Expectant parents' perspectives on the influence of a single antenatal relaxation class: a qualitative study.

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2021

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Aim

This study explores the perspectives of expectant parents on the influence of a single antenatal class incorporating education on childbirth physiology and relaxation techniques.

Method

The data for this qualitative descriptive study were collected via in-depth interviews with six women and three birth partners.

Findings

An enhanced understanding of childbirth physiology formed a '*different way of thinking'* about childbirth, '*inspired and motivated'* the exertion of the learnt relaxation techniques which led to a '*deep sense of calmness'* associated with increased confidence and reduced fear. However, reaching such sense of calmness during childbirth required a '*space for relaxation'* which was influenced by birth attendants. An overarching theme of *'a positive outlook'* towards childbirth was identified.

Conclusion

Including education on childbirth physiology and a range of relaxation techniques may reduce fear, empower prospective parents and positively influence their experiences of pregnancy and childbirth.

Keywords:
Antenatal Education, Relaxation, Women, Partners, Childbirth

INTRODUCTION

Previous research has focused on antenatal relaxation education as a pain management method for childbirth and investigated its impact on processes of care such as assisted birth and caesarean section with the primary outcome measure being epidural use. Cochrane reviews, however, fail to show a clear reduction in epidural use or caesarean section following relaxation classes (Madden *et al.* 2016, Smith *et al.* 2018).

Conversely, research investigating the influence of such interventions on childbirth experiences and maternal psychological wellbeing, consistently demonstrate a positive influence (Bastani *et al*. 2004, Mehl-Madrona 2004, Ip *et al.* 2009, Werner *et al.* 2013, Downe *et al*. 2015, Isbir *et al.* 2016, Levett *et al.* 2016a). Indeed, evidence from randomised control trials (RCTs), consistently suggest that antenatal relaxation training can alleviate fear and anxiety (Mehl-Madrona 2004, Werner *et al.* 2012, Downe *et al.* 2015), whilst enhancing feelings of agency and childbirth self-efficacy (Ip *et al* .2009, Levett *et al.* 2016a). These results are congruent with the findings of the few qualitative studies that have been conducted, where women consistently report feeling calmer, less fearful and anxious about the upcoming birth (Abbasi *et al.* 2009, Finlayson *et al.* 2015, Levett *et al.* 2016b). Indeed, an increased sense of confidence and agency as well as satisfaction with childbirth experience are the most common themes reported.

Despite these positive findings, the length and complexity of the employed interventions in some studies is a barrier in implementing them in routine care due to the cost, time and resources required. On the other hand, the interventions that included multiple brief sessions (three one-hour sessions or two 90-minute sessions), were negatively influenced by high attrition rates. For example, Cyna et al. (2013) reported, *'only a minority of women attended all sessions'*. These limitations may explain why, despite the evidence on positive influence, relaxation classes are not

included in routine antenatal education in NHS maternity services in the UK and many other countries.

A recent service evaluation (Tabib and Crowther 2018) of a **single** three-hour relaxation class offered as an initiative at a Scottish NHS Board, examined the experiences of 503 women attendees. This was the first published paper exploring the influence of a single relaxation session on childbirth experiences. Consistent with previous research, the study demonstrated that participants of this single class felt more confident and less fearful towards and during childbirth. In addition, feedback collected from around 2000 participants via anonymous evaluation forms demonstrated that all of them found the class useful and would recommend it to others (Gray 2019). However, it is still unclear how and why this occurs, or what contextual factors may influence the effectiveness of the class, particularly during labour. The current study aims to answer these questions by exploring the influence of ARC on childbirth experiences from women and birth partners' perspectives, within the context of the UK maternity services.

Antenatal Relaxation Class (ARC)

ARC is a single childbirth preparation class known as the 'antenatal relaxation class'. ARC is offered to pregnant women and their birth partners at a NHS tertiary maternity hospital in Scotland. Midwives trained in relaxation techniques deliver the class to a maximum of 16 participants in each session. ARC does not overlap with routine antenatal classes and is supplementary to them. The class is available to all women, however, attendance of women expressing anxiety or apprehension of childbirth is actively encouraged by their maternity care providers. Most women attend in the third trimester of pregnancy. ARC is a unique initiative underpinned by the theoretical and empirical evidence in the field, as well as the feedback collected from participants and practitioners through the service evaluation processes. The class is guided by self-efficacy (SE) theory presented by Bandura first (1977, 2010). Childbirth self-efficacy is defined

as the belief in one's own capacity to cope with childbirth (Lowe 1993). Four origins for SE are suggested including performance of accomplishments (a), vicarious experiences (b), verbal persuasion (c), and physiological/emotional status (d) (Bandura 1977). ARC aims to enable the participants to develop self-care behaviours through enhancing these four origins by:

- practising techniques of relaxation using different exercises (a)
- educating women about the theory on physiology of childbirth and sharing experiences (b)
- using empowering language, affirmations and analogies (c)
- exploring physiological and emotional reactions to the performed exercises (d).

This three-hour class starts with a comprehensive explanation of the physiological responses of the body to emotions (particularly during childbirth) using a PowerPoint presentation containing several illustrations. This is underpinned by theories of Fear-Tension-Pain (Dick-Read 2013) and physiological/hormonal processes in childbirth (Odent 1992, Buckley 2015). The theory is followed by several relaxation exercises including breathing, visualisation, hypnosis and relaxation in labour exercises (the scripts are available on request). After each exercise the participants are given the opportunity to share their experiences of the exercise and ask any questions they may have. At the end, the participants are provided with leaflets and audios to practise at home. The class and resources are free of charge for participants. The content of the class is outlined in Figure 1.

METHOD

Design

Fundamental qualitative descriptive (FQD) methodology (Sandelowski 2000) was selected to explain the meanings participants attributed to

their experiences. FQD methodology is not highly interpretive and provides the necessary freedom to allow the data to guide the enquiry without being restricted to a theoretical framework (Sandelowski 2000). This suits an enquiry that is more complex than exploring one single phenomenon. The study was a pilot study to inform the feasibility of a larger-scale study in terms of recruitment strategy and data collection tools. The sample size was guided by the information power model (Malterud, Siersma and Guassora 2016) and deemed to be appropriate for a pilot study. The interviews were conducted by the researcher who is a midwife. The researcher had no affiliation with the study participants and was not responsible for delivery of ARC.

Ethics and governance

Informed written consent was obtained from the participants and full ethical approval was granted by National Research Ethics Service (NRES) (Study Reference 17/LO/0666).

Setting, participants and recruitment

The study setting was a tertiary hospital in Scotland with around 6,000 births per annum. Midwives delivering ARC accessed the NHS database system to identify and send invitations to 36 potential participants of whom 20 consented to participate in the study. Employing purposive sampling intended to include a population of women that was diverse in terms of age, ethnicity, educational level and parity in order to gather sufficient experientially rich accounts (Sandelowski 1986). Eligible participants were women attending ARC and their birth partners. The inclusion criteria included being over the age of 16, able to read, write and understand English, and receiving midwifery led care at the point of recruitment. Women were recruited in their third trimester of pregnancy. Participants were excluded if they had severe mental health problems or if they did not meet the inclusion criteria. Although receiving midwifery led care at the time of recruitment was necessary for inclusion, participants

were not excluded if their care pathway changed after recruitment. Although interest for participation was high among women following the class, the majority of those who agreed to take part did not respond to the invitations after birth. This might be due to them transitioning to their new roles as parents. Ultimately out of the 20 recruited to the study, 6 women and 3 birth partners responded to the text reminders following birth and participated. Six interviews were conducted. Three of the women were interviewed individually and 3 participated in joint interviews with their birth partners.

Data collection

Single face to face interviews were conducted between November 2017 and June 2018. Through in-depth, semi structured interviews the participants were first invited to speak freely about their childbirth experiences to obtain a broad range of information about the event. Such information included the events during labour and birth, the woman's feelings, thoughts and coping behaviours as well as the influential environmental and social factors from their perspective. Questions followed regarding their experiences of attending ARC and how such attendance unfolded towards and during childbirth. A summary of the study topic guide is presented in Table 2. A distress protocol (Modified from: Draucker, Martsolf and Poole 2009) was developed for managing the potential difficult emotions experienced by participants during the interviews. The interviews lasted between 40 to 60 minutes, were digitally recorded and transcribed verbatim. Four interviews were conducted in the participants' homes, one in a private room in the hospital and one in a private room at the University.

Analysis and Interpretation

Thematic analysis (Braun and Clarke 2006) was employed for data analysis. Thematic analysis is a method for systematically identifying and organising qualitative data into patterns of meanings or themes and offers clear guidelines and flexibility (Braun and Clarke 2006). The overall approach to data coding and analysis was inductive and data driven,

through which core themes and the relationship between themes were identified. The data were analysed by a team of four researchers and findings were reflexively discussed and debated to reach consensus in the research team. Reflexivity and having an audit trail were employed to enhance trustworthiness of the study (Walsh and Downe 2006).

FINDINGS

The socio-demographic characteristics of the participants are presented in Table 1. Participating women were all married and educated to degree level. Five of the women gave birth at an NHS tertiary hospital and one woman had a home birth. Labour was induced for four women, three due to prolonged pregnancy and one for having a 'large baby' on the ultrasound scan. Of five women who gave birth in the hospital, one had a spontaneous vaginal birth, two required forceps for birth and the remaining two underwent caesarean section. Three birth partners participated in the study of whom two were women's husbands and the other one was the woman's mother. Only one of the birth partners (James) had attended ARC.

Identified themes:

The four sub-themes that emerged from the data gave rise to the overarching theme of '***Positive outlook'*** (Fig 2). The participants' own words were used to label the identified themes. To maintain anonymity, the names have been changed to pseudonyms which participants chose for themselves.

1. *Different way of thinking*

Participants reported that the theory of childbirth physiology taught at the beginning of class was the main influence in changing their mindset towards childbirth. They reported *'being sceptical'* about the class before attending, however, understanding the theory of childbirth physiology '*made total sense'* (Neave). James said, *'I was sceptical until I understood*

the theory behind it, something clicked, it was a switch in the mindset'. Women who were not accompanied by their partners in the class shared their learning of the theory with the partners at home. Frank who had not attended ARC stated*, 'I was sceptical until you (to Lara) explained it (the theory) to me'.* Some thought the theory was novel and challenged the traditional views of society and health professionals about childbirth. Understanding the theory appeared to be the main motive for using the techniques during childbirth, Charlotte said, '*I pictured my womb and was thinking of flushing lactic acid out of it to ease off pain'*. Lara described, '*realising that womb is a muscle and you can work with it'* as '*liberating*'. Neave with a history of phobia of medical procedures, used relaxation techniques in the midst of a major haemorrhage following caesarean section. She stated, '*while the surgeons were patching me up, I knew the calmer I can stay the better I will be, you know the theory side of it'*. It was the theory that motivated practice of the relaxation exercises, Louise commented, '*without that scientific reasons, I wouldn't have done it, I'm more of an evidence-based camp'.*

A deep sense of calmness

The participants referred to an altered state of consciousness and implicitly used different terms of getting into *'the zone'* or '*the mood'* when referring to practice of the techniques, describing their feelings as, '*a heavy feeling, a deep sense of calmness'* (Charlotte), or a sense of '*physical presence and awareness of my body'* (Lara). Some depicted it as the cessation of compulsive mind activity resulting in a sense of relaxation in the body, *'To start off (using the techniques) my mind goes like 20 million places but then I get to the point that I stop having such an active mind, I then feel my whole body relaxes with it'.* (Rosie)
They practised the techniques at home from *'not regularly, every now and then'* (Louise) to *'three times a day'* (Rosie) and customised a variety of methods for relaxation such as conscious breathing, or visualisation, Margaret portrays her relaxation as visualising, *'a beach'* saying, *'with my*

mind I was always going there'. For some, the preferred techniques during pregnancy changed when it came to labour. Lara describes her experience of relaxation in labour as, '*I thought I was going to be like in my happy place on a beach and stuff, like we did it (in class), but actually it was more my physical presence of what was happening in my body'.*

Inspired and motivated

Whilst women reported arriving at the class with preconceived fears of '*labour pain'*, '*medical procedures'*, '*own behaviour during labour'* and '*fear of unknown'*, they left inspired and motivated to exert their learning from ARC during pregnancy and childbirth. Recognising a sense of purpose in the process of childbirth was reported, *'it's (labour) all there for a purpose'* (Charlotte).

It seems, '*knowing what would be happening in the body during labour'* (Margaret) in combination with experiencing a '*deep sense of calmness'* (Charlotte) via the exercises, alleviated fear and anxiety whilst enhancing a sense of control and confidence towards childbirth. Neave commented, *'I think I'd been quite apprehensive and trying not to think about it (childbirth), but after the class I was feeling a lot more settled about it'*. Likewise, Louise said, *'I left feeling quite empowered, quite excited for my birth, I wanted to labour, to birth my child, strange thing to say'*.

Women universally reported ARC had helped them to *'keep calm'* for the remaining part of the pregnancy, influencing their wellbeing in various ways such as improving their sleep quality, bonding with the unborn baby and reducing anxiety. Rosie commented, *'I managed to sleep with it (using the techniques), which was quite good cause I wasn't sleeping the night at all'*. Such influence was not limited to women, James said, *'I was having a trouble sleeping at night and so, just using it for myself'*.

Rosie who was experiencing regular panic attacks in pregnancy stated, '*by doing the relaxation, my everyday panic attacks went down to one per week within the first week'.* The partners noticed such effect too, Frank said, '*when she was anxious that (relaxation exercises) would really help,*

kind of bringing and calming her down'. Although, the discussion on place of birth is not included in ARC, Louise reported her choice for a homebirth was influenced by ARC, *'it was actually the course that made me realise this (childbirth) is not an illness, you go into hospital when you're ill'*. Women described how using relaxation techniques influenced their experiences of labour pain. Louise stated, *'I could feel the pain at the tail end of the contraction but, at the peak of the contraction I felt nothing, no pain',* whilst her birth partner James recalled the experience as, '*she just seemed to go down into herself, aye, really shut out the world, disappear into this little bubble,…she was so relaxed through'*. Lara stated attending ARC gave her the confidence to stay at home during labour, *'I was in the bath for about 3 hours listening to the audio, I kind of knew what to do'*. On admission to hospital, her labour was in the advanced stages. Charlotte who underwent induction of labour and had a forceps birth reported, '*there wasn't honestly part of me that felt the need to ask for anything stronger (than gas and air)*, *I think I could've coped with more, I felt in control like a 100%'*. Margaret, a second time mum, compares her two experiences of labour pain, '(during the first childbirth) *when the pain became really strong, I started to shout, 'I want something for pain' but this time, I never felt like that'*.

Conversely, Rosie who requested an epidural explained, *'I didn't use the relaxation techniques through the actual contractions as much'.* She continues, *'but I used them in the induction process and when I got the cannula put in or taking the catheter out, I was really stressed about those things'.* It seems attending ARC may have reduced her fear of medical procedures and positively contributed to her overall experience of childbirth.

Space for relaxation

The participants identified an uninterrupted environment as essential for the effectiveness of techniques in getting women into a '*deep sense of calmness*'. In pregnancy the practice took place in a specific place where

they were not interrupted, '*I would go up to my bedroom and, you know, create a kind of darker environment'* (Charlotte).

During labour, support from significant others including partners or health professionals appeared to be crucial to protect the environment from disturbances, Amy (birth partner) commented, *'we knew just not to speak to her, let her deal with it and she just totally dealt with it'*. The home environment provided protected space, whereas in hospital, the space was significantly influenced by the practitioners' behaviour and clinical picture. Rosie described her experience of using relaxation techniques in labour ward as *'quite hard',* explaining, '*because there was so much going on, we had so many (people) coming in and out of the room, it was just too overwhelming'.* She continues to highlight the role of the midwife, '*the first midwife was like quite used to doing relaxation, but then shift changed, we had another midwife who wasn't doing that, and I got to a point that it (sense of relaxation) just wasn't happening'.*

Women expressed that midwives' comments and approach to intrapartum care seemed to have a significant impact on women's confidence in exerting their relaxation techniques and decisions on pain relief options, Lara said, *'I was progressing quite well and I just got to that point of the transition, and she (the midwife) was like 'we've still got time to give you Morphine' and I took it and then everything just went slow motion, I was annoyed at myself for like caving in'*.

Overarching theme: Positive outlook

Participants described ARC as contributing to a positive approach towards childbirth. Neave explained, *'understanding better what was going on with my body, I felt more in tune and positive about giving birth and the whole labour process'.* Charlotte said, '*It (ARC) made me approach it (the labour) differently, thinking of it as a positive experience not like 'oh, I'm dreading labour'. I went into it like, this is so exciting, I was excited to meet him. Thinking let's do it with a positive attitude, you know, grab the bull by the horns kind of thing'.*

Neave stated that ARC provided her with tools she could rely on during childbirth, she highlighted, *'I felt positive about whatever it (childbirth) throws at us rather than thinking well this is my birth plan, this is what's going to happen … knowing that I had lots of things to rely on meant that it didn't matter what happened, you had the tools to deal with whatever was gonna go on'.* She suggested, *'it's (offering the classes) kind of looking after people's mental health as well, that's really important'.*

DISCUSSION

The study suggests that attending ARC may lead to positive perceptions of childbirth experiences. Four sub-themes of ***'different way of thinking'***, ***'deep sense of calmness'***, ***'inspired and motivated'*** and ***'space for relaxation'*** gave rise to the overarching theme of ***'a positive outlook'***. The enhanced understanding of how states of fear and anxiety as opposed to calmness could influence the physiological function of the body during labour (the theory of childbirth physiology) appeared to create a '*different way of thinking*' towards childbirth amongst women and partners. This understanding seemed to cause women to actively engage in the practice of relaxation techniques. The techniques were the gates to a '*deep sense of calmness'*, however another prerequisite for entering such a state was a protected *'space for relaxation'* which could be influenced by significant others. This '*new way of thinking'* along with experiencing a '*deep sense of calmness'* appeared to '*inspire and motivate'* participants towards and during childbirth, creating an overall more '*positive outlook'* towards childbirth (Figure 2).

The study was undertaken in response to the recommendations from the Scottish Government (2017, 2019), NICE guidelines (2014a, 2014b) and WHO (2018). The qualitative data collected from in-depth interviews with women and partners have provided valuable insight into how and why antenatal relaxation classes positively influence childbirth experiences.

In previous studies, participants attributed their reduced fear and anxiety to a discussion on the physiology of childbirth (Downe *et al*.2015,

Finlayson *et al.* 2015, Tabib and Crowther 2018) and found such understanding necessary for incorporating the taught techniques in their childbirth experiences (Levett *et al.* 2016b). This aligns with the theme of a *'different way of thinking'* towards childbirth where the participants considered the theory on childbirth physiology delivered in ARC playing a major role in easing their fear and enhancing confidence. The study surpasses the previous research by explaining why this may occur. The traditional view on childbirth held by society is entrenched in the mind and body dualism derived from the medical model of care, where a woman's body is perceived as an entity separated from her mind, and childbirth is considered as pathological requiring treatment (Oakley 1984, Teijlingen 2005). Conversely, a holistic view denies such dichotomy between mind and body (Kirmayer 1988, Lundgren and Wahlberg 1999), recognising the woman as a lived body not separated from her body (Goldberg 2001, Merleau-Ponty1962/2013). The theory on childbirth physiology presented in ARC is filled with the notion of lived body, evidencing how intertwined the emotions and physiological function of the body in childbirth are. Women reported that understanding the self as a lived body that is capable of influencing the physical body at a physiological level led to feelings of confidence and empowerment whilst alleviating fear and anxiety (Reiger and Dempsey 2006). This explains why the theory on childbirth physiology was seen as new, liberating and challenging the traditional societal and health professionals' views. The study suggests inclusion of this theory positively affected women's attitudes toward childbirth. This may have implications for the design of routine antenatal education.

Data from existing literature indicates participants of antenatal relaxation classes tend to creatively customise a range of strategies (Finlayson *et al*. 2015, Levett *et al.* 2016b, Tabib and Crowther 2018), however, the literature is silent on why women do so and what the aim of such customisation is. The current study adds to the existing knowledge by

identifying the taught techniques as the entry gates to an altered state of consciousness, a deep sense of calmness. The participants indicated reaching this state was the destination for using relaxation techniques. Such state seems to remain unexamined in the previous studies. This state was recognised by study participants as a state of subsided mind activity, a sense of bodily relaxation, a state in which feelings of fear, anxiety and labour pain were alleviated. Odent (1992), Dick-Read (2013), and Buckley (2015) collectively suggest hyperactivity of the neocortex, and the subsequent emotional arousal in forms of fear, stress and anxiety can be translated in the physiological dysfunction of the body during childbirth and increase labour pain.

The practice of relaxation exercises in class complimented the understanding of theory and generated experiential evidence of women's ability to enter a state of calmness. The combination of theoretical and experiential understanding *'inspired and motivated'* a more proactive attitude towards childbirth and encouraged further practice at home as well as the use of techniques for a variety of purposes.

Generally, evidence suggests the birth environment can affect both birth physiology (Stark *et al*. 2016) and women's psychological wellbeing (Taghizadeh *et al*. 2015). However, there is a paucity of evidence about the impact of environmental factors on the use and effectiveness of relaxation techniques during childbirth. This study provided insight on this under-researched area. The participants recognised a particular *'space for relaxation'* as essential for applying the techniques and experiencing a state of calmness.

The data suggest when the situation stimulated or demanded intense mind activity, the space for relaxation became obscured. According to the participants, 'lack of privacy and calm ambience in the labour room', 'practitioners being in a utilitarian mood and disregarding the woman's body instinct', and 'adverse clinical pictures', stimulated intensive mind activity and shattered their perceived space required for use or

effectiveness of the relaxation techniques. Participants also suggested the space for relaxation was not necessarily a physical space and a woman could have two different experiences of the same physical space under the care of different midwives. The study highlights the significant role of practitioners as well as the organisational culture in protecting or inadvertently violating such space.

Previous large sized RCTs investigating the effectiveness of brief hypnosis training on epidural use (Cyna *et al*. 2013, Werner *et al*. 2012, Downe *et al*. 2015) failed to demonstrate a reduction in epidural. These studies, however, seem to have disregarded the significant impact of practitioners and birth environment. Indeed, Downe *et al*. 2015 acknowledges the need for more in-depth qualitative work to explore the known effect of labour ward context, organisational ethos and practitioners' preferences on women's decision making about interventions in childbirth.

The current findings indicate that the space and therefore the use and effectiveness of the techniques in the hospital was influenced by the care providers and clinical pictures. The maternity services and practitioners that are geared toward dualism of mind and body, seeing women's childbearing bodies as mechanical entities requiring treatment may offer a type of intrapartum care that conflicts with applying the relaxation techniques incorporated in antenatal education. Educating maternity care providers in the childbirth hormonal physiology recommended by Buckley (2015), along with providing training on relaxation techniques (to facilitate the physiology) would enable the practitioners to create a space conducive to practice of relaxation techniques.

Women in the study whose labour started at home managed to apply the techniques effectively which encouraged a longer stay at home during labour. This could have implications for both women and maternity services. Indeed, a recent cost-effectiveness analysis of latent versus active labour hospital admission for low-risk, term women revealed delaying admission until active labour resulted in a considerable reduction

in epidural use, caesarean section rate, and maternal deaths (Tilden *et al*., 2015).

Increased satisfaction with childbirth experience as well as positive attitudes and feelings towards labour have been reported in previous studies (Cyna 2011, Levett *et al.* 2016a). The overarching theme of positive outlook seems to be complementary to the existing literature. In contrast to previous research, however, women attending ARC demonstrated a positive outlook and childbirth experience irrespective of the mode of birth or experiencing challenges. Finlayson *et al*. (2015) reported that using self-hypnosis raised women's expectations and led to disappointment when labour and birth failed to meet such expectations. It is likely that the information provided in ARC has influenced this. During ARC, the importance of having a positive childbirth experience (regardless of the clinical outcomes) on maternal psychological wellbeing and mother-infant bonding is highlighted. It seems such awareness could prompt women to play a more proactive role in seeking positivity even in the midst of seemingly adverse clinical situations.

STRENGTHS AND LIMITATIONS

The findings of this study complement and build on the existing small body of research exploring women's experiences of using relaxation techniques towards and during childbirth. The study is the first in the field providing new insights on the childbirth experiences of women who undergo childbirth complications. This study offers rich accounts from a group of women with a range of childbirth experiences, such variety of accounts further enhances our understanding of how antenatal relaxation education may be translated in the realities of contemporary maternity services and practices. It is the first in the UK to directly interview birth partners and explore their views on the topic. The study has identified the significant role of health professionals, particularly midwives in holding the space for relaxation during the intrapartum period.

Although a purposive sampling method facilitated recruitment of a range of women in terms of parity and ethnicity, the sample variation was ultimately limited to those who volunteered to participate. In addition, in terms of birth outcomes, the sample was not representative of the pregnant population in the UK. All women were educated to degree level and aged in their thirties. A more diverse sample in terms of age and educational background could have portrayed views of a more diverse population. The women who participated in the study may also be those with more positive childbirth experiences. The study findings were generated from data collected from a small number of participants and may not represent the views of all women attending ARC and their birth partners. These limitations are planned to be addressed in a larger mixed method study that will recruit more women from a wider range of ethnicity, parity, age groups and educational backgrounds.

CONCLUSION

National and international maternity reviews and guidelines outline the paramount importance of positive childbirth experiences for women and their families (Scottish Government 2017, NHS England 2016, WHO 2018). Antenatal education is a window of opportunity to prepare women and their families for a positive experience of childbirth. This study suggests ARC as an innovative educational intervention is promising in promoting positive childbirth experiences. Women and partners in the study valued the education on physiological processes of childbirth and the strategies that could facilitate them. The study also highlights the significant role of practitioners on the effectiveness of the intervention during labour and birth.

To draw more robust conclusions, further in-depth qualitative research is being conducted to provide a more comprehensive understanding of the phenomenon. In addition, investigating the generalisability of qualitative findings through follow up quantitative studies may provide better

credibility with policy makers and funding bodies (Johnson and Onwuegbuzie 2004).

Conflict of interest:
None

Funding:
MT is supported by the Iolanthe Midwifery Trust.

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Table

Table 1

Sociodemographic characteristics of women participants, background information and mode of birth. The names are all pseudonyms.

Participants	Parity	Nationality/ Ethnicity	Education	Employment	Marital status	Age	Mode of Birth	Short history
Lara & Frank (husband)	1st	White British	Univ	Engineer	Married	32	Forceps in theatre	History of anxiety referred by her community midwife
Rosie	1st	White British	Univ	School teacher	Married	33	IOL/ C-sections	History of recurrent miscarriage, IVF, sever anxiety, needle phobia, daily panic attacks during pregnancy, referred by her community midwife
Louise & James (husband)	2nd	White British	Univ	Housewife	Married	33	Refused IOL/ Home birth	Referred by a friend in 1st pregnancy and repeated the class in 2nd pregnancy-no history of anxiety
Charlotte & Amy (mother)	1st	White British	Univ	Marketing	Married	34	IOL/ Forceps in room	Recommended by a friend, no history of anxiety
Margaret	2nd	White Polish	Univ	Charity manager	Married	32	IOL/ SVD in labour ward	Recommended by friends, no history of anxiety
Neave	1st	White British	Univ	School teacher	Married	34	IOL/ C-Sections	Needle phobia, blood phobia & phobia of medical procedures, referred by her community midwife.

Univ, University- IOL, Induction Of Labour- SVD, Spontaneous Vaginal Delivery

Table 2.

Topic guide

Interview question guide for women and birth partners
1. Can you tell me about your labour and birth? 2. Can you tell me about your experience of the antenatal relaxation class? The following supplementary, follow up questions if necessary: o What caused you to attend the class? What were your expectations? o How did you feel during and after the class? o How did you practice the techniques during pregnancy? o What was the purpose of practice for you? o Did you use any of the techniques during labour? o What influenced the use of relaxation techniques in labour? What helped or hindered the use of the techniques? o What was your experience of labour pain? o How would you describe your overall experience of late pregnancy and childbirth?

Class outline
Part 1 (1 hour) **-**Overview and objectives of the class -Introduction to Fear-Tension-Pain theory and physiological/hormonal processes in childbirth (based on theories of Odent 1992, Dick-Read 2013, Buckley 2015,) **Part 2 (1.5 hours)** -Practising 4 relaxation exercises including 'breathing', visualisation', 'hypnosis', and 'relaxation in labour'. **Part 3 (0.5 hour)** - Tips on the strategies that could contribute to a sense of relaxation and control during childbirth including mobilisation, positions, use of music, low lighting, water immersion, gentle massage, and partner's support. - The learning points are summarised and the importance of regular practice at home is highlighted. -Handouts and audios are provided for further practice at home.

Figure 1. Outline of the Antenatal Relaxation Class (ARC)

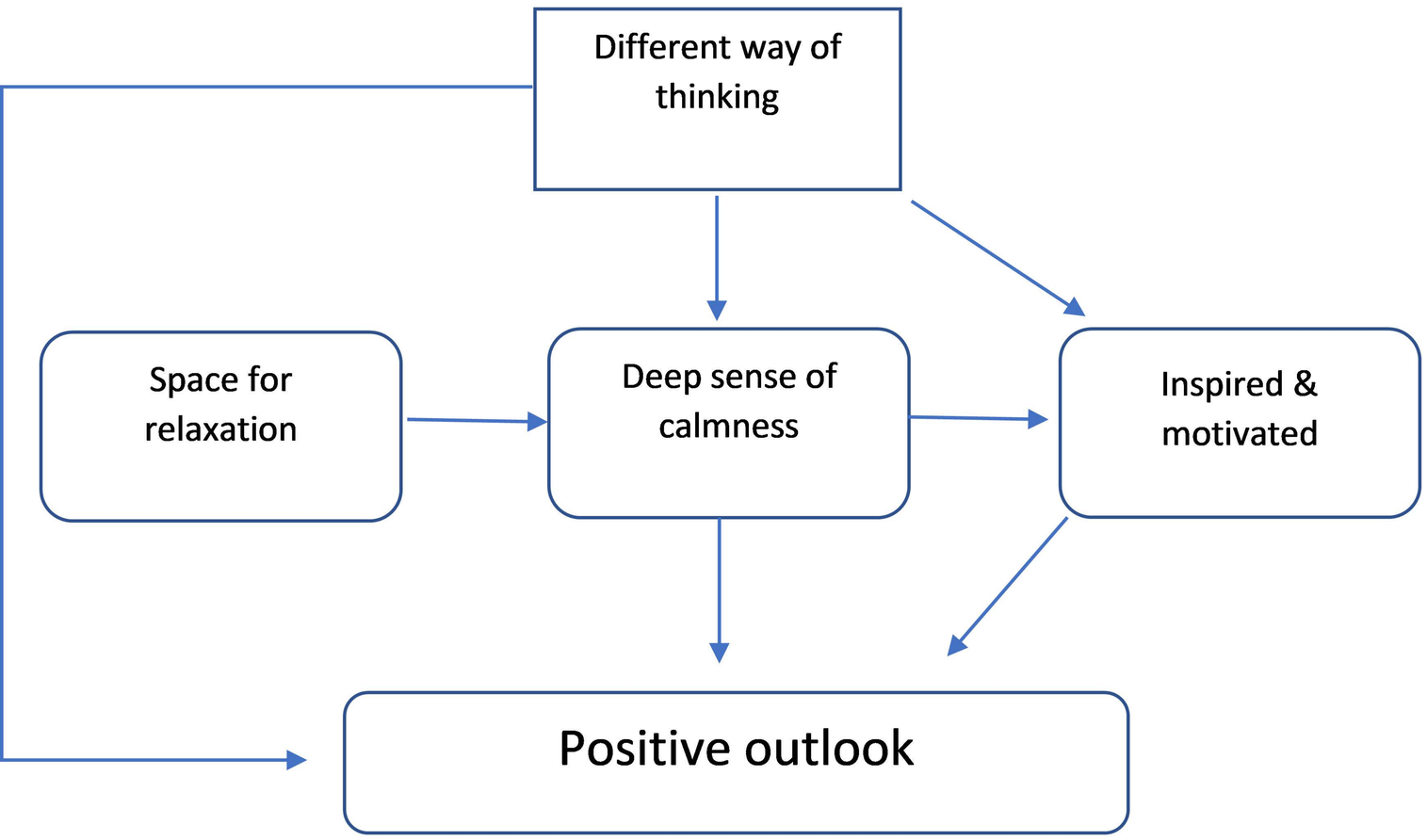

Figure 2. The identified themes and their relationship