

---

# The Lived Experience of Knowing in Childbirth

Jane Staton Savage, RN, PhD, LCCE, FACCE

## ABSTRACT

Research on knowing in childbirth has largely been a quantitative process. The purpose of this study was to understand the ways first-time mothers learn about birth. A phenomenological approach, using a feminist view, was used to analyze two in-depth interviews and journals to understand nine first-time expectant mothers' experiences of knowing in childbirth. The findings demonstrated a range of knowledge that contributed to issues of control and conflict. The participants also described an increased dependency on their mothers and a lack of their own intuition contiguous to the birth process. These findings contribute understanding to how expectant mothers know birth, suggesting that their knowing does not diminish conflict surrounding the event and may even exacerbate it when not combined with learning skills to manage conflict. Childbirth educators may want to include instruction on negotiating power differential in relationships encountered during childbirth in order to strengthen a first-time mother's ability to receive the care she wants. Educators may also want to assess the expectant mother's view of birth and her expectations for birth. Schools of nursing should consider the inclusion of women-centered care curricula at both the undergraduate and graduate levels. The mothers' responses in this study clearly reveal that the politics surrounding birthing remain in place and must be removed in order to provide a supportive environment for normal birth.

---

*Journal of Perinatal Education*, 15(3), 10–24, doi: 10.1624/105812406X118986

*Keywords:* maternal relationality, intuition, childbirth education, adult learners

Sources of knowledge surrounding a major life event such as childbirth are manifold. Women come to pregnancy with ideas and information acquired since childhood, and a majority of first-time, middle-class mothers attend childbirth classes conducted within the hospital setting (Lamaze International, 2004). Expectant mothers have come to rely on television programs and childbirth classes to impart information that was once shared from woman to woman, mother to daughter (Belenky, Clinchy,

Goldberger, & Tarule, 1997; Boston Women's Health Book Collective, 1979; Dwinell, 1992; Walker, 1984; Zwelling, 1996).

Usually, varieties of knowledge foundation are valued as beneficial and fruitful to life experiences such as childbirth (Munhall, 2001). However, researchers claiming an advanced knowledge base have been shown to devalue the worth of personal knowing related to birth. This assertion polarizes knowledge into superior and inferior categories,

thus fracturing traditional knowledge systems (e.g., woman-to-woman) and accelerating their replacement by technology (Nakashima, Prott, & Bridgewater, 2000). Authoritative knowledge invariably supercedes personal knowing. In that process, a woman's knowledge of her own bodily functioning is minimized (Hanson, VandeVusse, & Harrod, 2001; Lazarus, 1997; Nelson, 1986; Oakley, 1986, 1999; Romalis, 1981). As modern women distrust their intuition regarding their ability to give birth, they embrace authoritative, medical knowledge.

Connecting with other women—relationality—as a source of knowledge, albeit a subculture of knowledge, is essential to the human experience of giving birth (Belenky et al., 1997; McHugh, 2001; van Manen, 1990). The purpose of the current research was to understand the ways first-time mothers learn about birth. The research question for the study was the following: What are the experiences of knowing in birth for first-time expectant mothers?

## LITERATURE REVIEW

Earlier studies concerning formal childbirth learning environments were largely descriptive and found that prenatal education imparted knowledge and confidence and helped participants deal with fear related to childbirth (Bennett, Hewson, Booker, & Holliday, 1985; Broussard & Weber-Breaux, 1994; Crowe & von Baeyer, 1989; Knapp, 1996; Lazarus, 1997; Mackey, 1990). Recently, Schmied, Myors, Wills, and Cooke (2002) investigated the relationship between satisfaction with new parenting and antenatal education. Significant results included the benefits of using adult education principles and gender-specific groups as they related to women's later reports of satisfaction with parenting.

Most of the reported research on perinatal education was descriptive in design and concerned the impact of formal childbirth learning environments (Bennett et al., 1985; Broussard & Weber-Breaux, 1994; Crowe & von Baeyer, 1989; Mackey, 1990; Schmied et al., 2002; Slaninka, Galbraith, Strzelecki, & Cockroft, 1996). From these investigations, a wide range of reasons for women attending class has been reported. Although the range included gaining more information in order to lower anxiety and increase confidence, some participants did not use the strategies they learned. In some studies, the potential of the health-care provider's role in aiding women to view their birth experience was a positive one (Davis-Floyd, 1990; Sargent & Bascope, 1996;

VandeVusse, 1999). Furthermore, many women do not have access to formalized knowledge such as classes, so researchers do not have an appreciation of what formalized learning would mean to those women.

Understanding how and what American women learn about birthing and their perceived role within that context is critical to implementing an effective childbirth education program. What role does an expectant mother's pre-existing knowledge play in her birth experience? How can childbirth educators capture that knowledge and build on it?

Most recent childbirth education research lacks a strong theoretical base and connection to the concept and impact of how women impart knowledge with one another on an informal basis. Little is known about enabling women to embrace their inherent wisdom and reclaim their role in the birth of their children. There is a dire need for investigation of the impact of this culturally repressed phenomenon in America.

Hermeneutic phenomenology, the method used in the current study, concerns understanding people in their daily lives and viewing life experience as a whole. Phenomenology is the examination of the lived experience, the lifeworld, with the intent to discover the underpinnings of the lived experience in question. Thus, phenomenology is the use of language and mindfulness to describe a specific aspect of lived experience. Hermeneutic inquiry is validated by the fullness of examination of the topic, depth, and breadth to which the analysis expands understanding, not by numbers of participants (Moules, 2002).

Preparing for childbirth can be defined as any experience in which a woman acquires knowledge about the birth process. To formulate a foundation for the acquisition of knowledge that women possess surrounding the uniquely gendered perspective of giving birth, concepts are derived from experiential knowledge that are transferred from narratives (e.g. birth stories), social interaction, and culture. Knowledge of normal birth lessens women's fear and gives them a sense of control in childbirth (Zwelling, 2000). Researcher van Manen (1990) contends that the scientist, like the expectant mother, comes to the phenomenon with prior knowledge.

Understanding how and what American women learn about birthing and their perceived role within that context is critical to implementing an effective childbirth education program.

*W* Researchers describe women's ways of knowing as having been influenced first by silence imposed by others, followed by received knowledge from others, and then by subjective knowledge (inner voice) in which the woman respects her own opinions and ways of seeing things. For an excellent review of the book *Women's Ways of Knowing: The Development of Self, Voice, and Mind* by M. Belenky, B. Clinchy, N. Goldberger, and J. Tarule, log on to [http://www.achillesheel.freeuk.com/br15\\_11.html](http://www.achillesheel.freeuk.com/br15_11.html)

*W* Marcia Westkott's essay, "Female Relationality and the Idealized Self," offers an excellent resource for further reading ([http://plaza.ufl.edu/bjparis/essays/westkott\\_relation.html](http://plaza.ufl.edu/bjparis/essays/westkott_relation.html)). Westkott includes reviews of authors who examine the thought that women's great desire for affiliation can be a strength they bring to the world, but it may also lead to dysfunction for achieving their own goals.

*W* For more information on phenomenology and applying Max van Manen's framework of hermeneutic phenomenological research, log on to <http://www.otal.umd.edu/~paulette/Dissertation/phenomenology.html>

Research has begun to delineate what comprises “feminist knowledge,” what is implied by women’s ways of knowing, and research from women’s lives (Durna, 1991; Johnson, 1995). Feminist epistemology (Alcoff & Potter, 1993) is a means of summarizing and integrating women’s knowledge and experiences and frames the current phenomenological study. Uncovering variations in how women learn about childbirth could alter the current thinking in childbirth preparation. A feminist approach increases awareness of relationships of power and “listens” to women’s voices of knowledge (Boxer, 1998; Harding, 1991; Pugh, 1990; Tritten, 1992). By listening to women share their understanding, an essential component to childbirth education, childbirth educators would hear the lived experience and validate the worth in that unique experience (Anderson, 1998).

## **METHOD**

### ***Sample***

With the goal of achieving a diverse picture of women’s knowledge in childbirth, data saturation and redundancy were reached with a purposive sample of nine participants. Inclusion criteria were English-speaking women who were over 18 years of age, having their first baby, experiencing pregnancy to date without complications, and willing to participate. The highest grade of school completed for the participants ranged from 11<sup>th</sup> grade to a master’s degree. Five of the participants had arranged to attend, were attending, or had completed hospital-based prenatal classes or classes conducted by a Lamaze Certified Childbirth Educator. Four of the nine participants gave birth before the second interview. Two of the four women’s labors were induced with synthetic oxytocin for nonmedical reasons. Two other participants had babies that were born 3 and 4 weeks early. Three of the women received prenatal care from midwives. All mothers anticipated giving birth in a hospital. At the time of the first interview, all participants were from 16 to 33 weeks into their pregnancy (mean gestation 25.7 weeks). All participants who gave birth during the study had labor support. Four expectant mothers had their partners with them. In addition, two participants’ mothers attended the births of their grandchildren.

Four of the participants did not grow up in the southern United States, the setting of the study. The ethnicity of the participants was self-described. Two participants identified their ethnic background as

African American, and seven participants described themselves as Caucasian. At the time of the interviews, which occurred in the participants’ homes or offices, four of the women were married and living with their spouses, while two were single and living with a partner, and the remaining three were single and living in or would soon return to their parents’ homes. Thus, the participants represented a broad range of backgrounds.

### ***Procedure***

After receiving approval by the institutional Human Subject’s Protection Committee, the researcher used first and second interviews and journals from the participants as primary data sources. It was hoped that voluntary journaling on the part of the expectant mothers would provide an intimate reflection on the experience of pregnancy and new motherhood. Secondary sources were field notes recorded immediately after each interview. An open, exploratory approach was used for interviewing. The narratives unfolded without restrictions of chronology. Interviews were audiotaped with the participant’s permission. Each participant selected the pseudonym of her choice and that name, along with the date, was used to label each audiocassette. Second interviews were conducted 4 to 12 weeks after the first interview.

To gently guide the first interview, opening questions posed to the study participants included the following:

1. How would you describe your pregnancy?
2. What do you remember hearing about giving birth as a child?
3. Who were the tellers of those stories?
4. How would you describe your inner wisdom as it relates to childbirth?
5. What has facilitated/impaired the acquisition of this wisdom?

The second interview focused on the experience of how the participant’s knowledge would be accepted and valued and whether or not this knowledge impacted the relationship between the care provider and the participant. Time was also spent exploring the participant’s perception of her impending birth experience and what her role in that process would be.

### ***Rigor***

Conceivably, all social inquiry is connected to ethical consideration. Informed consent was obtained

as both an initial and ongoing component of the negotiated research relationship. Many issues surround exposing normally hidden thoughts and feelings during an interview. As the interviewer, I tried to remain faithful, nonjudgmental, and respectful of the commitment to confidentiality and to maintain the researcher's role. Trust, compassion, and empathy permeate the research relationship (Munhall, 2001).

In addition, rigor and trustworthiness constitute validity for qualitative research (Munhall, 2001). To avoid compromising description validity, interviews and field notes were audiotaped. Such verbatim accounts allow accurate analysis and conclusions. To maintain the integrity of the interpretation process, active listening was used to understand the meanings the expectant mothers assigned to their words and behaviors. Care was taken to record and reveal the experiences of the participants by using open-ended questions that encouraged the illumination of the participant's lived experience. In examining the researcher-participant relationship, my personal influence on the participants could not be eliminated; however, I was aware that my multiple roles as a woman/childbirth educator/nurse/researcher influenced the interview process. To offset this power differential, the participants chose the time and place for the interviews. The settings for interviews included offices, health-care facilities, and, most often, the participant's home.

## ANALYSIS

The following steps, as suggested by Creswell (1998), were taken. Each interview transcript was read multiple times for understanding of meaning to identify groupings of categories. Care was taken to avoid severing the connection to the original narrative. Theme clusters were then formed, with discrepancies within and across data noted, to provide a comprehensive description of the experience.

As recommended by Cohen, Kahn, and Steeves (2000), Spall (1998), and Spillet (2003), peer debriefing was used to open the inquiry process. With an initial peer debriefer, the narratives were independently read and reread. Coding comments were made in the margins. The interviewer and a peer reviewed each transcript in order to come to an agreement on category interpretation. Categories were then revised and compared to the narrative. The development of major themes occurred at

this point. Relationships existed among the themes to provide textural (what was experienced) and structural (how it was experienced) descriptions. Only those points in the journals that were relevant to the research questions were transcribed for data analysis. The journals were returned to each participant. Each interview was transcribed verbatim and copies were mailed to participants to review for accuracy and revision. The only changes made in the transcripts were elements with identifying information, which would compromise anonymity, or elements requested by the participants.

## FINDINGS


The lifeworld existentials of van Manen (1990) are "the lived world as experienced in everyday situations and relations" (p. 101). Three concepts—corporeality (lived body), temporality (lived time), and relationality (lived other)—from van Manen's lifeworld existentials structured the organization of the themes, as illustrated in the Figure. Six major themes emerged that were related to the participants' knowing surrounding the childbirth experience: 1) disquieting intuition, 2) power, 3) conflict, 4) mother (engaging and disengaging), 5) birth stories, and 6) knowing (sources and barriers). The Figure categorizes these themes according to van Manen's (1990) three concepts.

### *Disquieting Intuition*

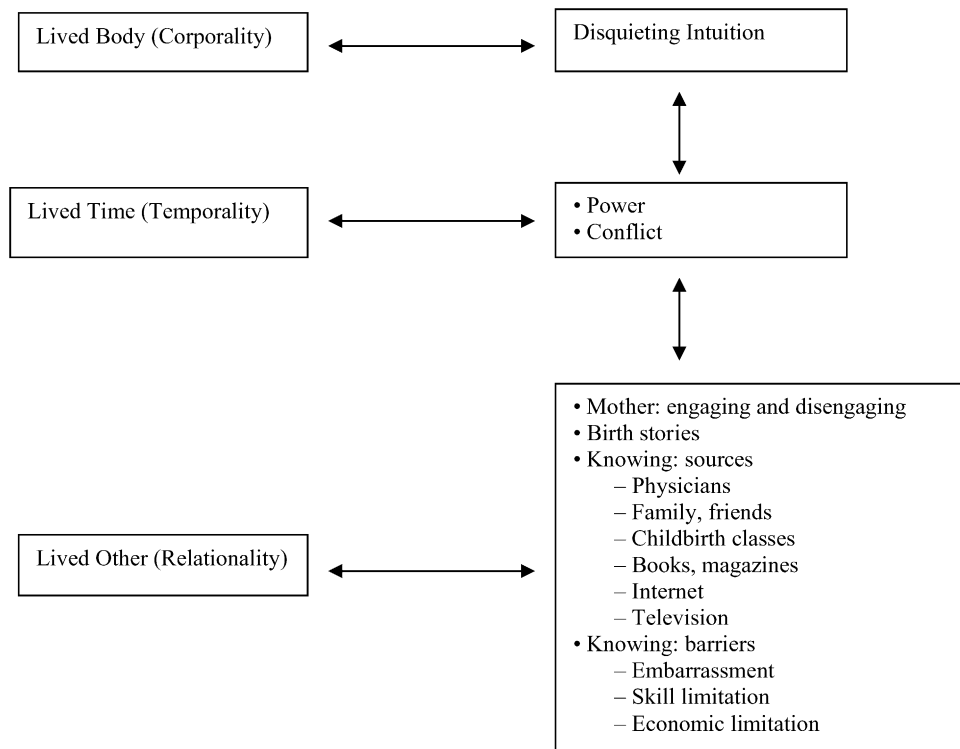
The corporeality of the lived experience of pregnancy entailed internal processes as well. One example is an inner wisdom to guide a woman through birth. Many of the expectant mothers described their experience as an understanding of their own intuition being absent or as being distrustful of their intuition.

At the time of our first interview, Anna was 16 weeks pregnant and lived over 1,000 miles from her family while she attended college. She was quick to relate her sense of intuition about birth as something she did not trust:

*You know, it is very easy—'cause for now, my mom was my intuitive sense. No decision was made without my mom knowing. . . . I do not have an intuitive sense just yet—really, to be*

 According to Max van Manen (1990), "lived body" is the subjective concept of how one is bodily within the world; "lived time" is subjective time as opposed to clock or objective time and appears to speed up when one enjoys oneself and to slow down when one is bored or anxious; and "lived other" is the concept of lived human relations or how one relates with and to other people.

Many of the expectant mothers described their experience as an understanding of their own intuition being absent or as being distrustful of their intuition.



**Figure** Themes from Expectant Mothers' Lived Experience of Knowing in Childbirth

*honest—I do not think I really have one—maybe that comes with the motherhood package. I will get it. For now, I am still someone else’s child. I cannot find it. I do not trust my own inner wisdom. I do not trust what is going on inside of me.*

Erin wanted to stay home as long as possible before going to the hospital in order to “listen to my body at that time and not have all the other distractions.” She explained her sense of birth intuition and expressed concern that the hospital experience might affect it:

*The whole process of giving birth is a natural process and your body does respond. Look at what has happened during pregnancy; look at all the changes. I would say—how do I describe my intuitive sense? Moderate. . . That is your body, there is really not a whole lot, sometimes you can do mind-over-matter but—so I do trust that I will be able to follow the contractions and give birth and that my body knows how to do that. . . I do believe that if I were stranded on a deserted island that I could give birth and follow my body signals, provided there are not any bad complications I can handle that I can do that. I do worry. In a hospital setting, I worry about all those other things the medication*

*is going to affect that some; the people that are around me are going to affect it. They are going to affect me by giving me the directions that I need to do what I need.*

At the time of our first interview, Lily, a marathon runner, was 19 weeks pregnant. She described her reluctance to think about her own intuition as it related to birthing: “I just started to think about that. . . It is a little scary to think about going through the whole thing. Then, sometimes, I don’t let myself wander as deeply as I should and need to.”

During the first interview, all nine study participants were in their second or third trimester of pregnancy. They expressed varying degrees of intuition surrounding the birth of their baby. The examples of these first-time expectant mothers ranged from no belief of existence of intuition to ambiguity about, discounting of, or relinquishing their intuition or inner wisdom. Several of the participants used their mothers to validate their intuition. Most of the expectant mothers were doubtful of their intuition. While some childbirth education organizations contend that women possess an inner wisdom regarding birth, the experience of most of the participants did not confirm a prenatal connection to that intimate knowing.

Intuition surrounding the phenomena of birth did not improve for participants who had given birth at the time of the second interview. It seemed that intuition correlated with confidence and with an air of disappointment for these new mothers. For example, nine days after her induced birth, Olivia described her experience:

*I guess I felt like I knew what to expect, but the pain was a lot different. I felt confident that I could endure the pain of labor. It was a little disappointing to not be able to do it. I tried to do it for a few hours, and it was a little bit upsetting that I was not able to do it naturally. I think some of the descriptions that we talked about were accurate as far as being like menstrual cramps, but much more severe, but it is hard to describe [laughter]. I guess the thing that was hard for me was that it was impossible to get away from. It just seemed to be impossible to escape.*

### **Power**

The issues surrounding control related to birthing were two-pronged: expectant mothers spoke of how others had controlled the amount and type of knowledge they were receiving from childhood to adulthood and dilemmas related to the struggle of communicating needs and preferences because of their increased knowledge base. Because pregnancy is time-limited, temporality subjectively constitutes the cognitive and emotional threads of feelings and thoughts. The participants shared a perception that friends, family, and care providers often withheld essential information about the experience of birth.

In her ninth month of pregnancy, Harper, a self-described feminist, explained her perception of knowledge being withheld from her:

*You are operating your whole pregnancy out of fear. I will do whatever the doctor says. I do not know anything. It is terrible. Why do we need to make women afraid? Because we can control them better. Keep people ignorant and down. They are much easier to control. The worst thing they ever did was let us go to college!*

Harper also described her disappointment with her interaction with the prenatal nurse educator at the hospital:

*I want to know what to do to have the baby. I did not find that was very forthcoming. You go*

*to the hospital and ask, "Do you have a whirlpool?" "Oh no, we don't have that." "Do you have showers?" "No." "Do you have a birthing ball?" "No." There was no response, "We don't have that, but we do have this option. You can bring this in. You can use this." Not all willing and ready to give you information. It is like a secret-society thing. Not until you go through the horrors of it are you inducted into the club. . . .*

Harper's experience reflects an interaction with a hospital nurse who did not seem responsive to her effort to get the birth environment she envisioned. She felt the nurse withheld information from her and was not willing to offer alternative options.

Although Shantell had not yet read the educational literature given to her by her midwife, she initially revealed that she would attend childbirth classes at the hospital where she planned to have her baby. However, at the time of the second interview, she expressed the following sentiments:

*My mama changed her mind about the childbirth classes. She says I do not need that . . . she did not go . . . I might go. My aunt did not go either. Next year at [high] school, I will take classes about having babies, but I haven't had that yet.*

Sophie expressed her experience this way:

*Normal. This is what we are after: We are after normal. You want to be practical. There are so many agendas out there. . . . This is what my doctor was afraid of. "Don't take that Lamaze class." People have such agendas that teach Lamaze class, sometime.*

The participants identified examples of knowledge control by others as it influenced their learning about birth. Eight participants shared nine illustrations of dilemmas they had encountered because of their knowing.

In many cases, the expectant mothers were resentful of knowledge being withheld or controlled. When they had information that caused them to question medically based practice related to their birth, most remained passive. Certainly, prior knowledge and perhaps current knowledge are not empowering if the expectant mother does not view the environment in which the knowledge is applied as supportive.

Many of the expectant mothers had concerns about their lack of empowerment related to their birth. Utilizing knowledge about birth options was a challenge.

Many of the expectant mothers had concerns about their lack of empowerment related to the birth. Utilizing knowledge about birth options was a challenge, and this frustration was attributed to their learning. Initially, Olivia expressed feelings of frustration related to her new knowledge: “No matter how prepared you think you are or whatever choices you think that you want to make about what is going to happen, there is really no certainty in it.”

The participants gave examples that acknowledged their feelings surrounding the complex issues of their perception of lack of control when giving birth. Erin was concerned that her knowledge from a variety of sources might present a problem. She shared the following:

*As long as I don't go in thinking I know more than they do—which I definitely don't—and acting like it, [my job would be] listening to instructions. I think I am going to rely on the nurses and the doctor to let me know what I should be doing or what I should not be doing. I think that is the key.*

Although knowing what is best for them seemed reasonable and realistic, the participants expressed doubt that such justification would prove viable. As sound as the espoused rationale might be, in the reality of the practice setting, it might not work for them. Within the arena of the medicalized birth model, the more involved an expectant mother is in her birth experience, the more likely she is to experience confusion and increased anxiety (Berg, Lundgren, & Lindmark, 2003; Green, Coupland, & Kitzinger, 1990). However, a well-supported midwifery model of care has the potential to create a peak experience that can positively influence a woman's life (Humenick, 1992). Expectant mothers' concerns are valid, yet the reality of most birth environments demands that they remain flexible and yielding during birth.

### **Conflict**

Five participants revealed specific feelings of interpersonal and intrapersonal conflict resulting from knowledge gained. The expectant mothers explained that their knowledge influenced their desire

for a natural birth, but they were afraid that they could not do it. Having information did not reduce conflict for the participants; in fact, it may have increased it.

Some information, such as using a birthing contract, may make an expectant mother appear demanding or give an impression of a false sense of security. Sophie expressed concern about threatening her relationship with her physician:

*I know the birthing contract makes him crazy. Because he said, “I am going to tell you everything along the way.” In a way, I think it makes you feel like you are too informed. I have a lot of faith in the doctor. That is how I feel. I told him, “I know that you have the best in mind and, ultimately, we have the same goal, to have a healthy baby. If there are forceps, or any episiotomy, I might be disappointed.” I would imagine that it makes them feel like they are second-guessed. . . . I am not going to be very controlling. It sounds like many of the women go in there very controlling. I am not going in there trying to control this.*

Undecided about medication, Olivia expressed her feelings about labor pain:

*I feel a conflict between my feminist views and the medical establishment, but at the same time, I understand the arguments for natural childbirth. I also feel there is a tremendous amount of pressure to do that. Childbirth is the only major medical procedure involving so much pain and you are expected not to have anything. I am trying to keep my options open and not pin myself down to a specific idea as to what is going to happen.*

Conflict for the expectant mothers was shrouded in indecision related to personal expectations and meeting the needs of others. Clearly, pain is a powerful phenomenon. Although the pain of birth is normal, it is universally feared by women. Labor pain had been cited numerous times previously; three examples of interpersonal conflict included issues related to pain management and subsequent decision-making. Each example had at its core the issues of communication breakdown and distrust.

### **Mother: Engaging and Disengaging**

All nine participants described a relationship to their own mothers as it related to their experience

of pregnancy. This connection ranged from an emotional one to an informative one. Most of the relationships were discussed as positive. All participants expected help from their mothers in various ways. Their thoughts were reflected in the following statements by the expectant mothers. Shantell said, “My mama is going to tell me when to go to the hospital. She is going to tell me everything I need to know.” Another participant, Jenn, said, “My mom tends to be the one I go to to ask for advice about things.” Kayla described her need for her mother in this way:

*I have always had somebody to give me everything. Now even. Emotionally, I always have to depend on someone else. I cannot do the emotional stuff by myself. My mom will be there; she can help me. That is my support. I want her to be there.*

Olivia’s mother attended the birth, and in describing the experience Olivia stated:

*The most important is the relationship with my mom because she was probably the person that I ask for advice the most and compared experiences with the most. I did not think that I would want her in the delivery room when I was actually giving birth, but I am glad she was there. That was probably the most important.*

Every pregnancy influences all family relationships. The mother of each participant used overt and covert ways to communicate her feelings about her daughter’s pregnancy. Because all nine participants related their knowing in childbirth to a maternal connection, numerous examples of this need were expressed. The expectant mothers expressed the need to have a positive, reliable connection with their own mothers. This relationality with their mothers over their partners was also evident in the participants’ journals. Pregnancy brings with it increased dependency on nurturing and support. These needs may be an effort to connect again with their mothers. The participants experienced joy, concern, and stress, no doubt similar to those felt by their mothers (Lowdermilk & Perry, 2004).

### **Birth Stories**

None of the expectant mothers remembered hearing stories or reading about birth as a child. However, they cited numerous examples of birth stories they had heard later in life. In addition, three expectant mothers expressed the need for other women

to share their stories with them. One participant, Harper, encouraged other women by saying:

*Tell your stories! This is how we decipher information. Then, after you finish yakking about it, write it down and leave a paper trail. I do not understand the keeping of the information. Locking it up and not saying anything. How are all the lay people supposed to know what the truth is?*

Storytelling relies greatly on relationships and communication—it creates a bond between women and their shared history (Lindesmith & McWeeny, 1994). Expectant mothers’ willingness to share their stories is an expression of the universal need to explain the unknown, to lessen fear, and to obtain a sense of control over childbirth (Zwelling, 2000).

### **Knowing: Sources and Barriers**

All participants shared other resources for obtaining birth information, including the Internet, books, childbirth classes, obstetricians, family, and friends. Most frequently used sources by the participants were their mothers and obstetricians. Although most of the participants relied on firsthand information from mothers, friends, and their physicians, they used a variety of resources such as books, classes, television, and the Internet. Most of the participants indicated a preference for reality television shows and books, yet acknowledged distaste for Internet chat rooms.

Barriers to learning have been described in the literature and include lack of time, resources, and prior knowledge, irrelevancy and unrealistic viewpoints, an absence of support, and a poor learning environment (Caffarella, 1994; Kemerer, 1991; Martin & Mazamian, 1991). When asked, several participants in the current study overtly identified personal reasons—such as embarrassment, financial limitations, and a lack of technical skill—as barriers in their learning environments.

Uncovering an expectant mother’s experience of learning about birth adds to the richer understanding of the gender-specific experience of knowing in pregnancy and birth. The experience of knowing for an expectant mother has far-reaching social and cultural implications. With the descriptions of those experiences and subsequent explanations, these examples of knowing are a wellspring of data. In support of feminist research, the exploration was done for women.



## LIMITATIONS OF THE STUDY

Several limitations within this phenomenological investigation are noted. The use of a small, self-selective, and purposive sample mandates that the results are not representative of all women. Nevertheless, in keeping with the philosophy of phenomenology by including participants who have knowledge of the experience, the findings aid in understanding first-time expectant mothers' experience of learning about childbirth.

## DISCUSSION

The first theme derived from participant interviews and journals was "Disquieting Intuition." In many ways, this theme is paradoxically related to the others. It became clear from the interviews that participants acknowledged their physical capacities related to pregnancy, but most were hesitant or unable to recognize their intuition. The first-time expectant mothers explained that the concept of intuition related to birth was not well formed for them. Several participants denied having any inner wisdom at all. The data are supported by Melender and Lauri's (2002) investigation of factors related to security for pregnant women. The women in the sample indicated they did not have knowledge based on personal experience. This finding is in contrast to the belief held by Lamaze International (2002) that women possess an inner wisdom related to birthing. It would be interesting to explore the question, "When would one expect such wisdom to appear: during the prenatal period, the intrapartum period, or with subsequent pregnancies and births?"

Intuitive knowing is often described as a universal human experience fundamental to the knowing process. Intuitive knowing has many obstacles that originate from an American demand for scientific problem solving. Additionally, beliefs by some that intuition is exclusive to women and that it is not accompanied by reliability, and beliefs about how it interplays into the scientific domain may be barriers as well (Belenky et al., 1997; Ruth-Sahd, 2003; Seibold, 2004).

The idea that the participants minimized or denied their intuition is evidenced by their hesitancy to discuss their inner knowing (Zelman, 2002). When intuition is used, it is in an attempt to understand the uncertainty of the ever-present, ever-changing reality in today and tomorrow. Birgerstam (2002) states that, in general, the interplay between rational, logical thinking and intuition creates more

value in the learning process; however, the data from the present study do not support this added value. The expectant mothers in this study denied their knowing as it related to birth and, thus, as a basis for learning and decision-making.

Additional themes that emerged from the current study were "Power" and "Conflict". If an expectant mother makes real choices, a process of sharing and negotiation of information will facilitate that decision-making process. Informed decision-making about choices in childbirth necessitates that women must first have the information they need to make their determination. Even if an expectant mother has the information, a spirit of cooperation must exist between the participant and her health-care provider for that knowledge to be valued (Campbell, Thompson, & Lavender, 2002; Madi & Crow, 2003; Tran et al., 2004).

Sources of knowing are as diverse as knowledge itself—for example, empirical evidence, professional ethos, or intuition (Daviss, 1997). Inherent in authoritative knowing, based on empirical evidence, is the hierarchical relationship. The expectant mother may presume that her health-care provider knows what is best for her. Any resistance to this ordering of a knowledge source may risk that person (the resistor) being labeled as "abnormal" or "on the fringe." The technocratic model founded on authoritative knowledge has the effect of asserting control over the expectant mother (Stewart, 2001). Mary Stewart (2001) used a qualitative approach to understand how health professionals, midwives, and physicians in childbirth services viewed evidence. The participants of this study confirmed that they were going to yield to the health-care professionals and not portray themselves as knowing more.

Relationships with family members, mothers in particular, and health-care providers who withheld or controlled information while the participants were growing up or seeking care were a source of tension for the expectant mothers. Participants' feelings ranged from disappointment to frustration at this exertion of external control. Four participants acknowledged the struggle they experienced in maintaining a positive relationship with their health-care provider. They did not want their knowledge to jeopardize that relationship or the care they would receive. Only one expectant mother was so frustrated with her physician's unwillingness to discuss her birth plan that she found another physician in her last month of pregnancy. A recent

study indicated that if an expectant mother makes a decision from a position that she believes is one of power and understanding, then she will consider her views as being respected (O’Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002).

Another reason for feelings of frustration relates to lack of power, lack of knowledge, and a negative view of the health-care provider, as specified in Fowles’ (1998) study of the lingering concerns of women who have given birth. Green (1999) takes issue with the concept of control for a woman in childbirth, stating that “for many women it is likely that the belief that ‘they know best’—that one is being cared for by experts—is essential to the feeling of control” (p. 52). The expectant mother who believes she has a choice feels an enhanced sense of control. Arguably, a woman who delegates her decision-making may also feel a sense of control.

Two recent studies described the importance of empowerment for the participants. Using a phenomenological approach, Gibbons and Thomson (2001) interviewed eight expectant mothers and found that they all wanted to have an active role in the birth of their child. In the correlational study conducted by Goodman, Mackey, and Tavakoli (2004), personal control was a significant predictor for total childbirth satisfaction in 60, low-risk, postpartum women.

Although three expectant mothers in the current study were under the care of midwives, all of the expectant mothers planned to give birth in hospitals. Because of the birthing environment, the participants had an increased likelihood for confusion and anxiety related to their birth experience. The participants’ prevailing belief that any attempt by them to control their labor would be futile is consistent with the findings of Armstrong and Feldman (1990): birth with its own agenda will ultimately sabotage any attempt to control it.

Cleeton (2001) qualitatively examined college students’ responses to watching a birth video. Her findings showed a wide range of awareness and knowledge among the participants. Cleeton felt that high school students’ lack of knowledge about birth contributed to their fear and that providing specifics about birthing would reduce anxiety and increase maternal control. The findings associated with the relationship between not having formal knowledge and having fear are not consistent with the findings in the current study. The majority of expectant mothers in this study had formal knowledge and still identified fear as an issue for

them. Perhaps the closer one gets to the act of giving birth, the less control one feels, or the less need one has to have control. Additionally, researchers do not always distinguish between the types of control: having control over labor itself, maintaining self-control in response to labor, or influencing control over what is done to or for oneself by care providers. Using one word to describe all three types of control may lead to contradictory findings.

Historically, decisions surrounding birth have been made by women from active and aggressive positions that have shaped birthing for generations. These decisions were made with good intent, most often arising from the intense realities of birth (Armstrong & Feldman, 1990). The findings of the current study support findings from Lazarus (1997), who determined that knowledge alone does not empower women to speak for themselves and identify preferences for birth with their health-care provider. Additionally, the current study’s findings support Butani and Hodnett (1980), who determined that a woman in labor needs to maintain self-control, to live up to her expectations, and to preserve her self-esteem.

Atkinson’s (1957) explanation of expectancy learning theory defines motivation for the learner as an impetus to act from a desire to reach success or to avoid failure in achieving one’s goals. Eight of the nine mothers in the current study expressed the need to have a positive, safe birth. The participants’ motives varied, not without conflict, with the majority seeming to lower their personal expectations and responsibility to avoid failure in achieving a positive, safe birth.

### ***Relationships***

Expectant women sharing their personal domain of pregnancy with their mothers is an example of intimacy that bids or brings forth relationality. Human connectedness gives life purpose and meaning. All nine participants spoke of the importance of the relationship with their mothers at this time. There was evidence of discounting information from their mothers, primarily because they had given birth so long ago; yet, most expectant mothers indicated that their mothers were influential in their pregnancy

The expectant mother who believes she has a choice feels an enhanced sense of control. Arguably, a woman who delegates her decision-making may also feel a sense of control.

and birth. Mothers of the participants were present for two of the four births of the women who gave birth during data collection. All four mothers of the participants who gave birth helped their daughters after the birth. The expectant mothers all were pleased that their mothers attended their births. One participant indicated that she received an epidural because her mother wanted her to have one. The issue of an enmeshed mother-daughter relationship to the exclusion of the husbands was also identified in the narratives.

No prior studies have identified the mother-daughter relationship as a finding. While it may be tempting to attribute the strong mother-daughter relationship to the culture of the region, four of the participants did not grow up in the study area. Because embarrassment was identified as a barrier, perhaps the participants felt the least embarrassed when confiding in and exploring with their own mothers. Another explanation for the finding of increased relationality is one of a diminishing generation gap. As daughters reach adulthood with a milestone of pregnancy and childbirth, mothers and their expectant daughters may find that they have more in common than ever before.

In the absence of any memory of receiving substantial information about childbirth as children, the experience of hearing birth stories was universally desirable for the participants. Some of the participants expressed a need to hear others' stories. Birth storytelling is well documented as an effective way for expectant mothers to learn about birth (Armstrong & Feldman, 1990; Davis-Floyd, 1992; Drake, 2002; Leight, 2002; Livo & Ruitz, 1986; McHugh, 2001; Razak, 1993; Sargent & Stark, 1989; VandeVusse, 1999; Zwelling, 2000). The development of personal knowing through relationality may be facilitated through storytelling to comprehend the storyteller as if the listener were inside her world (White, 1995).

### ***Sources of Knowing***

The participants in this study identified a variety of sources for information, direct and indirect. The expectant mothers drew upon their mothers, physicians, books, childbirth classes, the Internet, and television reality programs for information and knowledge about childbirth. These findings are supported by previous studies (Mackey, 1990; Maternity Center Association, 2002; Stamler, 1998). A recent study concerning information resources was conducted by Levy (1999) using a grounded

theory approach to investigate how women used information to make informed choices. The participants were 12 midwives practicing in the United Kingdom. Midwives were observed using information to guide their patients through available birth options that were perceived to be mutually safe, realistic, and acceptable. Australian research on pregnancy and childbirth has determined that expectant mothers access information from media, books, magazines, pamphlets, midwives, and parenting classes (Department of Health, 1990). Specifically, advice from friends and health-care providers, books, and pamphlets was considered important if the participant valued the informant. A report of a British national survey of women's views of maternity care indicated that women want good information about childbirth and the chance to learn more as needed (Garcia, Redshaw, Fitzsimons, & Keene, 1998). Because uncertainty surrounds the issue of birth, valued knowledge from the culture, other mothers, classes, television, and books brings the demands of childbearing to life (Ewy-Edwards, 2000). Thus, there is wide agreement that expectant mothers want information. The studies reported here support the findings from the current research.

Barriers to obtaining information that were identified from the interviews included personal reasons such as embarrassment, financial limitations, and lack of personal skill in finding resources. Although these were identified as barriers, the participants were still able to obtain the information they sought. The current study's findings share similarities with Marion Bowl's (2001) study of 32 nontraditional female learners. Bowl described three participants' experiences of barriers in education. Key barriers were identified as lack of family support, need for support and guidance, frustration by participants, and anticipating change.

The experience of learning about childbirth shares many parallels with the findings from Kilgore and Bloom (2002). Their stories of learning from women in prison indicate short-lived transformation. The researchers learned that women in crisis experience powerlessness and, consequently, submission or an acceptance of fate. The system dictated what to do and how to do it to create discipline. Comments like, "I just did it," validated that perception. One finding surrounded the notion of disorienting dilemmas as a threat to knowing. When an experience of learning occurs in a way different from what is known, it has the potential to be

a positive transformation. However, if a disagreement occurs in context—a resistance to knowing—a refusal transpires (Taylor, 1998). Knowledge is a constant state of becoming and knowing. Women in crisis can also include women who are pregnant, in labor, and giving birth. Certainly, the authoritative position would have the public believe so. The current study's findings also demonstrate that fear prohibits active participation in discourse.

## CONCLUSIONS

From the findings of the present study and literature reviewed on the experience of knowing in childbirth for expectant mothers, the following conclusions were drawn. Family secrecy and the lack of children's literature may have a negative impact on a child's perception of the childbearing process. The lack of information that would be age-appropriate lends an air of mystery to events associated with being pregnant and giving birth. What they have and have not been told and the manner in which the information was conveyed influences women of all ages as they make choices about their lives.

Although pregnancy is an exciting time, it also produces feelings of confusion, conflict, and control. No matter how well substantiated the information is, confusion exists concerning information that is received about childbearing (Treicher, 1990). The expectant mother must juggle a myriad of factors as she begins making conscious and unconscious decisions about what she wants to have happen. Yet, some women will make final decisions primarily based on what their mothers or doctors tell them or want them to do. The importance of an expectant mother's own mother in the childbearing process has been largely overlooked in the literature, but the present study's findings suggest that the mother-daughter relationship plays a major role in childbearing.

Expectant mothers know they must "birth" their babies. They physically have to do it. However, they are unaware of any substantial, trustworthy intuition about their knowing connected to the birthing process, even after they have given birth. One explanation may be that this intuition has been and continues to be repressed with a high degree of success.

## IMPLICATIONS FOR CHILDBIRTH EDUCATION AND RESEARCH

The findings of this study provide direction for needed changes in childbirth education. Childbirth

educators must acknowledge the significant and powerful relationship that exists between an expectant mother and her doctor and between an expectant daughter and her mother. Among the participants' responses in the current study, the recognition of the nursing role for the mother during labor and birth was almost nonexistent. Yet, skills to negotiate within and around those relationships should be taught if the expectant mother desires a woman-centered birth.

This study's findings note the need for childbirth educators to assist and, therefore, support the expectant mother in her decision-making process. To help her understand the motivation underlying her decisions and, consequently, whose needs are being met, an open learning environment must be established. Additionally, because expectant mothers are at risk for disappointment and depression, it is recommended that the childbirth educator help the expectant mother develop a realistic, flexible plan for birthing. Inherent in this process is an understanding of how active a role the mother wants to take in her birth experience.

Schools of nursing may want to strengthen or consider including women's studies courses in their curricula so that nurses working with expectant mothers can understand and oppose the oppression that women may endure and may unwittingly foster during the childbirth experience. To undermine the barriers, nursing curricula should also present women-centered care in undergraduate and graduate maternity nursing courses (Giarratano, 2003).

Having information about childbirth did not necessarily lower anxiety and eliminate conflict for the expectant mothers in this study. In fact, conflict and confusion may have actually increased as they experienced cognitive dissonance. This evolutionary process of knowing is the first step for the childbirth educator to acknowledge changing the learning environment for the expectant mother (Mies, 1999). Programs for certification of childbirth educators and textbooks for childbirth educators should address this dilemma to assist the childbirth educator to better prepare the expectant mother to deal with this outcome.

Childbirth will always be rich with multifaceted meanings for mothers and daughters. Although on a certain level birth may appear to be natural and normal, it is embedded with politics that limit real choices women have in childbirth. These limitations undermine any natural or normal characteristics surrounding a healthy birth. Are pregnant

women who give birth in a medicalized setting marginalized? How do caregivers, especially female caregivers, contribute to the marginalization of these women?

This phenomenological study presents several new research findings concerning the experiences of expectant mothers as they learn about childbirth; however, the findings must be seen as an initial effort. This sample of pregnant women was small and limited. A larger study with more diverse participants from a different geographical location would bring more richness and understanding of women's experience. Data collection using focus groups may increase the spontaneity of the participants.

Based on the themes derived from the interview texts, additional studies could be developed; for example, future studies may qualitatively examine the relationship of an expectant daughter and her mother, specifically investigate the phenomena of birth wisdom or intuition for women, and examine the relationship of knowledge and an enabling birthing environment. In addition, future investigation should examine more thoroughly the influence of preexisting knowledge on the birthing experience. To determine educational strategies and teaching methodologies that are most effective in facilitating the transfer of learning to the birthing environment is of extreme importance.

Findings from the literature review and findings of this study support the conclusion that the experience of learning about birth extends well beyond the expectant mother. Even in the presence of physical confidence, controlling forces in the expectant mother's environment are impediments to her knowing: confusion, control, and conflict. What inhibits families and health-care providers from being more forthcoming with information about birthing for their daughters and clients? What would a birthing environment entail that encouraged women to acknowledge, to work with, and to reclaim what they know best about their bodies? How does the voice of the expectant mother reach the same level of importance as the other players involved in her birth process? When will the value of personal knowing approximate that of authoritative knowledge? Childbirth educators face these and other major challenges to assist the mother to transfer her learning to the childbirth experience.

#### ACKNOWLEDGMENTS

I gratefully acknowledge the valuable guidance of Cory Buxton, PhD, during this investigative pro-

cess. I also thank all the women who participated by opening their lives to me, without whom this study would not have been possible.

#### REFERENCES

- Alcoff, L., & Potter, E. (1993). *Feminist epistemologies*. New York: Routledge.
- Anderson, G. (1998). Creating moral space in prenatal genetic services. *Qualitative Research*, 8(2), 168–187.
- Armstrong, P., & Feldman, S. (1990). *A wise birth: Bringing together the best of natural childbirth with modern medicine*. New York: William Morrow.
- Atkinson, J. W. (1957). Motivational determinants of risk-taking behaviors. *Psychological Review*, 64, 359–372.
- Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1997). *Women's ways of knowing: The development of self, voice, and mind*. New York: Basic Books.
- Bennett, A., Hewson, D., Booker, E., & Holliday, S. (1985). Antenatal preparation and labor support in relation to birth outcomes. *Birth*, 12(1), 9–15.
- Berg, M., Lundgren, I., & Lindmark, G. (2003). Childbirth experience in women at high risk: Is it improved by use of a birth plan? *Journal of Perinatal Education*, 12(2), 1–15.
- Birgerstam, P. (2002). Intuition—The way to meaningful knowledge. *Studies in Higher Education*, 27(4), 431–444.
- Boston Women's Health Book Collective. (1979). *Our bodies, ourselves: A book by and for women*. New York: Simon and Schuster.
- Bowl, M. (2001). Experiencing the barriers: Nontraditional students entering higher education. *Research Papers in Education*, 16(2), 141–160.
- Boxer, M. J. (1998). *When women ask the questions: Creating women's studies in America*. Baltimore: Johns Hopkins.
- Broussard, A., & Weber-Breaux, J. (1994). Application of the childbirth belief-efficacy model in childbirth education classes. *The Journal of Perinatal Education*, 3(1), 7–15.
- Butani, P., & Hodnett, E. (1980). Mothers' perceptions of their labor experiences. *Maternal Child Nursing Journal*, 9, 73–82.
- Caffarella, R. S. (1994). *Planning programs for adult learners: A practical guide for educators, trainers, and staff developers*. San Francisco: Jossey-Bass.
- Campbell, E., Thompson, S., & Lavender, T. (2002). Providing women with evidenced-based information. *British Journal of Midwifery*, 10(12), 728–731.
- Cleeton, E. R. (2001). Attitudes and beliefs about childbirth among college students: Results of an educational intervention. *Birth*, 28(3), 192–201.
- Cohen, M., Kahn, D., & Steeves, R. (2000). *Hermeneutic phenomenological research: A guide for nurse researchers*. Thousand Oaks, CA: Sage.
- Creswell, J. (1998). *Qualitative inquiry and design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Crowe, K., & von Baeyer, C. (1989). Predictors of a positive childbirth experience. *Birth*, 16(2), 59–63.

- Davis-Floyd, R. E. (1990). The role of obstetrical rituals in the resolution of cultural anomaly. *Social Science Medicine*, 31(2), 175–189.
- Davis-Floyd, R. E. (1992). *Birth as an American rite of passage*. Berkeley, CA: University of California Press.
- Daviss, B. (1997). Heeding warnings from the canary, the whale, and the Intuit: A framework for analyzing competing types of knowledge about childbirth. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 441–473). Berkeley, CA: University of California Press.
- Department of Health. (1990). *Final report of the ministerial review of birthing services in Victoria*. Retrieved May 19, 2004, from <http://www.health.vic.gov.au/maternity/docs/research.pdf>
- Drake, E. (2002). The power of story. *The Journal of Perinatal Education*, 11(2), ix–xi.
- Durna, J. (1991). *Toward a feminist epistemology*. Savage, MD: Rowman & Littlefield.
- Dwinell, J. (1992). *Birth stories: Mystery, power, and creation*. Westport, CT: Bergin.
- Ewy-Edwards, D. (2000). Transitions to parenthood. In F. Nichols & S. Humenick (Eds.), *Childbirth education: Practice, research and theory* (pp. 84–113). St. Louis, MO: W. B. Saunders Company.
- Fowles, E. R. (1998). Labor concerns of women two months after delivery. *Birth*, 25(4), 235–240.
- Garcia, J., Redshaw, M., Fitzsimons, B., & Keene, J. (1998). *First class delivery: A national survey of women's views of maternity care*. Audit Commission and National Perinatal Epidemiology Unit. Abington, Oxon: Audit Commission.
- Giarratano, G. (2003). Woman-centered maternity nursing education and practice. *Journal of Perinatal Education*, 12(1), 18–28.
- Gibbons, J., & Thomson, A. M. (2001). Women's expectations of childbirth. *Midwifery*, 17(4), 302–313.
- Goodman, P., Mackey, M. C., & Tavakoli, A. S. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, 46(2), 212–219.
- Green, J. M. (1999). Commentary: What is this thing called “control”? *Birth*, 26(1), 51–52.
- Green, J. M., Coupland, V. A., & Kitinger, J. V. (1990). Expectations, experiences, and psychological outcomes of childbirth: A prospective study of 825 women. *Birth*, 17(1), 15–24.
- Hanson, L., VandeVusse, L., & Harrod, K. (2001). The theater of birth: Scenes from women's scripts. *Journal of Perinatal Nursing*, 15(2), 18–35.
- Harding, S. (1991). *Whose science? Whose knowledge? Thinking from women's lives*. New York: Harding, Cornell.
- Humenick, S. (1992). The empowering element of prepared childbirth. *Journal of Perinatal Education*, 1(1), 64–65.
- Johnson, A. (1995). *The Blackwell dictionary of sociology: A user's guide to sociological language*. Cambridge, MA: Basil Blackwell.
- Kemerer, R. W. (1991). Understanding the application of learning. *New Directions for Adult Learning and Continuing Education*, 49, 67–80.
- Kilgore, D., & Bloom, L. R. (2002). “When I'm down, it takes me a while”: Rethinking transformational education through narratives of women in crisis. *Adult Basic Education*, 12(3), 123–133.
- Knapp, L. (1996). Childbirth satisfaction: The effects of internality and perceived control. *The Journal of Perinatal Education*, 5(4), 7–16.
- Lamaze International. (2002). Position paper—Lamaze for the 21st century. *Journal of Perinatal Education*, 11(1), x–xii.
- Lamaze International. (2004, November). *Lamaze International awards \$75,000 research grant for new study, “understanding childbirth education”*. Retrieved July 10, 2006, from <http://www.lamaze.org/eventsnews/documents/04ResearchGrantRelease.pdf>
- Lazarus, E. (1997). What do women want? Issues of choice, control, and class in American pregnancy and childbirth. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 132–158). Berkeley, CA: University of California Press.
- Leight, S. (2002). Starry night: Using story to inform aesthetic knowing in women's health nursing. *Journal of Advanced Nursing*, 37(1), 108–114.
- Levy, V. (1999). Protective steering: A grounded theory study of the processes by which midwives facilitate informed choices during pregnancy. *Journal of Advanced Nursing*, 29(1), 104–112.
- Lindesmith, K., & McWeeny, M. (1994). The power of storytelling. *The Journal of Continuing Education in Nursing*, 25(4), 186–187.
- Livo, N., & Ruitz, S. (1986). *Storytelling: Process and practice*. Boulder, CO: Libraries, Unlimited.
- Lowdermilk, D. L., & Perry, S. (2004). *Maternity and women's health care* (8<sup>th</sup> ed.). St. Louis, MO: Mosby.
- Mackey, M. (1990). Women's preparation for the childbirth experience. *Maternal-Child Nursing Journal*, 19(2), 143–173.
- Madi, B. C., & Crow, R. (2003). A qualitative study of information about available options for childbirth venue and pregnant women's preference for place of delivery. *Midwifery*, 19(4), 328–336.
- Martin, K. O., & Mazamanian, P. E. (1991). Anticipated and encountered barriers to change in CME: Tools for planning and evaluation. *The Journal of Continuing Education in the Health Professions*, 11(4), 301–318.
- Maternity Center Association. (2002). *Listening to mothers: Report of the first national U.S. survey of women's childbearing experiences executive summary and recommendations issued by the Maternity Center Association*. New York: Author.
- McHugh, N. (2001). Storytelling and its influence in passing birth culture through the generations. *Midwifery Matters*, 89, 15–17.
- Melender, H. L., & Lauri, S. (2002). Experiences of security associated with pregnancy and childbirth: A study of pregnant women. *International Journal of Nursing Practice*, 8(6), 289–296.
- Mies, M. (1999). Towards a methodology for feminist research. In A. Bryman & R. G. Burgess (Eds.),

- Qualitative research* (Vol. IV, pp. 66–85). Thousand Oaks, CA: Sage.
- Moules, N. J. (2002). Hermeneutic inquiry: Paying heed to history and Hermes – An ancestral, substantive, and methodological tale. *International Journal of Qualitative Methods*, 1(3). Retrieved November 22, 2002, from <http://www.ualberta.ca/~ijqm/>
- Munhall, P. L. (2001). *Nursing research: A qualitative perspective*. Boston: Jones and Bartlett.
- Nakashima, D., Prott, L., & Bridgewater, P. (2000). Tapping into the world's wisdom. *UNESCO Sources*, 125, 12.
- Nelson, M. (1986). Birth and social class. In P. Eakins (Ed.), *The American way of birth* (pp. 142–174). Philadelphia: Temple University Press.
- Oakley, A. (1986). *The captured womb: A history of the medical care of pregnant women*. New York: Basil Blackwell.
- Oakley, A. (1999). Interviewing women: A contradiction in terms. In A. Bryman & R. G. Burgess (Eds.), *Qualitative research* (Vol. IV, pp. 44–66). Thousand Oaks, CA: Sage.
- O'Caithain, A., Thomas, K., Walters, S., Nicholl, J., & Kirkham, M. (2002). Women's perceptions of informed choice in midwifery care. *Midwifery*, 18(2), 136–144.
- Pugh, A. (1990). My statistics and feminism—A true story. In L. Stanley (Ed.), *Feminist praxis: Research, theory, and epistemology* (pp. 103–112). London: Routledge.
- Razak, S. (1993). Story-telling for social change. *Gender and Education*, 5(1), 55–70.
- Romalis, S. (Ed.). (1981). *Childbirth: Alternatives to medical control*. Austin, TX: University of Texas Press.
- Ruth-Sahd, L. A. (2003). Intuition: A critical way of knowing in a multicultural nursing curriculum. *Nursing Education Perspectives*, 24(3), 129–134.
- Sargent, C., & Bascope, G. (1996). Ways of knowing about birth in three cultures. *Medical Anthropology Quarterly*, 10(2), 213–236.
- Sargent, C., & Stark, N. (1989). Childbirth education and childbirth methods: Parental perspectives on control, anesthesia, and technological intervention in the birth process. *Medical Anthropology Quarterly*, 3(1), 36–51.
- Schmied, V., Myers, K., Wills, J., & Cooke, M. (2002). Preparing couples for new-parent experiences: A comparison of two models of antenatal education. *Journal of Perinatal Education*, 11(3), 20–27.
- Seibold, C. (2004). Young single women's experiences of pregnancy, adjustment, decision-making and ongoing identity construction. *Midwifery*, 20(2), 171–180.
- Slaninka, S., Galbraith, A., Strzelecki, S., & Cockroft, M. (1996). Collaborative research project: Effectiveness of birth preparation classes at a community hospital. *Journal of Perinatal Education*, 5(3), 29–36.
- Spall, S. (1998). Peer debriefing in qualitative research: Emerging operational models. *Qualitative Inquiry*, 4(2), 280–292.
- Spillet, M. D. (2003). Peer debriefing: Who, what, when, why, how. *Academic Exchange Quarterly*, 7(3), 2529–2532.
- Stamler, L. (1998). The participants' views of childbirth education: Is there congruency with an enablement framework for patient education? *Journal of Advanced Nursing*, 28(5), 939–947.
- Stewart, M. (2001). Whose evidence counts? An exploration of health professionals' perceptions of evidence-based practice, focusing on the maternity services. *Midwifery*, 17(3), 279–288.
- Taylor, E. (1998). Analyzing research on transformative learning theory. In J. Mezirow & associates (Eds.), *Learning as transformation: Critical perspectives on theory in progress* (pp. 285–328). San Francisco: Jossey-Bass.
- Tran, A. N., Haidet, P., Street, R., O'Malley, K. J., Martin, F., & Ashton, C. M. (2004). Empowering communication: A community-based intervention for patients. *Patient Education and Counseling*, 52(1), 113–121.
- Treicher, P. A. (1990). Feminism, medicine, and the meaning of childbirth. In M. Jacobs, E. F. Keller, & S. Shuttleworth (Eds.), *Body/Politics: Women and the discourses of science* (pp. 113–138). New York: Routledge.
- Tritten, J. (1992, Autumn). Editorial: Giving voice to wisdom. *Midwifery Today*, 23. Retrieved April 4, 2003, from <http://midwiferytoday.com/articles/givingvoice.asp>
- VandeVusse, L. (1999). The essential forces of labor revisited: 13 Ps reported in women's stories. *MCN: The American Journal of Maternal/Child Nursing*, 24(4), 176–184.
- van Manen, M. (1990). *Researching the lived experience: Human science for an action sensitive pedagogy*. Ontario, Canada: The University of Western Ontario.
- Walker, A. (1984). *In search of our mothers' garden*. San Diego, CA: Harcourt, Brace & Co.
- White, J. (1995). Patterns of knowing: Review, critique, update. *Advanced Nursing Science*, 17(4), 73–86.
- Zelman, A. W. (2002). Nurturing intuition through group learning. *New Directions for Adult and Continuing Education*, 94, 33–41.
- Zwelling, E. (1996). Childbirth education in the 1990s and beyond. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 25(5), 425–432.
- Zwelling, E. (2000). The pregnancy experience. In F. Nichols & S. Humenick (Eds.) *Childbirth education: Practice, theory, and research* (pp. 35–47). St. Louis, MO: W. B. Saunders Company.

---

JANE SAVAGE is an assistant professor of clinical nursing in the School of Nursing at Louisiana State University Health Sciences Center in New Orleans.