

Postpartum Adaptation and Competence
of Mothers Who Use Hypnosis to Birth

by

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A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Approved November 2015 by the
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ARIZONA STATE UNIVERSITY

December 2015

ABSTRACT

This qualitative study investigated the postpartum experiences of mothers who used hypnosis to birth. This research project was based on a constructivist version of Grounded Theory. Qualitative inquiry and analysis were conducted on 15 semi-structured interviews; two pilot interviews were also conducted. Phone and in-person interviews were completed with Caucasian, Hispanic, and multiracial mothers who were between one month and 15 months postpartum. The following 12 major themes emerged: bonded with child, development of self-efficacy, breastfeeding success, family criticism, online support, impact on family, practice effect, amazement to misevaluation, induction overwhelm, holistic benefits, minimal post partum depression, and birth stories. Mothers of two or more children appreciated birth more, reported an increased sense of calm and closeness within their nuclear and extended family, believed that the benefits of hypnosis for birthing assisted in the areas of bonding with their newborn, self-efficacy, breastfeeding and overall postpartum success. First-time mothers appreciated the physical aspect of recovery after delivery. They emphasized the birth narrative despite cultural differences in sharing their stories. Although they attributed much success to the use of hypnosis for birthing, they tended to make more indirect attributions to the bond with their child, self-efficacy, breastfeeding, and overall postpartum success. Mothers who required a c-section, epidural, or induction during birth experienced feelings of guilt and viewed hypnosis as an isolated tool for birth and a tool to reduce guilt and stress postpartum. Mothers who birthed naturally used hypnosis postpartum in more ways. Hispanic mothers expressed greater difficulty with balancing their roles as a career woman and mother. They had different expectations around the participation of their

partner during birth preparation and postpartum. Breastfeeding was most important to this group and reflected communal values. Hypnosis for birthing was described as being helpful for mothers who had a psychological history with depression, anxiety, or trauma. Participants reported overall effectiveness of hypnosis for birthing methods despite mixed reactions from birthing professionals, family, and friends. The importance of these findings for counseling psychology is discussed.

DEDICATION

For my grandmothers and their bravery, strength,
and the vision they had
for their own children and future generations to come.

For the two most important, missed, and influential men in my life:

Radames Felipe Lafaurie

Dandrick Magic Moton

Thank you for your continued guidance, support and love.

ACKNOWLEDGEMENTS

I am filled with eternal gratitude for my beloved and countless family, friends, and community that have always supported and prayed for me.

Specifically:

Damone Scott, Virginia Lafaurie, Leilani Lafaurie, Cesar Garcia,
Radames Lafaurie II, Graziella Caredda, Carol Delfosse Kidd, and Nicole Bartolomucci

Thank you for constantly reminding me that my success

reflects the success of countless others.

Thank you to my committee members for their continued guidance and patience:

Sharon Robinson Kurpius

Richard Kinnier

Miguel Arciniega

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Chapter 1

The Problem in Perspective

Clinical hypnosis has been attacked by the church and endorsed by a Pope. It has been acknowledged by the American Medical Association, the American Psychological Association, and the National Institutes of Health. It has been used as the sole anesthetic in thousands of medical procedures and operations, has helped to solve crimes and is used in psychotherapy to treat anxiety, depression and many other conditions. Still, there are detractors and the exact definition of hypnosis remains elusive (Willmarth, n.d).

Willmarth is past President of the Society for Psychological Hypnosis, a division of the American Psychological Association (APA). His statement encapsulates the history of hypnosis as a technique within psychology and medicine and the range of opinions regarding it among health professionals.

A study by Rodolfa, Kraft, Reilley, and Blackmore (1982) exemplifies counselors' position on hypnosis. They examined hypnosis training in APA and non-APA accredited programs. Only 25% offered a course in hypnosis and a small percentage of programs encouraged students to seek hypnosis training elsewhere. Current standards across psychology training programs are unclear. The Rodolfa et al. study suggested that trained mental health professionals may be no different than the lay community in regards to their perceptions about hypnosis. This presents a challenge because research (Landolt & Milling, 2011; Stewart, 2005) suggests that hypnosis is a helpful technique that is being overlooked by mental health professionals. Furthermore, some of the therapeutic interventions that counselors and psychologists use may involve aspects of hypnosis.

It has been suggested that many hidden hypnotic patterns exist but go unrecognized in the counseling therapy process. One example is guided meditation, a common therapeutic technique that closely resembles the induction phase in hypnosis. As

a result, counselor awareness of hypnotic patterns and the use of hypnosis seem imperative (Gunnison, 1990). It seems ethically sound for mental health professionals to be versed in treatments and techniques that could be most helpful to their clients. If negative perceptions about hypnosis prohibit counselors and therapists from considering hypnosis as a viable treatment alternative, they may be doing a disservice to their clients.

Although hypnosis has more footing within medical research, it is still not widely used and accepted by practitioners. The field of obstetrics, however, has incorporated hypnosis to assist women with the birthing process. For example, women who use some form of hypnosis during uncomplicated, normal, childbirths report feeling relaxed, calm, and in control of the process (Simpson, 2001). Hypnosis helped the women feel they were in control of pain, handled the situation well, and were confident. This gave them a sense of pride and self satisfaction. Mothers who felt like they could manage pain also felt that they performed well during childbirth. The sense of control optimized mothers' feelings of confidence, control, and satisfaction (Simpson, 2001).

Overall, hypnosis is a valuable health care technique. It is successfully used in several disciplines, dispelling the historic speculation surrounding it. This is especially true for its use in reducing the effects of traumatic experiences for psychological patients and for pain management during medical procedures. The success for both of these applications is seen when hypnosis is used during childbirth. Before outlining the existing research on birthing and hypnosis, working definitions of hypnosis and related terms are needed.

Definitions of Hypnosis and Key Terms

A single definition of hypnosis has eluded the psychological community. Most definitions are a hybrid of a description of hypnotic techniques and their results. The current study used Chip's (2004) definition: hypnosis is an altered state of consciousness that lies between awake and sleep. It is usually brought on by the individual by the use of a combination of concentration, relaxation, suggestion, and expectation. This study's definition also included that the goal of hypnosis is to enact change when it is utilized in the context of psychological treatment. (Intro to Hypnosis, n.d). The ways in which other researchers define hypnosis are also important to enumerate.

Kazdin's (2000) definition states, "Hypnosis is a therapeutic technique in which clinicians make suggestions to individuals who have undergone a procedure designed to relax them and focus their minds" (p. 211). The Society for Psychological Hypnosis, Division 30, of APA, published what could be described as a procedural definition of hypnosis on their website. "When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behavior" (Division 30, n.d.). Division 30 also gives a procedural description of hypnosis. Details of hypnotic procedures and suggestions differ depending on the goals of the practitioner and the purposes of the clinical or research endeavor. Procedures traditionally involve suggestions to relax (though relaxation is not necessary for hypnosis), and a wide variety of suggestions can be used (Division 30, n.d.).

Definitions provided by Division 30 goes on to report, "Hypnosis involves learning how to use your mind and thoughts in order to manage emotional distress (e.g.,

anxiety, stress), unpleasant physical symptoms (e.g., pain, nausea), or to help you change certain habits or behaviors (e.g., smoking, overeating)” (p. 2). Although different procedural aspects are emphasized depending on the audience, the general definition is consistent and tailored to a specific target audience. Simultaneously, given that the Society for Psychological Hypnosis offers multiple definitions for hypnosis, this may explain the variety of definitions found within the counseling and psychology field.

Within the field of hypnosis, there are three key procedural terms, trance, induction, and suggestions that require definitions in order to further understand hypnosis. Trance is the actual state of the mind during hypnosis. Trance is also regarded as a common and daily activity of the mind that occurs regularly. Trance occurs when one reads a book, daydreams, or is engrossed in a movie (Stewart, 2005).

Induction is the state of heightened receptivity for suggestions (Stewart, 2005) or positive words delivered to the client by the hypnotherapist. Inductions are phrases that lead the client into hypnosis (Chips, 2004). Every hypnotic procedure consists of a hypnotic induction and suggestions (Hilgard, 1965). The induction establishes a hypnotic context and typically includes instructions for relaxation and wellbeing, accompanied by statements that the person is becoming hypnotized.

A suggestion invites the person to experience some imaginary situation as if it were real (e.g., “your hand is numb and insensitive, as if you were wearing a thick glove, and you can't feel much of anything through that glove.”) (Landolt & Milling, 2011; Stewart, 2005). Typically, the patient or client is invited to experience the suggestion during the course of a hypnotic session. However, when the person is invited to

experience a suggestion at some point after the hypnotic session has ended, it is referred to as a posthypnotic suggestion (Landolt & Milling, 2011).

The current study used the following definition: hypnosis is considered to be an altered state of consciousness that lies between awake and sleep. It is usually brought on by a combination of concentration, relaxation, suggestion, and expectation (Chips, 2004) with the goal of enacting change (Intro to Hypnosis, n.d). Although simplified, this working definition is clear and easy to understand. The only phrase missing from Chip's (2004) definition is that the goal of hypnosis is to enact change when it is utilized in the context of psychological treatment. That portion of the definition can be found in the Division 30 educational materials (Intro to Hypnosis, n.d). In addition, this practical definition is one that can be used with both lay persons and by practitioners. Given that the current study touched upon beliefs and attitudes about hypnosis, this definition was appropriate since this research addressed the overarching phenomenon of hypnosis instead of discussing it at a procedural level.

As previously indicated, the definition of hypnosis has changed over time. In order to understand how and why views of hypnosis have evolved one should understand the history of hypnosis. A complete review of the history of hypnosis is available in Appendix C. The following literature review focuses on the use of hypnosis in the medical field.

Use of Hypnosis in the Medical Field

Despite dynamic applications such as using hypnosis in the 1700s for pain control in the absence of pharmaceuticals and in the 1800s in India where hundred of surgeries were performed with hypnosis as the only anesthesia (Gezundhajt, 2007; Stewart, 2005),

the medical profession's acceptance of it as a legitimate technique is slow to happen. Researchers, practitioners, and advocates of hypnosis are quickening that acceptance, however, with studies across disciplines that demonstrate the way hypnosis positively impacts clients.

Hypnosis became a popular treatment for medical conditions in the late 1700's when effective pharmaceutical and surgical treatment options were limited (Stewart, 2005). Some of the oldest and best established uses of hypnosis are in analgesia or hypnoanaesthesia, which is hypnosis-induced anesthesia. Esdaile performed hundreds of complex surgeries during the mid-1800s in India with hypnosis as the sole anesthetic. Esdaile's highly documented work was eventually discounted, despite an abundance of evidence for his effectiveness (Esdaile, 1957). In addition, quicker forms of inhalation anesthesia became popular and squelched any interest in hypnosis for medical procedures (Esdaile, 1957). Overall, acceptance of hypnosis in medicine has evolved slowly. In 1847 the Roman Catholic Church indicated acceptance of hypnosis. In 1956 Pope Pius XII cautiously endorsed hypnosis for childbirth (Stewart, 2005). The most significant approval by the American Medical Association came in 1958 following a two-year study by the Council of Mental Health. Hypnosis is now recommended and empirically studied in medical and dental practices (Stewart, 2005).

Stewart (2005) reviewed all published medical literature around the topic of hypnosis and medicine. His endeavor revealed the successful use of hypnosis in a vast array of medical subfields, the most notable in the fields of allergy, anesthesia for pain, anesthesia for surgery, and obstetrics. The use of hypnosis with skin prick testing sensitivity after tuberculosis vaccinations demonstrated that participants were able to

increase and decrease their allergic reactions to the skin prick. Overall, hypnosis resulted in a significant reduction in both pain and flare reactions at the skin prick test site (Zachariae, Bjerring, & Arendt-Nielsen, 1989).

Hypnosis for pain relief has been well established. Patterson and Jensen (2003) distinguished between the placebo effect and the experience of physical anesthesia that commonly occurs during hypnosis. This was accomplished by giving patients a medication named naloxone to block the production of the endorphins known to be present when a placebo effect is responsible for a patient's reaction. This finding suggested that there is more to hypnosis than mere belief in a positive outcome.

Faymonville, Meurisse, and Fissette (1999) highlighted the safety and comfort of patients under hypnosis. They stated that hypnosis prevents pharmacological unconsciousness, allows patient participation, and may allow for faster recovery and a shorter hospital stay, but it does require some changes in the atmosphere of the operating room because of the conscious state of the patient. LaBaw (1992) conducted a study with hemophilia patients. Those who received hypnosis had a significant decrease in the need for transfusions. In numerous studies, children or younger individuals have been shown to have positive results with hypnosis (Wakeman & Kaplan, 1978). In their studies with burn patient victims, Wakeman and Kaplan (1978) taught patients self-hypnosis that led to significant results in helping patients better manage their pain.

Last, and most relevant to the current study, is the support from several clinical trials demonstrating the effectiveness of hypnosis as an anesthesia for childbirth. The literature reveals that women who use hypnosis for birthing report less discomfort and shortened labor (Stewart, 2005). Hypnosis also results in a decrease of complications,

fewer surgical interventions, and a shorter hospital stay. Additional findings include decreased need for anesthesia, postpartum analgesia or reduction of pain, and infant admissions to the intensive care unit, despite a lack of statistical significance, (Stewart, 2005).

Literature, in the field of birthing education, reveals the conventional beliefs about hypnosis and birthing during the 1950s. A physician, described his method of conditioning women for childbirth utilizing the method of Dr. Grantly Dick Reed. In 1956, Clark presented a series of cases using hypnosis as a training method for childbirth (Read at the 65th Annual Convention of the National Medical Association. Pittsburgh, Pennsylvania, August 10, 1960). The word "relaxation" was used instead of hypnosis because the public associated the word hypnosis with seduction, crime, and mysticism.

There appears to be specific advantages of using hypnosis with pregnant patients:

1. It completely eliminates maternal and fetal death from chemical anesthesia and respiratory depression from narcotics and barbiturates.
2. Patients are free from exhaustion.
3. It eliminates fear and apprehension before and after labor.
4. The mother can experience the sensations of childbirth without pain.
5. The average amount of analgesia given to patients can be reduced.
6. The patient cooperates more fully during the second stage.
7. Blood loss appeared to be reduced although this was not specifically measured.
8. Weight gain is controlled easier.
9. Troublesome nausea and vomiting can be completely eliminated in these patients without drugs. (Bradford, 1961)

As indicated, the use of hypnosis in facilitating childbirth has been well established for decades, both in normal childbirth and in caesarian sections (Spiegel, 1983). Landolt and Milling (2011) reviewed studies of women in their child-bearing years; however, only three of the 14 studies identified the race of participants (Harmon, Hynan, & Tyre, 1990; VandeVusse, Irland, Berner, Fuller, & Adams, 2007; Venn, 1987).

These three studies focused primarily on White females. Because cultural influences play a role in the perception of pain, women from other ethnic groups may respond differently to labor and delivery than do White women (Leeman, Fontaine, King, Klein, & Ratcliffe, 2003; Woodrow, Friedman, Siegelau, & Collen, 1972). As such, the samples used in these three studies were not representative of the population of all child-bearing women. Moreover, the lack of specification of race/ethnicity in the other 10 studies makes it impossible to determine how well the results of those investigations generalize to the population of all childbearing females.

In addition to reducing reports of pain, as well as the use of analgesic medications and epidural anesthesia, hypnosis has been found to have other benefits for expectant mothers and their infants. The administration of hypnosis is associated with better infant Apgar scores (Harmon et al., 1990; VandeVusse et al., 2007), as well as shorter Stage 1 labor (Davidson, 1962; Harmon et al., 1990; Jenkins & Pritchard, 1993). This latter finding is noteworthy, because it is during Stage 1 labor that women experience the most painful uterine contractions and often request pain medication (Harms, 2004).

Landolt and Milling's (2011) analysis revealed a clear pattern when considering the nature of the hypnotic interventions used in the surveyed studies. Hetero-hypnosis (Rock, Shipley, & Campbell, 1969), self-hypnosis (Davidson, 1962; Harmon et al., 1990; Jenkins & Pritchard, 1993; Letts, Baker, Ruderman, & Kennedy, 1993; Mairs, 1995; VandeVusse et al., 2007), and a combination of hetero-hypnosis with self-hypnosis (Guthrie, Taylor, & Defriend, 1984) were consistently found to be more effective than comparison conditions in alleviating pain. There were no studies contradicting this pattern. However, only two of the five studies evaluating hypnotic preparation were able

to show that it was significantly more effective than a comparison condition, such as Lamaze or other birth education methods, in reducing some indicator of pain (Cyna, Andrew, & McAuliffe, 2006; Mehl-Madrona, 2004). This pattern suggests that hypnosis may be more effective if it is experienced during the actual labor process, either in the form of self-hypnosis or hetero-hypnosis. When hypnosis is delivered by someone else, such as a birth partner or trained medical staff, this is referred to as hetero-hypnosis. (Landolt & Milling, 2011).

Therefore, evidence for the effectiveness of hypnosis is substantiated in the literature; however, the reason for the success of the hypnotic trance has yet to be understood. Some of the reasons for this relate to challenges with researching hypnosis. The nature of hypnosis makes clinical trials difficult. Cooperation and rapport between client and therapist are needed to achieve a receptive trance state (Stewart, 2005). Hypnosis can occur through other means, such as audiotape, and trance is not always necessary for a client to be hypnotized. The most efficacious techniques for hypnosis are not known (Stewart, 2005). Additionally controlled trials emphasizing random assignment to condition, specification of study samples, and the use of treatment manuals are needed to establish hetero-hypnosis and self-hypnosis as empirically supported therapies for managing labor pain (Landolt & Milling, 2011).

In brief, hypnosis is an accepted tool that can assist birthing mothers. Hypnosis has been shown to increase comfort, shorten labor, decrease complications of birth, and lead to fewer interventions, a shorter hospital stay and faster recovery. The effects of hypnosis also extend to the postpartum period and to the newborn baby. The reasons why hypnosis works for birthing and the most efficacious methods for researching and

delivering hypnosis to research participants are still unknown. Since hypnosis now has an established place in birth, a discussion about the way women birth in America is needed.

The Medicalization of Birth and a Cultural Feminist Model

Childbirth was once a social process where midwives and other women attended to the mother and child (Dye, 1986). The combination of medical advancements in Europe and the fear of mother and child mortality caused childbirth to come out of the social setting and into a clinical space. According to Dye (1986) and Gaskins (2003), the medicalization of childbirth was solidified as physicians sought out ways to legitimize their presence at and fees for childbirth events.

Today, the majority of women give birth in hospitals; however, not too long ago both home births and natural births were the most prevalent. The transition away from home births, which was synonymous with natural birth, has a clearly delineated and relatively recent history. Dye (1986) described three distinct periods in the history of American childbirth. They first occurred in the early seventeenth century through the mid-eighteenth century where social birthing or birthing among a community of women with midwives was standard. This period was followed by a transitional stage from the 1750's to the early nineteenth century. During this time American doctors became aware of obstetrical procedures and practices that were occurring in Britain and France. Physicians in the U.S. attempted to carve out a role for the place of male-assisted physicians that ushered in the techno-medical model (Gaskins, 2003). Lastly, from 1870 to 1940 the medical community cemented its authority over the birth process, fundamentally changing the ways in which women gave birth in the United States.

During the first era of American birthing, midwives were the only practitioners present during labor. Dye (1986) wrote, “This gathering together of women served several social functions: the presence of friends and relatives at birth ensured women that they would have support during labor and the first weeks of mothering” (p.25). Births, although viewed as natural, were regarded as a dangerous event due to the high number of infant and child deaths; therefore, midwives and attendants believed they managed birth but did not assume they exercised control over the experience. This point of view stands in contrast to future philosophies about birth, particularly the philosophies held by male physicians (Dye, 1986).

In the second era of American childbirth, there was an evolution in obstetrical knowledge. This knowledge primarily came from earlier procedures in European nations. The first anatomical dissections of the pregnant uterus and the baby’s position in the womb were realized in England. French physicians discovered a way to chart the mechanical processes of labor and pioneered the science of pelvic measurements, which assisted in predicting normal versus difficult births (Wertz & Wertz, 1977). However, the most important piece of technology was the utilization of the obstetrical forceps. Previous to the invention of forceps, deadly and mutilating operations were practiced on mother and newborns (Dye, 1986). This new knowledge shifted the philosophy of birth to one where both doctors and mothers began to believe that they were mastering aspects of the natural world.

Additionally, physicians utilized medical books and journals to disseminate clinical findings and medical discoveries that were often learned from midwives. Although midwives had the knowledge that many physicians published in medical

writings, they had no effective way of communicating their findings and experiences, since a significant percentage of American women were illiterate in the 1800s (Thomas, 1933). The written word was an early tool that later helped legitimize obstetrical knowledge, by highlighting the lack of organized communications among midwives, ultimately resulting in their decline (Dye, 1986).

Many physicians practicing during the 19th century believed birth to be a natural and healthy process; however, they wanted to justify their presence at births. They claimed that modern urban life was unnatural, making women unfit to birth without assistance. The presence of men was not standard practice yet, and many considered it indecent. Feminist social conservatives preferred the midwifery model or the training of female physicians (Dye, 1986). Differences based on class and race/ethnicity were the tool by which physicians created a chasm in obstetrics. Medical literature referenced the ease with which Native Americans and African Americans birthed, claiming that they were “less “civilized” and, therefore, closer to nature than the middle class urban women who made up their practices” (Dye, 1986, p. 31). Recognition of these historical differences led to the cultural feminist model (Enns, 1997).

By the mid-nineteenth century doctors regularly attended births along with midwives and supportive women. Women and midwives still dictated the practices during birthing, granting physicians little control and limited authority (Dye, 1986). Physicians engaged in delicate negotiations in order to participate in aspects of birthing. Physicians tried to convey danger and the perils of birth to husbands and partners so that companions would permit a man to examine his female partner (Dye, 1986).

Ultimately, the practice of birthing became fully medicalized from 1870 to 1940 (Dye, 1986). Several developments hastened medicalization, the first being the professionalization of medicine in the early 20th century. Obstetrics introduced more rigor to standards of training and practice and aligned with the surgical specialty of gynecology yielding prestige (Dye, 1986). Midwifery was eliminated as a safe and practical way to birth. Then, antiseptic techniques moved birth from the home to the hospital. Last, this time period coincided with the maternal and child welfare movement that highlighted the high death rates of American mothers and babies, ultimately encouraging women to think of birth as a medical process that required specialized care (Dye, 1986).

At the end of the era of the revolution of obstetrical knowledge, physicians were aware of their limitations, and in the 20th century few practitioners were interested in the new field. Previous training was based entirely on didactic lectures and lacked clinical teachings. American physicians went to Austria and Germany to observe in teaching hospitals. The patients were women who were destitute and, in exchange for free medical care, agreed to serve as clinical material (Dye, 1986).

During post Civil War in the U.S., a clandestine practice of providing medical care for poor urban women in exchange for clinical instruction already existed in the form of lying-in hospitals. Lying-in hospitals were founded in the early 19th century and were charitable hospitals for homeless women and for “fallen” women who were pregnant with illegitimate children (Dye, 1986). In lying-in hospitals, doctors achieved autonomy and power. They did not have to please or accommodate their patients nor the cultural standards of the time. This imbalance of power allowed doctors to become the

experts, which led to a restructuring of the relationship between doctors and their patients (Dye, 1986), a restructuring that played into a patriarchal system.

Despite this change in the relationship between patients and doctors, only 5% of women birthed in hospitals in 1900. At the time, hospitals were associated with depravity and were dangerous due to the high incidence of puerperal sepsis (Dye, 1986), otherwise known as childbirth fever (De Costa, 2002). Physicians played on the fears of middle class women and erroneously claimed that their practices were safer. Doctors operated with greater confidence in their ability to control infection and with greater confidence in their surgical tools. From the 1890s through the 1920s, the incidence of cesarean section, internal version, forceps deliveries, and labor induction, or forced birth rose dramatically along with the creation of and experimentation with new operations that were designed to widen the birth passage (Dye, 1986).

Mortality rates were greater with physicians than midwives; however, it was generally believed that death rates were high due to a lack of access to skilled medical care (Dye, 1986). Sepsis was the actual killer of women and children before the medicalization of birth. Hand washing on the part of midwives saved women during home births. Physicians scoffed at such a simple solution and believed that, “doctors... are gentlemen, and gentlemen’s hands are clean” (De Costa, 2002, p. 669).

Simultaneously, physicians sought to eliminate the role of midwives in an effort to solidify the status of obstetrics. Midwives initially posed no economic threat to doctors, until lying-in hospitals (serving low income women and ethno-racial minorities) became the training facilities for obstetrics (Dye, 1986). Second, if poor, uneducated women, such as midwives, could deliver babies, then the field of obstetrics could not

claim prestige or that delivering babies required skill, knowledge, and scientific practices (Dye, 1986). By the 1920s, midwives found it difficult to practice due to regulatory and licensing requirements and the expansion of free hospital care for immigrant, poor, or African American woman.

Prenatal care was introduced by social reformers who focused on medical and educational information. They stressed the necessity of medical attendance at birth, preferably in a hospital. These programs were increasingly prevalent in lying-in hospitals, thus serving both outreach and referral functions for physicians (Dye, 1986). Because doctors did not play a large enough role in the watchful waiting practice of the midwifery model, they sought to pathologize the birthing process so that they could legitimize their role, administer pain medication, and utilize obstetric instruments (Dye, 1986).

By 1960, nearly 100% of births occurred in hospitals. During World War II more than 75% of urban births took place in hospitals, and in the 1920s only about 50% of births in large cities occurred in hospitals (Dye, 1986). In less than 60 years, physicians convinced the public that male physician-assisted hospital births were natural and necessary in preventing the dangers of birth. This shift in the American culture stripped mid-twentieth century women of the social capital and knowledge of the process of birthing (Dye, 1986), their power in the birthing setting and interventions of their choice, and their confidence as natural birth mothers.

The history of birthing covers important periods throughout the feminist movement that included reproductive health of women's bodies and aspects of cultural feminism (Enns, 1997). These aspects are difficult to separate, but as Eakins (1996) described, as knowledge becomes power for a physician, the pregnant woman

experiences a concomitant loss of power. This was particularly true for Caucasian, however, women of color, the economically disadvantaged, or women birthing outside of wedlock began to draw attention to the different experiences of women of color. Therefore, the explanation of the medicalization of birth from those of midwifery practices enumerates the cultural feminist model that along with the resilience model are the two major conceptual models for the current study.

The midwifery model. The study of childbirth began to appear in the social sciences in the 1970s. Feminist scholarship placed women at the center of their own experience, challenging basic assumptions and conceptual frameworks of social science (Dye, 1986). According to Gaskins (2003), sociologist Barbara Katz Rothman pointed out the difference between the humanistic or midwifery model and the techno-medical model. She described the midwifery model of care as female-centered and the woman as the central agent. The midwifery model of care recognized the oneness of mind and body and the power of women in the creation of new life. The model also viewed conception of pregnancy and birth as a healthy process and the idea that mother and baby were an inseparable unit resurfaced. According to this model, the emotions of the woman had a real impact upon the well-being of the baby.

When the woman's emotional needs are filled, there is less risk for the baby. The baby is presumed to feel what the mother feels (Gaskins, 2003, pg. 184). When the midwifery model of care is applied, between 85 and 95 percent of healthy women safely give birth without surgery or instruments (Gaskins, 2003). Within the midwifery model, medical intervention is inappropriate unless truly necessary. Labor has its own rhythms, so it is not expected to conclude within any rigid and arbitrary time limit to this

physiological process. The midwifery model of maternity care recognizes that medical intervention is sometimes necessary and that it should be applied in special cases. At the same time, it maintains that medical intervention may be harmful when used purely for convenience or profit (Gaskins, 2003, pg. 184).

The techno-medical model. This model of maternity care, unlike the midwifery model, is comparatively new, having existed for barely two centuries. Gaskins (2003), claims that the male-derived framework for care is a product of the industrial revolution. Anthropologist Robbie Davis-Floyd's describes the technocratic mode of care as assuming that the human female body is a machine that is full of shortcomings and defects (Gaskins, 2003). According to Gaskins (2003) pregnancy and labor are seen as illnesses that in order not to be harmful to mother or baby must be treated with drugs and medical equipment. Within this model, some medical intervention is considered necessary for every birth, and birth is safe only in retrospect. According to the techno-medical model, once labor starts, birth must take place within 24 hours (Gaskins, 2003). Mind and body are considered to be separate from birth. Gaskin's (2003) explains:

Because of this, emotional ambience is of importance only when it comes to marketing the service. Instead of being the central actor of the birth drama, the woman becomes a passive, almost inert object, representing a barrier to the baby's eventual passage to the outside world (pg. 186).

The Influence of Hypnosis on Birth

The childbirth paradigm in the United States views childbirth as a painful, unpleasant, and traumatic experience rather as than a natural process (Dye, 1986; Gaskins, 2003; Tuschhoff, 2011). To counter that, hypnosis is used to help women see childbirth as a natural process and to give them confidence in that process. This removes

stress, fear, and worry. The results are reports of pleasant birthing experiences and ease through the postpartum period (Gaskins, 2003; Tuschhoff, 2011).

Hypnosis has a presence in birthing procedures among those who view birth as a natural process as opposed to a medical one. Midwives and proponents of natural unmedicated birth respect hypnosis as a technique to help women birth. Reviewing psychoanalytic and behavioral studies of surgical patients, Janis (1958) postulated that the anticipatory thought processes preceding a stressful event plays a major role in determining how an individual will cope during the conditions of imposed threat as well as during the period after the event has taken place. The ‘work of worry’ described by Janis has a parallel in the childbirth expectations of pregnant women (Beaton & Gupton, 1990). Furthermore childbirth educators and mental health professionals are often tasked with helping women prepare for the realities of the childbirth experience and that should include exploration of expectations and of the women’s birth fantasies (Beaton & Gupton, 1990). The power of expectations is poignantly described in the *Hypnobabies Home Study Course Workbook* (Tuschhoff, 2011). Tuschhoff (2011) explains,

During World War II many soldiers came back from China with stories of having watched women there delivering their babies. They were amazed to see a pregnant woman, climb up on the dike and deliver a baby with no apparent discomfort. After a short rest she would give her newborn to a grandmotherly caretaker and get back to work. When asked why they had no pain, these women said they were never told that delivering a baby was painful. If a woman delivers a baby expecting that it will be a relaxed, loving, gentle and beautiful experience, that is exactly what she experiences! With hypnosis, woman can reprogram fears into beliefs that her delivery will be comfortable and enjoyable.” (p. 14-15).

Nursing research operating from a resilience paradigm suggests that healthy adaptation, rather than pathology, may characterize an individual's response to a stressful event (Schachman, 2001).

Beaton and Gupton (1990) posed a two-part question, how can a sense of accomplishment rather than feelings of failure about birth be cultivated and how can those feelings of mastery of the birth experience be used to promote confidence in mothering abilities? Is it possible that using natural birthing methods, specifically hypnosis, aids in helping women feel great confidence and control of their bodies and over the birthing process? In addition, how does this affect their confidence as mothers once their child is born? If hypnosis techniques during birth lead to greater confidence among mothers, are there benefits beyond labor and delivery and do mothers who use hypnosis experience less postpartum depression? In addition, childbirth education researchers stress that expectation is key for mothers during childbirth (Beaton & Upton, 1990; Janis, 1958; Tuschhoff, 2011) and introduce resilience (Schachman, 2001) as a major factor in the development of mothers' response to birth.

Maternal Adaptation

Further supporting research on birth expectations, women who are happy and satisfied with their pregnancy and childbirth experiences are less likely to suffer from postpartum depression or postpartum PTSD (Simpkin, 1972). Using hypnosis during pregnancy to assure the mother of a pleasant childbirth experience increases her confidence in herself, her body, and the birth process. Confidence is enhanced when women are informed about the childbirth process, when they have clear expectations, are encouraged to ask questions, and have supportive individuals in the delivery room.

Entwisle and Doering (1981) found that a woman's satisfaction with the birth experience significantly affected her level of self-esteem as well as the character of her relationships with her children. Three important factors determine the quality of the birth experience for the mother. These are control, awareness, and support. Control involves regulation of oneself as the mother withstands the birthing process and manages the birthing situation as well. Awareness encompasses being informed of what is happening and accepting what is happening to her. Gibbins and Thompson (2001) described acceptance as the woman feeling that this is about me, instead of happening to me; my body confidently knows what to do leading to a sense of control. Mercer (1995) extended the need for this sense of control to the prenatal phase as well, because pregnancy represents some loss of control over one's body through physical changes, symptoms of pregnancy, obstetrical examinations, and childbirth. Lastly, support refers to supportive individuals such as a spouse, doula, or midwife. Support of a "coach" has been found to be inversely related to pain (Niven, 1985; Norr et al., 1977) and linked to satisfaction (Quine et al., 1993). Following the birth of the baby, maternal role adaptation is marked by satisfaction and gratification in the maternal role, when there is a sense of competence and comfort in the performance of maternal role skills, and when marital, extended family, and community bonds are fostered (Koniak-Griffin, 1993; Mercer, 1985; Schachman, 2001).

Gibaud-Wallston (1977) suggested that there are four categories of postpartum tasks that new parents must accomplish. These include: meeting the physical needs of the baby; learning to observe and interpret correctly the cues of the baby; changing the family system to accommodate the new member; and adjusting and maintaining

boundaries. These categories overlap with the variables necessary for a sense of competency during birth. The proposed theories of Entwisle and Doering (1981) and Gibuad-Wallston (1977) enumerate the positive markers of maternal adaptation.

Schachman (2001) outlined the effects of maladaptive maternal role adaptation through the stages of pregnancy, labor, and postpartum period. During pregnancy, maternal role maladaptation is characterized by inadequate prenatal care, excessive ambivalence, and continuation of risky behaviors that threaten the developing fetus (Lederman, 1996; Mercer, 1995). In the postpartum period, maternal role maladaptation is characterized by a lack of competence and skill in carrying out mothering behaviors, as well as self-reported attitudes and feelings of depression, stress, and lack of gratification in the maternal role (Koniak-Griffin, 1993; Reece & Harkless, 1998).

Adaptation during pregnancy. According to Lederman (1996), pregnancy is a period of transition between two paradigms: from the “woman-without child” to the “woman-and-child” (p.19). This conceptual paradigm shift takes place in incremental steps, which Lederman (1996) likened to a “psychological unfolding that keeps place with and compliments the physical unfolding of the fetus inside” (p. 23). During pregnancy, maternal identity formation develops gradually and systematically through cognitive restructuring (Rubin, 1984). This important psychological work facilitates a more realistic image of self as a mother, a sense of relatedness to baby, and family preparation for incorporation of the expected baby (Burr & Klein, 1994).

Even when the pregnancy is welcomed and anticipated, the expectant mother may be assailed by doubts, weighing pros and cons, and rethinking her motives and the ultimate consequences of a changed reality (Schachman, 2001). Lederman’s (1996)

research revealed that as pregnancy unfolds, fear of loss of self-esteem and loss of control during labor were precipitated by women's doubts about their bodily endurance and emotional stability. Fears of injury or death and lack of trust in medical and nursing staff were common prenatal concerns.

Postpartum adaptation. Rubin (1967) referred to the first month after birth as the "neomaternal period" (p. 391), noting that the physical and psychological changes required of the mother are comparable to the adjustments of the infant. The demands of the 24-hour cycle of physical care of the infant exacerbate this period of adjustment for new mothers (Ziegel, 1972). Pain both during childbirth and afterwards affects not only the new mother's ability to care for her infant but also her perceptions of the infant (Schachman, 2001). Priel, Gonik, and Rabinowitz (1993) found that views of labor as difficult or painful were associated with negative perceptions of the baby. Appraisals of labor and delivery events are part of the mental restructuring that takes place following childbirth (Affonso, 1992). Shereshefsky and Yarrow's (1974) study of maternal adaptation revealed that mothers indicated that they had not anticipated their fatigue, disorganization, the physical complications following delivery, and their feeling of inadequacy in the face of the infant's demands and the demands of their husbands.

Integration of the new baby into the family system is another potential source of stress for the new mother (Schachman, 2001). Often, these changes in role relationships and expectations are accompanied by personal and marital conflict. A decrease in marital satisfaction during the first year of parenthood has been demonstrated in a number of studies (Schachman, 2001). For example, wives experienced more marital discord than husbands, with the greatest impact at three months (Belsky, Lang, & Rovine, 1985).

Discrepancy between the mother's expectations of forthcoming spousal help (Logsdon, 2000) and lack of time for romantic and emotional expression (Belsky et al., 1985) were cited as primary contributors to the decline in marital satisfaction among new mothers. When one occupies just one key role, there is less potential for positive feelings to offset negative ones. It appears that becoming a parent may reduce the number of roles from which a woman may derive gratification and a sense of competence, the opposite is true for men (Gibaud-Wallston, 1977).

The expression of love and the securing of love are needs that may undergo a shift in focus from the marital relationship to the new baby (Leighton, 1959). However, the infant cannot fulfill all the parents' needs to be loved in return, and the parents' extreme expectation that the baby will fulfill these unmet needs has been found to be associated with physical abuse of the child (Spinetta & Rigler, 1972). Leighton (1959) indicated that the need to express hostility produces frustration and stress. Employing most of the socially acceptable means of dealing with the frustrating behavior of others is inappropriate with a new baby. Awareness of any anger or hostility toward the infant can cause parents to doubt themselves as "good" people and competent parents. Thus, the need to express hostility may be thwarted or vented on other people such as the spouse (Gibaud-Wallston, 1977). The first few weeks of mothering are particularly vulnerable for the new mother, because she is still assimilating maternal behaviors and has not yet found the fit or mutuality with her infant (Mercer, 1995).

Hence, birth satisfaction has been shown to correlate with self-esteem in mothers during the postpartum period (Entwisle & Doering, 1981). Control, awareness, and support are theorized as the keys to a positive birth experience (Entwisle & Doering

1981). These concepts extend to the postpartum phase; however, adaptation of the child into the new family structure and parental adaptation of family roles are also introduced during the postpartum phase (Gibaud-Wallston, 1977).

A Resilience Model

Resilience provides the second conceptual framework for the current study. Resilience is defined in many ways and the definition is largely based on whether or not resilience is viewed as a trait, state, or process (Woodgate, 1999). People both select and shape environments (Rutter, 1985); therefore, certain factors considered to be personality traits are associated with external variables that interact with the environment (Woodgate, 1999). These external factors compose the process view of resilience, which is based on the idea of protective and vulnerability factors. Therefore, Haase's (1997) definition of resilience regards resilience as a process of identifying or developing resources and strengths to flexibly manage stressors to gain a positive outcome, a sense of confidence, mastery, and self-esteem.

Viewing resilience as a process is suited to the present study of women who use hypnosis to birth, because it acknowledges that resilience is something that can be learned (Woodgate, 1999) allowing participants to explain their own process. Additionally, a process view offers a more comprehensive understanding that allows for other variables that influence resilience, such as external factors, to be understood and for common outcomes of resilience to be accounted for (Woodgate, 1999). As a result, the theoretical underpinnings of the current study emerge from a resilience paradigm.

Protective and vulnerability factors contribute to resilience by modifying one's response to a stressor (Schachman, 2001). Vulnerability factors intensify reaction to a

factor that ordinarily leads to a maladaptive outcome (Rutter, 1987). For example, a mother who suffers from low self-esteem may be vulnerable if her attending nurses are abrupt and condescending. By predisposing an individual to a negative outcome, vulnerability factors decrease resilience, making it more difficult for an individual to manage a stressor successfully. In contrast, protective factors refer to influences that ameliorate a person's response to a stressor, increasing resilience and enhancing the likelihood of an adaptive outcome (Rutter, 1987; Schachman, 2001). A particular variable may act as a protective factor in one situation but a vulnerability factor in another (Rutter, 1987). Returning to the previous example of self-esteem, if a mother has high self-esteem she may be able to cope better with difficult medical practitioners. This high self-esteem may convert into a strength that allows her to view her birth experience as a positive one. Conversely, high self-esteem may also create high expectations, and mothers who do not live up to self-expectations may overly criticize themselves.

Resilience research stipulates that protective factors can be classified as internal resources and external resources (Rutter, 1987; Schachman, 2001). External resources consist of social support networks and relationships that encourage and reinforce adaptive efforts (Gore & Ekenrode, 1996; Schachman, 2001). Internal resources encompass individual attributes; some involve a strong biological component such as gender and physical health, while others are closely linked to experiences in the social environment, such as self-esteem and mastery beliefs (Gore & Ekenrode, 1996). External resources and internal resources are often interrelated, as individual attributes can influence relationships and interactions with others and the environment (Rutter, 1987).

External resources and internal resources of resilience. Social support is defined as “information leading the subject to believe that [she] is cared for and loved, esteemed, and a member of a network of mutual obligations” (Cobb, 1976, p. 300). Support systems typically available to women include their partner/spouse, extended family, friends, and community (Majewski, 1987; Splonskowski & Twiss, 1995). Benefits derived from external resources can be tangible and include material goods, financial aid, physical assistance, information, or intangibles such as enhancement of self-esteem, decreased role overload, and a sense of belongingness (Logsdon, 2000). In difficult situations, social support may be efficacious in protecting against depression, pain, illness, and even death (Gibaud-Wallston, 1977).

The quantity and quality of support provided to a new mother appears to be critical to maternal role adaptation. Mothers who reported a greater number of people in their social support networks, both prenatally and postpartum, were more sensitive in their interactions with their infants at three months postpartum (Goldstein, Diener, & Mangelsdorf, 1996). The individual providing the support is crucial, and according to Lieberman (1986) is termed “support specificity” (p. 461). Following the birth of the baby, social support has been found to increase the mother’s self-confidence and assurance in her role as a mother (Logsdon, 2000). Encouragement, support for the mother’s decision-making, and tangible forms of support yield decreased in the stress associated with maternal role transition and increased satisfaction in the maternal role (Dakof & Taylor, 1990).

Kenner and Lott (1990) found that a lack of support led to feelings of powerlessness, confusion, frustration, and conflict. Inadequate social support was found

to be an etiologic factor in the development of postpartum depression (Ritter, Hobfall, Lavin, Cameron, & Hulsizer, 2000) and predictive of lower levels of maternal self-efficacy (Reece & Harkless, 1998). Expectant and new mothers with low social support have been shown to be high consumers of health care. In addition, women with low support were three times more likely to rate their prenatal and postpartum health status as “poor” or “very poor” (Webster et al., 2000). Therefore, frequent healthcare contact may represent a somatization of emotional problems or may fill a social need not met elsewhere (Logsdon, 2000).

Goldstein et al. (1996) found that women who received more varied types of support from their spouses during the prenatal period were more sensitive to their infants after birth. Additionally, women who were satisfied with the support they received from their spouses prenatally reported more positive moods postpartum. However, the type of support given by spouses is important. Lederman and Lederman (1987) found emotional support from the husband to be the best predictor of satisfaction with the maternal role and confidence in infant care at six weeks postpartum. According to Tarkka, Paunonen, and Laippala (1999), coping of first time mothers was most influenced by emotional support from the spouse/partner.

Crnic, Greenberg, Robinson, and Ragozin (1984) also found intimate support to be the strongest predictor of maternal satisfaction with life and parenting among mothers at the one month and eight month marks. As dealing with the daily demands of infant care was the primary stressor identified by new mothers (Logsdon, Birkimer, & Barbee, 1997), assistance from the spouse has been shown to be an important tangible benefit influencing maternal role adaptation. In addition, husband’s participation in family life

positively affected mothers' sensitivity to infant cues (Broom, 1994), maternal self-efficacy (Teti & Gefland, 1991), and maternal role satisfaction and competence (Mercer, 1981). Hassert and Robinson Kurpius (2011) found that partner conflict, not support was the strongest predictor of postpartum depression among Latina mothers. In their national sample of 144 new mothers Hassert and Robinson Kurpius, and Tracey (2015) also found that postpartum depression was positively related to partner conflict. In contrast, maternal efficacy was negatively related to postpartum depression.

Extended family members also play a vital role in the transition to motherhood. Family members serve as role models and transmit the appropriate behaviors, sentiments, and goals necessary to achieve maternal role adaptation (Meleis & Trangenstein, 1994). Role modeling provides inspiration and skill on how to succeed in maternal role tasks (Bandura, 1986), as well as providing an important source of knowledge on childbearing and childrearing (Tarkka et al. 1999). Copying a successful role model provides a degree of certainty at a time of great uncertainty (Meleis, 1975). Their mothers are the primary role models for first time new mothers at one year after birth (Mercer, 1985), and this relationship is a major factor influencing maternal role adaptation. However, similar to spouses, it is emotional closeness that has been found to be more strongly associated with perceptions of support rather than actual help given or received between mothers and daughters (Martell, 1990). Resnick and his colleagues found that separation from the extended family and enduring social networks often coincides with first parenthood (Resnick, Packer, Wilson, & Resnick, 1975). Support from other family members may serve as a substitute. For example, adequate prenatal care and positive pregnancy

outcomes have been associated with the presence and availability of sisters and mothers in pregnant Hispanic women (Rossa & Yeti, 1999).

Friends have a less salient but still valuable role for new mothers. Friends who have experienced labor, delivery, and motherhood are often sought out as role models (Schachman, 2001). Support from friends and peer groups tend to be limited to material/informational support (Logsdon et al., 1997), in contrast with the emotional support provided by spouses and mothers. It is to be expected that friends or peer groups could provide better informational support, because they are likely to be up to date on prenatal, birth, postpartum, and current child rearing techniques. Lastly, those in the community, specifically health care providers, are sought out for informational support. Affirmation, in the form of expert advice on infant growth and development, was the most strongly related form of social support provided by the public health nurses, followed closely by affect (Tarkka et al., 1999). There is a need for personalized guidance that may not be met through standard reading materials (Gibaud-Wallston, 1977). Additionally, the breadth of information available to mothers may be overwhelming, and both medical and psychologically-based practitioners can assist with distilling the most appropriate information for new mothers.

Utilization of social support is influenced by the expectant/new mother's perception of the availability of resources, the composition and characteristics of the social support network, and her previous experience with social support (Schachman, 2001). Research on internal resources have revealed that they are not a fixed attribute but rather are a constellation of personal factors developed and molded through interaction with the social environment (Garmezy, 1993). One difference between child and adult

development is paramount. Although institutions that interpret, guide, and encourage children appropriately in each stage of their development exist, no such institutions exist for adults (Kuypers & Bengston, 1974). As one grows older, he or she experiences a loss of normative guidance in many domains. It becomes less clear exactly what is expected and whether one is performing successfully or unsuccessfully particularly for new parents (Rossi, 1968). When uncertainty regarding one's performance cannot be reduced by social comparison or objective physical criteria, the "magnitude of stress should become sizeable" (Simpkins, 1972, p.12).

Internal resources are the attributes possessed by an individual that contribute to resilience and subsequent adaptation by exerting their influences as either a protective or vulnerability factor (Schachman, 2001). Self-esteem, self-efficacy, knowledge, and experience are all internal resources closely linked to experiences in the social environment. Although biologically-based internal resources remain fairly constant, environmentally-derived internal resources vary over time and with circumstances (Rutter, 1987). Environmentally derived internal resources are malleable either directly, through interventions to enhance these factors, or indirectly through the manipulation of the social environment (Schachman, 2001). Internal resources that have been shown to influence resilience and subsequent adaptation in the expectant/new mother include self-efficacy, self-esteem, knowledge, and experience (Splonskowski & Twiss, 1995).

Self-efficacy and self-esteem. Self-efficacy, confidence, and a sense of mastery are related concepts and reflect the new mother's perception of her competence in fulfilling the maternal role (Schachman, 2001). Perceived self-efficacy is concerned with judgments of how well one expects to cope with upcoming situations. According to

Bandura (1986), perceptions of self-efficacy affect how much effort people will expend and how long they will persist despite obstacles or aversive experiences. Individuals with greater self perceptions of efficacy are able to channel their attention toward mastering the situation at hand, while individuals with lowered self-efficacy channel their energy toward worrying about negative outcomes (Bandura, 1986). Low self-efficacy is a liability that has been associated with sub-optimal performance of maternal skills and a lack of persistence in problem-solving efforts. Reece and Harkless (1998) assessed behavioral competence and self-efficacy in 86 mothers during their first postpartum year. Self-efficacy was found to be the variable most related to parenting competence, with low self-efficacy mothers providing less responsive and nurturing care to their infant.

Self-efficacy judgments also affect cognitive and affective reactions to stressors (Schachman, 2001). Individuals with high self-efficacy beliefs are persistent, avoid self-denigrating attributions, and experience less anxiety and depression. In contrast, those with low efficacy tend to give up easily, make internal attributions for failure, and experience high levels of anxiety or depression (Bandura, 1986). Postpartum depression has been found to be higher in women with low self-efficacy beliefs (Hassert et al., 2015). In a comparison of depressed and nondepressed mothers in the first postpartum year, Teti and Gelfand (1991) also found that depressed women in the sample had lower self-efficacy than did the nondepressed women. At four months, self-efficacy has been positively associated with confidence in parenting and maternal role satisfaction (Reece & Harlkess, 1998). Additionally, self-efficacy beliefs often originate in interactions with others, primarily the spouse and infant (Schachman, 2001). Support for the maternal role

and a good relationship with one's spouse were positively correlated with self-efficacy at four months postpartum (Reece & Harkless, 1998).

Self-efficacy and self-esteem are interrelated concepts that often overlap. Self-esteem is a global attitude of liking and accepting oneself (Schachman, 2001). Maternal self-esteem is the value a woman places on her appraisals of herself as a mother (McGrath & Meyer, 1992). The changing body image and appearance (Flagler, 1990), performance during labor and delivery, and changes in previous abilities during the postpartum period (Lederman, 1996; Gibaud-Wallston, 1976), real or imagined inadequacies in knowledge and skill levels (Gibaud-Wallston, 1976), unrealistic standards (Gibaud-Wallston, 1976), infant temperament (Cutrona & Troutman, 1986; Pridham, Chang, & Chiu, 1994), and inadequate emotional support or negative feedback (Gibaud-Wallston, 1976) can all contribute to a new or expectant mothers' feelings of self worth. Reece and Harkless (1998) found self-efficacy to be a greater indicator of parenting competence than self-esteem. These two closely related concepts are often simultaneously measured. Given their high level of similarity, including the findings of Reece and Harkless (1998), self-efficacy seems to be a better concept with which to evaluate maternal competence in the current study.

Characteristics of the baby. Characteristics of the baby and temperament can significantly affect maternal adaptation. The difficult baby is one who tends to be irregular rather than rhythmic in needs and behavior, low in adaptability, slow to warm up, intense, predominantly negative in mood, and extremely active and distractible (Carey, 1972). According to Korner (1974), "the mother's capability in soothing her infant is one of the cardinal challenges she faces in the infant's earliest weeks of life, and

her success or failure cannot help but leave an impact on her feelings of effectiveness and competence as a mother” (p. 108). Mothers who believe that their mishandling and inability to comfort their infants is the source of their baby’s problems may become demoralized to the point of serious depression and ineffectuality (Brazelton, 1961), or they may become over-anxious, rejecting, frustrated, or annoyed with a baby difficult to pacify (Prechtl, 1963).

Interactions with the infant also influence maternal self-efficacy beliefs (Schachman, 2001). Cutrona and Troutman (1986) found that self-efficacy was mediated by infant temperament, which in turn exerted indirect effects on postpartum depression. Women who rated their infants as difficult received little positive reinforcement from their infants, which resulted in the self-blaming causal attributions and low self-confidence that are characteristic of low self-efficacy. Social support appeared to exert its protective function against postpartum depression primarily through the mediation of self-efficacy (Schachman, 2001).

Knowledge and experience. Knowledge and experience is the third key internal resource. Near the end of the pregnancy, the woman’s focus often shifts to the imminent reality of childbirth. Fears and anxieties about pain, her performance in labor, and about possible injury to herself or to her infant precipitate educational readiness for childbirth (Lederman, 1996). Prenatal classes are a primary source of information dissemination about childbirth (Schachman, 2001). Women have the opportunity to share feelings, fears, and experiences with other women (Lederman, 1996). Being informed about labor and delivery has been found to increase self-confidence regarding labor and delivery performance (Mackey, 1990), decrease anxiety (Lumley & Brown, 1993), and decrease

pain in labor (Lederman, 1996). Childbirth preparation has been associated with positive childbirth experiences, and birth experiences have been shown to affect emotional responses toward the infant (Priel et al., 1993).

In addition, the success or failure of the woman's previous experiences has been shown to impact maternal role adaptation by enhancing or diminishing her self-efficacy beliefs. Previous experiences with childbirth and childrearing are protective factors that have been shown to facilitate maternal role adaptation (Schachman, 2001). Women who had previous experience with infants and children reported an easier adaptation to motherhood at three months postpartum (Curry, 1983).

Therefore, successful adaptation hinges upon whether the mother viewed her pregnancy and childbirth experiences as satisfying (Entwisle & Doering, 1981). Three factors, the women's sense of control, her awareness of the process and what was happening to her body, and the amount and quality of support she had from supportive people around her determine whether a woman will ultimately evaluate her childbirth experience as satisfactory (Gibbins & Thompson, 2001; Mercer, 1995). When that is the case, transition into motherhood and the integration of the new child into the family are smoother and easier than when a mother's evaluation of her childbirth experience is negative (Gibaud-Wallston, 1978; Schachman, 2001).

Maladaptive behaviors or traits innately present in the mother and whether or not she has experienced childbirth before come into play (Rutter, 1986). When present, these maladaptive reactions can detract from the experience even in the most optimum of situations. However, those issues are diminished when countered by increasing a women's sense of control by keeping her aware of what is happening and surrounding her

with supporting and loving attendants during childbirth (Mercer, 2005). Resilience and the combination of internal and external characteristics, in conjunction with feeling satisfied about the birth experience, tend to lead to fewer postpartum difficulties.

Integration of Maternal Adaptation Concepts

Responses to stressors vary along a continuum from adaptation to maladaptation (Woodgate, 1999), and individuals with copious protective factors are more resilient (Schachman, 2001). In contrast, those with fewer protective factors are less resilient, predisposing them to maladaptive outcomes (Rutter, 1987). Although observer ratings of maternal competence are valued for their objectivity, they are limited to observations of “externalizing” features of maladaptation such as abuse, neglect, withdrawal, or adaptation that includes sensitive and nurturing interactions (Gaffney, 1992).

Assessments of maternal role adaptation based solely on observable behavior overlook the fact that although expectant/new mothers may be functioning in a competent, adaptive manner, they may experience thought-oriented “internalizing” symptoms more consistent with maladaptation, such as postpartum depression, excessive ambivalence, and anxiety (Schachman, 2001). Studies on resilience have indicated that overt social competence among high-risk individuals is not necessarily paralleled by superior adaptation on covert mental health indices (Luthar & Ziglar, 1991). Zigler and Glick (1986) found that, in women, pathology tended to be expressed more often in internalizing symptoms than in externalizing ones. These thought-oriented internalizing features make up the affective component of adaptation and are assessed not by observer ratings but instead through self-report. Self-rated assessments of maternal behaviors assess attitudes or confidence, with the assumption that positive maternal attitudes and

high confidence in maternal skills are indicative of maternal competence. Affective maternal role adaptation in the postpartum period is characterized by satisfaction and gratification in the maternal role and by harmony in other life roles as wife, career woman, student, sister, etc. (Koniak-Griffin, 1993; Mercer, 1985).

The sense of mastery and confidence that results from successfully managing a stressor can affect future responses to stressors. When confronted with a new stressor, increased confidence and sense of mastery may serve as protective factors, thereby facilitating adaptive responses (Garmezy, 1993, Rutter, 1987). This provides what Werner (1993) has termed “the steeling effect” (p. 512), where successful adaptation in one situation strengthens the individual’s competence to deal with adversity in the future. Strength comes not in avoiding the adversity but in successfully engaging with it.

Because resilience is a dynamic process that changes over time and with circumstances, it is amenable to manipulation through intervention (Schachman, 2001). In Kelly’s (1955) terms, the person’s way of construing the experience or event has more impact than the nature of the experience or event itself. Individuals who adapt successfully and without difficulty at one point in their life may react adversely to other stressors when their situation is different (Rutter, 1987).

Extreme maternal role maladaptation in the postpartum period has been associated with insensitive and non-nurturing infant care, child abuse, and child neglect (Gaffney, 1992). Developmental researchers who are interested in attachment and bonding between mother and child pay special attention to infants of depressed mothers. Postpartum depression thwarts a baby’s effort to establish predictable contact, leading to more negative emotional periods for the infant and increased levels of self-directed coping

(Field, Hernandez-Reif, & Diego, 2006). Physiological studies have documented differences in the brain activity of infants of depressed and non-depressed mothers (Dawson et al., 1999; Field, Fox, Pickens, & Nawrocki, 1995). In addition, infants of depressed mothers show elevated heart rates and cortisol levels, both symptomatic of stress (Field, 1989). Last, Field and colleagues (1988, 2006) hold the view that a mother's depression predisposes her child to more depressed affect.

Taking a broader perspective, Walker et al. (2009) reviewed popular methods that mothers' use to prepare for childbirth. Their premise is that currently there is an abundance of childbirth information that is easily and widely accessible. It is the role of psychologists and other health practitioners who work with new mothers to help their clients navigate their options. Poet and feminist Adrienne Rich (1976) wrote,

“We need to imagine a world in which every woman is the presiding genius of her own body. In such a world women will truly create new life, bringing forth not only children ... but the visions, and the thinking necessary to sustain, console and alter human existence – a new relationship to the universe” (p. 292).

As a result, a new mother's level of resilience during the postpartum period depends on how many protective factors she had during childbirth that gives her a sense of mastery over stressors (Rutter, 1987; Schachman, 2001; Woodgate, 1999). The confidence derived from that sense translates into feelings of gratification and satisfaction in the maternal role. The key to mastery is the number of protective factors present during the childbirth experience. Protective factors that promote awareness in conjunction with hypnosis may foster confidence during birth. The process will likely bolster successful adaptation, and may prevent, diminish, or correct the negative experience associated with maladaptation (Rutter, 1987; Schachman, 2001; Woodgate, 1999;). When a woman has

the confidence created by the application of these protective factors, she is more likely to have a greater sense of confidence that is internalized and, therefore, more likely to have a successful transition into the mother role postpartum.

Research Question

Overall, the literature indicates that hypnosis is a valuable psychological and medical technique that is being successfully used in those disciplines. This is especially true of its use in reducing the effects of traumatic experiences for psychological patients and for pain management during medical procedures (Landolt & Milling, 2011; Stewart, 2005). The success of this application is also observed when hypnosis is used during childbirth. Although there is sufficient support for the utilization of hypnosis in childbirth (Landolt & Milling, 2011), current research restricts the demonstration of its efficacy to the actual birth and time in the hospital (Landolt & Milling, 2011; Stewart, 2005). Once a mother and child leave the hospital, little is known about the effects of hypnosis for birthing on the postpartum period.

Studies focusing on prenatal birth education models indicate that control, support, and awareness are cornerstones of most models (Entwisle & Doering, 1981; Gibbins & Thompson, 2001). These three factors also contribute to successful postpartum maternal adaptation (Gibaud-Wallston, 1977). Because hypnosis during childbirth enables greater control and awareness, this method of birthing has the potential to facilitate satisfaction with both birth and maternal adaptation (Werner, 1993). Again, studies linking prenatal birth models with labor and delivery and a mother's postpartum transition are missing.

Existing literature on postpartum maternal adaptation suggests that resilience is a key component in promoting maternal adaptation (Rutter, 1987 & Schachman, 2001). In

addition, nursing research operating from a resilience paradigm suggests that healthy adaption, rather than pathology, may characterize an individual's response to a potentially stressful event (Schachman, 2001), such as birth. Internal resources such as self-efficacy, self-esteem, knowledge, and experience serve as protective factors that support resilience and maternal adaptation. Social support is the primary external resource important for maternal competency (Rutter, 1987; Schachman, 2001).

Childbirth education researchers stress that expectation is key for mothers during childbirth (Beaton & Upton, 1990; Janis, 1958; Tuschhoff, 2011) and introduce resilience (Schachman, 2001) as a major factor in the development of mothers' response to birth. Support is clearly stated as a major part of both resilience and birth education models. It is possible that self-efficacy, self-esteem, and knowledge could help shape one's awareness. In addition, one's level of self-efficacy impacts one's belief about ability to cope to a specific event (Bandura, 1977). This may mirror aspects of control necessary during the prenatal preparation phase.

In summary, the current literature reveals that hypnosis is effective for pain management, decreases labor length and decreases a mother's length of hospital stay. (Stewart, 2005; Landolt & Milling, 2011). Control, support and awareness lead to greater satisfaction with the birth which leads to greater self-esteem (Entwisle & Doering, 1981). The cultural-feminist model supports a woman's inner knowing, acknowledges the mind body connection, supports less intervention while birthing, leads to a satisfactory birth for mother and child, and leads to a smoother postpartum. (Gaskins, 2003; Simpkin, 1972; Entwisle & Doering, 1981; Gibbons & Thompson, 2001). In addition, maternal adaptation and the development of self efficacy are based on having a strong support

system, being able to read a baby's cues, meeting the physical demands of a baby and adaptations to the family system. Moreover, quantitative measures may not adequately assess the internal symptoms of postpartum depression and anxiety. It is unknown how the use of hypnosis for birth influences maternal adaptation. Furthermore the way natural non-medicated birthing methods and hypnosis for birthing is received in a techno-medical birthing setting is unknown.

In addition, qualitative inquiries on the intersection of hypnosis and birthing pose a two-part question; how can a sense of accomplishment rather than feelings of failure over birth be cultivated and how can those feelings of mastery of the birth experience be used to promote confidence in mothering abilities (Beaton & Gupton, 1990)? Is it possible that using natural non-medicated birthing methods, specifically hypnosis, aids in helping women feel confident and in control of their bodies during the birthing process? In addition, how does this affect their confidence as mothers of a newborn? Once postpartum, a new mother may find that meeting the needs of a new infant is a complex and changing task requiring maternal sensitivity, specialized skills, knowledge, creativity (Gibaud-Wallston, 1977), and intuition. If hypnosis techniques during birth lead to greater confidence among mothers, are there benefits beyond labor and delivery? Based on the existing research and knowledge base, this qualitative study sought to answer the global question, what is the postpartum experience of maternal adaptation and competence among mothers who use hypnosis to birth?

Chapter 2

Method

Research Design

This research project was based upon Grounded Theory techniques of qualitative inquiry and analysis. This approach to qualitative research aims to understand participant action and the meaning participants give to what they do in order to develop a descriptive theory (Charmaz & Mitchell, 2001). The goal of grounded theory is to explain the way in which categories relate to one another in order to explain a phenomenon (Charmaz & Mitchell, 2001; Glaser & Strauss, 1994). Grounded theory is also useful in creating a predictive theory; however, this study was initiated using a philosophy of constructivism. Grounded theory analysis methods were used to determine themes from semi-structured interviews to understand the role of hypnosis for birth on the postpartum experience.

Within qualitative research, the paradigm of constructivism aims to understand and reconstruct the constructions individuals initially hold. The goal is for consensus, while leaving room for new interpretations (Guba & Lincoln, 1994). The areas of maternal adaptation and self-efficacy are well researched. Despite the depth of literature, however, potential intersections between the birthing method, maternal adaptation, and self-efficacy still needs to be explored. The constructivist philosophy and method allow for different social, political, cultural, economic, ethnic, and gender factors to be considered in the light of the stories of the women who attempt to birth naturally. In this study, the goal is to understand postpartum adaptation with mothers who used hypnosis to birth.

Similarly, grounded theory is based on Interpretivism, or the belief in multiple realities. Constructivists and interpretivists share the view of multiple realities (Guba & Lincoln, 1994). People's actions are thought to be based on the way they construct the world (Charmaz & Mitchell, 2001; Guba & Lincoln, 1994). Additionally interactionism and structurism rest on the ideas that people construct society as opposed to society constructing the person. This interactionist point of view is one of the major sociological theories upon which this approach is based. These views lead to inductive and ever evolving research design. Although these views align with the deductive viewpoint that theory serves to explain and predict, the path to that theory is based on discovering conclusions from qualitative analysis (Guba & Lincoln, 1994). This comparative analysis is what makes it grounded theory. In this theory, conclusions are not considered to be definite. Conclusions gain value because they are established using logic and categorization and are then reviewed for inconsistencies. Grounded theory takes an eclectic approach to the method of data collection. It is pragmatic and allows for the topic being studied to dictate the research approach. Its approach to data analysis is clear and logical (Charmaz & Mitchell, 2001; Guba & Lincoln, 1994).

Pilot Interviews

Prior to recruiting study participants, to refine the interview questions and as practice interviews two pilot interviews were collected with mothers who were 19 and 30 months postpartum. Pilot interviews were completed with two Hispanic women who used hypnosis for birthing methods in preparation for labor and delivery. Pilot interviews ranged from 60 to 90 minutes. Completion of the pilot interviews helped to confirm

expectations around interview length and provided the researcher with interview experience. The interview questions were clear and did not necessitate any changes.

Recruitment

Women who purchased a self-study at home hypnosis for birthing course or attended a five to six week series of courses and who were one month to 12 months postpartum were invited to be interviewed. Eligible hypnosis for birthing programs included *Blissborn*, *Birth Hypnosis Method*, *Hypnobabies*, and *Hypnobirthing the Mongan Method*. An informed consent letter, description of the current study, and contact information for the researchers were shared with the potential participants.

Research participation was announced on Facebook groups and listserves for the eligible organizations such as *Blissborn*, *Birth Hypnosis Method*, *Hypnobabies*, and *Hypnobirthing the Mongan Method*. Individuals who offered and announced classes for one of the four methods were contacted and asked to advertise the study via a flyer. Additionally, doulas, birthing centers, birth related organizations, and medical facilities, known to integrate hypnosis for birthing methods, were asked to announce the study on their Facebook pages or in their centers of care. A snowball method of recruitment was also used. After mothers completed their interviews, they were asked to share recruitment material with individuals who had used hypnosis for birthing or within their private mom-focused Facebook groups. Participants who resided outside of the United States were not eligible to participate in the study.

Once participants were recruited, they were read and agreed to an informed consent letter (see Appendix A). Demographic information was then collected. Interviews were digitally recorded and took place either in person, or over the phone.

Participants who were unable to speak and read English or were younger than 18 years of age were excluded. Hypnosis for birthing materials are predominantly produced in English; therefore, the current study only invited English speakers to participate.

Participants were added as needed to reach thematic saturation.

Participants

Among the 15 mothers who participated in the study, 14 mothers were within the desired recruitment window of one month to 12 months postpartum, and one was 15 months postpartum. Nine mothers identified as Caucasian, five as Hispanic, and one as multiracial. Among the Hispanic participants, five were of Mexican descent. The multiracial participant identified as Caucasian, Mexican, and Native American, Pima Indian.

Mothers were aged 25 to 40 years old with a mean age of 31 years old. Participants resided in seven states which included: Arizona, California, Michigan, New Mexico, Pennsylvania, Washington, and Wisconsin. Nine participants were first-time mothers, four had two children, and two had three children. Six mothers prepared by attending classes for *Hypnobirthing the Mongan Method*, two used the *Hypnobabies* at home course and three attended classes, two mothers attended *Blissborn* classes, and one used the at home course. Lastly, one mother took *Birth Hypnosis Method* classes. Eleven mothers gave birth in a hospital setting and four had a home birth.

Overall, seven women in the current study held bachelor's degrees, six had advanced degrees and two did not have college degrees. Of the five Hispanic women participating in this study, three had bachelor's degrees and one had a graduate degree. One Hispanic mother was currently working toward her bachelor's degree. Similar to the

Hispanic mothers, the single multiracial mother had finished a bachelor's degree. Of the nine Caucasian women participating in this study, one had completed an associate's degree, three had bachelor's and five had graduate degrees. Fourteen participants were married, and one was in a long term partnered relationship. All of the mothers identified as heterosexual. Family incomes ranged from \$20,000 per year up to \$320,000 per year. The majority of households, ten in total, earned between \$60,000 to \$110,000 per year.

The Researcher and Development of Questions

This biracial Latina researcher has both personal and professional experience with hypnosis and hypnosis for birthing methods. Research interest was formed based upon holding professional certification as a hypnotherapist and after supporting family and friends who used hypnosis for birthing methods prenatally and during labor and delivery. Once the research interest was established, the existing literature was reviewed to identify relevant studies. After reviewing the current literature, a list of questions was constructed. Interview questions were piloted. Pilot interviews acted as practice sessions because they were conducted with family and friends. The two pilot interviews were conducted to ensure the clarity and appropriateness of questions. No changes were made to the questions after the pilot interviews.

After the current literature on maternal adaptation and hypnosis for birthing was reviewed, areas of daily life that required adjustment during the postpartum period were noted. Adjustments are required of a new mother and of her friends or family during labor and delivery and postpartum. The areas of labor and delivery that contribute to satisfaction with birth include: quality of the birth experience; and the mother's sense of control, awareness, and support during labor. Postpartum adjustments include the

following key areas: physical needs; appropriately observing and interpreting the baby's cues; changes within the family system; feeling support from one's partner; adjustments to the couple's romantic life; and adjusting and maintaining boundaries. Additionally, the literature review indicated that a mother undergoes cognitive restructuring in the following domains during the first month postpartum: negotiating a potentially negative view of pain in a way that does not create a negative view of her baby; support from others; body image; and expressions of hostility, frustration, and negative emotions (Rubin, 1984). This literature provided a rationale for the interview protocol and for interviewing new mothers who were at least one month postpartum to uncover how they believe hypnosis for birthing was related to their postpartum experiences.

Hypnosis for Birthing as an Intervention

Various types of hypnosis for birthing programs exist. *Blissborn*, *Birth Hypnosis Method*, *Hypnobabies*, and *Hypnobirthing the Mongan Method*, classes or home-study programs were selected for this study because of their similarity in structure and content. Additionally, the four programs have an online or social media presence necessary for recruitment in this study. Generally hypnosis for birthing uses medical hypnosis techniques, such as hypno-anesthesia, which is used when preparing for surgery without drugs or other painful procedures. The intent of the programs is to use medical hypnosis to eliminate the fears and pains of childbirth (Mongan, 2005; Tuschhoff, 2011).

The Hypnobabies Home Study Course for Expectant Mothers text and courses were developed by Kerry Tuschhoff (2011). Both *Hypnobabies* and *Hypnobirthing the Mongan Method* are based on Gerald Kein's *Painless Birth Method* (Mongan, 20005; Tuschhoff, 2011). Tuschhoff is a certified hypnotherapist and birth educator. The

Hypnobabies program format is through a six-week, six-part home study course or through a classroom or in-home setting. The six-week module includes: special place and easy comfortable childbirth; deepening; creating anesthesia and learning self-hypnosis; hypnotic childbirth #1; joyful pregnancy affirmation; and hypnotic childbirth #2 (Tuschoff, 2011).

Marie Mongan's (2005) approach is based on the theories of Dr. Jonathan Dye (1891) and Grantly Dick-Read (1959, 2013). *Hypnobirthing the Mongan Method* utilizes a five-week series of in-person classes. A book, five hypnosis scripts, and two cds further the mother's birth preparation. Mongan is a master level certified hypnotherapist and licensed master's level counselor in New Hampshire. Hypnobirthing has both a national presence across the U.S. and internationally in the UK and Australia. The classes cover the following topics: building a positive expectancy; falling in love with your baby preparing mind and body; getting ready to welcome your baby; an overview of birthing – a labor of love; birth, breathing love, bringing life (Mongan, 2005).

The *Blissborn* program was founded by Laura Wood and Shelly Black (Black, 2011). Both are certified hypnotherapists. The *Blissborn* program is similar to the aforementioned programs in that it focuses on the reduction of pain and fear through the use of hypnosis. It too offers a self-study, home-based course or classes offered in person. The program runs for five weeks but is comprised of six compact discs (cds). The modules include the following topics: discovering self hypnosis; practical skills for mom and partner; birth without fear; tame labor pain with your brain; and putting it all together.

Lastly, the *Birth Hypnosis Method* program was developed by Luree Nicholson (Nicholson, 2000), a certified hypnotherapist. The *Birth Hypnosis Method* program is similar to the aforementioned programs in that it focuses on the reduction of pain and fear via hypnosis. It offers four in-person classes for the couple and four self-study cds. Topics include the following: glove anesthesia, hypno-epidural, hypnosis suggestions, birth partner cues, and instructions for walking and remaining in hypnosis.

This research endeavor focused on women who elected to use either the in-home or class course from *Blissborn*, *Birth Hypnosis Method*, *Hypnobabies*, and *Hypnobirthing the Mongan Method*. The criteria for including these four programs was: having founders who were certified in hypnosis; classes or at-home study programs that were similar in length and content; an online or social media presence; and similar course length to other hypnosis for birthing methods.

Interview Protocol

Demographic sheet. The first half of the demographic sheet captured information that was generally based on the pregnancy (see Appendix B). This included questions about pre-birth and post-birth employment status and the methods used to prepare for the birth. Basic demographic information including the mother's age, number of children, ethnicity, sexual orientation, marital status, income level, and highest obtained level of education were collected. Depression and anxiety history were assessed on the demographic survey. Mothers were asked to respond (yes/no) to "have you ever been clinically diagnosed with depression" and "have you ever been clinically diagnosed with anxiety". If they respond "yes," they were asked "have you ever sought professional help for depression" or "have you ever sought professional help for anxiety". Then they were

asked to respond yes/no to whether they experienced depression or anxiety during their pregnancy. Additionally they were asked to identify any previous experiences with hypnosis during birth.

Questions focusing on the actual labor and delivery and postpartum completed the demographic sheet. The questions included queries about the infant's age, gender, baby's date of birth, baby's length, baby's weight, length of time in labor, individuals present during the labor and delivery, type of birth (natural vs. caesarian), type of birth setting (hospital, birthing center, home birth), and any other types of postpartum preparation tools (e.g. books, listservs) that mothers used to adjust to motherhood.

Birth complications and medical birth intervention strategies were also assessed on the demographic sheet. Mothers were asked to respond (yes/no) to whether they or the baby had medical complications or required medical intervention during labor and delivery. If they responded yes, they were asked to list specific complications or interventions needed by the mother or baby. An example of a medical intervention may be the use of forceps or a heart Doppler.

In order to ensure the study participants had sufficient exposure to the hypnosis for birthing course, participants were told that the study was for women who had completed the majority of their program. This was initially reviewed over the phone upon scheduling an interview. Given the unpredictable nature of anticipated delivery dates and challenges during pregnancy, mothers were accommodated if an unanticipated delivery occurred earlier than planned. After reviewing the four applicable hypnosis for birthing methods, it was determined that women who completed at least four of the six *Hypnobabies* cds or classes, four out of five *Hypnobirthing the Mongan Method* courses,

and four out of five *Blissborn* courses or cds, three out of four *Birth Hypnosis Method* courses and three out of four cds were invited to participate in the study.

Interview questions. The following interview questions guided the semi-structured interview. The order of questions was based upon participant responses, and questions were not always asked in order; however, all content was covered within each interview.

1. Please tell me about your pregnancy (if not mentioned) and the ways you prepared for birthing
 - a. Probe for other preparation methods other than hypnobirthing (Lamaze, reading birth related books, internet research, yoga etc..)
2. Tell me about your most recent labor and birth
 - a. Probe as needed: were they able to effectively use the hypnobirthing methods? Why/why not? How was hypnobirthing received by the birthing professionals? Family?
 - b. Probe on areas of control, awareness, and support when appropriate
3. What is it like being a new mom?
 - a. Probe on postpartum adjustments such as, emotions, physical adjustments, and body image when appropriate.
4. Who or what helped you adjust to being a mom?
5. How has having a baby impacted your family or other relationships?
 - a. Probe on support from partner, extended family, friends, and or changes in the couple's romantic life.
6. Can you tell me about your relationship to your baby?

- a. Probe on confidence during prenatal and postpartum periods, ability to read the baby's cues.
7. Can you explain how using hypnobirthing has impacted you postpartum (if at all, if not, why)?
 - a. (If has not been mentioned) What led you to choose hypnobirthing as a part of your birth preparation?
 - b. Now that you are postpartum, how satisfied are you with hypnobirthing and why?
8. Is there anything else that you think I should know?

Participants were asked whether the researcher could contact them after the interview to clarify portions of their interview or for brief follow up questions. All participants agreed.

Procedures

Initially, administrators of hypnosis for birthing programs internet and social media sites for the four programs were contacted to determine whether they would be willing to announce the current study on their social media sites or through their contacts. Interested women were asked to contact the lead researcher by phone or email to receive information about the study. At that time they were read and/or sent an informed consent form, a study description, and the lead researcher's contact information. They completed relevant demographic questions in order to determine study eligibility. Participants were offered the opportunity to construct an alias upon being determined eligible for the study. It was explained that this would allow for the researcher to de-identify their data. All identifying information was destroyed as soon as all interviews were complete.

Potential study participants were asked to identify the type of hypnosis for birthing method used and how much of the program they completed. In addition, basic contact information such as their name, assigned alias, phone number, and email address was gathered in order to send them copies of the informed consent and postpartum resource list for the current study. Demographic data were collected over the phone and via email. All interviews were digitally recorded. All data were kept confidential and de-identified once interviews were complete. Transcribed interviews were stored in a locked cabinet throughout the study. Participants were informed that after every set of five interviews completed; they would have approximately a one in 5 chance of winning a \$75 gift card.

Data Analysis

The following steps were used to carry out the data analysis:

1. Transcription of the taped interviews was conducted by the researcher.
2. When appropriate, creation of at least one memo or field note for each interview capturing the researcher's initial impressions of the respondent's interview. This focused on the meanings assigned by the participant, themes in the interview, and unanswered questions for future follow-up.
3. First Layer of Analysis - Preliminary reading of the transcription searching for overarching themes and codes was conducted by the sole researcher.
4. Utilization of a comparative method attempting to look at each incident and transcript individually and to code it for themes was conducted by the sole researcher.

5. Transcript themes were then compared to other transcripts and fieldwork memos using an Excel based charting system was conducted by the sole researcher.
6. Initial themes that seemed to repeat often or that carried great significance or richness of description were coded.
7. After these themes were refined, a final reading of the transcripts occurred, by the sole researcher, in an effort to identify what other information may have been missing or what alternative explanations better accounted for an identified construct or theme. Saturation, the state of affairs when one cannot find any new properties, was the desired level of analysis to declare a theme (Charmaz & Mitchell, 2001). This was not always possible in all cases.

Overall, 15 women were interviewed after the completion of two pilot interviews. The in-person and phone interviews were digitally recorded and then transcribed for analysis using Ground Theory. The sample included a group of Caucasian mothers, Hispanic women, and one multiracial mother, first-time mothers and mothers of two or more children. The mothers had similar levels of education. All of the mothers identified as heterosexual, and all but one were married.

Chapter 3

Results

In total, 12 major themes emerged from the interview data. They included: bonded with child, development of self-efficacy, breastfeeding success, family criticism, online support, impact on family, practice effect, amazement to misevaluation, induction overwhelm, holistic benefits, minimal post partum depression, and birth stories. Where possible, a single quote that embodies a subset of participants is presented. Relevant demographics for the subset are provided in order to describe the range of women represented by the single or minimal quotes used to explain each theme. Names have been changed to ensure confidentiality for all participants. Some of the most repeated themes occurred around bonding to one's child, confidence in adjusting to the demands of motherhood, and breastfeeding. The following section explores each theme individually and the ways that the three themes were interrelated for some mothers.

Bonded with Child

Originally, the bond between mother and child was coded as a part of a mother's development of self-efficacy as she adjusts to becoming a mom. Because every mother specifically commented on the bond with her child when interviewed, bonding with one's child was coded as a separate theme. All of the 15 participants reported feeling bonded to their newborns, creating one of the strongest themes across all interviews. Only one mother described her bond with her child as "not instant", with the bond occurring when the child was a month old. She attributed this to being unprepared for the process of the afterbirth and to ongoing visitors in her first month postpartum:

I think a lot of people don't talk about how as soon as you give birth, you have to birth the placenta and you have to do all these things, and if you tore they have to stitch you up and it's not just holding your baby and that's it... So, I feel like that kind of affected my expectation of bonding. And then, we have a lot of family and really good friends that are like family to us. Everyone came to visit within a week or two, which was nice and it made us feel like we had a lot of support, but I felt like it was still taking away from that bonding experience that I wanted to have with her. It wasn't until maybe, after the first month, once things finally settled down, that I really felt like I started to connect more (Alexia).

Despite these challenges, this mother was able to bond eventually with her child. The particular situation and factors that may have affected the mother's postpartum relationship are explored in future themes.

For the remaining mothers, five directly attributed their bond to the use of hypnosis at birth. Four of these five women were Caucasian, and three were mothers of two or more children. The mothers of two or more children seemed to contrast their current experience with previous births. One mother compared the bond formed with her last two children. She used hypnosis for birthing methods for the second and third children:

It was that instant love. It was very much very fast. I also didn't feel traumatized from that birth. The second baby was like instantly in love, it didn't matter if it was a boy or a girl, whatever, whatever. It was my baby. And this baby it was mostly the same way. (Jessica).

This quote embodied comments from the five other mothers who felt that the use of hypnosis during birth directly enhanced the bond with their newborn. More will be explained about their joy and appreciation for the birthing process in future themes, but the next subset of mothers focused on how hypnosis indirectly helped them bond with their child.

A subset of four different mothers indirectly attributed the mother-child bond to hypnosis. Aspects such as experiencing a natural birth, confidence from birthing naturally with hypnosis, and the subconscious bond present between mother and child were discussed as more direct reasons for the mother-child bond. For these four mothers, hypnosis was the intermediary through which natural birth occurs resulting in the mother-child bond. This subset included two Caucasian women who had two or more children and two first-time Hispanic mothers. “Jessica” explained how she felt during her natural birth, “I felt more calm and in control. I feel like that probably helps facilitate the better oxytocin rush post-birth that probably facilitates bonding better”. This mother was referring to the neuroscience involved with birthing and the hormones that are responsible for experiencing love.

In regard to the quote, the mother’s use of the word “facilitates” demonstrates the indirect relationship of using hypnosis for birth and bonding with one’s baby. Although she did not clearly highlight the importance of the birth being natural, her words are taken from an interview excerpt where she was describing the benefits of her unmedicated birth. Also, because she is a mother of more than two children, her ability to compare across multiple births was reflected in her statement. This underscores the advantage that mothers of two children had when evaluating the effects of the use of hypnosis at birth.

To this point, the quotes focus more heavily on the experience of the Caucasian women in the study. Six mothers did not attribute the bond with their newborn to the use of hypnosis; instead, breastfeeding was viewed as responsible for the connection. Four of the six first-time mothers who believed that breast feeding created the mother-child bond were Hispanic, and two were Caucasian. This is one of the larger ethno-racial differences

within the theme of feeling bonded to one's child. For example, LT, a first-time Hispanic mother stated:

It's not a direct technique that I learned in hypnobirthing... Nobody else can feed him. Nobody else can have that time that I have with him. Knowing that every ounce that he gains or every inch that he's growing is something that I've worked very hard for, I think that's what helps with the bonding. I feel sort of proud. That's a big bond with him.

All of the mothers who participated in the current study successfully breastfed their most recent child, but with respect to bonding, Hispanic mothers echoed the closeness and pride felt because of the breast feeding relationship and being able to nourish one's child. The breastfeeding relationship and potential differences by ethnicity and race will be explored in greater detail in future themes.

The remaining participants also pointed to attachment parenting and "baby wearing" for a portion of the mother-child bond. Baby wearing includes the utilization of a durable sling or cloth that allows parents to securely hold the baby against their body (Schön & Silvén, 2007) while they are still able to move and have the use of their arms. Almost all of the mothers in this subset were first-time mothers. Two were Caucasian, one was multiracial, and another identified as Chicana. According to one mother:

In my words, attachment parenting is like being very attentive to your baby's needs. Not letting them cry it out. Just kind of treating them, especially after you give birth, they call it the fourth trimester, still carrying your baby as if they were in your womb. So we've done that baby wearing as well, which, I think, is a part of attachment parenting (Alexia).

Many of the mothers who reported using attachment parenting to raise their child cited books on parenting written by William Sears, a pediatrician and his wife Martha Sears, a nurse. For these four mothers, baby wearing and attachment parenting were part of a larger commitment to natural parenting that happened to include hypnosis for birthing,

because it facilitated unmedicated birth. This first-time Hispanic mother explained the importance of natural parenting and the way that some women emphasize natural parenting over the importance of using hypnosis for birthing.

To me it's like to be natural and that I make myself and my baby have everything we need for this birth to be really good. Just that it should come naturally and that we are made to do that. So likewise once I had my birth that's exactly what I felt about it, the whole experience of birthing and once my baby was here I just again, deeply felt that me and my baby would figure it out. Like we had all these awesome resources and external help but at the end of the day I felt like I needed to understand my baby that we were made to do that. Just like we were made to understand our body to know how to birth; our bodies also knew how to work together in life. To me it's the same, I can say I can see how hypnobirthing helped me in my relationship with my baby and things after in my relationship postpartum (Maxine).

This mother repeated basic principles of attachment parenting that teach mothers to follow their instincts to read the cues of their baby (Sears & Sears, 2001). In her words, “hypnosis for birthing was a tool that enabled” both her and her child to “work together”. Aside from fostering the mother-child bond for some, attachment parenting also helped to build a mother's self-efficacy in adjusting to the demands of motherhood.

In summary, five women believed that the use of hypnosis had a direct relationship to the bond between them and their child. Four reported an indirect relationship that largely focused on natural birth being the primary source of the bond but recognized that the use of hypnosis for birthing facilitated natural birth. Six focused on the breast feeding relationship as the primary reason for the bond between mother and child, while the remaining respondents attributed the bond to attachment parenting and baby wearing.

Development of Self-Efficacy

Mothers were asked about the development of their confidence and the ways that using hypnosis for birthing may have impacted such development. During the interviews the word confidence was used as a lay term for self-efficacy. Responses included mothers feeling a clear or indirect relationship of hypnosis for birthing on their self-efficacy, having previous experience because of being a mother of more than two children, support people, attachment parenting, reading and taking classes, and comparing one's baby to others. Six mothers, equally represented across ethno-racial groups, felt that there was a direct relationship between the use of hypnosis for birthing and their self-efficacy as a mother. In total, three were mothers of more two or more children, and three were first-time moms. This particular mother of three, drew a connection between confidence during the birth and confidence while postpartum:

It absolutely gives me the confidence that I need, it as in Hypnobirthing, and especially those birthing affirmations [part of the Hypnobirthing program]. They completely boost your confidence and I feel like that is so important for a new mom. For the birth because you are then able to really establish what you want and then stand up for it, but also as a mom I can see with my own experience and with my experience with other moms; mom's know how to be moms. Women just a lot of times they're instinctual and the things that we need to do like reading the baby's cues and meeting their needs come to us. Sometimes if we don't have that confidence or we have something going on in the head that's holding that part back from letting our instincts just take over, that's what makes it hard. That's what makes mothering hard, especially like the breast feeding relationship. You have to have a lot of confidence to do that because in our society listening to your mommy instincts is almost against everything that you see (Lauren).

This mother clearly linked the use of "hypnobirthing" prenatally to experiencing a successful birth. She seemed to feel that a mother's ability to feel empowered enough to craft the birth she wants establishes the instincts necessary for motherhood. She reported the ways that she and mothers in general are not supported in developing their instincts.

Therefore, this subset of six mothers reported that the use of hypnosis during birth led to greater self-efficacy.

One may expect that mothers of more than two children may also gain confidence based on their level of experience. Five of the six women who fit such a profile also stated that their experience as mothers helped them to develop their confidence. This was not stated as the sole reason for the development of their confidence when they become mothers once again, but instead was offered as an additional reason. Kara explained, "...just the fact that she's the second kid. We've already gone through a lot with the first too, we knew what to expect."

Similar to the theme on bonding, a subset of mothers felt that hypnosis for birthing indirectly led to self-efficacy. Again, being able to accomplish the task of birthing naturally was the primary reason for the development of self-efficacy; however, hypnosis allowed for the natural birth to occur. For example, Jennifer explained how going through natural childbirth lead to her sense of maternal confidence:

It was the whole birthing experience and I guess, also, studying the Hypnobirthing just the fact that I went through childbirth so easily, then gave me, just now gives me all the confidence in myself in the world that I maybe didn't have [before] (Jennifer).

This mother was a part of a subset of six mothers, four Caucasian and two Hispanic women, three first-time mothers and three mothers of two or more children, who had made similar statements. Two of these first-time mothers stressed that being able to maintain a calm state, because of the use of hypnosis during birth and throughout labor, supported the development of their self-efficacy as mothers. One mother remarked:

I feel like, again, there's that residual of just being able to just be in a calm state and something that I do that I think I do consciously practice. So, it's not

necessarily that I'm doing any particular exercise or technique of hypnosis, but I think it's just kind of the subconscious awareness of it (Violet).

Violet's use of the word residual indicated the indirect relationship that she and other mothers drew between hypnosis for birthing and their level of confidence. In addition, her explanation of how the calm state is maintained without practice was another reason for her to believe that hypnosis was ultimately affecting her postpartum. In her mind, because she was not actively engaging in the techniques, they were not a direct result of using hypnosis for birthing.

Next, three mothers, two first time and one mother of two or more children, also shared that having support people in their lives helped them to develop their maternal self-efficacy. One stated:

Definitely talking things out with my partner... And then having help and support from other people, including some professionals, like a lactation consultant and our naturopath helped a lot in the early days. You know, finding a good pediatrician was a bit of a difficult struggle at first. We had good family support as well, family who are local and they'd come over and help out (Veronica).

The mothers who used hypnosis for birthing did not negate the impact of positive social support. Similar to experience, support was another ancillary factor leading to their sense of self-efficacy.

In all, the experiences of 12 mothers are explained by their perceptions of the direct or indirect role of hypnosis on maternal self-efficacy while accounting for experience and social support. The remaining mothers' responses with respect to self-efficacy were attributed to attachment parenting as mentioned by three mothers, reading books or attending classes on parenting or postpartum related maternal tasks as

mentioned by two mothers, and comparing the development of one's child to other children as mentioned by one first-time mother.

One final theme related to maternal self-efficacy and adjusting to one particular aspect of maternal demands was specific to four Hispanic first-time mothers. They discussed their struggles with returning to work and balancing their roles as mothers and young professionals.

I'm no longer working as of two months ago, so I have to, not that I have to, but this is my own pressure that I put on myself. I feel like I have to, because I'm home, have to keep up with the house. I have to keep up with dinner and lunches and food and so I definitely stress myself out a lot. And, I think that, I feel like I'm still that career woman, and I don't know how to turn that off. It's still really hard for me to think I need to be in mommy mode 100%, and chill out on all the other stuff. It's hard for me to accept that. I want to, it's just an adjustment. I went from being a student to a career woman and just two months ago, to full time mommy, and I'm picking up[a] part time job here, there, and I'm like, what am I doing to myself?... I wanted to be the stay at home mom with lots of kids. So, it's an adjustment and it's very emotional. It's something that I wish we didn't take for granted. And, the reason I say that is because I always knew I wanted to be that person, I just didn't know how, and I'm still trying to figure it out, but it's hard work. (Jasmine)

Although all mothers candidly discussed some common struggles with balancing their various roles, these four women expressed feeling torn over how to balance being a mother with their career. Two mothers in this subset returned to fulltime jobs. One eventually moved to part time work while the other left her job to become a fulltime mother. One mother who was currently on maternity leave was candid about being unsure whether she would return to work once her leave concluded. The following mother explained how leaving her job involved a process of mourning:

So being home, I was really excited to come home but that's also been more challenging. Although I really value staying home and spending as much time as possible with children while they are young, it's something I've always wanted to do, it's really difficult for me. Limited social interaction and [no] external rewards

and all these things that would help me perform. I've had I guess a period of loss for a few months, which I'm just recently starting to feel like I'm coming out of (Maxine).

In contrast, similarly educated Caucasian mothers did not express this tension. Four were mothers of two or more children and previously were stay-at-home mothers. One first-time mother began to work 30 hours a week from home after temporarily returning to work fulltime. More importantly, four more mothers returned to their careers.

In summary, a group of mothers established a clear relationship between self-efficacy and the use of hypnosis for birthing. Another subset believed that both previous experience along with the use of hypnosis lead to self-efficacy. The indirect relationship between maternal self-efficacy and the use of hypnosis to birth emphasized the fact that using hypnosis allowed for a natural birth. The natural birth led to the bond, but hypnosis helped the birth process. Last, a subset of Hispanic mothers experienced difficulty with managing career and maternal roles. Despite experiencing strong self-efficacy as new mothers.

Breastfeeding Success

The last theme mentioned in conjunction with bonding with one's child and maternal self-efficacy was breastfeeding. All mothers in the current study chose to breastfeed their child. As was mentioned with the subset of Hispanic mothers and bonding, successful breastfeeding outcomes affected the evaluation of a positive postpartum for most participants, particularly for Hispanic mothers. In addition to feeling that breastfeeding "facilitated the bond" and to experiencing a sense of "pride" around breastfeeding, four Hispanic mothers also mentioned resources that help mothers receive and share breast milk. As mothers made the transition back to work or heard of breast

milk banking resources, they seemed to align themselves with such services. One mother stated:

It was really important to me, I wanted my baby to have breast milk and only breast milk so I was hoping that he didn't have to have any formula. So that was okay when I was at home but going back to work I was not able to pump enough milk to last him throughout the day and that was real stressful for me. The midwife, they had a lot of amazing resources and social network... So that's what helped me through that stage. So what it actually is, is milk sharing, breast milk sharing so mother's who have excess breast milk are able to offer it to mothers who aren't able to pump enough or aren't able to provide it. So I actually did enjoy that resource and that was really helpful (Maxine).

Another mother mentioned:

I love resources in general because one of the things that I feel has helped make me heal has been reaching out to other people and feeling like, even though things didn't go right with my body in terms of birth, my body has done a lot of other really miraculous things. I have this ridiculous supply of breast milk and I've reached out to moms who don't have breast milk and have shared and given them [breast milk]. That was therapeutic and healing for me (Penelope).

These two quotes reflect both the resourcefulness and the communal nature of the Hispanic participants. The second quote from the mother who donated breast milk reinforced the sense of pride mentioned by other Hispanic women who were proud of their breast feeding relationship with their children. Penelope and another mother who donated breast milk underscored how important it was to the Latina mothers to prioritize breast milk when possible and to support mothers in their community that felt similarly. Moreover, none of the Caucasian mothers mentioned these services or donating to them. Overall, mothers were generally asked to comment on their adjustments to motherhood. Participants were not directly asked about the breastfeeding relationship although nearly all women commented on it.

Another important factor that was introduced by Penelope's quote is the impact that breastfeeding had on mothers who had unplanned events or medical intervention

occur during their birth. These were mothers who had some level of medical intervention or unexpected occurrence during their birth. Five of the women experienced challenging births that either included a need to be induced, an epidural, c-section, or combination of these. It is important to state that these women still used their hypnosis for birthing techniques while laboring. Four of these five women were Hispanic. Because these women were not able to or had complications with realizing their goal of natural childbirth, the breastfeeding relationship seemed to become even more important to them. Among this group of women, breastfeeding was mentioned as the primary reason for feeling connected to their child and for assuaging the guilt related to not having a natural birth. One mother who experienced unplanned events during birth explained:

We're still breast feeding, and I feel like that helps us to really connect. So, when she wants to nurse, I have to sit there and be very present. When I do that, we connect, she looks at me, she touches my face. Sometimes she holds her hand like brushing my arm, and it just feels so comforting. It just makes me feel so loved and it makes me feel like I'm doing something right (Alexia).

This woman's quote reflects a sense of self-efficacy, confidence, and pride that women who planned on using hypnosis for birthing were not able to experience due to the inability to birth naturally. Women in this subset discussed some of the ways that their breastfeeding relationship helped them ease their guilt. Although the current study focused on the mothers' most recent births, two of the mothers with two or more children experienced medicated births during their first pregnancies. Experiences with medicated births, that did not involve the use of hypnosis for birthing, negatively altered the breastfeeding relationship with their first born children.

Other women who'd tell me about their epidural experience said they'd take the most glorious nap and then feel great. That didn't happen to me. I felt a little cheated. Then I wasn't able to breastfeed. And I said, "well, I'm supposed to give

my son breast milk for a year," and we couldn't do that so, ok, I guess I'll pump. I was convinced that if we'd had more help and a different type of birth, that things would've gone differently... That's what really spoke to us about the Hypnobirthing was that we are parents and not patients; that we have choices, that we can discuss things, that we don't have to go along with what the hospital says (Kara).

The two mothers of multiple children did not use hypnosis for birthing during their first births, and both were also administered epidurals. Both connected the use of hypnosis for birthing to their positive breastfeeding relationship with their second child.

Overall, Hispanic mothers expressed great pride over the breastfeeding relationship to the extent of participating in breast milk sharing resources. Mothers who experienced unplanned events during birth focused on the breastfeeding relationship because of difficulty with birthing naturally. Breastfeeding success helped them cope with feelings of guilt. Mothers who previously birthed emphasized how experiencing unplanned events did not allow them to easily breastfeed, whereas the mothers who experienced difficulty in the present study were able to do so. One final topic related to breastfeeding, segues into the next theme of family criticism. One first-time Hispanic mother discussed the way that lack of support from family members for her natural birth choices and parenting methods affected her breast milk supply in her second month postpartum. She stated:

I actually had a really hard time after the first month breast feeding because he had gained really well, weight wise, and the second month didn't. I was going [sic] under a lot of stress from family who didn't understand why I wanted to breast feed him. [They] would get mad at me or would make remarks like how they should be able to help me with bottles and if only they could do that. Why I had to be the one to feed him and how selfish it was of me. That unfortunately hasn't been as easy as I would have liked it to be. I know that being stressed out the second month definitely affected my supply because I could feel it (Roxy).

This mother's experience of family criticism was specific to breastfeeding; however, she and other mothers experienced isolation because of their birth choices and parenting methods. This leads to the next related theme that emerged more frequently for Hispanic mothers.

Family Criticism

In total, six mothers revealed feelings of isolation or frustration because of others reacting to their use of natural methods of birth, specifically hypnosis, and natural childrearing methods, including breastfeeding. Four mothers were Hispanic, two were Caucasian, two had more than two children, and four were first-time mothers. Although these six mothers had support from their families both prenatally and postpartum, they felt criticized by family members. The family members who were reported as being most vocal with their criticism were their own mothers and mothers-in-law. The only Caucasian mother experiencing this explained:

My mother, she was pretty defensive throughout the entire pregnancy about the choices I was making because I think they were very different from the choices she made. I think she took it as a personal attack on her...It's my interpretation. We talked breast feeding, and initially she was like, "Yeah, there's really no reason not to". Then one day she said, "well, you were formula fed and you were fine," and I was like, "Yeah, I know, but I want to breast feed him." So, back when I was born, the majority of people were formula feeding. I just feel like it was a lot through the whole pregnancy. It was like, "Well, I never did that. Well, I didn't have to do that". I think, overall, it just made me want to dig in my heels a little bit deeper. (Bianca)

Ultimately this participant maintained a relationship with her mother but stated, "we never got super close like everybody told me [would happen]".

In contrast, despite experiencing similar feelings of isolation, Hispanic mothers expressed a desire to remain close to their questioning family members:

So I definitely feel for my relationship with my mom in how I want to do things. I'm still trying to figure out how to portray the information that I have to kind of justify the things that I do without her feelings being hurt or without her feeling like I am somehow shaming the way she went about things (Roxy).

Another mother mentioned:

I think she's still questioning if I weren't so adamant about being natural, would I have been on the monitor? I think in the future, we talked about it, she would want me to be on a monitor but I think she would be comfortable with doing the hypnosis to help myself relax and cope because I think she thought that was advantageous to me as well (Penelope).

Generally, Caucasian mothers seemed to separate themselves more easily from criticism and negative views both from family and friends. Often, Caucasian mothers were the primary or sole caregivers. Support from family was temporary and lasted for a shorter duration than for Hispanic women. For example, Jessica, a Caucasian mother of three children, described her reaction to having her father help after the births of her children:

He was here for all the kids to help out but it was weird, especially the first time. We actually said, "Ok, well we hope he doesn't stay because he doesn't live here." I'm like "ugh, you want to come stay? Ugh." But we're going to kick you out for at least the first three days after the baby's born just so we can bond and maybe a week and come back.

While Lulu, a first time Hispanic mother, explained, "Grandparents are part of feeding, baby sitting etc... they are who cares for the baby after so they have a say". It may also be important to note that out of the six mothers who experienced family criticism for their birth choices, five of them experienced unplanned events during their birth. The effects of social support are further explained in the following theme. With respect to isolation, three mothers experienced brief isolation after the birth. These experiences were fleeting and focused on the ways their lives had changed after immediately having a child.

Reaching out to social support networks or establishing a support network was important for these women.

In summary, a subset of Hispanic mothers discussed feeling criticized because of their birth and parenting choices. They tried to maintain a strong relationship with family despite facing criticism by their mothers or mother-in-law. This was in contrast to Caucasian mothers who experienced less actual help from parents. The experience of criticism from support people requires a fuller conversation about the impact of one's support network.

Online Support

When discussing the ways that mother's gained self-efficacy as they adjusted to motherhood, the importance of social support was explored. In this section, support is differentiated by ethnicity and race, and the impact of online support is also discussed. Social support from others facilitates one's adjustment to motherhood while postpartum. Hispanic mothers discussed relying on family, friends, and their community despite also accessing online support, similar to their Caucasian counterparts. Alexia stated, "So, I did a lot of talking with people in my circle of friends and in my community, and making a lot of phone calls." She later noted that she researched topics online as well but her emphasis was on more personal human contact. Bridget, a first-time Caucasian mother explained:

In the first week, when my husband was first home, I had two crying spouts that week. One out of loneliness, in the sense that everything is different now and the adjustment period felt isolating... I think at that point, I was craving some of those connections from the outside world or someone that wasn't going through the same thing that we were going through. And then, we had family come over one night that first week we were home, and I realized that I had craved it so much and when they were here, it was so nice. I realized that was what the feeling I had was; that it was that everything is different and you feel very isolated even though you're not. There are tons of people going through the same thing. At that point, I just hadn't found them and hadn't reached out to them. I hadn't

found my Facebook support group yet. I would talk with family on the phone but it's not the same.

Bridget seemed surprised to realize or remember that her family could help her work through feelings of isolation. More importantly, it seemed as if her Facebook group turned into her primary support group instead of relying on her friends and family.

Hispanic mothers also accessed Facebook groups; however, the emphasis on online social support was prioritized less. The only exception to this was for mothers who experienced unexpected interventions during their birth. In these cases, mothers also reconciled their feelings of guilt using social media. Having individuals who had personal experiences with their particular situation became more important. For example, LT remarked:

I feel like not a lot of people understand that when you have a c-section you weren't planning for, that you are sad or depressed about not having the natural birth that you expected. Everybody sees you as not being grateful for having your baby. It's difficult to talk to friends or family because they only see that you brought a healthy baby to the world, not all the hard work or all the hours that you put into something that meant a lot to you. Talking about it with my doula or finding groups on Facebook, for example the Informed Cesarean Association Network, which is for people who probably had c-sections that they were not planning for or that were traumatic and so they're on their second pregnancy and trying to go for a VBAC. There are a lot of stories of women who went through the same thing that I went through and, reading their stories, and reading their successful VBACs afterward kind of helps to not feel alone. As well as having the support of my husband because he understands how much we had worked. He doesn't dismiss my sadness for not having the natural birth that we wanted. He fully understands what that meant to me.

LT's quote demonstrates the understanding and comfort she found online that she may not have relied on as heavily if she had been able to have birthed naturally. The importance of supportive people such as her husband was also mentioned as equivalent and a source of hope for this mother.

Penelope offered an example of having the best of both worlds for the Hispanic mothers who encountered unplanned events. She stated:

We have such extended family that pretty much all functions as immediate family, both on my husband's side and my own. I think when the counselor came in and asked "do you want to talk about it," I was, "you know what? I'm good. I'd rather talk to people that I already know and love. I'm sorry, no offense." But I found more comfort in that: aunts and cousins and friends that had had c-sections and moms of my friends who had a traumatic experience and NICU nurses. Actually, NICU nurses, I talked to some of them and that was comforting as well.

Ultimately, online support was viewed as significant and equivalent to physical support for mothers who required intervention. They obtained practical answers via online support and were assured that the individual online would not misunderstand their complexity of emotions.

To review, all mothers utilized online support; however, it seemed to be a greater priority for Caucasian mothers. Hispanic mothers who experienced unplanned events also turned to online support. Online support offered a common bond to gain support around feeling associated with not being able to birth naturally.

Impact on Family

Differences due to ethnicity and race continued to emerge from the data. Caucasian mothers evaluated their husbands and family as being more positively impacted by the use of hypnosis for birthing. Of the families with two or more children, four felt that both the father and the siblings were closer as a result of using hypnosis for birthing. The evaluations of closeness also coincided with families where the father was involved in practicing hypnosis techniques during pregnancy. The husbands of five Caucasian mothers practiced the hypnosis for birthing techniques in addition to or with their wives. Jessica, a Caucasian mother, remarked:

For my husband, this is the second Hypnobabies birth. The first one he didn't really get to participate in terms of preparation. He was working full time and having to remodel our house. This time he's felt more immediately connected to the baby than to the other two. I think that from participating in more of the hypnosis stuff, being more familiar with it, and just engaging with it more by reading the scripts and everything during the birth, he got to participate and engage and assist me in feeling more comfortable.

In contrast, the husbands of Hispanic mothers did not practice with their wives. Many of the Hispanic mothers did not think to have their partners be a part of the additionally required home practice, if the couple attended a course together. If the mothers used a home-study course, their partners had little interaction with the preparation materials. Hispanic mothers, however, did not report feeling unsupported by their husbands. As Jasmine explained:

No. I never thought about it, [having her husband practice] but now that we're talking about it, I'm like, Oh, that would be a great idea... So, I was listening to the CD's on my own. He was supportive in the way that he would take care of my daughter or give me that break or go pick her up so I could get that time to do it. But, in regards to him actually listening to the CD's with me, no. So, that would definitely would be something I think would be important for next time, too, him doing the CD's with me.

A comment from one Hispanic mother may explain one reason for the differences between the spouses of Caucasian and Hispanic mothers. LT, the Hispanic mother, stated:

When I first talked about it [hypnosis for birthing] with my husband, he was a bit hesitant but then he was really on board, I think. He never rejected going to the classes. I guess he was nervous of being there during the delivery, especially because most of his friends are not really there. They just show up for the delivery of the baby [laughs]. He hadn't heard of stories of his friends helping their wives in those hours at the hospital. He was a little bit nervous but he got really familiar with the whole thing. He was really on board.

Caucasian mothers also described their spouses as being more hands on postpartum.

Again, Hispanic mothers did not complain about their partner's level of participation but

rarely mentioned the role of their partner with household or baby related responsibilities.

Violet, a Caucasian mother shared:

I think I'm really lucky because my husband's a really active partner, and he has been the whole time since we were pregnant. I explained to him what hypnobirthing was to him, and he did a little research and he was game. He basically was like, "I will support you. We will do this together." I felt like it was important to him, too because he had a really active role throughout labor, but he, obviously, has a really active role now.

Ultimately, the partners of some of the Hispanic mothers were different from some of the Caucasian partners in relationship to practicing the hypnosis for birthing methods and reporting their perceptions of the father's bonding to their child. Caucasian and Hispanic mothers seemed to have different expectation of how their husbands would participate during birth preparation and while the mother was in labor. A quote from first-time

Caucasian mother, Lucy, reflected some of the differences by ethnicity and race:

I liked the way it was structured in that he was supposed to be a coach and he had kind of different jobs to do and I also felt like it really wasn't fair for him to kind of be just an accessory, or whatever, which is how guys are treated a lot of times. I wanted him to be actively involved in the whole process, so that seemed like a good way for both of our perspectives, for him to be actively involved with the whole thing but also be helpful and not annoying, or whatever.

Similar to the Hispanic women who experienced a criticism from family because of their natural parenting methods and natural birth choices, a similar tension existed for their partners with the extended family. Roxy, a Hispanic mother, explained:

I know it's been really hard for him. He supports me by allowing me to do these things but he in himself, it's new to him also. I mean it's not necessarily conventional in our experiences so I think he feels very alone because I'm like forging against my little family or my little world's way of doing things. He's with me on that but I think the doubts of our family members definitely affect him in a more vocal way. I think they affect me and I internalize them and struggle with them within myself but he has no one else to talk to about it except for me. So he will often say, 'well why are we doing this, or I don't understand or is it

really necessary, you know we survived'. You know and that kind of thing which is the same stuff like that our families have said to us.

Mothers infrequently mentioned changes in their romantic relationship, but they did discuss the marital relationship and family dynamics. Sophia, a multiracial mother, shared:

I would attribute it to hypnobirthing and to myself. I feel like because I was more present with myself. It helped everybody and it helped my relationship with my husband. It helped my relationship with the two kids and it kind of everything integrated easier. Like with my first everything felt separate. I felt separate from my husband, my husband felt separate from me. I felt really connected to my baby, he felt really connected to the baby, but like there was this gap and we weren't like this unit and with the second, we were like a unit because I was the foundation. I was the glue that was holding it together.

Sophia's quote was reflective of the way that Hispanic mothers often described the nuclear family becoming closer after the birth. The women rarely discussed growing closer to extended family, perhaps because those bonds were already forged. Caucasian mothers more often mentioned a connection between the couple. As Bridget explained, "We kept saying to each other that this was so great and we can't imagine going through it without the other one. It was nice to feel as if we were in it together." She and many of the other Caucasian mothers who used hypnosis for birthing felt that the birth of their child strengthened the relationship and frequency of contact with extended family. For example, Veronica, a first-time Caucasian mother shared:

I think maybe we've developed a closer relationship with our family who both live locally. We see them more frequently. They come help out with the baby. I see my parents more frequently as well. They're not local. I mean it strengthened the partnership with my husband.

The theme of impact on family revealed that support differed by ethnicity and race. Caucasian mothers expected their spouse would be a critical part of birth

preparation. As a result of this participation they seemed to describe a close bond as a couple. Caucasian mothers also reported increased contact with extended family members after the birth. A subset also described their partners as hands on. In comparison, Hispanic mothers rarely practiced hypnosis for birthing techniques with their partner. The majority also failed to comment on the father being hands on with the newborn. The next theme explores the ways that support and practice may have affected the success of the hypnosis for birthing.

Practice Effect

Moms who committed to practicing, despite possible skepticism, seemed to have the most successful births. For many, a successful birth was defined as one that was “natural” or where the mother felt a sense of “calm or “control” of herself and the labor. Mothers also focused on their “breath” to stay out of the “fear-tension-pain cycle”.

Veronica, a Caucasian mother, shared:

Um, well mainly just the fact that it was focused on not going into the fear-[tension]-pain cycle. In the end I kind of thought that, okay, that’s one of the kind of amazing things that we’re not talking about at all, but just the fact that talking about that Hypnobirthing can be just a natural path to birth. It doesn't have to be painful, and by going through all these techniques for relaxation that a woman can put herself in a more calm state. So basically that’s what I was looking for, was something that had that holistic perspective focused on the calming.

Of the eight mothers who mentioned this cycle during their interview, six of them birthed in less than 13 hours. This group consisted of four Caucasian mothers, three Hispanic mothers, and one multiracial mother. Three were mothers of more than two children, and five were first-time mothers.

Similar to the way Veronica discussed her goal of natural birth, others also stated that a successful birth included one where labor was without unnecessary interventions.

Lulu, a Hispanic mother, explained:

I knew that I didn't want an epidural, even before I got pregnant. I knew that I wanted to try a natural birth and I think I knew that because just from the different readings that I had done... I also didn't want to the doctors to have that much control over the process, or the nurses. Like I wanted more control over that process.

Although this was a goal of many women, receiving interventions during birth was not necessarily viewed as "failing". Lauren, a Caucasian mother, shared:

I feel like Hypnobirthing is more of the emotional preparation of it. I think that's why with Hypnobirthing mom's have really good outcomes no matter what they're goals are because they're more emotionally prepared for birth to go however it needs to go. So just because you end up getting an epidural and your goal was to have a natural birth it doesn't make it a failure. Sometimes baby's in a funny position and you need an epidural because the birth is really long and that's hard. All you can do is prepare as much as possible and then you do the best with what you know and that's what you do with mothering too.

For mothers who had unplanned events occur during their births, they felt that hypnosis for birthing offered them a way to make decision about necessary interventions without fear. Bianca, a Caucasian mother, stated:

I have a friend who ended up, her labor started similar to mine, but they put her on Pitocin after 24 hours and they gave her 12 hours to make enough progress and then it was an emergency c-section, and she felt like she didn't have the information that she needed and the time that she needed to process as it was happening, and I feel like I got that. So, it may not have been the picture perfect birth that I had in my mind, and it may not have been the hypnobirth that we saw on all the YouTube videos, but I still had enough time to process and be on board with where we were going. So, I still look at that as a positive.

One area where practice did affect the participants was with respect to hours in labor. During the interviews, four mothers identified themselves as not having practiced as much as they were told too or as much as they felt they should have. Mothers who

practiced more often practiced daily. The following quotes are from mothers with differing levels of practice. The following is a quote from a mother, Jennifer, who felt she adequately practiced.

Then, gosh, I tried to prepare as much as I could. Every single night, almost, of my third trimester, after dinner, after my 3 year old went to bed, I went upstairs and, I don't know how many times I read that Marie Mongan book. I don't know how many times I went through the Hypnobabies CD thing, and I would just study, practice and study. But, I wasn't sure either. I wasn't sure how it was going to go. I was kind of skeptical, too. I tried not to be. I tried to be as positive thinking as I could.

This mother stresses her daily commitment; however, the mothers who persisted despite skepticism were highly successful. This mother birthed her second child in a total of 2.5 hours. In contrast, the next mother Alexia, felt that she could have practiced more.

I don't know if it worked for me exactly as I expected, but I think it definitely helped me stay calm, and it helped me not freak out or give into the pain of. "Oh, my gosh! I'm getting another contraction, it hurts." I wasn't like that. I was like, OK, just breathe through it. I think a lot of why it didn't work the way I intended is because I didn't practice it as often as I needed to. I went to the class, we'd practice it there, I took the material home, I occasionally practiced it. They gave us the audio to practice at home, and it was supposed to be like every day. My husband didn't practice.

Of the mothers who believed they adequately practiced, many found it difficult to teach others how to use the hypnosis for birthing technique to deal with every day painful situation. Many emphasized that the "breath" was the tool for focusing oneself and to avoid the fear-tension-pain cycle. Lulu explained that the hypnosis for birthing techniques required practice to master, "It's something I try to tell other people, to breathe but they don't understand. So I stop telling people. You really have to practice. It isn't something that you can learn quickly."

Table 1 separates mothers who engaged in less practice and compares them to mothers who felt that they practiced as instructed by their hypnosis for birthing program. One's total hours in labor is differentiated from active labor, or dilation from four to 10 cm (Albers, 1999). With the exception of the last two mothers who believed that they adequately practiced, those who practiced more were in labor for an overall shorter period of time. Mother 15 delivered her baby at 43 weeks gestation via a successful vaginal birth after cesarean (VBAC) that required her to be induced. She was in labor for three days before beginning the active phase of labor.

Albers (1999) reported that the average hours in active labor for women undergoing natural unmedicated labor is 7.7 hours. The upper limit of active phase labor, but still within normal limits is 19.4 hours. For women with more than two children, the active labor average is 5.7 hours with an upper limit of 13.7 hours. Six mothers of more than two children in the current study birthed well below the upper limit of 13.7 hours for active labor and two birthed below the 5.7 average hours for active labor. All first-time mothers in the current study birthed well below the upper limit of 19.4 hours for active labor, and six birthed below the 7.7 average hours for active labor. This included women laboring with an epidural. According to Albers (1999), labor with an epidural increases the average time in labor. Mothers 4, 10, and 15 all received epidurals. Mothers 11 and 12 birthed via cesarean section. There was little difference due to ethnicity or race, or for mothers whose husbands practiced with them at home. The data suggest that hypnosis for birthing was related to the hours of the active labor phase for the participants in the current study.

Table 1

Hours in Labor by Levels of Practice

Less Practice			Practiced		
Mothers	Total Hours in Labor	Hours of Active Labor	Mothers	Total Hours in Labor	Hours of Active Labor
Mother 1: (C)(FT)*	23	7	Mother 5: (C)(2+)	2.5	2.5
Mother 2: (H)(FT)	24	7	Mother 6: (C)(2+)	4	4
Mother 3: (C)(FT)	24	5	Mother 7: (C)(FT)*	7	7
Mother 4: (C)(FT/UNP)	42		Mother 8: (C)(2+)	10	6
			Mother 9: (H)(FT/UNP)	12	12
			Mother 10: (H)(FT/UNP)	12	7
			Mother 11: (C)(2+)*	12	12
			Mother 12: (M)(2+)*	13	13
			Mother 13: (C)(FT)	19	10
			Mother 14: (H)(FT)	29	5.5
			Mother 15: (H)(2+/UNP)	72	10

Note. FT = first-time mothers; 2+ = mothers of two or more children; UNP = unplanned events: induction, epidural, c-section; * = Home labor; C = Caucasian; H = Hispanic; M = Multiracial. Hours of active labor indicates dilation from 4 - 10 centimeters.

In addition to more time in overall labor, those who practiced less seemed to have a more difficult time incorporating techniques during labor and delivery. They also struggled to adapt as pain increased and recognized signs of effective hypnosis for birthing. First-time mother Lucy's overall assessment of her birth was:

Actually the hypnosis didn't quite work like I had expected. Nonetheless, I had a very calm, unmedicated birth. In fact, my 70 year old OB/GYN, who has delivered tons of babies and my doula both, said they had never seen anyone so calm during labor.

Despite her assessment of her birth, Lucy provided one of the clearest descriptions of common symptoms of someone who is under hypnosis:

It was kind of like I was in a room, and I could tell that I was there with other people, but I just didn't really care about anything. Like, I could hear people talking, but I just didn't care, and I was just so not interested in what was going on, that I just didn't feel like opening my eyes. I didn't feel like getting up. The only thing I wanted to do was just like sit on the couch that I was on, you know. Even though I was conscious of things going on around me, I was just kind like, meh, I'll just stay here and hang out because this feels good.

The room that Lucy struggles to describe is her hospital room. She unknowingly labored at home until she dilated to eight centimeters, potentially risking delivering her baby in her home. While in the hospital, she repeatedly commented on how quiet her room was. She had awareness of her surroundings but preferred not to interact with her environment because of her "good feelings", and she struggled to remember details about the birth similar to the way that those under hypnosis lose track of time. The example offered by Lucy demonstrated some of the ways that the participants in the study potentially misevaluated their progress.

Overall, mothers who felt they committed to practicing despite skepticism birthed in fewer hours. Those who experienced unplanned events still valued the hypnosis for

birthing techniques because it facilitated decision making without fear. Practice allowed mothers the ability to master their breathing that they believed kept them out of the fear-tension-pain. Some mothers may have misevaluated their progress which leads to the following theme.

Amazement to Misevaluation

Fourteen of 15 mothers in the current study misevaluated occurrences such as the onset of their contractions, time in labor, progress of labor, and who was present for their birth. The most frequently mentioned explanation for a potential misevaluation was lack of pain. Kara offered her experience with attempting to recognize her contractions:

I woke up in the morning and I was feeling pressure in the back. I wouldn't say it was pain because Hypnobirthing is really not for that word, "pain." It didn't travel to the front like they say contractions will. It would just come and go in the back. I was trying to do my visualizations. I was playing the CDs, to help me relax and trying different positions at home. It was getting kind of hard to focus and, at that point, my husband said, "this means we should go." I said, "no, this doesn't feel anything like what I've been told it's supposed to feel like." [Her husband replied], "Whatever these things are, they're five minutes apart".

Kara added that the hospital staff did not want to accept her birth plan, because they did not believe that she was far enough along. When they examined her, she was dilated to seven centimeters.

Nine mothers, six Caucasian women, and three Hispanic women, attributed their misevaluations during labor and delivery to expectations based on watching videos that demonstrated birth with the use of hypnosis. Many believed they were supposed to be more quiet and serene instead of "animal like". At times this led them to second guess their own efficacy despite a successful birth. Bridget explained:

The urge to push was so strong and it took me by surprise. I had thought, based on videos in our Hypnobirthing class, that the women didn't even feel the urge to

push and, when I felt that urge my body was shaking with the contractions and pushing the baby down. I was very vocal. I was moaning and grunting a lot. Again, in the videos, some of the women you couldn't even tell that the baby was going down. I felt like I was really primal and it must look that way to other people... It felt like I was losing control a little bit. It didn't scare me but made me, at the time, almost disappointed in myself that I wasn't calmly breathing the baby down. It sort of distracted me.

A small number of mothers also wished to be told that there may be pain and that is

“okay”, instead of framing the goal of birth as being painless:

I still want to embrace the fact that I did feel that intensity, and that I took it and was able to handle it. Because at one point I was like, “my gosh, no wonder women take epidurals during their pregnancy or when they’re going to give birth”. So, I almost felt like, you know what, it was painful and I am going to say it was painful, and that’s OK. It doesn’t mean that it wasn’t a smooth birth, because it was. It was very smooth (Alexia).

Mothers were often further along than in the labor process believed to be, with the exception of mothers who had unplanned events occur during their births. Those mothers reported being discouraged by receiving information about their labor progress. This often led them to decide to request intervention for the remainder of their labor:

I think I got discouraged when after 6 or 7 hours I was still at a 6 [centimeters]. I think that shook me a little. That’s why I said I think I lost my concentration because of the pain and feeling as though there was no progress, not even a centimeter that was kind of discouraging (LT).

In other circumstances mothers felt as if they had to battle the staff in addition to being improperly evaluated. Roxy shared:

I was having the stronger contractions and the resident on staff did not like how during the contractions they would lose the signal of his heart beat so they wanted to place a little wire on the top of his head in order to track it better. I went ahead and asked if we had time if we could maybe move the device to a different position. Thankfully our nurse, which was such a blessing totally went to bat for us and said, ‘you know look doctor I actually get a better read here. It’s perfect even during the contraction’. But the resident wasn’t satisfied so she called the doctor again and came back to tell us that no we had to do it that there was no other option. So at this point it’s about 3:10 in the morning and we agreed to it

and she came back in with the instruments to do so. As she started checking me she was making these strange faces only to say well you're fully dilated and effaced so we're not gonna do anything and I'm just gonna call the physician to come. Within five or 10 minutes I adjusted my positioning because I was not comfortable the way I was sitting. The doctor came in and she was like, 'okay push'. I was like, 'What! What's going on, what do you mean?' She's like, 'yeah don't waste a contraction, go ahead and push'. Probably within five minutes of pushing he was out and it was all over.

Of the 10 mothers who felt that they had to battle the staff or environment, six were Caucasian and four were Hispanic. Although more Caucasian mothers reported more difficulty, their challenges more often related to the environment. Lauren offered:

Because I was at the hospital I had neighbors and I could hear [that] she was not enjoying her birthing experience at all and being really vocal and loud about it. Screaming the entire time that I was pushing so I feel like on a subconscious level that was kind of speaking to me too. So next time I'll be doing a home birth.

As was demonstrated with Roxy's depiction about the resident requesting a fetal monitoring device, all of the circumstances where Hispanic mothers battled staff were around issues of serious interventions. Penelope described the ways that doctors responded to her after her emergency cesarean section:

The one thing that one of the doctors mentioned was "I'm so glad that you knew to advocate for yourself to not go on Pitocin." Because we had talked about it in our training, the different effects of Pitocin. She said "I'm glad you advocated and asked questions about that because, given the fact that your placenta abrupted, it could've completely detached and created a bigger issue than what had happened. I'm glad that you knew to follow your intuition."

Prior to the abruption, this mother discussed being encouraged to consider taking medication to induce labor on three different occasions.

In summary, misevaluation of one's labor progress was common. The absence of pain made it difficult for mothers to recognize contractions often also amazing medical staff. Mothers who experienced unplanned events felt discouraged by the misevaluation

of their progress. Caucasian mothers more frequently battled elements within the birthing environment while the Hispanic mothers battled the staff on interventions. The next theme explores interventions in greater detail.

Induction Overwhelm

So far, differences across themes for mothers who experienced unexpected events or medical intervention during labor and delivery have revealed a different experience for those mothers. Despite the successful natural births that the majority of women experienced with the use of hypnosis for birthing, four women required the use of medical interventions for their births. Three of the four mothers who eventually required induction with medications as opposed to natural means were not able to concentrate and use the techniques because of the intense frequency of contractions. They described their contractions as being on top of each other or having an unnatural rhythm that did not allow for the mothers to recuperate between contractions. Bianca shared:

I think we started to get something going, but I think that Cytotec, just like the Pitocin, is some pretty strong stuff. So I think that kind of over rode everything because I feel like, initially, we were doing really well. My husband was walking me through things. We were doing some of the visualizations through the contractions because they were spaced like 10 minutes apart. Things were going well and I was like, "I can totally do this." Once they were just on top of each other, I lost it.

Mothers who experienced unplanned events or medical intervention during labor and delivery believed they were successful to a point with the hypnosis for birthing techniques. Once postpartum they tended to view hypnosis as a tool but experienced less appreciation for the birth. These mothers, however, believed that because they used hypnosis for birthing that they were able to make choices about intervention without fear.

Successful breastfeeding was considered to be more responsible for the bond to their child and their sense of confidence with adjusting to motherhood.

They experienced some guilt for “things not going as planned” and wondered if they could have done things differently. For example, LT, a Hispanic mother shared:

I think it's taking me a while. I think I'm sort of mourning doing the birth that I wanted but, looking back, I still feel strong and I still feel like I did everything in my power to have this baby. I do have some questions sometimes like, “what would've happened if I hadn't been induced, if I had just waited? Or the baby didn't want to come. Or what would've happened if I had been a little bit stronger and not have an epidural. Did that have an effect on my contractions and not dilating”? Honestly, I think that Hypnobirthing gave me everything that I wanted for that day. I wasn't expecting Hypnobirthing to give me my vaginal birth, if I would put it into words. I wanted to have the atmosphere and that's what I got.

LT's comment about her expectation about “the atmosphere” demonstrates some of the ways that mothers isolated hypnosis as a tool for birthing. Her comments about using hypnosis as a tool to combat guilt emphasized the ways that hypnosis was a postpartum tool.

Penelope offers another example of the way that mothers viewed hypnosis as a multi-faceted tool. She experienced a placental abruption that required a “true” emergency cesarean. This first-time Hispanic mother explained:

The next thing I remember was a big bucket of iodine being poured on me. Then the surgeon came in and started performing a c-section on me and getting the baby out very quickly. At that point, I was still awake and aware of what was going on. My husband wasn't there and I was trying to use my let go cue to go into hypnosis and relax. I feel like I remained pretty calm, given the situation but I was really emotional that my husband wasn't there of all things. That was my main concern that he was going to miss it. I don't think I really understood the danger that either of us were in myself and my son. At that point, I remember feeling the start of the c-section and I remember a lot of screaming between the anesthesiologist and the surgeon because I was aware that I was being operated on and I remember them exchanging words, “what are you doing?” I was relaxing

and I'm not sure if I passed out at that point or if I was put under anesthesia (Penelope).

In order to cope with her traumatic birth and ongoing concerns over potential brain injuries that her child may have experienced due to aspirating because of the placental abruption, Penelope also relied on hypnosis while postpartum:

Even though there was all this stuff that happened, I really felt comforted with hypnosis and allowing myself to relax with it because I don't know that I really took a lot of time to turn off my mind before that. Just talking to my hypnosis coach, that she addressed all of those things very well and I felt a lot better after just working with her for a few weeks... Then when our son came home and we were transitioning into the day-to-day and caring for our son and managing everything else, we definitely used guided imagery. Even before bed or the day before a big doctor's appointment, we would say "let's picture going to neurology and sharing the good news and that they'll tell us that everything is going well and is going to go well."

Like other mothers who experienced unexpected events postpartum, all of the mothers viewed hypnosis during birth as a tool that was also useful at birth and postpartum. The next theme explains the way that some mothers viewed the use of hypnosis for birthing holistically.

Holistic Benefits

Given that mothers who experienced unplanned events during birth viewed hypnosis as a tool only for both birthing and postpartum stress, nine total mothers of two or more children, and first-time mothers drew a clearer overall relationship between hypnosis during birth and their postpartum success. Through the process of being interviewed Bridget realized:

I felt so connected to my baby when he was inside and that was because of Hypnobirthing; because of the approach. I felt very connected to him during labor and delivery and that connection has just grown infinitely now that he's here. That was because of Hypnobirthing that fostered that connection and that love and that idea that you're already doing the best for your baby in utero and

that just stays so strong once they're here. I feel like not that I'm starting from scratch with my baby but that we already had this connection that happened long before he was born. It's really fascinating to think about... And, no, postpartum-wise I've seen people and they've been "you look great, you sound great, I can't believe it." I 100% think that that's because of how my labor and delivery went. It wasn't traumatic, it was amazing, can't wait to do it again. Postpartum-wise, everything is going just like it went for pregnancy, labor, and delivery and I attribute that to the Hypnobirthing method.

As was discussed within the topic of differences between direct and indirect attributions to bonding, self-efficacy, and breastfeeding, the three mothers of more than two children believed hypnosis facilitated their experience and made comments similar to first-time mother Maxine:

Again it's hard for me to say but I think, I believe that Hypnobabies helped me have a positive birthing experience and I just think that my positive birthing experience really impacted me as far as my own self image and my confidence as a mother. So I think through that I guess you could say it indirectly helped me in my postpartum period and just starting to be a mother.

Other attributes made about hypnosis for birthing by mothers of two or more children included believing that they had a successful postpartum and that hypnosis during birth was one major reason for their positive postpartum experience. Five out of the six mothers of two or more children felt similarly. Mothers of two or more children reported feeling more calm postpartum, appreciated their birth more than their previous births, and appreciated more parts of the birth than did first-time mothers. It seemed that prior experience allowed them to have a baseline for how different birth could be. They were able to concretely articulate differences. Jessica, a mother of three children all below the age of five shared:

I knew that I was going to have exactly the kind of birth that I and my baby needed. I think having that peace of mind going into the birth can really affect the postpartum. So I was just relaxed and comfortable. I don't know if I can chalk it up to Hypnobabies or how the baby was born. I had a very slight internal tear, which I had never felt, and my midwife never stitched. By the next day, I actually

felt perfectly normal. It wasn't sore, I wasn't anything. It was really great. I don't know if that was simply because with Hypnobabies you're spending time seeing yourself open easily and that your placenta will detach well and that you feel all this stuff is inclusive to the whole birth experience. It definitely contributed to me feeling great the next day. Or just because I got more sleep? I don't know but I have felt really good this time, throughout this postpartum, more energy.

Jessica's comments demonstrate the multi-faceted appreciation that mothers of more than two children experienced because of hypnosis for birthing methods being a part of their experience.

Whereas Violet, a first time mother, focused solely on the physical benefits of her birth:

You just don't know what's going to happen afterwards. I was able to get up after I had her. I was able to get up right away, take a shower, walking around. The nurses were like, "How's your pain? How's your pain?" and I'm like, "I'm actually feeling fine." I was still sore, my muscles, obviously felt sore, but I wasn't in a tremendous amount of pain.

Appreciation for the birthing experience that involved hypnosis included fascination with the biology of birthing and the body's ability to recover quickly. Similar to Violet, other mothers reported healing faster or physically feeling good because of the way birth went. First time mothers focused on aspects such as recovery and being able to walk quickly after giving birth. Not surprisingly, mothers who did not experience unplanned birth events failed to report feeling physically good after birthing.

Five mothers of two or more children reported feeling calmer and better able to cope postpartum, despite expecting that they would have a more difficult time mothering multiple children.

Yeah, I think it was easier... with our second we were just falling into a groove with each other and with our second it didn't feel... it felt like we had already always been there. I feel like what was different about this time than with my first is like when things got overwhelming, I didn't do the things I did with my first,

which was like to get all flustered and overwhelmed and just like frazzled. I just took one step at a time cause that's all you can do is one thing at a time. I just took more time to do things and wasn't so hard on myself (Sophia).

First-time mothers may have described themselves as feeling more calm postpartum, but they did not consistently attribute their tranquility to hypnosis. This was one way that first-time mothers often lacked the experience to recognize how successful their postpartum experience might have been. First-time mother Lucy stated:

Again, the whole birth process, like kind of went exactly as I, for the most part, as I had planned and thought it would. Now, I've heard enough stories that I know that usually doesn't happen, but in any case, it happened for me. So, really, I feel like I'm kind of surprised that I have not been as anxious about things with the baby as I thought I would. I have a bunch of friends who are all torn up in knots about like, what is the right thing to do? And I just kind of don't. I just feel like I know intrinsically what's right for my kid.

With the exception of two mothers, all participants reported using some of the hypnosis for birthing techniques postpartum. Five used techniques to calm themselves down, and five to cope with pain or stress postpartum. Three reported using hypnosis to help themselves get to sleep or to cope with sleep deprivation and exhaustion. Other mothers used the hypnosis of birthing techniques to help them reframe their experiences, to envision the life they desired for their family and children, to cope with the demands of raising multiple children, to cope with past traumatic experiences, and to cope with feelings of guilt. For example, Veronica commented:

I think some of things that might also play into it were the different affirmations, even though those were specific to the context of the birthing, kind of still having those positive or optimistic messages can kind of help as well postpartum. I can't say that I practice all that as much, as the months have gone by, those things have maybe dropped off, but there's some sort of relationship too. I think some of the things learned in hypnobirthing can definitely carry through into our daily lives.

In addition to mothers feeling calmed by hypnosis during the postpartum period, mothers who experienced unmedicated childbirth also credited the use of hypnosis for birthing with their baby having a calm temperament. First-time mother Violet stated, “I fell like my daughter is fairly low key.” Lauren, a mother of more than two children shared:

My third baby has been the most laid back, relaxed, calm happy little baby that I’ve had by a long shot. He has, you know he sleeps great he has gas still and stuff and a little colic but he handles it much better than the other two did. So it’s just really, I’ve seen a huge difference with him. I really think that it’s because of that relaxation practice that I always did.

Although the differences are subtle between mothers who experienced unplanned events and mothers who were able to birth naturally, they expressed a holistic view of the benefits of hypnosis for birthing. Similar to previous themes, some mothers made direct and indirect attributions between hypnosis for birthing and their overall postpartum success. More variation for continued uses of hypnosis while postpartum was enumerated. Mothers described their child as being calm, but most importantly mothers of two or more children felt more calm postpartum. The following theme emphasizes some of the psychological benefits that mothers experienced.

Minimal Postpartum Depression

Overall, mothers reported few incidences of postpartum anxiety or depression. This was true for mothers who had this psychological history. Of the 15 participants in the study, 10 reported some history of depression, anxiety, trauma or previous bouts with postpartum depression or anxiety. For three mothers with long histories of depression, which included suicidal ideation or a history of trauma, they decided to encapsulate their placentas. Two believed that the combination of placenta encapsulation and the use of

hypnosis for birthing was what kept their depression and anxiety at bay while postpartum.

Kara shared:

I think that it has given me solutions that, if something doesn't feel quite right, to trust my instinct and to feel good asking questions. It opened my eyes that there's lots of resources out there and to have faith in myself and my partner and my baby. It definitely helps me be less anxious, I guess I would say. There's another thing from the back of the book that I read, I'm like, "that would be nice if it happened, it it's possible." [reading aloud] "And in general, Hypnobirthing the Mongan Method will help you in other areas of life." And it did. Maybe I'm drinking the Kool-Aid, I don't know, but its fine for right now. It's working.

Mothers with a psychological history of depression and/or anxiety shared that it was especially important to them to experience a calm and peaceful birth. For some, the primary motivation for considering hypnosis for birthing was to prevent being triggered by past traumas or to help them eliminate the use of psychotropic medications while pregnant. Sophia was a survivor of childhood sexual abuse and experienced a traumatic birth with her first child. She shared:

I mean I didn't know very much about it [hypnosis for birthing] when I first started. I felt like if I can remember to breathe and to not, cause I do a thing, I dissociate from my body when things are hard. So I didn't want to do that in labor, cause I did that with my first and I didn't want to do that with my second. I wanted to stay in my body even when it scared me and felt like Blissborn can help me not dissociate (Sophia).

Jennifer explained:

I saw a psychologist for that [anxiety] because I didn't want to be on it [anti-anxiety medication] when I was pregnant. So I wanted to get my ducks in a row and I saw an acupuncturist to help with anxiety and this psychologist tried to give me some tools to cope with anxiety to get off of it [medication] during my pregnancy, and it was really hard. My husband and I both knew, because I was off of it for my first pregnancy as well, we really knew that the hardest part of my pregnancy is my emotion and my anxiety, and how that affects our marriage... I was just on such a natural high with my second birth..Whereas with my first birth, I was just annoyed with everyone.

In addition, mothers who faced unplanned events during birth described themselves as having to mourn the birth they wanted and at times combate feelings of guilt, but they stated that they did not feel like they were experiencing postpartum depression. They qualified this by stating that they still loved their child and felt connected. In addition to being induced at 42 weeks, getting an epidural and ultimately a c-section, LT also overcame a history of depression and anxiety.

So I have all those questions. I did everything –we did everything- that was in our power to have this baby and we took the best decisions to get out of the hospital being three, not just two. It’s a bummer that you weren’t able to have what you were preparing for but it’s just a process. You heal.

Two other mothers who experienced unplanned events during their labor stressed that “things were better than before”, despite some on-going challenges. They both experienced anxiety and depression while pregnant due to a myriad of personal issues. They included factors such as postpartum depression from a previous birth to marital conflicts with one’s spouse. Jasmine explained:

I would get emotional not just about his birth, because it wasn’t something that I felt that was affecting me, but more of, what am I doing with myself? Why can’t I figure out how to balance this? That kind of stuff came out. That stuff was giving me anxiety, not so much his birth but, how do I figure this out with two kids? How do I figure out being a career woman? How do I figure out being a mom and wife and all of that at the same time? And, it was hard. It’s hard. I definitely don’t have any regrets or any negative feelings around his birth, just because I was really happy. I’m very happy that it was a successful VBAC, and that’s what I wanted. And, it didn’t happen in full how I wanted it, but I wanted the VBAC. So now it’s more like trying to figure out balancing two kids versus one. Balance and figure out my current life.

Again, Jasmine stressed that the birth itself was not what was causing her stress. It seemed that there were factors outside of the birth that were present before her pregnancy and remained despite a successful birth.

Therefore, hypnosis for birthing was reported as being helpful to avoid postpartum depression and anxiety for mothers with previous psychological histories. This was true for mothers who were able to birth naturally and those who experienced unplanned events during birth. The last finding explains what mothers experienced by sharing their birth stories.

Birth Stories

Lastly, all of the participants mentioned difficulty finding a space to tell their birth story. Many had little experience with birth before delivering their own child. Lucy explained,

I had such a positive experience with the whole birth process and everything that I feel like talking about it. It's not really the norm, I guess, so it's kind of, it's not like everyone wants to talk about it, you know. So, it's kind of nice to just share my experience with someone who cares. I feel like most people are just kind of like, I don't know what you're doing. You're just weird.

It was the researcher's experience that conversations related to the birth story required a type of reverence. The following field note was written after the final interview:

I feel like there's one thing I'm trying to figure out how to write, it's not a finding, but the birth stories have demanded that I not interrupt, totally let that portion of the interview take over and take as long as is needed, although my question is about the postpartum part. I was actually talking about it in the car today, "I don't know how to write about the way a birth story demands a certain level of reverence; and it's not really a finding of my research."

It soon became clear that the act of telling one's birth story was a finding that impacted all of the participants, including the researcher. In addition to the significance of hearing the birth stories, allowing mothers to reconnect with their entire path to motherhood, from pregnancy to postpartum, allowed them to draw connections between pregnancy,

labor and delivery, and then postpartum. The telling of one's birth story included some cultural differences.

The six Hispanic mothers and multicultural mother seemed to immerse themselves into the birth narrative. For some, this included viewing birth as a spiritual experience. They inserted themselves into the story, into the narrative of "all women". First time mothers seemed to have a stronger appreciation or connection to this "birth narrative" than necessarily valuing or appreciating the biological aspects of their birth. For example, Maxine shared:

I see birth as a spiritual experience, as well as a physical experience and I feel that you know if it is at all possible, if you're healthy and there's no absolute need for an intervention in order to save a life then, getting to have that experience as completely as possible, as nature intended, to me is a very special experience. That connects me with ancestors before me and just you know all females. Yeah, so that to me is all just a rite of passage and I wanted to have that experience and I wanted to be as fully present; for my child and myself as well.

Maxine stressed joining with all other females. Her birth was about more than her own experience. The phrase "rite of passage" or "wanting to experience what childbirth felt like" was something said by many of mothers of color. The verbiage used by Caucasian mothers seemed more individually focused and specific to desiring a natural pregnancy. They told their stories slightly differently, even if their story included a theme of empowerment. For example, Bridget shared:

We had been trying to get pregnant for a year and a half, spending a lot of time thinking about how I wanted the pregnancy to go and the childbirth. I'm older. I was 33 when we got pregnant so I've had a lot of time to think about how I would want things to go and the kind of care that I would want. So, when we got pregnant, I knew that I wanted an unmedicated birth and that I wanted a midwife.

The emphasis and importance of natural childbirth is clear in Bridget's story. In addition, it seems that birth was her experience instead of being about other individuals besides her partner and child.

Interestingly, five Caucasian mothers discussed concerns over bragging or competing when sharing their birth stories with other women. Kara explained:

It's probably more my thought. I also notice that a lot [of mothers] like to kind of have a pissing contest when it comes to birth. I don't know why, they like to talk about how many hours, how painful it was, how much they tore.

Caucasian women also discussed not wanting to hurt another's feelings by telling their positive birth story. Jessica, a mother of three, shared:

We all need a place to share our birth stories. For women who were really happy with their births, it really is an accomplishment and they don't want the people around them to feel poorly. So it feels like the only people you can tell your positive stories to are people who haven't had kids yet or other people who have had a similar experience. Otherwise, you have to be really careful lest you end up hurting your friends.

These words are extremely thoughtful; however, the solution to her sense of needing to protect her friends was to hold back her story instead of sharing it and joining with the women she did not wish to harm. This was a stark contrast to one multiracial mother who explained the way that sharing her birth story healed her own trauma and trauma within her community. Sophia revealed:

I had planned a home birth with my first and I was in labor for a very long time. I would say maybe about 52 hours. When I transferred to the hospital I was 9 centimeters dilated. The events that happened at the hospital were so traumatizing because I was treated so badly because I was seeing a lay midwife and I didn't have a track record of prenatal care. So they kind of treated me like if I was a drug addict. They watched me, they like threatened they were going to take my sons blood to see if he had drugs in his system. They drug tested me, which I know that is protocol if somebody comes in without a paper trail of prenatal care. So I mean I wasn't mad about that, but they were like, "there's no drugs in your system, but there may be in his". They were just like doing these really passive aggressive things and I had just given birth and it was very traumatizing. I didn't get to be in

that first hour you know with just me and my husband and my baby. I was like being berated by the hospital. It was very hard.

In response, Sophia did the following:

Umm I did a lot of things that... I went to therapy. I started studying... I just did weird things. I started studying placenta medicine and became a placenta encapsulator and I also started a birth story sharing circle in my community. All of those things really did help me to heal birth trauma. Just too like be in a community where I can talk about it and also like hold space for other women and group therapy around it, it was very hard. Definitely hard, but it helped to have those things.

Although Sophia's traumatic story was unique to her, telling her story is what she believed healed her. She was similar to many of the mothers in the current study that said, "thank you so much for letting me share my story", or "I love telling my birth story". If Sophia's experience is similar to the other 14 mothers, it is possible that sharing their story may have been beneficial to them as well.

Summary of Findings

Overall, 12 themes were found to explain the experience of mothers who used hypnosis to birth. Mothers of two or more children appreciated birth more, reported an increased sense of calm and closeness within their nuclear and extended family, provided direct and indirect attributions for the benefits of hypnosis for birthing in the areas of bonding with their newborn, self-efficacy, breastfeeding and overall connections to postpartum success. First-time mothers appreciated the physical aspect of recovery after delivery. They emphasized the birth narrative despite cultural differences in sharing their stories. Although they attributed much success to the use of hypnosis for birthing, they tended to make more indirect attributions to the bond with their child, self-efficacy, breastfeeding, and overall postpartum success.

Mothers who experienced unplanned events during birth experienced feelings of guilt and viewed hypnosis as an isolated tool for birth and a tool to reduce guilt and stress postpartum. Mothers who birthed naturally used hypnosis postpartum in more ways. Hispanic mothers expressed greater difficulty with balancing their roles as a career woman and mother. They had different expectations around the participation of their partner during birth preparation and postpartum. Breastfeeding was most important to this group and reflected communal values. Hypnosis for birthing was described as being helpful for mothers who had a psychological history with depression, anxiety, or trauma. Some potential explanations for these findings are discussed in the following chapter.

Chapter 4

Discussion

Application of the Resilience Model

Previously mentioned resilience-based theories and prior studies may help to provide context for the findings in the current study. All of the mothers in the study reported feeling bonded to their child and nearly all expressed a sense of self-efficacy in their role as mothers. There was variation based on whether or not mothers directly or indirectly attributed that bond to the process of birthing with hypnosis. Women who believed that their bond and self-efficacy was a result of hypnosis seemed to be reporting successful maternal adaptation. This supports the findings of Gibaud-Wallston (1977), who studied hypnosis for birthing and found confidence that adjusting to the demands of motherhood was one of the primary tasks that mothers must master in order to feel successful postpartum.

For mothers who believed there was a direct relationship, it may have also been because of witnessing or working through prior negative experiences with birthing. According to the literature, prior experience is another primary factor leading to maternal adaptation (Rutter, 1987; Schachman, 2001). Although these findings relate to positive experiences or experience that fostered increased contact with children or mothering tasks, it is possible that a negative experience may suggest to mothers what they hope to avoid. For example, all of the mothers with more than two children were largely motivated to use hypnosis for birthing because of previous experience with a difficult birth. A mother's negative experience with previous childbirth may have facilitated

greater recognition of the positive experience offered through the use of hypnosis for birthing.

Bandura (1986) explained that perceptions of one's self-efficacy affects the degree to which an individual will persist on difficult tasks. Prior negative experiences with birth may have motivated mothers to channel their efforts toward mastery. With mothers who felt that hypnosis for birthing facilitated their self-efficacy, it is possible that both prior experience and the hypnosis techniques were an internal resource that influenced their maternal adaptation, similar to Splonskowski and Twiss (1995) findings on internal resources.

Prior experience may also explain attributing an indirect relationship between hypnosis for birthing, bonding, and self-efficacy for mothers with two or more children. For example, the tasks of mothering may be easier to cope with when these tasks are no longer novel. Moreover, mothers of two or more children who reported an indirect relationship between hypnosis, bonding, and self-efficacy previously encountered struggles with tasks that were unique to the postpartum period. Breastfeeding was one of those primary tasks.

Initially, many mothers only considered hypnosis for birthing at the time of birth. They may have divorced the possibility of a connection between their birth experience and the postpartum period, particularly with tasks that were exclusive to the postpartum period. They quickly realized, however, that the use of hypnosis for birthing helped them to be calmer mothers, to cope with stressors related to raising multiple children, and to evaluate their new baby as being calm. This is consistent with findings that suggest that mothers of children with calm temperaments experience better maternal adjustment

(Carey, 1972; Priel et al., 1993). Much to the surprise of mothers of two or more children and contrary to prior studies, hypnosis for birthing may be related to their ability to remain calm postpartum.

Next, first-time mothers were more likely to attribute an indirect relationship between the impact of hypnosis and the postpartum period. Lack of experience may have not afforded them the ability to isolate the factors that impacted their postpartum success in the way that mothers of two or more children were able to do. Many of these first-time mothers seemed to be encouraged by the fact that they were able to realize the natural and comfortable birth that they were planning for while pregnant. Their ability to execute their birthing plan may have given them the opportunity to feel a sense of competence in their first major task as a mother: the task of birthing their child. This sense of accomplishment may have transferred to their postpartum success. Said differently, because hypnosis for birthing facilitated a positive birthing experience, mothers may then have been able to attribute success to themselves and their decision-making ability as a new mother.

This is consistent with the literature that states that experiencing a sense of control and ability to manage pain during birth leads to a mother evaluating her birth as successful, which lead to confidence, pride and self-satisfaction (Simpson, 2001). If she views her birth as being successful, then she is more likely to evaluate herself positively as a mother. Resilience-focused research labels this phenomenon the steeling effect (Werner, 1993). The ability to execute the birth they envisioned, defying the doubts of others that a natural comfortable birth was possible, and enduring the physical pain or sensations they experienced may have transferred to a sense of competence as a mother.

In addition, hypnosis for birthing also offered them the advantage of increased awareness during the birth. Having the ability to make informed decisions also may have fostered a sense of competence (Schachman, 2001).

Also, support was offered by their spouse and/or other family or friends. Having these witnesses for the events of birthing potentially allowed the mother to create an even stronger sense of competence. Because others observed her birth occurring in the way that she planned, this may have increased the mother's belief of her own capabilities. Many mothers discussed the importance of having support people respond in amazement, particularly during periods of more intense physical sensations. Therefore, support people during the birth may have increased awareness of birthing success for some of the mothers. Mothers who had to battle the staff or the environment also felt competent as mothers. A commitment to hypnosis for birthing methods may explain their ability to successfully persist despite facing obstacles. Moreover, their ability to adapt may be a mark of their mastery over the hypnosis for birthing method.

In addition, all of the mothers in this study were able to breastfeed successfully. This is consistent with findings from Lothian (2005) who stated that high levels of endorphins help women cope with painful contractions and contribute to their becoming more instinctive and entering into an almost dream-like state. Endorphins help make the transition easier for the baby, facilitating relaxation and calm. The breastfeeding-related findings in the present study partially support Lothian's (2005) findings that natural birth sets the stage for problem-free breastfeeding. In contrast, a complicated, intervention-intensive labor and birth may set the stage for problems. Many of the birthing practices that are considered almost routine, such as induction, epidurals, and separation of the

mother and her baby, interfere with the necessary interaction of hormones during labor and birth and ultimately with breastfeeding (Lothian, 2005). According to the findings of Friedman et al. (2008), the national average for episiotomy rates is 25%. Their study found current episiotomy rates to be 15.7% for Caucasian women, and 14.9% for Hispanic women. Bansal et al., (1996) found that the national trend for episiotomy rates was as high as 86.8% in 1976 and as low as 10.4% in 1994. None of the participants in the current study on hypnosis for birthing received an episiotomy during their delivery. Therefore, the experience of birthing naturally with hypnosis may have been a collaborative factor that led to successful breastfeeding for women, even in the cases of medicated births.

The Centers for Disease Control (2008) report suggested that postpartum depression might be associated with the discontinuation of breastfeeding. This underscores the importance of breastfeeding for mothers who experienced unplanned birth events. It may be even more significant that these mothers were able to have a positive breastfeeding relationship. The mothers of two or more children who struggled to breastfeed after previous medicated births emphasized the potential link between breastfeeding challenges and medicated births. Given the literature on the neuroscience of birthing, hypnosis for birthing may have played a role for those who experienced unplanned birth events, specifically medicated births in that they reported ease with breastfeeding. Hassert and Robinson (2011) stated that researchers are hesitant to claim causal links between breastfeeding and symptoms of postpartum depression, because it is unclear if the symptoms of postpartum depression affect a mother's decision to breastfeed or vice versa. The mothers in the current study had all decided to breastfeed prior to the

birth and were successfully breastfeeding their infant, regardless of whether they experienced any postpartum depression symptoms, which was reported by only two mothers.

It is important to note that a birth without interventions is not the only acceptable outcome for programs that teach hypnosis for birthing. Mothers who experienced unplanned events during birth experienced fewer, yet similar, postpartum benefit as those who birthed naturally. Although these mothers expressed sadness and guilt over the birth, they reportedly felt connected to their child, were able to breastfeed effectively, established a support system, and were able to keep using hypnosis as a tool postpartum. For mothers who experienced unplanned events the emotional support system more frequently consisted of online support or like-minded friends, which is contrary to Schachman's (2001) finding that friends are less salient to maternal adaptation.

In regard to postpartum depression, one mother experienced occasional depression and another struggled to adjust to the demands of having multiple children. Both mothers adamantly stated that their difficulties existed prior to becoming pregnant. Both experienced issues related to support from extended family and one experienced marital difficulties while pregnant. The morbidity and mortality weekly reports (MMWR) from the Centers for Disease Control (2008) found that mothers experiencing partner-related stress are more likely to develop postpartum depression. The literature indicates that women who experience struggles with depression (Le, Munoz, Soto, Delucchi & Ippen, 2004), challenges within their romantic relationship (Gross, Wells, Radigan-Garcia & Dietz, 2002) or conflict with their partner (Hassert & Robinson Kurpius, 2011)

are more likely to experience postpartum depression. Hassert et al., (2015) found that postpartum depression was also negatively related to maternal efficacy.

It is notable that the mothers of two or more children who believed they had experienced postpartum depression in previous pregnancies did not experience a second incidence of depression or anxiety. Hypnosis for birthing may have played a role in the resilience demonstrated by the various mothers who had a history of depression and anxiety, experienced depression while postpartum, and for the mother who experienced difficulties with her partner. These findings support the study of Patterson and Jensen (2003) that found that the effects of hypnosis operated despite blocking endorphins that are responsible for the placebo effect. The mothers described something tangible and real that assisted them in developing their maternal self-efficacy and sense of competence. The following findings may be better explained by the cultural feminist model.

Application of the Cultural Feminist Model

Some of the findings in the current study emphasized ethno-racial differences. Comments that suggested that Hispanic women were not feeling supported by their family because of choosing to have a natural birth and their parenting choices were unexpected given the literature that describes Hispanic families as collective (Sue & Sue, 2012; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). In addition, Hispanic mothers seemed to struggle more than their Caucasian counterparts with their various roles as women. It is possible that these women struggled with “being both”, whatever “both” was in their particular case. For some, it may have been being “Chicana” and being a natural focused mom; for others it may have been being a “Mexican-American”

mother who is also a working professional. In order to explain this finding, the concept of *marianismo* may be helpful.

Marianismo is defined in terms of Catholic and colonial tradition that confines women to images of the Virgin Mary and Madonna as being spiritually superior to men and capable of surviving all suffering at the hands of men (Comas-Diaz, 1988). Some of the study participants may have been unconsciously holding on to the ideal of *marianismo* despite their religious affiliation. They seemed to be experiencing conflict over how to execute a traditional image of a mother and care-taker and that of an educated professional. In their mind, perhaps some of the skills necessary to complete their degrees may not be conducive to their version of the ideal mother. A cultural feminist view point may help to explain some of these internal struggles.

These experiences of the women in the current study are consistent with feminist theories of women of color (Enns, 1997). Comas-Diaz (1994) stated that deconstructing polarized images and finding ways to understand oneself and the world in more meaningful ways is highly challenging. Flores-Ortiz (1995) noted that Chicanas often feel pressure to simultaneously fulfill multiple roles such as mother, sister, spouse, and comrade (*compañera*) in the socio-political struggle. Despite experiencing a successful birth, several Hispanic mothers seemed to be struggling with their multiple roles. By honoring the role of motherhood, some felt a void when that meant leaving their role as professionals.

The findings beg the question of why the Hispanic mothers encountered these difficulties given similar levels of education, income, similar prenatal preparation, and birthing experiences to the Caucasian mothers. Greene (1990) stated that women of color

are especially vulnerable to being blamed for family difficulties or pressures that are often products of institutionalized racism. Because of the effects of racism and sexism, women of color are often confined to polarized or narrow representation of a woman's role (Enns, 1997).

The current study supports this theory in that the Hispanic women did not have expectations that their spouses would practice the birth for hypnosis methods. Many of the Hispanic women also discussed desiring to feel and endure the pain of childbirth because it was a rite of passage. As one Hispanic mother discussed her feelings about her medicated birth, she stated, "I don't feel like less of a woman for not having a natural birth". Although she was negating experiencing a sense of diminished self-esteem or competency, her statement gives credence to the idea that some Hispanic mothers may believe that part of their womanhood is based on bearing the challenges of birth. Those who felt that hypnosis was indirectly or not at all related to their bond with their newborn often cited their experience of enduring natural birth as the overriding factor. Hassert and Robinson Kurpius (2011) claimed that giving birth and raising children is viewed as an important cultural role for Latinas. Being able to do it all and endure all may also be why some of the Hispanic mothers considered breastfeeding to be more responsible for their bond and overall maternal confidence. Being able to nourish one's child physically may emphasize the marianismo ideal because breastfeeding one's child is something that men and others cannot do.

On a macro level, Comas-Diaz (1988) stated that the process of colonization lead colonized people to evaluate that which was associated with the dominant culture as good and that which was associated with the minority culture as bad. She also noted that

finding ways to understand oneself and the world in more meaningful ways is highly challenging. The women in the current study seemed to be engaged in the challenge of redefining not only their views of motherhood but also their views of being a woman. The mothers or mothers-in-law of many Hispanic participants in the study criticized the participants for their birth and parenting choices. Perhaps these mothers or mothers-in-law felt that the way they raised their own children was “the right way”, but when it came time for them to step into the role of grandmother, something “different” or non-dominant in this generation potentially threatened their roles as women and grandmothers. Education is often believed to be the “great equalizer” for persons of color. The fact that the process of becoming educated about birthing led them to consider a birthing method that was inconsistent with their previous generation may have led to intergenerational conflicts (Santiago-Rivera et al., 2002). People of color often experience a sense of isolation between their professional or educational space and also feel misunderstood by family and friends for being more educated (Santiago-Rivera et al., 2002).

Individuals of oppressed groups often rely on their social capital and collective ways for more than cultural reasons. Relying on others ensures survival and allows others to move ahead. This is consistent with literature on the resilience-based model that suggests that encouragement and support from the mothers of those with newborns in the areas of support for decision making and physical support decreases stress, therefore, increasing maternal adaptation (Dakota & Taylor, 1990; Mercer, 1985). Lack of support can lead to new mothers feeling powerless, confused, and frustrated, and creates conflict (Kenner & Lott, 1990) and less self-efficacy (Reece & Harkless, 1988). A recent study by

Hassert and Robinson Kurpius (2011) found that social support from a new Latina mother's spouse and her own mother to be tied to the new mother's mental health and functioning.

At the level of the community, Enns (1997) highlighted that acting on behalf of oneself and others, through advocacy and political action, and methods to improve the conditions of people of color marks a fully integrated identity for women of color. Some of the Hispanic women in the current study seemed to embody Enns' stance given their use of breast milk sharing and their emphasis on the birth narrative. The hypnosis for birthing methods could have aided these mothers in that integration and their maternal efficacy. Various mothers stated that being able to birth with the method taught them that their conceptions of birth and the body were "right". In addition, other sources of support such as Facebook groups and like-minded friends were listed as valuable sources of support that helped natural focused mothers to experience validation for their birth related and parenting choices.

Nearly all participants faced skepticism, amazement, misevaluation, and resistance from birthing professionals. Unfortunately, these reactions are similar to microaggressions (Sue & Sue, 2012) that can threaten a woman's "knowing". Mothers experienced mixed reactions from birthing professionals, friends, and family over the notion that their birth could potentially be painless. The sense of "rightness" that many of the participants felt about birthing naturally supports basic tenets of feminism. Enns (1997) asserted that control over one's reproductive health was the key to liberation for women in the early 1900's. Women in the current study may be perceived as asserting

their ability to birth in a way that they felt was best for their bodies. Early feminists also had met great resistance for these radicalized actions and thoughts.

Historically, for Caucasian women, control over motherhood was believed to be an important way of ensuring the pursuits of their career and self-development dreams. By controlling the number of children they had and when they birthed it was believed that this would lead to women's liberation. This emphasis is for Caucasian women given that women of color were not afforded the same privileges at the time (Enns, 1997). The use of a cultural feminist model does not suggest that Caucasian women are immune to the process of negotiating their role as mothers, women, and/or professionals; however, they reported fewer struggles with this transition. Arguments within feminist psychotherapies may attribute this to Caucasian woman having a wider array of versions to choose from when defining what it means to be a woman and mother. The fact that the Caucasian mothers felt they could more easily choose to distance themselves from their family and easily reintegrate back to work may be indicators of their privilege. Overall, shifting from the dominant cultural views regarding a woman's body and the control she exerts over her own body continues to be defined as radical politically for all the women in the current study.

Another important finding relates to the struggles that the partners of Hispanic mothers encountered. The men similarly faced greater tension with family members and did not experience the increased family closeness as was reported for Caucasian families. Machismo is the corollary concept of marianismo. Machismo is more frequently associated with Hispanic men; however, according to Panitz, McConchie, Sauber, and Fonseca (1992) expectations related to machismo extend to men from other Latin

American countries. According to Santiago et al., (2002) machismo was historically associated with virility, sexual aggression, and arrogance, however, Latino researchers have begun to include the original Latino meaning of machismo. The definition of machismo now includes the notion of being an honorable and respectable man.

Arciniega, Anderson, Tovar-Gamero, and Tracey (2008) found that machismo involves both positive and negative aspects of masculine characteristics with positive traits being referred to as caballerismo. This is important because Hispanic men are also subject to the effects of institutionalized racism that dictate a narrow version of a man's role and father's role.

According to some of the Hispanic mothers, the partner struggled with finding their role within the birth preparation, adjusting to the criticisms from extended family members to the couple's parenting choices, and adjusting to the shift in roles to a father and husband. Similar to the Hispanic mothers, the partners may have been subject to polarized views of their roles as men, husbands, and fathers. The positive traits associated with caballerismo that are relevant to this study included being more emotionally connected (Arciniega et al., 2008), nurturing, protective of family honor, and spirituality (Casas et al., 1994; Mirande, 1997).

In summary, the partners of Hispanic mothers were less likely to practice hypnosis for birthing. The partners of Caucasian women may have vicariously benefitted from learning tools for relaxation and emotional management. The majority of the mothers in the current study reported using some form of hypnosis postpartum and that it helped them adapt as new mothers. By not practicing, the spouses of Hispanic mothers may not have benefitted from the hypnosis for birthing methods leading to increased

difficulties. The fact that the partners of Caucasian mothers did not regularly experience similar stresses offers more evidence for the ethno-racial differences described in the cultural feminist model.

Limitations and Future Research

Despite the rich and explanatory findings of qualitative research, qualitative methods do not allow for statistical comparisons that could strengthen the findings of the current study. Future studies could compare self-efficacy, support people, breastfeeding duration, and symptoms of prenatal and postpartum depression or anxiety with mothers who have used hypnosis to birth. All of those factors seemed to be grouped together and prior studies have attempted to understand the relationship between these variables. Since current study utilized self-report as the only means of identifying postpartum anxiety and depression, follow-up questions that were more diagnostically focused may have offered important additional information about the struggles of certain mothers.

Mixed method or quantitative research studies may be helpful to draw directional conclusions between the stated variables. For example, a pre-post test design with mothers who are pregnant and following them into the postpartum period may allow for a better explanation of how self-efficacy, support, breastfeeding and postpartum depression interact with one another. Although there may be challenges with longitudinal methods, the participants in the study were eager to offer their experiences. Given the niche community of those that birth using hypnosis; participants may be more eager to participate in longer term studies.

Another limitation relates to the sample size and characteristics. The sample consisted of 15 women who were ethno-racially diverse and may have reflected a self-

selection bias in the study. Mothers seemed to be similar in education and income. The sample was too small to specifically examine ethno-racial differences, although some differences did emerge from the interviews. Furthermore, the sole interviewer and analyzer who was a current hypnotherapist was used, and that may have biased the interviews. The utilization of more interviewers, coders or analyzers may have led to greater validity of results.

The findings related to culture would benefit from further research. The Hispanic mothers in the study encountered unique challenges despite being well educated, similarly prepared, and being from relatively similar economic backgrounds as their Caucasian counterparts. The diversity literature within Counseling Psychology may be refined by studies of the within group differences that the Hispanic mother and their partners revealed. Furthermore, because the current study focused on the experiences of the mothers, future research might explore the development of paternal adaptation and the way that hypnosis for birthing may offer fathers emotion-focused coping strategies.

Implications for Counseling Psychology

Overall, feminist psychotherapy implores psychologists and counselors to assist clients in finding the power within themselves as they cope with power that is exerted upon them (Enns, 1997). Mothers who are natural-focused and use hypnosis for birthing represent a niche that may benefit from additional support. Mental health professionals may find themselves in a unique position when working with female clients who are pregnant or considering starting or adding to their family. For those who have a history of taking psychotropic medication for depression, anxiety, or trauma, hypnosis may be

beneficial in helping them adjust to pregnancy, labor and delivery, and postpartum demands with little or no intervention.

Despite being accepted by APA and AMA, hypnosis is still considered to be a fringe or complementary alternative medicine within psychology. Mental health professionals may want to reconsider their stance and be more receptive to some of the benefits that participants with a mental health history experienced in the current study. Mental health professionals can assist in supporting the idea that preparation during a mother's pregnancy and birth has the possibility of impacting one's postpartum competence and maternal adaptation.

Counselors and psychologists should also be aware of some of the nuances faced by mothers, particularly Hispanic mothers, who relied on hypnosis for birthing methods. Although many Hispanic mothers had an abundance of support from friends and family, they experienced a sense of isolation when their birthing and parenting methods were criticized by those close to them. In addition, it was more important to them than to Caucasian mothers to work through their differences with their family members. The individual focus within psychology errs on the side of putting the needs of one over the needs of the collective. Interventions that focus on individual success and contentment may be met with confusion, resistance, or only provide temporarily results for Hispanic mothers.

In addition, all of the participants in the study reported continued use of hypnosis for rest, relaxation, to endure pain, and to cope with stress. There are many psychological disorders and symptoms that would benefit from the reduction of pain and increased relaxation to cope with stress. Although hypnosis for birthing may not be appropriate for

all clients, some of the general principles may apply to other clients and other presenting problems. Mental health professionals may find it easier to suggest coping strategies that support the resources gained from the hypnosis for birthing methods. While mental health professionals may be reticent to endorse hypnosis for clients, ethical guidelines implore counselors and psychologist to remain current with theories and techniques that may be beneficial to clients (ACA, 2014; APA, 2010). Based on the literature and the findings in the current study, hypnosis for birthing and hypnosis in general may be used effectively when working with clients, particularly during the birthing process.

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APPENDIX A

RECRUITMENT AND INFORMED CONSENT

Recruitment Letter

Greetings,

I am a graduate student in Counseling Psychology at Arizona State University who is interested in exploring postpartum factors related to hypnobirthing. I am inviting women who gave birth within the last year and who used a hypnobirthing method to participate in this study. Women will complete a confidential demographic questionnaire over the phone or on-line, which will take approximately 10 minutes, and be involved in a 1 to 1.5 hour interview over the phone, Skype, or in person.

If you are a new mother, 18 years or older, live in the US, are able to complete the interview in English, 1 month to 1 year postpartum, and used a hypnobirthing program such as *Blissborn*, *Birth Hypnosis Method*, *Hypnobabies*, and *Hypnobirthing the Mongan Method*, you may be eligible to participate in the study. Participants will have approximately a 1 in 5 chance of winning a \$75 gift card for participation.

Your participation is voluntary and all of your responses will be kept confidential. Participating in this research study may contribute to a greater understanding of factors related to hypnobirthing. There are no known risks from taking part in this study. The study has been approved by the ASU Office of Research Integrity and Assurance.

Please email Enjolie Lafaurie at Enjolie.Lafaurie@asu.edu or call (480) 907-9813 if you are interested in this study.

Thank you,

Enjolie Lafaurie, M.S.Ed
Doctoral Candidate, ASU

Sharon Robinson Kurpius, PhD
Professor, Counseling Psychology, ASU

Informed Consent

Dear New Mother,

I am a graduate student under the direction of Dr. Sharon Robinson Kurpius, a professor in the Counseling Psychology Program at Arizona State University in Tempe, Arizona. I am conducting a study to explore postpartum factors related to hypnobirthing.

I am inviting your participation in this study. You will be asked to fill out basic demographic questions about you and your support system, and birthing preparation materials you used. Filling-out the questions online or over the phone will take approximately 10 to 15 minutes. Your responses to the questions will be confidential. You will then be asked to complete a 1 to 1.5 hour interview and able to choose if you would like to meet in person, over Skype, or over the phone. The interview will include questions about your preparation for birth, labor and delivery, and any adjustments while postpartum.

Your participation is totally voluntary. You must be at least 18 years old, able to conduct the interview in English, live in the United States, be one month to one year postpartum and have used Blissborn, Birth Hypnosis Method, Hypnobabies, or Hypnobirthing the Mongan Method to participate. You may choose not to participate or to withdraw from the study at any time. You can skip any questions you do not wish to answer. If you choose not to participate or to withdraw from the study, there will be no penalty. At no time during the study will anyone be informed about whether or not you chose to participate. I would like to audio record this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be recorded; you also can change your mind after the interview starts, just let me know.

The results of the study may be published but your name will not be used. Your name will be collected in order to link your demographic and interview responses; however, your name will be omitted from all data. You will be asked to provide a first name alias as an added level of security.

Your participation in this research study may contribute to a greater understanding of factors related to hypnobirthing. There are no known risks from taking part in this study, but in any research, there is some possibility that you may be subject to risks that have not yet been identified. If your participation in this study produces any emotional discomfort, please review the provided postpartum support resources. Those who are interviewed will have approximately a 1 in 5 chance of winning a \$75 gift card for participating.

If you have any questions concerning the study, you can contact me at <Enjolie.Lafaurie@asu.edu> or Dr. Robinson Kurpius at <sharon.kurpius@asu.edu>.

If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at 480-965-6788.

You will be asked to provide verbal recorded consent if you wish to be part of this study. If you would like to think it over, I can mail or e-mail you a copy of this document. If you decide you would like to participate in this project, you may schedule an interview now or call/e-mail me to schedule an interview later. Please let me know if you wish to be part of this study and how you would like to proceed.

Sincerely,

Enjolie Lafaurie, M.S.Ed
Doctoral Candidate, ASU

Sharon Robinson Kurpius, PhD
Professor, Counseling Psychology, ASU

EXEMPTION GRANTED

Sharon Kurpius

CLS - Counseling and Counseling Psychology

480/965-6104

sharon.kurpius@asu.edu

Dear Sharon Kurpius:

On 9/8/2015 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	The Role of Hypnobirthing on Maternal Experiences
Investigator:	Sharon Kurpius
IRB ID:	STUDY00003113
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Hypnobirthing Demographic Sheet , Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • IC Hypnobirthing, Category: Consent Form; • Hypnobirthing Flyer , Category: Recruitment Materials; • Hypnobirthing and Postpartum Protocol, Category: IRB Protocol; • Hypnobirthing Interview Questions, Category: Measures (Survey questions/Interview questions

	/interview guides/focus group questions); • Hypnobirthing Recruitment Letter, Category: Recruitment Materials; • Hypnobirthing Postpartum Resources, Category: Resource list;
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The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 9/8/2015.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Enjolie Lafaurie

Enjolie Lafaurie

APPENDIX B
INTERVIEW PROTOCOL

Interview Protocol

Name: _____ Phone: _____
Alias: _____ Email: _____
Address: _____

Prenatal Demographic Information

1. What is your current age? _____
2. What is your race/ethnicity? _____
3. What is your marital status?
 Married Live-in Partner Single Separated
 Divorced Widowed
4. How many children do you have? _____
What are their ages? _____
5. How do you identify your sexual orientation?
 Heterosexual Homosexual Bisexual
6. Which hypnobirthing method did you use?
 Hypnobabies Blissborn Hypnobirthing Mongan Method
 Birth Hypnosis Method
7. What format did you use to learn hypnobirthing?
 At home, self study (books and cds) private or group classes
8. Aside from the hypnosis for birth method you used, what other methods have you used to prepare for birth? Include all classes, books, blogs, Facebook groups, or listservs.

9. What practices do you use to relax?
 Yoga Meditation Reading Tai Chi Exercise
Prayer Massage Other: _____
10. What was your **prenatal** employment status?
 Full-time Part-time Student Self- employed Stay at home mom
 Not employed

11. What is your **postpartum** employment status?
 Full-time Part-time Student Self-employed Stay at home mom Not employed

12. What is your family yearly income level?
 Below \$19,999 \$20,000-\$29,999 \$30,000-\$39,999
 \$40,000-\$49,999 \$50,000-\$59,999 \$60,000-\$69,999
 \$70,000-\$79,999 \$80,000-\$89,999 \$90,000-\$99,999
 \$100,000+

13. What is your highest completed education level?
 Less than 12th grade High school diploma or GED
 Some college or technical school Associate degree
 Bachelor's degree Graduate degree

14. Have you ever been clinically diagnosed with **depression**?
 Yes No

15. Were you **depressed** during your pregnancy?
 Yes No

16. Have you ever sought professional help for **depression**?
 Yes No

17. Have you ever been clinically diagnosed with **anxiety**?
 Yes No

18. Were you **anxious** during your pregnancy?
 Yes No

19. Have you ever sought professional help for **anxiety**?
 Yes No

Postpartum Demographic Information

20. What is the gender of your baby?
 Male Female

21. What was your baby's weight at birth? _____

22. What was your baby's length at birth? _____
23. How many hours were you in labor? _____
24. Who was present during your labor and delivery?
 ___ Mother ___ Mother-in-law ___ Baby's Father/Partner ___ Doula
 ___ Sister ___ Sister-in-law ___ Friend Other: _____
25. What type of birth did you have?
 ___ Vaginal ___ Cesarean
26. Did you elect to have an epidural?
 ___ Yes ___ No
27. In what type of birth setting did you deliver your baby?
 ___ Hospital ___ Birthing Center ___ Home Birth ___ Other: _____
28. What methods (if any) have you used to help you adjust to motherhood? Please include all classes, books, blogs, Facebook groups, or listservs.

29. Did **you** have any complications or require medical intervention during the delivery?
 ___ No ___ If yes, please list your complications:

30. Did **your baby** have any complications or require medical intervention during the delivery or at birth?
 ___ No ___ If yes, please list your complications:

31. After your baby was born, who helped you with your new baby?
 ___ Mother ___ Mother-in-law ___ Baby's father/partner ___ Father-in-law
 ___ Sister ___ Sister-in-law ___ Child's great grandparent ___
 Nanny/baby-sitter ___ Friend Other: _____

Interview Questions

The following interview questions will guide the semi-structured interview. The order of questions will be based upon participant responses and may not be asked in order; however, all content will be covered within an interview.

Instructions: In order to protect the confidentiality of others, please refrain from using names when describing events or situations. You may want to refer to individuals in general terms such as ‘a friend’. Do you have any questions before we begin?

9. Please tell me about your pregnancy (if not mentioned) and the ways you prepared for birthing
 - a. Probe for other preparation methods other than hypnobirthing (Lamaze, reading birth related books, internet research, yoga etc..)
10. Tell me about your most recent labor and birth
 - a. Probe as needed: were they able to effectively use the hypnobirthing methods? Why/why not? How was hypnobirthing received by the birthing professionals? Family?
 - b. Probe on areas of control, awareness and support when appropriate
11. What is it like being a new mom?
 - a. Probe on postpartum adjustments such as, emotions, physical adjustments, and body image when appropriate.
12. Who or what helped you adjust to being a mom?
13. How has having a baby impacted your family or other relationships?
 - a. Probe on support from partner, extended family, friends, and or changes in the couple’s romantic life.

14. Can you tell me about your relationship to your baby?
 - a. Probe on confidence during prenatal and postpartum periods, ability to read the baby's cues.
15. Can you explain how using hypnobirthing has impacted you postpartum (if at all, if not, why)?
 - a. (If has not been mentioned) What led you to choose hypnobirthing as a part of your birth preparation?
 - b. Now that you are postpartum, how satisfied are you with hypnobirthing and why?
16. Is there anything else that you think I should know?

Participants will be asked whether the researcher is allowed to contact them after the interview to clarify portions of their interview or for brief follow up questions.

Postpartum Resources

If you're having thoughts of harming yourself or your baby, it is vital to get support immediately. Call 911 or go to the nearest emergency room.

TOLL-FREE / NATIONWIDE / COUNSELING ASSISTANCE

Immediate Emergency: 911

National Suicide Prevention Lifeline: 1-800-273-8255

Suicide Prevention Hotline: 1-800-SUICIDE

National Postpartum Depression Hotline: 1-800-PPD-MOMS

<http://www.1800ppdmoms.org/>

Postpartum Support International

<http://www.postpartum.net/>

1.800.944.4773 (not a 24-hour hotline)

- This site provides information, connects you to local resources and offers a weekly chat line with other mothers

Jenny's Light

<http://jennyslight.org>

- Information and success stories

MGH Center for Women's Health

<http://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/>

- This resource provides information about postpartum disorder

APPENDIX C

HISTORICAL PERSPECTIVE ON HYPNOSIS

Historical Perspective of Hypnosis

It wasn't until the mid 19th Century that the term hypnosis came into being (Gezundhajt, 2007.) However, the roots of modern hypnosis are ancient. Throughout history, societies demonstrated evidence of using trance like states for healing both physiological and psychological ailments and to control pain. The history of hypnosis has been met with great opposition. Despite this, the use of trance states as a way to heal has continued worldwide, evolving into what we refer to as hypnosis today.

James Braid is credited with coining the term "hypnosis" in 1843, after the Greek word *hypnos* which means sleep. In Greek mythology, the god of sleep was known as Hypnos (Chips, 2004; Gezundhajt, 2007). Before Braid, however, Egyptians used dream temples, Socrates and his contemporaries referred to the power to heal with words, and sacred texts such as the Bible and the Talmud referenced a number of situations that could be identified as hypnotic experiences. In earlier, more ritualistic times, indigenous cultures had druids, gururs, shamans, and priests who performed a variety of rituals that induced trance-like states that would now be construed as a form of hypnosis (Gezundhajt, 2007).

The Medieval times may be responsible for some of the links to the occult that are connected to hypnosis. The Middle Ages were perceived as an era of irrationality, superstition, and tyranny; therefore, trance states were no longer considered healing or spiritually enlightening (Gezundhajt, 2007). Christianity rejected the idea of trance states for religious practices, and trances began to be considered satanic or demonic states driven by occult forces. Evil spirits were expelled through exorcism performed by priests and ministers.

In 1551, Girolamo Cardano, an Italian mathematician, wrote about his experience of a peculiar trance or ecstatic state that allowed him to gain relief from the pain of gout (Gezundhajt, 2007). In 1529, the Swiss physician Paracelsus believed that the stars could influence humans through a magnetic force called magnetism (Gezundhajt, 2007). Paracelsus believed that this magnetic fluid came from heavenly origins and was healing. Introducing the idea of animal magnetism, he was one of the first individuals to attend to levels of suggestibility. Heinrich Cornelius Agrippa von Nettesheim, a German magician, occult writer, astrologer, and alchemist, published a book on the occult. The techniques he used to captivate his audiences and convey his message were similar to the ‘pre-talk’ used by modern stage hypnotists and client-focused work by hypnotherapists (Gezundhajt, 2007).

William Maxwell, a Scottish physician, also believed in magnetism and its healing properties. He hypothesized that imagination and suggestion influenced a person’s ability to heal (Chips, 2004). Father Johann Joseph Gassner practiced exorcisms in the 1770s, and his procedure for healing was very similar to what would be used to perform regressions in hypnosis. Some would call him the real precursor to modern hypnotherapy (Gezundhajt, 2007). Father Maximilian Hell, a Jesuit priest, court astronomer, and head of the observatory in Vienna, helped numerous individuals with their pain through the use of naturally magnetized minerals called lodestones, essentially employing the idea of magnetism. Swiss-German physician, Franz Anton Mesmer learned of his work, and Hell eventually became Mesmer’s mentor (Gezundhajt, 2007).

When referencing the history of hypnosis, Mesmer is the most recognized contributor. Before the label of hypnosis became popular, this phenomenon was referred

to as mesmerism, named after Franz Anton Mesmer (Gezundhajt, 2007). Mesmer's work began to link hypnosis with the medical tradition. He worked during the Enlightenment period that placed reason and science above religion and authority. Before mesmerism, the hypnotic relationship was often linked with religious concepts such as magic and even witchcraft (Chertok, 1981). While his approach was very different from modern day hypnosis, he is considered by many to be the first psychotherapist (Gezundhajt, 2007).

Just like his mentor, Mesmer believed in and credited magnetism as a cure. He felt that other objects such as stones, wood, paper, metals, glass, vegetal substances, and living creatures could be channels of energy (Gezundhajt, 2007). When he observed Grassner's work in Switzerland in 1777, he discarded the idea of curing through magnets, because Grassner cured without any external or physical manipulation. Mesmer did not believe that disease was a form of demonic possession and dismissed supernatural explanations. He believed that magnetism and early hypnosis were grounded in nature and the idea of a universal fluid, present in everything (Gezundhajt, 2007), much like the idea of Qi in Asian medicine (Chen, 2001).

Mesmer enjoyed great prestige, had a successful practice, and because of his wife lived as an aristocrat. He was eventually labeled a charlatan by the medical faculty in Vienna, after temporarily curing a woman of her blindness. He then went to Paris, France to continue his work (Gezundhajt, 2007). Animal magnetism suited the ideas and the scientific work that was being performed in France in 1778, and Mesmer's charisma and reputation gained him access to the aristocracy. Quickly building another practice, he tried to convince the medical community to use magnetism as an alternative to electric shock therapy. His clients visited him for healing in his baquet, a large drum filled with

bottles of water that he had previously magnetized. Patients would sit holding hands, creating a circuit that would buttress the magnetic fluid. These sessions, said to be quite theatrical and ritualistic involved many techniques seen in shamanic traditions (Gezundhajt, 2007).

Eventually Mesmer experienced difficulties similar to the ones he had experienced in Vienna. Because his treatment style employed physical contact, instead of verbal instruction, both he and his students began to gain the attention of the King of France, the Academy of Science, and the Academy of Medicine (Gezundhajt, 2007). Mesmer induced convulsion-like states in his patients, and his female clients seemed to experience convulsions that were compared to orgasmic reactions. The academies completed reports that ultimately concluded that a magnetic fluid did not exist, was not curative, and was merely a form of imagination and imitation. In response, Mesmer retired and left Paris. His work, however, had a lasting influence, and his followers and supporters continued versions of his work that began to take on the form of early hypnosis (Gezundhajt, 2007).

Thus, hypnosis entered the verbal lexicon in 1843; however, evidence of related practices can be traced back to the ancient Greeks and Egyptians. The Medieval Ages also ushered in a connection between hypnosis and the occult. The concept of magnetism, a magnetic force, preceded mesmerism. Franz Anton Mesmer changed associations between hypnosis and religious occult practices. He blazed the trail for others to view hypnosis as a medical and psychological treatment.

Post Mesmer. Mesmer's successors furthered the field of hypnosis. His immediate and most noted followers included Armand-Marie-Jacques de Chastenet and

Marquid de Puysegur. In 1784, Puysegur accidentally discovered a phenomenon called ‘magnetic sleep’ or ‘magnetic somnambulism’, today known as hypnotic amnesia (Chips, 2004; Gezunhajt, 2007). Neither violent convulsions nor touch was necessary to induce such a state. Puysegur was able to have his client reach the sleep-like state through words, relaxation, and suggestion. Puysegur emphasized rapport between the therapist and patient in opposition to Mesmer’s authoritarian style. It is speculated that Puysegur’s style laid the groundwork for Charcot and Freud, who shared Puysegur’s ideas about transference and countertransference (Gezunhajt, 2007).

According to Chertok (1981), Puysegur’s sessions involved listening to the client, helping them re-experience painful emotions, and holding regular and frequent sessions of a standard duration. The magnetist had to be neutral, and patient and the client guided the session. While the client was in a somnambulist state, the magnetist could suggest different fantasy situations, similar to today’s guided meditation. While in a sleep-like state, participants would suggest a diagnosis and predict their treatment, recovery, and future difficulties (Gezunhajt, 2007).

Puysegur, whose approach was more psychological and client focused than Mesmer’s, was not concerned with approval from the scientific community (Gezunhajt, 2007). Although he valued the input of his clients, he preferred direct suggestion and felt that clients should be submissive in order to recover their “divine parts”. Although Puysegur was part of the aristocracy he primarily worked with peasants who had previously worked for his family. Followers of Puysegur’s, ultimately split into two camps. The first was interested in the therapeutic side of his work, focusing on the

patient, their knowledge and experience, and their relationship. The second group focused on establishing supernatural reasons for the healing technique (Gezundhajt, 2007).

Although magnetism was helpful to clients, it was forgotten during the French Revolution and did not resurface until the work of Joseph Phillippe Francois Deleuze (Gezundhajt, 2007). Deleuze was a highly respected scholar. He was the first to introduce what is now known as the method of suggestion in hypnosis and post-hypnotic suggestion. He realized that an attachment may occur between the magnetist and the client, similar to the idea of transference and countertransference, so he ensured that there was a witness present for every session. Similar to Puysegur, he emphasized the working relationship and felt that the magnetist should feel a sense of attachment to the client (Gezundhajt, 2007).

After Puysegur and his followers, some individuals began what is recognized as the imaginationist movement. The father of this movement was an Indo-Portuguese monk, Jose Custodio de Faria, who introduced oriental hypnosis to Paris (Gezundhajt, 2007). He did not believe in the idea of a magnetic fluid, and he felt that Mesmer's technique of the baquet was an illusion. He was surprised that people would look toward external means for a state that tends to occur naturally in humans. He felt that trance was due to the fascination of the client with the hypnotist and a function of persuasion. He used techniques of conditioning, suggestion and introduced the notion of lucid sleep (Gezundhajt, 2007). Today we refer to this phenomena as lucid dreaming. When this occurs individuals become aware that they are dreaming and while remaining asleep, can control some of the events or contents of their dreams (Bligrove & Hartnell, 2000) Hypnosis is not considered to be a state of sleep although it may appear that way to a

novice. According to Gezundhajt (2007), Faria was the precursor to stage hypnotists. Stage hypnosis was important to the movement, because at the time the medical academy had banned magnetism.

Dr. Pierre Foissac attempted to have the French Medical Academy open a new commission. The result was that it was decided that physicians were the only ones who could utilize magnetism, since it was agreed that it could be considered a therapeutic agent. Overall, mesmerism and somnambulism lost standing in France and other European countries, although in England the field of hypnosis continued to evolve (Gezundhajt, 2007). On the whole, Puysegur and his successors introduced concepts that foreshadowed the therapeutic relationship between client and hypnotist. During this period practitioners demonstrated concern for early versions of transference, countertransference, and attempted to move Mesmer's work away from physical touch. Magnetism became appropriate solely within a medical context. This pattern would continue and become solidified throughout England.

England and modern hypnosis. John Elliotson, professor of medicine and inventor of the stethoscope, was the first to promote hypnosis in the United Kingdom. He published a magazine titled *The Zoist*. Interested in mesmeric surgery and popularized hypnoanesthesia (Chips, 2004), he gave lectures on clairvoyance, phrenology, and odyllic force, otherwise known as a type of animal magnetism. His colleague, James Esdaile a fellow Zoist author and Scottish surgeon, was the pioneer of mesmeric analgesia. In lay terms, he performed surgeries in India before the invention of chloroform or anathesia (Gezundhajt, 2007). Although successful, he faced opposition from church and state.

James Braid, also a Scottish surgeon, ended the era of mesmerism and gave birth to modern hypnosis. He renamed and reinvented the procedure, coining the term hypnotism. In his view, hypnosis was a function of nervous sleep as opposed to natural sleep and a function of straining the eye muscles through fixation on an object (Gezundhajt, 2007). He rejected the idea of a magnetic fluid and felt that hypnosis should be limited to medical and dental professionals.

With the end of mesmerism, the golden age of hypnosis occurred, in France, between the years of 1880-1890. The Nancy School of Hypnotism was founded by two doctors, Auguste Ambroise Liebeault and neurologist Hippolyte Bernheim. Liebeault, who was introduced to hypnosis by his medical professors (Chips, 2004; Gezundhajt, 2007), believed that 95% of people were hypnotizable through means of verbal suggestion. He was eventually regarded as the father of suggestive-therapeutic hypnosis. Bernheim initially opposed Liebeault but eventually came to respect the power of suggestion. Believing that hypnosis was a form of sleep, Bernheim introduced the idea that the client was an automaton in the hands of the hypnotist. This new framework attracted a great deal of attention. Sigmund Freud and Jean-Martin Charcot were two noteworthy individuals who demonstrated interest in the Nancy School (Gezundhajt, 2007).

Jean-Martin Charcot, a neurologist at Salpêtrière Hospital in Paris, presented hypnosis to the French Academy of Sciences (Gezundhajt, 2007). In his view, hypnosis was an alternate state of consciousness, a pathological state linked to hysteria, and could not be considered as a cure. He carried out inappropriate experiments with a sample of only three women who were described as pathological. He used Braidian and Mesmerian

approaches that, by this time, were not regarded as credible techniques. Charcot even created a school of hypnosis at Salpetriere (Chips, 2004). Two of his pupils, Alfred Binet and Charles Fere, pointed out his errors in their book *Animal Magnetism*, and The Nancy School of Hypnosis opposed his view of hypnosis as a state of hysteria. The Nancy School's version of hypnosis, based upon suggestion, eventually won. Ironically, two of Charcot's other pupils, Josef Breuer and Freud, would later use hypnosis as a tool to treat hysteria (Gezundhajt, 2007).

According to Cambor's (2009) review of personal letters between Freud and a friend, Freud regarded Charcot as a mentor, which led him to study at the Nancy School with Leibeault and Bernheim in 1889. He translated Bernheim's text, *De la Suggestion*, into German (Gezundhajt, 2007). Although Freud practiced hypnosis in Vienna, he viewed it as nothing more than ordinary sleep. He later changed his mind. Freud used hypnosis to help neurotic individuals recall repressed memories. He would then take them through Breuer's cathartic methods. Freud felt that change occurred in hypnosis and that mental functions, absent during sleep, were retained while under hypnosis. He quickly became frustrated with his difficulty with inducing trance and his inability to hypnotize all patients. He came to believe that hypnosis only treated the symptoms of hysteria for a short time and did not cure the disease (Freud, 1910). When a female patient 'woke' from trance and threw her arms around his neck, Freud abandoned hypnosis for his own method of free association (Gezundhajt, 2007).

Once Freud denounced hypnosis, and after Charcot's death, interest in hypnosis became dormant until after World War I. In 1958, AMA endorsed hypnosis as a valid therapeutic tool (Chips, 2004). There was a movement to encourage all medical schools

to offer their students training in hypnosis. During the 1960s, it became a part of most medical school curriculum. Hypnosis for childbirth became a viable option during this time period (Chips, 2004).

Both Carl Jung and Edgar Cayce utilized hypnosis at similar times and ushered in a new era. Cayce, referred to as the sleeping prophet, would enter into self-induced hypnosis and be able to diagnosis individuals accurately. He gained the attention of physicians. His impact and work were more supernatural in nature and involved prophecy. He introduced terms such as karma, life readings, and the akashic records as a storehouse of detailed information on all individuals (Chips, 2004).

Jung, on the other hand, referred to these same ideas as the collective unconscious (Chips, 2004). In Jung's version, common forms of thought came to be known as archetypes. The collective unconscious was the storehouse for the content available in dreams and imagination. Jung believed that the collective unconscious originated from other people and involved intuition. He implied that intuition was an important variable within the therapeutic process. Overall, Jung's contribution to hypnosis had a more metaphysical nature (Chips, 2004).

Last, Milton H. Erickson helped the technique of hypnosis become more accepted by the medical and mental health community (Gunnison, 1990). He combined the pathological and psychological schools of thought and led others to believe that hypnosis was a naturally occurring state. He introduced the idea of waking hypnosis, such as daydreaming or meditating. Erickson was a master of language and storytelling. An adept listener, he was dubbed the master of rapport (Chips, 2004). For Erickson, rapport was the basis for transformation. Reframing was also another of Erickson's contributions

(Chips, 2004). Erickson viewed language as being therapeutic in and of itself and that language allowed for access to unconscious processes through hypnotic patterns (Gunnison, 1990). He and his followers introduced the idea of hypnocounseling, which did not necessitate trance and instead focused on planned interspersing of Ericksonian language patterns to facilitate a therapeutic relationship (Gunnison, 1990).

Physicians such as Elliotson, Esdaile and Braid advanced the practice of hypnoanesthesia and successfully performed countless surgeries with hypnosis as the sole anesthetic. Braid renamed mesmerism to hypnotism and reinvented hypnosis, putting to rest the idea of magnetism. Simultaneously, the golden age of hypnosis occurred in France. The first school for hypnosis was established and key figures in modern psychology such as, Freud, Charcot, and Binet had connections to the Nancy School of Hypnotism. Hypnosis began to be more closely linked with sleep and suggestion became the new method by which hypnosis was delivered. Jung and Cayce introduced metaphysical and transpersonal terms. They brought hypnosis back into the forefront of medicine and psychology after the AMA officially recognized hypnosis. Milton Erickson rounded out this historic period of hypnosis, solidifying a role for hypnosis in counseling. Acceptance of hypnosis allowed researchers to empirically study this phenomenon.