of the thesis examines what was unique about the workshop and considers whether its unique features could improve all preparation for childbirth programmes. The chapter examines the strengths and limitations of the research and concludes by making a number of recommendations for further research in this important area.

What was unique about this programme?

This childbirth preparation workshop had at its centre, the interrelationship between body and mind. In common with most childbirth preparation classes, the workshop goal was to boost women's self-confidence about their ability to give birth. However, this unique workshop had an emphasis on providing a safe space for self-exploration and self-awareness where women were invited to re-discover themselves, physically, emotionally and spiritually. An integral and unique underpinning of the workshop was movement therapy which engaged women in 'lifelike' or 'do it for real' experiences involving their senses. This included visual (sight), auditory (hearing) and tactile/kinaesthetic (touch and movement) sensory experiences with the goal of assisting women to discover their own tools for alleviating emotional stress that is often felt through the body; emotions such as anxiety and fear. The women also discovered and practised their own inherent physical movements for giving birth which I have called the 'women's birth signature™'. The workshop was interactive and provided many opportunities for women to ask questions and share stories and where all the evidence-based knowledge, as provided in traditional childbirth education classes, was interwoven. Importantly, the workshop also equipped women with

increased awareness and appreciation of their own physical and emotional strengths thereby assisting them to feel confident and competent to give birth. The findings provide preliminary evidence that using movement therapy for childbirth preparation may be an effective method for improving birth outcomes. While a larger more robust study such as a randomised controlled trial needs to be undertaken, the findings from this study reveal that this innovative programme is indeed feasible and attractive to women who want to be prepared for childbirth, physically, emotionally and intellectually.

Why I recommend this programme is a better way of providing childbirth preparation

The workshop fostered women's intuitive tools, as a direct sense of knowledge, which were essential for women to build self-confidence in their ability to give birth. Women gained access to those tools through the experiential intervention of movement therapy that focused on connecting movement and emotions. Further, the programme facilitated women's confidence to make decisions for themselves and their babies. Making decisions meant that women got to know themselves and their needs, discuss and share these with others, and became well informed and educated through evidence based knowledge.

Strength of the study

The strengths of this study were that it focused on the use of movement therapy in preparation for childbirth; and the workshop was attended by women only. By using body awareness and mindfulness/relaxation techniques, the women revealed that they had experienced emotional, physical and intellectual changes. This programme used sensory, bodily experiences and emotions as the drivers of intentional change. The women-only group provided a safe environment for the women to share and experience their positive as well as negative emotions such as fear of childbirth. This is the first time, to my knowledge, that the concept of connecting motion and emotion for childbirth preparation has occurred. The study demonstrates the potential for an

integrated childbirth education programme that combines midwifery, movement therapy and mindfulness to increase women's confidence to cope with childbirth.

Evaluation of the current group format

The participants were diverse in terms of cultural background. In the facilitator's experience the diversity of women from different lifestyles, religions, and marital status added value to the experience of all workshop members. The women expressed that the variety of thoughts, opinions and ideas around the same journey not only introduced different opportunities; it further helped the women to value and respect themselves and others.

What was surprising?

Although the women highly valued attending a women-only group for several reasons, the women also missed the birthing partner's involvement. When the women raised this need they recommended holding a 2-4-hour evening session after the workshop rather than including the birth partner in the workshop. The women wanted to share what they experienced and learned during the workshop and they wanted to create a meaningful connection with their partner allowing the birth partner to express their views and concerns about the upcoming birth.

Further, the women recommended being able to meet fortnightly or monthly for an evening to continue to share their pregnancy experience and to re-connect to their own birth signature™ and to nurture their own emotional well-being.

Limitations of the study

The main limitations of this study are its small size and the qualitative study design. Initially, the study aimed to recruit ten women, however, the group consisted of only five women. From the perspective of conducting the workshop, five participating women were sufficient to undertake the workshop, however based on the facilitator's previous experience, a group size of eight to ten women would be considered ideal as it fosters better group dynamics. Witte and Davis (2013) state that there is no simple

way to find the ideal group size but it might be worth investigating some of the correlates of group size or to simply ask people to describe the ideal size for this kind of group. The women stated that they could imagine up to ten participants as ideal but they appreciated that the small group allowed for more individual time and attention. The qualitative nature of the study meant that large numbers of participants were not required if the data obtained from a small number is rich in detail and insights. Taking this into account the five participating women were sufficient.

Although the women who participated in this study had different ideas and desires regarding birth, in some ways they were all motivated to approach childbirth as naturally and as physiologically, as possible. Knowing the women's positive attitude toward a physiological birth raises the question of whether the findings may have been affected by unmeasured characteristics of these women.

Another limitation was the structured workshop design. The workshop itself was set for two continuous days with the second day building on the previous day. Therefore, the way the workshop was constructed prevented the option of attending only one day of the programme. Also the workshop focused on childbirth only, with limited attention paid to postnatal issues such as breastfeeding. At first, the women did not mention this need. However, in the later interview six weeks after the birth of their babies, some women expressed a desire for more mother-craft information. Offering an additional two-hour session in order to cover the postnatal time would fulfil this need.

The pre-post study design using focus groups and one-to-one interviews to collect qualitative data, before and after the workshop, has some limitations. It is not possible to make any robust conclusions as to whether the workshop contributed to the women's positive birth outcomes. This group of women were motivated towards a straightforward, physiologically normal birth. They may have achieved this with traditional childbirth preparation classes. Only a randomised controlled trial of the workshop would provide robust answers as to its effectiveness in terms of birth

outcomes. Nevertheless, this study can be viewed as a pilot or feasibility study where the results point to the relevance and value of an experiential movement therapy intervention for childbirth preparation. The women reported that they felt the workshop had helped them to approach childbirth with confidence and that they enjoyed the workshop experience. The study therefore provides a rationale for further research in this area.

Recommendations arising from the findings

The ideal group size is eight to a maximum of twelve participants in women-only groups, where a sense of group cohesion (interconnection) can develop over time. The shift from mixed gender groups, as occurs in most childbirth preparation programmes, to women-only groups is recommended as it added value to the experience of all members.

Woman-centred approach

It is strongly recommended that preparation for childbirth programmes have a woman-centred approach. This means that the facilitator works in partnership with the women, recognising each woman as an individual and acknowledges that learning is a shared responsibility. Further, the facilitator shares information that is relevant to the participating women. This is a dynamic approach where scientific and evidence-based knowledge becomes integrated and interwoven into shared conversations (dialogue) and experiential interventions. The shared knowledge is derived from the art and science of midwifery, from experience and research. However, the facilitator acknowledges, respects and supports different ways of knowing.

Connecting motion and emotion

Integration of movement therapy (connecting motion and emotion) should be considered as an important aspect of childbirth preparation for women who are interested in learning the emotional and physical effects of childbirth. Identifying a person's individual movement signature, gaining an understanding about the interconnection of movement and emotions and knowing how to use it as a central

learning resource, would provide valuable new tools to childbirth preparation facilitators. This knowledge would also provide invaluable tools to any person who supports women in the process of childbirth. This may mean that childbirth preparation would become more holistic, rather than based on simple knowledge provision or physical exercise that keeps the mind and body separated.

Recommendations for further research

Based on the findings of this study, the following recommendations are made:

- Further research investigating women's perceptions of childbirth after attending a childbirth preparation programme that is based on connecting motion and emotion (movement therapy) should be done. A well-performed randomised controlled trial is highly recommended to determine women's birth satisfaction and birth outcome when attending such a programme.
- Movement therapy should be considered as a potential strategy for integration into childbirth preparation programmes for women who are interested in learning the emotional and physical effects of childbirth. However, a mixed methods study is highly recommended to determine the real value of movement therapy in childbirth preparation.
- Replication of this study using a larger sample of women across all socio-demographic and cultural backgrounds is recommended. The women in this study were white European women, college educated and with an average household income.
- Exploring maternal self-confidence for childbirth and birth outcomes after participating in this unique childbirth preparation programme from a focus of stakeholders might be useful given that the women stated their self-confidence level towards childbirth greatly increased.
- Further research is needed to better understand the interconnection and interaction of motion and emotion during pregnancy and its influence in childbirth.

- The implications of this shift from mixed gender groups to women-only groups in regards to childbirth preparation is recommended as this approach added value to the experience of all members. Group members supported different views of the same journey and therefore helped the women to value and respect themselves and others.

The findings of this study offer theoretical and practical contributions to understanding women's expectations and their emotional, motional (physical) and intellectual needs regarding preparation for childbirth.

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APPENDICES

Appendix One: Sample participants' invitation letter

Appendix Two: Sample consent form for women participants

Appendix Three: Childbirth preparation workshop outline

Appendix Four: Focus groups and one-on-one interview questions

Appendix Five: Sample Fetal movement notation

Appendix Six: Sample childbirth preparation workshop flyer

Appendix 1: Sample participants' invitation letter.

**CONNECTING MOVEMENT AND EMOTION: A UNIQUE CHILDBIRTH
EDUCATION PROGRAMME**

Information Sheet for Focus Group Participations

Dear

You are invited to participate in a study regarding the childbirth education programme will prepare mothers-to-be for labour and birth. The objective of this study is to hear women's opinions about the programme; to assess if the programme contributed in any way to their experience of labour and birth and their understanding of the relationship between emotion and motion. The study will be conducted by Sabina Handorf who is a registered midwife and a movement therapist. The study is being undertaken for a Masters of Midwifery degree under the supervision of Professor Maralyn Foureur, and Dr Christine Catling of the University of Technology Sydney. The Health and Disability Ethics Committee of New Zealand, and the University of Technology Sydney, Human Research Ethics Committee have provided ethical approval for the study.

The childbirth education programme is a newly designed programme based on knowledge of Midwifery, movement therapy and Kundalini yoga and will be running over a weekend (Saturday and Sunday). If you agree to participate in this study, you will be asked to:

1. Attend the weekend childbirth education programme (Friday evening, Saturday and Sunday).
2. Participate in three discussion groups or individual interview;
 - One immediately before the programme starts (Saturday morning)
 - One immediately after the programme has finished (Sunday afternoon)
 - One approximately four to six weeks after your baby is born.

During our group discussion you will be asked questions about the childbirth education programme you are about to attend or have attended. The first two discussion groups will be held at the same place you are attending the childbirth education programme and the third group or individual interview will be held at a place of your convenience.

I am interested in hearing what you believe should be included in a childbirth education programme, how you found the experience of attending the programme and whether you think that it contributed to your experience of giving birth.

All aspects of the study, inclusive of the collected results, will be treated confidentially. Only the researcher involved in the study and her academic supervisors will have access to information given by participants. Individual participants will not be identifiable in any written information generated from the focus group. Participation in this study is entirely voluntary. If you do participate, you can withdraw at any time. After reading this information sheet, Sabina Handorf, will discuss this further with you and will answer any questions you might have. If you would like to have more information please feel free to contact Sabina Handorf on 027 2273187 or her academic supervisors at University of Technology Sydney, Professor Maralyn Foureur and Dr Christine Catling on 0061 2 95144914.

Appendix 2: Sample participants consent form

**CONNECTING MOVEMENT AND EMOTIONS: A UNIQUE
CHILDBIRTH PREPARATION PROGRAMME**

FOCUS GROUP PARTICIPANT CONSENT FORM

I, [name]

.....[address]

agree to take part in the **CHILDBIRTH PREPARATION PROGRAMME** research project.

I have read and understood the study purpose as described.

I am aware of the procedures involved in the study, including any inconvenience, risk and implications.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to be involved into the study

NAME:

SIGNATURE:

DATE:

NAME OF WITNESS:

SIGNATURE OF WITNESS:

Appendix 3: Outline childbirth preparation programme

Description of the various components of the proposed childbirth education programme

Component	Programme - Description
<p>Introduction to the programme and the research</p>	<p>Participation in the study and consent will be revisited.</p>
<p>Increasing knowledge of childbearing</p> <p>Fostering realistic expectations</p> <p>Exploring attitudes to change</p>	<p>Evidence-based knowledge regarding pregnancy, labour, childbirth, and the postpartum period, and basic objective knowledge (such as anatomy/physiology of pregnancy and childbirth) will be given and shared between the programme convenor who is a qualified and experienced midwife, and participants.</p> <p>Objective knowledge will be combined with experiential midwifery knowledge about the experiences of childbearing women.</p> <p>Aim:</p> <ul style="list-style-type: none"> ▪ Women developing a more accurate picture (realistic expectations) of labour and childbirth. ▪ Empowering and supporting women to make well-informed decisions during their labour and birth. <p>Active listening to and engaging in participants' stories will be used as a way to develop empathic understanding and build trusting relationships.</p> <p>Aim:</p> <ul style="list-style-type: none"> ▪ Creating a safe space where personal change and growth can evolve. ▪ Women sharing experiences and stories with each other as a way of learning from other pregnant women. ▪ Discovering the influence of external and internal circumstances of birth. <p>Women will explore attitudes towards labour and birth through experiencing movement interventions, practicing repetition rituals, and creativity.</p> <p>Aim:</p> <ul style="list-style-type: none"> ▪ Increase women's receptiveness to change and for learning new ways of being and coping. ▪ Raising women's determination and confidence in their ability to give birth.

	<ul style="list-style-type: none"> ▪ Women taking responsibility for themselves.
<p>Improving self-knowledge</p> <p>Strengthen creativity</p> <p>Nurture mother and baby bonding</p> <p>Increase knowledge of art based approaches</p>	<p>Creativity based on movement therapy will be used in practice as a catalyst for women to increase awareness, self-reflection, and personal growth. Movement therapy (MT) intervention involves using strategies and techniques for women to find their own movement signature and support emotional regulation through semi-guided movement, the use of art and rituals, and meditation.</p> <p>Aim:</p> <ul style="list-style-type: none"> ▪ Building an understanding of the connection between mind and body. ▪ Preparing women, physically and emotionally for labour and birth. ▪ Building a strong bond between the mother and her unborn child. <p>Evidence-based knowledge emerging from different areas such as Arts-based approaches (MT or music therapy), social, physical and behavioural sciences will be shared with participants.</p>
<p>Practising Meditation in motion</p>	<p>Evidence-based knowledge will be shared regarding meditation in motion known as Breath walking. This includes practising rhythmic breathing while walking mindfully, being in the present moment.</p> <p>The exercise will be practiced several times during the programme to encourage women to practice meditation in motion, daily.</p> <p>Aim</p> <ul style="list-style-type: none"> • Create a sense of physical, emotional and spiritual presence and strength. • Moving and breathing awareness. • Increase awareness of physical and emotional state change.

Appendix 4: Participant questions for focus groups and on-on-one interviews

Focus group and one-on-one interview questions

Pre- workshop: Focus group one

Questions to focus group interview one will include, but are not limited to:

- Can you tell me what you expect from a childbirth preparation course?
- Can you tell me about your ideas, expectations and/or hopes in regards to the birth of your baby?
- What do you know and/or understand about the involvement of emotion and motion (movement) in childbirth?
- Can you tell me if you know anything about movement therapy?

Post workshop: Focus group two

Questions to the focus group post-test interview will include, but are not limited to:

- What did you like or dislike about the workshop?
- Did you notice any difference within yourself, emotionally, mentally and/or physically?
- Can you tell me how you feel when you think about the upcoming labour and birth of your baby?
- Can you tell me your experiences of movement therapy?

After birth: (6-8 weeks) One-on-one interviews

Questions of the past experience will include, but are not limited to:

- How was your birth experience?
- Did you practice, before or during childbirth, what you had learned or discovered in the course?
- Can you tell me what you learned or discovered?

Appendix 5: Sample fetal movement notation (Kerstenberg 1980)

Your Baby Within: Movement Notation

Do you feel your baby within moving?

Feeling above your navel

Feeling below your navel

Feeling Bubbles?

Feeling Flutters?

Feeling your baby twisting
or changing position?

Feeling your baby kicking?

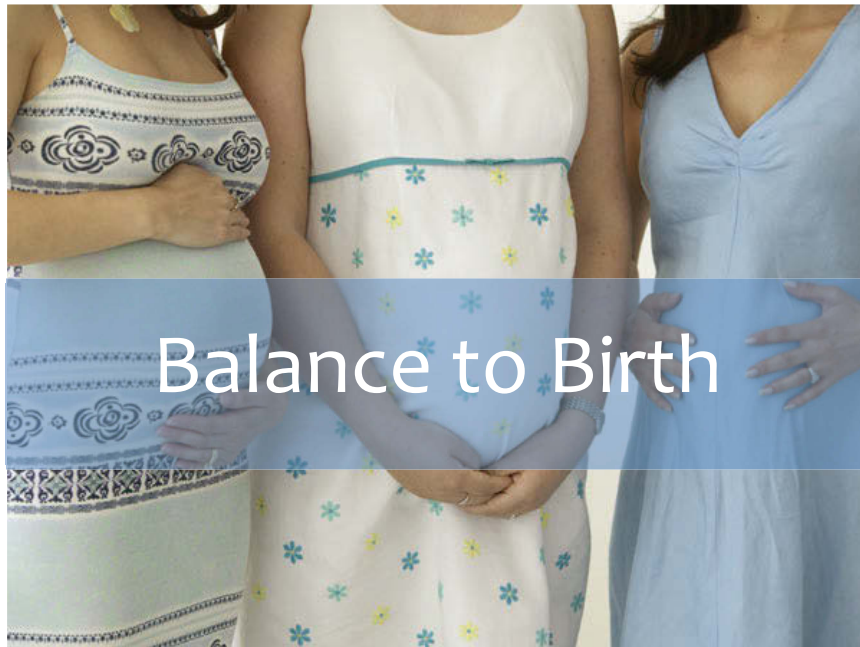
Feeling your baby pressing
or pushing?

How many weeks are you pregnant?

Please circle:

20 22 24 26 28 30 32 34 36 38 40 41

Appendix 6: Sample invitation flyer



This childbirth preparation retreat is cost free

The desire to feel confident in giving birth to your baby is something that every woman can relate to. The two-day program, “Balance to Birth Weekend” will provide you with a unique opportunity to develop confidence in your own abilities for birthing through learning about specific tools and strategies derive from the Art of Midwifery and Dance and Movement Therapy. The learning is experiential (body learning) which means you will absorb this knowledge into your body so that it’s there when you need it.

November / December 2014

Sabina is a practising midwife, registered nurse, senior dance and movement therapist, mother and a clinical educator in Midwifery at the Auckland University of Technology (AUT). This program is being evaluated as part of a supervised Masters in Midwifery research degree undertaken by the program facilitator Sabina Handorf, at UTS. The research has been approved by the Human Research Ethics Committee of UTS.

If you would like to participate in the Balance to Birth Weekend or for more information please contact Sabina on 027 2273187

